

Spring 5-2012

# The Impact of Education and Gender on Perception of Borderline Personality Disorder

Jennifer J. Noonan  
*Seton Hall University*

Follow this and additional works at: <https://scholarship.shu.edu/theses>

 Part of the [Psychology Commons](#)

---

## Recommended Citation

Noonan, Jennifer J., "The Impact of Education and Gender on Perception of Borderline Personality Disorder" (2012). *Theses*. 214.  
<https://scholarship.shu.edu/theses/214>

The Impact of Education and Gender on Perceptions of Borderline Personality Disorder

by

Jennifer J. Noonan

A thesis submitted in partial fulfillment of the requirements for the degree of

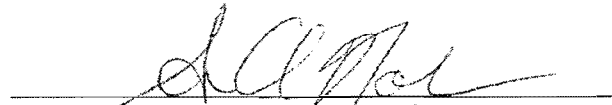
Master of Science in Experimental Psychology

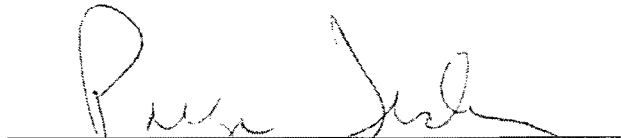
Department of Psychology

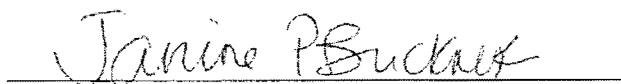
Seton Hall University

May, 2012

Approved by:

  
Dr. Susan A. Nolan, Faculty Mentor

  
Dr. Paige Fisher, Committee Member

  
Dr. Janine Buckner, Committee Member  
Director of Graduate Studies

## Dedication

*This thesis is dedicated to my mother, who gave me the strength to keep working when I didn't think I had it, and has offered unconditional love and support through every step of the way. It is also dedicated to my father, who has also given unconditional love and support as well as useful advice which helped me accomplish my goals.*

## Acknowledgements

It is a pleasure to thank the many people who helped make this thesis possible.

I wish to extend my greatest appreciation to my graduate advisor, Dr. Susan Nolan, whose knowledge and enthusiasm helped guide me at every step of the way. She provided sound advice and lots of good ideas which I had not thought of that helped further my own thoughts and work. Her encouragement and willingness to provide new opportunities was priceless to my progress.

I would also like to extend my gratitude towards my thesis committee members, Dr. Janine Buckner and Dr. Paige Fisher. Their willingness to listen and guide my thoughts and writing has been invaluable to me.

I would like to thank my colleagues in the Experimental Psychology program who have offered endless advice, feedback, and support. Specifically, I would like to thank Annette Resenhoeft who helped guide me through much of the process along the way, as well as Chelsea Reichert for her assistance in proofreading and offering feedback.

I am indebted to Dr. Janice Stapley, my undergraduate advisor, who has been there through every step of the process. Throughout my undergraduate and graduate careers, she has been there offering advice and ideas, providing encouragement, and has provided me with countless opportunities, all of which have led me in the right direction. I would truly be lost without her guidance and support.

I would like to thank the Monmouth University Psychology faculty, including Dr. Van Volkom and Dr. Hatchard, who helped generate my interest in the field. They gave their assistance through useful advice, wisdom, and support as well as writing letters of recommendation, which helped lead me to where I am today.

I also would like to thank my friend Izabela Jeremus for her willingness to provide her experiences with borderline personality disorder. Her wisdom and experiences helped shape some of my thinking and provided insight that has helped guide my thinking.

Finally, I'd like to thank my family who helped me through their encouragement and support. Specifically, I'd like to thank my parents for providing a loving and supportive environment for me during the difficult times. I'd also like to thank my friends including Alexis Dull, Louis Pisaniello, Ryan Travis, Joshua Wallenfels, and Victoria Santora for allowing me to bounce ideas off of them and provide a comfortable and relaxing environment when I needed a break.

## Table of Contents

Approved By.....	i
Dedication.....	ii
Acknowledgements.....	iii
Table of Contents.....	iv
List of Tables.....	vi
Abstract.....	vii
Introduction.....	1
Borderline Personality Disorder Overview.....	1
Relationships and Borderline Personality Disorder.....	2
Gender Issues in Borderline Personality Disorder.....	4
Stigma and Borderline Personality Disorder.....	7
Combating Stigma.....	10
Purpose of the Present Study.....	14
Hypotheses.....	16
Methods.....	17
Participants.....	17
Materials.....	18
BPD Fact Sheet.....	18
BPD Flyer.....	18
Student Vignette.....	18
Social Rejection Questionnaire.....	19
Demographic Questionnaire.....	20

Procedure.....	20
Results.....	22
Statistical Analyses.....	22
Discussion.....	26
Prior Awareness of Borderline Personality Disorder.....	28
Awareness Tools and Borderline Personality Disorder.....	29
Character Gender and Borderline Personality Disorder.....	29
Strengths, Limitations, and Future Direction.....	30
Conclusions.....	32
References.....	34
Appendices.....	39
Appendix A.....	40
Appendix B.....	41
Appendix C.....	42
Appendix D.....	43
Appendix E.....	44
Appendix F.....	45

## List of Tables

Table 1. Means and Standard Deviations of Rejection Scores by Awareness Tool.....	23
Table 2. Means and Standard Deviations of Rejection Scores by Gender.....	23
Table 3. Summary of Education and Gender on Rejection Scores.....	25



## Abstract

Borderline personality disorder (BPD) is a pervasive disorder which impacts an individual through stormy or unstable interpersonal relationships, marked impulsivity, and instability in self-image and affect. Although BPD seems to carry a heavy stigma among mental health professionals, there has been a lack of research examining this stigma amidst the general population. Therefore, the present study sought to examine the amount of stigma surrounding BPD among college students. It was hypothesized that students who read about BPD before reading a vignette of a college student with BPD would report less average rejection than would students in a control group. It was also hypothesized that, on average, students would reject a male character in the vignette more than a female character. Students were randomly assigned to an awareness tool about BPD (a flyer, fact sheet, or a control group with no awareness tool). Students then read a vignette of a college student with BPD that varied by gender, and rated the character on several different measures, including a rejection questionnaire. There was no support for the hypothesis that, on average, those reading an awareness tool would report less rejection of the character than would those not reading an awareness tool. Furthermore, there was no support for the hypothesis that level of rejection would differ, on average, when rating a male character versus a female character. It is possible that the awareness tools may not have had the desired impact.

## Introduction

In the past few decades, methods focused upon increasing awareness have been used to teach patients, their families, and the general population about the impact of mental illness. The purpose of this awareness is to educate people about certain mental illnesses as well as the stigmas and prejudices associated with them in hopes that this will reduce the effects of the negative stereotypes and promote a greater sense of understanding for the individuals who suffer from them. A second purpose of raising mental health awareness is to educate patients, their families, professionals in the mental health field, and the general public about what it's like to live with a mental illness. One method of raising awareness is through the use of information campaigns.

One campaign focused on borderline personality disorder led to House Resolution 1005, which was unanimously passed by the U.S. House of Representatives on April 1, 2008 (H. R. Res. 1005, 2008). This resolution recognizes the month of May as borderline personality disorder awareness month and is meant, “as a means of educating our nation about this disorder, the needs of those suffering from it, and its consequences” (p. 2) With the assistance of the National Alliance on Mental Illness (NAMI), borderline personality disorder awareness month is intended to provide tools and information; however, it is unclear how much of this information is reaching the general population about borderline personality disorder, and how much of an impact is it making.

### **Borderline Personality Disorder Overview**

Borderline personality disorder has been described by the American Psychiatric Association (2000) as a pervasive pattern of unstable or stormy interpersonal relationships, marked impulsivity, and instability in self-image and affect—all of which

are presented in a variety of contexts. Those who are diagnosed with BPD must meet at least five of nine diagnostic criteria as outlined by the American Psychiatric Association. Frantic efforts to avoid abandonment, identity disturbance, chronic feelings of emptiness, and self-destructive behaviors including impulsivity (e.g., sex, binge eating, spending) or self-mutilating or suicidal behaviors are a few among these criteria (American Psychiatric Association, 2000).

