Borderline Personality Disorder, Stigma, and Treatment Implications

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Borderline personality disorder (BPD) is often viewed in negative terms by mental health practitioners and the public. The disorder may have a stigma associated with it that goes beyond those associated with other mental illnesses. The stigma associated with BPD may affect how practitioners tolerate the actions, thoughts, and emotional reactions of these individuals. It may also lead to minimizing symptoms and overlooking strengths. In society, people tend to distance themselves from stigmatized populations, and there is evidence that some clinicians may emotionally distance themselves from individuals with BPD. This distancing may be especially problematic in treating patients with BPD; in addition to being unusually sensitive to rejection and abandonment, they may react negatively (e.g., by harming themselves or withdrawing from treatment) if they perceive such distancing and rejection. Clinicians' reactivity may be self-protective in response to actual behavior associated with the pathology. As a consequence, however, the very behaviors that make it difficult to work with these individuals contribute to the stigma of BPD. In a dialectical relationship, that stigma can influence the clinician's reactivity, thereby exacerbating those same negative behaviors. The result is a self-fulfilling prophecy and a cycle of stigmatization to which both patient and therapist contribute. The extent to which therapist distancing is influenced by stigma is an important question that highlights the possibility that the stigma associated with BPD can have an independent contribution to poor outcome with this population. A final issue concerns the available means for identifying and limiting the impact of stigmatization on the treatment of individuals with BPD. (Harv Rev Psychiatry 2006;14:249–256.)

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Individuals with borderline personality disorder (BPD) often struggle with multidimensional problems, including affective instability, difficulty containing impulses, limited ability to self-soothe, and suicidal and other forms of self-destructive behavior.[1] Clinicians can expect that during certain periods, the treatment of an individual who has BPD will be emotionally demanding. Because of the unpredictability of behavior and the intense range of emotion associated with BPD, it may be challenging for clinicians to maintain a view of the problems that emerge as reflecting the "nature of the pathology" and not the "nature of the individual." If an individual comes to be seen as the problem, he or she is less likely to be regarded with neutrality, and more likely to be condemned.

A stigma is the perception of a negative attribute that becomes associated with global devaluation of the person.[2] As a consequence of belonging to a stigmatized group,

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individuals are denigrated and perceived to have less value, and may be more isolated.[3–8] Goffman[3] characterizes stigma as an attribute that is discrediting. Those who are stigmatized, Goffman writes, are diminished—in the minds of those perceiving the negative attribute, the stigma—"from a whole and usual person to a tainted, discounted one." Individuals who belong to a stigmatized group are perceived to have a blemish of individual character.[3] In many cases, people begin to blame the stigmatized individual for being the cause of the "discrediting characteristic," changing the focus from the attribute (e.g., mental illness) to the person. An important feature of Goffman's analysis is that persons perceiving the stigma voluntarily distance themselves from those who are stigmatized. Mental illness has consistently been one of the most stigmatized disabilities.[8] In a review about stigma and mental illness, Hinshaw and Cicchetti[9] concluded that empirical research has not "even begun to document the actual levels of harm related to the stigmatization of mental disorder."

STIGMA AND PERSONALITY DISORDERS

The stigma associated with personality disorders has received limited attention compared to stigma in the context of other mental illnesses. Beales[10] warns that overlooking the stigmatization of personality disorders risks perpetuating negative perceptions of these individuals by mental health workers. The fact that their difficulties are usually triggered by, and experienced during, interpersonal situations may make it especially hard to work with these people. Individuals with personality disorders tend to experience powerful and intense feelings, which may affect feelings experienced by clinicians, such as feelings of intrusion or even manipulation. Clinicians may respond to such demands in unintentionally damaging ways. For example, Hinshelwood[11] speculates that professional staffs working with these individuals tend to "retreat emotionally" under the guise of a "scientific attitude." This description of an "emotional retreat" by mental health workers is similar to a "voluntary distance" as described by Goffman[3]—which suggests that the possibility of physical and emotional withdrawal by mental health professionals is worth considering. Such withdrawal may cause difficulties for patients and also lead mental health professionals to miss important information about the subjective experience of patients.[11] Hinshelwood[11] concludes that these patients are considered "difficult" because they evoke personal emotional difficulties that challenge the clinicians' assumptions about professional identity.

