Mental Health Workers' Attitudes towards Individuals with a Diagnosis of Borderline Personality Disorder: A Systematic Literature Review.

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Declarations of interest: None

Word Count (excluding tables, figures and references): 7,385

Abstract

Mental health workers' attitudes towards individuals with mental health conditions can impact on the quality of care they provide. Negative attitudes amongst 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 towards individuals diagnosed with BPD, specifically focusing on studies comparing workers' attitudes towards BPD with attitudes towards other mental health diagnoses. The findings suggest that mental health workers have more negative attitudes towards individuals labelled as having BPD compared to 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 towards BPD.

Keywords: Borderline Personality Disorder, Mental Health Stigma, Attitudes, Mental Health Workers

Introduction

Background

Public stigma towards people with mental health difficulties is widely documented throughout the literature (Corrigan, 2004; Wood et al., 2015; Sheehan, Nieweglowski & Corrigan, 2016). Corrigan and Kosyluk (2014) propose that 'stereotype', 'prejudice' and 'discrimination' are the three main components of stigma, and that these impact upon cognitive, emotional and behavioural responses to others. Mental health 'Stereotypes' occur when overgeneralisations are applied to an individual based on their mental health; common examples include that people with mental health difficulties are unpredictable, hard to talk to and unlikely to recover (Crisp et al., 2000). 'Prejudice' arises when the public agree with these stereotypes and experience negative emotions in response to individuals with mental health conditions; 'discrimination' occurs when the public behave unfairly towards 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 behaviours. Thus, by signalling 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 on 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. Additionally, assuming higher levels of responsibility led to decreases in pity and increases in fear, anger and rejecting responses such as with-holding help, avoidance, segregation and coercion.

Such issues may be relevant to the attitudes of mental health workers towards people with mental health conditions. Mental health workers can hold negative attitudes towards people with mental health difficulties, for example, 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 patronised and humiliated (Thornicroft, Rosem, & Kassam, 2007). Research also suggests that negative attitudes amongst mental health professionals may contribute to lower quality care (Henderson, Evans-Lacko & Thornicroft, 2013).

In regards to specific diagnoses, there are a number of studies that indicate mental health professionals can show stigmatising attitudes towards individuals with schizophrenia. For example, Nordt, Rossler and Lauber (2006) found that mental health professionals desired more social distance from patients with schizophrenia compared to those with depression, and people with no mental health diagnosis. Negative attitudes amongst mental health professionals have also been found in response to people with substance use disorders (Rao et al., 2009; Foster & Onyeukwu, 2003), whereas more positive attitudes have been found in response to depression and PTSD (Maier et al., 2015).

Attitudes towards Borderline Personality Disorder (BPD)

Negative beliefs amongst 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 towards individuals with BPD compared to 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 (Deans & Meocevic, 2006; Cleary et al., 2002). Additionally, some mental health workers believe that BPD is "untreatable" (Bateman & Fonagy, 2009), despite the fact that a number of effective psychological interventions for BPD exist (Meuldijk, McCarthy, Bourke & Grenyer, 2017; Byrne & Egan, 2018). This mis-perception can lead to stigmatising behaviour, 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 behaviours associated with BPD, such as self-harm, dropping-out of treatment and intense interpersonal reactions (Dickens, Lamont & Gray, 2016). Alternatively, stigmatising reactions and attitudes towards individuals with BPD may relate to the meaning attached 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 developed, and instead suggests the problem is located within their personality. Demonstrating this, 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). There are a few studies which explore attitudes towards other types of personality disorders, although negative attitudes have also been found amongst clinicians in response to patients with Antisocial Personality Disorder (Bowers et al.; 2005 Schwartz et al., 2007).

The Current Review

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

(1) What types of attitudes do mental health workers hold towards individuals with a diagnosis of BPD?

(2) Do mental health workers hold different attitudes towards 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, 2009).

Data Sources and Search Strategy

The databases PubMed, PsycInfo and Embase were searched using a pre-defined 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 the searches were 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 Appendix A for the PubMed search strategy). Following this, the databases were electronically searched 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, emotional and behavioural responses) of mental health workers or student/trainee mental health workers and (2) Studies

comparing mental health workers' attitudes towards individuals diagnosed with BPD to their attitudes towards individuals diagnosed with, or showing symptoms of, a different mental health difficulty.

