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MENTAL HEALTH WORKERS' ATTITUDES TOWARD INDIVIDUALS WITH A DIAGNOSIS OF BORDERLINE PERSONALITY DISORDER: A SYSTEMATIC LITERATURE REVIEW

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The attitudes of mental health workers toward individuals with mental health conditions can impact the quality of care they provide. Negative attitudes among mental health workers seem particularly common in response to people diagnosed with borderline personality disorder (BPD). The current review aimed to identify and review the literature regarding mental health workers' attitudes toward individuals diagnosed with BPD, specifically focusing on studies comparing workers' attitudes toward BPD with attitudes toward other mental health diagnoses. The findings suggest that mental health workers have more negative attitudes toward individuals labeled as having BPD than toward individuals with other diagnoses, such as depression. This is likely due to factors associated with the label itself, in addition to workers' perceptions of BPD symptoms and previous experiences of delivering treatment. The implications of these findings are considered, with a particular focus on how mental health services can effectively address negative attitudes toward BPD.

Keywords: borderline personality disorder, mental health stigma, attitudes, mental health workers

Public stigma toward people with mental health difficulties is widely documented throughout the literature (Corrigan, 2004; Sheehan, Nieweglowski, & Corrigan, 2016; Wood et al., 2015). Corrigan and Kosyluk (2014) propose that "stereotype," "prejudice," and "discrimination" are the three main components of stigma, and that these impact cognitive, emotional, and behavioral responses to others. Mental health stereotypes occur when overgeneralizations are applied to an individual based on the person's mental health; common examples include that people with mental health difficulties are unpredictable, hard to talk to, and unlikely to recover (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000). Prejudice arises when the public agrees with these stereotypes

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and experiences negative emotions in response to individuals with mental health conditions. Discrimination occurs when the public behaves unfairly toward these individuals (Corrigan & Kosyluk, 2014). This is in line with Link's (1987) theory of mental health stigma, which suggests that having a label of "mental illness" can activate beliefs about what it means to have a mental illness, and that these beliefs can lead to discriminatory behaviors. Thus, by signaling that an individual has a mental health condition, mental health labels can cue public stigma (Corrigan, 2007).

Diagnostic labels may also highlight that the individual is in some way "different," creating a separation between "us" and "them" (Link & Phelan, 2001). Applying attribution theory (Weiner, 1985), Corrigan, Markowitz, Watson, Rowan, and Kubiak (2003) propose that diagnostic labels contribute to the attributions people make about the controllability of a mental health condition. Conditions deemed to be more controllable and stable (unlikely to change over time) are viewed more negatively (Corrigan, 2000; Muschetto & Siegel, 2019), and research suggests that perceptions of controllability impact willingness to help (Ruybal & Siegel, 2017). Furthermore, Corrigan et al. (2003) found that people with conditions rated as more controllable were also thought to have more responsibility for their symptoms. In addition, assuming higher levels of responsibility led to decreases in pity and increases in fear, anger, and rejecting responses, such as withholding of help, avoidance, segregation, and coercion.

Such issues may be relevant to the attitudes of mental health workers toward people with mental health conditions. Mental health workers can hold negative attitudes toward people with mental health difficulties, for example, by perceiving them to be dangerous and unpredictable (Kingdon, Sharma, & Hart, 2004; Magliano, Fiorollo, De Roas, Malangone, & Maj, 2004). People who access mental health services have consequently reported feeling patronized and humiliated (Thornicroft, Rose, & Kassam, 2007). Research also suggests that negative attitudes among mental health professionals may contribute to lower quality care (Henderson, Evans-Lacko, & Thornicroft, 2013).

In regard to specific diagnoses, a number of studies indicate that mental health professionals can show stigmatizing attitudes toward individuals with schizophrenia. For example, Nordt, Rössler, and Lauber (2006) found that mental health professionals desired more social distance from patients with schizophrenia than from those with depression and people with no mental health diagnosis. Negative attitudes among mental health professionals have also been found in response to people with substance use disorders (Foster & Onyeukwu, 2003; Rao et al., 2009), whereas more positive attitudes have been found in response to individuals with depression and posttraumatic stress disorder (PTSD) (Maier, Moergeli, Kohler, Carraro, & Schnyder, 2015).

ATTITUDES TOWARD BORDERLINE PERSONALITY DISORDER

Negative beliefs among mental health workers seem particularly common in response to individuals who have been diagnosed with borderline personality

disorder (BPD) (Aviram, Brodsky, & Stanley, 2006). In a narrative literature review, Sansone and Sansone (2013) found that mental health professionals felt uncomfortable, anxious, frustrated, and manipulated in response to patients with BPD. They found some evidence to suggest that mental health professionals hold more negative attitudes toward individuals with BPD than toward those with other mental health conditions, but this was not the focus of the review.

These negative attitudes may be related to a lack of knowledge about BPD. Research indicates that mental health staff lack confidence in their skills and knowledge regarding BPD and report a need for further training (Cleary, Siegfried, & Walter, 2002; Deans & Meocevic, 2006). In addition, some mental health workers believe that BPD is "untreatable" (Bateman & Fonagy, 2009) even though there are a number of effective psychological interventions for BPD (Byrne & Egan, 2018; Meuldijk, McCarthy, Bourke, & Grenyer, 2017). This misperception can lead to stigmatizing behavior, such as denying treatment to patients with BPD (Bonnington & Rose, 2014; Sulzer, 2015). Conversely, negative emotional reactions from mental health workers may indicate difficulty or distress linked with the behaviors associated with BPD, such as self-harm, dropping out of treatment, and intense interpersonal reactions (Dickens, Lamont, & Gray, 2016). Alternatively, stigmatizing reactions and attitudes toward individuals with BPD may relate to the meaning attached to the diagnostic label.

The BPD label may elicit particularly negative attitudes because the term *personality disorder* can suggest that an individual is characteristically flawed. It does not provide information about a person's difficulties (e.g., problems regulating emotions or interpersonal struggles) or how these difficulties developed, and instead suggests that the problem is located within the individual's personality. Demonstrating this, Commons Treloar (2009) found that mental health practitioners commonly related difficulties they had with patients with BPD to personal characteristics such as being "manipulative" or "highly strung." Furthermore, it could be argued that other mental health labels fit more readily into the medical model of disease, which typically suggests that mental health conditions are extrinsic to the individual (Blackburn, 1988). A few studies explore attitudes toward other types of personality disorders; for example, negative attitudes have been found among clinicians in response to patients with antisocial personality disorder (Bowers et al., 2006; Schwartz, Smith, & Chopko, 2007).

THE CURRENT REVIEW

By conducting a systematic review of the relevant literature, we aimed to answer the following research questions:

1. What types of attitudes do mental health workers hold toward individuals with a diagnosis of BPD?
2. Do mental health workers hold different attitudes toward individuals with a diagnosis of BPD compared to patients with other mental health diagnoses?

METHOD

This systematic review was registered with the International Prospective Register of Systematic Reviews (PROSPERO) (ID Number: CRD42018111435). As far as was relevant for the current review, the methodology adhered to PRIMSA (Preferred Reporting Items for Systematic Reviews and Meta-analyses) guidelines (Moher, Liberati, Tetzlaff, & Altman, 2009).

DATA SOURCES AND SEARCH STRATEGY

The databases PubMed, PsycInfo, and Embase were searched using a predefined search strategy. Search terms were constructed using the Population, Intervention, Comparison, and Outcome (PICO) framework (Liberati et al., 2009). Population was defined as Mental Health Workers, the Intervention/Exposure was Borderline Personality Disorder, and the Outcome was Attitudes of Mental Health Workers. The Comparison element of the framework was not incorporated into the final search terms to ensure that the searches were as inclusive as possible.

The search strategy was developed by using synonyms for "Mental Health Workers," "Borderline Personality Disorder," and "Attitudes," linked together using the Boolean Operators "OR" and "AND" (see the Appendix for the PubMed search strategy). Following this strategy, we searched the databases electronically for articles published in English, with no date restrictions applied.

