AN EXPLORATORY STUDY OF PSYCHOLOGISTS' PERCEPTIONS OF THE PHENOMENON CURRENTLY UNDERSTOOD AS 'BORDERLINE PERSONALITY DISORDER'.

Research article submitted by

Lekha Daya

g18D7339

Research article submitted in partial fulfilment of the requirements of the degree of

Master of Arts in Counselling Psychology

Rhodes University

February 2021

Supervisor: Mr. Alan Fourie

Abstract Word Count: 225

Article Word Count: 5468

ABSTRACT

The phenomenon currently understood as 'borderline personality disorder' (BPD) has been complex and multifaceted since its inception. Previous studies have focused on the validity of The Diagnostic and Statistical Manual of Mental Disorders (DSM) conceptualisation of BPD, aetiologies of BPD, the psychologies of persons diagnosed with BPD, and the gendered nature of BPD. This study aimed to specifically explore South African practising psychologists' perceptions of BPD. Through thematic analysis from a constructivist, post-modern paradigm, this study aimed to explore the perceptions and experiences of practising psychologists on BPD, as well as the usefulness of the DSM in working with BPD in a non-western society such as South Africa (SA). The study sampled two Counselling and two Clinical psychologists practising in the South African context, with exposure to and experience in working with BPD. Collectively, results in this study identified psychologists' perceptions of shortcomings in the usefulness of the DSM's approach to categorising phenomena associated with BPD, and brought attention to a need for further research and attention into the role of psychologists' in the construction of BPD. This study seeks to represent psychologists' practical experiences and perceptions, in an attempt to add contextually relevant findings on the DSM's construction of BPD, and to contribute to challenging the stigma and misunderstanding associated with BPD. Specific practice implications and recommendations for future research are discussed within.

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ACKNOWLEDGMENTS

I express my gratitude to the following:

- To my parents and my brother, for your unwavering support of my career pursuits.
- My family and friends, for consistently believing in me.
- Perishka, for being my ally and cheerleader through every high and low.
- The Rhodes University Counselling and Clinical Psychology Masters cohort of 2018, and my fellow intern psychologists at The University of Johannesburg – for the invaluable role each of you have played in my journey.
- My supervisor, Mr. Alan Fourie, for your guidance, wisdom, and patience throughout the course of this study.
- The participants of this study, for your time, enthusiasm, and candour.
- To those who experience what we currently understand as 'borderline personality disorder', for your resilience.

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SECTION A: JOURNAL SELECTED AND SPECIFICATIONS FOR AUTHORS

Journal Selected

The content and technical requirements of the article are based on those of the *South African Journal of Psychology (SAJP).* The *SAJP* publishes contributions in English from all fields of psychology. Whilst their emphasis is on empirical research, the journal also accepts theoretical and methodological papers, review articles, short communications, book reviews and letters commenting on articles published in the journal. Priority is given to articles relevant to Africa and that address psychological issues of social change and development.

Specifications for Authors

All manuscripts should be written in English and include an abstract of not more than 250 words. New submissions should not exceed 5500 words, including references, tables, figures, etc. the writing must be of a high grammatical standard and follow the technical guidelines provided on the *SAJP* website. The publication guidelines of the American Psychological Association 6th edition (APA 6th) must be followed in the preparation of the manuscript. The text should be double-spaced throughout and with a minimum of 3cm for the left and right-hand margins and 5cm at head and foot. Text should be standard 12-point. For a full copy of the specifications, see Appendix A.

SECTION B: ARTICLE SUBMITTED FOR EXAMINATION

Title of Article, Author and Contact Particulars

An exploratory study of psychologists' perceptions of the phenomenon currently understood as 'borderline personality disorder'.