Excluded studies were those that: (1) Measured public attitudes towards 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 health professionals, (5) Did not compare attitudes towards BPD with attitudes towards 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 (KM) 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. KM and the reviewer had a 98% agreement rate; they then met to discuss and re-assess the papers which caused discrepancies, leading to a 100% agreement rate.

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 et al., 2013). Studies were assessed for quality using the National Heart, Lung and Blood Institute's (NIH) Quality Assessment Tool for Observational

and Cohort Studies (NIH, 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).

The data extraction table was piloted using three of the included studies. The primary researcher (KM) then piloted the quality assessment tool on three of the included studies whilst another member of the research team (JG) 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 were given more weight in the results and discussion sections.

Results

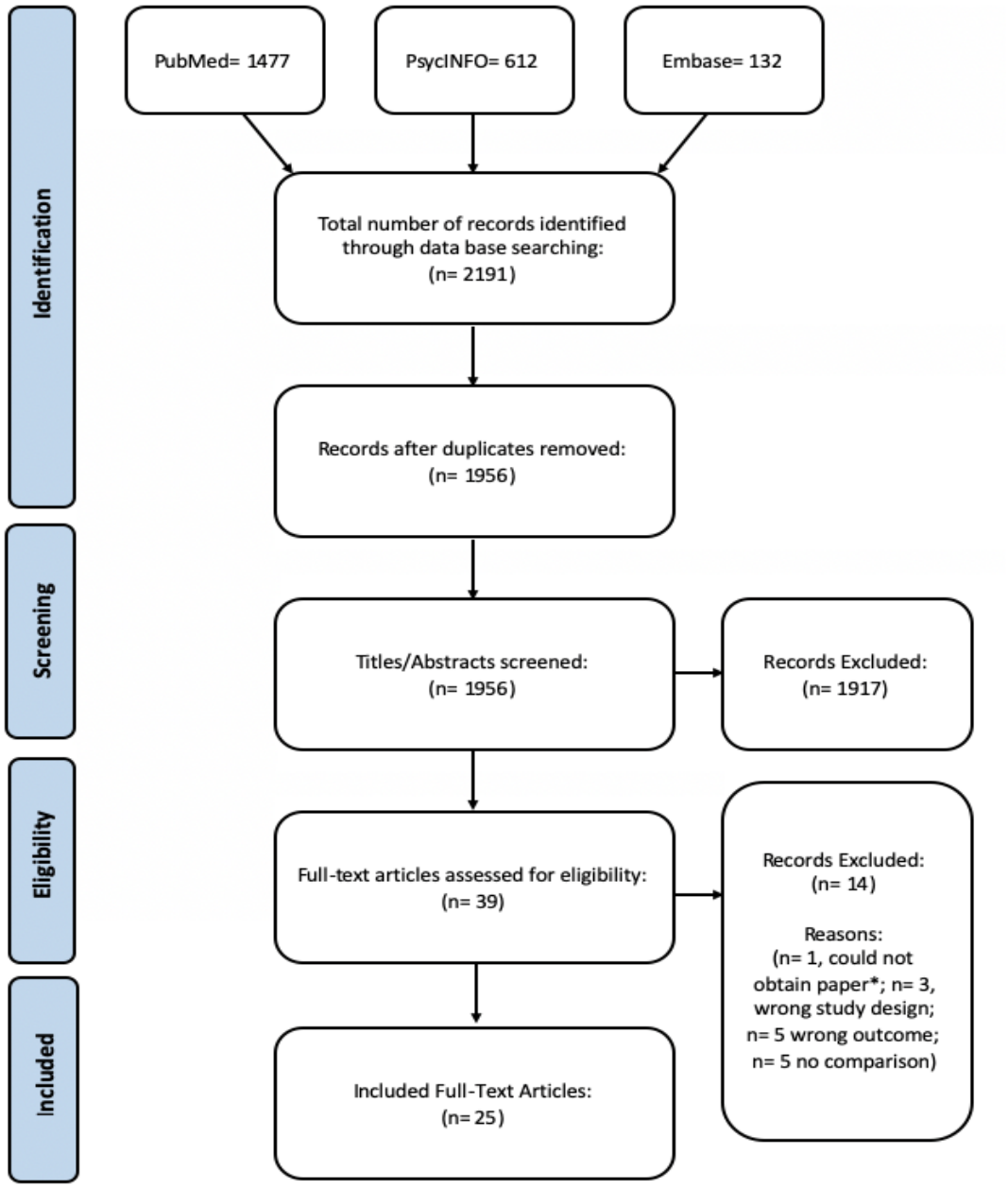
Study Characteristics

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 last 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 'good' and three were 'poor'.