Clinical theorists believe that both biological and environmental factors influence the development of BPD (Gunderson, 2006). Some research has proposed that BPD has a biological basis which may stem primarily from genetics and heritability, including a 68% chance that BPD patients may inherit predisposing temperaments which may later develop into borderline pathology (Gunderson, 2006; Gunderson, 2008). Environmental causes such as childhood abuse have also been explored as a possible cause in the development BPD because 70% of individuals diagnosed with BPD reported a history of physical and/or sexual abuse (Gunderson, 2006). Other forms of abuse such as neglect and emotional abuse also seem to be prominent among BPD patients (Wilkins & Warner, 2001). Understanding the social factors which may aid in the development in BPD are important because they play a role in how individuals suffering from BPD may react to the people around them.

### **Relationships and Borderline Personality Disorder**

Unstable interpersonal relationships are a major aspect of BPD. Some of the current research on interpersonal relationships in borderline personality disorder has focused primarily on romantic relationships of those who have been diagnosed with the disorder. A study by Bouchard, Sabourin, Lussier, and Villeneuve (2009) examined the

stability and quality of relationships among couples when one partner has been diagnosed with BPD because relationships involving BPD partners are often unstable and unsatisfactory. The researchers discovered that almost 70% of couples with one BPD partner would experience a termination of the relationship followed by a reunion once every six months. It was also found that women who were diagnosed with BPD had a tendency to be less satisfied with their relationships than women who were not diagnosed. Research has also suggested that BPD patients have a tendency to report higher frequency of romantic partners as well as sexual partners than those who are not diagnosed with the disorder (Clifton, Pilkonis, & McCarty, 2007; Bouchard, Godbout, & Sabourin, 2009). These findings outline some of the difficulties that individuals who have been diagnosed with BPD sometimes experience within romantic relationships and other interpersonal interactions.

Although unstable interpersonal relationships impact those who suffer from BPD, some research has explored the impact on an individual who is in a romantic relationship with an individual who has been diagnosed with BPD. Weddige (1986) noted that people with borderline spouses often report feelings of dysphoria and outlined techniques that individuals with spouses diagnosed with BPD utilize as a result of living with their partner. According to the author, spouses of borderline patients employ different defense mechanisms in reaction to living with these individuals, such as denial, displacement, assessing the past, and retreat. Spouses of individuals who have been diagnosed with BPD sometimes also have extramarital affairs, which are not sexual in nature, in order to satisfy their emotional needs. It is important to consider how the interpersonal dynamics of BPD impact not only the patient, but also his or her romantic partner because these

interactions help to paint the disorder in the minds of those who do not suffer from it. If an individual who is romantically involved with someone who suffers from BPD does not understand why his or her partner is acting the way he or she is, he or she may be more rejecting of the partner's behavior.

Sometimes, in extreme cases of BPD, rejection from significant others around them may lead to feelings of self-worthlessness, which may trigger self-destructive behaviors. Self-destructive behaviors are common in individuals who suffer from BPD and can manifest in different ways. These behaviors can take the form of suicide attempts or parasuicide, or suicidal gestures or behaviors performed by an individual who does not intend to die. Self-mutilation is also an issue in BPD and can take many forms such as burning, cutting, or pulling out one's hair. These behaviors can be problematic not only for the physical damage that it may cause (e.g., scarring, disability), but also because patients who self-harm may feel pleasure from endorphins released in such acts, which may lead to an addiction of self-injurious behaviors (Gunderson, 2006). Therefore, awareness of these behaviors is important in order to aid in the prevention and detection of these behaviors in people diagnosed with BPD in order to ensure their safety and well-being.

### **Gender Issues in Borderline Personality Disorder**

The role of gender in BPD has been a focus of some research on the disorder. It has been estimated that approximately 75% of those diagnosed with BPD are women (Gunderson, 2006; American Psychological Association, 2000). This has sparked some controversy within the field in an attempt to explain why more women than men are diagnosed with the disorder. A study conducted by Becker and Lamb (1994) examined

the possibility of a sex bias among clinicians in the diagnosis of BPD. They utilized a sample consisting of psychologists, social workers and psychiatrists who were asked to read a case study about a patient and to rate him or her based on what they felt the diagnosis should be. The researchers found that clinicians were more likely to diagnose a woman with BPD than they would a man, indicating that a sex bias may be playing a role in the high percentage of women who suffer from the disorder. Evidence of diagnostic biases also has been found for histrionic personality disorder, which is more frequently diagnosed among women, as well as antisocial personality disorder, which is more frequently diagnosed among men (e.g., Ford & Widiger, 1989).

Considering the high diagnostic rates of BPD among women compared to men, one may ask why this tends to occur. To date, there has not been much research which has focused on the behavioral differences of men and women who suffer from BPD, and how and behavioral differences might translate into diagnostic differences. However, it may be argued that because affect and affective instability play a large role in BPD, the gender difference may be comparable on some level to depression. Howerton and Van Gundy (2009) sought to examine the differences in perception of men and women who suffer from it, and discovered that some of the answers may lie in different coping mechanisms employed by the patients. The different coping mechanisms which are most prevalent include problem-focused coping, which are coping behaviors which attempt to solve the problem directly; emotion-focused coping, which are coping behaviors that involve managing the emotions to deal with stress; and avoidant focused coping, or coping behaviors which attempt to avoid or escape the situation that is causing stress (Howerton & Van Gundy, 2009). Of these, emotion-focused coping, which tends to

include characteristics such as rumination and other emotionally driven behaviors, was most strongly associated with and employed by women. Men, conversely, were more likely to utilize problem focused coping in order to handle problems they faced on a day to day basis. According to the authors, men who employed emotion-focused coping skills were more likely to experience higher levels of depressed mood than did women. This difference in coping strategies may reflect cultural norms and gender socialization practices which dictate that it is acceptable for women to express emotions, but the same may not be said for men, due to a social stigma that men who show their emotions or utilize emotion-focused coping are weaker than men who utilize problem-focused coping.

### **Stigma and Mental Illness**

One problem that stands in the way of those who suffer from BPD or mental illness in general is negative stigmas and labels. Stigma is defined as prejudice or negative stereotypes, which may lead to discrimination through poorly justified knowledge structures (Corrigan & Penn, 1999). Some of the literature surrounding stigma has illustrated that there are several components which create and perpetuate different stigmas. One such theory was proposed by Link and Phelan (2001), who theorized that there are four components of stigma:

- 1) people are able to distinguish and label differences;
- 2) culture links labeled persons to negative characteristics and stereotypes;
- 3) labeled persons are separated into categories to better distinguish between “us” and “them;”
- 4) labeled persons experience unequal outcomes which are created by status loss and discrimination

When these different components converge, those who have been labeled may experience more social rejection, exclusion, and discrimination. These components are important, as they outline how a stigma is created as well as how it can be maintained.

There has been a lot of research on the impact of stigma on mental illness among the general public (Corrigan et al., 2002; Link et al., 1999). A portion of this research has focused on public perceptions of causes of mental illness. One study conducted by Link, Phelan, Bresnahan, Stueve, and Pescosolido (1999) sought to examine public perceptions of the causes of mental illness. While some of the participant responses regarding the causes of mental illness were chemical imbalances in the brain or stress (specifically surrounding depression and schizophrenia), other responses indicated that there were also perceptions of a personal control component to mental illness in regards to disorders such as substance dependency and alcohol abuse. Indeed, cultural beliefs that individuals hold responsibility and are able to control their disorders may make individuals suffering from mental illness reluctant about sharing that they suffer from a disorder out of fear of being treated differently or looked down upon by others (Barney, Griffiths, Christensen, & Jorm, 2009). It was also found that once someone has been labeled with a mental illness, even if it is known by others that they have been treated, he or she may still be treated negatively by others around him or her (Piner & Kahle, 1984). In terms of BPD, individuals who have been diagnosed may therefore be less likely to disclose their diagnosis to others if they feel that they will somehow be rejected or ridiculed by others around them because of the stigma and negative stereotypes that the disorder tends to carry.

### **Stigma and Borderline Personality Disorder**



This particular impact of “social distancing” (Link et al., 1999; Corrigan et al., 2001) by individuals suffering from mental illness may stem in large part from stereotypes perpetuated through media and the fear that those who suffer from mental illness may be dangerous (Coverdale, Nairn, & Claasen, 2002). Indeed, some people perceive those who have received diagnoses such as schizophrenia and BPD to be more dangerous than the general public; this is a bigger gap in perceived dangerousness than between those diagnosed with substance abuse or depression versus the general population (Marie & Miles, 2008; Markham, 2003). Yet, Marie and Miles (2008) noted that media outlets appear to underreport violent acts committed by those under the influence of illegal substances, thus perpetuating the inaccurate psychosis-based stigma of dangerousness. This perception of dangerousness may lead to social rejection by not only those in the general population, but among mental health professionals (Markham, 2003). Perceived dangerousness of those who have been labeled or diagnosed mentally ill is an issue which must be addressed because the social rejection associated with it is a form of discrimination which mentally ill patients must face in addition to coping with the symptoms of their disorders.

