Neuroendocrinology Letters Volume 44 No. 4 2023
ISSN: 0172-780X; ISSN-L: 0172-780X; Electronic/Online ISSN: 2354-4716
Web of Knowledge / Web of Science: Neuroendocrinol Lett
Pub Med / Medline: Neuro Endocrinol Lett

REVIEW ARTICLE

Stigma and self-stigma in borderline personality disorder: A narrative review

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Submitted: 2023-03-15 Accepted: 2023-06-03 Published online: 2023-06-03

Key words: **Stigma; self-stigma; internalised stigma; borderline personality disorder; discrimination; prejudice; stereotypes**

Neuroendocrinol Lett 2023; **44**(4):206–215 **PMID:** 37466060 NEL440423R01

Abstract

INTRODUCTION: Borderline personality disorder (BPD) presents a highly stigmatised condition. Individuals with BPD may experience stigmatising attitudes and remarks from the general population and mental health professionals. Significant self-stigma also seems common. The paper reviews the current knowledge regarding the stigma connected to BPD.

METHOD: The Web of Science, Medline, and Scopus databases identified studies published from January 1990 to January 2023. Additional references were found using analyses of the primary articles. The search terms included "borderline", "stigma", and "self-stigma".

RESULTS: Public knowledge of BPD is scarce. The general population may interpret the BPD symptoms as "purposeful misbehaviour" rather than signs of a mental disorder. Mental health professionals commonly distance themselves from patients with BPD and may prematurely give up their treatment efforts. This stance often comes from believing BPD is difficult or impossible to treat. Therefore, treating patients with a personality disorder should be consulted with a supervisor, especially when the psychotherapist shows a negative attitude towards the patient. Generally, few BPD-specific destigmatisation interventions have been verified by research. Limited evidence suggests that targeted training of the healthcare providers can reduce stigmatising attitudes and that interventions combining positive messages of the recovery potential with biological aetiology of the disorder are most impactful in reducing the stigma.

CONCLUSION: BPD is commonly stigmatised by the general population and mental health professionals. Destigmatising efforts need to tackle the stigma's primary sources, namely the general population's lack of understanding and the pessimistic beliefs in the healthcare providers. More BPD-specific research on stigma is needed.

INTRODUCTION

The stigma of mental disorders presents a common obstacle that complicates the approach of psychiatric patients to a timely and effective treatment (Aviram *et al.* 2006, Lauber *et al.* 2006, Schulze 2007, Thornicroft *et al.* 2007). Borderline personality disorder (BPD) is a commonly stigmatised mental disorder (Markham & Trower 2003; Koivisto *et al.* 2022a). The core symptoms of BPD present marked affective instability, impulsivity, and a fear of abandonment that significantly impair daily functioning (Southward & Cheavens 2018). Individuals with BPD might also engage in impulsive aggression, self-destructive behaviour, and unstable relationships and experience identity disturbance, dissociative symptoms, emptiness, or temporary paranoid ideas (American Psychiatric Association 2013). Labelling strong and volatile emotions can be challenging, which adds to the chronic stress perceived by this population (Ebner-Priemer *et al.* 2008; Tyrer 2022). Self-invalidation is another common issue that impairs the patient's relationship with oneself and others (Koivisto *et al.* 2022b). These struggles result in low quality of life (IsHak *et al.* 2013) and impaired functioning (Thadani *et al.* 2022).

The lay public, nurses, psychiatrists, psychologists, and other healthcare professionals relatively often perceive patients with borderline personality disorder (BPD) negatively (Klein *et al.* 2022a). Patients' experiences with BPD have been the primary focus of several studies in the last thirty years (Kaysen 1993, Miller *et al.* 1994, Nehls 1999, Byrne 2000, Castillo *et al.* 2001, Fallon 2003, Holm and Severinsson 2011, Rogers and Dunne 2011). These participants often described feeling like they live with a demeaning label, that their self-harming behaviour is viewed as a form of manipulation, and that they have limited access to adequate treatment. They felt that mental health professionals held prejudices and negative attitudes towards them and reported feeling they were not diagnosed but labelled (Byrne 2000) and have felt being negatively evaluated (Nehls 1999). Some patients spoke of fears of non-acceptance or disapproval, particularly from their psychotherapists (Miller *et al.* 1994). They also mentioned the reluctance of professionals to tell them their diagnosis (Fallon 2003; Castillo *et al.* 2001).