SELECTION CRITERIA

Studies meeting the following criteria were included: (1) studies quantitatively measuring the attitudes (including cognitive beliefs/appraisals and emotional and behavioral responses) of mental health workers or student/trainee mental health workers; and (2) studies comparing mental health workers' attitudes toward individuals diagnosed with BPD to their attitudes toward individuals diagnosed with, or showing symptoms of, a different mental health difficulty.

Excluded studies were those that (1) measured public attitudes toward BPD rather than the attitudes of mental health workers, (2) were not published in English, (3) had purely qualitative methodologies, (4) focused exclusively on the attitudes of non–mental health professionals, (5) did not compare attitudes toward BPD with attitudes toward other mental health conditions, and (6) measured clinical decision making regarding individuals with BPD (e.g., decision to prescribe medication) but not attitudes underlying these decisions.

STUDY SELECTION

The study selection process is shown in Figure 1. Following the main search, the principal researcher (K.M.) screened the titles and abstracts of the search results using Covidence software. To enhance the reliability of this process, an independent reviewer also screened 20% of the titles/abstracts. K.M. and the reviewer had a 98% agreement rate; they then met to discuss and reassess the articles that caused discrepancies, leading to a 100% agreement rate.

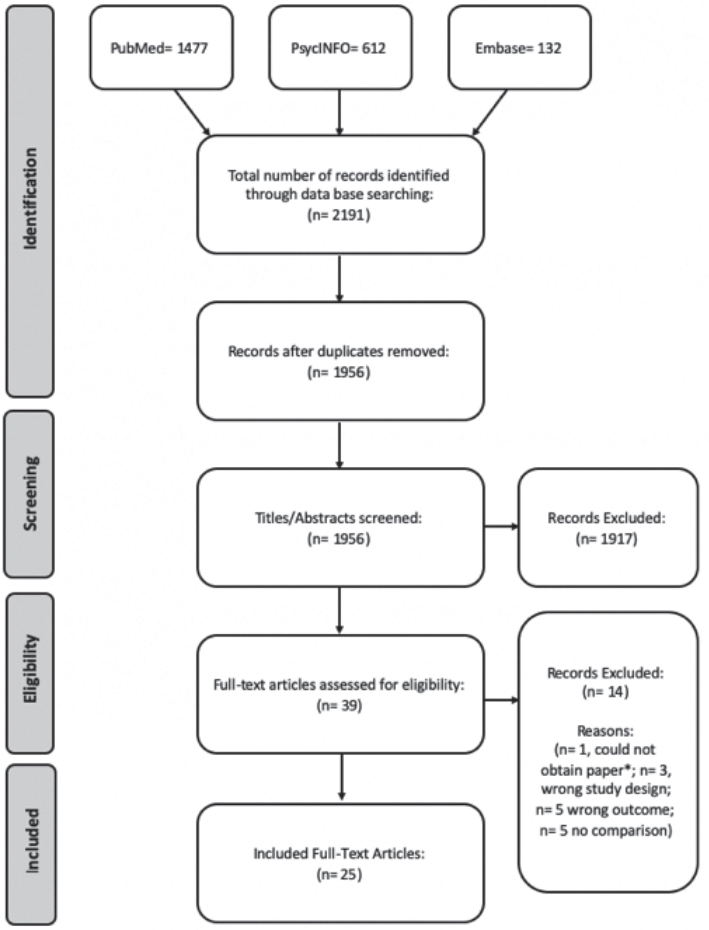

FIGURE 1. A flowchart of the study selection process in accordance with PRIMSA Guidelines (Moher et al., 2009).

DATA EXTRACTION AND QUALITY ASSESSMENT

Data including the author, location of the study, sample size, recruitment strategy, research design, study population, outcome measures, and main findings were extracted using a data extraction table. The table was created by the primary researcher, with guidance from similar research (e.g., van Boekel, Brouwers, Van Weeghel, & Garretsen, 2013). Studies were assessed for quality using the National Heart, Lung and Blood Institute's Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies (National Heart, Lung and Blood Institute, 2014), a well-established tool that was suitable for assessing the methodologies of the included studies. The tool assesses quality according to 14 criteria, resulting in a poor, fair, or good rating (see first column of Table 1 for ratings).

TABLE 1. Overview of the Included Studies

Study	Country	Sample Size & Population[a]	Design	Outcome Measure(s)	BPD Comparison	Main Findings
Bourke & Grenyer (2010)**	Australia	*N* = 20, Clinical psychologists recruited via snowball sampling	Interviews about experiences with real patients.	Core Conflictual Relationship Theme-Leipzig/Ulm category system (Luborsky, 1998).	MDD	Multilevel modeling revealed significantly more negative responses to patients with BPD (coefficient = −1.29, *SE* = 0.19, deviance = 202.54, $p < .05$) who were perceived as 'withdrawing,' ($p < .05$) and the MDD group as 'attending' ($p < .05$). No significant differences in how 'rejecting' groups were perceived to be. Therapists felt more confident supporting patients with MDD than with BPD ($p < .05$).
Bourke & Grenyer (2013)**	Australia	Same as above.	Interviews about experiences with real patients and measured relationship patterns via questionnaire.	Psychotherapy Relationship Questionnaire (PRQ) (Westen, 2000). Leximancer and content analysis used to analyze interviews (Smith & Humphreys, 2006).	MDD	Multilevel modeling showed a significant effect of diagnosis on PRQ Score ($p < .05$). High scores on hostility (coefficient = 0.75), avoidant/dismissive (coefficient = 0.5), narcissistic (coefficient = 1.07), and sexualized (coefficient = 0.33) were related to a diagnosis of BPD ($p < .05$); high scores on positive therapeutic alliance were related with MDD (coefficient = −0.34, $p < .05$).
Bourke & Grenyer (2017)**	Australia	Same as above.	Interviews about experiences with real patients.	Linguistic responses were analyzed using Linguistic Inquiry & Word Count (Pennebaker, Francis, & Booth, 2001).	MDD	Discriminant function analysis showed that participants' linguistic styles differed depending on diagnosis (Wilks's $\lambda = 0.16$, $\chi^2 = 120.53$, canonical correlation = 0.92, $p < .000$); the BPD group were associated with higher use of words portraying negative emotions (structure weight = −0.62) and lower use of words portraying positive emotions (structure weight = 0.53).
Brody & Farber (1996)**	USA	*N* = 336, CPs and CP graduate students	Clinical vignettes and questionnaires	Experience and Attitude Scale (EAS) and Vignettes Rating Scale (both designed by the authors).	Schizophrenia and depression	Least positive countertransference predicted for BPD (all $p < .001$), excluding 'challenge' and 'gratification'; Anxiety ($F = 166.43$) and hopelessness ($F = 166.43$) > for BPD than schizophrenia and depression (both $p < .001$). Anger ($F = 126.68$) and irritation ($F = 51.5$) > for BPD than schizophrenia and depression (both $p < .01$). Likelihood of running over in time in sessions ($F = 30.37$), thinking about patient in leisure time ($F = 68.16$), and providing advice ($F = 16.85$) < BPD than schizophrenia and depression (all $p < .001$). Letting patients know they're liked/valued > depression than BPD and schizophrenia ($F = 24.7$, $p < .001$).
Calvert (1997)**	USA	*N* = 186, Psychologists	Between-subjects design. Clinical vignette and questionnaires. Each group responded to a different diagnosis.	Working Alliance Inventory (WAI)- Bond subscale (Horvath & Greenberg, 1989); Countertransference Scale (created by the authors).	PTSD	Significantly more negative predictions of the working alliance were made for patients with BPD versus PTSD ($F = 10.48$, $p = .0014$). Participants who evaluated individuals with BPD predicted significantly more negative countertransference than those who evaluated patients with PTSD ($F = 13.73$, $p = .0003$).