The stereotypes which are often linked to BPD may also negatively impact a patient’s treatment by perpetuating damaging myths and misconceptions about the disorder. Hersh (2008) explored some of these myths and stereotypes surrounding BPD, and how these ideas may be affecting both clinicians as well as the general public. One important myth is centered on the belief that the stigma attached to BPD would be eliminated if the name of the disorder was changed, moved to a different diagnostic category, or a new method of assessing personality disorder symptoms is utilized. As

Hersh points out, changing the name or reclassifying the disorder may be useful to research and possibly to clinical settings, but the stigma attached to borderline pathology is likely to remain associated with the disorder. This may suggest the weight and frustration often associated with a borderline diagnosis, and must be considered as a contributing factor to how professionals and individuals the general public may similarly perceive those who are diagnosed with BPD.

The only literature which has examined stigma in BPD has focused on the amount of reported stigma and negative stereotyping of those diagnosed with BPD among professionals in a clinical setting (Markham, 2003; Markham & Trower, 2003). One population which has often shown a negative perception of BPD patients based on labels and stigma is mental health nursing staff (Markham, 2003; Markham & Trower, 2003). For instance, Markham's (2003) study of perceptions of dangerousness among nursing staff found that Resident Mental Health Nurses were more likely to rate patients diagnosed as BPD as more dangerous than they did patients diagnosed as schizophrenic (Markham, 2003). Similarly, nursing staff have been found to show less sympathy and more rejection towards a patient diagnosed with BPD than a depressed patient (Markham, 2003; Markham & Trower, 2003). For these and other reasons, it is important to find a method to combat the stereotypes and feelings of rejection that those in the professional field of mental health hold towards individuals diagnosed with BPD. Since stigma research in BPD has focused primarily on perceptions held by mental health professionals, such work may be a useful guide in understanding stigma surrounding BPD in the general population because members of the general population may be likely

to hold similar feelings as a result of stigmatized media, such as television, news reports, or movies, as well as stereotypes regarding BPD that they have been exposed to.

### **Combating Stigma**

Many studies have been conducted which note the amount of stigma surrounding mental illness; however, it must be noted that there has been a movement in several countries to attempt to reduce the stereotypes which are perpetuated. There have been several notable methods which have been employed in order to combat the stereotypes and stigma which surround mental illness. One method of combating this is through awareness programs. To date, there have been several studies and program evaluations which have sought to assess the impact which awareness programs have had on the community around them (Jorm, 2009; Morgan & Jorm, 2007). Many of these programs have specifically focused on depression. Two awareness programs, *beyondblue* and *headspace*, were aimed specifically at Australian youth in order to raise depression awareness and education (Jorm, 2009; Morgan & Jorm, 2007). Data were collected through a telephone survey of mental health literacy among Australian youth aged 12-25 years, in which participants were asked to name any organizations related to mental health that they could think of. The findings from these studies revealed a high frequency of recognition of local organizations related to mental health among the youth during the first initial evaluation, and again at follow-up two years later. This rate of recall for depression awareness programs is promising for those who work to promote mental health awareness because it is an indication that the outcomes of their efforts are evident in the general population.

Another method of increasing knowledge in the general public includes providing direct contact with an individual who suffers from a mental illness (Corrigan & Penn, 1999). It has been argued that this is one of the most effective ways of battling mental illness stereotypes and stigma. This contact exposes individuals to personal testimony directly from a mental ill person, and allows others to ask him or her questions regarding everyday functioning and life experiences with mental illness. One study sought to examine the impact of contact on perceptions of personal responsibility and dangerousness of those diagnosed as mentally ill (Corrigan et al., 2002). The authors discovered that individuals who were taught about mental illness through a discussion with someone who had been previously diagnosed with a serious mental illness yielded higher education and less stigma among members of the general public. Individuals who suffered from serious mental illness were asked to speak to a group of participants about their experiences. The benefits of the education for those who spoke with someone who has been diagnosed with a serious mental illness were also present at the follow up. These findings suggest that interpersonal contact may be an effective method of battling negative stigmas because people have a chance to see firsthand that stereotypes are not always accurate.

Another common method used to battle mental illness stigma is education through different forms of media, such as television commercials, newspaper articles and advertisements, radio commercials, and internet resources (i.e., blogs and websites), since some of the most prevalent stereotypes and stigmas surrounding mental illness have been perpetuated. A study analyzing depictions of mental illness among newspaper ads and articles found that while there were some positive depictions of mental illness (especially

through human rights themes), negative depictions portraying the mentally ill as being dangerous to others or criminals were the most common (Coverdale, Nairn & Claasen, 2001). Therefore, it is important to have forms of media to combat these negative stereotypes in order to provide a more accurate portrayal of those who suffer from different mental disorders.

Some organizations such as the Mental Health Action Team (MHAT) have been established in order to educate the general public through media such as magazine and newspaper articles, as well as by organizing community events such as mental health screenings and educational programs (Buila, 2009). Although this program has not yet undergone a formal program evaluation, the feedback from the author's local community seems to be mostly positive; some people are thankful that awareness is being raised because they or someone they love has been suffering from a mental illness and they feel that it is important for people to be educated about the effects; others simply find the articles and programs informative, interesting, and allow people to better understand the behaviors of those who have been diagnosed with a mental illness around them. However, the effectiveness of media campaigns such as the one driven by MHAT has been debated. A study conducted in Cambridge found that while short-term media anti-stigma campaigns were able to temporarily raise awareness and knowledge about mental health, the effects were not long-lasting (Evans-Lacko et al., 2010). Nevertheless, considering the far-reaching nature of media such as newspapers, TV, and radio, anti-stigma campaigns may help to amplify awareness when taken together with other forms of mental health education.

At a governmental level, anti-stigma movements may occur in the form of research and legislation. Some government agencies such as the National Institute for Mental Health (NIMH) seek to raise awareness about mental illness through research and distributing tools such as pamphlets and creating outreach programs to inform the public. These organizations also work towards legislation to be passed to further increased public mental health awareness. Again, an example of legislation which seeks to combat the stigma of mental illness is House Resolution 1005 (H. R. Res. 1005, 2008), which declared the month of May to be Borderline Personality Disorder Awareness Month. The passing of this particular piece of legislation promotes education about BPD and was made possible by an organization called the National Education Alliance for Borderline Personality Disorder. This organization seeks to improve the quality of life for individuals suffering from BPD through annual and regional conferences to showcase many of the trends in BPD research, workshops, panels, meet and greets, and family programs for individuals suffering from BPD as well as their loved ones.

The NEA-BPD promotes BPD awareness among the general population by providing different educational tools and resources for those who may not be familiar with the disorder, or those who have heard of it but wish to learn more about it. The organization has released printed materials such as a copy of House Resolution 1005 (H. R. Res. 1005, 2008), a fact sheet, and a flyer which provide basic yet important information about BPD, such as prevalence rates and challenges in treatment. There has been no evaluation of the effectiveness of the NEA-BPD's efforts to educate the general population about BPD. The printed materials such as the fact sheet and flyer are currently some of the only educational tools meant for the general population. However, it is

unclear what impact, if any, these awareness tools have in reducing stigma and stereotypes surrounding BPD among members of the general population.

### **Purpose of the Present Study**

Most of the literature surrounding BPD from a social perspective has focused primarily on the perceptions and stigmas harbored among health practitioners about individuals suffering from this mental illness. Yet, there seems to be a lack of research examining the level of stigma surrounding BPD among the general population.

Individuals who suffer from BPD interact with not only doctors, nurses, and counselors regularly, but they also encounter people in everyday life, such as friends, family, and people they encounter in their daily activities. Understanding how people in the general population perceive and react to individuals suffering from BPD is critical because it may act as a guide to better comprehend the current amount of stigma still surrounding the BPD diagnosis. Measuring this level of stigma may provide the opportunity to develop and execute new plans to battle the negative stereotypes and beliefs that people may hold about BPD patients. Similarly, it's important to measure how dangerous they are perceived to be by the same population, because this may reveal a need for further education about the disorder through newer, faster reaching methods. Thus, as a beginning step in this direction, the first purpose of the present study was to determine the level of awareness that college students had about BPD prior to entering the study by measuring it directly how college students perceive another college student described in a vignette who suffered from BPD symptoms.