Mental health stigma

The personality disorder diagnosis has been tightly connected with the issue of stigma. A prominent figure of stigma research, Erving Goffman, dealt with the issue of social stigma, its impact on a person's identity and subsequent behaviour towards other people. In his monography, he understands stigma as the exclusion of a person who cannot conform to the standards of the majority populace. The non-conforming individuals are rejected due to their difference by various forms of discrimination - restriction of rights, ridicule, rejection, and punishments (Goffman 1963).

Stigma generally consists of three components – ignorance (lack of sufficient awareness of the nature of mental disorders), prejudice (negative attitudes), and discrimination (behaviour that violates or limits the rights and self-fulfilment of an individual). Stigma then operates at three levels – societal, structural (in other words, institutional), and internalised (in other words, self-stigmatisation) (Livingston & Boyd 2010). Self-stigmatisation is a process during which an individual accepts the negative stereotypes society holds toward them. The internalisation of stigma begins when the individual notices that others behave differently and becomes aware of the prejudices that lead to such behaviour. During the second internalisation stage, the person believes society's views and attitudes toward people with mental disorders, including themselves, are justified. In the last step, the individual applies stereotypes to themselves, accepts them uncritically, and acts accordingly (Corrigan *et al.* 2011).

Self-stigma contributes to an adverse change in the identity of the person with a mental disorder. It affects the positive perception of oneself, leading to a loss of expectations and positive beliefs about one's person. The consequences of stigma internalisation manifest at different levels –an increase in dysphoric emotions, a decrease in self-esteem and quality of life, and an increase in anticipatory anxiety when expecting negative actions from others. Individuals who internalise social stigma become socially isolated and may develop social anxiety disorder (Camp *et al.* 2002; Livingston & Boyd 2010). Another common model explains the internalisation of stigma in four steps: awareness of stereotypes, agreement with them, their application to oneself, and reduction of self-esteem and hope (Corrigan *et al.* 2011). The effects of self-stigma lead to little effort to achieve set life goals, and repeated failures reinforce these factors during life experiences (Corrigan *et al.* 2009).

Individuals with BPD seem more stigmatised than patients suffering from other mental disorders and tend to internalise this stigma (Grambal *et al.* 2016; Koivisto *et al.* 2022a). The causes of this connection have not been sufficiently clarified (Grambal *et al.* 2016; Klein *et al.* 2022b). This study aimed to explore the complex nature between BPD and stigma. The following research questions were set:

(1) What is the public stigma of BPD?
(2) What is the stigma of BPD among healthcare professionals?
(3) Is there a structural stigma in BPD?
(4) What about stigmatisation in the BPD patients' families?
(5) What does self-stigma look like in individuals with BPD?
(6) How does BPD stigma affect treatment?