Attitudes towards BPD were most commonly (n=17) compared to attitudes towards 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 towards BPD to attitudes

towards 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.



*This refers to a paper by Bongar (1991). This paper met inclusion criteria at title/abstract screening but full text could not be obtained via the university library or via the author directly.

Figure 1. A Flowchart of the Study Selection Process in accordance with PRIMSA guidelines (Moher, 2009).

Table 1.
An Overview of the Included Studies

Study	Country	Sample Size & Population†	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.	The Core Conflictual Relationship Theme-Leipzig/Ulm category system (Luborsky, 1998)	MDD	Multi-level modelling 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 compared to BPD ($p<.05$).
Bourke & Grenyer (2013)**	Australia	Same as above.	Interview about experiences with real patients and measured relationship patterns via questionnaire.	Psychotherapy Relationship Questionnaire (PRQ) (Westen, 2000). Lexi-mancer and content analysis used to analyse interviews (Smith & Humphreys, 2006).	MDD	Multi-level modelling 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 sexualised (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 analysed using Linguistic Inquiry & Word Count (Pennebaker, Francis & Booth, 2001).	MDD	Discriminant function analysis showed that participants' linguistic styles differed depending on diagnosis (Wilks $\lambda=0.16$, $\chi^2=120.53$, canonical correlation= 0.92, $p<0.000$); 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).

*Note: *= poor quality, **= fair quality, ***= good quality (NIH Quality Assessment Tool for Observational and Cohort Studies (NIH, 2014))*

Table 1 (*Continued)*

Study	Country	Sample Size & Population	Design	Outcome Measure(s)	BPD Comparison	Main Findings
Brody & Farber (1996)**	USA	N= 336 CPs and CP Graduate Students	Clinical Vignettes and Questionnaires	The Experience and Attitude Scale (EAS) and Vignettes Rating Scale (both designed by the authors)	Schizo-phrenia 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 Quest-ionnaires. Each group responded to a different diagnosis.	The Working Alliance Inventory (WAI)- Bond subscale (Horvath & Greenberg, 1989); The Counter-transference 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 ($F= 13.73$, $p= .0003$).
Chartonas, Kyra-tsous, Dracass, Lee & Bhui (2017)*	UK	N= 73, Trainee psychiatrists	Clinical vignettes and Questionnaires.	22 Semantic differentials (Lewis & Appleby, 1998); The Attitude to Personality Disorder Questionnaire (APDQ) (modified) (Bowers & Allan, 2006).	Depression	Significantly more rejecting responses to individuals with BPD compared with depression ($X^2= 11.38$, $p=.01$). Higher scores on APDQ subscale 'purpose' for people with depression than BPD ($p=.03$). Total APDQ scores indicated slightly (not significantly) more negative attitudes towards BPD compared to depression.

*Note: *= poor quality, **= fair quality, ***= good quality (NIH Quality Assessment Tool for Observational and Cohort Studies (NIH, 2014))*

