WHAT'S IN A NAME: CAN A DIMENSIONAL TRAIT MODEL REDUCE BIAS AGAINST BORDERLINE PERSONALITY DISORDER?

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Jennifer Katherine Boland

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To everyone who was there for me when I pushed myself too hard during my doctoral program. I literally would not be here without you.

ABSTRACT

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For decades, there has historically been a lack of agreement on the definition, presentation, development, best treatment practices, and even existence of borderline personality disorder (BPD). Over time, a complex set of beliefs has arisen surrounding the BPD diagnosis, leading many mental health professionals to hold a bias against these clients. The current study investigated a way to potentially reduce this bias, by asking mental health professional and laypersons to respond to clinical vignettes assessing clients through the traditional, categorical model of diagnosis and through the DSM-5's Alternative Model for Personality Disorders (AMPD). Attitudes were further assessed through the use of the Revised Causal Dimension Scale (CDSII), Emotional Responses, and a modified version of the Attitude to Personality Disorder Questionnaire (APDQ). Professionals were also asked to report their familiarity with the AMPD.

Results showed current-day bias may look differently than it has in the past and that general professional opinions of individuals with BPD may be improving. Additionally, professionals in this sample were largely unfamiliar with the AMPD. Clinical relationships between individuals with BPD and their treatment providers can still be improved through the collaborative efforts of future research in the areas of personality assessment and personality disorders.

KEY WORDS: Borderline personality disorder, DSM-5 Alternative model of personality disorders, AMPD, Stigma, Professional bias

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TABLE OF CONTENTS

Page

LIST OF TABLES

CHAPTER I

Introduction

Overview of Borderline Personality Disorder

Description

According to the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-5; American Psychiatric Association [APA], 2013), borderline personality disorder (BPD) is a severe form of psychopathology characterized by a pervasive pattern of marked impulsivity and instability of interpersonal relationships, self-image, and affect, which begins by early adulthood and is present in a variety of contexts. In order to meet criteria for this categorical diagnosis, an individual must show at least 5 of the 9 potential symptoms listed in the DSM-5. This list includes such symptoms as frantic efforts to avoid real or imagined abandonment, a pattern of unstable and intense interpersonal relationships, identity disturbance, impulsivity, recurrent suicidal or self-mutilating behavior, and affective instability, among others (see Table 1).

Research on BPD paints a clinical picture of individuals with this disorder as often experiencing profound changes in self-image, affect, cognition, and behavior in response to significant psychological pain (Lieb et al., 2004; Zanarini & Frankenburg, 2007). They may be severely distressed by impending separation or rejection from someone important to them because of reduced expectations of social acceptance and heightened sensitivity to changes in environmental circumstances. In some cases, this sensitivity can facilitate intense abandonment fears in the context of relatively minor, unavoidable changes in plans (Liebke et al., 2018; Matthies et al., 2018; Palihawadana et al., 2019).

Table 1

DSM-5 Criteria for Borderline Personality Disorder

Diagnostic Criteria
A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following: **1.** Frantic efforts to avoid real or imagined abandonment (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.) **2.** A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation. **3.** Identity disturbance: markedly and persistently unstable self-image or sense of self. **4.** Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.) **5.** Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior. **6.** Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days). **7.** Chronic feelings of emptiness. **8.** Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights). **9.** Transient, stress-related paranoid ideation or severe dissociative symptoms.

Note: Table adapted from the *Diagnostic and Statistical Manual of Mental Disorders-5th Edition* (DSM-5; APA, 2013, p. 663).

These fears and other distressing life events often lead to radical, marked changes in mood (e.g., periods of poorly controlled, inappropriately expressed anger, or symptoms of panic or despair; Koenigsberg et al., 2002; Russell et al., 2007) or self-damaging

impulsive actions, including self-harming or suicidal behaviors (Links et al., 1999; Zanarini & Frankenburg, 2007). In severe cases, episodes of dissociation or transient, paranoid ideation may occur in response to triggers of intense psychological pain (Zanarini et al., 1990).

For an individual with BPD, these rapid changes in affect and behavior in response to seemingly minor slights often lead to a pattern of unstable and intense interpersonal relationships, in which others are idealized upon first meeting and later devalued when they are unable to meet the individual's excessive need for interpersonal support or live up to their idealized standards (Bender & Skodol, 2007; Zanarini & Frankenburg, 2007). It is also common for an individual with BPD to lack a stable sense of self; instead, they present with sudden and dramatic shifts in self-image, often based on being bad or evil, or not existing at all (Bender & Skodol, 2007). They may be plagued by chronic feelings of emptiness or boredom, which exacerbate a desire to participate in impulsive, sensation-seeking behaviors, including self-harm and suicide (Ellison et al., 2016; Elsner et al., 2018).

Epidemiology

Studies have estimated BPD affects between 1.6-2.7% of adults in the United States, with rates up to 10% in samples of psychiatric outpatients and 20% in samples of psychiatric inpatients (APA, 2013; Lieb et al., 2004; Tomko et al., 2014; Zimmerman, Rothschild, & Chelminski, 2005). In clinical practice, BPD is diagnosed predominately (about 75%) in women (APA, 2013); however, epidemiological data show only slightly higher rates of BPD among women (i.e., a 3.0% prevalence rate in women and 2.4% prevalence rate in men; Tomko et al., 2014), or no significant difference across genders,

depending on whether self- or informant-report methods are used (Busch et al., 2016). These epidemiological data also show higher rates of BPD among Native Americans (5.0%), Blacks (3.5%), people younger than 30 (4.3%), those with income lower than $20,000 per year (4.8%), and those with less than a high school education (3.3%). Conversely, significantly lower rates of BPD symptomatology have been found in Asian Americans (1.2%; Tomko et al., 2014). BPD also shows high rates of comorbidity with other forms of psychopathology. Up to 85% of individuals with a BPD diagnosis have been diagnosed with a comorbid anxiety disorder, up to 83% have been diagnosed with a comorbid mood disorder, and up to 78% have been diagnosed with a comorbid substance use disorder (Sansone & Sansone, 2011; Tomko et al., 2014).

Course & Prognosis

Research suggests that symptoms of BPD begin developing in late childhood, though individuals do not typically seek treatment until late adolescence or young adulthood, when the functional impairment associated with the disorder become apparent (Lieb et al., 2004; Zanarini, Frankenburg, Khera, & Bleichmar, 2001). Substantial rates of both mental and physical disability have been associated with BPD, and individuals with BPD display significant impairment in functioning (often compounded by elements of another personality disorder; Zimmerman et al., 2005). In both the general community and clinical settings, individuals with BPD are significantly less likely to experience good overall functioning, (defined as steady, consistent employment and at least one good relationship) than community-based individuals without BPD (Javaras, et al., 2017). They also show lower ratings of global satisfaction, recreational activity, and ability to complete household tasks, and higher ratings of social impairment in friendships than

individuals who are diagnosed with mood, anxiety, or other personality disorders (Ansell et al., 2007).

Additionally, rates of self-harm and suicide are particularly high among BPD samples, with an estimated range of 50 to 80% of individuals with BPD engaging in self-harm behaviors, and 5 to 10% of individuals with BPD completing suicide, which is at least 500 times higher than the rate of the general population (Oumaya et al., 2008; Paris & Zweig-Frank, 2001; Stone, Stone, & Hurt, 1987).

Despite early pessimistic views of outcomes for BPD individuals (e.g., Stern, 1938), longitudinal studies have shown the disorder to have an unexpectedly good course; generally, as individuals age, symptoms of BPD decrease. At 10 to 27 years after initial assessment, adults across several longitudinal studies generally met less than two criteria for a BPD diagnosis, and 85% of individuals were considered to be in remission, with few of those in remission experiencing a later recurrence (Gunderson, Stout, & McGlashan, 2011; Paris & Zweig-Frank, 2001; Zanarini, Frankenburg, Hennen, & Silk, 2003). Even so, there is evidence for decreased longevity in individuals with BPD when compared with national data on life expectancy, which appears to be related both to the high rates of suicide in this population (usually occurring prior to age 40) and the negative effects on general health associated with their impulsive and affectively unstable personality traits (Paris & Zweig-Frank, 2001).

Treatment

The levels of distress and functional impairment shown by individuals with BPD, compounded by their high likelihood of experiencing comorbid psychological disorders, result in this population being highly likely to seek therapy or medication to address their

mental health concerns (Grant et al., 2008). Across several modalities, including psychotherapy, day treatment, psychiatric medications, and psychiatric hospitalizations, individuals with BPD are likely to report higher rates of treatment service utilization than individuals with mood or anxiety disorders, or other personality disorders (Ansell et al., 2007; Bender et al., 2006). These characteristics have important ramifications not only for the individuals experiencing this disorder, but also for the economic and social costs of a BPD diagnosis.

Over the course of their lifetime, individuals with BPD are likely to engage in treatment in many settings, across many modalities. Indeed, one study showed that compared to patients with depressive disorders, patients with BPD were over four times more likely to have received individual psychotherapy, more than twice as likely to have received group psychotherapy, and approximately five times as likely to have been psychiatrically hospitalized in their lifetimes (Bender et al., 2001). In early studies of treatment utilization in this population, up to 97% of individuals with BPD who were actively engaged in treatment at the time of the study had received outpatient therapy across an average of 6 treatment providers, and about 72% had been psychiatrically hospitalized; however, treatment episodes were generally brief (Perry & Cooper, 1985; Skodol, Buckley, & Charles, 1983). Additionally, in an early survey of 11 clinicians with expertise in the treatment of BPD, only 54% of these clinicians' patients with BPD continued treatment for more than 6 months, only 33% "completed" treatment, and only 10% were considered "successfully treated" at termination (Waldinger & Gunderson, 1984).

In the late 1980's, Marsha Linehan developed Dialectical Behavior Therapy (DBT; Linehan, 1993), a comprehensive cognitive-behavioral treatment for chronically suicidal individuals. Over the next decade, DBT grew to become the de facto treatment for BPD and other behavioral disorders involving emotional dysregulation. Through the five functions of DBT[1], individuals with BPD learn important interpersonal, self-regulation, and distress tolerance skills that allow them to better navigate the personal and environmental barriers to functional behavior in their daily lives (Dimeff & Linehan, 2001). In the first randomized clinical trial of DBT with individuals with BPD, participants receiving DBT were less likely to engage in parasuicidal behavior, less likely to drop out of treatment, less likely to be psychiatrically hospitalized, and more likely to show improvement on scores of global and social adjustment than were participants receiving treatment-as-usual; these advantages in the DBT condition were maintained at one-year post-treatment (Linehan et al., 1991; Linehan, Heard, & Armstrong, 1993; Linehan, Tutek, Heard, & Armstrong, 1994). Later studies continued to show the effectiveness of DBT in the treatment of BPD; following a 1-year intervention protocol, participants maintained therapeutic gains from DBT at 2 years post-treatment in the areas of suicidal behaviors, anger, interpersonal functioning, and depression (McMain et al., 2012). Even when only some elements of the full DBT protocol are implemented, participants can make significant therapeutic gains (e.g., Iverson, Shenk, & Fruzzetti, 2009; Trupin, Steward, Beach, & Boesky, 2002; Sambrook, Abba, & Chadwick, 2006).

[1] Enhancing behavioral capabilities, improving motivation to change, assuring new capabilities generalize to the natural environment, structuring the treatment environment to support client and therapist capabilities, and enhancing therapist capabilities and motivations to treat clients effectively.

Since the introduction of DBT, treatment outcomes for clients with BPD have improved significantly; however, implementing the full DBT protocol with fidelity, including individual therapy, group skills training, phone coaching, and a treatment consultation team, can be a costly, time-consuming, and resource-heavy process (Dimeff & Linehan, 2001).

History and Conceptualizations of BPD

History of a Diagnosis

Although BPD is currently diagnosed within a large percentage of clinical populations, several controversies have arisen in the history of this disorder (Zandersen, Henriksen, & Parnas, 2019). These controversies stem from the origin of BPD as a diagnosis in the 20th century, during a time when the psychoanalytic paradigm classified disorders by their responses to psychoanalysis; individuals with neuroses were analyzable and treatable, whereas individuals with psychoses were not analyzable, and thus, untreatable (Gunderson, 2009). Using this classification system, psychiatrists found that certain people tended to regress to "borderline schizophrenia," and the term "borderline" became an inconsistently used term to describe individuals who bordered on psychosis but did not fit into the category of schizophrenia (Gunderson, 2009; Stern, 1938; Zandersen et al., 2019). According to early investigators of this type of "borderline" person, these individuals were "extremely difficult to handle effectively by any psychotherapeutic method," and it was generally accepted that "the knowledge we possessed was not adequate to treat these people" (Stern, 1938, p. 467).

In 1967, the phrase "borderline personality organization" was first used by Otto Kernberg to more accurately categorize individuals who displayed a specific, stable,

pathological personality organization between neurosis and psychosis, rather than a transitory fluctuation between these two poles. In his investigation of the borderline label, Kernberg found that this term was used to refer to both of these distinct patterns of psychopathology. In an attempt to curtail the confusion surrounding this term, Kernberg proposed the earliest version of what would become the diagnostic criteria for BPD:

> The term "borderline" should be reserved for those patients presenting a chronic characterological organization which is neither typically neurotic nor typically psychotic, and which is characterized (i) by typical somatic constellations; (ii) by a typical constellation of defensive operations of the ego; (iii) by a typical pathology of internalized object relationships; and (iv) by characteristic genetic-dynamic features. (Kernberg, 1967, p. 643)

He further described these individuals as displaying a diffuse sense of identity, impulsivity, fragile reality testing, and troubled interpersonal relations. Kernberg also stressed the important role of accurate diagnostic assessment in the treatment of patients showing borderline personality organization, noting that this condition required specific therapeutic approaches that differed from those used to treat neuroses. This explanation for the poor prognosis of many individuals with BPD represented a large step forward from Stern's time 30 years earlier, when these same individuals were considered wholly resistant to all existing forms of treatment.

The next significant step forward in the diagnosis of BPD occurred in 1980, with the publication of the 3rd edition of the DSM. The inclusion of BPD in the DSM was largely based on the work of Grinker and colleagues (1968) in the seminal book *The Borderline Syndrome* that set the stage for further refinement to the "borderline" concept

by identifying four core characteristics of borderline patients: anger as the main affective presentation, defects in affectional relationships, impaired self-identity, and depressive loneliness, which were ultimately incorporated into the diagnostic criteria of BPD. Although upwards of 20 variations of the borderline concept existed in the lead-up to the publication of DSM-III, including characterizations of borderline as a form of schizophrenia, a characterological disorder, or a disorder separate from both of these, the disorder was officially operationalized as a PD through its inclusion in the DSM (Zandersen et al., 2019). This milestone was also significant for the concurrent inclusion of schizotypal PD in the DSM-III, which served to differentiate BPD further from schizophrenia spectrum disorders (Spitzer, Endicott, & Gibbon, 1979). Within the DSM-III (APA, 1980), the diagnostic criteria for BPD were largely similar to the criteria that have been retained through DSM-5 (APA, 2013) and included symptoms such as impulsivity, unstable interpersonal relationships, poor anger control, and affective instability.