Similarly, the study also sought to examine how effectively the information and tools distributed by NAMI and the NEA-BPD for the borderline personality disorder

awareness month campaign are reaching the general population, and how this information impacts the reactions to individuals labeled as mentally ill or not. The tools which were utilized in this study included a fact sheet, which provided statistics as well as important facts about BPD, and a flyer, which provided some statistics, but focused more on establishing feelings of hope for individuals who have been diagnosed with BPD. Again, these tools were selected because they are currently at the forefront of BPD awareness information that has been provided for the general population, and not just for individuals who have been diagnosed and their loved ones. Because some depression awareness campaigns have been successful in reaching the general public—and specifically, young people (Morgan & Jorm, 2007; Jorm, 2009)—it is believed that the BPD awareness campaign may be able to have the same impact on the general public if the information reaches their target audience. Thus it is important to note that the present study sought to examine how much of the sample was aware of BPD prior to entering the study.

For the present study, the percentage of college students who were aware of BPD prior to entering the study will be measured in order to determine the level of awareness of BPD among college students. Currently, research has not examined the level of awareness of BPD among the general population. Furthermore, the percentage of college students who have met someone who was diagnosed with BPD prior to entering the study will also be measured in order to help determine the amount of exposure people have had to individuals diagnosed with BPD, and whether this impacts rejection of a character with BPD symptoms. Previous research has not ascertained such awareness levels.

A second purpose of this study is to measure whether the impact that the tools and information these tools provide positively or negatively affect perceptions of BPD among



the general population. That is, are these tools useful in combating the negative stigma surrounding the BPD diagnosis, and useful in promoting empathy and understanding in others? Since there has not been a program evaluation of the usefulness of the awareness tools provided by the NEA-BPD, this study will allow preliminary insight into how the general public assimilates the information provided within the fact sheets. Likewise, this insight will allow for a better understanding of whether or not these tools are able to efficiently combat the negative stereotypes and myths surrounding BPD.

A third purpose of this study is to examine whether or not gender plays a role in the way someone perceives an individual with BPD. That is, are college students more likely to reject a woman who suffers from BPD, compared to a man? Considering the impact of different coping styles utilized by men and women, as well as the cultural norms that men should not express their emotions in the same way a woman would, it is believed that a man who shows signs of BPD symptoms might be more rejected by others, on average, than a woman who has the same symptoms.

### **Hypotheses**

It was that college students who report that they had knowledge of BPD prior to entering the study would be less likely to reject a character in a vignette described with BPD symptoms than college students who had not heard of BPD prior to entering the study.

On average, we expect the least rejection from those who read the personalized flyer, followed by those who read less personal fact sheet, and then by those who did not read either awareness tool. It was hypothesized that college students who report that they had met someone with BPD prior to entering the study would be less likely to reject a

character in a vignette described with BPD symptoms compared to college students who had not met someone diagnosed with BPD prior to entering the study.

It is also hypothesized that college students who read the NEA-BPD flyer would be less likely to reject a character described in a vignette with BPD symptoms than participants who read the fact sheet. It was also hypothesized that college students who read the fact sheet would be less likely to reject a character in a vignette with BPD symptoms than participants who were in the control group.

The final hypothesis is that, on average, college students will be more accepting of a woman with BPD described in a vignette than a man with the same symptoms. No interaction between type of awareness tool and gender of the character was hypothesized.

## **Methods**

### **Participants**

The sample of the present study consisted of 145 undergraduate students from a small/medium sized private university in the Northeast. Of the 145 participants, three were dropped due to missing data or failure to follow instructions. The age range of participants was 18-27 ( $M = 19.70$ ,  $SD = 1.55$ ). The study consisted primarily of women (75.4%), with 24.6% males. The sample was primarily white (62%); 19% of the participants were black, 9.9% were Hispanic, and 9.2% were Asian. Students were fairly balanced in their year in school with 24.6% freshmen, 34.5% sophomores, 27.5% juniors, and 13.4% seniors who participated in the study. The participants were enrolled in an undergraduate psychology course, and were recruited through SONA, an internet-based departmental research participant pool. All participants were treated in accordance with the APA ethical standards (American Psychological Association, 2002).

## **Materials**

**BPD Fact Sheet.** The fact sheet employed in this study is one of the NEA-BPD awareness tools (National Education Alliance for Borderline Personality Disorder, 2008a). It is one page long and provides percentages and prevalence rates in regards to BPD, such as the prevalence of the disorder in America, suicide rates among those who suffer from BPD, and the economic impact of BPD (see Appendix A). It also provides the names of the Board of Directors of the NEA-BPD, contact information, and a link to the NEA-BPD website. This fact sheet was selected due to its short length, as well as the quality and amount of information provided within it.

**BPD Flyer.** The flyer employed in this study is another one of the NEA-BPD awareness tools (National Education Alliance for Borderline Personality Disorder, 2008b). Like the fact sheet, it is also one page long, and provides some basic prevalence rates and percentages (see Appendix B). It does not contain as many facts as the fact sheet. The main aspect that sets this flyer apart from the fact sheet is the information provided in it appears to be more focused on how the disorder is misunderstood, and personalizes the disorder and those who suffer from it more than the fact sheet does.

**Student Vignette.** Because many of the vignettes surrounding BPD often take place in a clinical setting, such as a therapist's office or hospital, none of the existing vignettes in the literature seemed appropriate for the present study. Therefore, the vignettes employed in the present study were adapted from a vignette written by Johnston (2007), which depicts a student who suffers from BPD traits, though is not directly labeled as suffering from BPD in the vignette (see Appendices C and D). The character in the vignette was a college student who dropped out of school due to lack of interest in

going to class, alcohol abuse, and other traits often linked to BPD. A vignette describing a college student was utilized as it was assumed that a target in the sample's age group would be more relatable to participants of the study. Moreover, participants might have displayed more stigma and negative feelings about target characters in vignettes if they were set in a hospital or other clinical setting, because those institutions tend to carry stigma on their own.

In order to manipulate the gender of the study, one male name and one female name were selected. In order to control for familiarity with the names among the participants, the names were selected from a list of the top 10 baby names of the year 1990, the approximate birth year of the participants (Social Security Administration, 2011). From this list, two names were selected which had similar rank and number of letters. The character described in the male vignette was named Andrew, and the character described in the female vignette was named Amanda.

**Social Rejection Questionnaire.** Social rejection was measured using a scale from Gotlib and Robinson (1982), which was adapted from an earlier study (Coyne, 1976). The wording of this scale was adapted to match study descriptions (see Appendix E). The scale consisted of eight items which ask participants to rate on a scale of 1 (definitely no) to 7 (definitely yes), reflecting whether the participants would want to associate with the character described in the vignette, such as, "would you like to meet this person?", "would you ask this person for advice?", and "would you want to sit next to this person on a three-hour bus trip?". All items were summed to create a total score which could range from 7 to 56, with lower scores indicating greater levels of rejection.

The coefficient alpha for this scale has been reported as approximately .90. Data for the social rejection questionnaire were collected online through the Survey Monkey website.

**Demographic Questionnaire.** A demographic questionnaire created by the (see Appendix F) was used to ascertain basic information regarding participants, such as age, race, year in college, and gender. This questionnaire also included a section regarding individuals' own BPD awareness. For this portion, participants were asked whether or not they had heard of BPD or had met somebody diagnosed with BPD prior to entering the study. These items afforded insight into how much knowledge and experience participants had with BPD. Data for the demographic questionnaire were collected through online through the Survey Monkey website.

### **Procedure**

Participants were recruited for the study through the internet-based departmental research participant pool open to students enrolled in undergraduate psychology courses. The title of the study was shortened on SONA to "Social Impressions," so that participants were not made aware of the focus on BPD and could not research the disorder prior to entering the study. Prior to arrival, participants were randomly assigned to one of six conditions, which determined which of the stimuli they were exposed to in the study, including which awareness tool they received (the flyer, fact sheet, or no reading), and gender of the target student described in the vignette (male or female).

Once participants arrived for the study, they were seated in a lab with a computer and the researcher read the informed consent form aloud to them. It must be noted that participants were not informed of the study's emphasis on BPD. Instead, participants were told that the purpose of study to examine factors affecting first impressions; they

were informed that they would be asked to read a brief vignette of a college student and then asked to complete several questionnaires about this person.