(*continued*)

TABLE 1. ***continued***

Study	Country	Sample Size & Populationa	Design	Outcome Measure(s)	BPD Comparison	Main Findings
Chartonas, Kyratsous, Dracass, Lee, & Bhui (2017)**	UK	*N* = 73, Trainee psychiatrists	Clinical vignettes and questionnaires.	22 Semantic differentials (Lewis & Appleby, 1988); Attitude to Personality Disorder Questionnaire (APDQ) (modified) (Bowers & Allan, 2006).	Depression	Significantly more rejecting responses to individuals with BPD than to those with depression (χ^2 = 11.38, p = .01). Higher scores on APDQ subscale 'purpose' for people with depression than BPD (p = .03). Total APDQ scores indicated slightly (not significantly) more negative attitudes toward BPD than toward depression.
Colli, Tanzilli, Dimaggio, & Lingiardi (2014)***	Italy	*N* = 203, Psychotherapists (randomly selected).	Attitudes to real patients measured via questionnaire.	Therapist Response Questionnaire (Zittel Conklin & Westen, 2003).	Antisocial, Paranoid, Schizotypal, and Narcissistic Personality Disorders	BPD was significantly correlated with helpless/inadequate (r = .036), overwhelmed/disorganized (r = 0.51), and special/overinvolved (r = 0.22) countertransference (all p < .001); correlations were stronger and more significant for BPD than for other diagnoses.
Fishman (2012)**	USA	*N* = 138, Psychologists, psychiatrists, psychology trainees, psychiatry residents (snowball sampling).	Clinical vignettes and questionnaires.	Anticipated Treatment Questionnaire (ATQ) (developed by authors).	MDD	No significant differences in ATQ scores for vignettes depicting patients with a prior diagnosis of BPD, MDD, or no prior diagnosis.
Forsyth (2007)**	UK	*N* = 26, Mental health nurses and support workers.	Clinical vignettes and Likert scales.	Likert scales taken from the Empathy Scale (Burns & Nolen-Hoeksema 1992).	MDD	Nurses were significantly more likely to help people with MDD than with BPD (F = 5.2, p = .03); they expressed more anger and less empathy in response to BPD patients than wit MDD patients, but differences were not statistically significant.
Fraser & Gallop (1993)**	Canada	*N* = 17, Psychiatric nurses	Responses to real patients were observed. Questionnaire used to measure attitudes toward different diagnoses.	Heineken Confirmation/ Disconfirmation Rating Instrument (Heineken, 1982) and the Staff Response subscale of the Hospital Treatment Rating Scale (Colson et al., 1986).	Schizophrenia, affective disorder, and "other."	Main effect of diagnosis on nurses' behavioral responses (F = 5.239, p < .001); number of 'impervious' and 'indifferent' responses > BPD than affective disorder; no differences in responses toward BPD compared to schizophrenia. Expressed negative feelings > BPD (F = 12.561), positive feelings > schizophrenia and affective disorder (F = 22.769) (both p < .001).

Funtowicz (1996)*	USA	*N* = 134, Psychotherapists recruited via random sampling.	Each diagnosis rated in terms of level of impairment, social dysfunction, occupational dysfunction, and personal distress.	Participants rated the diagnoses as "mild," "moderate," or "severe" on each criterion.	Paranoid, antisocial, compulsive, dependent, and histrionic personality disorders.	Patients with BPD were rated as more distressed than those with other personality disorder diagnoses. BPD had the highest level of dysfunction across all items (no statistical comparisons were made).
Gallop, Lancee, & Garfinkel (1989)***	Canada	*N* = 113, Psychiatric nurses.	Clinical vignettes, questionnaire, and a written statement.	Staff-Patient Interaction Response Scale (Gallop & Lancee, 1986); written statements analyzed via semantic analysis.	Schizophrenia	A chi-square test revealed significantly more empathy was shown toward schizophrenic patients than toward patients with BPD ($p < .01$). Significantly less affective involvement and care shown toward BPD patients ($p < .001$). BPD patients significantly more likely to receive belittling and contradicting responses ($p =< .0001$) (chi square statistics not reported).
Hillman & Stricker (1998)*	USA	*N* = 64, Clinical psychology students.	Clinical vignettes and questions to measure their social and clinical biases toward these patients.	Questions developed by the authors.	MDD and MDD with BPD.	Significant main effect of diagnosis on participants' predictions about therapy-related issues ($F= 24.20$, $p < .01$). Patients with MDD and BPD were rated as less motivated for therapy ($F = 12.43$, $p < .01$), less likely to gain insight into their problems ($F = 4.98$, $p < .05$), less likely to develop rapport with the psychotherapist ($F = 18.50$, $p < .01$), and having a poorer prognosis than patients with just MDD.
Jury (2014)**	South Africa	*N* = 86, Psychiatrists[b]	Questionnaires were used to measure participants' attitudes toward various diagnostic labels.	Questionnaire developed by the authors using questions from an instrument made by Crisp, Gelder, Rix, Meltzer, & Rowlands (2000).	Schizophrenia and Depression	Bowker's test of symmetry showed that people with were BPD were rated as significantly more dangerous than those with depression (but not schizophrenia) and significantly more unpredictable, to blame for their condition, and less likely to improve in treatment than those with depression and schizophrenia (all $p < .0001$).
Karakashian (2005)**	USA	*N* = 248, Psychologists and doctoral students in psychology.	Between-subjects design. One group listened to an interview with a patient and viewed a clinical report; the other group were only shown the report.	WAI-Bond Subscale (Horvath & Greenberg, 1993), Global Evaluation of Patient Scale (made by authors), Therapist Expectancy Inventory (Bernstein, Lecomte, & Des Harnais, 1983).	MDD and MDD with borderline traits	Patients with MDD were rated more favorably than those with MDD and borderline traits ($F = 4.72$, $p < .05$), a better therapeutic relationship expected with MDD patients ($F = 7.38$, $p = < .01$), and professional appraisals of these patients were more positive ($F = 8.93$, $p < .01$). Patients with MDD and borderline traits were expected to be in greater distress ($F = 6.04$), less likely to benefit from therapy ($F = 7.02$), and in need of more direction, structure/ guidance in therapy ($F = 5.43$) than MDD patients (all $p < .05$).

(*continued*)

TABLE 1. *continued*

Study	Country	Sample Size & Populationa	Design	Outcome Measure(s)	BPD Comparison	Main Findings
Knaak, Szeto, Fitch, Modgill, & Patten (2015)**	Canada	*N* = 191, Health care providers (mental health and non-mental health).	Between-subjects design. Responses to one of two diagnostic labels measured via questionnaire.	'Opening Minds for Healthcare Providers' tool (Kassam, Papish, Modgill, & Patten, 2012).	"Mental illness"	Significant main effect of survey type (BPD versus 'mental illness') found, with stigma toward BPD significantly greater than toward 'mental illness' ($F = 39.63$, $p < .01$).
Lam, Salkovskis, & Hogg (2016)***	UK	*N* = 265 (psychiatrists, psychologists, social workers, nurses and mental health students).	Between-subjects design. Participants watched a video of a patient and each group read different vignettes.	Clinical Assessment Questionnaire (CAQ) (designed by authors).	Panic Disorder (no label), BPD symptoms (no label), and BPD symptoms (label)	Participants in 'Label' condition predicted the client would have a poorer therapeutic outcome ($F = 9.4$, $p < .0001$), posed elevated risks of harm to self and others ($F = 10.99$, $p < .0001$), and was less likely to engage in future therapy ($F = 4.49$, $p < .012$) than those in the 'no label' conditions.
Lam, Poplavskaya, Salkovskis, Hogg, & Panting (2016)***	UK	Same as above.	Same as above.	Numbers of "optimistic" and "pessimistic" responses were counted.	Same as above	Significantly fewer optimistic ratings given in the 'Label' condition than in both 'No label' conditions ($F = 5.17$, $p < .005$). No significant differences in the number of pessimistic ratings between conditions. Participants in the 'Label' condition noticed significantly fewer 'signs of positive efforts towards self-help' ($\chi^2 = 11.3$, $p = .004$).
Leibowitz (2009)**	USA	*N* = 184, CPs and CP graduates.	Clinical vignettes and questionnaires. Participants gave diagnostic impression of vignette.	Emotions Rating Scale (ERS) (created by authors).	PTSD and depression	Significant main effect of diagnosis on ERS scores was found ($F = 3.95$, $p = .021$); Tukey multiple comparisons showed participants who diagnosed a hypothetical patient with BPD showed more negative emotions than those diagnosing depression ($p = .018$), but not PTSD.
Markham (2003)**	UK	*N* = 71, Registered mental health nurses (RMNs) and health care assistants (HCAs).	Questionnaires used to measure responses to diagnoses.	A modified version of the social distance scale (Ingamells, Goodwin, & John, 1996); Beliefs about dangerousness scale (Link, 1987).	Schizophrenia and depression	Experiences of working with patient: RMNS- schizophrenia ($t = 9.851$) and depression ($t = 8.905$) > BPD (both $p < .01$), HCAs- schizophrenia ($t = 2.298$, $p = .033$) and depression ($t = 2.54$, $p = .02$) > BPD. Optimism: RMNs- Depression ($t = -7.157$) and schizophrenia ($t = -6.269$) > BPD (both $p < .01$), HCAs- Depression ($t = 2.677$, $p = .015$) and schizophrenia ($t = -2.346$, $p = .031$) > BPD. Social distance: RMNS- BPD > depression ($t = 12.958$) and schizophrenia ($t = 7.235$) (both p < .01), HCAs- BPD > depression ($t = 5.819$, $p < .001$), but not significantly different for schizophrenia. Dangerousness: RMNs- BPD > depression (t = 12.431) and schizophrenia ($t = 6.337$) (both $p < .01$), HCAs- BPD > depression ($t = 5.316$, $p < .001$), not significantly different for schizophrenia.

