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## YOU CALL US TREATMENT RESISTANT: THE EFFECTS OF BIASES ON WOMEN WITH BORDERLINE PERSONALITY DISORDER

Cassidy Acosta

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YOU CALL US TREATMENT RESISTANT: THE EFFECTS OF BIASES ON  
WOMEN WITH BORDERLINE PERSONALITY DISORDER

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A Project  
Presented to the  
Faculty of  
California State University,  
San Bernardino

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In Partial Fulfillment  
of the Requirements for the Degree  
Master of Social Work

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by  
Cassidy Jack Acosta

May 2023

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May 2023

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## ABSTRACT

This study explored how negative attitudes toward and discriminatory practices against women with Borderline Personality Disorder (BPD) affect them and impact their treatment. The study adopted a constructivist paradigm, and data was collected via virtual interviews with research partners (i.e., women with BPD) who use online mental health forums. A final construction was established after the data was interpreted. Ultimately, it was determined that women with BPD face stigma and are described as treatment resistant; however, by providing a supportive treatment environment, women with this diagnosis see positive outcomes. The results of the study are intended to support women with BPD by addressing the discrimination they face while also encouraging clinicians to challenge the biases they hold against people with the disorder. Adjustments made in clinical settings due to the study's findings could provide better treatment outcomes for people with BPD.

## ACKNOWLEDGEMENTS

I would like to acknowledge my research advisor and research professor, who gave me the opportunity to pursue a project near to my heart. I would also like to thank my late mother – although she may have been the catalyst for my own borderline diagnosis, I would not be here without her. But, more than anyone, I thank the love of my life, my wife, for believing in me and inspiring me to pursue something better for myself.

## DEDICATION

This study is dedicated to the research participants brave enough to tell their stories. It is dedicated to every woman with Borderline Personality Disorder who has been told she is too crazy or not crazy enough – you deserved better. We deserved better.

## TABLE OF CONTENTS

ABSTRACT .....	iii
ACKNOWLEDGEMENTS.....	iv
CHAPTER ONE: ASSESSMENT .....	1
Introduction.....	1
Research Statement .....	1
Paradigm and Rationale for Chosen Paradigm.....	2
Literature Review.....	4
Prevalence .....	5
Causes.....	6
Consequences .....	7
Interventions and Preventions.....	9
Conclusion .....	10
Theoretical Orientation.....	11
Potential Contribution of the Study to Micro and Macro Social Work Practice.....	13
Summary .....	14
CHAPTER TWO: ENGAGEMENT.....	15
Introduction.....	15
Study Site .....	15
Engagement Strategies for Gatekeepers at Research Site .....	17
Self-Preparation.....	18
Diversity Issues.....	20
Ethical Issues.....	21



Political Issues .....	22
The Role of Technology .....	23
Summary .....	24
CHAPTER THREE: IMPLEMENTATION .....	25
Introduction .....	25
Study Participants .....	25
Selection of Participants .....	26
Data Gathering .....	27
Phases of Data Collection.....	28
Data Recording.....	29
Data Analysis.....	30
Summary .....	31
CHAPTER: FOUR EVALUATION.....	32
Introduction .....	32
Data Analysis.....	32
Participants .....	32
Data Collection.....	32
Developing Constructions .....	34
Data Interpretation .....	34
Stigma and Bias Associated with a BPD Diagnosis .....	34
Importance of Supportive Treatment.....	39
Final Construction and Discussion .....	42
Limitations.....	45
Implication of Findings for Micro and Macro Practice .....	46

Summary .....	47
CHAPTER FIVE: TERMINATION AND FOLLOW UP .....	48
Introduction .....	48
Termination of Study .....	48
Communication of Findings and Dissemination Plan .....	49
Ongoing Relationship with Study Participants .....	49
APPENDIX A INFORMED CONSENT .....	51
APPENDIX B PRE-SCREENING SURVEY .....	54
APPENDIX C SAMPLE INTERVIEW QUESTIONS .....	56
APPENDIX D SAMPLE DEBRIEF .....	58
APPENDIX E INSTITUTIONAL REVIEW BOARD LETTER OF APPROVAL.....	60
REFERENCES .....	63

## CHAPTER ONE

### ASSESSMENT

#### Introduction

This chapter provides an overview of the study's research statement, chosen paradigm, literature review, theoretical frameworks, and contribution to social work practice. This research project explored the ways in which harmful beliefs and actions affect women with Borderline Personality Disorder (BPD). The study used a constructivist paradigm to approach the research statement and applied the Social Constructionist Theory, Feminist Theory, and Person-in-Environment Perspective as theoretical frameworks. Additionally, this study filled a gap in research and contributed to both micro and macro social work practice by offering a voice to women with BPD and acknowledging the need for further educational opportunities for social workers.