Table 1 (*Continued)*

Study	Country	Sample Size & Population	Design	Outcome Measure(s)	BPD Comparison	Main Findings
Colli, Tanzilli, Dimaggio& Lingiardi (2014)***	Italy	N= 203, Psychotherapists (randomly selected).	Attitudes to real patients measured via questionnaire.	The Therapist Response Questionnaire (Zittel, Conklin & Westen, 2003).	Antisocial, Paranoid, Schizotypal and Narcissistic Personality Disorders.	BPD was significantly correlated with helpless/inadequate (r= .036), overwhelmed/disorganised (r=0.51) and special/overinvolved (r=0.22) countertransference (all p<.001); correlations were stronger and more significant for BPD compared with other diagnoses.
Fishman (2013)**	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 compared with BPD (F= 5.2, p= .03); they expressed more anger and less empathy in response to BPD patients compared with 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 towards different diagnoses.	The Heineken Confirmation/ Disconfirmation Rating Instrument (Heineken, 1982) and The Staff Response subscale of the Hospital Treatment Rating Scale (Colson, 1986).	Schizo-phrenia, Affective Disorder and 'Other'.	Main effect of diagnosis on nurses' behavioural responses (F= 5.239, p<.001); number of 'impervious' and 'indifferent' responses > BPD than affective disorder; no differences in responses towards 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	Participants rated the diagnoses as either 'mild' 'moderate' or 'severe' on each criteria	Paranoid, Antisocial, Compulsive, Dependent, and Histrionic Personality	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

*Note: *= poor quality, **= fair quality, ***= good quality (NIH Quality Assessment Tool for Observational and Cohort Studies (NIH, 2014))*

Table 1 *(Continued)*

Study	Country	Sample Size & Population	Design	Outcome Measure(s)	BPD Comparison	Main Findings
Gallop, Lancee & Gar-finkel (1989) ***	Canada	N= 113, Psychiatric Nurses.	Clinical vignettes, questionnaire and a written statement.	The Staff-Patient Interaction Response Scale (Gallop & Lancee, 1986); written statements analysed via semantic analysis.	Schizophrenia	A Chi-Square Test revealed significantly more empathy was shown towards schizophrenic patients compared with patients with BPD (p<.01). Significantly less affective involvement and care shown towards 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 questions to measure their social and clinical biases towards 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 compared with patients with just MDD.
Jury (2014) **	South Africa	N= 86, [1]Psychiatrists[1]	Questionnaires were used to measure participants' attitudes towards 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 compared to those with depression and schizophrenia (all p<.0001).

*Note: *= poor quality, **= fair quality, ***= good quality (NIH Quality Assessment Tool for Observational and Cohort Studies (NIH, 2014))*

[1] This sample also included 433 non-psychiatric doctors but these results have been excluded from the current review.

Table 1 *(Continued)*

Study	Country	Sample Size & Population	Design	Outcome Measure(s)	BPD Comparison	Main Findings
Karakashian (2005)**	USA	N= 248 Psychologists and doctoral students in psychology.	Between-subjects design. One group listened to an interview with patient and viewed a clinical report; the other group were only shown the report.	The WAI-Bond Subscale (Horvath & Greenberg, 1993), The Global Evaluation of Patient Scale (made by authors), The Therapist Expectancy Inventory (Bernstein, Lecomte & DesHarnais, 1983).	MDD and MDD with borderline traits.	Patients with MDD were rated more favourably 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) compared to MDD patients (all p<.05).
Knaak, Szeto, Fitch, Modgill & Patten (2015)**	Canada	N= 191, Healthcare providers (mental health and non-mental health).	Between-subjects design. Responses to one of two diagnostic labels measured via questionnaire.	The 'Opening Minds for Healthcare Providers' tool (Kasaam, Papish, Modgill & Patten, 2012)	'Mental illness'.	Significant main effect of survey type (BPD versus 'mental illness') found, with stigma towards BPD was significantly greater than towards '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.	The 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) compared to 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 compared to 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 less 'signs of positive efforts towards self-help' (X^2 = 11.3, p=.004).

*Note: *= poor quality, **= fair quality, ***= good quality (NIH Quality Assessment Tool for Observational and Cohort Studies (NIH, 2014))*

Table 1 *(Continued)*

Study	Country	Sample Size & Population	Design	Outcome Measure(s)	BPD Comparison	Main Findings
Leibowitz (2009)**	USA	N= 184, CPs and CP graduates.	Clinical vignettes and questionnaires. Participants gave diagnostic impression of vignette.	The 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, Owen & John, 1996); Beliefs about dangerousness scale (Link, 1987).	Schizo-phrenia 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)	Schizo-phrenia and depression.	Stability: BPD > depression (t= 2.1, p=.004) and schizophrenia (t= 3.165, p= .042); no differences in internality ratings. Control over behaviour: 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.