Following its inclusion in the DSM-III, BPD became a subject of increased study. In the following years, researchers began compiling knowledge relevant to both the diagnosis and treatment of BPD. Since its first inclusion in DSM-III, the only significant change to the BPD diagnosis within the DSM was the addition of a ninth criterion in DSM-IV: transient, stress-related paranoid ideation or severe dissociative symptoms (APA, 1994), based largely on the work of psychologists who conceptualized BPD as a trauma spectrum disorder, similar to a chronic form of posttraumatic stress disorder (PTSD) or a dissociative disorder, such as dissociative identity disorder (Herman & van der Kolk, 1987).

Although the outline of BPD within the DSM has not changed significantly in the past several decades, researchers have continued to examine alternative ways of conceptualizing the disorder. Using the DSM's current categorical system of assessing and classifying PDs, a BPD diagnosis requires the presence of any five of nine potential symptoms (APA, 2013). Thus, there are 256 symptom combinations of BPD, and the literature suggests several clinically meaningful "subtypes" of BPD may exist (Critchfield et al., 2008). Though some research has found evidence for a unidimensional structure of BPD symptoms (Hawkins et al., 2014; Clifton & Pilkonis, 2007), the validity of a single, categorical BPD diagnosis has been under debate since its introduction in DSM-III. Indeed, many scholars continue to criticize the DSM conceptualization of BPD and have suggested that alternative measures of personality disorder traits or conceptualizations considering BPD as a disorder of mood and/or impulsivity (rather than personality) could best describe the clinical picture of this complex, controversial disorder (Costa & Widiger, 2002; Livesley, 2003; Paris, 2009; Tyrer, 2009). Additionally, there is ongoing debate as to whether the concept of BPD is sufficiently disentangled from the diagnosis of schizotypal PD and other schizophrenia spectrum disorders to merit its own diagnostic label, particularly following the addition of the ninth criterion of BPD in DSM-IV, which includes transient, stress-related paranoid ideation or severe dissociative symptoms (Zandersen et al., 2019). Another ongoing argument suggests that BPD criteria reflect the broad, underlying bases of PDs or psychopathology more generally, rather than a specific, unitary disorder, thus arguing against the existence of the BPD construct entirely (Sharp et al., 2015). This view is widely shared by experts in the field of PD research; in a survey of experts in this field preceding the release of the

DSM-5, only 31% of participants wanted the BPD diagnosis to be retained in the DSM-5 (Bernstein et al., 2007). Of those who do see the value in retaining this diagnostic concept, many have insisted from early on that BPD (like other PDs) is best conceptualized through a dimensional, rather than categorical, system of assessment and measurement (Trull et al., 1990).

Categorical and Dimensional PD Models

For much of the history of the DSM, criteria for the disorders contained within was based largely upon clinical judgment (Widiger & Clark, 2000). It was not until the publication of the DSM-III that author committee members began to resolve disputes in clinical judgment through an appeal to objective data, and even then, these data were seldom available or useful (APA, 1980; Spitzer, 1985). Though the process of diagnostic revision improved in later additions to the DSM as the available research base increased, many diagnoses have retained their structural roots from the earliest iterations of the DSM; that is, most diagnoses remain in a categorical framework, in which they are judged present or absent on the basis of discrete symptom counts. This approach has several inherent problems for both PDs and psychopathology at large, including contributing to high diagnostic comorbidity, arbitrary diagnostic thresholds, uncertain diagnostic validity for certain disorders, and the high proportion of cases that are best classified in an “Unspecified/Not Otherwise Specified” category. Indeed, the use of this categorical approach for PDs specifically has been criticized practically since its inception, with critics advocating for the use of dimensional models of PDs instead, utilizing traits that range on a spectrum that includes normality, rather than discrete symptoms (Bernstein et al., 2007).

For many years, researchers have examined psychopathology from a dimensional perspective, wherein symptoms or traits of differing severities common among many co-morbid disorders are organized into hierarchical models beneath broader superordinate dimensions of psychopathology (Clarkin et al., 2015; Krueger & Markon, 2006; Kotov et al., 2017; Markon, 2010; Slade & Watson, 2006). Regarding PDs specifically, early models supported a four-factor structure of personality pathology, including a trait for neuroticism or negative emotionality, a trait for disagreeableness, a trait reflecting conscientiousness or lack thereof, and a trait reflecting extraversion and positive emotion, or lack thereof (O'Connor & Dyce, 1998). These models often presented PDs as extreme variants of normal personality traits, rather than categorically separate instances of traits and behaviors (Bernstein et al., 2007).

Dimensional models of assessing personality pathology have been "uniformly accepted as nearer reality" (Eysenck, 1986, p. 77) than categorical labels for over 30 years (Eysenk, 1986; Widiger, 1992); however, a categorical model of diagnosing PDs has persisted. In 2004, a workshop sponsored jointly by the American Psychiatric Association, World Health Organization, National Institute for Mental Health, and National Institute on Drug Abuse was held to discuss PD models. This workshop looked towards the steps necessary for implementing a dimensional model of PDs in the upcoming DSM-5 and examined existing models from many perspectives (Clark, 2007). Workshop attendees ultimately concluded that the current categorical system of PDs was scientifically untenable (Widiger & Simonsen, 2005), and that implementing a dimensional PD system was a question of "not whether, but when and which," as had been declared almost 15 years previously by Allen Frances (1993, p. 110; Clark, 2007).

Indeed, choosing which dimensional model to implement was a significant challenge; over the last several decades, at least 18 dimensional models of PDs had been proposed (Clark, 2007). These models varied in their foundations, with some being based upon the well-established Five Factor Model (FFM; Costa & McCrea, 1992) of normal-range personality traits (e.g., Lynam & Widiger, 2001) and others being based upon other theoretical systems, such as temperament (Cloniger, 1987) and functional impairment (Hill et al., 2000). In 2005, Widiger and Simonsen proposed an integrative, hierarchical model of PDs in an effort to combine the strengths and minimize the weaknesses of the 18 extant dimensional system proposals. This hierarchical model featured several levels of dimensions, beginning with two superfactors that broke down into three to seven broad dimensions, which were in turn composed of personality trait facets that were further specified in terms of affects, behaviors, and cognitions. Though this theoretical model had its flaws and was not adopted outright, it represented a firm, research-supported base from which future dimensional models could be developed (Clark, 2007).

In the lead-up to the publication of DSM-5 (APA, 2013), experts were surveyed regarding their opinions on the current system of PDs contained within the DSM-IV-TR (APA, 2000). Of these, 74% opined that the current categorical system of PDs should be replaced, with 80% of the full sample believing that PDs are better conceptualized as personality dimensions than as categories (Bernstein et al., 2007). Later, the DSM-5 Personality and Personality Disorders Workgroup convened with the task of establishing a provisional trait model, with the goal of integrating dimensional personality traits into the forthcoming edition of the DSM (Krueger et al., 2012). The Alternative DSM-5 Model for Personality Disorders (AMPD) was placed in Section III of the DSM-5, titled

"Emerging Measures and Models," reflecting a decision "to preserve continuity with current clinical practice, while also introducing a new approach that aims to address numerous shortcomings of the current approach to personality disorders" (APA, 2013, p. 761).

The DSM-5 Alternative Model for Personality Disorders (AMPD)

In the AMPD, PDs are characterized by two primary criteria: impairment in personality functioning (Criterion A) and the presence of pathological personality traits (Criterion B), broken down into five domains comprised of 25 specific facets (see Tables 2 & 3). In this system, discrete symptoms are replaced with dimensional constructs to assess personality style and severity. Though the AMPD currently contains proposed trait structures for six existing PDs—including BPD—for the sake of maintaining clinical continuity in the transition to this system, it also allows for the specification of pathological personality trait structures without the attachment of a specific categorical label. The five domains of personality pathology in the AMPD (negative affectivity, antagonism, detachment, disinhibition, and psychoticism) show convergence with normative FFM traits (neuroticism, low agreeableness, low extraversion, low conscientiousness, and openness to experience, respectively), and similar domains of pathological personality in the Personality Psychopathology-Five model (Harkness & McNulty, 1994; negative emotionality/neuroticism, aggressiveness, low positive emotionality/extraversion, (dis)constraint, and psychoticism, respectively) lending credence to earlier dimensional conceptualizations of personality pathology (Anderson et al., 2013; Bagby et al., 2008; Thomas et al., 2012).

Authors of the AMPD model specified that a comprehensive assessment of personality using the AMPD includes four components: (1) levels of personality functioning, (2) PD types, (3) pathological personality trait domains and facets, and (4) general criteria for personality disorder. Together, these four components identify personality psychopathology with increasing degrees of specificity (Skodol et al., 2011).

Table 2

AMPD Criterion A: Elements of Personality Functioning

Self:
1. ***Identity***: Experience of oneself as unique, with clear boundaries between self and others; stability of self-esteem and accuracy of self-appraisal; capacity for, and ability to regulate, a range of emotional experience. 2. ***Self-direction***: Pursuit of coherent and meaningful short-term and life goals; utilization of constructive and prosocial internal standards of behavior; ability to self-reflect productively.
Interpersonal:
1. ***Empathy***: Comprehension and appreciation of others' experiences and motivations; tolerance of differing perspectives; understanding the effects of one's own behavior on others. 2. ***Intimacy***: Depth and duration of connection with others; desire and capacity for closeness; mutuality of regard reflected in interpersonal behavior.

Note: Table adapted from the *Diagnostic and Statistical Manual of Mental Disorders-5th Edition* (DSM-5; APA, 2013, p. 762). AMPD = Alternative DSM-5 Model for Personality Disorders.

Table 3

AMPD Criterion B: Definitions of DSM-5 Personality Disorder Trait Domains and Facets

DOMAINS (Polar Opposites) and *Facets*	**Definitions**
NEGATIVE AFFECTIVITY (vs. Emotional Stability)	Frequent and intense experiences of high levels of a wide range of negative emotions (e.g., anxiety, depression, guilt/ shame, worry, anger) and their behavioral (e.g., self-harm) and interpersonal (e.g., dependency) manifestations.
Emotional lability	Instability of emotional experiences and mood; emotions that are easily aroused, intense, and/or out of proportion to events and circumstances.
Anxiousness	Feelings of nervousness, tenseness, or panic in reaction to diverse situations; frequent worry about the negative effects of past unpleasant experiences and future negative possibilities; feeling fearful and apprehensive about uncertainty; expecting the worst to happen.
Separation insecurity	Fears of being alone due to rejection by—and/or separation from—significant others, based in a lack of confidence in one's ability to care for oneself, both physically and emotionally.
Submissiveness	Adaptation of one's behavior to the actual or perceived interests and desires of others even when doing so is antithetical to one's own interests, needs, or desires.
Hostility	Persistent or frequent angry feelings; anger or irritability in response to minor slights and insults; mean, nasty, or vengeful behavior. *See also* Antagonism.

(continued)

DOMAINS (Polar Opposites) and *Facets*	Definitions
Perseveration	Persistence at tasks or in a particular way of doing things long after the behavior has ceased to be functional or effective; continuance of the same behavior despite repeated failures or clear reasons for stopping.
Depressivity	*See* Detachment
Suspiciousness	*See* Detachment
Restricted affectivity (lack of)	The *lack of* this facet characterizes *low levels* of Negative Affectivity. *See* Detachment for definition of this facet.
DETACHMENT (vs. Extraversion)	Avoidance of socioemotional experience, including both withdrawal from interpersonal interactions (ranging from casual, daily interactions to friendships to intimate relationships) and restricted affective experience and expression, particularly limited hedonic capacity.
Withdrawal	Preference for being alone to being with others; reticence in social situations; avoidance of social contacts and activity; lack of initiation of social contact.
Intimacy avoidance	Avoidance of close or romantic relationships, interpersonal attachments, and intimate sexual relationships.
Anhedonia	Lack of enjoyment from, engagement in, or energy for life's experiences; deficits in the capacity to feel pleasure and take interest in things.
Depressivity	Feelings of being down, miserable, and/or hopeless; difficulty recovering from such moods; pessimism about the future; pervasive shame and/or guilt; feelings of inferior self-worth; thoughts of suicide and suicidal behavior.

(continued)

DOMAINS (Polar Opposites) and *Facets*	Definitions
Restricted affectivity	Little reaction to emotionally arousing situations; constricted emotional experience and expression; indifference and aloofness in normatively engaging situations.
Suspiciousness	Expectations of—and sensitivity to—signs of interpersonal ill-intent or harm; doubts about loyalty and fidelity of others; feelings of being mistreated, used, and/or persecuted by others.
ANTAGONISM (vs. Agreeableness)	Behaviors that put the individual at odds with other people, including an exaggerated sense of self-importance and a concomitant expectation of special treatment, as well as a callous antipathy toward others, encompassing both an unawareness of others' needs and feelings and a readiness to use others in the service of self-enhancement.
Manipulativeness	Use of subterfuge to influence or control others; use of seduction, charm, glibness, or ingratiation to achieve one's ends.
Deceitfulness	Dishonesty and fraudulence; misrepresentation of self; embellishment or fabrication when relating events.
Grandiosity	Believing that one is superior to others and deserves special treatment; self-centeredness; feelings of entitlement; condescension toward others.
Attention seeking	Engaging in behavior designed to attract notice and to make oneself the focus of others' attention and admiration.
Callousness	Lack of concern for the feelings or problems of others; lack of guilt or remorse about the negative or harmful effects of one's actions on others.
Hostility	*See* Negative Affectivity

(continued)

DOMAINS (Polar Opposites) and *Facets*	Definitions
DISINHIBITION (vs. Conscientiousness)	Orientation toward immediate gratification, leading to impulsive behavior driven by current thoughts, feelings, and external stimuli, without regard for past learning or consideration of future consequences.
Irresponsibility	Disregard for—and failure to honor—financial and other obligations or commitments; lack of respect for—and lack of follow-through on—agreements and promises; carelessness with others' property.
Impulsivity	Acting on the spur of the moment in response to immediate stimuli; acting on a momentary basis without a plan or consideration of outcomes; difficulty establishing and following plans; a sense of urgency and self-harming behavior under emotional distress.
Distractibility	Difficulty concentrating and focusing on tasks; attention is easily diverted by extraneous stimuli; difficulty maintaining goal-focused behavior, including both planning and completing tasks.
Risk taking	Engagement in dangerous, risky, and potentially self-damaging activities, unnecessarily and without regard to consequences; lack of concern for one's limitations and denial of the reality of personal danger; reckless pursuit of goals regardless of the level of risk involved.
Rigid perfectionism (lack of)	Rigid insistence on everything being flawless, perfect, and without errors or faults, including one's own and others' performance; sacrificing of timeliness to ensure correctness in every detail; believing that there is only one right way to do things; difficulty changing ideas and/or viewpoint; preoccupation with details, organization, and order. The *lack of* this facet characterizes *low levels* of Disinhibition.

(continued)

DOMAINS (Polar Opposites) and *Facets*	**Definitions**
PSYCHOTICISM (vs. Lucidity)	Exhibiting a wide range of culturally incongruent odd, eccentric, or unusual behaviors and cognitions, including both process (e.g., perception, dissociation) and content (e.g., beliefs).
Unusual beliefs and experiences	Belief that one has unusual abilities, such as mind reading, telekinesis, thought-action fusion, unusual experiences of reality, including hallucination-like experiences.
Eccentricity	Odd, unusual, or bizarre behavior, appearance, and/or speech; having strange and unpredictable thoughts; saying unusual or inappropriate things.
Cognitive and perceptual dysregulation	Odd or unusual thought processes and experiences, including depersonalization, derealization, and dissociative experiences; mixed sleep-wake state experiences; thought-control experiences.