#### Research Statement

A professional acquaintance once said that I could not have BPD because I had not attempted to drink battery acid. This stereotype and others like it are often expressed by clinicians, family members, and the general society. Women with BPD are considered manipulative, difficult, and treatment-resistant (Black et al., 2011; Potter, 2006). Often, family members experience negative feelings toward their loved ones with the diagnosis (Lawn & McMahon, 2015), and many clinicians would prefer not to work with clients who have BPD (Black et al., 2011).

This raises important questions about the consequences of negative attitudes toward and discriminatory practices against women with BPD. Do those with the diagnosis internalize these stereotypes? Do they impact treatment outcomes or increase symptomology? How do women with BPD feel about these stereotypes?

The current literature explores the attitudes of those who interact with women with BPD (i.e., clinicians, nurses, family members, etc.) but rarely examines this from the opposite viewpoint. Thus, this research provided a different perspective by exploring the thoughts, behaviors, and emotions of women with a BPD diagnosis, the key informants in this study. This research provided a voice to the women with the diagnosis by allowing them to share their experiences. Therefore, the purpose of this research was to explore how negative attitudes, biases, and discriminatory practices affect women with BPD.

#### Paradigm and Rationale for Chosen Paradigm

This study was conducted using the constructivist paradigm. Constructivism assumes that the researcher, as an observer, works in collaboration with research partners or participants and develops a collaborative process to form conclusions (Morris, 2013). Reality is subjective within constructivism, and data is gathered through individual interpretations that are everchanging, also known as a hermeneutic dialect (Morris, 2013). Additionally, constructivism argues that the authentic human experience that forms this paradigm's data collection is unique to its time and place, and it acknowledges

that biases exist among researchers and participants alike and, therefore, will impact research regardless of the paradigm (Morris, 2013).

Constructivism lends itself to research about exploring the lives of individuals experiencing mental illness because these individuals may empathize with the idea of subjective realities. Women with BPD, for example, may experience “imagined” abandonment and, therefore, may relate to the idea that realities can differ depending on the situation surrounding them (who they are speaking with, at what time of day, etc.). Furthermore, this research was intended to understand how discrimination affects women with BPD, so interviews with women who have this diagnosis were imperative to the study. It was crucial, then, to include these women as active participants, and constructivism welcomes this approach by using qualitative research methods, such as observations and interviews. Ultimately, the constructivist paradigm allowed both researcher and research partners to understand that the experiences collected as data may not apply in all situations to all people at all times.

Furthermore, the constructivist paradigm encourages research participants to interpret their own data and create an action plan to address the issues that surfaced during the study (Morris, 2013). Assuming that the beliefs and behaviors of clinicians, family members, and the general public affect women with BPD negatively, there are potential actions that the research partners could engage in to address these concerns. This could include an agreement between

women with BPD and treatment providers to better their relationships. In this case, service providers may realize how their biases impact both women with BPD and their treatment plans and challenge their beliefs. On the other hand, women with BPD may decide to strengthen their assertiveness skills to directly address the mistreatment they receive from clinicians and family members. Regardless of the actions taken, the decision to move forward with any of them will be determined in partnership with the research participants (Morris, 2013).

### Literature Review

BPD, although one of the most researched personality disorders, is still largely understudied compared to other mental illnesses. BPD is a mental illness characterized by emotional and dramatic behaviors, including a “pervasive pattern of instability in affect regulation, impulse control, interpersonal relationships, and self-image” (Lieb et al., 2004, p. 453). BPD symptoms tend to be unstable and lead to remission for hospitalization; suicide mortality rates among those with BPD are estimated to be between 9% and 10% (Lieb et al., 2004). The trauma related to and symptomology of BPD can lead to poor treatment outcomes as well (Lieb et al., 2004). With this understanding of the disorder, it may be unsurprising that mental health clinicians, nurses, and family members find individuals with the disorder to be “difficult.” However, these negative attitudes can lead to negative consequences for individuals with BPD. It is necessary, then, to examine the multiple perceptions of BPD. This literature review will further explore the prevalence, causes, and consequences of negative

attitudes held by clinicians and family members, as well as the current interventions and preventions available to challenge these negative beliefs.

### Prevalence

The current literature estimates that between 0.5% and 3.9% of the United States population have BPD (Lenzenweger, 2008). However, the prevalence fluctuates often between epidemiological and clinical studies. For example, when using the National Comorbidity Survey Replication, Lenzenweger (2008) found that BPD had a national prevalence of 1.4%. On the other hand, Grant and colleagues (2008) found the prevalence of BPD to be 5.9% of the population.