The perception that patients have control over their own behavior can perpetuate the stigmatization of personality disorders, in general, and BPD, in particular. In a 1988 study, Lewis and Appleby[12] found evidence that a perception that individuals with personality disorders have "self-control" is present among mental health professionals. They report that psychiatrists were less favorable toward a vignette with information that the patient had seen a psychiatrist two years prior and was given a "diagnosis of personality disorder," compared to other scenarios in which "personality disorder" was left out. Results with this sample suggest that when a diagnosis of personality disorder is present, clinicians form pejorative, judgmental, and rejecting attitudes. These patients were more likely to be described as "manipulative, difficult to manage, unlikely to arouse sympathy, annoying, and not deserving of [National Health Service] resources." Importantly, a suicide attempt was mentioned in the vignette and was considered by clinicians to be "attention seeking" rather than genuine for the personality disorder group. Lewis and Appleby state that patients given a diagnosis of personality disorder may be rejected and not considered ill, even when they have symptoms; "those labeled as personality disordered appear to be denied the benefits of being regarded as ill, but also denied the privilege of being regarded as normal." The authors speculate that the reason for this prejudice stems from an assumption by clinicians that personality disorders are not a form of mental illness, with the consequence that clinicians see patients as capable of controlling their symptoms and behaviors. We can speculate that, at times, clinicians interpret the intense and problematic behavior of individuals with BPD as the patient's choice to make an interpersonal demand upon the clinician, rather than as a symptom of the personality disorder. This study did not differentiate between various personality disorders, but the authors indicate that different personality disorders may elicit different levels of condemnation.

STIGMA AND BORDERLINE PERSONALITY DISORDER

As practitioners have struggled in their efforts to treat BPD, a prototype has emerged in the mental health field about these individuals.[13] This prototype may map onto the actual experiences of these individuals in a very imperfect way. Clinicians described them in pejorative terms such as "difficult," "treatment resistant," "manipulative," "demanding," and "attention seeking."[14–16] While each of these descriptors may reflect certain aspects of the patient's behavior, they can have an impact upon the treater's a priori expectations. Left unexamined the descriptors potentially become a justification for stigmatization and hence for discrimination, early termination, and other possible negative outcomes.

The stigmatization of BPD is likely to be a result of several characteristics of the BPD syndrome. For example, psychotherapy with an individual struggling with BPD may involve disturbing and frightening behavior, including intense

anger, chronic suicidal ideation, self-injury, and suicide attempts. Often the level of functioning in people with BPD fluctuates, making progress very slow. At the same time that such behaviors occur, the clinician is aware of the stigma associated with this disorder—which labels these individuals as difficult patients because of the behaviors. Without any intention on the part of clinicians, the stigma associated with the disorder may influence them to see lower levels of functioning as deliberate and within a patient's control, or as manipulation, or as a rejection of help. Subsequently, therapists may react in typical ways that have been documented to occur between stigmatized and nonstigmatized people in society; for example, they could initiate self-protective behavior such as distancing.[3,11] This kind of reaction is particularly unfortunate in the case of BPD, given that individuals with BPD are especially sensitive to rejection and may react to perceived abandonment with self-harm or by withdrawing from treatment. In such cases, the stigmatization of BPD can independently contribute to negative outcome. We will discuss specific ways that stigmatization might affect outcome and clarify how practitioners can minimize the risk of stigma contributing to negative results.

IMPACT OF STIGMA ON BPD

Little is known about the impact of stigmatization upon the course of treatment and upon clinical outcomes for individuals with BPD. Although the literature describes difficulties in clinical management of BPD,[17] these issues have not been examined from a standpoint of incorporating the influence of the clinician's negative perception of BPD. We will discuss the sparse research about stigmatization and BPD below, and begin to formulate the implications for clinicians and researchers.