Markham & Trower (2003)**	UK	*N* = 48, Mental health nurses	Questionnaires in response to different diagnoses.	Attributions questionnaire (Dagnan et al., 1998).	Schizophrenia and depression	Stability: BPD > depression (t = 2.1, *p* = .004) and schizophrenia (*t* = 3.165, *p* = .042); no differences in internality ratings. Control over behavior: BPD > depression (*t* = −7.104) and schizophrenia (*t* = −9.362) (both p < .001). Sympathy: schizophrenia (*t* = −10.834, *p* < .001) and depression (*t* = −9.042, *p* < .001) > BPD. Optimism: schizophrenia (*t* = −5.016, p < .001) and depression (*t* = −7.406, *p* < .001) > BPD. Experiences of working with patients: depression (*t* = 9.217, *p* < .001) and schizophrenia (*t* = 11.005, *p* < .001) > BPD.
McIntyre & Schwartz (1998)***	USA	*N* = 155, Psychotherapists recruited via systematic sampling.	Between-subjects design. Participants watched a video of a patient with a diagnostic label and completed questionnaires.	Impact Message Inventory (Perkins et al., 1979) and Stress Appraisal Scale (Carpenter & Suhr, 1988).	Major Depression	BPD patients were seen as significantly more hostile (*F* = 8.95, *p* < .05) and dominant (*F* = 14.78, *p* < .05) than patients with MDD, indicating they evoked feelings like competition, mistrust, hostility, detachment. Patients with MDD were rated as significantly more friendly (*F* = 16.78, *p* < .05), submissive (*F* = 18, *p* < .05), and salient (*F* = 10.31, *p* < .05), indicating they evoked emotional reactions including nurturance, importance, and agreeableness.
Miller (2016)***	USA	*N* = 332, Masters and doctoral level psychotherapists.	Between-subjects design. Clinical vignettes and questionnaires. Each group responded to different diagnostic labels.	Clinical Attribution Scale (Chen, Froehle, & Morran, 1997), Feeling-Word Checklist (Hoffart & Friis, 2000; Holmqvist, 2000), WAI-Bond subscale, Therapist Attitudes Questionnaire (created by the authors).	Complex PTSD (C-PTSD)	No significant main effects for diagnosis were found in regard to anger, dispositional attributions, working alliance predictions, or unfavorable attitudes. Agreement with BPD diagnosis was significantly positively correlated with dispositional attributions (*r* = .24, *p* = .014), feelings of anger (*r* = .31, *p* = .001), and unfavorable attitudes (*r* = .30, *p* = .003). There was a significant interaction between diagnostic agreement and diagnostic label (*F* = 4.09, *p* = .044). Among the participants who rated their agreement as moderate/strong, attitudes toward BPD were significantly more unfavorable (*p* = .034).
Shachner & Farber (1997)***	USA and Canada	*N* = 389, Child psychotherapists	Clinical vignettes and questionnaires.	Brief Symptom Inventory (Derogatis & Spencer, 1993); "Countertransference" to children scale (created by the authors).	Dysthymia and Conduct Disorder	Positive countertransference > dysthymia compared to conduct disorder (*t* = −3.74, *p* < .001) or BPD (*t* = 9.93, p < .001). Negative countertransference > BPD than dysthymia (*t* = −13.14, *p* < .001), but > for conduct disorder compared with BPD (*t* = 5.94, *p* < .001).

(*continued*)

TABLE 1. *continued*

Study	Country	Sample Size & Populationa	Design	Outcome Measure(s)	BPD Comparison	Main Findings
Slaght (2017)**	USA	*N* = 218, CPs and CP doctoral students.	Between-subjects design. Clinical vignettes.	Likert scales were created by the authors.	MDD, no diagnosis, and substance use disorder (SUD)	Significant main effects found for likelihood of taking on the patient ($F = 29.48$, $p < .000$), confidence in ability to help ($F = 20.37$, $p < .000$), feelings about working with the patient ($F = 24.03$, $p < .000$), optimism ($F = 12.88$, $p < .000$), and prognosis ($F = 13.19$, $p < .000$). MDD was consistently rated more favorably than BPD and SUD (all $p < .000$).

Note. *poor quality, **fair quality, ***good quality (NIH Quality Assessment Tool for Observational and Cohort Studies [National Institutes of Health, 2014]). [a]These studies represent 22 different samples, as the studies by Bourke and Grenyer (2010), Bourke and Grenyer (2013), and Bourke and Grenyer (2017) used the same sample. The studies by Lam, Salkovkis, and Hogg (2016) and Lam, Poplavskaya, Salkovskis, Hogg, and Panting (2016) also shared the same sample. Markham (2003) and Markham and Trower's (2003) studies used the same sample of mental health nurses, but the former study also included a sample of health care assistants (HCAs). These studies were included separately because they all used different approaches to measure attitudes toward BPD. [b]This sample also included 433 non-psychiatric doctors, but these results have been excluded from the current review. MDD: major depressive disorder; CP: clinical psychologist; PTSD: posttraumatic stress disorder.

The data extraction table was piloted using three of the included studies. The primary researcher (K.M.) then piloted the quality assessment tool on three of the included studies while another member of the research team (J.G.) rated the same three studies independently. The researchers then met to discuss their findings and, given they had a high level of agreement and both felt the criteria were relevant to the methodologies of the three piloted studies, they agreed this tool would be suitable. Higher quality studies are given more weight in the Results and Discussion sections.

RESULTS

STUDY CHARACTERISTICS

Twenty-five studies met inclusion criteria. The studies were conducted in the following countries: Australia (n = 3), USA (n = 11), UK (n = 6), Canada (n = 3), South Africa (n = 1), and Italy (n = 1). The largest number of studies were conducted in the past decade (between 2010 and 2020) (n = 12), five were conducted between 2000 and 2010, and eight were conducted before 2000. In terms of quality assessment, the majority of studies were rated fair (n = 15), seven were rated good, and three were rated poor.

Attitudes toward BPD were most commonly (n = 17) compared to attitudes toward individuals diagnosed with mood disorders (mainly depression and major depressive disorder [MDD]). Other comparison diagnoses included schizophrenia, PTSD, panic disorder, conduct disorder, and substance misuse. Only two studies compared attitudes toward BPD to attitudes toward other personality disorders (these included narcissistic, schizotypal, antisocial, paranoid, compulsive, dependent, and histrionic personality disorders).