Despite BPD being less prevalent than other diagnoses, it has been singled out by clinicians and nurses as a difficult disorder to work with (Black et al., 2011; Woollaston & Hixenbaugh, 2008). Black and colleagues (2011) surveyed 706 mental health clinicians – including psychiatrists, social workers, psychologists, and nurses – and found that they primarily hold negative attitudes towards individuals with BPD, with 47% preferring not to work with individuals with this diagnosis. This research has been supported in other studies as well. Indeed, in both Australia (Bodner et al., 2011) and Ireland (James & Cowman, 2007), 80% of mental health clinicians surveyed found this population more challenging to work with. In Israel, nurses and psychiatrists were more likely to report negative attitudes toward individuals with BPD (Bodner et al., 2015). Further research supports nurses' attitudes specifically. Woollaston & Hixenbaugh (2008) stated that nurses perceived individuals with BPD “as a

powerful, dangerous, unrelenting and unstoppable force which leaves a trail of destruction in its wake” (p. 706). These negative views transcend the psychiatric setting as well. Family members also express negative attitudes toward their loved ones with BPD, including despair, regret, humiliation, guilt, and shame (Kay et al., 2018). Thus, negative attitudes are both prominent and common among mental health clinicians, nurses, and family members.

### Causes

The negative attitudes expressed by mental health clinicians and family members alike stem from their perceptions of BPD as a disorder. Research suggests that some symptoms of the disorder, such as suicidal tendencies, create animosity among mental health providers, with some clinicians believing that individuals with BPD are not only difficult but also at fault for their behaviors (Sulzer, 2015). Kay and colleagues (2018) found that family members who experienced their loved ones with BPD display symptoms of the disorder, such as self-dysregulation, were more likely to experience negative feelings toward their relatives due to the interpersonal and marital conflict and financial challenges these symptoms seemed to create.

Moreover, nurses believe that individuals with the diagnosis are more in control of their manipulative behaviors than those with other disorders (Bodner et al., 2011). According to Bodner and colleagues (2011), nurses reported that individuals with BPD were “bad” rather than mentally ill, while Woollaston & Hixenbaugh (2008) found that nurses felt they could not “treat” individuals with



BPD, which led to feelings of disheartenment and frustration. Nurses also reported feeling demonized, manipulated, and threatened by individuals with BPD, which increases negative attitudes toward this population (Woollaston & Hixenbaugh, 2008). In addition, although most mental health clinicians disagree that the treatment prognosis for BPD is hopeless, some clinicians are not optimistic about treatment options (Black et al., 2011). BPD is often considered to be treatment-resistant (Kay et al., 2018), leading to frustration from clinicians and providers. Experience also plays a role in a mental health clinician's attitude toward BPD. The more experience a clinician has in treating individuals with BPD, the more likely they are to express positive attitudes toward the population (Black et al., 2011). In other words, those without experience with the disorder are more likely to hold negative attitudes toward individuals with BPD.

### Consequences

Unsurprisingly, negative attitudes from mental health clinicians, nurses, and family members can lead to consequences for individuals with BPD. Sulzer (2015) describes one of the primary outcomes of these attitudes and beliefs as the passive or active denial of care. Sulzer (2015) goes on to claim that the "refusal of care denies one of the most fundamental sick role rights: access to treatment" (p. 85). Therefore, denial of care ties directly with the perception that individuals with BPD are untreatable. Additionally, the lack of empathy that mental health clinicians, especially nurses, have towards this population leads to the desire not to support individuals with BPD (Black et al., 2011 & Bodner et al.,

2015). Bodner and colleagues (2015) also found that psychiatrists were less likely to admit individuals with BPD to hospitals, decreasing their likelihood of accessing treatment.

Furthermore, the idea that BPD is untreatable may lead some clinicians and providers to be reluctant to diagnose individuals with this disorder. On the other hand, a previous BPD diagnosis may lead to rejection by the current mental health system or other clinicians (Paris, 2007). Clinicians often minimize the severity of symptoms individuals with BPD experience as well, believing them to be manipulative, attention-seeking, and not mentally ill (Sulzer, 2015). When this particular thought pattern is not in play, clinicians argue that BPD is “difficult” to work with, which Sulzer (2015) describes as a code word used by mental health providers to legitimize their dismissal of providing treatment to individuals with BPD. Thus, this population is likely to experience a lack of treatment for their disorder.

Unfortunately, most of the literature explores these consequences from the clinician’s point of view. The limited research available from the perspective of individuals with BPD, however, suggests that women with BPD require specific characteristics from their treatment providers, such as being caring and genuine, capable and competent, and comfortable balancing structure and flexibility (Goldstein, 2020). When these conditions were not met, individuals were more likely to terminate therapy (Goldstein, 2020). Clinicians who hold negative attitudes toward this population may have difficulty meeting these conditions and

may encourage the stigmatization of the disorder, “thereby discouraging further treatment seeking” (Goldstein, 2020, p. 133). Further research is needed to address this gap because, without hearing from the individuals themselves, it is impossible to understand all the consequences associated with the negative attitudes of mental health clinicians, nurses, and family members.