Gallop, Lancee, and Garfinkel[21] found that the label of BPD was enough to change the behavior of treatment providers. These researchers compared nurses' responses to hypothetical patients with BPD and schizophrenia. They found that a significant proportion of nurses were more likely to remain sympathetic toward patients with schizophrenia, and made belittling or contradicting responses to statements made by patients with BPD. It is likely that the nurses' perception of the underlying motive of the patients (implying self-control) influenced their responses. Gallop and colleagues[21] suggest that the behavior of a patient with BPD is interpreted as manipulative and not "mad." They posit that the nurses' behavior may constitute a defensive behavior to protect against feelings of helplessness, anger, and frustration. Strikingly, Gallop and colleagues believe that the nurses felt that they could respond in a belittling manner because it was acceptable to derogate patients with BPD.

Fraser and Gallop[17] provide additional evidence regarding a relationship between stigma and the emotional reactivity of therapists. They surveyed 17 psychiatric nurses about patients with a variety of diagnoses who participated in group psychotherapy. They reported that nurses were less empathic to patients with BPD than to patients with affective disorder and "other" diagnoses, which included all other diagnostic categories except schizophrenia. Importantly, individuals with BPD aroused more negative feelings than other patients. In an earlier, pilot study, Gallop and Wynn[14] asked 25 psychiatric nurses and 12 psychiatric residents to identify behaviors and characteristics of "difficult patients." Content analysis of the responses showed that two themes emerged to represent the personal experiences of the nurses and residents with these patients: "lack of control" and "incompetence." In an effort to protect themselves, the nurses tended to personalize their reactions, wanting action from their patients, whereas the residents objectified and distanced themselves from feelings of isolation and lack of support, which seemed to reduce the intensity of the experience. Both reactions ultimately attributed the problematic experiences to the patient—and could exacerbate problems in psychotherapy. These results support Piner and Kahle's finding[22] that more bias is present against individuals with mental illness during situations that are personally involving.

The discussion above suggests that clinicians may misattribute certain behaviors of individuals with BPD, which perpetuates the stigma of BPD. Furthermore, actual behaviors found within the BPD population become integrated into an overall perception of these individuals. Gunderson, Frank, Ronnington, and Wachter's report[18] that BPD patients tend to terminate treatment within the first three months and that they also utilize multiple services and therapists. Bender and colleagues[19] state that in comparison to other personality disorders and major depression, individuals with BPD receive significantly more psychosocial treatment and try more medication regimens than other groups. Widiger and Weissman[20] report that the prevalence of BPD in the community is about 1.5%, yet it accounts for approximately 15% of hospital admissions. Such figures not only reflect the difficulties faced by these individuals, but simultaneously have become part of the stigma itself. Is it possible, however, that stigma associated with BPD unintentionally influences therapists and may inadvertently lead therapists to behave in ways that exacerbate symptomatic behavior of BPD? At this point we do not know the extent to which the behaviors of therapists, such as emotional or physical withdrawal, is influenced by the stigmatization of BPD. If it is, it becomes imperative to determine whether these reactions could contribute to increased turnover, self-injury, and mortality rates in this population.

BPD, STIGMA, AND THE SELF-FULFILLING PROPHECY

It has been found that when one person has negative expectations of another, the former changes his or her behavior toward the latter. These interpersonal situations have been described as self-fulfilling prophecies.[23,24] In other words, one person's expectations and attitudes about another person can cause the former to behave in a manner that induces the latter to act in a way that confirms the former's false perception.[25]