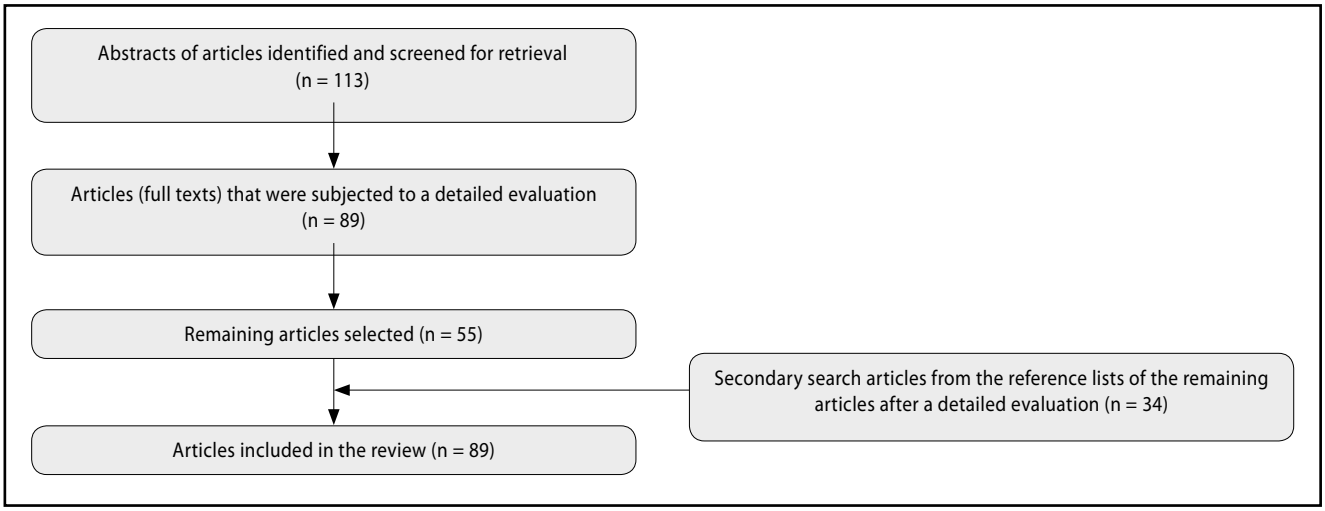

Fig. 1. Summary of the selection process

(7) What interventions can help patients with BPD with stigmatisation?
(8) What does self-stigma look like in BPD patients?
(9) How does self-stigma affect the psychotherapy of patients with BPD?
(10) How does self-stigma affect the pharmacotherapy of patients with BPD?
(11) What are the interventions to help BPD patients with self-stigma?

METHODS

Studies used in this narrative review were identified through Web of Science, Medline, and Scopus among texts published from January 1990 to January 2023. Keywords included the terms "borderline", "stigma", and "self-stigma". The search was performed by repeatedly using the words in different connections without language constraints. The articles were collected and sorted by relevance; critical publications in the bibliography were identified, and additional publications were searched manually. The manuscripts were organised and systematised according to their significance. The designated manuscripts meet the following inclusion criteria: (1) human studies; (2) published in peer-reviewed journals; (3) reviews; (4) book chapters on a related topic. The exclusion criteria meet the following conditions: (1) extracts from conferences; (2) comments. A primary keyword search yielded 113 manuscripts whose 89 pieces met the criteria and was examined in detail by two researchers. After a complete inspection of the full texts, 55 papers were nominated; a secondary search from the reference lists of primarily assigned articles was studied, assessed for appropriateness, and added to the preliminary list (n = 34). The resulting review also includes information from monographic referenced by other studies. A total of 89 articles (Figure 1) were included in the review process.

STIGMA IN BPD

Individuals with BPD struggle with many facets of stigma. The experiences occur in the patients' daily lives as well as in their treatment.

Public stigma of BPD

The general public often perceives the diagnosis of BPD as a sign of a troublesome individual and has a negative attitude towards these patients. Individuals with BPD who act out in public are seen as 'crazy', 'hysterical', 'angry' or simply 'weird' (Ociskova & Prasko 2015). The general population expects them to be cold, aloof, and exhibit problematic behaviour. However, they are not usually seen as dangerous (Grambal *et al.* 2017). The neighbourhood keeps its distance from them but is primarily unafraid of them. The general population often believes that the cause of this disorder is a personality defect and thus expects that the patient "should try and do something about himself" or should be "re-educated".

Healthcare provider stigma of BPD

Labelling is widespread for diagnoses that are stereotyped as challenging to treat. These are mainly personality disorders, primarily the borderline type (Sheppard *et al.* 2023). Patients with BPD are often given labels related to the expected difficult treatability or intractability, complexity, demandingness, manipulative tendencies and attention-seeking, usually put in the context of self-injurious behaviour (King & McCashin 2022). Individuals with this disorder are significantly more stigmatised than patients suffering from other mental illnesses, but the origin of this process is still poorly understood (Aviram *et al.* 2006; King & McCashin 2022; Masland *et al.* 2022). Professionals' high stigmatisation is associated with countertransference, mainly when it includes excessive criticism, labelling, denial of anger, emotional abuse, boundary crossing, and role reversal (Praško *et al.* 2010).