### Interventions and Preventions

Although the current literature has explored the negative attitudes of mental health clinicians, nurses, and family members toward individuals with BPD, it is limited regarding the intervention methods available to combat these perceptions. Shanks and colleagues (2012) found that negative attitudes and beliefs about BPD can be modified through education. Specifically, by attending a presentation on the Systems Training for Emotional Predictability and Problem Solving (STEPPS) treatment program for BPD, clinicians reported feeling more empathy toward individuals with BPD and an increase in desire and competency to work with them (Shanks et al., 2012). Miller and Davenport (1996) found similar findings in nurses. After participating in a self-instructional program on BPD, nurses reported increased knowledge and a different attitude toward individuals with the disorder. The longevity of this education as an intervention has been positive at 6-month follow-ups (Krawitz, 2004; Treolar, 2009), although it depends on the content of the education (Treolar, 2009).

Family members, on the other hand, require their own level of support. According to Lawn and McMahon (2015), family members reported not receiving

adequate education or support from mental health providers. Kay and colleagues (2018) also suggest that family members require more knowledge about BPD from mental health clinicians and skills to empower them to manage their own mental health. A greater understanding of the disorder and an increase in their adaptive coping skills may help family members develop a positive attitude toward their loved ones with BPD.

Even less research has been conducted on preventive measures. In one example, Bowen (2012) explored good practice experiences among mental health clinicians working with BPD and found that an optimistic view toward change and considering complex behaviors as learning opportunities supported good practice. In other words, keeping a positive attitude while providing treatment is more likely to lead to positive outcomes for individuals with BPD, increasing the likelihood that a clinician will view BPD through a positive lens. Surprisingly, no research was found on whether clinicians are taught negative attitudes by their professors or supervisors. Further research is needed to determine whether positive and negative attitudes from professors and supervisors impact student clinicians' attitudes and beliefs.

### Conclusion

The current literature helps determine the prevalence, causes, and consequences of the negative attitudes toward BPD held by mental health clinicians, nurses, and family members. It also allows for a limited investigation into the current intervention and preventive measures to challenge these beliefs.

Ultimately, negative attitudes are prevalent among clinicians and family members, often caused by the “difficult” behaviors that characterize BPD. This most often leads to a denial of care and the inability of individuals with BPD to access treatment. The most common intervention for this issue is to provide education about the disorder to clinicians and family members, while the most common prevention is keeping a positive attitude while providing treatment. However, it is essential to note that almost all the current research explores this from the clinician, nurse, or family member’s perspective. There is a significant gap in the research, one that fails to examine this issue from the viewpoint of the individual with the disorder, those who are directly affected by these negative attitudes and beliefs. Therefore, it is essential to explore the ways in which harmful beliefs and actions affect the experiences of women with BPD. As stated previously in this chapter, this research offered an alternative perspective to the current literature by exploring the thoughts, behaviors, and emotions of the actual women with the disorder.

### Theoretical Orientation

The following theories were used within the study: Social Constructionist Theory, Feminist Theory, and the Person-In-Environment Perspective. Gergen’s Social Constructionist Theory (1985) is “concerned with explicating the processes by which people come to describe, explain, or otherwise account for the world (including themselves) in which they live” (p. 266). Gergen (1985) outlines four assumptions, which focus on the multiple understandings of the

world and examine the ways in which these understandings are impacted and determined by culture, history, and social context (Gergen, 1985). The Social Constructionist Theory provided a framework for this study by examining BPD as a social construct impacted by the diagnosis' history. This theory allowed the researcher and research participants to explore the experiences of women with BPD in a cultural, historical, and social context.

Additionally, the feminist theory was used alongside the Social Constructionist framework. Generally, the feminist theory claims that “women’s oppression [is] rooted in the social structures of patriarchal societies” (Collins, 1986). The feminist theory recognizes and critiques the patriarchy and other class oppressions (e.g., racism, cis/heterosexism, classism, etc.) while also defining a set of values and ideas required for the desired change (Collins, 1986). This study explored women’s experiences and their intersecting identities, such as being a woman with a mental illness. Therefore, feminist theory supported this exploration.

The Person-in-Environment (PIE) Perspective is the final theoretical orientation that impacted this research. PIE “provides a system for sorting out the client’s interpersonal, environmental, mental, and physical health problems” and delivers a comprehensive depiction of an individual’s issue (Karls et al., 1997, p. 49). Additionally, it explores the issues that arise from one’s environment and how these problems affect the individual’s social functioning (Karls et al., 1997). In other words, PIE provides a comprehensive overview of an individual’s

behaviors in the context of their environment. Since this study examined the experiences of women with BPD, it addressed their experiences with their clinicians and family members and explored how these experiences have impacted them overall.