Author: Lekha Daya

Master of Arts in Counselling Psychology student, Department of Psychology, Rhodes University, P.O. Box 94, Makhanda, 6140, Eastern Cape, South Africa. e-mail: lekha.daya01@gmail.com

Supervisor: Mr Alan Fourie

Senior Lecturer and Program Co-ordinator for Professional Training in Clinical Psychology, Department of Psychology, Rhodes University, P.O. Box 94, Makhanda, 6140, Eastern Cape, South Africa. e-mail: A.fourie@ru.ac.za

AN EXPLORATORY STUDY OF PSYCHOLOGISTS' PERCEPTIONS OF THE PHENOMENON CURRENTLY UNDERSTOOD AS 'BORDERLINE PERSONALITY DISORDER'.[1]

Abstract

The construct of 'borderline personality disorder' (BPD) has been complex and multifaceted since its inception. Previous studies have focused on the validity of The Diagnostic and Statistical Manual of Mental Disorders (DSM)[2] conceptualisation of BPD, aetiologies of BPD, the psychologies of persons diagnosed with BPD, and the gendered nature of BPD. This study aimed to specifically explore South African practising psychologists' perceptions of BPD. Through thematic analysis from a constructivist, post-modern paradigm, this study aimed to explore the perceptions and experiences of practising psychologists on BPD, as well as the usefulness of the DSM in working with BPD in a non-

[1] In this study I will use the term "borderline personality disorder" to refer to the psychiatric diagnosis of borderline personality disorder under the personality disorders category in the DSM-5 (APA, 2013). This term is used for the purpose of general understanding and to identify individuals who have met the DSM-5 diagnostic criteria, bearing in mind that it is this term that is under debate. For the purposes of this research, I use the term here descriptively and synonymously with "borderline symptomology", maintaining awareness that the use of professionally clinical terms such as "borderline PD" and "PD" are controversial and hold medical connotations that perpetuate stigmatisation of the experiences of clients (Aviram, Brodsky and Stanley, 2006).

[2] The "DSM' utilised in this study is in reference to the current DSM-5 (APA, 2013) as well as historical developments of previous DSM revisions in relation to BPD.

western society such as South Africa (SA). The study sampled two Counselling and two Clinical psychologists practising in the South African context, with exposure to and experience in working with BPD. Collectively, results in this study identified psychologists' perceptions of shortcomings in the usefulness of the DSM's approach to categorising phenomena associated with BPD, and brought attention to a need for further research and attention into the role of psychologists' in the construction of BPD. This study seeks to represent psychologists' practical experiences and perceptions, in an attempt to add contextually relevant findings on the DSM's construction of BPD, and to contribute to challenging the stigma and misunderstanding associated with BPD. Specific practice implications and recommendations for future research are discussed within.

Keywords: borderline personality disorder, borderline symptomology, diagnosis, withdrawal, practitioners.

The phenomenon currently understood as borderline personality disorder (BPD) is a serious (Lieb et. al, 2004) and common clinical presentation in contemporary mental health treatment settings (Hengartner, 2015), with a characteristic pervasive and enduring pattern of instability in affect regulation, impulse control, interpersonal relationships, and self-image

(APA, 2013). BPD is one of the most researched of psychiatric disorders, and the most researched personality disorder (Gunderson, 2009). Due to substantial treatment use, persons diagnosed with BPD[3] require more mental-health resources than do individuals with other psychiatric disorders (Hersh, 2008), which warrants public health attention (Suliman, Stein, Williams & Seedat, 2008). Factors such as hypersensitivity, sudden shifts in emotion, and affective dysregulation experienced by clients can make treatment a complex process and have brought attention to the psychotherapeutic aspects of BPD (Hoffman, 2007). Studies have focused on understanding psychologists' experiences of BPD (Liebman & Burnette, 2013; Aviram, Brodsky & Stanley, 2006), but further research is required, particularly related to the context of SA (Elphick, 2008).