Stigma may play a role during psychotherapy by establishing preconceptions about patients with BPD, and may establish a priori negative expectations about the course of treatment. Therapists may defend against certain patient characteristics and emotional demands frequently encountered during work with individuals with BPD. These reactions can trigger additional behaviors in patients that confirm preexisting, stigmatizing notions about BPD. The stigma seems to be confirmed by the actual behavior exhibited by the patient, but what has not been taken into account is the influence of the therapist—which may itself have been shaped by the stigma. For example, a treater's expectation that a particular case will be difficult could lead to a perception that a patient is manipulative. The therapist may emotionally withdraw so as to avoid feeling manipulated, and interpret the behavior as being within the patient's control. Unintentionally, this stance may exacerbate self-destructive behavior; the therapist's unresponsiveness, or unconscious retaliation, can activate the patient's self-critical tendencies and a cycle that involves self-loathing and self-injury, followed, in turn, by the therapist's confirmation of the stigma and his or her own emotional withdrawal from the patient (see Figure 1).

STIGMA, SELF-HARM, AND EARLY WITHDRAWAL

As discussed above, distancing by therapists may inadvertently contribute to self-injury and early withdrawal from treatment. It is not difficult to imagine how a therapist's emotional distancing can unconsciously initiate desperate reactions by a person with BPD. For example, sensitivity about rejection and its association with being unworthy can increase self-loathing and, ultimately, self-destructive behaviors. The independent contribution of stigma associated with BPD toward these negative outcomes is subtle and difficult to determine in relation to the underlying pathology of BPD.

CLINICAL VIGNETTE: THE CHANGE FROM "STIGMA" TO "SYMPTOM"

In this section, we present a case that illustrates the difficulties that therapists may encounter during psychotherapy of an individual with BPD. Acknowledging the real difficulties and struggles associated with the BPD syndrome does not eliminate the stigma itself. The focus here is on maintaining a perspective that these behaviors are not fully controllable by the patient and that symptoms of the disorder do not reflect an intention to undermine the therapist or treatment.

> Ms. A is in her mid-thirties and has known her diagnosis of BPD for several years. She received a referral to her current treatment following an involuntary hospitalization that was ordered after she cut herself on her legs and stomach. She had longstanding suicidal ideation that did not remit over the course of her previous 18-month treatment, which included weekly individual psychotherapy, a weekly skills/therapy group, and psychotropic medication.

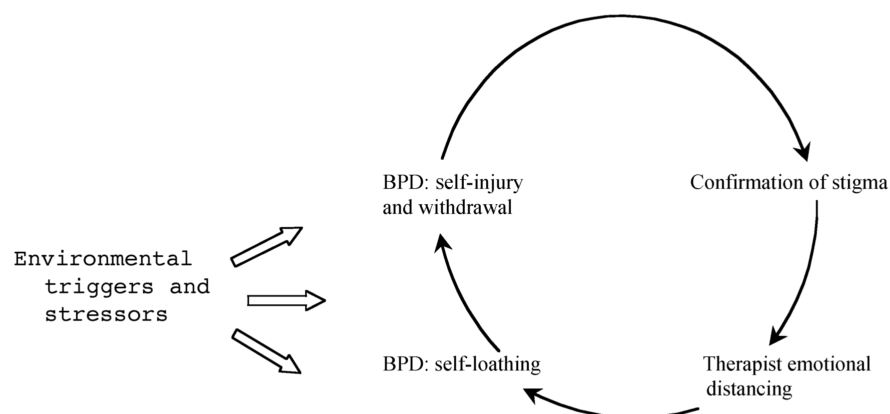

FIGURE 1. Cycle of stigma confirmation and behavioral dysregulation in BPD.

Her most recent treatment providers decided to discontinue treatment following this recent hospitalization, the second in six months. They felt that Ms. A had not improved and may have gotten worse. They were concerned that she needed a more structured day-treatment setting, as opposed to the outpatient services she was receiving.