#### Potential Contribution of the Study to Micro and Macro Social Work Practice

As stated above, most of the current literature focuses on identifying the negative attitudes of clinicians and family members and offering suggestions that can impact clinicians' attitudes toward the diagnosis (Black et al., 2011). However, limited research has been conducted on the experiences of individuals with BPD and their perceptions of the discrimination they face. Therefore, this study contributed to a gap in research and directly impacted micro and macro social work practice. This study provided micro social work practice contributions, specifically to the women who have a BPD diagnosis and the clinicians who serve them. It provided a cathartic opportunity for women with the diagnosis to share their stories, express their concerns, and advocate for their desired changes. On the other hand, it may also help provide an avenue for social workers, clinicians, and other professionals to understand how their negative attitudes and discriminatory practices impact their clients with BPD. Additionally, this study contributed to macro social work practice, as it should help create a motivation to develop further education for social workers who will inevitably work with clients with BPD and improve the services provided to these clients.

## Summary

Chapter One reviewed the study's research statement, chosen paradigm, the current literature on the subject, theoretical frameworks, and its contribution to social work. This study researched the consequences of negative attitudes toward and discriminatory practices against women with BPD in order to fill a gap in the current literature, which almost exclusively explores this topic from the perspective of the clinician, nurse, or family member. It used a constructivist paradigm to give voice to the women in the study while also acknowledging that reality is subjective and that the data collected was unique to this research. Additionally, this study used the Social Constructionist Theory, Feminist Theory, and the Person-In-Environment Perspective as its theoretical orientations. It also helped impact both micro and macro social work, as it supported both the women with the diagnosis and the clinicians who serve them while also serving as a motivation to develop further education to help address these issues.



## CHAPTER TWO

### ENGAGEMENT

#### Introduction

This chapter addresses the engagement phase of the research project, an ongoing process throughout the study due to the use of the constructivist paradigm. It discusses the chosen study site, strategies for working with gatekeepers, and how the researcher will prepare for research and data gathering. It also examines issues related to diversity, ethics, and politics and identifies strategies for handling these issues. The chapter ends with a brief overview of how technology will be used throughout the study.

#### Study Site

Due to the nature of this project, it would be difficult to partner with mental health facilities to conduct research. Facilities that serve those with BPD may be hesitant to partner on a research topic that has the possibility of casting them in a negative light. Facility gatekeepers, such as executive, administrative, and clinical staff, may have reservations, believing that a constructivist study may give their patients more agency, which could prove problematic for staff accustomed to a certain type of attitude from their patients. Therefore, this research project was conducted in partnership with individuals found through online public forums.

Online public forums are spaces created by a specific demographic and accessed by that same demographic. While the forums exist as part of larger platforms, including Reddit and Mental Health Forum, the specific forums used in this research project have been created by individuals with BPD for individuals with BPD. There are typically little to no restrictions on who can access online forums. Thus, they serve thousands of individuals with various demographics from around the world. However, the online forums that were used for this research project are accessed mainly by individuals within the U.S.

Furthermore, online forums offer psychoeducation and support groups, and the platform allows individuals to teach each other about beneficial coping strategies and independent living skills. Additionally, some BPD online forums provide a space for family members and friends to engage with one another and discuss their experiences with their loved ones with BPD. However, these sites are not typically monitored or accessed by mental health providers such as psychologists, social workers, and rehabilitation specialists. Instead, online forums have moderators who are not professionals and who are not required to participate in specific trainings to become moderators. Rather, they are volunteers who often have BPD themselves and control what is and is not allowed on the forum. For example, some BPD forums limit conversations around self-diagnosing and self-harm. Moderators also handle concerns regarding harassment and inappropriate posts or discussions occurring on the platform.

## Engagement Strategies for Gatekeepers at Research Site

Moderators on the online forums were the primary gatekeepers for this project. Confidentiality, forum reputation, and research legitimacy were possible concerns for moderators, as they may see the research as a potential scam. Many researchers seek to use mental health forums to gather participants, so forums may also have strict requirements for posting. In this case, a post that seeks research participants may be removed from the forum unless previously approved by the moderators. Additionally, forum users may position themselves as gatekeepers for similar reasons. Forum users may engage with one another more regularly than with moderators and, as such, may be protective of each other. Specifically, they may warn one another if they have reason to believe the research project is not in their best interest or consider it fraudulent activity on the forum.

Thus, gatekeepers – specifically moderators – were engaged before posting on the forum. Moderators often have a specific inbox where they can be reached. These inboxes were used to discuss the study, including the prospective research partners, the study's methods, and its objectives. Some forum moderators did not respond to initial engagement, so the researcher was required to find alternative online public forums and assure different gatekeepers that the research was legitimate and essential. For example, in order to persuade gatekeepers to support this project, it was necessary to explain how the current study can support women with BPD and ensure that research participants will

benefit from participating in the study. On one occasion, self-disclosure was also required to confirm the researcher was an individual with lived experience. Regardless of the forum, moderators also requested that the findings be shared once the study was complete. The researcher agreed to provide a research brief that showcases the findings of the study. Although not needed, the researcher was also prepared to suggest that gatekeepers engage in the study as research participants to better understand what forum users will be participating in.