The inclusion of BPD as an identifiable category by the DSM, *Third Revision* (DSM-III) seems to be marked by the prominence of biological psychiatry in the 1980s (Gunderson, 2009) and the decline of psychoanalysis and a psychosocial perspective (McWilliams, 2011). Much of the literature pertaining to BPD highlights widespread misunderstandings (Hoffman, 2007). As an example, the polythetic criteria required for a DSM diagnosis of BPD results in over 256 different ways for BPD to present (Bateman & Fonagy, 2004). Further, there are high rates of co-occurrence of BPD with anxiety disorders, mood disorders,

[3] The use of the term "patient" is largely omitted in this study and is replaced with "client" or "persons diagnosed with borderline personality disorder".

post-traumatic stress disorder, eating disorders and substance abuse (Cartwright, 2008) with symptom overlap, which makes accurate diagnosis challenging (Hersh, 2008). The literature highlights a tendency to train practitioners to focus on symptoms and interventions to reduce symptoms (Paris, 2014). Such a focus seems to obscure understanding personality on a biopsychosocial level (McWilliams, 2011).

The Psychodynamic Diagnostic Manual (PDM) and its successor the PDM-2 (Lingardi & McWilliams, 2017) stands in contrast to biomedical models, with aims to add a person-centred perspective to the conceptualisation and classification of psychological dysfunction (Bornstein, 2018). Furthermore, the PDM-2 follows Kernberg's (1967) understanding of discriminating between borderline personality *organisation* and borderline personality *disorder*, and thus defines personality by inferred internal dynamics rather than externally observable traits (McWilliams, 2011).

It is important to highlight that one of the primary purposes of classification systems in mental health has historically been to provide concepts useful for treatment planning and intervention, however, the personality disorders section of the DSM has been critiqued for lacking clinical utility (McWilliams, 2011). For instance, one could qualify for a BPD diagnosis by meeting five symptom criteria of the DSM-5 that reflect milder presentations of borderline symptomology, where another might qualify for a smaller number of more severe

symptoms, but not meet the threshold for formal diagnosis (Bornstein, 2011). As such, the DSM lacks sensitivity to how borderline symptomology could be differentially weighted according to associated degree of impairment or dysfunction (Bornstein, 2011).

It was recommended by the consultants of the DSM-5 Personality and Personality Disorders Work Group (PPDWG) that an amalgam dimensional-categorical system of classification (Bornstein, 2011) be employed to provide a more valid representation of personality challenges for both therapeutic and non-therapeutic purposes (Huprich & Bornstein, 2007). The decision to reject these recommendations was thought to be influenced by the longstanding notion that valid diagnoses in psychiatry need to meet certain criteria originally proposed by Robins and Guze in 1970 (Paris, 2005). Some of these criteria emphasised bio-behavioral factors, with little reference to clinically significant criteria such as differences in treatment response (Morey & Benson, 2016). It has been suggested that further research should be carried out on psychological, biological, and social aetiological factors alongside a focus on development, longitudinal course, and treatment (Paris, 2005).

Aetiologies of BPD are multidimensional, with several interacting factors (Bornstein, 2011). Prominent diathesis–stress theories highlight the interaction between a child's genetic vulnerability and harsh invalidating family environments (Gunderson & Lyons-Ruth, 2008; Linehan, 1993), the latter viewed as a key aetiological factor of BPD in Linehan's (1993)

Dialectical Behaviour Therapy (DBT), which has been noted as one of the most empirically valid treatments for BPD (Lieb at al., 2004). Important factors in the development of BPD include but are not limited to an insecure base (Bateman & Fonagy, 2004), attachment trauma (Levy, 2005), neurobiology and genetics (Lieb et al., 2004) and complex trauma (Herman, 1992). A common factor in the outcomes of change from psychotherapy is the strength of the therapeutic relationship and the way client and practitioner interact (Liebman & Burnette, 2013). It has been argued that persons diagnosed with BPD appear more likely than individuals with other psychiatric diagnoses to evoke negative therapist reactions, which can be unsettling for practitioners (Hersh, 2008), and can impact treatment (Liebman & Burnette, 2013). Markham (2003) found a greater likelihood of therapists 'distancing themselves' from clients diagnosed with BPD in comparison to major depressive disorder and schizophrenia. Socio-cultural and extra familial factors are also thought to be contributing factors in the development of borderline symptomology (Paris, 1996).