Following the hospitalization she was referred to a structured outpatient treatment program that specialized in BPD, but involved only individual therapy. The initial emphasis in her current, twice-weekly outpatient supportive psychotherapy (see Aviram, Hellerstein, Gerson, & Stanley)[26] focused on her frustration and desperation after she was fired the previous year from a job that she enjoyed very much—and felt to be "all I am good at." Since then it has been uncertain, for reasons not within her control, whether she will be able to pursue work in her field again. This exacerbated her depression, and in circular fashion, she contended that her improvement was dependent upon returning to work. She stated, "Life is not worth living if I cannot return to work . . . [to] the work that I am meant to do." At that point she was unable to consider changing her career. Initial therapeutic efforts addressed her fixed, negative self-worth and her hopelessness in an ongoing discussion about "black or white thinking" and how an "all or none" perspective can be a BPD symptom. In this way, behavior that can be frustrating or anxiety provoking for the therapist was normalized, and the symptoms and struggles stemming from BPD were disassociated from the interpersonal demands that the therapist may experience. Suicidal ideation continued in a fixed way, and the urges to cut herself were ongoing. Acknowledging her suicidality proved to be crucial, given one of her past experiences in a similar situation. Ms. A discussed a previous episode during which she felt like hurting herself and was not sure of her safety. She went to an emergency room for treatment. The ER staff were familiar with her and told her that they did not believe her, so they did not hold her for extended evaluation. Ms. A reports that she left the ER and immediately cut her wrists and swallowed all the medication she had. She then walked back into the ER and, needless to say, was admitted.

During the initial phase of treatment she paged her therapist between sessions to report urges to cut herself or to die. Sometimes a short conversation would help her feel better, but at other times her hopelessness and misery did not shift. After six weeks in her current treatment she cut herself in a serious way without intending to die, and contacted her therapist a day later. She agreed to see a physician, who called the therapist, concerned about the nature of the self-injury. Hospitalization was not considered to be a helpful course following this episode, given that suicidality was not present and urges to cut herself remitted. Similar behavior was anxiety provoking for her previous treatment providers, and now for her current therapist, especially when she would state that there was nothing that her therapist could do to help. Her suicidal ideation was difficult to tolerate and seemed to be a limiting factor in her progress, along with her negative view of herself and her hopelessness about whether anything could help.

DISCUSSION OF VIGNETTE

Several aspects of Ms. A's behavior reflect the difficulties encountered with BPD. In this case, there are interpersonal demands that reflect the intense need for contact, along with the frustration stemming from her minimization of the therapist's help. An additional struggle in this case involves the patient's apparent past competence in relation to her current helplessness. The challenge is upon the therapist to engage Ms. A in a therapeutic dialogue about these behaviors and not allow them to become self-defining and stigma confirming. Ms. A's behavior was frightening when she described her suicidal ideation and when she cut herself. As Hinshelwood[11] states, these kinds of problems challenge the therapist's self-identity as a "help provider" by causing concern, anxiety, and the feeling of being out of control. The risk is that there will be either a self-protective emotional retreat by the therapist or, perhaps, an angry accusation about the patient's effort to control the therapist. In determining how to deal with patients who are displaying self-injurious or suicidal behaviors, the standard of care discussed in the American Psychiatric Association guidelines for patients with BPD[27] and suicidal behaviors is helpful.[28] Risk is actively assessed during such crisis episodes, and patients are encouraged to call their therapists if they have urges to harm themselves. These measures can provide a buffer between the immediate emotional crisis and the patient's response, and they can help both the therapist and the patient feel that there are ways to gain control over feelings that appear uncontrollable. This active effort can help reduce the risk that the therapist will rationalize the behavior as the "typical," stigmatizing behavior of patients with BPD—which could help avoid the vicious cycle (see Figure 1) described above.