### Self-Preparation

Self-preparation is vital when using the constructivist paradigm, mainly because of the shared construction produced at the conclusion of the study. Erlandson and colleagues (1993, as cited in Morris, 2013) discuss seven planning categories to be aware of, including planning for engagement, renegotiation with the research site, selecting a sample, data collection, analysis, auditing, and dissemination. This section specifically discusses preparing for data collection and the steps the researcher had to take. Initially, the researcher needed to prepare for potential time constraints. For example, the researcher's full-time employment and field practicum were barriers to availability. Therefore, although observations are often used in constructivism, only interviews were used in this study.

The researcher then reviewed the literature, which detailed the current constructions related to the research statement. This helped to identify potential interview questions. Using a reflective research journal, the researcher also

documented prospective questions, acknowledging that this is the preliminary stage and that interview questions evolved throughout the data gathering process. When new questions arose, the researcher documented them in the journal.

Additionally, it was necessary to understand how online public forums operate and how this could impact potential research partners' interests in participating in the study. For example, did forum users discuss the study amongst themselves? If so, this could have impacted a research participant's responses during the interviews. The researcher also has prior experience working with individuals with severe mental illness, particularly facilitating support groups, which assisted the researcher in navigating the online public forum and research partners. This also helped the researcher play the role of facilitator and data collector, which is necessary when using this paradigm. Therefore, reflection on these past experiences was required for preparation to understand what was effective previously.

Furthermore, interview questions could be triggering to research participants, as discussing experiences with treatment teams and family members can produce negative feelings and memories. Thus, the researcher developed interview questions that did not require participants to disclose details about past distressing scenarios or situations. Participants were reminded throughout the study that they did not have to participate in any part of it that made them uncomfortable and were free to remove themselves from the study at

any time. In addition to preparing language for these situations, the researcher developed procedures to assess for participant distress and implement safety protocols. Although the safety protocols were not used, the researcher conducted a debrief (see Appendix D) at the end of each interview and in the final email communication with participants.

### Diversity Issues

Although this study explored women with BPD, there are still several diversity issues that arose. The study is limited to women who have BPD at a specific research site. The participants did not include many women of color, queer and transgender women, low-income women, or women of varying ages. Even with the online public forums being open to women with BPD with these intersecting identities, they may have been uninterested in participating in the research due to historical abuse in clinical studies (e.g., Tuskegee Syphilis Study). Diversity is crucial when using constructivism since individual experiences can impact constructions. Indeed, if a study only explores the experiences of white women in their twenties with BPD, then the constructions will vary significantly from a study that includes marginalized women of all ages.

The researcher remained aware of any possible interference from gatekeepers to prevent certain marginalized women from participating in the study and was prepared to address them if they occurred as part of the renegotiation process. Regardless of the research partners' varying backgrounds, the researcher acknowledged their own power as the facilitator and

their privileges in the situation, such as their whiteness. Addressing these concerns as they appear and documenting how they impact the study is necessary to maintain dependability and confirmability.

### Ethical Issues

The National Association of Social Workers (NASW) Code of Ethics will be followed to prevent ethical issues within the study. However, possible ethical problems may still arise, including limitations to privacy and confidentiality. Privacy and confidentiality are challenging to maintain in constructivist research due to the paradigm's openness (Morris, 2013). Constructions were shared and may be easily identified by fellow research partners and other key players (Morris, 2013) due to the limited sample size and research site.

Therefore, research participants were made aware of these risks (Morris, 2013) through informed consent, reminders of the right to withdraw from the study, and assurance that no penalties would be given if the individual determined they did not want to participate. See Appendix A for the full Informed Consent document. Additionally, a pre-screening survey (see Appendix B) was developed to limit participation to those who were currently in treatment, had not self-harmed in the past four weeks, and had not been hospitalized in the past six months. The researcher also kept recordings, documentation, and analysis in the cloud service (i.e., Google Drive) provided by California State University, San Bernardino, which includes an additional firewall for security. Generally, constructivist research is everchanging, so any unpredicted situations that arose

were addressed to ensure no harm would come to the research participants (Morris, 2013). Considering Morris' (2013) values – moral, competency, personal, and societal – helped the researcher with any difficult decisions during the study. Furthermore, the study was submitted and approved by California State University, San Bernardino's Institutional Review Board (IRB) before research was conducted to ensure that privacy, confidentiality, and anonymity were protected to the greatest possible extent.