Further information about the study characteristics is shown in Table 1.

COGNITIVE BELIEFS AND APPRAISALS

General Stigma. Mental health workers show more stigmatized beliefs about people with BPD than about people with a nonspecified "mental illness" and those with depression. Knaak, Szeto, Fitch, Modgill, and Patten's (2015) findings indicated that stigma toward BPD was significantly higher than toward the label of "mental illness," both before and after an antistigma training program. The generalizability of their findings was limited, however, because 13% of participants had no experience treating someone with a mental illness, and the authors did not analyze their data separately. In a smaller study, Chartonas, Kyratsous, Dracass, Lee, and Bhui (2017) found that psychiatrists' scores on the Attitude to Personality Disorder Questionnaire indicated slightly more negative attitudes toward patients with a prior diagnosis of BPD than toward those with depression; however, the differences were nonsignificant. It is likely that this study was underpowered, and the validity of using the APDQ to measure stigma toward depression is questionable.

In contrast, Miller (2014) measured anticipated attitudes toward a hypothetical patient with either BPD or complex PTSD (C-PTSD) in a large sample

of psychotherapists. Agreement with the assigned diagnosis was also measured. Attitudes toward patients with BPD and C-PTSD were not found to be significantly different. However, therapists who rated their agreement with the BPD diagnosis as moderate/strong (i.e., they felt the vignette accurately depicted a patient with BPD) had significantly more unfavorable views of the BPD patients than of the C-PTSD patients.

Specific Stereotypes. Several studies have also indicated that mental health workers hold a range of specific, negative stereotypes about individuals with BPD. For example, psychotherapists perceived patients with BPD to experience higher levels of personal distress and social dysfunction than patients with other personality disorders (Funtowicz, 1996). Karakashian (2005) also found that patients with MDD and "borderline traits" were expected to be in greater distress than those with MDD only. However, attitudes were measured using an unvalidated questionnaire, limiting the validity of the findings.

Several studies indicate that mental health workers believe people with BPD are more dangerous than people with other mental health difficulties. In an experimental study (Lam, Salkovskis, & Hogg, 2016), participants watched a video of a patient with symptoms of panic disorder after reading (1) a behavioral description consistent with BPD but without a diagnosis ("no label"), (2) the same description and were informed the patient had a BPD diagnosis ("label"), or (3) background information consistent with panic disorder ("no label"). Participants rated the risks of harm to self and others as significantly higher in the "label" condition than in the "no label" conditions. Two studies found that individuals with BPD are thought to be more dangerous than those with depression (Jury, 2014; Markham, 2003). However, the findings comparing attitudes toward BPD and schizophrenia are mixed; Markham (2003) found that nurses perceived people with BPD to be more dangerous than people with schizophrenia, but health care assistants gave these two groups similar dangerousness ratings. Using an unvalidated questionnaire, Jury (2014) found that psychiatrists perceive patients with BPD to be more dangerous than those with depression, but less dangerous than patients with schizophrenia. However, both of these studies used small sample sizes, restricting the generalizability of the findings.

Beliefs About Causes and Controllability. The literature exploring mental health workers' assumptions regarding the causes and controllability of BPD is equally mixed. Two studies found no significant differences in workers' dispositional bias (i.e., whether they believe a person's symptomatic behavior is a result of personal characteristics) toward people with BPD than toward people with schizophrenia and depression (Markham & Trower, 2003; Miller, 2014). However, Markham and Trower (2003) found that nurses felt that patients with BPD had more control over their symptoms than patients with schizophrenia and depression. In contrast, Jury (2014) found that most psychiatrists disagreed that people with BPD are "to blame" for their condition; however, their level of agreement with this statement was significantly higher for people with BPD than for those with depression and schizophrenia. Markham and Trower's (2003) study was the only one that explored perceived stability of

BPD symptoms; these were seen as more stable (less likely to change) than symptoms of depression and schizophrenia.

BELIEFS ABOUT TREATMENT

Experiences of Treatment and Confidence. Mental health workers appear to associate patients with BPD with more negative experiences in therapy than other patients. Slaght (2017) found that psychologists felt less positive about working with clients with BPD than with clients with substance use disorder (SUD) and clients with MDD. Two studies (Markham, 2003; Markham & Trower, 2003) found that nurses reported more negative personal experiences of working with patients with BPD than with patients with schizophrenia and patients with depression. Furthermore, Chartonas et al. (2017) found that psychiatrists expressed a significantly lower sense of purpose (i.e., felt their work was less meaningful) when working with patients with BPD than with patients with depression. Two studies found that mental health workers lack confidence when working with people with BPD compared to those with depression (Bourke & Grenyer, 2010; Slaght, 2017). One study (Fishman, 2012), however, found no significant differences in psychologists' and psychiatrists' predictions about therapy experiences with BPD patients compared with other patients.

Beliefs About the Therapeutic Alliance. The majority of studies found that workers made more negative predictions about the therapeutic alliance in response to patients with BPD than about those with other diagnoses. Measuring responses to real patients, Bourke and Grenyer (2013) found that psychotherapists reported having more positive therapeutic alliances with their MDD patients than with their BPD patients, and they experienced a range of negative relational patterns with their BPD but not their MDD patients. Karakashian (2005) found that, in response to an interview with a real patient, psychologists and doctoral psychology students expected they would form better therapeutic relationships with patients with MDD than with those with MDD and "borderline traits."

Similarly, in a vignette study, Hillman and Stricker (1998) found that doctoral-level psychology students felt that patients with MDD and BPD were less likely to develop rapport with the therapist than patients with MDD only. However, this study had a small sample size and the measures used to assess participants' attitudes were unvalidated. Furthermore, all participants were students; thus their lack of experience with BPD patients may have confounded the findings. In another vignette study, Calvert (1997) found that participants' predictions of the working alliance were more negative for patients with BPD than for those with PTSD. Using the same measure, Miller (2014) found no differences in the predicted therapeutic alliance with hypothetical patients with BPD and C-PTSD.

Beliefs About Treatment Engagement, Outcome, and Prognoses. The findings regarding treatment engagement, outcome, and overall prognoses suggest that mental health workers have more negative predictions about individuals with BPD than about people with other conditions. Two studies (Lam,

Poplavskaya, Salkovskis, Hogg, & Panting, 2016; Lam, Salkovskis, & Hogg, 2016) found that mental health workers who were informed that a client had a BPD diagnosis were less optimistic about their therapeutic outcome than those workers who were not informed of the BPD diagnosis. Supporting this finding, both Markham (2003) and Markham and Trower (2003) found that staff optimism was lower for patients with BPD than for both patients with schizophrenia and depression.

Two studies found that patients with BPD were believed to have poorer prognoses than patients with MDD (Hillman & Stricker, 1998) and SUD (Slaght, 2017). In McIntyre and Schwartz's (1998) study, participants' questionnaire responses indicated that they cared more about their performance in therapy and felt the therapy outcome had more important consequences for patients with depression than for those with BPD, indicating a belief that therapy was less beneficial for patients with BPD. Similarly, two studies (Jury, 2014; Karakashian, 2005) found that participants felt patients with BPD/borderline traits would be less likely to improve in treatment than patients with depression and schizophrenia.

Participants in Karakashian's (2005) study predicted having to provide more structure and guidance in therapy with patients with borderline traits, perhaps indicating they were more pessimistic about their engagement. Similarly, Lam, Poplavskaya, et al. (2016) found that participants who were informed that the patient had been diagnosed with BPD predicted lower levels of engagement in therapy and less likelihood of engaging in future therapy than participants in the other experimental conditions.