Within the South African context there are unique characteristics which differ from the contexts within which diagnostic tools such as the DSM were developed (Elphick, 2008). Different personality syndromes appear more prevalent in different cultures, suggesting a relativity associated with personality disorder diagnoses (Millon, 2000). Research conducted suggests that socio-cultural factors (Selby & Joiner, 2008) such as strong family ties,

community resources and extended family networks, are protective factors in the development of BPD (Paris, 1996). Furthermore, the accuracy of reported psychological risk factors in the development of personality challenges might be mediated by various cultural factors that encourage the expression of emotion (Paris, 1996).

In a global survey of nearly 5000 psychiatrists in 44 countries, only 23% stated using the DSM for diagnostic classification in clinical practice, and 70% reported using The International Classification of Diseases (ICD) (Burns, 2013), which raises questions on the widespread use of the DSM in SA.

Research Questions and Aims

The overarching aim of this research was to critically investigate South African practising psychologists' perceptions of the phenomenon currently understood as BPD. Principally, the study focused on the following main objectives:

a) To explore in what way are current diagnostic constructions helpful (or not) in working with BPD?
b) To explore in what way current diagnostic constructions encapsulate (or not) the lived experiences of individuals diagnosed with BPD?
c) To explore what changes might be needed for the South African context?

Theoretical Framework

This study was theoretically grounded in a post-modern, constructivist paradigm. This suggests that there are numerous versions of social reality (Willig, 2013). Therefore, information gathered is regarded as accounts of reality, so that the foregrounded issue is one of the integrities of those accounts rather than whether they are correct or incorrect in any total sense (Bryman, 2012). Research from this perspective is concerned with finding the various ways of constructing social reality that are available in a culture, to discover the circumstances of their use and to trace their consequences for human experience and social practice (Willig, 2013). Analysis therefore focused on deconstructing the phenomenon of BPD to better understand the perceptions of practicing psychologists in relation to it.

Methods

Study Design

This study was executed using an explorative qualitative approach. Open-ended questions guided the gathering of experiential data. With a scarcity of academic research in SA regarding the role of practicing psychologists in relation to BPD, exploratory qualitative research was chosen for its potential of attaining new insights through exploration of phenomena (Terre Blanche, Durrheim & Painter, 2006).

Sample

The study made use of purposive, non-probability sampling and snowballing (Bless, Higson-Smith, & Sithole, 2001), and participants (P1 – P4) of the study were identified within a collegial network. To direct sampling, inclusion/exclusion criteria of Counselling and Clinical psychologists were as follows: (1) Registered with the Health Professions Council of South Africa (HPCSA); (2) currently operating as a practitioner with a minimum of five years of experience; and (3) experience of working therapeutically with persons diagnosed with BPD or exhibiting borderline symptomology. The registration categories of Counselling (P1 & P2) and Clinical (P3 & P4) psychologists were included as these two categories commonly work with BPD in a psychotherapeutic capacity. The final sample included two male and two female participants, from a range of racial and cultural backgrounds falling under the categories of 'Black African', 'White' and 'South African Indian/Asian'. The sample size was determined by the scope of the study so that allowance could be made for sufficient in-depth engagement with each participant (Bless, Higson-Smith, & Sithole, 2001).

Ethical Considerations

Ethical approval was granted by the Rhodes University Ethical Standards Committee (RUESC) – Human Ethics (HE) sub-committee. This study involved human participants and

was therefore marked at a level of 'moderate' risk. The privacy and anonymity of participants were protected by excluding their names, locations, and any further identifying information.

Data Collection

Face-to-face, semi-structured interviews were guided by an interview schedule of five questions, which allowed the researcher to cover themes that were aligned to the purpose of the study (Terre Blanche, Durrheim & Painter, 2006). Questions in the interview schedule matched the principle aim and corresponding objectives of the study and were facilitated through one-on-one interviews averaging 45 - 90 minutes. The means of data collection also created room for flexibility to explore different avenues of insight that arose during the interviews (Terre Blanche, Durrheim & Painter, 2006).