Upon completion of the informed consent procedure, participants were exposed to one of three reading conditions before the rest of the study continued. Participants in one condition were asked to read the NEA-BPD *fact sheet* (National Education Alliance for Borderline Personality Disorder, 2008a). Participants in a different reading group were asked to read the NEA-BPD *awareness flyer* (National Education Alliance for Borderline Personality Disorder, 2008b). In the control condition, participants would receive *no reading*, before continuing immediately into the rest of the study.

The fact sheet or flyer were distributed to participants in these reading conditions in paper form. Participants in these groups were given these readings while the researcher stepped out of the room “to grant [the participant] course credit.” Participants were also asked to open the door of the lab they were seated in after they had finished the reading to signal the researcher that they were ready to continue with the study. The researcher remained with participants in the control condition throughout this section of the study.

Next, the researcher provided participants with a copy of the student vignette and opened the Survey Monkey screen on the computer. The researcher then instructed the participant to read the vignette and then complete the surveys on the computer via Survey Monkey once they had finished reading. Participants were instructed to open the door to notify the researcher when they had finished. The researcher left the room and the participant read the vignette and then completed the Social Rejection Questionnaire and the Demographic Questionnaire (Gotlib & Robinson, 1982).

When the participants indicated that they were finished, the researcher verbally debriefed the participant following a script. The researcher revealed the manipulation employed, and answered any questions the participant had, if any. Participants were verbally debriefed for this study so that any short term risks such as discomfort regarding mental illness or about being deceived could be mitigated. If in the event participants experienced a great deal of discomfort as a result of participating in the study, they were provided with contact information for the University Counseling Center. No participants reported that they felt discomfort while completing the study. Following the debriefing, the participants were thanked for their time and were free to leave.

## **Results**

### **Statistical Analyses**

In order to examine the first hypothesis of this study—this is, to determine whether prior exposure to BPD played a role in the level of rejection reported toward the character in the vignette—frequency rates were calculated for the number of participants who were aware of BPD prior to participation in the study, as well as for whether participants knew someone who had been diagnosed with BPD prior to their participation in the study. Independent-samples *t* tests were conducted between college students who reported that they had heard of BPD prior to entering the study and college students who reported that they had not heard of BPD prior to entering the study to determine whether individuals had heard of BPD prior to entering the study as well as whether individuals had met someone who had been diagnosed with BPD prior to entering the study.

In order to test for the impact of type of awareness tool and character gender on the perceptions college students had for the character in the vignette, a 3X2 between-

subjects factorial Analysis of Variance (ANOVA) design. Main effects of awareness tools in the form of awareness tool (control, fact sheet, or flyer) and gender (male, female) as well as the interaction between education and gender were calculated. Awareness tools and gender were then compared to the total rejection scores, with higher scores indicating greater levels of rejection. Although an interaction was not hypothesized, the interaction of awareness tools and gender were also calculated in order to examine whether a relation between these variables existed.

The means and standard deviations of rejection scores were calculated. The means and standard deviations for rejection scores by awareness tools can be found in Table 1, and the means and standard deviations for rejection scores by character gender can be found in Table 2.

Table 1.

*Means and Standard Deviations of Rejection Scores by Awareness Tool*

Awareness Tool	<i>M</i>	<i>SD</i>
Control	22.04	7.62
Flyer	23.00	9.34
Fact Sheet	21.56	7.35

Table 2.

*Means and Standard Deviations of Rejection Scores by Character Gender*



Character Gender	<i>M</i>	<i>SD</i>
Male	21.91	8.32
Female	22.46	7.82

In order to ascertain rates of prior knowledge of BPD, frequency data were examined. About half of participants (45.8%) reported that they had heard of BPD prior to entering the study, and 11.3% of participants reported that they had met somebody diagnosed with BPD prior to entering the study.

In order to determine whether or not these two factors played a role in rejection scores, two separate independent-samples *t* tests were conducted. The first independent-samples *t* test examined the impact of having heard about BPD prior to the study. It appears that, on average, participants who had heard of BPD prior to entering the study did not statistically significantly differ in rejection scores from those who had not heard of BPD prior to entering the study,  $t(140) = .17, p = .87, d = .17, [-2.47, 2.92]$ . All effect sizes calculated were almost zero unless noted otherwise. Therefore, these findings did not support the hypothesis that participants who had heard about BPD prior to entering the study ( $M = 22.29, SD = 7.61$ ) would report lower mean rejection than participants who had not heard of BPD before.

A second independent-samples *t* test was conducted to examine the impact of having met an individual diagnosed with BPD on rejection scores. It appears that, on average, participants who had met someone who was diagnosed with BPD did not statistically significantly differ in rejection scores from those who had not met someone diagnosed with BPD prior to entering the study,  $t(140) = .60, p = .55, d = .60, [-2.95, 5.53]$ , a medium effect. Therefore, these findings do not support the hypothesis that participants who had met someone who was diagnosed with BPD ( $M = 23.31, SD = 8.00$ ) would report lower mean rejection scores than participants who had not met someone diagnosed with BPD before ( $M = 22.02, SD = 8.09$ ).

A 3X2 factorial Analysis of Variance (ANOVA) was conducted to determine the relation between awareness tool (no reading, flyer, fact sheet) and gender of character in the vignette (male, female). The results displayed below in Table 3 revealed no significant main effects or interaction of variables.

Table 3.

*Summary of Awareness Tool and Gender on Rejection Scores*

Source	<i>F</i>	<i>df</i>	<i>p</i>	<i>R</i> <sup>2</sup>
Awareness Tool	.371	2	.691	.005
Gender	.184	1	.669	.001
Awareness Tool*Gender	.041	2	.960	.001

For the findings relating to awareness tools, it appears that, on average, the control group's rejection scores of the character in the vignette did not differ significantly from the scores of participants who read the flyer or the fact sheet. As such, these findings do not support the hypothesis which predicted that rejection scores would be lower among participants who read the flyer compared to participants who read the fact sheet or were part of the control group. Furthermore, it appears that these findings also do not support the hypothesis that participants who read the awareness tools overall would report less mean rejection than participants in the control group.

Rejection scores did not differ significantly, on average, by target character gender. The effect size for the main effect of gender of the character was reported as .001, which is a small effect. These findings do not support the hypothesis that a female character described in a vignette with BPD would receive lower mean rejection scores than a male character described with the same symptoms.

We did not specifically hypothesize that there would be an interaction between awareness tools and gender, and no statistically significant interaction between education type and gender of the character in the vignette was found. Therefore, there is no evidence that type of education and gender of the target character described in a vignette suffering from BPD interacted with each other in determining participants' rejection scores.

## **Discussion**

The present study sought to examine different factors that play a role in perceptions of a character described as having BPD symptoms. The results did not support the hypothesis that people who had heard of BPD would report less rejection of

the target character than people who had not heard of the illness prior to reading about the target. Further, there was no support for the hypothesis that people who had met someone diagnosed with BPD would report lower mean rejection than people who had not met someone with BPD. Overall, these findings indicate that college students who had prior knowledge or knew someone diagnosed with BPD did not significantly impact rejection scores compared to college students who did not. Although it is important not to accept the null hypothesis, the very small effect size is an indication that there may be no mean difference. However, the findings may also be explained by the possibility that participants may not have been able to tell that the character in the vignette suffered from BPD. Because label was not directly included in the vignette, even participants who had heard of BPD before may not have made the connection that the character in the vignette was suffering from BPD. Another consideration is that those individuals who had heard of BPD prior to entering the study may have attributed the character's behaviors and symptoms as being under his or her control and that he or she is responsible for his or her actions. Indeed, a few participants reported after they had been debriefed that they felt that the character in the vignette was not suffering from a mental disorder, but was simply "whiny" and "annoying." These findings may suggest that some participants may have felt as though the target character was not suffering from a disorder, and may have attributed the character's behavior to personality traits rather than a mental illness.

Also likely is the possibility that the age of the target person (Andrew or Amanda), may have inducted participants to view the character as more or less a peer of the participants; perhaps viewing the target more like the self may have led participants to be less likely to recognize BPD symptoms in the vignettes to which they were exposed,

or simply to excuse the targets' behaviors as typical college-aged reactions to stress and difficulty with academic work.