EMOTIONAL REACTIONS TO CLIENT PRESENTATION

Countertransference. A number of the studies reported measuring mental health workers' "countertransference" reactions to patients. *Countertransference* can be defined in a number of different ways, but in the included studies it is broadly defined as a therapist's conscious or unconscious emotional reactions toward a client (Gabbard, 2001). Studies measuring emotional countertransference responses via questionnaires indicated that mental health workers experience stronger and more negative countertransference in response to individuals with BPD than those with other diagnoses.

Colli, Tanzilli, Dimaggio, and Lingiardi (2014) found that, compared with other personality pathologies, borderline pathologies elicited more overwhelming feelings in therapists in response to their real patients, as well as high levels of anxiety, tension, and concern. Three studies measured countertransference responses to case vignettes (Brody & Farber, 1996; Calvert, 1997; Shachner & Farber, 1997). Brody and Farber found that schizophrenia evoked more feelings of anxiety and hopelessness than BPD and depression evoked, but responses to BPD were more negative overall.

Calvert (1997) found that trainee and qualified psychologists and psychiatrists expressed higher levels of negative countertransference in response to descriptions of patients with BPD than to descriptions of patients with PTSD. Shachner and Farber (1997) measured countertransference reactions in a large sample of child psychotherapists and found that hypothetical

patients with BPD evoked significantly higher levels of negative countertransference than those with dysthymia, but patients with conduct disorder evoked more negative countertransference reactions than patients with BPD and patients with dysthymia. Because the participants in this study were all child psychotherapists, their level of experience with BPD patients is questionable; although this may have been a confounding variable, it was not measured by the researchers.

Specific Emotional Reactions. Using a different design, McIntyre and Schwartz (1998) explored psychotherapists' responses to an interview with patients requiring support for either BPD or MDD. Questionnaire responses signified that the patients with BPD evoked more challenging emotional reactions, related to hostility and dominance, whereas the patients experiencing MDD elicited less challenging reactions, related to submissiveness and agreeableness. Studies measuring the levels of anger that mental health workers experience or expect to experience in response to individuals diagnosed with BPD produced mixed findings, possibly due to variance in the measurement of anger, in addition to differences in study populations. In a large UK study, Brody and Farber (1996) found that clinical psychology students and qualified psychologists expected that they would feel greater anger and irritation toward a client diagnosed with BPD than toward clients with depression or schizophrenia. However, the scale used to measure emotional responses was not validated.

In contrast, both Miller (2014) and Forsyth (2007) found no significant differences in participants' expected anger toward patients with BPD and toward patients with other diagnoses. However, in Miller's study, the more that psychotherapists agreed with the BPD diagnosis, the more anger they expected to feel; this was not true for the C-PTSD diagnosis. The validity of the BPD vignette used in Miller's study is questionable, however, because therapists' level of agreement with the C-PTSD diagnosis was significantly higher than for the BPD diagnosis, indicating that they felt the BPD vignette depicted the symptoms less accurately. Furthermore, Forsyth's findings should be interpreted with caution because the study had a small sample size and consequently may have lacked statistical power.

Positive Versus Negative Emotional Reactions. Studies measuring the valence of workers' emotional responses toward individuals with BPD indicate a trend toward more negative reactions in response to this client group than to individuals diagnosed with other mental health conditions. Using questionnaires, Fraser and Gallop (1993) found that nurses' feelings were more negative in response to the BPD label than to schizophrenia, affective disorder, and "other" mental illness. Two studies indicated that mental health workers experience more negative emotions in response to patients with BPD than to patients with depression but not those with SUD (Slaght, 2017) or PTSD (Leibowitz, 2009).

Two studies with similar methodologies (Bourke & Grenyer, 2010, 2017) found comparable results when the authors interviewed psychotherapists about their real patients. Participants expressed more negative affect when describing patients with BPD compared patients with MDD. Although these

studies advantageously measured responses to real patients, their sample sizes (N = 20) potentially restrict the generalizability of the findings.

BEHAVIORAL RESPONSES

Expressed Empathy. The included studies suggest that mental health workers behave more negatively toward individuals diagnosed with BPD than toward those with other diagnoses. One study indicated that mental health workers show fewer empathic behaviors toward patients with BPD than toward those diagnosed with other conditions. Using a validated questionnaire, Gallop, Lancee, and Garfinkel (1989) found that nurses expressed lower levels of empathy and care in response to hypothetical patients with BPD than to patients with schizophrenia. Furthermore, patients with BPD were more likely to receive belittling or contradicting responses from nurses.

Rejecting and Dismissive Behavior. Several studies suggest that mental health workers' behavior is more dismissive and rejecting toward individuals diagnosed with BPD. In Fraser and Gallop's (1993) study, nurses were observed interacting with patients during a therapeutic group. The authors, who were blind to patients' diagnoses, assessed therapists' behavioral responses to patients. Therapists showed significantly more indifferent (failing to acknowledge another's attempts to communicate) and impervious (more judgmental and implying they know what the other person is thinking or feeling) responses toward patients diagnosed with BPD than toward those with affective disorder, but their behavior toward individuals diagnosed with schizophrenia was not significantly different from their behavior toward those with BPD. This study advantageously measured responses to real patients, but the findings are subjective because only one rater was used to determine therapists' responses. Furthermore, the rater was one of the authors and an experienced psychiatric nurse. This is likely to have introduced experimenter bias and means they may have been able to identify patients' diagnoses through observing their behavior.

Using a questionnaire, Brody and Farber (1996) measured graduate clinical psychology students' imagined behavioral responses to patients depicted in vignettes. Their findings indicate that, out of patients with BPD, schizophrenia, and depression, participants expected that they would be least likely to let patients with BPD know that they are liked, to think about them in their leisure time, and to run overtime in their treatment sessions. Furthermore. Forsyth's (2007) findings indicate that nurses believe they are significantly less helpful to patients with BPD than to those with MDD.

Bourke and Grenyer (2010) found that participants were more likely to withdraw from their real patients with BPD than from those with MDD. Chartonas et al. (2017) also found that when psychiatrists were asked about their imagined assessment/management of a hypothetical case, they predicted they would show more rejecting behavior toward patients with BPD. Other studies showed that mental health workers were less likely to take on a client with BPD (Slaght, 2017) and desired greater social distance from them than from patients with MDD. Interestingly, Slaght's (2017) study found similarly negative attitudes toward individuals with SUD.

DISCUSSION

This review explored the types of attitudes that mental health workers hold toward individuals with a diagnosis of BPD and how these compare to their attitudes toward individuals with other mental health diagnoses. A systematic review of the literature has shown that mental health workers hold a wide range of negative attitudes toward individuals with BPD, encapsulated by their emotional, cognitive, and behavioral responses to these patients. Although there was some evidence to show that mental health workers hold negative attitudes toward individuals with conduct disorder (Shachner & Farber, 1997), SUD (Slaght, 2017), schizophrenia (Jury, 2014; Markham, 2003) and other personality disorders (Colli et al., 2014), the findings strongly suggest that they have more negative attitudes toward individuals with BPD than toward individuals with other mental health diagnoses.

The findings indicate that symptoms associated with BPD are more likely to provoke negative reactions than symptoms related to other diagnoses. For instance, people with BPD commonly experience difficulties in interpersonal relationships (American Psychiatric Association [APA], 2013), which may increase the likelihood of negative emotional reactions to these clients in therapy. Further research is warranted to explore how workers' fears for patients with BPD (e.g., of possible suicidal behavior) may impact their responses to these patients. Recurrent suicidal behavior is a symptom of BPD (APA, 2013), and approximately 10% of people with BPD complete suicide (Schneider et al., 2008). Woollaston and Hixenbaugh (2008) interviewed mental health nurses in order to explore their experiences of working with patients with BPD. Several participants discussed how suicidal behavior among this client group caused them to experience negative emotional reactions, such as anger, resentment, and fear. Particular concerns are not only the possibility that such reactions in staff may limit patient opportunities in therapy, but also that mental health workers may perpetuate these negative emotional reactions themselves if they pass on negative narratives about the symptoms of BPD to the next generation of workers. These will be important avenues for future research to explore.