Data Analysis

Once the interviews were transcribed *verbatim*, Braun and Clarke's (2006) six phases of data analysis were utilised, which has been noted for its adaptability, and providing a rich and detailed, yet complex account of data (Braun & Clarke, 2006). NVivo 12 qualitative data analysis software was used to arrange the data into initial codes. Possible issues of proceduralism with thematic analysis (Braun & Clarke, 2006) was managed by coding and analysing data recursively, through software as well as manually in a research journal. Data were understood reflexively, utilising a reflexive journal and through reviewing analytical

processes, interpretative bias, and positionality within supervision (Willig & Stainton Rogers, 2017).

Results

The analysis of data yielded three main themes namely, 'withdrawal from the use of diagnostic frameworks', **'**implications of withdrawing from diagnostic frameworks on practitioners' work with BPD symptomatology', and **'**withdrawal, adaptations and diagnostic frameworks'. Themes were found to be relevant due to frequency and cross-participant agreement. These most relevant themes and subthemes are reported on here together with representative extracts:

Theme 1: Withdrawal from the use of diagnostic frameworks.

Participants mentioned withdrawing from diagnostic frameworks, particularly the DSM, they no longer see value in as practising psychologists. The factors associated with this withdrawal are grouped into three subthemes.

The value placed on diagnostic frameworks during professional training versus practice. Two participants highlighted the initial value they placed on the DSM during their professional training, which aided trainees to categorise an individual's presentation.

Through work experience these participants endeavoured to further their understanding of the *person*, and found the DSM and its taxonomy to be unhelpful in this regard:

> P4: The move to DSM III was the move away from a psychoanalytical approach to a more biological, psychiatric movement, so that you could just see the client and look at their behaviours and not make inferences about why they were doing that […] then that *absolutely* minimises internal experience.

> P3: But there are other points where me thinking in that fashion [diagnostically] has allowed me to understand the person better. But I've tended to think less diagnostically […] it just obscures the person for me […] therapy is about getting to know a person and their idiosyncrasies rather than fitting them into a diagnostic category.

BPD as a diagnostic category and stigma. Participants highlighted the stigmatisation of persons diagnosed with BPD by mental health practitioners and through the discourses surrounding the DSM categorisation of BPD. The impact that this has had on how participants themselves view the person has also contributed to their devaluation of the DSM:

> P3: They don't always get the empathy that they might require at times because you've already got this idea in your mind that this person is going to be quite time consuming, and won't be an easy type of client […] it [the BPD diagnostic category] has not really been helpful and that makes it hard.

BPD and the context of South Africa. In exploring how the DSM encapsulates experiences of BPD within the context of SA, participants stressed the importance of not

only acknowledging culture but also acting to incorporate different approaches into practice:

> P2: This person [sangoma] has never even seen a door of Grade 12 and is able to treat a person you have seen for months in therapy who you were unable to treat. And they make use of traditional, indigenous, spirit-related therapies […] how would I be able to actually get to the bottom of my client, if I don't understand such?

> P4: SA particularly with migrant working, we have higher rates of disorganised attachment than the average rates of any western country. And I think that's part of why we see so much pathology […] and I think that's about history and about real attachment problems. […] that's part of the legacy of apartheid and of migrant labour, and colonialism, there are very traumatised people in SA with very fractured personalities.

Theme 2: Implications of withdrawing from diagnostic frameworks on practitioners' work with BPD symptomatology.

The aspects alluded to by practitioners are grouped into two subthemes:

The challenges in understanding and engaging with borderline symptomology. Two of the participants spoke to challenges of a trial-and-error approach when working with BPD:

> P3: It is difficult because people understand BPD very differently […] And that doesn't necessarily mean the person has borderline personality *disorder,* which makes it hard to say what it is. […] if somebody doesn't understand what is going on with this person, maybe they will lump them into the BPD category, I don't know.