An adverse countertransference reaction to patients with BPD can lead to the insufficient establishment of a therapeutic relationship, emotional coldness and distancing from the patient, problems in empathising with the patient, the belief that the patient's condition cannot be changed, premature termination of treatment, rationalisation of treatment failure, blaming the patient for manipulation, and administration of multiple psychotropic drugs in high doses (Aviram *et al.* 2006, Fraser & Gallop 1993, Markham & Trower 2003, Markham 2003, Forsyth 2007, Sansone & Sansone 2013).

Research has found that psychiatrists often report anger, frustration and feelings of inadequacy when responding to patients with BPD (Deans & Meocevic 2006, Commons Treloar 2009a). Also, when comparing BPD with other highly stigmatised disorders, such as schizophrenia or mood disorders, attitudes and behaviours towards patients with BPD tend to be more negative (Fraser & Gallop 1993, Markham & Trower 2003, Markham 2003).

Nurses are the most common group of mental health professionals in whom the influence of prejudice on the mental state of patients with BPD has been investigated. That is followed by groups of mental health professionals from various fields, psychologists and psychotherapists (Sansone & Sansone 2013). However, there is no study in which psychiatrists are the only research group.

The structural stigma of BPD

Structural stigma can influence the accessibility of services, quality of services, insurance coverage, and research on BPD (Klein *et al.* 2022). Clinicians have encountered obstacles in billing insurance companies for BPD (O'Donohue *et al.* 2007). Although BPD is more prevalent than many other diagnoses, fewer services, research, and funding exist. Zimmerman (2015) continues that there has been less funding from the National Institute of Mental Health for BPD than for bipolar disorder and, thus, much less research dedicated to its understanding and treatment. Stigma also influences the assessment process; diagnostic and screening tools are insufficient to assess this population accurately (Zimmerman 2015; Klein *et al.* 2022a). Individuals with BPD in Australia have reported experiences of discrimination within the healthcare setting and trouble getting services and information about their diagnosis (Lawn & McMahon 2015).

The family stigma of BPD

Stigma affects not only psychiatric patients but also their family members. Some authors found that family members are more likely to conceal the mental disorder if they do not live with their affected relative, if the relative is female, and if the relative has less severe positive symptoms (Nehls 1998; Kay *et al.* 2018; Meshkinyazd *et al.* 2021). Relatives are usually aware of stereotypes regarding mental disorders, and this awareness may lead them to discourage the patient from seeking adequate psychiatric care (Fossati *et al.* 2018). Once a patient comes into contact with psychiatry and is diagnosed with a mental disorder, accepting this fact befalls the sufferer and his family. Acknowledging the reality of a mental disorder goes hand in hand with the emerging fear of stigmatisation (Trosbach *et al.* 2003). Therefore, relatives of patients with BPD often try to keep the existence of the diagnosis a secret (Sheehan *et al.* 2016). They may develop various forms of behaviour to prevent "shame" and prevent their loved ones or themselves from being stigmatised (Kirtley *et al.* 2019). Some relatives preemptively isolate patients from the environment or make enormous efforts to hide from the outside world the presence of the diagnosis of the disorder but also its symptoms (Grambal *et al.* 2017).

STIGMA AND HEALTH PROFESSIONALS

Many health professionals hold negative judgments and stereotypes about patients with BPD (Sheppard *et al.* 2023). The established personality disorder diagnosis often evokes the idea of difficult treatment, problems and little hope for success (Wu *et al.* 2022). That can influence the conscious and unconscious attitudes of the psychiatrist or psychologist and their subsequent behaviour right from the beginning of the patient's treatment. Most physicians and psychologists believe that the presence of a personality disorder automatically means a worse response to treatment, more prolonged therapy, more frequent repetitions, a worse prognosis, and more expensive treatment (Tyrer 2022). Attitudes towards the patient are usually negative, moralising, and, according to Tyrer & Davidson (2000), somewhat rigid and even "delusional". The stigmatisation of patients diagnosed with a personality disorder is strongly implied here.

Results are diverse concerning different healthcare professions (Wu *et al.* 2022). Bodner *et al.* (2015) found that psychiatrists and nurses with more experience working with BPD had less empathy and more negative attitudes than social workers or psychologists. A survey by Egan *et al.* (2014) described more positive attitudes among clinical psychologists towards clients with personality disorders. However, only a few studies have examined stigma-change interventions specific to BPD.