*Note: *= poor quality, **= fair quality, ***= good quality (NIH Quality Assessment Tool for Observational and Cohort Studies (NIH, 2014))*

Table 1 (Continued)

Study	Country	Sample Size & Population	Design	Outcome Measure(s)	BPD Comparison	Main Findings
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.	The Impact Message Inventory (Perkins et al., 1997) and The 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) compared to 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.	The Clinical Attribution Scale (Chen, Froehle & Morran, 1997), Feeling-Word Checklist, (Holmqvist, 2000; Hoffart & Friis, 2000), WAI-Bond sub-scale, Therapist Attitudes Questionnaire (created by the authors).	Complex-PTSD (C-PTSD).	No significant main effects for diagnosis were found in regards to anger, dispositional attributions, working alliance predictions or unfavourable attitudes. Agreement with BPD diagnosis was significantly positively correlated with dispositional attributions (r= .24, p= .014), feelings of anger (r=.31, p= .001) and unfavourable attitudes (r= .30, p= .003). There was a significant interaction between diagnostic agreement and diagnostic label (F=4.09, p= .044). Amongst the participants who rated their agreement as moderate/strong, attitudes towards BPD were significantly more unfavourable (p=.034).
Shachner & Farber (1997)***	USA and Canada	N= 389, Child Psychotherapists	Clinical Vignettes and Questionnaires.	The Brief Symptom Inventory (Derogatis & Spencer, 1993); The 'Counter-transference to children scale (created by the authors).	Dysthymia and Conduct Disorder.	Positive countertransference > dysthmia 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).

*Note: *= poor quality, **= fair quality, ***= good quality (NIH Quality Assessment Tool for Observational and Cohort Studies (NIH, 2014))*

Table 1 (*Continued)*

Study	Country	Sample Size & Population	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 favourably than BPD and SUD (all p<.000).

*Note: *= poor quality, **= fair quality, ***= good quality (NIH Quality Assessment Tool for Observational and Cohort Studies (NIH, 2014))*

† Please note that these studies represent 22 different samples, as the studies by Bourke & Grenyer (2010), Bourke & Grenyer (2013), and Bourke & Grenyer (2017) used the same sample. The studies by Lam, Salkovkis & Hogg (2016) and Lam, Poplavskaya, Salkovskis, Hogg & 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 healthcare assistants (HCAs). These studies were included separately as they all used different approaches to measure attitudes towards BPD.

Cognitive Beliefs and Appraisals

General Stigma.

Mental health workers show more stigmatised beliefs about people with BPD compared to people with a non-specified 'mental illness' and those with depression. Knaak et al. (2005)'s findings indicated that stigma towards BPD was significantly higher than towards the label of 'mental illness', both re and after an anti-stigma training programme. Restricting the generalisability of their findings, 13% of participants had no experience of treating someone with a mental illness and the authors did not analyse their data separately. In a smaller study, Chartonas et al. (2017) found that psychiatrists' APDQ scores indicated slightly more negative attitudes towards patients with a prior diagnosis of BPD compared with depression; however, the differences were non-significant. It is likely that this study was

underpowered, and the validity of using the APDQ to measure stigma towards depression is questionable.

In contrast, Miller (2014) measured anticipated attitudes towards a hypothetical patient with either BPD or C-PTSD in a large sample of psychotherapists. Agreement with the assigned diagnosis was also measured. Attitudes towards 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 unfavourable views of the BPD patient compared with the C-PTSD patient.

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 compared to 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 either a behavioural description consistent with BPD but without a diagnosis ('no label'), the same description and were informed the patient had a BPD diagnosis ('label') or 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 compared with the 'no label' conditions. Two studies found that individuals with BPD are thought to be more dangerous than those with depression (Markham, 2003; Jury, 2014). However, the findings comparing attitudes towards BPD and schizophrenia are mixed; Markham (2003) found that nurses perceived people with BPD to be more dangerous than people with schizophrenia, but HCAs gave these two groups similar dangerousness ratings. Using an unvalidated questionnaire, Jury's (2014) findings indicate 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 generalisability 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 behaviour is a result of their personal characteristics) towards people with BPD compared to people with schizophrenia and depression (Miller, 2014; Markham & Trower, 2003). However, Markham and Trower (2003) found that nurses felt 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 BPD compared with depression and schizophrenia. Markham and Trower (2003)'s study was the only one which explored perceived stability of BPD symptoms; these were seen as more stable (less likely to change) compared to 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 compared with other patients. Slaght (2017) found that psychologists felt less positive about working with clients with BPD compared 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 compared to 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 compared 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, 2016), 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 compared to those with other diagnoses. Measuring responses to real patients, Bourke et al. (2013) found that psychotherapists reported having more positive therapeutic alliances with their MDD patients compared with BPD patients, and experienced a range of negative relational patterns with their BPD but not 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 compared to those with MDD and 'borderline traits'.