Note. Table adapted from the *Diagnostic and Statistical Manual of Mental Disorders-5th Edition* (DSM-5; APA, 2013, pp. 779-781). Some trait facets appear under multiple domains. AMPD = Alternative DSM-5 Model for Personality Disorders.

In conjunction with the development of this model, assessment tools have been created for the measurement of both pathological personality trait domains and functions (e.g., the Personality Inventory for DSM-5 (PID-5; APA, 2013)) and levels of personality functioning (e.g., the Levels of Personality Functioning Scale (LPFS; APA, 2013)). Both measures are easily accessible to clinicians and researchers through the DSM-5 and its online supplemental materials, and the APA has solicited feedback and data on the instruments' usefulness in improving patient care. Though the field of personality assessment research has readily incorporated the use of these AMPD scales, rates of clinical familiarity with and use of this new model and its associated assessment tools are unknown.

Early research showed a sample of mental health clinicians preferred the AMPD over the current categorical model of PDs with respect to communication, comprehensiveness, descriptiveness, and utility for treatment planning (Morey et al., 2014), suggesting this model could be applied successfully to the arenas of therapy and assessment. Although research has consistently supported the utility of the AMPD in the assessment of PDs, it is unclear exactly how this model will be translated into clinical practice (Hopwood, 2018; Waugh et al., 2017). Experts predict that knowledge and familiarity with the AMPD will spread as training programs begin to instruct future psychologists in the use of the AMPD (Waugh et al., 2017), but the extent to which this practice has become commonplace since the DSM-5's publication in 2013 is unclear.

BPD in the AMPD

Although the ultimate goal of the AMPD is to allow for the dimensional assessment and diagnosis of maladaptive personality traits and impairment, there has been concern regarding the implementation of this model and the resulting overhaul of the widely used categorical system of PD diagnosis. Thus, for the sake of maintaining clinical continuity in the transition to this system, the AMPD contains proposed trait structures for several existing personality disorders, including BPD. Within the AMPD, BPD is characterized by instability (of self-image, personal goals, interpersonal relationships, and affects), accompanied by impulsivity, risk taking, and/or hostility (APA, 2013; Skodol et al., 2011). The proposed diagnostic criteria for BPD in the AMPD, including specific traits and descriptions of common areas of impairment, can be found in Table 4.

Stigma

Defined

In 1963, Erving Goffman published Stigma: Notes on the Management of Spoiled Identity, one of the most influential explorations of stigma of its day. In this work, Goffman defined stigma as being based on an "attribute that is deeply discrediting" and reduces someone "from a whole and usual person to a tainted, discounted one" (Goffman, 1963, p. 3). Goffman theorized the existence of three types of stigma: "abominations of the body" (i.e., physical), "blemishes of individual character" (i.e., mental), and "tribal" stigmas (i.e., group-based: race, nationality, etc.). According to Goffman, these "discrediting attributes" vary in intensity based upon factors such as their visibility, publicity, obtrusiveness, and relevance.

Table 4

Borderline Personality Disorder in the AMPD

Proposed Diagnostic Criteria

A. Moderate or greater impairment in personality functioning, manifested by characteristic difficulties in two or more of the following four areas:

1. ***Identity:*** Markedly impoverished, poorly developed, or unstable self-image, often associated with excessive self-criticism; chronic feelings of emptiness; dissociative states under stress.
2. ***Self-direction:*** Instability in goals, aspirations, values, or career plans.
3. ***Empathy:*** Compromised ability to recognize the feelings and needs of others associated with interpersonal hypersensitivity (i.e., prone to feel slighted or insulted); perceptions of others selectively biased toward negative attributes or vulnerabilities.
4. ***Intimacy:*** Intense, unstable, and conflicted close relationships, marked by mistrust, neediness, and anxious preoccupation with real or imagined abandonment; close relationships often viewed in extremes of idealization and devaluation and alternating between overinvolvement and withdrawal.

B. Four or more of the following seven pathological personality traits, at least one of which must be (5) Impulsivity, (6) Risk taking, or (7) Hostility:

1. ***Emotional lability*** (an aspect of **Negative Affectivity**): Unstable emotional experiences and frequent mood changes; emotions that are easily aroused, intense, and/or out of proportion to events and circumstances.
2. ***Anxiousness*** (an aspect of **Negative Affectivity**): Intense feelings of nervousness, tenseness, or panic, often in reaction to interpersonal stresses; worry about the negative effects of past unpleasant experiences and future negative possibilities; feeling fearful, apprehensive, or threatened by uncertainty; fears of falling apart or losing control.
3. ***Separation insecurity*** (an aspect of **Negative Affectivity**): Fears of rejection by—and/or separation from—significant others, associated with fears of excessive dependency and complete loss of autonomy.

(continued)

Proposed Diagnostic Criteria

4. ***Depressivity*** (an aspect of **Negative Affectivity**): Frequent feelings of being down, miserable, and/or hopeless; difficulty recovering from such moods; pessimism about the future; pervasive shame; feelings of inferior self-worth; thoughts of suicide and suicidal behavior.
5. ***Impulsivity*** (an aspect of **Disinhibition**): Acting on the spur of the moment in response to immediate stimuli; acting on a momentary basis without a plan or consideration of outcomes; difficulty establishing or following plans; a sense of urgency and self-harming behavior under emotional distress.
6. ***Risk taking*** (an aspect of **Disinhibition**): Engagement in dangerous, risky, and potentially self-damaging activities, unnecessarily and without regard to consequences; lack of concern for one's limitations and denial of the reality of personal danger.
7. ***Hostility*** (an aspect of **Antagonism**): Persistent or frequent angry feelings; anger or irritability in response to minor slights and insults.

Specifiers. Trait and level of personality functioning specifiers may be used to record additional personality features that may be present in borderline personality disorder but are not required for the diagnosis. For example, traits of Psychoticism (e.g., cognitive and perceptual dysregulation) are not diagnostic criteria for borderline personality disorder (see Criterion B) but can be specified when appropriate. Furthermore, although moderate or greater impairment in personality functioning is required for the diagnosis of borderline personality disorder (Criterion A), the level of personality functioning can also be specified.

Note. Table adapted from the *Diagnostic and Statistical Manual of Mental Disorders-5th Edition* (DSM-5; APA, 2013, pp. 766-767). AMPD = Alternative DSM-5 Model for Personality Disorders.

In 1984, Jones and colleagues built on this idea of intensifying factors by asserting the level of stigma held against an individual or group can vary depending on factors such as how detectable the "mark" of the stigma is, how much that mark obstructs interpersonal interactions, and whether it induces feelings of danger or threat in others. Link and Phelan (2001) further expanded this concept by noting that stigma is dependent on social, economic, and political power statuses that allow it to unfold.

Stigma and Mental Illness

Generally, individuals experiencing mental illness face the effects of stigma and discrimination. Indeed, the general public both in the United States and elsewhere endorse stigmatizing attitudes about mental illness, with an increasing proportion of the population supporting coercive treatment for psychological conditions that they perceive as signs of danger and personal weakness (Pescosolido, et al., 2019; Phelan et al., 2000; Venkataraman et al., 2019).

This stigma can materialize in many forms for individuals experiencing mental illness; these experiences can be indirect, such as witnessing stigmatizing comments or depictions of mental illness in the media, or they can be direct, such as being treated as less competent than others or being shunned or avoided because of their mental illness. Although the experience of discrimination against mental illness in a legal context is less common than stigma experiences, some individuals have faced discrimination from job hiring staff, law enforcement officers, and health insurance companies related to their status as a consumer of mental health treatment services (Wahl, 1999). These experiences of stigma and discrimination can lead to potentially harmful circumstances for individuals experiencing mental illness, such as creating a fear of disclosing mental

health conditions and discouraging the utilization of available mental health care services (Corrigan et al., 2016).

For some groups, this stigma can be amplified by other aspects of an individual's identity (e.g., race/ethnicity, sexuality). This "Double Stigma" (Gary, 2006) works to inhibit individuals from seeking mental health treatment both through the same societal mechanisms that inhibit non-minority members, and through the added stigma and discriminatory practices leveled against them because of their additional minority status. For some, this discrimination may come not only from general societal views, but also from individually held biases of researchers and clinicians within the mental health field. These biases manifest within treatment through mechanisms such as misdiagnosis, lack of cultural competence, and conscious and unconscious stereotyping, and they can lead to outcomes such as delayed or terminated treatment, increased morbidity and mortality, and decreased well-being (Gary, 2006).

Individuals may face stigma and discrimination from within the mental health system even without the double jeopardy status conferred by an additional minority identity. Diagnostic classification itself often implies a sense of homogeneity within groups that can lead mental health professionals to view individuals in terms of their diagnostic labels (Corrigan, 2007). These diagnostic labels enhance the salience of "groupness" for the collection of people with mental illnesses by providing an easily identifiable "mark" of group membership and distinguishing them from the general population (Link & Phelan, 2001). For some, such as those with diagnoses of schizophrenia and psychosis, this level of prejudice is further worsened (Phelan et al., 2000). Researchers have questioned whether these labels or the aberrant behaviors

displayed by those with symptoms of mental illness are the source of public stigma, and the literature shows that members of the general public stigmatize individuals labeled as mentally ill, even in the absence of aberrant behavior (Link, 1982; Link, 1987; Link et al., 1987; Link et al., 1999).

Stigma and BPD

Taken together, the components of stigma discussed thus far provide insight to clinicians' attitudes toward clients with BPD. These individuals carry a diagnosis that can be considered both a "blemish of individual character" and the mark of a tribal, group-based stereotype. These individuals are considered part of a visible, easily labeled group often seen as disruptive, dangerous, and unchangeable, and they often threaten to unbalance power statuses within the treatment relationship. Thus, individuals with the "mark" of a BPD diagnosis are grouped together in an entity representing "tainted, discounted" persons.

This stigma against BPD among mental health professionals originates, in part, from the fact that individuals with this disorder tend to experience powerful and intense feelings, particularly in the context of interpersonal relationships, which can often be observed within the treatment dyad. Indeed, a long-standing stereotype of BPD has emerged among many clinicians, in which they describe individuals with BPD in pejorative terms such as "difficult," "treatment resistant," "manipulative," "demanding," "fickle, egocentric, irresponsible, love-intoxicated," and "attention seeking," and some opine that these individuals use psychiatric hospitalizations to shirk responsibilities (Gallop & Wynn, 1987; Houck, 1972; Klein, 1972; Nehls, 1998; Shedler & Westen, 2004; Stone et al., 1987). Indeed, some clinicians once considered BPD wholly

untreatable, and professionals involved in the treatment of BPD have commonly reported experiencing feelings of incompetence and lack of control while treating individuals with BPD (Gallop & Wynn, 1987; Gunderson, 2009).

Research has shown clinicians are likely to rate a client with BPD as more dominant and hostile than other clients and provide fewer empathic responses towards these highly distressed individuals than towards other clients with similarly severe psychopathology (Fraser & Gallop, 1993; McIntyre & Schwartz, 1998). Previous research has also shown the diagnosis of BPD alone reduced inpatient nursing staff's levels of expressed empathy toward hypothetical patients when compared to the diagnosis of schizophrenia, indicating that the label of BPD itself is enough to invoke the preconceived stereotype of an undesirable individual (Gallop et al., 1989). Additionally, inpatient nursing staff have been shown to attribute negative behaviors displayed by patients with BPD to causes that are more stable and controllable than the causes of these same behaviors when displayed by patients with schizophrenia or depression diagnoses, and this tendency has been correlated with lower reports of sympathy and optimism in treatment of BPD patients (Markham & Trower, 2003). Thus, in addition to the perceived (and actual) difficulty in implementing the most effective forms of treatment for these highly impaired individuals, the therapeutic relationship between client and clinician is further complicated by this stigma associated with reduced reports of sympathy and empathy by treatment providers.

Presentation in Treatment

The stereotypes surrounding BPD can be reinforced in the course of treatment, when a client begins to show behaviors the clinician finds frightening, such as anger,

suicidal ideation, self-injury, or suicide attempts. Additionally, treatment often progresses slowly with individuals with BPD, with fluctuating levels of functioning over time. This fluctuating pattern of recovery, when coupled with clinicians' pre-existing stigma and activated feelings of incompetence, can sometimes lead clinicians to perceive lower levels of functioning as within the individual's control, or worse, as a deliberate act of manipulation (i.e., "bad, not mad"; Aviram, Brodsky, & Stanley, 2006; Nehls, 1994).

The perception of these individuals as manipulative and attention-seeking has been theorized to play a role in the treatment of BPD by establishing a priori negative expectations about the course of treatment by the therapist. These expectations can become self-fulfilling prophecies, in which clinicians defend against certain expected behaviors and characteristics of a client with BPD, which can trigger behaviors in clients that serve to confirm clinicians' pre-existing, stigmatizing notions about BPD (Aviram et al., 2006). For the biased clinician, these negative expectations may produce feelings such as anger, irritation, anxiety, pity, or fear. These emotional reactions are often observable by the client, and they provide an important statement about a clinician's response to the client as a person. Client responses to clinicians' emotional reactions may include such emotions as embarrassment, shame, fear, alienation, or anger that are displayed through behaviors such as "acting out" or terminating treatment prematurely (Link et al., 2004). Thus, when clients respond to the negative expectations of their clinicians, these clinicians may interpret their pre-existing notions as correct, without acknowledging the role that their own behaviors played in triggering these behaviors in their client.

When clinicians experience negative reactions to these clients' behaviors and attitudes, or even to the idea of this type of client, this can lead to emotional distancing from specific clients within the therapeutic relationship (Hinshelwood, 1999). This emotional distancing can be particularly damaging to individuals with BPD, who are highly sensitive to rejection and abandonment, and who may respond by engaging in self-harm or withdrawing from treatment prematurely (Aviram et al., 2006). Additionally, this distancing can lead clinicians to miss important information about their clients' subjective experiences, decreasing the quality and effectiveness of the care they can provide and threatening their ability to establish a trusting, collaborative therapeutic alliance (Hinshelwood, 1999).

The relationship between clinician and client has been emphasized as one of the core components to successful therapy; therapeutic alliance has been shown to have robust, significant effects on clinical outcomes across multiple forms of psychotherapy, with strong evidence that a better therapeutic alliance can result in better treatment outcomes, and a poor therapeutic alliance can increase the likelihood of premature psychotherapy dropout (Horvath & Bedi, 2002; Horvath et al., 2011; Horvath & Symonds, 1991; Martin et al., 2000; Sharf et al., 2010). Additionally, research has found that clients who have difficulty maintaining social relationships, such as individuals with BPD, are already less likely to develop strong therapeutic alliances (e.g., Moras & Strupp, 1982), and clinicians who have had past interpersonal relationships with certain types of clients tend to recreate the original interpersonal patterns in subsequent relationships (Henry & Strupp, 1994). Thus, one bad experience in the treatment of a client with BPD, partially augmented by the clinician's creation of self-fulfilling

prophecies, may reinforce these stigmatized notions and impede a clinician's ability to develop effective therapeutic alliances with subsequent clients with BPD, who retain the same group "mark" of this categorical diagnosis.