### Political Issues

Political issues are typically addressed before the study begins (Morris, 2013), specifically when interacting with gatekeepers. As discussed briefly earlier in this chapter, the main political issue that arose from this study was the concern about the forum's reputation and the impact the study could potentially have on the forum itself and its users. Morris (2013) claims that getting gatekeepers to agree to the constructivist process, sharing power, and the study's intense commitment during the initial negotiation stage is the most effective strategy for addressing this concern. It reminds the research site that there are no favorable or unfavorable outcomes of the study, but rather a development of an action plan that will address the study's constructions (Morris, 2013).

However, as the study developed, it was possible that gatekeepers at the research site could alter their perspectives. Due to implicit biases or research legitimacy concerns, the online forum could have determined that the research influences or impacts its users negatively and could potentially prohibit the



forum's participation in the study, removing communication about the research project from the platform. Research participants could have also developed similar concerns about the research process and removed themselves from the study, warning others in the forum not to participate. In these situations, renegotiation with the research site and participants would have had to occur to address their concerns. Reminders of the constructivist process would have been important in these situations, as would have been reporting if the politics of the research setting impacted the development of an action plan (Morris, 2013). Although these were possibilities, these issues did not occur for this study.

### The Role of Technology

Technology was a necessary tool for this research and was used in multiple ways throughout the study, from engaging with gatekeepers to working with participants. Initial and follow-up contact with gatekeepers was handled over email and forum messaging centers, and online libraries were used to gather research, both of which required the use of a computer and the internet. Additionally, informal interviews were recorded via Zoom, as these were also held online. A qualitative data analysis software (Dedoose) was also used. Lastly, a computer was required to draft findings and the final study, which was shared online with research participants due to the nature of the research site.

## Summary

This chapter addressed the study's initial engagement process, including the research site and its gatekeepers and the researcher's self-preparation. It also discussed the diversity, ethical, and political issues that occurred and the use of technology throughout the study. To summarize, the study site was two online public forums that offer a supportive platform for individuals with BPD. Its gatekeepers included forum moderators and other forum users. Although minor issues arose, these were dealt with as the research progressed, as the nature of the constructivist paradigm requires open discussions with research participants and key players. Technology was also used and, in some situations, needed to be approved by the gatekeepers and research participants. The engagement process impacted and guided the following stages of the study.

## CHAPTER THREE

### IMPLEMENTATION

#### Introduction

Chapter Three discusses the implementation stage of the study. Like engagement, implementation in constructivist research is an ongoing process that will occur throughout the research project. This chapter reviews the demographics and sampling of the study's participants, along with the study's use of data gathering methods, phases, recording, and analysis. It also explores how the constructivist paradigm impacts sampling, data, and termination.

#### Study Participants

Due to the constructivist nature of this study, it was conducted with the support of research partners. The main research partners were three English-speaking women who had been diagnosed with BPD. These participants were located throughout the U.S. and used online public forums dedicated to BPD. Lastly, the research partners were also required to attest that they currently had a mental health provider, had not self-harmed in the past four weeks, and had not been hospitalized in the last six months. Additional participant demographics are described in the following chapter.

## Selection of Participants

Research participants were selected using maximum variation sampling, which selects participants based on their ability to participate in the hermeneutic dialect and on who can add to a “diversity of experiences” of a shared phenomenon (Morris, 2013, p. 144). Maximum variation sampling is the typical sampling method used in constructivist research and will provide a foundation for the study’s sampling approach. Additionally, the study also utilized non-probability sampling, as generalizability is not feasible within the constructivist paradigm. Specifically, this study used criterion sampling, as it sampled a population based on specific characteristics (Morris, 2013). In this case, the criterion included women with BPD.

The study also used snowball sampling, which uses the networks of the research partners to expand the sample (Morris, 2013). Indeed, the initial research partners may have been able to facilitate communication between the researcher and other women with BPD or other forum users, who may have felt uncomfortable participating initially. However, the researcher is unaware of whether snowball sampling occurred. It is also important to note that the sample size for the study was restricted due to the potentially limited number of women with BPD who used the online forums and were interested in participating in the study. However, the minimum sample size was three participants. The researcher did not discourage potential research partners from participating as

long as they met the criterion for the study and could participate in the hermeneutic dialect.

### Data Gathering

Constructivism uses qualitative methods to collect subjective data, so this study utilized one-on-one interviews to determine the final construction (Morris, 2013). The researcher took a feminist approach to interviewing, ensuring that the research partners were treated as “human beings to be engaged rather than subjects with identification numbers who are a source of predetermined data” (Morris, 2013, p. 224). Observations were not included due to the research being conducted online, and documents and artifacts were not reviewed.

According to Morris (2013), constructivist interviews would, theoretically, be conducted with no preconceived questions. However, this can create issues, tension, and/or anxiety for both the researcher and the research partners (Morris, 2013). Therefore, interviews were conducted using Patton’s (2002, as cited in Morris, 2013) six categories of questions: demographic, behavior, values, feeling, knowledge, and sensory. See Appendix C for a list of example interview questions. Due to time constraints, member check meetings were not conducted for this study. These meetings typically bring all the individual participants together to identify areas of agreement and disagreement as well as additional issues to be addressed (Morris, 2013). Since the researcher did not use member check meetings, the final construction was determined solely by the researcher’s analysis of the data.