P1: It's because when people are confused, when they see symptomology of certain things, they'll choose the one that more or less fits. Because it's easiest. […] And so BPD is the one that's most spoken about because it covers so many areas.

In adapting to withdrawal from the DSM, participants alluded to experiencing anxiety and insecurity on a professional level around diagnosing and misdiagnosing more complex client presentations. Challenges experienced were often minimised or negated because of a need to cope independently:

P1: psychologists are too afraid to trust themselves. They are too afraid that there's something going on here that I don't understand but it's definitely borderline so it must be x, y, and z. Okay so y and z are missing, but really, x is there so it must be this. Because then it gives a sense of comfort. And there is performance anxiety.

P3: there's probably a tendency maybe with this population [psychologists] to think you can do it all, you can make a diagnosis or at least treat the person without knowing exactly what's happening with them from a personality standpoint.

A lack of collegial discussion and transparency of how practicing psychologists are working with more complex cases. The excerpt below alluded to a tendency to work in silos and perhaps too independently:

P2: We need to but don't always document, put into writing, our own experiences as psychologists, so that it becomes a bible of our experience, something that people can reference.

Theme 3: Withdrawal, adaptations and diagnostic frameworks.

Despite professional uncertainty at times, participants have navigated the complex transition from training into practice and have turned to alternate frameworks that better explain the phenomenon of BPD for them. This theme is grouped into two subthemes:

Professional training programmes for psychology and diagnostic frameworks.

Participants spoke to the need for training programs to include a more nuanced approach to working with BPD, and the need to impart on psychology students a critical stance towards the DSM, prior to professional training of psychologists:

P4: as we understand more about nuance, it [DSM] becomes less useful. There needs to be a more nuanced training around personality. In general, from undergrad to masters, to move away from a reliance on DSM, to have critical thinking about it.

P1: The universities do not give us enough when working with personality issues. Once you've done your training, you should be finding another way […] You owe it to yourself and to your clients to be looking at the picture differently.

In a further comment a participant speaks to the importance of training on BPD for *all* psychologists who work therapeutically. Her view is supported through her professional experience of interconnected discourses between clinical psychology, psychiatry, and the DSM:

P4: one of my very strong views is that scope of practice is used to divide, manage, and control. To stop seeing personality pathology as clinical, where it is actually so pervasive in

our society, that every psychologist must be able to deal with it, and to be able to work long term with people who have borderline personality issues. Which will also aid in de-stigmatising.

Diagnostic frameworks, personal reflections, and practice. Participants advocated for exercising personal agency, multicultural competency, and autonomous thinking to navigate through the complexity associated with the presentation of borderline phenomena:

P2: When I talk to M1's [student psychologists], I know you've got all of this knowledge now, which is good. But don't underestimate your *own* experience when starting to work with people […] Can you consider other school of thoughts when you do your diagnosis, when you do your treatment with borderline? […] Is there one way of doing things? No.

In exploring what participants have been utilising in their professional work with BPD, and what they suggest could be useful for others, ideas were presented for improving understanding and working with BPD:

P3: I think we probably need to use diagnostic tools. I think if someone is struggling, they need to maybe bring in a family member or a partner and get some collateral information.

P3: I do like the newer [DSM-5 Section III] proposed system of looking at it [BPD] on a spectrum, how severe are the symptoms that present, how much of impairment it's creating and looking at it in terms of, not ticking off impulsivity, feelings of emptiness, or, rapidly shifting mood, or whatever. I do not find that very helpful.

P4: Nancy McWilliams makes sense to me […] that borderline-ness is *not* a personality disorder in itself, it's a level of functioning […] your defences are characterised by an absence of higher order defences, and a predominance of primitive defences like splitting, projection, projective identification.