Little research exists on lay perceptions of individuals with BPD; thus, there is little evidence to evaluate in pinpointing whether clinicians learn about BPD in a way that creates, or simply augments, a pre-existing stigma in their professional training. Laypersons show considerable difficulty in identifying the label that encompasses BPD symptoms; in one study, when assessing vignettes, 86% of lay individuals were able to perceive a psychological problem in a BPD vignette, whereas only 1% identified this problem as BPD (Furnham, Abajian, & McClelland, 2011). Thus, while laypersons are able to identify an individual experiencing symptoms of BPD as facing psychological difficulties, these symptoms are not necessarily linked to the stigmatizing label of BPD. In other words, telling a patient or their family members that they have BPD is, by itself, unlikely to be meaningful; whereas, helping them understand the presenting problems as involving fluctuating moods and impulsivity that result in disruptive interpersonal behavior may be understandable. In this sense, lay individuals may already conceptualize BPD in a dimensional way, with a focus on functional impairment related to the disorder; however, it is unknown whether a similar stigma towards individuals exhibiting symptoms of BPD exists among this lay population.

The Current Study

The Problem

Despite the extensive research base surrounding BPD, there has historically been a lack of agreement on the definition, presentation, development, best treatment practices,

and even existence of this disorder. Over time, a complex set of beliefs rooted in these historical disagreements, some of which are based on outdated or false information, has arisen surrounding the BPD diagnosis. Thus, the high rate of treatment-seeking behaviors in BPD populations presents a challenge both for individuals with this disorder, which is highly impairing and difficult to treat, and for their treatment providers, who must navigate the complicated web of ideas surrounding this disorder.

Although a proposed set of diagnostic criteria for BPD are contained in the AMPD, it would be possible, under this new system, to instead highlight specific areas of pathological presentation and functional impairment as foci for treatment of a specific individual, rather than simply providing a label that does not specify which symptoms the individual displays, as in the categorical system. It is yet unknown what role, if any, this system of diagnosis will play in the improvement of stigma; however, the literature suggests that dimensional models generally reduce the "groupness" of psychiatric disorders, and that using a dimensional model of diagnosis can temper the distinction between "mentally ill" and "normal" individuals by conceptualizing mental illness as a continuum that includes normalcy (Corrigan, 2007).

Given the lack of research in this area, it is necessary to investigate this new model's relation to existing stigma against BPD. If individuals who would be diagnosed with BPD under the current, categorical diagnostic system were instead assessed individually regarding their levels of maladaptive personality traits, would this approach reduce stigma that clinicians bring to treating and managing these clients? In other words, would removing the stigmatizing label associated with these traits and behaviors lessen clinician bias towards individuals displaying these symptoms? Based on current research,

it is also unknown whether lay individuals demonstrate a similar stigma towards individuals exhibiting symptoms of BPD, given their demonstrated difficulties connecting the symptoms of this disorder to a categorical label (Furnham et al., 2011). Because lay perceptions of psychological difficulty may be based more on the demonstrations of perceived personality traits and functional impairment than on categorical labels or symptom lists, it is also unknown whether lay levels of sympathy towards an individual would change based on the presence of a BPD label.

Research Questions

The current study aims to investigate the following research questions: (1) Do mental health professionals still view individuals with a BPD diagnosis more negatively than individuals with other diagnoses, and do they do so more than laypersons? (2) Would assessing the symptoms of BPD through a model of dimensional personality traits (i.e., removing the categorical diagnosis) mitigate this stigma? and (3) Are clinicians and mental health trainees currently learning about the AMPD's dimensional model and measures of personality disorders in their training? In other words, if utilizing a dimensional model leads to reduced stigma, to what extent has the movement to this example of a dimensional system already occurred?

Hypotheses

Based on the existing literature, I proposed the following hypotheses to address these three areas of inquiry. First, I predicted clinicians and mental health trainees would endorse higher levels of negative emotions and lower levels of positive emotions towards a BPD-diagnosed individual than an individual with another, similarly severe categorical diagnosis (i.e., schizophrenia), whereas individuals without advanced mental health

training would show no differences on these metrics. To further assess the presence of this bias, I also predicted that mental health professionals and trainees would ascribe ratings reflecting a more internally-focused locus of causality, higher personal control of symptoms, and higher symptom stability for individuals with a BPD diagnosis than for individuals with a schizophrenia diagnosis; whereas, lay individuals would show no significant difference in these metrics.

Attitudes towards clients with BPD will also be directly assessed in clinicians and trainees; I hypothesized that the endorsement of negative beliefs about the causality of behaviors seen in BPD individuals would predict explicitly expressed negative attitudes towards working with clients with BPD.

Second, I predicted clinicians and trainees would endorse higher levels of negative emotions and lower levels of positive emotions towards an individual categorically diagnosed with BPD than an individual displaying identical symptoms whose conceptualization is presented through levels of elevated maladaptive personality traits. I also predicted that mental health professionals and trainees would ascribe ratings reflecting a more internally-focused locus of causality, higher personal control of symptoms, and higher symptom stability for individuals when their vignette presents a categorical BPD diagnosis than when it presents their profile of traits and impairment.

No directional hypotheses were posed for my third, exploratory area of this project, which focused on mental health clinicians' and trainees' familiarity and current use of the AMPD and its associated measures in both research and clinical practice.

CHAPTER II

Methods

Procedures & Research Design

Participants

The current data collection was approved by the IRB at a large southern university in the US. Participants were recruited from three samples: graduate-level mental health clinicians (i.e., MA/MS or PhD/PsyD-level psychologists, counselors, and social workers), mental health trainees, and undergraduates. Clinicians were recruited via clinical list-serves, state hospital list-serves, and social media; mental health trainees were recruited by contacting program directors via e-mail and social media; undergraduate students were recruited using an undergraduate research recruitment system at a large southern university in the US. Each participant completed an online survey through Qualtrics. Participants had the option to provide an e-mail address at the end of their survey if they were interested in receiving an incentive for their time, which consisted of course credit for undergraduates or entry into a $10 Amazon.com gift card raffle for trainees and clinicians. When the project received additional funding partway through data collection, all clinician participants (the only recruitment group that remained active) from that point forward were guaranteed to receive a $10 Amazon.com gift card incentive for their time if they provided their e-mail address.

Although the survey received over 1500 responses across all recruitment settings, the pattern of these responses indicated that many were invalid or otherwise not representative of the intended sample. Participants were removed from analyses if they did not pass validity checks, which included a minimum survey completion time of 300

seconds, demographic information consistency checks, and an embedded validity scale (described below) designed to screen for random responding. Participants were also removed from analyses if they indicated they were part of a group for which I was no longer recruiting (e.g, all undergraduates after a specific date).

As a result of these recruitment and screening measures, final sample groups consisted of 146 undergraduates, 108 trainees, and 76 clinicians, for a total of 330 participants. Participants ranged in age from 18 to 70 years old. Mean age for the undergraduate group was 20.14 (*SD* = 3.62) years, for the trainee group was 27.55 (*SD* = 4.77) years, and for the clinician group was 36.97 (*SD* = 10.66) years. The majority of trainee participants were pursuing a doctoral degree in a mental health-related field (*N* = 89, 82.4%). On average, clinicians reported about 13 years of clinical experience (*M* = 13.28; *SD* = 8.83). Most clinicians reported being licensed to practice in their area of residence (*N* = 62, 81.6%) and being currently employed in a clinical practice setting (*N* = 61, 80.2%) with specialties related to forensic psychology (*N* = 28, 36.8%), counseling (*N* = 22, 28.9%), and social work (*N* = 13, 17.1%), among others. Additional data regarding clinician specialty areas are available upon request. One trainee and one clinician resided in Canada, one clinician resided in Australia, and the rest of the participants resided in the US. Demographic information for each participant group can be found in Table 5.

Design

A 2 (Training Level) x 2 (Vignette Type) experimental design was used, for a total of six conditions.

Table 5

Sample Demographic Information by Group

	Undergraduate (N = 146)		Trainee (N = 109)		Clinician (N = 75)	
	n	%	*n*	%	*n*	%
Gender						
Cisgender man	17	11.6%	12	11.0%	8	10.7%
Cisgender woman	119	81.5%	88	80.7%	64	85.3%
Transgender man	1	0.7%	0	0%	0	0%
Transgender woman	0	0%	1	0.9%	0	0%
Non-binary	5	3.5%	5	4.6%	2	2.7%
Other/No Response	4	2.7%	3	2.8%	1	1.3%
Race and Ethnicity						
White (non-Hispanic)	72	49.3%	83	76.1%	58	77.3%
Black	22	15.1%	6	5.5%	5	6.7%
Hispanic/Latino	37	25.3%	3	2.8%	7	9.3%
Asian	7	4.8%	12	11.0%	3	4.0%
Native American/Alaska Native	1	0.7%	1	0.9%	1	1.3%
Multiracial/Other	6	4.1%	3	2.8%	1	1.3%
No Response	1	0.7%	1	0.9%	0	0%
Highest Education Completed						
High School/GED	116	79.5%	0	0%	0	0%
Associate degree	25	17.1%	0	0%	0	0%
Bachelor's Degree	5	3.4%	38	34.8%	0	0%
Master's Degree	0	0%	68	62.4%	32	42.7%
Doctoral Degree (PhD, PsyD)	0	0%	2	1.8%	43	57.3%
Other Professional (MD, JD)	0	0%	1	0.9%	0	0%

Participants in each of our three groups were randomly assigned to one of two conditions, with one half of each group assigned to a condition with a vignette that includes an individual with a BPD diagnosis and the other half assigned to a condition with a vignette

of the same individual without a mention of a BPD diagnosis. For the purpose of analyses, the clinician and trainee groups were merged.

Materials and Procedure

All three groups completed online self-report surveys, developed through Qualtrics, each of which varied slightly in its composition depending on the target group. The surveys included the following elements:

Demographics. Questions included in each version of the survey were used to collect basic demographic information on each participant. The survey administered to clinicians and graduate students also included questions assessing areas of clinical specialty and level of training, whereas the survey administered to undergraduate participants included questions assessing current academic status, career goals, and level of mental health training/familiarity.

Vignettes. A total of two vignettes were presented to each participant; the order of presentation was randomized. Each vignette was adapted from existing DSM-5 case examples of individuals displaying symptoms of either BPD or schizophrenia (Tamminga, 2014; Yeomans & Kernberg, 2014). In the first condition, participants received a vignette featuring an individual displaying symptoms of BPD, which included a diagnosis of BPD within the text of the vignette, and a vignette featuring an individual with a diagnosis of schizophrenia within the text of the vignette. In the second condition, participants received identical vignettes, except that the diagnosis of BPD was removed from the first vignette and replaced with a description of the individual's maladaptive personality traits.

Revised Causal Dimension Scale. (CDSII; McAuley, Duncan, & Russell, 1992). Following each vignette, participants were asked to evaluate the symptoms and behaviors of the individual presented in the vignette using the CDSII, a 12-item rating scale in which individuals are asked to rate the extent to which varying causes influenced displayed behaviors. These items comprise four subscales: locus of causality (α = .51/.56; Cronbach, 1951), external control (α = .66/.72), stability (α = .45/.44), and personal control (α = .68/.75). This measure was modified for the current study to reference the individuals in the vignettes. Because alpha values for most subscales fell below the acceptable range of reliability (α > .70), likely due to the small number of items on each subscale, mean inter-item correlations were also calculated as a secondary measure of subscale reliability. These values generally fell within the acceptable range of *r* = .15-50 (Clark & Watson, 1995) for all four subscales: locus of causality (*r* = .26/.31), external control (*r* = .39/.46), stability (*r* = .20/.22), and personal control (*r* = .41/.51).

Emotional Response Questions. Following each vignette, participants were asked to rate their levels of emotional response to the patient described in the vignette on a seven-point bipolar scale ranging from 'not at all' to 'extremely', with higher scores indicating greater levels of emotion (Dagnan & Cairns, 2005; Dagnan, Trower, & Smith, 1998; Markham & Trower, 2003). The emotions evaluated included 'angry', 'disgusted', 'sympathetic', 'pity', 'anxious', 'depressed', 'happy', 'loving', and 'relaxed', which have loaded onto two factors of positive emotions (sympathy, pity, loving) and negative emotions (anger, disgust, anxiety, depression, [low levels of] relaxed) in previous research (Dagnan et al., 1998). In the current study, alpha reliabilities for positive emotions in response to the BPD vignette (α = .45) and for negative emotions in response

to the BPD vignette (α = .59) were low; mean inter-item correlations for both subscales were acceptable (rpos = .22; rneg = .21). A similar pattern held true for both positive (α = .46; r = .22) and negative (α = .54; r = .21) emotional responses to the schizophrenia vignette.

Attitude to Personality Disorder Questionnaire. (APDQ; Bowers, McFarlane, Kiyimba, Clark, & Alexander, 2000). Clinicians and graduate students were administered the APDQ, a 40-item self-report scale assessing clinician attitudes towards working with personality disordered clients. For the purposes of this study, this scale was modified to assess attitudes towards BPD specifically (i.e., all references to PDs have been replaced with BPD). The APDQ consists of statements of attitudes towards BPD clients (e.g., I feel frustrated with BPD clients). These items comprise five subscales: enjoyment vs loathing (α = .93), enthusiasm vs exhaustion (α = .79), security vs vulnerability (α = .89), purpose vs futility (α = .84), and acceptance vs rejection (α = .76). Alpha reliability levels for these subscales ranged from acceptable to excellent.

Assessment of AMPD Familiarity. Clinicians and mental health trainees were asked to report their level of familiarity with the AMPD along a 5-point scale, ranging from "Not at all Familiar" to "Very Familiar," with descriptors for each choice (i.e., Moderately Familiar – I am familiar with the model but do not have specialized knowledge in it). They were then asked whether they have ever used the AMPD or its related measures in the course of their clinical and research work.

Validity Indicator. As none of the measures used in this study have built-in validity scales and considering the data were gathered online, six validity indicator items were dispersed throughout the protocol. The purpose of these questions was to ensure

participants were not randomly responding and were responding appropriately to the item content. Validity indicator items were compromised of statements to which a majority of participants would disagree, such as, “I wrote three best-selling novels last year” or “I am close personal friends with the Prime Minister of Zanzibar.” Individuals who agreed with or skipped two or more validity items were removed from statistical analyses.

Statistical Analyses

Multivariate Analyses of Variance (MANOVAs) were used to assess my first set of hypotheses across a 2 (training level: professionals (i.e., clinicians & trainees combined), undergraduate) x 2 (vignette: BPD, schizophrenia) matrix of independent variables. These analyses compared mean scores across levels of endorsed positive and negative emotions, and CDSII subscales (measuring locus of causality, personal control of symptoms, and symptom stability) in response to the BPD and schizophrenia diagnosis vignettes for each group. Within-subjects *t*-tests analyzed the differences across scores on each of these measures within training group (e.g., clinician ratings on BPD vignette vs. clinician ratings on schizophrenia vignette).

These MANOVA and *t*-test analyses were repeated, using both the categorical and dimensional versions of the BPD vignette, and then using the dimensional vignette and the schizophrenia vignette. Then, linear regression analyses were used to examine the ability of hypothesized subscale scores on the CDSII to predict expressed attitudes on the APDQ.