Upon referral of a patient with a history similar to Ms. A's, many psychotherapists would be appropriately apprehensive. Some of the feelings that therapists can anticipate are anxiety, anger, frustration, and feeling helpless. Although these kinds of expectations are appropriate, they can also predispose the therapist to perceive behavior like Ms. A's self-injury as an overreaction to minimal stressors or as a behavior that seeks secondary gain of additional attention from friends, family, or the therapist. By implication, such

misattributions are perceived to be under the patient's control. Responses like these can be damaging and leave patients feeling blamed and misunderstood, especially if the stressors are experienced as overwhelming (regardless of how others may cope with them) or if, for example, the patients have no interest in letting others know that they cut themselves. The therapist may proceed on the assumption that the patient is overreacting or being manipulative—which might be partially valid but not take into account the possibility that the therapist is already prejudiced by the stigma of BPD. An alternative view, which recognizes the therapist's own potential prejudgment about BPD, offers a chance to respond differently. For example, the therapist could comment to Ms. A that it must be difficult for her to struggle with such overwhelming feelings and that cutting herself has been the only way for her to find relief. Another option is for the therapist to acknowledge the possibility of a rejecting countertransference stemming from a preexisting awareness of the stigma about BPD, and to reframe the interpretation from this perspective. For example, "Cutting yourself may be a way for you to distance yourself from me, or even to have me distance myself from you." These latter interventions offer a way for therapists to acknowledge the difficulty of their own emotional reactions, while simultaneously indicating acceptance and tolerance.

ADDRESSING THE STIGMA OF BPD

Supervision can be extremely helpful in recognizing how the pathology of BPD becomes intertwined with the social stigma of the disorder. Addressing how the stigma and pathology are interrelated could also be part of the therapeutic process itself. It makes sense for the therapist to inquire about the patient's experience of stigma with other mental health providers or in the community. The clinician's task is to be aware of the role of the stigma in his or her perception and interpretation of significant behavioral symptoms of BPD. This effort requires that the therapist and patient work together to understand and overcome the meaning of preexisting negative perceptions—which can then be related back to the fundamental struggles of BPD.

The treatment of BPD appears to be benefiting from new theoretical and empirical attention (see Linehan[32] and Bateman & Fonagy),[33] but individuals with the disorder are still viewed negatively by many practitioners. Training and professional support systems can help provide the foundation that therapists need in order to cope with difficult cases. Through experience, clinicians learn how pathology makes demands on the therapeutic process, and yet even the development of appropriate expectations about the course of treatment does not ensure that those expectations would not themselves become a stigma ascribed to the individual with the pathology. For example, the expectation that it may be a difficult course of treatment is simultaneously a reality and part of the stigma of BPD. Importantly, the stigma of this disorder may lead therapists to dismiss or minimize difficulties (as in Ms. A's case, in the ER) or, in contrast, to overlook real strengths that are overshadowed by a focus on the problematic behaviors alone.[26]

Stigma about BPD can be transmitted from clinician to clinician in subtle and not so subtle ways. Consider a therapist's description of a referral from another therapist: "As soon as I heard that the patient's history included self-injury, I said to myself, 'Oh, no, she's borderline." Likewise, a clinician might be discussing a patient's trouble with boundaries or his ambivalence about life, and remark, "That's very borderline." Or a referral might include the phrase "bad borderline." And so on. Evaluating the implications of such comments can help maximize the usefulness of psychotherapy for individuals with BPD. It can, in particular, offer psychotherapists the chance to attend to their own negative preconceptions about individuals with BPD.

STIGMA AND COUNTERTRANSFERENCE

Racker[29] has commented that certain emotional reactions may reflect unconscious identifications between the therapist and patient. These identifications have been described as representing a "needed" or "repeated" early relationship.[29,30] An awareness of the needed or repeated behavior can be extremely helpful to the therapist when confronting angry or distancing feelings toward a patient. Rather than permitting the stigma of BPD to justify the reaction, those feelings can themselves be utilized productively. Such feelings may represent the therapist's identification with the patient (e.g., self-representation) or with the patient's intrapsychic objects (e.g., object relationship with a parent). From this perspective, the self-injury of a patient may be regarded on multiple levels. It may be examined as interpersonally frustrating and anxiety provoking, as representing an aspect of the patient's early experience, and as a manifestation of his or her experience in society. In Ms. A's case, she saw herself as having been shunned in society (e.g., by losing her job or being told to leave the ER) and, as her therapist became aware, saw rejection as part of her life (i.e., in others rejecting her and her rejecting others). The stigma of BPD may blind a therapist from utilizing such emotional reactions and increase the chance of repeating the past experiences in the current treatment.