Similarly, in a vignette study, Hillman and Stricker (1998) found that doctoral level psychology students felt patients with MDD and BPD were less likely to develop rapport with the therapist compared to 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 compared to 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 compared to people with other conditions. Two studies (Lam, Salkovskis & Hogg, 2016; Lam et al., 2016) found that mental health workers who were informed that a client had a BPD diagnosis were less optimistic about their therapeutic outcome, compared with those 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 compared to patients with MDD (Hillman & Stricker, 1998) and SUD (Slaght, 2007). 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 compared to those with BPD, indicating a belief that therapy was less beneficial for patients with BPD. Similarly, two studies (Karakashian, 2005; Jury, 2014) found that participants felt patients with BPD/borderline traits would be less likely to improve in treatment compared to 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 et al. (2016) found that participants who were informed the patient had been diagnosed with BPD predicted lower levels of engagement in therapy, and less likelihood of engaging in future therapy compared to 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 towards 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 compared to those with other diagnoses.

Colli, Tanzilli, Dimaggio and Lingiardi (2014) found that, compared with other personality pathologies, therapists reported feeling more overwhelmed in response to their

real patients with borderline pathologies, and experienced high levels of anxiety, tension and concern. Three studies measured countertransference responses to case vignettes (Calvert, 1997; Shachner & Farber, 1997; Brody & Farber, 1996). Brody and Farber (1996) found that schizophrenia evoked more feelings of anxiety and hopelessness compared to BPD and depression, but responses to BPD were more negative overall.

In comparison to PTSD, Calvert (1997) found that trainee and qualified psychologists and psychiatrists expressed higher levels of negative countertransference in response to descriptions of patients with BPD. Shachner and Farber (1996) measured countertransference reactions in a large sample of child psychotherapists and found that hypothetical patients with BPD evoked significantly higher levels of negative countertransference compared to those with dysthymia, but patients with conduct disorder evoked more negative countertransference reactions than both patients with BPD and dysthymia. As 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 a patients either requiring support for BPD or MDD. Questionnaire responses signified that the patient with BPD evoked more challenging emotional reactions, related to hostility and dominance, whilst the patient experiencing MDD elicited less challenging reactions, related to submissiveness and agreeableness. Studies measuring the levels of anger mental health workers experience/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 they would feel greater anger and irritation towards a client diagnosed with BPD compared with depression or schizophrenia. However, the scale used to measure emotional responses was not validated.

Contrary to this, both Miller (2014) and Forsyth (2007) found no significant differences in participants' expected anger towards patients with BPD compared with patients with other diagnoses. However, in Miller's (2014) study, the more 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 this study is questionable, however, as 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 (2007) findings should be interpreted with caution, as 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 towards individuals with BPD indicate a trend towards more negative reactions in response to this client group compared 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 compared with schizophrenia, affective disorder and 'other' mental illness. Two studies indicated that mental health workers experience more negative emotions in response to patients with BPD compared with depression but not SUD (Slaght, 2017) or PTSD (Leibowitz, 2009).

Two studies with similar methodologies (Bourke & Grenyer, 2010; Bourke & Grenyer, 2017) found comparable results when they interviewed psychotherapists about their real patients. Participants expressed more negative affect when describing patients with BPD compared to patients with MDD. Although these studies advantageously measured responses to real patients, their sample sizes potentially restrict the generalisability of the findings (N= 20).

Behavioural Responses

Expressed Empathy.