### **Prior Awareness of Borderline Personality Disorder**

Approximately half of the sample reported having heard of BPD before participating in the study. Although there are no data on awareness in the general population, this percentage seems high given the lack of attention that BPD receives in the popular media. Although there is not an established norm for BPD awareness among the general population, the higher percentage in this study may be due to the fact that the sample included students from undergraduate psychology classes. Some students may have heard about BPD through some of their psychology courses. However, there may be a second explanation, which is that some participants may have confused the disorder with other disorders, such as bipolar depression or dissociative identity disorder (which participants often identified as multiple personality disorder). Several participants during the course of the study inquired whether BPD was another name for these two disorders, so it is therefore possible that more participants may have made a similar connection. Therefore, these results may not accurately reflect the true number of participants who were already aware of BPD prior to entering the study.

The number of participants who reported that they had met someone with BPD prior to entering the study was approximately 11%. It is possible that these participants may have encountered individuals who were diagnosed with BPD, but the individuals who were diagnosed may not have disclosed their diagnosis due to fear of being stigmatized or stereotyped based on their behaviors. Therefore, these individuals may have met individuals who were diagnosed with BPD but simply just never knew it.

Regardless, there are no previous data on the percentage of people who report that they have met someone with a BPD diagnosis, so this is a useful benchmark to which future research can be compared.

### **Awareness Tools and Borderline Personality Disorder**

The findings of the present study also did not support the hypothesis that people who read the NEA-BPD flyer would report lower rejection toward a character described in a vignette suffering from BPD, on average, than those who read the NEA-BPD fact sheet or the control group, who did not receive any reading. It is possible that college students may not have truly absorbed the information contained in the awareness tools that they were given. Although all of the college students who were given awareness tools read them, it is unclear how closely they paid attention to the material contained within them. It is also possible that the content of the awareness tools may need to be examined to improve the quality of understanding that both college students and members of the general public can learn about BPD and those who suffer from it. For example, the tools may need to go into greater depth about the different symptoms of BPD. These awareness tools alone may not be enough to educate individuals about BPD. Other forms of education may also be necessary, such as an information session, in whereby a mental health professional provides individuals with factual information regarding BPD and explains how these findings differ from some of the stereotypes which exist about BPD, or a meet-and-greet session where people can talk to a person who has BPD or lived with someone else who has been diagnosed.

### **Character Gender and Borderline Personality Disorder**

The findings of the present study did not show support for the hypothesis that gender of the character would impact rejection scores toward an individual described in a vignette who suffers from BPD. Specifically, we expected that a female character would receive lower rejection scores, on average, than a male character. These findings might suggest that the male character described in the vignette received similar rejection scores compared to the female character, suggesting that the rejection of men who show emotions (namely through emotion-focused coping) may not apply to these characters. Recall that one of the components of BPD is affect instability; we had expected that a male character would be seen in a more negative light than a female character, simply because his emotional instability may have been perceived as a sign of weakness.

### **Strengths, Limitations, and Future Direction**

One strength of the present study was that it appears to be the first study in the literature to examine perceptions of a character suffering from BPD among a general college student sample. Because most of the stigma literature surrounding BPD has been conducted among mental health professionals, this study may provide a first look into the amount of stigma members of the general population hold towards individuals who have been diagnosed with BPD. Furthermore, the study allowed for greater insight into how much members of the general population know about BPD.

A second strength of the study was its experimental design. Through the design, factors like gender of individuals suffering from BPD and which awareness tool participants received could be controlled. This adds strength to this field of inquiry because participants do not have to rely solely on their experience with BPD, which could be more difficult for individuals who reported that they had never heard of BPD

had never met someone diagnosed with BPD before. It also adds strength because every participant read about an individual suffering from BPD in the same context. Keeping a neutral character whom participants had never met before may help ensure that every participant was given the same exposure to an individual with BPD.

One limitation of the study was that it is unclear whether the students were actually aware of BPD when they were asked about it at the completion of the study, or if they were confusing it with other disorders, such as bipolar depression or dissociative identity disorder. As already mentioned above, some of the participants expressed confusion about the nature of the disorder; specifically, some asked if BPD was another name for the disorders listed above. Therefore, it is possible that the percentage of individuals who reported being aware of BPD prior to coming into the study may not be accurate because of this confusion. Future research should address this through asking participants to identify or list features of the disorder or include a test to determine how much accurate knowledge college students have regarding BPD as a manipulation check. This may also be expanded in order to include pre-exposure and post-exposure assessments of BPD knowledge in order to further explore if the awareness tools may adequately inform the general population about the disorder. Furthermore, future research would benefit to inquire where participants obtained their reported knowledge of BPD, such as an abnormal psychology class or through media such as television and movies.

Future research also may include an examination of different symptoms of BPD described in the vignette to see whether they play a role in amount of rejection. The traits and symptoms exhibited by the characters were mostly non-threatening, meaning that the character was not a threat to themselves or others. However, it would be interesting to see



whether participants would reject a character who exhibited some of the more threatening behaviors sometimes seen in BPD such as suicidal or parasuicidal behaviors and difficulty controlling anger. These traits are often seen in BPD and may be contributing to the stigma of dangerousness which can sometimes be found in mental health professionals. Furthermore, a future study may wish to examine the reaction toward a character shown in a video with BPD symptoms in order to determine whether college students reject the individual more or less than in a study utilizing a vignette.

Finally, future research may seek to vary the age of the target character. The target characters, Amanda and Andrew, were described as college students. As mentioned previously, it is possible that college students associated the characters' behaviors with college stress. Although most individuals who are diagnosed with BPD often are emerging adults, differences may emerge if the target character is older than college age.

Another limitation of the study is that the vignette did not include a clear label that the character suffered from BPD. As mentioned previously, it is possible that some of the participants may not have made the connection. Future research may seek to examine whether gender and awareness tool make an impact if a label is present in the vignette. As the present study asked participants to infer information from the readings, it is possible that they may not have realized the individual in the vignette suffered from BPD. Therefore, it might be possible that adding a label to the vignette may allow for more detailed knowledge about the character in the vignette, and thus, may play a role in the amount of reported rejection.

## **Conclusions**

Despite the creation of House Resolution 1005, it is unclear whether the education that is provided during the month of May is reaching the general public. Therefore, the present study sought to examine whether education in the form of awareness tools as well as the gender of a character suffering from BPD described in a vignette would play a role in rejection scores of that character. The findings did not support the hypotheses, indicating that members of the general population may not be receiving the information provided by the NEA-BPD and other organizations seeking to diminish the amount of stigma and stereotyping surrounding BPD. Findings regarding gender appeared to suggest that character gender did not play a role in rejection scores, and may mean that the amount of stigma that individuals who have been diagnosed with BPD face may not differ based simply on that person's gender. Future research is needed to further explore different anti-stigma techniques to determine which types (or combinations thereof) appear to make the most impact on the general population.

## References

- American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (Revised 4<sup>th</sup> ed.). Washington, DC: Author.
- American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, *57*, 1597-1611.
- Barney, L. J., Griffiths, K. M., Christensen, H., & Jorm, A. F. (2009). Exploring the nature of stigmatizing beliefs about depression and help-seeking: Implications for reducing stigma. *BMC Public Health*, *9*(61), 1-11. doi: 10.1186/1471-2458-9-61
- Becker, D., & Lamb, S. (1994). Sex bias in the diagnosis of borderline personality disorder and posttraumatic stress disorder. *Professional Psychology: Research and Practice*, *25*(1), 55-61.
- Bouchard, S., Godbout, N., & Sabourin, S. (2009). Sexual attitudes and activities in women with borderline personality disorder involved with romantic relationships. *Journal of Sex & Marital Therapy*, *35*(2), 106-121.
- Bouchard, S., Sabourin, S., Lussier, Y., & Villeneuve, E. (2009). Relationship quality and stability in couples when one partner suffers from borderline personality disorder. *Journal of Marital and Family Therapy*, *35*(4), 446-455. doi: 10.1111/j.1752-0606.2009.00151.x
- Buila, S. M. D. (2009). Using the media to enhance well-being and mental health. *Rural Society*, *19*(4), 363-367.
- Clifton, A., Pilkonis, P. A., & McCarty, C. (2007). Social networks in borderline personality disorder. *Journal of Personality Disorders*, *21*(4), 434-441.