Supporting Corrigan and Kosyluk's (2014) theory of mental health stigma, the findings provide strong evidence to suggest that the BPD label is enough to cue negative attitudes about BPD (Funtowicz, 1996; Gallop, 1989; Jury, 2014; Knaak et al., 2015; Markham, 2003; Markham & Trower, 2003). Studies by Lam, Poplavskaya, et al. (2016) and Lam, Salkovskis, and Hogg (2016) provide the most compelling evidence for this, demonstrating that workers have more negative attitudes in response to the BPD label alone than to the BPD label with information about symptoms. The findings of the review also suggest that the BPD label is a more prominent cue for mental health stigma than other diagnostic labels, further supporting Corrigan and Kosyluk's (2014) theory that stigmatizing attitudes toward BPD comprise cognitive, behavioral, and emotional responses to patients.

There is some evidence to suggest that attributions about stability and controllability are related to mental health workers' attitudes toward BPD. Only one study measured these assumptions directly (Markham & Trower,

2003), finding that BPD symptoms were thought to be more controllable and stable than symptoms of depression and schizophrenia. It is possible that the "personality" element of the BPD label affects these assumptions (e.g., if something is seen to be related to personality, it is assumed to be more stable and controllable; Weiner, 1988). However, one would also assume that the word *personality* would be associated with higher internality ratings (the degree to which the causes of the person's difficulties are attributed to the person or the environment; Kelley, 1971), because this language locates the problem within a person's personality rather than the environment. Contrary to this, Markham and Trower (2003) found no significant differences in internality ratings for patients with BPD versus those with schizophrenia and depression. Comparing attitudes toward BPD with attitudes toward other PDs may be particularly helpful in determining whether the term *personality disorder* is key when forming attributions related to stability, controllability, and internality, or whether other factors are involved.

Unfortunately, only two studies in this review compared attitudes toward BPD with attitudes toward other PDs (Colli et al., 2014; Funtowicz, 1996) and neither of them measured attributions. Colli et al. found that mental health workers felt some specific emotional reactions (e.g., feeling overwhelmed and anxious) more strongly in response to BPD patients than to those with antisocial, narcissistic, paranoid, and schizotypal PDs. Funtowicz's findings showed that workers believed BPD patients to be more distressed and to have higher levels of overall dysfunction than those with paranoid, antisocial, dependent, and histrionic PDs. However, this study made no statistical comparisons between diagnoses and instead relied on frequencies, meaning it is difficult to draw firm conclusions from the results. The results of these studies could be due to factors associated specifically with BPD, for instance, symptoms such as interpersonal difficulties and suicidal behavior, or attributions relating to the word *borderline*. However, further research making statistical comparisons between mental health workers' attitudes (including attributions of internality, stability, and controllability) toward people with BPD and people with other PDs is required to clarify this.

The current findings provide some, although limited, evidence to suggest that the BPD label activates more negative attitudes than other mental health labels due to lack of knowledge. For instance, Knaak et al.'s (2015) findings indicate that improving knowledge about BPD is effective in reducing stigma, which is consistent with previous research (Krawitz, 2004; Miller & Davenport, 1996). Furthermore, mental health workers feel less confident about working with people with BPD than with those with depression (Bourke & Grenyer, 2010; Slaght, 2017), which may relate to lack of knowledge. Mental health workers' pessimism about treatment outcomes may also reflect a lack of awareness that BPD is treatable; in fact, research shows that it is as treatable as MDD (Gunderson et al., 2011; Zanarini et al., 2019). Based on the current findings and previous literature which demonstrates that training interventions can help to improve staff knowledge and attitudes toward BPD (Dickens, Hallett, & Lamont, 2016), it is likely that increasing access to BPD training may help to improve mental health workers' knowledge, confidence, and attitudes toward this client group.

Mental health workers' previous treatment experiences with BPD patients may also contribute to negative attitudes. For instance, the findings suggest that mental health workers experience a lower sense of purpose (Chartonas et al., 2017), fewer positive therapeutic relationships (Bourke & Grenyer, 2013), and are less optimistic about treatment outcomes (Lam, Poplavskaya, et al., 2016; Lam, Salkovskis, & Hogg, 2016) in response to patients with BPD compared to those with other diagnoses. Mental health workers' experiences of these challenges may exacerbate their pessimism about treatment with their BPD patients. However, these negative attitudes could also feed into treatment challenges, for instance, making it more difficult to establish a positive therapeutic alliance. Furthermore, mental health workers' stigma toward people with BPD can impact the quality of the treatment provided, leading to poorer outcomes (Commons Treloar & Lewis, 2008; Rusch et al., 2008).

A further consideration is that BPD could generate more stigmatizing attitudes than other diagnoses because of the demographic variables associated with the diagnosis. Research indicates that BPD is more common among females in clinical settings, with a gender ratio of 3:1 (APA, 2000; Widiger & Trull, 1993). Thus, mental health workers are likely to have encountered more female than male BPD patients. In contrast, depression has a gender ratio of 2:1 (female to male) (Kessler, 2003), whereas schizophrenia is more common among men (Aleman, Kahn, & Selten, 2003). Given that a number of the studies included in this review measured responses to diagnostic labels alone, it is possible that the BPD label activated unhelpful gender stereotypes associated with women, leading to the negative attitudes reported in their findings (Bjorklund, 2009). Three studies included a sample of BPD patients, a larger proportion of whom were female compared to the group of MDD patients (Bourke & Grenyer, 2010, 2013, 2017). The mean age of the BPD group was also 10 years below the mean age of the MDD group, introducing the possibility that a bias against younger women may have contributed to the fact that responses were more negative toward BPD than MDD patients. However, other studies measuring responses to real patients did not include details about gender or age distribution, making it difficult to draw conclusions about the impact of gender and age on mental health workers' attitudes. This area warrants further research.

The current review provides evidence that the BPD label generates more negative attitudes among mental health workers than other mental health diagnoses. Furthermore, two studies showed that simply knowing that a patient has a diagnosis of BPD leads to more stigmatizing attitudes than knowing the diagnosis in addition to information about the patient's behavior/symptoms (Lam, Poplavskaya, et al., 2016; Lam, Salkovskis, & Hogg, 2016). Given these findings, in addition to qualitative research which found that patients with BPD consider the label to be confusing, and one that symbolizes rejection and is "not fitting" (Horn, Johnstone, & Brooke, 2007), it is important for mental health services to continue to reflect on the appropriateness and utility of the BPD label. The word *borderline* is vague and gives no indication of what difficulties a person may be experiencing. It could be argued that using an alternative, more descriptive label could guide therapeutic interventions more effectively by highlighting the symptoms requiring treatment. An example of

an alternative label which highlights that emotional dysregulation is a key symptom of BPD is *emotionally unstable personality disorder* (EUPD; World Health Organization, 1992). Bartels and Crotty (1998) also suggested that the term *emotional intensity disorder* could be used as an alternative to BPD. In addition to guiding treatment interventions, using a more descriptive label may make the diagnosis more relatable to mental health workers. This could weaken the belief that people with BPD are "different," which is often a trigger for stigmatizing attitudes (Link & Phelan, 2001). However, it is important to acknowledge that stigmatized attitudes toward BPD may remain despite using an alternative label, or that a different label could generate negative reactions that were not associated with BPD. Given the stigma associated specifically with BPD suggested by the present results, it is crucial to carry out research to explore whether using an alternative label, such as EUPD or emotional intensity disorder, may lead to reductions in stigmatizing mental health workers' attitudes toward people diagnosed with BPD, or whether these labels provoke similar, negative reactions.