The included studies suggest that mental health workers behave more negatively towards individuals diagnosed with BPD compared to those with other diagnoses. One study indicated that mental health workers show fewer empathic behaviours towards patients with BPD compared to 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 compared with schizophrenia. Furthermore, patients with BPD were more likely to receive belittling/contradicting responses from nurses.

Rejecting and Dismissive Behaviour.

Several studies suggest that mental health workers' behaviour is more dismissive and rejecting towards individuals diagnosed with BPD. In Fraser and Gallop's (1993) study, nurses were observed interacting with patients during a therapeutic group. The author, who was blind to patients' diagnoses, assessed therapists' behavioural responses to patients. Therapists showed significantly more indifferent (failing to acknowledge another's attempts

to communicate) and impervious (more judgemental and implying they know what the other person is thinking/feeling) responses towards patients diagnosed with BPD compared to those with affective disorder, but their behaviour towards individuals diagnosed with schizophrenia was not significantly different to those with BPD. This study advantageously measured responses to real patients, but the findings are subjective as only a single rater was used to determine therapists' responses. Furthermore, the rater was the author 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 behaviour.

Using a questionnaire, Brody and Farber (1996) measured graduate clinical psychology students' imagined behavioural 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 a patient with BPD know that they're liked, to think about them in their leisure time, and to run over time in their treatment sessions. Furthermore. Forsyth's (2007) findings indicate that nurses believe they are significantly less helpful towards patients with BPD compared with MDD.

Bourke et al. (2010) found that participants were more likely to withdraw from their real patients with BPD compared to 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 behaviour towards 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 compared to patients with MDD. Interestingly, Slaght's (2017) study found similarly negative attitudes towards individuals with SUD.

Discussion

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

The findings indicate that symptoms associated with BPD are more likely to provoke negative reactions compared to 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 behaviour, may impact on their responses to these patients. Recurrent suicidal behaviour is a symptom of BPD (APA, 2013) and approximately 10% of people with BPD complete suicide (Bateman & Fonagy, 2004). 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 behaviour amongst this client group caused them to experience negative emotional reactions, such as anger, resentment and fear. Of particular concern is 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 (Markham, 2003; Markham & Trower, 2003; Gallop, 1989; Funtowicz, 1996; Jury, 2014; Knaak, 2015). Lam et al. (2016) and Lam, Salkovskis and Hogg (2016)'s studies provide the most compelling evidence for this, demonstrating that workers have more negative attitudes in response to the BPD label alone, compared 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 compared to other diagnostic labels; further supporting Corrigan and Kosyluk's (2014) theory that stigmatising attitudes towards BPD comprises cognitive, behavioural and emotional responses to patients.

There is some evidence to suggest that attributions about stability and controllability are related to mental health workers' attitudes towards 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)), as 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 towards BPD with attitudes towards 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 towards BPD with attitudes towards other PDs (Colli et al., 2014; Funtowicz, 1996) and neither of them measured attributions. Colli et al. (2014) found that mental health workers felt some specific emotional reactions (e.g. feeling overwhelmed and anxious) more strongly in response to BPD patients compared to those with antisocial, narcissistic, paranoid and schizotypal PDs. Funtowicz's (1996) findings showed that workers believed BPD patients to be more distressed and have higher levels of overall dysfunction compared to 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 their results. The results of these studies could be due to factors associated specifically with BPD; for instance, symptoms such as interpersonal difficulties and suicidal behaviour, 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) towards 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 (Miller & Davenport, 1996; Krawitz, 2004). Furthermore, mental health workers feel less confident about working with people with BPD compared to 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 equally 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 towards 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 towards 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), less positive therapeutic relationships (Bourke et al., 2013) and are less optimistic about treatment outcomes (Lam, Salkovskis & Hogg, 2016; Lam et al., 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 towards people with BPD can impact upon the quality of the treatment provided, leading to poorer outcomes (Commons Treloar, 2008; Rusch et al., 2008).