- Corrigan, P. W., Edwards, A. W., Green, A., Diwan, S. L., & Penn, D. (2001). Prejudice, social distance, and familiarity with mental illness. *Schizophrenia Bulletin*, 27(2), 219-225.
- Corrigan, P. W., & Penn, D. L. (1999). Lessons from social psychology on discrediting psychiatric stigma. *American Psychologist*, 54(9), 765-776.
- Corrigan, P. W., Rowan, D., Green, A., Lundin, R., River, P., Uphoff-Wasowski, K., White, K., & Kubiak, M. A. (2002). Challenging two mental illness stigmas: Personal responsibility and dangerousness. *Schizophrenia Bulletin*, 28(2), 293-309.
- Coverdale, J., Nairn, R., & Claasen, D. (2002). Depiction of mental illness in print media: A prospective national sample. *Australian and New Zealand Journal of Psychiatry*, 36(5), 697-700.
- Coyne, J. C. (1976). Depression and the response of others. *Journal of Abnormal Psychology*, 85(2), 186-193.
- Evans-Lacko, S., London, J., Little, K., Henderson, C., & Thornicroft, G. (2010). Evaluation of a brief anti-stigma campaign in Cambridge: Do short-term campaigns work? *BMC Public Health*, 10, 339-344.
- Ford, M. R., & Widiger, T. A. (1989). Sex bias in the diagnosis of histrionic and antisocial personality disorders. *Journal of Consulting and Clinical Psychology*, 57(2), 301-305.
- Gotlib, I. H., & Robinson, L. A. (1982). Responses to depressed individuals: Discrepancies between self-report and observer-rated behavior. *Journal of Abnormal Psychology*, 91(4), 231-240.

- Gunderson, J. G. (2008). Borderline personality disorder: An overview. *Social Work in Mental Health*, 6(1-2), 5-12. doi: 10.1300/J200v06n01\_02
- Gunderson, J. G. (2006). A BPD brief: An introduction to borderline personality disorder. Retrieved from the National Education Alliance for Borderline Personality Disorder website: <http://www.borderlinepersonalitydisorder.com/BPD-brief.shtml>
- Hersh, R. (2008). Confronting myths and stereotypes about borderline personality disorder. *Social Work in Mental Health*, 6(1-2), 13-32. doi: 10.1300/J200v06n01\_03
- Howerton, A., & Van Gundy, K. (2009). Sex differences in coping styles and implications for depressed mood. *International Journal of Stress Management*, 16(4), 333-350.
- H. R. Res. 1005 (2008). Retrieved from <http://www.borderlinepersonalitydisorder.com/documents/H.Res.1005adopted.pdf>
- Johnston, E. (2007). An example of BPD in college [Vignette]. Retrieved from: <http://bpd.about.com/od/caseexamples/a/ExampleSchoolF.htm>
- Jorm, A. F. (2009). Australian young people's awareness of *headspace*, *beyond blue* and other mental health organizations. *Australasian Psychiatry*, 17(6), 472-474. doi: 10.1080/10398560902915596
- Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, 27(1), 363-385.
- Link, B. G., Phelan, J. C., Bresnahan, M., Stueve, A., & Pescosolido, B. A. (1999). Public conceptions of mental illness: Labels, causes, dangerousness, and social distance. *American Journal of Public Health*, 89(9), 1328-1333.

- Marie, D., & Miles, B. (2008). Social distance and perceived dangerousness across four diagnostic categories of mental disorder. *Australian and New Zealand Journal of Psychiatry, 42*(2), 126-133.
- Markham, D. (2003). Attitudes towards patients with a diagnosis of 'borderline personality disorder': Social rejection and dangerousness. *Journal of Mental Health, 12*(6), 595-612. doi: 10.1080/09638230310001627955
- Markham, D., & Trower, P. (2003). The effects of the psychiatric label 'borderline personality disorder' on nursing staff's perceptions and causal attributions for challenging behaviors. *British Journal of Clinical Psychology, 42*(3), 243-256.
- Morgan, A., & Jorm, A. (2007). Awareness of *beyondblue: the national depression initiative* in Australian young people. *Australasian Psychiatry, 15*(4), 329-333.
- National Education Alliance for Borderline Personality Disorder (2008a). Borderline personality disorder: Awareness brings hope [Fact sheet]. Retrieved from: <http://www.borderlinepersonalitydisorder.com/awareness/awareness-files/tools.shtml>
- National Education Alliance for Borderline Personality Disorder (2008b). May is borderline personality disorder awareness month [Awareness flyer]. Retrieved from: <http://www.borderlinepersonalitydisorder.com/awareness/awareness-files/tools.shtml>
- Piner, K. E., & Kahle, L. R. (1984). Adapting to the stigmatizing label of mental illness: Foregone, but not forgotten. *Journal of Personality and Social Psychology, 47*(4), 805-811.

Social Security Administration (2011). Top names of the 1990s. Retrieved from:

<http://www.ssa.gov/oact/babynames/decades/names1990s.html>

Weddige, R. L. (1986). The hidden psychotherapeutic dilemma: Spouse of the borderline.

*American Journal of Psychotherapy*, 40(1), 52-61.

Wilkins, T. M., & Warner, S. (2001). Women in special hospitals: Understanding the

presenting behaviour of women diagnosed with borderline personality disorder.

*Journal of Psychiatric and Mental Health Nursing*, 8(4), 289-297. doi:

10.1046/j.1365-2850.2001.00375.x

## Appendices

Appendix A: NEA-BPD Fact Sheet.....	40
Appendix B: NEA-BPD Flyer.....	41
Appendix C: Male Character Vignette.....	42
Appendix D: Female Character Vignette.....	43
Appendix E: Social Rejection Questionnaire.....	44
Appendix F: Demographic Questionnaire.....	45



## Appendix A: NEA-BPD Fact Sheet

**Board of Directors**  
Perry D. Hoffman, Ph.D.  
*President*  
Melissa Cunningham-Lynch  
*Vice President*  
Patricia Woodward, M.A.T.  
*Secretary/Treasurer*  
Lois P. Cleveland  
*Information Technology*  
Beth Elliott, Ph.D.  
*Director, The Connections Place*  
Alan E. Fruzzetti, Ph.D.  
*Director of Research*  
James A. Hall  
*NAMI Liaison*  
Christina Kallas, Esq.  
James O. Payne, Jr., J.D.  
*Congressional Liaison*  
Penny Steiner-Grossman, Ed.D., M.P.H.  
*Medical Editor*

**Counsel to the Directors**  
Constance E. Lieber, NARSAD

**Scientific Advisory Board**  
Herbert Pardes, M.D., Chairman  
Jack D. Barchas, M.D.  
Anthony W. Bateman, M.D., FRCPsych.  
Professor Martin Bohus, M.D.  
Benjamin S. Bunney, M.D.  
Dennis S. Charney, M.D.  
Emil F. Coccaro, M.D.  
Kate Comtois, Ph.D.  
Janet Feigenbaum, D.Phil.  
Robert O. Friedel, M.D.  
John G. Gunderson, M.D.  
Richard K. Harding, M.D.  
Jill M. Hooley, D.Phil.  
Kenneth S. Kendler, M.D.  
Otto F. Kernberg, M.D.  
Marsha M. Linehan, Ph.D., ABPP  
John S. McIntyre, M.D.  
John M. Oldham, M.D., M.S.  
Joel Paris, M.D.  
Nina P. Schooler, Ph.D.  
S. Charles Schulz, M.D.  
Larry J. Siever, M.D.  
Andrew E. Skodol, M.D.  
Barbara Stanley, Ph.D.  
Robert L. Trestman, Ph.D., M.D.  
Ming T. Tsuang, M.D., Ph.D.  
Janet B.W. Williams, DSW  
Mary C. Zanarini, Ed.D.

**Scientific Forum Advisory Board**  
Co-chair  
John G. Gunderson, M.D.  
John M. Oldham, M.D., M.S.  
Science Editor  
Kenneth R. Silk, M.D.



**National Education Alliance for  
Borderline Personality Disorder**  
NEA-BPD  
P. O. Box 974, Rye, New York 10580

### Borderline Personality Disorder: Awareness Brings Hope

Borderline personality disorder (BPD) is a serious mental illness that centers on the inability to manage emotions effectively. The symptoms include impulsivity, mood lability, rage, bodily self-harm, suicide, chaotic relationships, fears of abandonment and substance abuse. Officially recognized in 1980 by the psychiatric community, BPD is at least two decades behind in research, treatment options, and family education compared to other major mental illnesses.