Although there is evidence to suggest that at least mental health workers can hold comparatively negative attitudes toward BPD, there is also evidence to suggest that such attitudes are amenable to change. Researchers investigating staff attitudes toward recovery from BPD proposed that team formulation could help in providing consistent care (Dean, Siddiqui, Beesley, Fox, & Berry, 2018). Team formulation sessions may also help mental health workers to be less reliant on the BPD label for information about an individual's condition, deactivating mental health stigma and the negative responses this creates. Instead, workers may gain an increased awareness of their clients' life experiences, strengths, and goals, helping them and their team to deliver effective and compassionate care. Dickens, Lamont, Mullen, MacArthur, and Stirling (2019) developed a training program that led to positive changes in mental health workers' attitudes toward patients with BPD; this program included education regarding the biosocial understanding of the epidemiology and etiology of BPD, in addition to information about the personal story of an individual who had been diagnosed with BPD.

Team formulation is consistent with dialectical behavior therapy (DBT; Linehan, 1993/2013), a well-established and effective treatment for BPD (Bloom, Woodward, Susmaras, & Pantalone, 2012; Feigenbaum et al., 2012). Team consultations are a key component of DBT and provide regular opportunities for team formulation. These sessions aim to help the therapist to remain motivated while maintaining a compassionate and nonjudgmental stance toward patients (Chapman, 2006), and one study indicates that they help therapists to regulate the difficult emotions that arise when working with patients (Walsh, Ryan, & Flynn, 2018). Research also indicates that engaging in DBT training improves mental health workers' attitudes toward BPD (Haynos, Fruzzetti, Anderson, Briggs, & Walenta, 2016; Herschell, Lindhiem, Kogan, Celedonia, & Stein, 2014); however, further exploration of this finding is required.

A further approach to addressing mental health workers' stigma toward BPD may be to integrate peer support into BPD treatment. A study by Bowen (2013) found that clinicians felt that peer support was a key component of

good practice when working with people with BPD; they highlighted that their patients with BPD showed compassion toward each other, and that often they found feedback from their peers more helpful than feedback from professionals. A recent literature review found that including peer support in mental health care can help to reduce the perceived stigma experienced by patients (Shalaby & Agyapong, 2020). Peer support can be facilitated by involving Certified Peer Specialists (CPS) in mental health treatment; CPS have lived experience of mental health difficulties and are trained to provide recovery-oriented support to others (Pfeiffer et al., 2019). Further research is required to explore whether including CPS in treatment for BPD may help to ameliorate the impact of workers' negative attitudes toward patients with BPD.

LIMITATIONS AND FUTURE DIRECTIONS

There was a lack of consistency in how attitudes toward BPD were measured across the included studies, making it difficult to draw clear comparisons between their findings. Furthermore, a major limitation of many of the studies was that attitudes were measured using one-off, unvalidated outcome measures, meaning it was difficult to assess the validity of their results. This is a highly important limitation of the current research; greater homogeneity across measures of attitudes and clearer reporting of their psychometric properties are needed to enable more robust comparisons between studies. In addition, most studies measured responses to hypothetical patients via clinical vignettes. Many studies did not include information about how the vignettes were written or discuss strategies to check their reliability, making it difficult to determine the validity of their findings. The majority of the authors also failed to report the level of experience that participants had working with individuals with BPD, making it difficult to determine whether their attitudes stemmed from experiences with real patients, stigma related to the BPD label, or a combination of both.

To improve upon the methodological quality of the studies included in the current review, future work in this field should use multiple methods to assess the attitudes of mental health workers, including validated outcome measures and the observation of interactions with real patients. If vignettes are used, these should be assessed for reliability using an interrating process, and the reliability analyses should be reported. Furthermore, researchers should ensure that confounding variables such as level of clinical experience with BPD patients are measured.

In addition, to enhance an understanding of why mental health workers' attitudes toward BPD seem to be particularly negative, researchers should replicate Lam, Poplavskaya, et al.'s (2016) study to further explore whether the BPD label without information about BPD symptoms produces stigmatizing attitudes in comparison to the label with information about related symptoms, and whether this is also true of other diagnostic labels. Further research comparing attitudes toward BPD with attitudes toward other PDs would also be helpful in establishing whether the inclusion of the word *personality* is key in the formation of stigmatizing attitudes, or whether there are other

factors that make BPD a particularly stigmatized label. Qualitative research focusing on mental health workers' attitudes toward their patients with BPD and other diagnoses would be useful in providing a richer exploration of why attitudes toward BPD may be more negative; it would be particularly helpful to explore countertransference in more depth. There would be more scope in qualitative research to explore specific elements of countertransference (e.g., how the therapist's own schemas impact both therapist and client reactions in therapy; Prasko et al., 2010). Further quantitative research in this field would also be useful, particularly studies that measure how these attitudes affect therapy outcomes.

The findings of the current review pose some risk of bias due to the lack of an independent reviewer at all stages of the screening process. Furthermore, a meta-analytic approach was not possible due to heterogeneity in outcomes and measurement. In addition, relevant papers published in languages other than English may have been missed. Including non-English papers may have allowed for discussion of cross-cultural differences in attitudes toward individuals with BPD. This would be an interesting area for future research. Excluding papers that explored the attitudes of non–mental health professionals may also restrict the generalizability of the findings. Mental health nurses and psychological professionals were overrepresented in the included studies; thus, further research investigating the attitudes of other health professionals is required, and this should include non–mental health professionals such as general practitioners and doctors and nurses working in accident and emergency departments.

Lastly, it is likely that access to research highlighting negative attitudes toward BPD plays a role in activating stigma toward the condition. Qualitative research may provide scope to explore the positive attitudes of mental health workers toward their patients with BPD, which could help to deactivate stigma. In addition, as has been demonstrated in a recent study (Nagrodski & Zimbron, 2019), this research could also highlight the caring and understanding attitudes mental health workers show toward patients with BPD.

CONCLUSIONS

This review is the first to systematically explore how mental health workers' attitudes toward BPD compare to their attitudes toward other mental health diagnoses. The findings suggest that workers' attitudes toward BPD are more negative than toward other diagnoses, affecting their cognitive, emotional, and behavioral responses toward individuals with BPD. This may be related to the symptoms associated with BPD, workers' lack of knowledge, prior treatment experiences, and the language used in the label itself, which may lead to the perception that BPD is controllable and unlikely to change over time. Given the current findings and the negative implications for the treatment of individuals with BPD, it is crucial that mental health services address workers' negative attitudes by providing training on BPD and encouraging a holistic understanding of these patients by practicing team formulation. Furthermore, services should consider whether it is useful to continue using the BPD label and whether an alternative label would be less stigmatizing.

APPENDIX

Search Strategy for PubMed

1 Population: Mental Health Workers
#1 Mental Health Personnel
#2 Mental Health Worker
#3 Mental Health Workers
#4 Mental Health Professional
#5 Mental Health Professionals
#6 Psychiatrist
#7 Psychiatrists
#8 Psychologist
#9 Psychologists
#10 Psychotherapist
#11 Psychotherapists
#12 Psychological Therapist
#13 Psychological Therapists
#14 Social Worker
#15 Social Workers
#16 Support Worker
#17 Support Workers
#18 Nurse
#19 Nurses
#20 Nursing
#21 Clinician
#22 Clinicians
#23 OT
#24 OTs
#25 Occupational Therapist
#26 Occupational Therapists
#27 #1 OR #2 OR #3 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25 OR #26

2 Exposure: Borderline Personality Disorder
#28 Borderline Personality Disorder
#29 Emotionally Unstable Personality Disorder
#30 BPD
#31 EUPD
#32 Borderline Personality Disorder (MeSH Term)
#33 #28 OR #29 OR #30 OR #31 OR #32

3 Outcomes: Attitudes of Mental Health Workers
#34 Attitudes
#35 Stigma
#36 Stigmatising
#37 Stigmatised
#38 Response
#39 Beliefs
#40 Views
#41 Reactions
#42 Prejudice
#43 Bias
#44 Transference
#45 Transference (MeSH Term)
#46 Social Stigma (MeSH Term)
#47 Attitude of Health Personnel (MeSH Term)
#48 OR #34 OR #35 OR #36 OR #37 OR #38 OR #39 OR #40 OR #41 OR #42 OR #43 OR #44 OR #45 OR #46 OR #47

Combining Search Term Groups
#50 AND #27 AND #33 AND #48

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