Due to the substantial overlap between symptoms of BPD and other mental disorders, individuals with BPD are commonly misdiagnosed and have unsuitable treatments, such as overuse of pharmacy rather than evidence-based psychotherapy (O'Donohue *et al.* 2007; Paris 2007; Adebowale 2010). Psychiatrists might also avoid a diagnosis of BPD to protect individuals from the stigma or avoid telling the patient of their diagnosis altogether (Paris 2007; Adebowale 2010), which may affect the subsequent treatment attempts. Still, Perry & Bond (2000) emphasise that despite these prejudices

against patients with personality disorders, their treatment is ultimately relatively successful and often differs only minimally or not at all from the treatment of patients without a personality disorder.

The stigma of professionals by individuals with BPD

Individuals with BPD often stigmatise mental health professionals. It is a matter rarely studied but significant when understanding the dynamics of the patient-therapist relationship. Patients and their families, like society, also label psychiatrists. An apt but in some aspects cruel division was described by one of our patients with BPD, who divided psychiatrists into "Hens", "Blabbers", "Mengeles", "Alternatives", "Ints",, "Gold diggers", "Weasels",, "Psychos" and even other categories that we, unfortunately, do not all remember (Ocisková & Praško 2015). According to him, the "hens" are older outpatient psychiatrists that are usually nice but limited in their perspective; one cannot "chat" with them much because their view is limited by the three drugs they prescribe, a TV series, and talking about children. The "Blabbers" are jovial psychiatrists who talk cheerfully, pat the patient on the shoulder, do not listen to the patient because they are uninterested in them, and nap after lunch. The worst are the "Mengeles", who, with a smile, force the patient to research and try some drug that will surely help them, and their patients are walking subjects, suitable for some research. They do not discuss anything with patients except research matters. "Alternatives" insert acupuncture needles, make family constellations, or recommend meditation and incense sticks. The "Ints" like to chat about literature and poetry, discuss Indonesia's political situation, or tell which symptoms come from Neanderthals. Sometimes they are so absorbed in their intellectual greatness that they hardly ask how the patient feels. "Gold diggers" rotate patients after 5, better 3 minutes, "prescription and go", often also engage in studies and have the latest BMW parked in front of the clinic. "Weasels" are cute, often in leather, they look like they can bite, but at the same time, it is clear that they suck blood. They like patients to discuss which boutique in Milan they bought those new crocodile leather shoes and matching bags. The best is the "Psychos"; they are "funny" because they belong in an insane asylum, are often unkempt, run around the ambulance, look for something, and talk incoherently. Sadly, mental health professionals' perceptions have not been rigorously studied yet.

Anti-stigma interventions

Several studies indicate that psychoeducation training can improve health professionals' attitudes (Krawitz 2004, Commons Treloar 2009b, Shanks *et al.* 2011). Psychoeducation is one approach to modifying stigma by revising misunderstandings about psychiatric disorders and providing knowledge (Proctor *et al.* 2021). Concentrating on service providers to psychoeducation about BPD patients was related to more positive attitudes to patients with personality disorders in Australian clinical psychologists (Egan *et al.* 2014). A second frequently used approach to fight stigma involves members of the stigmatised people engaging in personal interaction with others, such as through an interactive demonstration of their recovery story from a mental disorder (Proctor *et al.* 2021). A meta-analysis of stigma-change interventions for psychiatric disorders, in general, found that both interventions that educate and provide meaningful interpersonal contact with people with a mental disorder are the most effective. Still, contact interventions have a distinct benefit (Corrigan *et al.* 2012).

Destigmatisation interventions targeting providers may benefit from designs that combat diagnostic-specific stigma. In one intervention, health professionals completed two days of BPD anti-stigma training (Clarke *et al.* 2014). Professionals were assigned to either self-management (using acceptance and commitment therapy) or skills training (using dialectical behaviour therapy). Compared to the pre-test, clinicians in both groups had more positive attitudes, improved relationships with patients, and decreased desire for social distance from their patients after the intervention. Additionally, stigma reduction was maintained at six months. Healthcare workers who completed a two-day self-management workshop positively changed attitudes, therapeutic relationships, and social reserve towards people with BPD at post-test and 6-month follow-up (Clarke *et al.* 2014).