AMBIGUITY MAY FOSTER DISCRIMINATION

Psychotherapists may justify and rationalize the situation when they turn down referrals or when individuals

with BPD terminate therapy prematurely. There may be legitimate reasons for such actions—for example, a concern about the projected time demands or the patient's self-destructive behavior, which the therapist might not feel equipped to manage. In many such circumstances, however, therapists may be unaware that their decisions are nevertheless being influenced by "nonconscious" prejudice shaped, perhaps unavoidably, by the preexisting stigma about BPD. This kind of dynamic has been discussed in the social psychological literature about prejudice. Dovidio, Kawakama, and Gaertner[31] suggest that discrimination could occur in situations that involve ambiguous choices. In such a context, even individuals with egalitarian views (and who would not consider themselves to be prejudiced) can make choices, influenced by "nonconscious" anxiety, that discriminate against a dissimilar person. The relevance of this research for us here is that the therapist may make certain decisions within a context that prevents those decisions from being consciously challenged as prejudicial. For example, the decision may be rationalized and considered legitimate, as mentioned above, because of the therapist's time limitations or the uncertainty about being able to manage certain problems effectively. Of importance, too, is that the psychotherapy context is one of inherent ambiguity and of multiple perspectives. In such a context, choices are potentially open to be influenced by stigma, though they may not be acknowledged or perceived as such.

NEED FOR RESEARCH

Research is needed in order to determine the extent to which stigmatization affects outcome in psychotherapy. This phenomenon seems especially relevant to the treatment of BPD, a hallmark of which is an exquisite sensitivity to rejection and abandonment. Research would have to take into account the preconceptions of both the therapist and the patient. Often individuals with BPD have prior experience of being stigmatized, as well as knowledge about the stigma associated with BPD, both of which may complicate the initial rapport with therapists. Given the prevalence of self-injury and suicidal behavior, as well as early withdrawal and therapist turnover with this population, clarifying the extent to which stigmatization makes an independent contribution to such outcomes is imperative.

CONCLUSION

Since stigmatization is a powerful force in society, eliminating the stigma of mental illness, and specifically that of BPD, may not be possible. Nevertheless, awareness of the impact that such negative perceptions have on persons with BPD may be a crucial factor for increasing success rates in treating members of this stigmatized group. Often clinicians are able to utilize their own feelings in a productive manner during psychotherapy. Acknowledging to oneself, and even sometimes to the patient, a desire to reject the patient may open the way to discussing the patient's experience of rejection or neglect in his or her life.

The stigma associated with BPD may predispose mental health workers to minimize functional difficulties or disregard the patient's complaints—given that those very complaints tend to confirm the stigma. Since distancing is a common reaction of nonstigmatized people to members of stigmatized groups, clinicians need to be vigilant about their own preconceptions and reactions when dealing with BPD patients. This group has become especially stigmatized in the mental health field—and recently in the community as well. One factor contributing to clinicians' different reactions to different disorders may be the erroneous perception that individuals with BPD can control their behavior, whereas other disorders are perceived as biochemically determined. Stigmatization could therefore be reduced if it were more broadly understood that emotional disorders such as BPD are legitimate illnesses and not examples of moral failings or lack of willpower.[34] Clinicians are, indeed, in a position to counter the hopelessness sometimes associated with BPD, as when patients are frightened to hear about a diagnosis of BPD because they have heard so much about its having a poor prognosis. The vulnerability of individuals with BPD is part of the dynamic that underlies the behavior leading to stigmatization, but this same vulnerability can, in many cases, provide opportunities for productive and gratifying experiences in psychotherapy for both patients with BPD and their therapists.

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