For my final aim, I assessed mean levels of AMPD familiarity among both clinicians and trainees, based on their answers to the questions regarding this knowledge. Furthermore, I analyzed percentages of individuals in each of these groups who reported

using the AMPD in their research and clinical work. Chi-square analyses were used to determine whether response frequencies differed between trainee and clinician groups. These novel data illuminate the current status of this model in research and practice, which will inform the implications of my earlier aims.

CHAPTER III

Results

Investigation of Overt Professional Bias

To assess baseline endorsement of overt bias against BPD clients, I examined clinician and trainee responses to the APDQ, and their relation to several of the causal attributions endorsed in response to the BPD vignettes. All clinician and trainee participants were included in these analyses. No significant differences were found between trainee and clinician mean ratings on any of the five subscales on the APDQ (*p*'s > .05). These groups were combined for regression analyses. See Table 6 for subscale means.

Table 6

APDQ Subscales Means and Standard Deviations

	Total (*N* = 172)	**Clinicians (*N* = 73)**	**Trainees (*N* = 99)**
Enjoyment (vs. Loathing)	3.47 (.76)	3.44 (.84)	3.49 (.69)
Enthusiasm (vs. Exhaustion)	3.38 (.89)	3.27 (.91)	3.47 (.87)
Security (vs. Vulnerability)	4.82 (.68)	4.87 (.70)	4.79 (.66)
Purpose (vs. Futility)	4.66 (.87)	4.62 (1.00)	4.72 (.77)
Acceptance (vs. Rejection)	5.17 (.59)	5.17 (.62)	5.20 (.57)

Note. All subscales used a Likert scale ranging from 1 = Never to 6 = Always indicating how often they feel this way about patients with BPD. All differences between clinician and trainee scores were nonsignificant.

For both clinicians and trainees in the combined group, locus of causality was a significant predictor of four of the five APDQ subscales, such that conceptualizing clients as having a more external locus of symptom causality predicted higher expressed attitudes of Enjoyment (vs. Loathing), $\beta = -.224$; $p = .004$, Security (vs. Vulnerability), $\beta = -.212$; $p = .006$, Purpose (vs. Futility), $\beta = -.291$; $p < .001$, and Acceptance (vs.

Rejection), β = -.202; p = .010, in working with clients with BPD. Other examined CDSII subscales (i.e., Symptom Stability; Personal Control) used in these hypotheses did not contribute significantly to these predictions, and predictive relationships were nonsignificant altogether for the APDQ subscale measuring Enthusiasm (vs. Exhaustion; R^2 = .01, all p's > .05). Overall, these models with a significant predictor explained between 5-10% of the variance in APDQ responses. See Table 7 for detailed regression results.

Research Question 1: Do Mental Health Professionals View Individuals with a BPD Diagnosis More Negatively Than Individuals with Other Diagnoses, and Do They Do So More Than Laypersons?

Research Question 1, Part 1

In order to investigate my first research question, I used ANOVA analyses to identify differences among lay and professional opinions across each type of vignette used. Specifically, I began by examining whether individuals in both groups showed differences in how they responded to the categorical BPD and schizophrenia vignettes. The purpose of this analysis was to answer the first part of my research question: whether mental health professionals and lay individuals view an individual with a BPD diagnosis more negatively than an individual with another, similarly severe type of diagnosed psychopathology (schizophrenia). These analyses included only participants that received the categorical BPD diagnosis vignette; those who received the trait-based BPD vignette were excluded. Mental health trainee and clinician groups were combined and compared to the undergraduate group.

Table 7

APDQ Subscales Regressed on Select CDSII Subscales

Predictors	**APDQ Enjoyment (vs. Loathing)**			
	R^2	β	r_{sp}	*p*
CDSII Subscales	.082			
Internal LoC		**-.224**	**-.225**	**.004**
Symptom Stability		-.119	-.122	.120
Personal Control		.118	.121	.123
	APDQ Enthusiasm (vs. Exhaustion)			
	R^2	β	r_{sp}	*p*
CDSII Subscales	.011			
Internal LoC		-.095	-.094	.230
Symptom Stability		.052	.051	.514
Personal Control		-.003	-.003	.967
	APDQ Security (vs. Vulnerability)			
	R^2	β	r_{sp}	*p*
CDSII Subscales	.074			
Internal LoC		**-.212**	**-.213**	**.006**
Symptom Stability		-.146	-.148	.059
Personal Control		.046	.047	.550
	APDQ Purpose (vs. Futility)			
	R^2	β	r_{sp}	*p*
CDSII Subscales	.100			
Internal LoC		**-.291**	**-.290**	**<.001**
Symptom Stability		-.099	-.102	.193
Personal Control		.001	.001	.994
	APDQ Acceptance (vs. Rejection)			
	R^2	β	r_{sp}	*p*
CDSII Subscales	.050			
Internal LoC		**-.202**	**-.200**	**.010**
Symptom Stability		-.079	-.079	.310
Personal Control		.027	.027	.727

Note. Bold values are statistically significant ($p < .05$). APDQ = Attitude to Personality Disorder Questionnaire. CDSII = Revised Causal Dimension Scale.

A summary of all means comparisons can be found in Table 8.

Within-Group Analyses. Within-subjects analysis showed that undergraduate participants showed significantly greater levels of negative emotional reaction towards the individual in the BPD vignette than the individual in the schizophrenia vignette,

Table 8

Group Comparisons for Categorical BPD Vignette vs. Schizophrenia Vignette

	Categorical BPD			**Schizophrenia**			**BPD vs. Schizophrenia**	
	Undergrad. (*M*(SD)) *N* = 73	**Prof. (*M*(SD)) *N* = 84**	**Undergrad. v. Prof. (η2p)**	**Undergrad. (*M*(SD)) *N* = 73**	**Prof. (*M*(SD)) *N* = 84**	**Undergrad. v. Prof. (η2p)**	**Undergrad. (*d*)**	**Prof. (*d*)**
Neg Emo	3.52 (.95)	3.08 (.73)	**.06***	3.26 (.90)	3.00 (.65)	**.03***	**.48**†	.12
Pos Emo	3.69 (1.14)	3.18 (1.12)	**.05***	3.84 (1.31)	3.31 (1.27)	**.04***	.12	**.22**†
Inter LoC	19.34 (3.72)	16.80 (3.26)	**.12***	19.79 (4.37)	18.63 (4.27)	.02	.11	**.45**†
Ext Control	12.50 (4.24)	12.40 (4.20)	.00	10.57 (5.32)	12.17 (4.78)	**.03***	**.32**†	.05
Stability	13.63 (3.57)	12.70 (4.03)	.02	17.68 (4.36)	17.25 (4.04)	.00	**.81**†	**.95**†
Pers Control	12.96 (4.55)	14.92 (3.99)	**.05***	8.16 (4.55)	12.47 (4.80)	**.18***	**.91**†	**.51**†

Note. Significant effects are bolded. * = significant between-groups effect within condition; † = significant within-group effect across conditions; BPD = borderline personality disorder; *M* = mean; SD = standard deviation; η2p = partial eta squared (effect size); *d* = Cohen's d (effect size); Undergrad. = undergraduate group; Prof. = professional group; Neg = negative; Pos = positive; Emo = emotions; Inter = internal; LoC = locus of control; Ext = external; Pers = personal.

47

$t(72) = 4.09$; $p < .001$; $d = .484$, greater levels of external symptom control for the individual in the BPD vignette than in the schizophrenia vignette, $t(72) = 4.09$; $p = .007$; $d = .322$, greater symptom stability for the individual in the schizophrenia vignette than in the BPD vignette, $t(72) = -6.89$; $p < .001$; $d = .806$, and greater levels of personal symptom control for the individual in the BPD vignette than the individual in the schizophrenia vignette, $t(72) = 7.78$; $p < .001$; $d = .911$.

Research Question 1, Part 2

The second half of my first research question asked whether any differences that emerged in mental health professionals' views towards an individual with a BPD diagnosis versus a schizophrenia diagnosis were greater than differences that emerged in undergraduates' views. Using further ANOVA analyses, I compared reactions to these same vignettes across the professional and undergraduate groups to determine whether difference emerged between the two groups' opinions.

Between-Groups Analyses. When examining reactions to the categorical BPD diagnosis vignette versus the schizophrenia vignette, there was a statistically significant ($p < .05$) main effect of training level on the dependent variables of CDSII subscale scores, $F(8, 148) = 6.84$; Wilks' $\Lambda = .730$; $\eta^2p = .270$, and emotional responses, $F(4, 155) = 4.42$; Wilks' $\Lambda = .898$; $\eta^2p = .102$.

Participants in the undergraduate group showed higher levels of both negative emotional reactions, $F(1, 155) = 11.20$; $p = .001$; $\eta^2p = .066$, and positive emotional reactions, $F(1, 155) = 8.90$; $p < .001$; $\eta^2p = .053$, to the BPD vignette than did mental health trainees and clinicians. Undergraduate participants also showed greater negative, $F(1, 155) = 4.63$; $p = .03$; $\eta^2p = .028$, and positive, $F(1, 155) = 6.77$; $p = .01$; $\eta^2p = .041$,

emotional reactions to the schizophrenia vignette than did mental health trainees and clinicians.

Undergraduate participants also rated individuals in the categorical BPD vignette as having a more internal locus of causality of their symptoms, $F(1, 155) = 20.90$; $p < .001$; $\eta^2p = .119$, but less personal control over their symptoms, $F(1, 155) = 8.27$; $p = .005$; $\eta^2p = .051$, than did mental health trainees and clinicians. For the schizophrenia vignette, undergraduate participants rated this individual as having less external control, $F(1, 155) = 3.95$; $p = .049$; $\eta^2p = .025$, and less personal control, $F(1, 155) = 33.04$; $p < .001$; $\eta^2p = .176$, of their symptoms than did mental health trainees and clinicians.

Research Question 2: Would Assessing the Symptoms of BPD Through a Model of Dimensional Personality Traits (i.e., Removing the Categorical Diagnosis) Mitigate Stigma?

Research Question 2, Part 1

To investigate the first part of my second research question, I used ANOVA analyses to examine whether mental health professionals and lay individuals view an individual with a presentation of BPD symptoms and maladaptive traits (but no specific diagnosis) more negatively than an individual with another, similarly severe type of diagnosed psychopathology (schizophrenia).

These analyses included only participants that received the dimensional, trait-based BPD vignette; those who received the categorical BPD diagnosis vignette were excluded. Mental health trainee and clinician groups were combined and compared to the undergraduate group. A summary of all means comparisons can be found in Table 9.

Table 9

Group Comparisons for Dimensional BPD Vignette vs. Schizophrenia Vignette

	Dimensional BPD			**Schizophrenia**			**BPD vs. Schizophrenia**	
	Undergrad. (*M*(SD)) *N* = 72	**Prof. (*M*(SD)) *N* = 92**	**Undergrad. v. Prof. (η2p)**	**Undergrad. (*M*(SD)) *N* = 72**	**Prof. (*M*(SD)) *N* = 92**	**Undergrad. v. Prof. (η2p)**	**Undergrad. (*d*)**	**Prof. (*d*)**
Neg Emo	3.60 (.85)	2.93 (.67)	**.16***	3.49 (.93)	2.91 (.69)	**.12***	.14	.04
Pos Emo	3.93 (1.24)	3.05 (.85)	**.15***	3.83 (1.15)	3.36 (1.08)	**.04***	.14	**.48†**
Inter LoC	18.57 (3.68)	17.01 (3.32)	**.05***	18.60 (4.85)	18.15 (4.83)	.01	.01	**.28†**
Ext Control	12.88 (4.39)	12.30 (4.07)	.01	11.19 (4.88)	11.45 (4.57)	.00	**.36†**	**.24†**
Stability	12.54 (3.55)	13.09 (3.71)	.01	17.39 (3.98)	17.12 (3.76)	.00	**1.02†**	**.89†**
Pers Control	13.03 (4.55)	15.26 (3.97)	**.07***	9.07 (4.61)	11.73 (4.03)	**.09***	**.73†**	**.71†**

Note. Significant effects are bolded. * = significant between-groups effect within condition; † = significant within-group effect across conditions; BPD = borderline personality disorder; *M* = mean; SD = standard deviation; η2p = partial eta squared (effect size); *d* = Cohen's d (effect size); Undergrad. = undergraduate group; Prof. = professional group; Neg = negative; Pos = positive; Emo = emotions; Inter = internal; LoC = locus of control; Ext = external; Pers = personal.

50

Within-Groups Analyses. Within-subjects analysis showed that undergraduate participants showed no differences in their levels of negative, $t(72) = 1.21$; $p = .231$, or positive, $t(72) = 1.14$; $p = .260$, emotional reactions towards the individual in the BPD vignette and the individual in the schizophrenia vignette. However, they continued to show greater levels of external symptom control for the individual in the BPD vignette than in the schizophrenia vignette, $t(71) = 3.03$; $p = .003$; $d = .359$, greater symptom stability for the individual in the schizophrenia vignette than in the BPD vignette, $t(71) = -8.64$; $p < .001$; $d = 1.02$, and greater levels of personal symptom control for the individual in the BPD vignette than the individual in the schizophrenia vignette, $t(71) = 6.17$; $p < .001$; $d = .727$.

Within-subjects analysis for the group of mental health trainees and clinicians showed they displayed greater levels of positive emotional reactions toward the individual in the schizophrenia vignette than toward the individual in the BPD vignette $t(94) = -4.58$; $p < .001$; $d = .477$, and equivalent levels of negative emotional reactions to the individuals in both vignettes, $t(94) = .43$; $p = .67$. Additionally, trainees and clinicians rated a higher level of internal locus of causality for the individual in the schizophrenia vignette than the individual in the dimensional BPD vignette, $t(91) = -2.70$; $p = .008$; $d = .280$, a higher level of external control of symptoms for the individual in the dimensional BPD vignette than in the schizophrenia vignette, $t(91) = 2.30$; $p = .024$; $d = .237$, a higher level of symptom stability for the individual in the schizophrenia vignette than the individual in the BPD vignette, $t(91) = -8.57$; $p < .001$; $d = .893$, and greater personal symptom control for the individual in the BPD vignette than for the schizophrenia vignette, $t(91) = 6.82$; $p < .001$; $d = .710$.

Research Question 2, Part 2

In tandem with my first research question, I also examined between-groups differences between ratings of the BPD traits vignette versus the schizophrenia vignette. In other words, I investigated whether any differences that emerged in mental health professionals' views towards an individual with a trait-based BPD presentation versus an individual with a similarly severe type of diagnosed psychopathology (i.e., schizophrenia) in the first part of my analyses were greater than differences that emerged in undergraduates' views on the same subject.

Between-Groups Analyses. When examining reactions to the dimensional, trait-based BPD vignette versus the schizophrenia vignette, there was a statistically significant ($p < .05$) main effect of training level on the dependent variables of CDSII subscale scores, $F(8, 155) = 5.34$; Wilks' $\Lambda = .784$; $\eta 2p = .216$, and emotional responses, $F(4, 163) = 14.62$; Wilks' $\Lambda = .736$; $\eta 2p = .264$.