While some persons with BPD are high functioning in certain settings, their private lives may be in turmoil. Others are unable to work and require financial support. The high prevalence of BPD and its high personal, social, and economic toll make it a national public health challenge. And yet people do get better. Hope starts with awareness.

#### Prevalence in Adults

- 4 million American individuals have BPD (~ 2% of general public)
- BPD is more common than schizophrenia
- 20% of psychiatric hospital admissions have BPD (more than for major depression)

#### Suicide and Self Injury in Adults

- 10% of adults with BPD commit suicide
- a person with BPD has a suicide rate 400 times greater than the general public
- a young woman with BPD has a suicide rate 800 times greater than the general public
- 55-85% of adults with BPD self-injure their bodies

#### Prevalence and Suicide in Youth

- 33% of youth who commit suicide have features of BPD

#### Treatment Challenges

- no FDA-approved medication exists for BPD
- BPD can co-occur with other illnesses (e.g., 60% also have major depression)
- research-based therapies for BPD are not widely available
- a 30-yr-old woman with BPD typically has the medical profile of a woman in her 60s

#### Economic Impacts

- up to 40% of high users of mental health services have BPD
- over 50% of individuals are severely impaired in employability
- 12% of men and 28% of women in prison have BPD

May 2008

Source: Research presentations of NEA-BPD conferences 2002-2007

[neabpd@aol.com](mailto:neabpd@aol.com)

[www.borderlinepersonalitydisorder.com](http://www.borderlinepersonalitydisorder.com)

(914) 835-9011

## May is Borderline Personality Disorder Awareness Month

### ***Why learn about Borderline Personality Disorder?***

Odds are that you know someone who has Borderline Personality Disorder.

### ***What is it?***

Borderline Personality Disorder (BPD) is a prevalent, yet misunderstood mental illness. It is often thought to be an emotion regulation disorder.

### ***What are the symptoms of BPD?***

Symptoms include impulsive behaviors such as bodily self-harm and substance abuse, chaotic relationships, unstable self-identity and moods, often including intense anger. Ten percent of individuals with BPD commit suicide, making this disorder a leading cause of suicide.

### ***Awareness Brings HOPE***

- 1 in 16 people suffer from BPD - 12 million adults and adolescents
- BPD is more common than bipolar disorder and schizophrenia, but is less recognized
- 17% of people in prison have BPD
- Compared to other disorders, BPD is at least two decades behind in treatment options, research and family education
- There is no FDA-approved medication for the treatment of BPD
- Specialized treatments for BPD are not readily available

### ***Increasing Awareness of BPD***

"It is essential to increase awareness of BPD among people suffering from this disorder, their families, mental health professionals and the general public by promoting education, research, funding, early detection and effective treatments."

\*H. RES 1005, PASSED 4/1/08

To learn more about BPD visit the National Education Alliance for Borderline Personality Disorder at [www.borderlinepersonalitydisorder.com](http://www.borderlinepersonalitydisorder.com), or the National Alliance on Mental Illness at [www.nami.org](http://www.nami.org)

## Appendix C: Male Character Vignette

### **Andrew**

Having taken the last year off, Andrew is planning on returning to college in the fall. His break came as a result of not participating in classes during his previous semester. Andrew just seemed to quit in the middle of his previous semester; he stopped going to class, only turned in some of his assignments, and started partying. Threatened with academic probation, he decided to take a year off.

This was not the first time that Andrew had problems in college. In high school, he was always a capable and focused student. When he started college, his future seemed planned and clear. Always one for a cause, Andrew initially planned to start and run a non-profit foundation for teenage boys. Once he started school, however, his plans began to get a bit hazy. Andrew began changing majors and plans.

When Andrew took his break, he had already changed his major three times in two years and was thinking of changing again. He had started going out to bars, often drinking in his dorm room before he went out. It was not uncommon for him to wake up not knowing where he was or who he was with.

Through all of this, he still managed to participate in classes just enough to keep his head above water. But in his last semester, he just stopped going or doing much of anything.

Andrew's last semester had started with a lot of enthusiasm. He was finally able to register for a class taught by a noted professor at the university. He would pour all of his efforts into assignments for the class and even stopped going out as much. He felt that he was really connecting with his classmates as well.

Andrew was very upset when his papers were not singled out as being exceptional. The professor did not seem to see him as a superior student. To Andrew, it seemed like the professor did not like him at all.

When Andrew mentioned this to his fellow students, they would assure him that the professor was treating all of the students the same. Their lack of validation was intensely frustrating and felt like an additional rejection. Andrew felt alone and angry when he thought of class. He stopped going to this class. He thought the lack of his valuable contributions would be missed. He was angry and did not want to be where he was not wanted, or he wanted everyone to know how hurt he was. Soon he stopped going to his other classes as well.

## Appendix D: Female Character Vignette

### **Amanda**

Having taken the last year off, Amanda is planning on returning to college in the fall. Her break came as a result of not participating in her classes during her previous semester. Amanda just seemed to quit in the middle of her previous semester; she stopped going to class, only turned in some of her assignments, and started partying. Threatened with academic probation, she decided to take a year off.

This was not the first time that Amanda had problems in college. In high school, she was always a capable and focused student. When she started college, her future seemed planned and clear. Always one for a cause, Amanda initially planned to start and run a non-profit foundation for teenage girls. Once she started school, however, her plans began to get a bit hazy. Amanda began changing majors and plans.

When Amanda took her break, she had already changed her major three times in two years and was thinking of changing again. She had started going out to bars, often drinking in her dorm room before she went out. It was not uncommon for her to wake up not knowing where she was or who she was with.

Through all of this, she still managed to participate in classes just enough to keep her head above water. But in her last semester, she just stopped going or doing much of anything.

Amanda's last semester had started with a lot of enthusiasm. She was finally able to register for a class taught by a noted professor at the university. She would pour all of her efforts into assignments for the class and even stopped going out as much. She felt that she was really connecting with her classmates as well.

Amanda was very upset when her papers were not singled out as being exceptional. The professor did not seem to see her as a superior student. To Amanda, it seemed like the professor did not like her at all.

When Amanda mentioned this to her fellow students, they would assure her that the professor was treating all of the students the same. Their lack of validation was intensely frustrating and felt like an additional rejection. Amanda felt alone and angry when she thought of class. She stopped going to this class. She thought the lack of her valuable contributions would be missed. She was angry and did not want to be where she was not wanted, or she wanted everyone to know how hurt she was. Soon she stopped going to her other classes as well.

## Appendix E: Social Rejection Questionnaire

Based on the person in the vignette you just read, please circle the number that most closely represents your answer to each of the following questions.

Would you like to meet this person?

definitely no

1                    2                    3                    4                    5                    6

definitely yes

7

Would you ask this person for advice?

definitely no

1                    2                    3                    4                    5                    6

definitely yes

7

Would you want to sit next to this person on a three-hour bus trip?

definitely no

1                    2                    3                    4                    5                    6

definitely yes

7

Would you invite this person to your house?

definitely no

1                    2                    3                    4                    5                    6

definitely yes

7

Would you approve if a close relative were going to marry them?

definitely no

1                    2                    3                    4                    5                    6

definitely yes

7

Would you be willing to work with them on a job?

definitely no

1                    2                    3                    4                    5                    6

definitely yes

7

Would you want to have them as an acquaintance?

definitely no

1                    2                    3                    4                    5                    6

definitely yes

7

Would you admit them to your close circle of friends?

definitely no

1                    2                    3                    4                    5                    6

definitely yes

7

## Appendix F: Demographic Questionnaire

Age: \_\_\_\_\_

Sex (Please check one):

(1) Male \_\_\_\_\_

(2) Female \_\_\_\_\_

Ethnicity:

(1) Caucasian/European American \_\_\_\_\_

(2) African American \_\_\_\_\_

(3) Asian American \_\_\_\_\_

(4) Hispanic \_\_\_\_\_

(5) Middle Eastern \_\_\_\_\_

(6) Other \_\_\_\_\_

Year in College:

(1) Freshman \_\_\_\_\_

(2) Sophomore \_\_\_\_\_

(3) Junior \_\_\_\_\_

(4) Senior \_\_\_\_\_

(5) Other \_\_\_\_\_

Had you ever heard of Borderline Personality Disorder prior to participating in this study?

(1) Yes \_\_\_\_\_

(0) No \_\_\_\_\_

Have you ever met somebody who has been diagnosed with Borderline Personality Disorder prior to participating in this study?

(1) Yes \_\_\_\_\_

(0) No \_\_\_\_\_