Discussion

In SA, practicing Counselling and Clinical psychologists are key agents in working with persons diagnosed with BPD. There are considerable challenges faced by practitioners in working with BPD, but despite challenges faced, participants have devised ways of reframing BPD to meet their clients' needs. Findings suggest that, due to the categorical approach of the DSM, and the heterogeneity of BPD, practicing psychologists have withdrawn from using the DSM as a guiding framework in their assessment and treatment of BPD. Participants have instead turned to alternate frameworks they deem as inclusive of aetiological factors in the development of borderline symptomology. This aligns with a more humanistic, non-pathologising approach (McWilliams, 2011; Herman, 1992) in the treatment of BPD. Although it is the aim of the DSM to aid in the identification rather than treatment of symptoms and symptom clusters (APA, 2013), treatment is understood as being dependent upon the identification of a disorder, which has been taught to South African psychologists in professional training through the DSM (Elphick, 2008).

Preference for alternate frameworks are aligned with Linehan's (1993) suggestion that the heterogeneity of the population referred to as 'borderline' has called for other conceptual systems to understand behavioural syndromes and aetiologies associated with the term. Findings from this study point to preferences for conceptualisations of BPD (Kernberg,

1967, Herman, 1992, Linehan, 1993), which move away from the symptom focused (Lingiardi & McWilliams, 2017), and nomothetic conceptualisation (McWilliams, 2011) of the DSM. One participant specifically utilises the PDM-2 (Lingiardi & McWilliams, 2017) in her work with BPD and has highlighted the usefulness of this framework. Other participants' preferences in approach to BPD align with the person-centered, dynamic approach of the PDM-2.

Findings from this study support current developments for re-conceptualising diagnosis, such as the DSM-5 PPDWG's suggestions for a hybrid, categorical-dimensional model of personality disorders. These findings are consistent with findings from Morey and Benson (2016) that indicate the constructs of this model may provide more clinically useful information for treatment planning than the official personality disorder nomenclature reserved in DSM-5 Section II. In considering the move toward dimensional models, it is often difficult for practitioners to imagine discussing and diagnosing a personality disorder without using a categorical label that illustrates the problem accurately (Huprich & Bornstein, 2007). This notion speaks to the uneasiness and difficulty participants in this study have experienced in diagnosing and treating BPD. Findings from this study are aligned with intense therapist reactions (Lingiardi and McWilliams, 2017), internal tensions and threats to professional identity and competency that might arise for psychologists treating BPD, modifying

treatment, and having to trust in their own abilities as practitioners (Hinshelwood, 1999). Consistent with one participant's recommendation, careful clinical assessment of BPD and possible co-occurring diagnoses is important at the beginning of a client's treatment, and semi-structured diagnostic interviews are becoming more usual (Lieb et al., 2004).

All participants in this study noted the stigma associated with the BPD diagnosis as a factor inextricably linked to their perceptions and experiences. McWilliams (2011) suggests that diagnostic practices that position human vulnerabilities as distinct disorders perhaps contribute to a sense of distancing from internal experience and potentiate less empathic identification (Markham, 2003) with those who are diagnosed with BPD. This notion is aligned with findings from this study which draw attention to larger discourses of stigma, and internalised stigma by practitioners toward persons diagnosed with BPD who are help-seeking.

Participants highlighted the prevalence of borderline symptomology outside traditional psychiatric settings, based on various settings they draw their current clients from. This supports a participant's suggestion that all categories of psychologists who provide psychotherapy should be trained and equipped on the nuance and complexity associated with BPD and other personality-related challenges. The largest survey to offer epidemiological data on personality disorders in SA has shown that less than one fifth of those with a possible

personality disorder diagnosis had received treatment for a mental health problem in the year preceding the study, and those who had received treatment had done so through general medical providers rather than from mental healthcare providers (Suliman et al., 2008). These findings highlight a need for further research into the social and contextual factors in the phenomenology of BPD and service utilisation, treatment, and ways of delivering treatment.