Recent research suggests another approach to stigma change. Current brain imaging studies provide evidence that BPD has visible neurobiological differences and challenge widespread ideas that personality disorders are merely a character flaw or the person's intentional actions (Schulze *et al.* 2013; Krause-Utz *et al.* 2014; Rossi *et al.* 2015; Whalley *et al.* 2015). Critics of the neurological approach suggest that seating the cause of mental illness with brain structure and function increases the notions of differentness and downplays the possibility for change and recovery (Kvaale *et al.* 2013). A brief training that stressed the neurology of PD showed a shift in knowledge and attitudes, but not empathy of healthcare staff (Clark *et al.* 2015). Using an experimental vignette, Lebowitz & Ahn (2012) found that combining neurobiological information about personality causes with recovery-orientated information was more effective in reducing stigma than the neurobiological approach or treatment information alone (Lebowitz & Ahn 2012). Participants who read vignettes emphasising the biological aetiology of PD and treatability anticipated lower social distance from individuals with PD.

Stigma and psychotherapy

Stigma may influence how healthcare staff interprets and acts upon the patients' behaviour, thoughts, and emotions connected with BPD. It can also lead

to tendencies to downplay the severity of symptoms, increase distress and aggressive behaviour of the patients, and lead to the patient's strengths being overlooked by the patient and health professionals (Aviram *et al.* 2006). Many people suffering from BPD prefer to try to help themselves rather than seek a psychologist or psychiatrist.

Fear of stigmatisation is a significant reason individuals with BPD fear a psychiatric diagnosis, even to the extent that they actively avoid or refuse adequate treatment. Medical personnel maintain a distance from patients with BPD primarily through emotional detachment when in contact with them. Such depersonalised behaviour can be particularly hurtful to people with BPD because, in line with their core beliefs, they perceive it as a sign of rejection and abandonment. The core belief may be more likely activated during psychotherapeutic guidance that is initially empathic and warm. When the therapist succumbs to unprocessed countertransference and becomes depersonalised over time, this behaviour change becomes all the more hurtful. The response to perceived rejection and abandonment is often maladaptive aggressive behaviour directed against the frustrating object as well as against oneself. Extreme devaluation of the psychotherapist and their workplace, swearing, or self-harm occurs. Termination of cooperation with a healthcare facility, or at least with a specific healthcare worker, is ordinary (Aviram *et al.* 2006).

When trying to find adequate treatment, patients with BPD are faced with the symptoms of their disorder, which can demotivate them by their very nature but also with possible manifestations of insufficient acceptance by the health professionals with whom the patient comes into contact (Kealy & Ogrodniczuk 2010). When patients severely stigmatise themselves, they may avoid entering psychotherapy because of the fears that the psychotherapist would stigmatise them. This is generally a transference issue that requires a sensitive approach from the psychotherapist. When they enter psychotherapy, they may perceive the therapeutic relationship through the lenses of self-stigma, which is more negative than it is (Owen *et al.* 2013). It is then a task for the psychotherapist to provide corrective emotional experiences for the patient.

Stigma and pharmacotherapy

Patients with BPD usually take high doses of medication, often switching drugs without much success. At the same time, many drugs prescribed do not match the diagnostic group for which the drugs are indicated and are of predictable effect (Gunderson & Philips 1995). The negative attitudes among psychiatrists and other doctors, psychologists and nurses contribute to the marginalisation of BPD patients. Some believe that BPD is not real and that patients with this diagnosis merely burden the healthcare system (Kealy & Ogrodniczuk 2010). Such an attitude can rationalise one's insufficient care and concern for individuals with BPD that may present in the overly pharmacotherapy-centric treatment. This attitude may clash with self-stigma in the patients overwhelmed with medication that brings them few benefits but reminds them that they are "mentally ill". Unsurprisingly, self-stigma has been associated with lower medication adherence among mental disorders, including BPD (Dubreucq *et al.* 2020). Still, the specific relationship between self-stigma and the pharmacotherapy of BPD remains unexplored.