Participants in the undergraduate group showed higher levels of both negative emotional reactions, $F(1, 166) = 32.51$; $p < .001$; $\eta 2p = .164$, and positive emotional reactions, $F(1, 166) = 28.81$; $p < .001$; $\eta 2p = .148$, to the BPD vignette than did mental health trainees and clinicians. Undergraduate participants also showed greater negative, $F(1, 166) = 21.51$; $p < .001$; $\eta 2p = .115$, and positive, $F(1, 166) = 7.27$; $p = .008$; $\eta 2p = .042$, emotional reactions to the schizophrenia vignette than did mental health trainees and clinicians.

Undergraduate participants also rated individuals in the categorical BPD vignette as having a more internal locus of causality of their symptoms, $F(1, 162) = 8.10$; $p = .005$; $\eta 2p = .048$, but less personal control over their symptoms, $F(1, 162) = 11.25$; $p =$

.001; η2p = .065, than did mental health trainees and clinicians. For the schizophrenia vignette, undergraduate participants rated this individual as having less personal control, F(1, 162) = 15.51; $p < .001$; η2p = .087, of their symptoms than did mental health trainees and clinicians.

Research Question 2, Part 3

For my final investigation into my second research question, I used ANOVA analyses to compare responses across the different types of BPD vignettes. Specifically, I first investigated whether differences emerged between professional and lay attitudes and opinions towards the individuals in the BPD diagnosis vignette versus the individual in the trait-based BPD vignette. Next, I investigated within-groups comparisons across these two types of vignettes in order to evaluate whether the use of a trait-based BPD presentation was linked to lower ratings of bias and stigma than the use of a BPD diagnosis in either group. These analyses included all participants. Mental health trainee and clinician groups were combined and compared to the undergraduate group. A summary of all means comparisons can be found in Table 10.

Between-Groups Analyses. When examining reactions to the dimensional, trait-based BPD vignette versus the categorical BPD diagnosis vignette, there was a statistically significant ($p < .05$) main effect of training level on the dependent variables of CDSII subscale scores, F(4, 316) = 14.70; Wilks' Λ = .843; $\eta^2p = .157$, and emotional responses, F(2, 324) = 30.13; Wilks' Λ = .843; $\eta^2p = .157$. Specifically, undergraduates rated the individual in the BPD vignette, regardless of vignette version, as having a more internal locus of causality than did trainees and clinicians, F(1, 317) = 27.61; $p < .001$; η2p = .08, while trainees and clinicians rated the individual in the vignette as having

Table 10

Group Comparisons for Dimensional BPD Vignette vs. Categorical BPD Vignette

	Dimensional BPD		**Categorical BPD**		**Combined BPD**	**Dimen v. Cat**	
	Undergrad.	**Prof.**	**Undergrad.**	**Prof.**	**Undergrad.**	**Undergrad.**	**Prof.**
	(*M*(SD))	**(*M*(SD))**	**(*M*(SD))**	**(*M*(SD))**	**v. Prof.**	**(*d*)**	**(*d*)**
	***N* = 73**	***N* = 93**	***N* = 73**	***N* = 84**	**(η2p)**		
Neg Emo	3.60 (.85)	2.93 (.67)	3.52 (.95)	3.08 (.73)	**.11***	.09	.22
Pos Emo	3.93 (1.24)	3.05 (.85)	3.69 (1.14)	3.18 (1.12)	**.10***	.20	.13
Inter LoC	18.57 (3.68)	17.01 (3.32)	19.34 (3.72)	16.80 (3.26)	**.08***	.21	.06
Ext Control	12.88 (4.39)	12.30 (4.07)	12.50 (4.24)	12.40 (4.20)	.01	.09	.02
Stability	12.54 (3.55)	13.09 (3.71)	13.63 (3.57)	12.70 (4.03)	<.01	.31	.10
Pers Control	13.03 (4.55)	15.26 (3.97)	12.96 (4.55)	14.92 (3.99)	**.06***	.02	.09

Note. Significant effects are bolded. * = significant between-groups effect within condition; † = significant within-group effect across conditions; BPD = borderline personality disorder; *M* = mean; SD = standard deviation; η2p = partial eta squared (effect size); *d* = Cohen's d (effect size); Undergrad. = undergraduate group; Prof. = professional group; Neg = negative; Pos = positive; Emo = emotions; Inter = internal; LoC = locus of control; Ext = external; Pers = personal; Dimen = dimensional; Cat = categorical.

more personal control over their symptoms than did undergraduates, $F(1, 317) = 19.37$; $p < .001$; $\eta 2p = .06$. Additionally, undergraduate participants displayed stronger positive, $F(1, 32) = 33.34$; $p < .001$; $\eta 2p = .09$, and negative, $F(1, 325) = 40.22$; $p < .001$; $\eta 2p = .11$, emotional responses towards the individual in the BPD vignette, regardless of vignette version.

There was no main effect of BPD vignette type (categorical vs. dimensional) on either CDSII subscales, $F(4, 316) = .32$; Wilks' $\Lambda = .996$; $p = .862$, or emotional responses, $F(2, 324) = .31$; Wilks' $\Lambda = .998$; $p = .734$. Interaction effects of training group and vignette type were also non-significant for both emotional responses, $F(2, 324) = 1.44$; Wilks' $\Lambda = .991$; $p = .239$, and CDSII subscales, $F(4, 316) = 1.21$; Wilks' $\Lambda = .985$; $p = .306$.

Within-Group Analyses. For the undergraduate group, there were no statistically significant differences on any of the CDSII subscale or emotional response scales between those who received the categorical diagnosis version or the dimensional trait-based version of the BPD vignette $F(6, 139) = .92$; Wilks' $\Lambda = .962$; $p = .482$. This lack of difference also held true in the group of clinicians and trainees, $F(6, 170) = .52$; Wilks' $\Lambda = .962$; $p = .793$.

Research Question 3: Are Clinicians and Mental Health Trainees Currently Learning About the AMPD's Dimensional Model and Measures of Personality Disorders in Their Training?

The aim of my final research question was primarily exploratory. In other words, I was interested in examining the frequency values to the possible responses about this model to determine the state of the model's spread throughout the field of mental health

professionals as a whole. These values can be found in Table 11. To further investigate this question, I also conducted *t*-tests to examine whether mental health trainees and clinicians displayed a difference in their levels of familiarity with the AMPD's dimensional model of diagnosis. After comparing these mean ratings of familiarity, I used chi-square analyses to compare the frequencies of endorsed responses related to familiarity, research use, and clinical use of the model across these groups.

The difference in mean familiarity with the AMPD between clinicians and trainees was nonsignificant ($t(173) = -1.80$; $p = .07$). The combined mean familiarity rating was 2.29 ($SD = 1.09$). Chi-square analyses indicated no differences between clinician and trainee response frequencies on the questions of AMPD familiarity and use of the AMPD in clinical work (p's > .05); however, clinicians were significantly more likely than trainees to indicate they had used the AMPD in their research, $\chi^2(1, N = 175) = 7.25$; $p = .007$.

CHAPTER IV

Discussion

The current study investigated three primary research questions: (1) Do mental health professionals view individuals with a BPD diagnosis more negatively than individuals with other diagnoses, and do they do so more than laypersons? (2) Would assessing the symptoms of BPD through a model of dimensional personality traits (i.e., removing the categorical diagnosis) mitigate this stigma? and (3) Are clinicians and mental health trainees currently learning about the AMPD's dimensional model and measures of personality disorders in their training? In other words, if utilizing a dimensional model leads to reduced stigma, to what extent has the movement to this example of a dimensional system already occurred?

Table 11

AMPD Responses Means and Frequencies

	Total (*N* = 184)	**Clinicians (*N* = 75)**	**Trainees (*N* = 109)**
Mean Familiarity (SD)	2.29 (1.09)	2.47 (1.20)	2.17 (.99)
Familiarity			
Not at All	49 (26.6%)	18 (24.0%)	31 (28.4%)
Somewhat	57 (31.0%)	24 (32.0%)	33 (30.3%)
Moderately	43 (23.4%)	14 (18.7%)	29 (26.6%)
Quite	21 (11.4%)	13 (17.3%)	8 (7.3%)
Very	5 (2.7%)	4 (5.3%)	1 (0.9%)
No Response	9 (4.9%)	2 (2.7%)	7 (6.4%)
Clinical Use			
Yes	26 (14.1%)	12 (16.4%)	14 (12.8%)
No	149 (81.0%)	61 (81.3%)	88 (80.7%)
No Response	9 (4.9%)	2 (2.7%)	7 (6.4%)

(continued)

	Total (N = 184)	Clinicians (N = 75)	Trainees (N = 109)
Research Use			
Yes	22 (12.0%)	15 (20.0%)*	7 (6.4%)*
No	152 (83.2%)	58 (77.3%)	95 (87.2)
No Response	9 (4.9%)	2 (2.7%)	7 (6.4%)

Notes. * = $p < .05$. For familiarity ratings, *Not at All* = "I have never heard of this model."; *Somewhat* = "I have heard of this model but do not know how it functions."; *Moderately* = "I am familiar with the model but do not have specialized knowledge in it."; *Quite* = "I have a good working knowledge of the model and use it in my research or clinical practice, OR I have learned about the model in one or more of my classes."; *Very* = "The AMPD is a main focus of my research or the primary diagnostic system used for PDs in my clinical practice, OR the model is referenced regularly in my classes."

Before investigating the answers to these specific questions, I also performed a general investigation of overt expressions of mental health clinicians' attitudes towards individuals with BPD.

Investigation of Overt Professional Bias

When examining professional bias using a measure that explicitly assessed attitudes towards individuals with BPD generally, rather than toward a specific individual, (the APDQ) there were no significant differences between mental health trainee and clinician ratings. Generally, this combined group of professionals expressed the lowest ratings on this measure for the subscales of enjoyment and enthusiasm. The group mean score on these subscales fell between the options of "occasionally" and "often", which represent the frequency with which participants enjoy and are enthusiastic about working with these clients. This rating reflects the approximate midpoint of the given scale, indicating that mental health professionals did not feel strongly in either direction when given questions to assess their levels of enjoyment and enthusiasm towards working with clients with BPD. These findings can be explained in several ways. On one hand, the lack of strongly positive or negative responses towards individuals with

BPD on several of these scales may have significant implications for the care of treatment of these clients because positive emotions, especially sympathy, have shown strong associations with the implementation of helping behaviors (Weiner, 1985). If these mental health professionals are not displaying particularly positive attitudes in working with these individuals, this could have implications for building rapport, trust, and other elements of the therapeutic relationship (Fraser & Gallop, 1993; McIntyre & Schwartz, 1998). In addition, this tendency may increase self-fulfilling prophecy behaviors such as distancing in the therapeutic relationship, possibly leading to missing important information and decreasing the quality and effectiveness of the care they can provide (Aviram et al., 2006; Hinshelwood, 1999). On the other hand, these responses could be indicative of participants being reticent to endorse particularly negative attitudes towards these clients in the context of a research study, even if they did not feel particularly positively towards these individuals either.

Other subscale means on the APDQ fell on the positive side of the scale (often to always), indicating that mental health professionals generally endorsed feeling secure, having purpose to their work, and feeling accepting toward clients with BPD. These findings are encouraging and indicate current mental health professionals' views of working with these clients have come quite a long way since Stern's day, in which individuals displaying this type of pathology were considered to be wholly untreatable (Stern, 1938). This finding also indicates a change from attitudes towards BPD as it became more well-studied, during which time clinicians outwardly described individuals with BPD in pejorative terms such as "difficult," "treatment resistant," "manipulative," and "demanding," and commonly reported experiencing feelings of incompetence while

treating individuals with BPD, indicating a lack of acceptance, security, and purpose when working with these clients (e.g., Gallop & Wynn, 1987; Houck, 1972; Klein, 1972).

I hypothesized that the endorsement of internal causality of symptoms seen in BPD individuals would predict explicitly expressed negative attitudes towards working with these clients. Given the general lack of expressed negative attitudes on the subscale of the APDQ, as previously discussed, it was unsurprising to find limited support for this hypothesis. Regression analyses of the APDQ subscales on a selection of CDSII subscales generally showed limited predictive power of the CDSII to explain APDQ scores overall. However, the specific subscale measuring internal locus of causality was significant in most regression models. Indeed, as ratings of internal (vs. external) causality increased, feelings of enjoyment in treating these clients decreased. This pattern also held true for feelings of security, purpose, and acceptance of individuals with BPD. In other words, the more strongly that mental health professionals believed in an internal cause of these symptoms (i.e., that they are due to something within the client rather than because of something that has happened to the client), the less likely they were to express attitudes of enjoyment, security, purpose, and acceptance in working with clients with BPD.

Research Question 1: Do Mental Health Professionals View Individuals with a BPD Diagnosis More Negatively Than Individuals with Other Diagnoses, and Do They Do So More Than Laypersons?

To address my first research question, I hypothesized that mental health clinicians and trainees (i.e., “mental health professionals”) would endorse higher levels of negative emotions and lower levels of positive emotions towards a BPD-diagnosed individual than

an individual with another, similarly severe categorical diagnosis (i.e., schizophrenia), whereas individuals without advanced mental health training would show no differences on these metrics. Findings demonstrated mixed support for this hypothesis. Mental health professionals endorsed similar ratings of negative emotional responses toward both vignettes, but they endorsed significantly lower positive emotional responses towards the client with a BPD diagnosis than they did toward the client with a schizophrenia diagnosis. Conversely, undergraduate participants endorsed significantly higher levels of negative emotional responses toward the client with a BPD but demonstrated no significant difference in level of positive emotional responses to either vignette. Generally, undergraduates demonstrated higher levels of all emotional responses when compared to mental health professionals.

The lack of difference in professionals' negative emotional responses towards both types of clients, and the lower ratings of negative emotions than undergraduates generally, provides a seed of hope when considering these emotional responses as proxies for measuring bias. At least outwardly, mental health professionals did not ascribe particularly negative feelings towards the client with BPD in the given vignette. This could have been due to a variety of factors, including that mental health professionals may now realize that they are not *supposed* to endorse or display these overtly negative attitudes towards individuals with BPD. However, they did demonstrate these differences more readily when assessing positive emotional responses towards both types of clients in the vignettes. In other words, although they did not demonstrate outward negative bias towards the client with BPD, they still reacted to this client less positively than they did the client with schizophrenia. When compared to these professionals' lukewarm

responses towards individuals with BPD as indicated by the APDQ, this finding reinforces the tendency that professionals showed towards not expressing strong positive nor strong negative reactions towards the given individual.

On the other hand, undergraduates were more likely to endorse outwardly negative emotions towards the client with BPD than they were towards the client with schizophrenia, with no differences in positive emotional responses. This implies that to the layperson who does not have advanced mental health training, the symptom presentation of an individual with BPD may be more threatening or otherwise unpleasant than the presentation of a client with schizophrenia. Alternatively, they may have found this client's presentation more frustrating or worthy of blame for their own problems than the client with schizophrenia. This finding was unexpected but has interesting implications when compared to mental health professional responses, in that advanced mental health training may influence the degree and type of outward expression of a bias that already exists in the lay population.

To further assess for the presence of bias, I also predicted that mental health professionals would ascribe ratings reflecting a more internally focused locus of causality, higher personal control of symptoms, and higher symptom stability for individuals with a BPD diagnosis than for individuals with a schizophrenia diagnosis, whereas lay individuals would show no significant difference in these metrics. Counter to my expectations, mental health professionals assigned a more externally focused locus of causality for the symptoms of the client with a BPD diagnosis than they did to for the client with a schizophrenia diagnosis. They also attributed lower symptom stability to the client with BPD. In contrast, they ascribed a significantly higher rating of personal

control of symptoms to the client with BPD, which was in line with my expectations. These findings remained consistent across both the categorical and dimensional versions of the BPD vignette.