Debates on the cultural appropriateness of the DSM (Burns, 2013) are aligned with participants' views on what might differentiate the development and prognosis of BPD in SA from other populations. It became especially important to participants to understand cultural representations of borderline features, especially if diagnosis is meant to inform treatment. As an example, adopting an inclusive understanding to variations in child-rearing in traditional African contexts, such as SA, becomes important in understanding the role of attachment in SA (Tomlinson et al., 2005; Millon, 2000).

Incorporating spiritually oriented therapies also became an important factor for two participants of this study, through suggestions that these approaches might be helpful in the treatment of BPD. These findings are supported through advocacy not simply for cultural sensitivity, but for further research and application of spiritually and indigenously oriented therapy (Sperry, 2012).

This study has raised questions around the potential dangers of psychologists not sharing experiences with colleagues of the management of complex cases such as BPD. Working too independently might be influenced by uncertainty, a potential lack of support, performance and competence anxiety, and the complexity attached to working with persons diagnosed with BPD (Linehan et al., 2000). There is a correlation between the independence identified in this study, and findings from Hitge and Van Schalkwyk's (2017) study on South African psychologists' wellbeing, which found that the issue of isolation and effective management of negative therapist reactions needed further investigation. Results support findings that place practitioners' personal reactions in direct relation to their level of empathy toward persons diagnosed with BPD and raise questions on the potential of stigma as an independent factor impacting treatment outcomes (Aviram, Brodsky & Stanley, 2006; Markham, 2003).

Despite the challenges treating practitioners face, findings from this study around the treatment of BPD signal positive developments, where the requirements necessary for successful treatments are more available in the current age (Paris, 2005). While there is good evidence for the efficacy of psychotherapy for BPD (Zanarini et al., 2003), not every clinical setting today has the human resources to provide this service (Paris, 2005).

Conclusion

This research sheds light on the diagnostic construction and discourses surrounding BPD from practising psychologists who have undergone psychology training and practice in SA. The current study contributes to literature on BPD as it highlights practitioners' withdrawal from utilising the DSM in working with BPD, and the importance placed by practitioners on contextual-specific diagnosis, conceptualisation, and treatment of BPD. These findings have bearing on current debates of the applicability of the DSM conceptualisation of BPD, and the relevance of this conceptualisation for practising psychologists in South Africa. Results suggest that practitioners' attitudes towards persons diagnosed with BPD and the diagnostic category are based on their assessments of the complexity of their clients and the dynamic interaction between both client and practitioner (Liebman & Burnette, 2013). Educational programs should be tailored to address these factors. For example, trainees may benefit from more specialised academic and practical training to address burnout, increase competence, and facilitate awareness of internal reactions to clients. Similarly, a thorough assessment of the strategies used by experienced psychologists to mitigate negative reactions toward clients might be an aid for less experienced practitioners who have been shown to experience more challenges in this regard (Liebman & Burnette, 2013; Linehan et al., 2000).

Limitations

The following main limitations to this study are noted. Firstly, given the scope of the study the sample size was limited. A larger number of participants could have provided a greater range of insight into the focus of the study. Secondly, all the participants were psychologists in private practice. Psychologists practising in a variety of settings could have yielded a greater range of experiences. Lastly, despite demographic diversity (race, culture, gender, age, linguistic) in the participant sample for this study, this study does not claim to be representative, but rather aims to elicit and examine diverse views on BPD.

Practice Implications and Recommendations for Future Research

Despite these limitations, the current study provided insight into practitioner's perceptions of BPD and has prompted the following recommendations:

Careful consideration needs to be given to the diagnostic-specific content of Psychology curricula which forms part of professional training. It is recommended that greater emphasis be placed on the potential of idiosyncrasies getting lost within diagnostic categories. Guidance and education on how this could be navigated as a psychologist is suggested.

Further research on practitioners' experiences in working in isolation with BPD and other complex cases and the impact of this on clients and practitioners is recommended.

Finally, findings from this study comment on the extent to which the professional community of psychologists in private practice are already engaging with more contextual-specific understandings and practices, and the extent to which further research should be undertaken to determine this change in practice, within a broader sample of this professional community in South Africa.

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