SELF-STIGMA IN BPD

Generally speaking, the risk of developing self-stigma increases with the presence of certain personality traits, which are lower self-directedness and persistence and a high level of shame (Margetić *et al.* 2010; Peters & Geiger 2016; Koivisto *et al.* 2022). Both personality traits are related to Snyder's theory of hope, according to which the experience of hope emerges when an individual sets a goal that he would like to achieve and realistic ways of achieving it and possesses an appropriate amount of energy or effort that will allow him to persevere and overcome potential difficulties (Snyder 2000). It turns out that people with more severe self-stigma have a lower level of hope than those who have not internalised it (Ociskova *et al.* 2014). They expect they cannot achieve their goal and are convinced that it is beyond their ability to lead a satisfying life (Corrigan *et al.* 2009). Patients who suffer from self-stigma also prefer emotion-focused rather than problem-solving coping strategies and avoid social contact. This approach worsens treatment cooperation and prognosis (Yanos *et al.* 2008; Rüsch *et al.* 2009). These general findings translate into the symptomatology of BPD.

Rüsch *et al.* (2006) found more severe self-stigma among individuals with BPD than with social phobia. As expected, self-stigma was negatively connected with self-esteem, self-efficacy, and quality of life. Grambal *et al.* (2016) later confirmed that, on average, patients with BPD had more pronounced self-stigma than patients with schizophrenia spectrum disorders, bipolar disorder, major depression, or anxiety disorders. The self-stigma positively correlated with the severity of the disorder, the number of underwent psychiatric hospitalisations, and the single status. Quenneville *et al.* (2020) reported similar findings and found a connection between unemployment status, quality of life, and self-stigma. In the same year, Dubreucq *et al.* (2020) compared the levels of self-stigma among several patient groups – BPD, autism spectrum disorders, schizophrenia, bipolar disorder, major depression, and anxiety disorders. The participants with BPD had the highest occurrence (43.8 %) of the elevated self-stigma, while the prevalence of the whole sample was 31.2 %. The increased self-stigma is positively connected with early stages of personal recovery, a history of a suicide attempt, insight, and negative well-being and

satisfaction in interpersonal relationships (Dubreucq *et al.* 2020).

Self-stigma and treatment

Research by Ritscher & Phelan (2004) shows that self-stigma in psychiatric outpatients leads to decreased belief in improvement. In these patients, a higher degree of internalised stigma predicted a greater incidence of depressive symptoms and more negative self-evaluations, measured four months after the degree of internalised stigma was estimated. Our study (Ociskova *et al.* 2014) focused on patients with anxiety disorders and comorbid depressive or personality disorders. It was shown that self-stigma led to a higher likelihood of substance use and increased the occurrence of resignation to cope with stress. Self-stigma had a significantly negative relationship with self-directedness and the ability to think about paths to a set goal. The self-stigma significantly negatively correlated with the ability to plan the next step in solving the problem and to find positive elements in hurtful and otherwise challenging life events that would enable personal growth. The degree of stigma internalisation was directly related to the severity of dissociative symptoms, and the causality of the findings was unclear (Ociskova *et al.* 2014).

Interventions against self-stigma

In the last decade, a deeper understanding of the process of stigmatisation has led to a gradual shift of attention from the problem of public stigma to the subjective experiences of stigmatised individuals. Research then identified interindividual variables that can increase or decrease the impact of stigma on individuals (Mueller *et al.* 2006), as well as intraindividual factors that modify the influence of stigma on health status (Gerlinger *et al.* 2013).

Several studies have addressed effective interventions for BPD patients and their family members (Banerjee *et al.* 2006, Murray-Swank & Dixon 2006, Zanarini & Frankenburg 2008, Long *et al.* 2015, Gunderson *et al.* 1997).

In the last decades, experts have tried to devise effective ways to change the maladaptive life stories and change them with more positive ones unaffected by stigma during psychotherapy (Brown *et al.* 1996). Similar to other cases, the basis of the work is a quality relationship between the patient and the therapist. For the patient to be willing to deal with their life story, which is often painful for them, the therapist needs to be natural, humane, warm, and able to create an environment of safety and trust. In group therapy, feelings of trust and safety emerge thanks to sharing one's life experiences and, over time, more intimate occasions, feelings, and thoughts (Roe *et al.* 2010).