Unexpectedly, undergraduates showed a similar pattern of differences across ratings of symptom stability and personal control of symptoms; in addition, they rated the client with BPD as being more receptive to symptom control from an external source than the client with schizophrenia. There were no significant differences across undergraduates' assignments of locus of symptom causality. These findings remained consistent across both the categorical and dimensional versions of the BPD vignette. To the extent that professional and lay ratings of these vignettes varied, undergraduates rated individuals in both vignettes as having less personal control of their symptoms than did mental health professionals; rather than being a marker of stigma, this difference may reflect an erroneous lay belief that all individuals with mental illness generally lack the skills or agency to manage and control their behavior.

Taken together, these findings broadly demonstrate that there are many commonalities between professional and lay opinions on clients with both BPD and schizophrenia. They provide less support for a clear professional bias against clients with BPD. However, it is worth exploring the differences that emerged among these ratings and whether they should be interpreted differently than originally implied in my corresponding hypotheses. For example, one significant difference counter to my expectations was that professionals assigned a higher rating of symptom stability to the client with the schizophrenia diagnosis. Rather than seeing this as an indication that these symptoms are chronic and unchangeable, as I first hypothesized, this may indicate that

they see clients with BPD as having a more unpredictable, difficult to manage symptom presentation than those with schizophrenia.

Research Question 2: Would Assessing the Symptoms of BPD Through a Model of Dimensional Personality Traits (i.e., Removing the Categorical Diagnosis) Mitigate Stigma?

For the investigation of my second research question, I predicted clinicians and trainees would endorse higher levels of negative emotions and lower levels of positive emotions towards an individual categorically diagnosed with BPD than an individual displaying identical symptoms whose conceptualization is presented through levels of elevated maladaptive personality traits. I also predicted that mental health professionals and trainees would ascribe ratings reflecting a more internally focused locus of causality, higher personal control of symptoms, and higher symptom stability for individuals when their vignette presents a categorical BPD diagnosis than when it presents their profile of traits and impairment.

Unexpectedly, the results of these analyses showed there were no significant differences in either lay or professional opinions across vignette types. In other words, presenting the client as having either a categorical BPD diagnosis or high levels of dimensional traits related to BPD did not influence participants' responses to the individual in the BPD vignette. This lack of significant difference across vignette conditions implies that both lay and professional opinions about the individual in the vignette were tied more to the individual's explicit symptom presentation than to the label attached to such symptoms and behaviors. In other words, using a dimensional diagnostic system for PDs may not be as effective of a tool in reducing the stigma against

individuals who display BPD symptoms as I had hoped in my original proposal of research questions and hypotheses.

This finding is discouraging, in that even when removing one of the obvious stigma "marks" of this group of individuals (Link & Phelan, 2001), attitudes remained consistent. Regarding the debate of whether labels or aberrant behaviors contribute to public stigma against individuals with mental illness (Link, 1982; Link, 1987; Link et al., 1987; Link et al., 1999), these results provide some support for the role of behaviors in shaping lay opinions and stigma. This is especially apparent given the differences discussed earlier about lay participants' reactions to the BPD and schizophrenia vignettes. For mental health professionals, this finding could have been due to a variety of factors, including those with professional training recognizing the symptoms displayed in the vignette as a presentation of BPD, even without the explicit label attached. Even if professionals did not explicitly recognize the symptoms of BPD, the inclusion of language about "maladaptive personality traits" in the description of the vignette may have indicated the presence of a PD generally, which have historically been subject to less favorable views from professionals overall when compared to other, non-PD symptoms and diagnoses (e.g., Bowers et al., 2000; Lewis & Appleby, 1988). Additionally, some professionals may have recognized this presentation as indicative of the AMPD's language related to BPD, thus nullifying the experimental condition change across vignette types.

Research Question 3: Are Clinicians and Mental Health Trainees Currently Learning About the AMPD's Dimensional Model and Measures of Personality Disorders in Their Training?

Although no directional hypotheses were posed for my third research question, the findings regarding mental health clinicians' and trainees' familiarity and current use of the AMPD were illuminating. Generally, professionals indicated some knowledge of this model, with the mean familiarity rating falling between being *somewhat* to *moderately* familiar with the model. For context, these response options were operationalized as "I have heard of this model but do not know how it functions" and, "I am familiar with the model but do not have specialized knowledge in it." However, much of the professional sample indicated they were not at all familiar with the AMPD. Generally, the model appears not to be in wide use across clinical or research settings, with less than 15% of the sample indicating they had ever used the AMPD in their clinical or research work. The one significant difference that emerged between mental health trainees and clinicians was in the category of research use, in that clinicians were more likely to indicate they had used the AMPD in research than were trainees. Even so, less than 20% of clinicians designated this option.

These findings indicate that the AMPD is not widely known about or used by mental health professionals, despite strong support for the inclusion of a dimensional model of PD diagnosis for the DSM-5 and positive preference ratings for the AMPD over the current categorical model of PD diagnosis (Bernstein et al., 2007; Krueger et al., 2012; Morey et al., 2014). At the time data for the current study were collected in 2020-2021, the DSM-5 had been in use for seven to eight years; almost a decade after this

edition's release, more than a quarter of surveyed mental health professionals have never heard of the AMPD model contained within Section III. In other words, the shift to this widely available dimensional model of PD diagnosis remains in its infancy. Given the lack of familiarity endorsed across professionals, it is unsurprising that use in clinical settings remains low; after all, diagnoses are only a useful tool insofar as they are understood by other professionals. Regarding the difference between trainees and clinicians in research use, this statistic was unsurprising in that clinicians have spent more time in the profession and likely explored more areas of research (from both a consumer and producer standpoint) in their careers than have trainees, who have had less exposure to various research topics and are still exploring their research interests.

Summary of Findings

In sum, the findings of the current study revealed a nuanced picture of professional bias in the treatment of clients with BPD. For instance, although mental health professionals did not endorse strong negative responses or attitudes towards this type of client, they did not endorse particularly positive responses either. The one significant exception to this trend was the finding that believing in a more internal locus of causality for BPD symptoms was predictive of these professionals expressing less enjoyment, security, purpose, and acceptance in working with clients with BPD. Discouragingly, presenting a client with BPD through the lens of the AMPD dimensional model, with a focus on maladaptive traits rather than a categorical diagnosis, did not affect professionals' responses to a client displaying prototypical symptoms of BPD. In addition, over half of these professionals reported being *Not at All* ("I have never heard of this model.") or only *Somewhat* ("I have heard of this model but do not know how it

functions.") familiar with the AMPD, indicating that the field has not yet begun its movement towards this widely-available dimensional system of PD diagnosis, despite overwhelming support for a dimensional model prior to the DSM-5's publication (Clark, 2007; Widiger & Simonsen, 2005).

Future Research Areas

Rather than providing explicit answers to my proposed research questions, the findings of the current study open the door to further study of these issues in different contexts. For example, the models I used to measure bias in the current study are only one possible way of assessing professional and lay bias towards this group of individuals. Future research should continue to assess for this bias in different ways, such as directly evaluating relationships between treatment providers and patients displaying symptoms of BPD. It would be especially informative to investigate whether these attitudes and behaviors towards clients with BPD differ across providers in different treatment settings, with different roles in their treatment (e.g., social workers in inpatient settings versus outpatient therapy providers). Examining these questions in a variety of ways will provide further insight to the nuanced attitudes that mental health professionals endorsed in the current study.

Additionally, mental health providers' understanding and use of the AMPD (and other dimensional PD diagnostic systems) requires further study, given the lack of familiarity endorsed by professionals in this study. If the field truly intends to move toward a dimensional PD diagnostic system, then we must further study how practicing clinicians feel about this first officially proposed model. Only through the examination of this model in practice will we be able to see whether it is *the* dimensional model that

should be used in the future. Although there were no significant differences between reactions to the categorical and dimensional PD vignettes in the current study, future studies should continue to assess these differences among clinicians with differing levels of knowledge and familiarity with the AMPD.

Another avenue for future studies to pursue includes client and patient reactions to a change to a dimensional diagnostic system. Because individuals with BPD often experience difficulties with their concept of identity, it is unclear how they would react to "losing" the categorical diagnosis they may see as an integral part of their identity. It may be fruitful for researchers to begin this research by looking to client reactions that occurred when the categorical diagnoses of Asperger syndrome and autism were combined into the dimensional autism spectrum disorder in DSM-5. In addition to ascertaining patients' own reactions to a move to a dimensional diagnostic system, it is also important to measure whether individuals with BPD feel that they experience a change in the amount or type of stigmatizing experiences in treatment when their categorical diagnosis is no longer used by mental health professionals.

Limitations

The results of the current study should be carefully considered within the context of several methodological limitations. First, the measurement of bias or stigma is a challenge in any context; individuals are unlikely to want to present themselves in a negative light by admitting to prejudices. Therefore, there was likely an element of response bias present in participant responses to the current study's self-report survey. Although I attempted to account for this limitation by using several different instruments

as proxies for the measurement of bias, it is difficult to say how strongly participants felt this pressure to suppress their negative attitudes and beliefs.

Another significant limitation was related to the recruitment difficulties I experienced in conducting the current study. I was unable to recruit my initially proposed group numbers in a timely manner, which limited some of the comparisons I was able to make with my data. To address this limitation, I combined mental health trainee and clinician groups for many of my analyses. It would have been interesting to examine differences that may have emerged between these two groups in a larger sample.

Additionally, because of the overwhelming amount of automated and invalid responses I received to my survey, it is possible that some valuable data was lost from actual trainees or clinicians in my attempts to clean the data. Although I attempted to clean the data in a way that included only valid responses, there is also the possibility that some invalid responses remained in my final sample, because of the limited ability to fully measure response validity in an online self-report survey.

Conclusion

For decades, there has historically been a lack of agreement on the definition, presentation, development, best treatment practices, and even existence of BPD. Over time, a complex set of beliefs rooted in these historical disagreements, some of which are based on outdated or false information, has arisen surrounding the BPD diagnosis, leading many mental health professionals to hold a bias against these clients. In the current study, I discovered that this bias may look differently now than it has in the past, and that general professional opinions of individuals with BPD may be improving. Still, these disagreements surrounding this disorder will not be quickly resolved, nor will these

mistaken beliefs be changed overnight. For now, looking for new solutions to this problem will continue to be an ongoing task for the fields of personality assessment and PD research. This may include the use of the AMPD or other proposed dimensional systems of PD diagnosis with which mental health professionals are generally not yet familiar. Hopefully, one day, through the combined efforts of researchers in these fields, clinical relationships between individuals with BPD and their treatment providers can be improved, leading to less distress, more consistency, and improved outcomes in treatment.

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APPENDIX

CASE VIGNETTES

Vignette 1: Borderline Personality Disorder[2]

A client sought therapy at age 33 for treatment of depressed mood, chronic suicidal thoughts, social isolation, and poor personal hygiene. They had spent the prior 6 months isolated in their apartment, lying in bed, eating junk food, watching television, and doing more online shopping than they could afford. The client's history included cutting themself superficially on a number of occasions, along with persistent thoughts that they would be better off dead. They had been in psychiatric treatment since age 17 and had been psychiatrically hospitalized three times after overdoses. The client also reported a history of mood swings, difficulty controlling their anger, instability in their interpersonal relationships and identity, feelings of emptiness, and brief, stress-related episodes of paranoia.

Ending in Categorical Vignette: The therapist diagnosed this client with borderline personality disorder (BPD).

Ending in Dimensional (AMPD) Vignette: The therapist diagnosed this client with high levels of several pathological personality traits, including emotional lability, hostility, impulsivity, depressivity, and separation insecurity.

Vignette 2: Schizophrenia[3]

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[2] *Note:* Case vignette adapted from Yeomans, F. & Kernberg, O. (2014). Case 18.5 Fragile and Angry. In Barnhill, J.W. (Ed.), DSM-5 Clinical Cases. Arlington, VA: American Psychiatric Publishing.

[3] *Note:* Case vignette adapted from Tamminga, C. A. (2014). Case 2.1 Emotionally Disturbed. In Barnhill, J.W. (Ed.), DSM-5 Clinical Cases. Arlington, VA: American Psychiatric Publishing.

A 32-year-old was brought to the emergency room (ER) after exhibiting odd behavior in public that caused a concerned citizen to notify emergency services. Because the individual appeared to be an “emotionally disturbed person,” a psychiatry consultation was requested. According to the psychiatrist, the patient had received a diagnosis of “childhood-onset, treatment-resistant paranoid schizophrenia.” They had started hearing voices by age 5 years. Big, strong, intrusive, and psychotic, they had been hospitalized almost constantly since age 11. Their auditory hallucinations generally consisted of a critical voice commenting on their behavior. The psychiatrist also believed that they had spent almost no period of life developing normally and so had very little experience with the real world. The psychiatrist diagnosed this client with schizophrenia.

VITA

Jennifer Katherine Boland, M.A.
Department of Psychology and Philosophy
Sam Houston State University

EDUCATION

Ongoing — **Doctor of Philosophy (Clinical Psychology)**
Sam Houston State University
Huntsville, TX

2018 — **Master of Arts (Clinical Psychology)**
Sam Houston State University
Huntsville, TX

2014 — **Bachelor of Science (Psychology, Honors)**
Fordham University
Bronx, NY

CLINICAL EXPERIENCE

Aug 2021–
Aug 2022

Psychology Intern

Pilgrim Psychiatric Center
West Brentwood, NY

Completed an APA-accredited doctoral internship program for the 2021-2022 training year at an NYS OMH inpatient state facility. Responsibilities included conducting intakes, group therapy (6 groups per week: DBT, RO DBT, Substance Abuse, MRT, Family Dynamics, Symptom Management), individual therapy, and assessment duties on both a general admission and a long-term forensic rehabilitation ward under the supervision of several licensed psychologists. Inpatient forensic population.

Supervisors: Jennifer May, PhD; Ann Marie Kavanagh, PhD; Howard Delman, PhD;

Aug 2020–
July 2021

Psychology Intern

Rusk State Hospital
Rusk, TX

Delivered individual therapy and conducted court-ordered competency to stand trial evaluations and violence risk assessments under the supervision of a doctoral-level licensed psychologist. All forensic population.

Supervisor: Sarah Rogers, PhD

Aug 2019–
July 2020

Clinic Coordinator

Psychological Services Center, Sam Houston State University
Huntsville, TX

Conducted initial phone screenings with clients to triage their priority level. Created and maintained clinic documentation, including wait list and active client lists. Led weekly staff meetings/case presentation sessions. Mentored early-level doctoral trainees, conducted forensic assessments (competency, sanity), provided both in-person and telepsychology therapy, and conducted psychodiagnostic assessments.

Supervisor: Laura Drislane, PhD

Jun 2018 –
July 2019

Psychological Services Extern

Walker County Community Supervision and Corrections Department
Huntsville, TX

Conducted psychodiagnostic assessments and substance abuse evaluations and provided individual counseling and anger management group services to adult probationers.