A further consideration is that BPD could generate more stigmatising attitudes compared to other diagnoses because of the demographic variables associated with the diagnosis. Research indicates that BPD is more common amongst females in clinical settings, with a gender ratio of 3:1 (Widiger & Trull, 1993; APA, 2000). 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 amongst men (Aleman et al., 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 (Bjorkland, 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; Bourke & Grenyer, 2013; Bourke & Grenyer 2017). The mean age of the BPD group was also ten years below the MDD group, introducing the possibility that a bias against younger women may have contributed to the fact that responses were more negative towards 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 amongst mental health workers compared to other mental health diagnoses. Furthermore, two studies showed that simply knowing that a patient has a diagnosis of BPD leads to more stigmatising attitudes than knowing the diagnosis in addition to information about the patient's behaviour/symptoms (Lam, Salkovskis & Hogg, 2016; Lam et al., 2016). Given these findings, in addition to qualitative research which found that patients with BPD

consider the label to be confusing, and one that symbolises rejection and '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. Emotionally Unstable Personality Disorder (EUPD) (World Health Organization, 1992) is an example of an alternative label which highlights that emotional dysregulation is a key symptom of BPD. Bartels and Crotty (1998) also suggested 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 stigmatising attitudes (Link & Phelan, 2001). However, it is important to acknowledge that stigmatised attitudes towards BPD may remain despite using an alternative label, or that a different label could generate negative reactions which 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 alternative label, such as EUPD or Emotional Intensity Disorder, may lead to reductions in stigmatising mental health workers attitudes towards people diagnosed with BPD, or whether these labels provoke similar, negative reactions.

Although there is evidence suggest that at least mental health workers can hold comparatively negative attitudes towards BPD, there is evidence to suggest such attitudes are amenable to change. Researchers investigating staff attitudes towards recovery in BPD proposed that team formulation could help in providing consistent care (Deans, 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 client's 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 programme which led to positive changes in mental health workers' attitudes towards patients with BPD; this training programme included education regarding the biosocial understanding of the epidemiology and aetiology 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 behaviour therapy (DBT) (Linehan, 1993), a well-established and effective treatment for BPD (Bloom et al., 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 whilst maintaining a compassionate and non-judgemental stance towards their patients (Chapman, 2006), and one study indicates that they help therapists to regulate the difficult emotions which arise when working with patients (Walsh, Ryan & Flynn, 2018). Research also indicates that engaging in DBT training has been shown to improve mental health workers' attitudes towards BPD (Herschell et al., 2014; Haynos et al., 2016); however, further exploration of this is required.

A further approach to addressing mental health workers' stigma towards BPD may be to integrate peer support into BPD treatment. A study by Bowen (2013) found that clinicians felt peer support was a key component of good practice when working with people with BPD; they highlighted that their patients with BPD showed compassion towards 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 towards patients with BPD .

Limitations and Future Directions

There was a lack of consistency in how attitudes towards 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 is needed to enable more robust comparisons between studies. Additionally, 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 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 inter-rating 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.

Additionally, to enhance an understanding of why mental health workers' attitudes towards BPD seem to be particularly negative, researchers should replicate Lam et al.'s (2016) study to further explore whether the BPD label without information about BPD symptoms produces stigmatising 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 towards BPD with attitudes towards other PDs would also be helpful in establishing whether the inclusion of the word 'personality' is key in the formation of stigmatising attitudes, or whether there are other factors which make BPD a particularly stigmatised label. Qualitative research focusing on mental health workers' attitudes towards their patients with BPD and other diagnoses would be useful in providing a richer exploration of why attitudes towards 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 which 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/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 towards individuals with BPD. This would be an interesting area for future research. Excluding papers which explored the attitudes of non-mental health professionals may also restrict the generalisability of the findings. Mental health nurses and psychological professionals were over-represented 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 GPs and doctors/nurses working in accident and emergency departments.

Lastly, it is likely that access to research highlighting negative attitudes towards BPD plays a role in activating stigma towards the condition. Qualitative research may provide scope to explore the positive attitudes of mental health workers towards their patients with BPD, which could help to deactivate stigma. Additionally, 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 towards patients with BPD.

Conclusions

This review is the first to systematically explore how mental health workers' attitudes towards BPD compare to their attitudes towards other mental health diagnoses. The findings suggest that workers' attitudes towards BPD are more negative compared to other diagnoses, affecting their cognitive, emotional and behavioural responses towards 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 BPD being perceived as 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 stigmatising.

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Appendix A: Search Strategy

The Search Strategy used in PubMed.

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 #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 #27 AND #33 AND #48