Leamy *et al.* (2011) investigated which elements therapists should focus on in story work when working with patients suffering from internalised stigma. The common factors they identified included, first and foremost, an emphasis on connecting individual events so that they make sense from the perspective of the whole life. That reduces patients' thinking, "Everything was going well until I got sick with a mental disorder. If it had never happened..." In the course of therapy, attention is also focused on the future. It is essential to reformulate the life story to evoke hope and optimism in the patient. Discovering the meaning of life and strengthening the sense of control became the focus of the sessions. The self-concept also changes. Patients abandon stereotypes about mental or (more specifically) personality disorders and become more content with themselves.

Psychoeducation aims to increase the audience's understanding of the disorder, strengthen hope for change, and point out that millions worldwide suffer from a similar disorder and that most of them find a way to control the symptoms and consequences of the disorder. Through psychoeducation, faith in treatment and compliance with it is strengthened, the risk of relapse is reduced, and the effects of stigmatisation and self-stigmatisation on the patient are mitigated. Psychoeducation programs already showed their effectiveness in decreasing self-stigma in patients with schizophrenia (Ivezić *et al.* 2017; Uchino *et al.* 2012). Recently, promising results were reported by Koivisto *et al.* (2022), who realised a psychoeducational intervention and evaluated five participants with BPD in a one-year follow-up. The findings suggested that good self-compassion and information about the BPD diagnosis are needed. The increased knowledge of symptomatology and other BPD-specific information may not decrease self-stigma and support adaptive identity development. Kindness, empathy, and normalisation must also be part of the process.

DISCUSSION

Most studies have focused on mental health personnel's perceived stigma and stigmatising attitudes, with other facets of the stigma being understudied. The studies generally reported commonly negative attitudes of healthcare professionals towards individuals with BPD (Sansone & Sansone 2013). Some authors conclude that mental health professionals judge and prejudice these individuals more than the general population. Patients with BPD are stigmatised significantly more than patients with other personality disorders. At the same time, persons suffering from this disorder sometimes show maladaptive behaviour in interpersonal relationships, which promotes rejecting reactions in others. The tendency of medical professionals to keep a distance from patients with personality disorder and their premature giving up of efforts to engage in the treatment of patients may be based on the belief that it is difficult to treat or directly untreatable is a natural human reaction to maladaptive behaviour of patients. It is essential to educate and train professionals who will

care for patients with BPD and improve their ability to communicate with these patients (Krawitz 2004, Commons Treloar 2009b, Shanks *et al.* 2011).

Several procedures have proven effective when reducing self-stigma, and combining them is advisable. Changing the life story and the story associated with the mental disorder represents a non-specific effective factor of psychotherapy. We can target and work on increasing adaptability and resistance to prejudices. Psychoeducation also is effective, which should include, in addition to a general introduction to the nature of psychiatry disorders and their treatment, the training of social skills and the optimisation of stress management strategies. Cognitive-behavioural elements of work can be used for this. Especially when treating patients with severe and chronic disorders, it is advisable to involve family members in the treatment process. The self-stigma in BPD presents an understudied topic that requires further research attention.

CONCLUSIONS

The general population and mental health professionals frequently stigmatise people suffering from BPD. As a rule, there is a belief about the incurability of the disorder, the manipulative nature of self-injurious behaviour or other symptoms, and the patient's strengths are overlooked. Negative attitudes of health professionals lead to the marginalisation of patients with BPD within the health care system. Awareness, cognisance, and emotional experiences of being stigmatised are essential factors that influence the daily functioning of individuals with BPD. A closer look at understanding and empathy towards these patients is necessary. That can be helped by greater awareness of stigma and self-stigma, training in therapeutic strategies that support the patients, supervision and increased self-reflection of professionals. Destigmatising efforts must challenge the stigma's primary sources, explicitly clinicians and the general population's lack of understanding of BDP patients. More BPD-specific research on stigma is needed.

ACKNOWLEDGEMENT

The authors have no conflict of interest.

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