Supervisor: Darryl Johnson, PhD

Aug 2017–
July 2018

Student Clinician

Psychological Services Center, Sam Houston State University
Huntsville, TX

Provided individual therapy and conducted diagnostic assessments of learning disabilities and other mental health concerns at a community mental health center under the supervision of doctoral-level licensed psychologists.

Supervisor: Wendy Elliott, PhD, ABPP

Jun 2014 –

Forensic Case Manager

July 2016 — *EAC Queens TASC Mental Health Diversion Program*
Queens, NY

Managed a caseload of offenders by making program referrals, supervising urinalysis screenings, conducting face-to-face meetings, communicating with Rikers Island staff, and preparing HRA 2010e forms. Conducted assessment interviews and wrote psychosocial evaluations. Reported on client progress in treatment to the Queens County Criminal and Supreme Courts' mental health recovery courts. Conducted CBT journaling with mental health clients.

Supervisors: Alexandra Garcia-Mancilla, PhD; Edward Fernandez, PsyD

May 2013–
May 2014 — **Mental Health Intern**

EAC Queens TASC Mental Health Diversion Program
Queens, NY

Assisted forensic case managers with tasks such as conducting assessment interviews, writing psychosocial evaluations and client progress notes, making collateral phone calls and implementing Cognitive Behavioral Therapy journaling with mental health clients.

Supervisor: Alexandra Garcia-Mansilla, PhD

Aug 2012–
Aug 2013 — **Psychiatry Volunteer**

Beth Israel Medical Center
Manhattan, NY

Participated as a member of a multidisciplinary team on three inpatient psychiatric units under Dr. Igor Galynker on weekly rounds. Worked as a research assistant under Dr. Galynker on inpatient psychiatric units.

Supervisor: Igor Galynker, MD

RESEARCH EXPERIENCE

Aug 2016 –
present — **Graduate Research Assistant**

Assessment of Personality Psychopathology Lab
Sam Houston State University
Huntsville, TX

Research Advisor: Jaime Anderson, PhD

July 2020 – March 2021

Research Group Co-captain

Huntsville Community Peace Coalition Research Team
Huntsville, TX

Research Advisors: Craig Henderson, PhD; Temilola Salami, PhD; Jeffrey Gardner, PhD

Aug 2016 – May 2018

Graduate Research Assistant

Sam Houston State University
Huntsville, TX

Research Advisor: Craig Henderson, PhD

May 2013 – May 2014

Undergraduate Research Assistant

Psychology-Law Research Lab
Fordham University
Bronx, NY

Research Advisor: Barry Rosenfeld, PhD

Sept 2012 – Sept 2013

Undergraduate Research Assistant

Family Center for Bipolar Research Lab
Mt. Sinai Beth Israel
Manhattan, NY

Research Advisor: Igor Galynker, MD

Sept 2011 – May 2014

Undergraduate Research Assistant

Animal Cognition Research Lab
Fordham University
Bronx, NY

Research Advisor: James MacDonall, PhD

PUBLICATIONS

Hobaica, S., Szkody, E., Owens, S., **Boland, J.,** Washburn, J., & Bell, D. (2021). Mental health concerns and barriers to care among future clinical psychologists. *Journal of Clinical Psychology.* Advance online publication. https://doi-org.ezproxy.shsu.edu/10.1002/jclp.23198

Ghamkharfard, Z. G., Pourshahbaz. A., Anderson, J. L., **Boland, J. K.,** Shakiba, S., & Mirabzadeh, A. (2021). The continuity between DSM-5 criterion-based and trait-based models for personality disorders in an Iranian community sample. *Current Psychology.* Advance online publication. https://doi.org/10.1007/s12144-021-01751-2

Harmon, J., **Boland, J.,** & Venta, A. (2021). An exploratory factor analysis of the Motivations for Electronic Interaction Scale. *Current Psychology.* Advance online publication. https://doi.org/10.1007/s12144-020-01300-3

Boland, J., & Henderson, C. (2020). The impact of personality on the physical activity and alcohol use relationship. *Clinical Psychology and Special Education, 9*(3), 62-75. https://doi.org/10.17759/cpse.2020090305

Boland, J., Rock, R. C., Johnson, A. K., Jones, M. A., Salekin, R. T., & Anderson, J. L. (2020). Pathways to incarceration: An examination of childhood maltreatment and personality psychopathology in incarcerated adults. *Psychology, Crime, and Law.* https://doi.org/10.1080/1068316X.2020.1798426

Henderson, C. E., Manning, J. M., Davis, C. M., Conroy, D. E., van Horn, L. M., Henry, K., Long, T., Ryan, L., **Boland, J.,** Yenne, E., Schiafo, M., Waldo, J., & Sze, C. (2020). Daily physical activity and alcohol use among young adults. *Journal of Behavioral Medicine, 43,* 365-376. https://doi.org/10.1007/s10865-020-00151-4

Boland, J. K., & Anderson, J. L. (2019) The role of personality psychopathology in social network site behaviors. *Personality and Individual Differences, 151.* https://doi.org/10.1016/j.paid.2019.109517

Boland, J. K., Damnjanovic, T., & Anderson, J. L. (2018). Evaluating the role of functional impairment in personality psychopathology. *Psychiatry Research, 270,* 1017-1026. https://doi.org/10.1016/j.psychres.2018.03.049

Boland, J. & Rosenfeld, B. (2018). The role of controlled substance use in diversion outcomes among mentally ill offenders: A pilot study. *International Journal of Offender Therapy and Comparative Criminology, 62*(9), 2709-2725. https://doi.org/10.1177/0306624X17735093

Kopeykina, I., Kim, H. J., Khatun, T., **Boland, J.,** Haeri, S., Cohen, L. J., & Galynker, I. I. (2016). Hypersexuality and couple relationships in bipolar disorder: A review. *Journal of Affective Disorders*, *195,* 1-14. https://doi.org/10.1016/j.jad.2016.01.035

CONFERENCE PRESENTATIONS

Boland, J. K., Fernandez, L., Sims-Rhodes, N., & Anderson, J. L. (2021, March). *Normative and maladaptive personality construct associations with the LPFS-SR over time.* [Conference paper]. Society for Personality Assessment Annual Convention, Virtual.

Henderson, C., Conroy, D., Van Horn, M. L., Henry, K., *Long, T., Ryan, L.,* ***Boland, J.***, Schiafo, M., Waldo, J., & *Sze, C.* (2020, November). A latent class analysis of correlates of college student alcohol use and physical activity group membership. In C. Henderson & K. E. Shin (Co-Chairs), *Uncovering Dynamic Clinical Processes: Statistical Approaches for Intensive Longitudinal Data*. Symposium presented at the Annual Meeting of the Association for Behavioral and Cognitive Therapies. Virtually presented.

Boland, J. K., Fondren, A., Bryant, W. T., Davis, K., Krishnamurthy, R. (2020, March). *SPAGS Presents: Gender and Sexual Minority Considerations in Personality Assessment Training*. [Conference roundtable]. Society for Personality Assessment Annual Convention, San Diego, CA. (Conference canceled due to COVID-19).

Boland, J., Owens, S., Hobaica, S., & Szkody, E. (2020, January). *Financial status and mental health reports among clinical psychology doctoral students.* [Conference paper]. Council of University Directors of Clinical Psychology Midwinter Meeting, Austin, TX.

Boland, J., Schiafo, M., & Anderson, J. (2019, October). *Epic trolls: The relationship of narcissism to online disinhibition.* [Conference poster]. Annual conference of the Texas Psychological Association, San Antonio, TX.

Boland, J. K., Fernandez, L., & Anderson, J. L. (2019, March). *The Role of Personality Psychopathology in Social Network Site Behaviors.* [Conference poster]. Society for Personality Assessment Annual Convention, New Orleans, LA.

Davis, K. C., **Boland, J. K.**, & Henderson, C. E. (2019, February). *The Intersectional Self: Opening the Narrative of Identities.* [Conference session]. Sam Houston State University Diversity Leadership Conference, Huntsville, TX.

Boland, J., & Henderson, C. (2018, November). *The Moderating Effects of Five Factor Model Personality Traits on the Physical Activity and Alcohol Use Relation.* [Conference poster]. Annual conference of the Texas Psychological Association, Frisco, TX.

Anderson, J. L., **Boland, J.,** Rock, R. C., Jones, M. A., & Johnson, A. K. (2018, November) *Exploring the relationship between trauma and maladaptive behavior in an incarcerated population.* In A. Venta (Chair), The Effects of Trauma on Mental and Physical Health in Special Populations. [Conference symposium]. Annual conference of the Texas Psychological Association, Frisco, TX.

Boland, J., Damnjanovic, T., & Anderson, J. (2018, March). *Evaluating the Role of Functional Impairment in Personality Psychopathology.* [Conference poster]. Society for Personality Assessment Annual Convention, Washington, D.C.

Boland, J. & Rosenfeld, B. (2018, March). *The Role of Controlled Substance Use in Diversion Outcomes among Mentally Ill Offenders.* [Conference poster]. American Psychology-Law Society Conference, Memphis, TN.

Boland, J., Damnjanovic, T., & Anderson, J. (2017, November). *Evaluating the Role of Functional Impairment in Personality Psychopathology.* [Conference paper]. Annual Texas Psychological Association Conference, Houston, TX.

Camins, J. S.**,** Henderson, C. E., Magyar, M. S., Schmidt, A.T., Crosby, J., Reinhard, E. E. & **Boland, J. K.** (2017, March). *Adolescent Behavior Typing in At-risk Youth: Validation Using a Latent Variable Approach.* [Conference paper]. American Psychology-Law Society Conference, Seattle, WA.

Boland, J., Garcia-Mansilla, A., & Rosenfeld, B. (2014, May). *Does Substance Abuse Predict Diversion Program Outcomes in Severely Mentally Ill Offenders?* [Conference poster]. Association for Psychological Science Annual Convention, San Francisco, CA.

Boland, J., Garcia-Mansilla, A., & Rosenfeld, B. (2014, April). *Predicting Success: Does Substance Abuse Predict Diversion Program Outcomes in Severely Mentally Ill Offenders?* Paper presented at the Fordham Undergraduate Research Symposium, Bronx, NY.

Boland, J., Kogan, I., Yaseen, Z., Hayashi, F., Kreiter, A., & Galynker, I. (2013, May). *Childhood Trauma and the Risk of Suicide: Analysis of the CTQ in Suicidal Psychiatric Inpatients.* [Conference poster]. American Psychiatric Association Annual Meeting, San Francisco, CA.

Boland, J., MacDonall, J. (2013, April). *Generalizing Letter Discrimination to Different Font Styles.* [Conference poster]. Fordham Undergraduate Research Symposium, Bronx, NY.

MANUSCRIPTS UNDER REVIEW

Davis, K. C., **Boland, J. K.,** Fernandez, L. A., & Anderson, J. L. *Do mental health breaks from social media correlate with lower psychopathology?*

Boland, J., Szkody, E., Daniel, K., Aggarwal, P., Selby, E., Peterman, A., & Washburn, J. *Doctoral-level psychology student training during the COVID-19 pandemic: May 1st to June 25th, 2020.*

MANUSCRIPTS IN PREPARATION

Boland, J. K. *What's in a name: Can a dimensional trait model reduce bias against borderline personality disorder?* **Dissertation.**

Boland, J., Szkody, E., Hobaica, S. Owens, S., Washburn, J., & Bell, D. *Financial stress among clinical psychology doctoral students.*

TEACHING EXPERIENCE

Aug 2020 – May 2021 **Teaching Assistant**

Sam Houston State University
Huntsville, TX

Teaching assistant for two masters-level sections (Fall 2020, Spring 2021) of Assessment of Intelligence and Achievement (PSYC 5395)

Aug 2017 – May 2018 **Instructor**

Sam Houston State University
Huntsville, TX

Online instructor for two undergraduate sections (Fall 2017, Spring 2018) of Abnormal Psychology (PSYC 3331)

EDITORIAL RESPONSIBILITIES

- *Frontiers in Psychiatry* (ad hoc)
- *Current Psychology* (ad hoc)
- *PLOS ONE* (ad hoc)
- *International Journal of Offender Therapy and Comparative Criminology* (ad hoc)
- Association for Psychological Science RISE Research Award (2018-2019)

HONORS & LEADERSHIP

- **Huntsville Community Peace Coalition Research Team**
    - Local Police Reform Research Group Co-captain (2020-2021)

- **Council of University Directors of Clinical Psychology** (CUDCP)
  - Student Representative to the Board (2019-2021)
- **Society for Personality Assessment Graduate Student Association** (SPAGS)
  - President (2021-2022)
  - President-Elect (2020-2021)
  - Board Member at Large (2019-2020)
- **Society for Personality Assessment**
  - Social Media Coordinator (Twitter; 2018-2020)
- **Texas Psychological Association Board of Trustees**
  - Student Division Co-chair (2018-2019)
- **Association for Psychological Science**
  - Campus Representative (2017-2019)
- **SHSU Graduate Student Psychology Organization**
  - Vice President (2017-2018)

- *Phi Beta Kappa* inductee (2014; Fordham University)
- Graduated *summa cum laude*, Fordham University (2014)
- *Fordham University Honors Program* (2010-2014)

AWARDS & GRANTS

Research Grants and Scientific Awards

- Texas Psychological Association Mary Alice Conroy Award for the Best Student Paper in Forensic Psychology, Honorable Mention; 2020
- Society for Personality Assessment Annual Dissertation Grant, **$800**; 2019.
- Society for Personality Assessment Poster Presentation, Honorable Mention; 2019.
- Society for Personality Assessment Student Research Grant, **$500**; 2017.
- Fordham University Undergraduate Research Grant, **$1500**; 2012.
- Outstanding Student Presentation in Novel-Topic Research, American Psychology-Law Society, **$200**; 2018.

Travel Awards

- Sam Houston State University Student Travel Grant, (total **$2600**); 2017-2019.
- Society for Personality Assessment Student Travel Grant, (total **$600)**; 2018-2020.
- Fordham University Student Travel Grant, **$500**; 2014.

Scholarships

- Office of Graduate Studies General Scholarship, SHSU, **$1000**; 2018.
- Graduate Organization Leadership Scholarship, SHSU, **$1000**; 2017-2018.

- National Merit Scholarship, Fordham University, (**full tuition**); 2010-2014.

TRAINING & CERTIFICATIONS

- Preventing and Managing Crisis Situations (PCMS; August 2021)
- PE Web: A web-based learning course for Prolonged Exposure (Spring 2021)
- Columbia Lighthouse Project Columbia-Suicide Severity Rating Scale (Sept 2020)
- Rusk State Hospital Treatment Intervention Prevention Strategies (TIPS; Aug 2020)
- American Heart Association CPR Certification (Aug 2020)
- American Psychological Association Telepsychology Best Practice 101 Series (May 2020)
- CPT Web: A web-based learning course for Cognitive Processing Therapy (Fall 2018)
- SHSU Haven 101 & 102: LGBTQ+ Diversity Training (Spring 2017)

PROFESSIONAL MEMBERSHIPS

- *Assessment of Personality Psychopathology Lab*
- *American Psychological Association (APA)*
- *Society for Personality Assessment (SPA)*
- *APA Division 12: Society of Clinical Psychology*
- *APA Division 12, Section 10: Graduate Students and Early Career Psychologists*