Furthermore, as was previously mentioned in Chapter Two, technology was used throughout the study, specifically during data gathering. As approved by the research partners, qualitative data was gathered via Zoom, which was used during the interview process. Zoom audio recordings also offer a reliable transcription. Thus, the recordings were transcribed using Zoom's audio transcription software for analysis.

### Phases of Data Collection

Data was gathered using a four-step interview process. The first step involved preparing for the interview (Morris, 2013), which included developing a list of preset questions and gathering initial research partners who self-selected to participate in the study. This step occurred after forum moderators had approved the research project to be marketed on their site. Once initial research participants were identified, informed consent was collected, and interviews were scheduled.

Before the interviews began, research partners were reminded of informed consent, including the use of Zoom's recording feature and the ability to withdraw from the study at any time without penalty. Once the participant confirmed they were ready to continue, the interview began with rapport building and led to demographic-based questions to offer an opportunity for the research partner to become more comfortable with the researcher. This step involved the researcher self-disclosing that they have BPD, ensuring that the key interviewees (i.e., women with BPD) knew they were being interviewed by someone similar to

them. Initiating the interview, as described above, was the second step of the data gathering process, and it led to the third step: maintaining productivity during the interview (Morris, 2013). Following rapport building, the interviewer asked open-ended questions about the research partner's experiences, values, and feelings on the topic. Constructivist interviews are informal, so although the researcher had a list of questions available, they followed the interviewee's lead.

The interview closed – the final step of the process (Morris, 2013) – at the 45-minute mark or when the research partner stated they did not have more to add to the construction, whichever came first. If the research partner wanted to continue the discussion after the first 45 minutes, a second interview was scheduled. Only one participant requested additional time with the researcher.

### Data Recording

Data was recorded using multiple methods, including notetaking in a virtual research journal, recordings via Zoom, and digital write-ups. Notetaking occurred throughout the study, from planning to termination and throughout the follow-up process. The research journal was used at length to develop a dependable data record. For example, the journal contained interview and meeting dates, a list of participants (using non-identifiable information), interview questions, etc. Audio recordings were used throughout data gathering activities (i.e., at one-on-one interviews). The recordings were labeled by date and the participant's pseudonym and stored on the cloud service provided by California State University, San Bernardino. Transcriptions of the recordings existed

digitally and were also kept on the cloud service. The researcher also used digital write-ups throughout the analysis and evaluation portions of the study.

### Data Analysis

In constructivism, data is continually analyzed throughout the study (Morris, 2013). Initial analysis was conducted after each one-on-one interview (Morris, 2013). Morris (2013) suggests using Erlandson and colleagues' (1993, as cited in Morris, 2013) seven standard questions throughout the initial analysis process, which includes collecting information on what the researcher learned, how it will shape the following interview, and the emerging themes. This assisted the researcher in developing a summary of data, which was used to identify units of information (Morris, 2013). The researcher grouped the units into similar categories to determine the final construction (Morris, 2013).

Units must be heuristic and able to be understood without explanation before being recorded in a data processing software (Morris, 2013). These units were then combined by similarity – using the researcher's judgment – to develop categories. After cataloging, the researcher determined relationships between categories (Morris, 2013). This step in the analysis process helped to build a complete construction (Morris, 2013). However, the researcher did not include the participants' analysis of the data to determine the final construction.



## Summary

This chapter examined the characteristics of the research partners – women with BPD – and the sampling methods that were used to gather them, such as maximum variation sampling and non-probability sampling. This chapter also addressed how the study collected and recorded data. The researcher used individual interviews to gather data and recorded them using Zoom. Before terminating and disseminating the study's findings, the researcher also analyzed the data; however, this did not include working with the research participants to determine a final construction.

## CHAPTER FOUR

### EVALUATION

#### Introduction

Chapter Four will evaluate the data collected for the study. In constructivism, the goal of data analysis is to determine a joint construction with the research participants and develop an action plan associated with that construction (Morris, 2013). Therefore, this chapter will describe the data analysis and interpretation processes in addition to the limitations of the study and the implications for micro and macro social work practice.

#### Data Analysis

##### Participants

A total of three women were interviewed for this study, ranging between the ages of 25 and 35. Two of three identified as White, while the other identified as Cuban. All three participants had some college education, with one having a bachelor's degree and another having a master's degree. Two of three participants stated they were single, and one shared she was married. All three lived in the United States (California and Texas). No other demographic information was requested during the interviews.

##### Data Collection

All participants were interviewed via Zoom, with each agreeing to have their audio recorded. To ensure confidentiality, each participant was given a

unique code (i.e., A1, B2, and C3) as their pseudonym by the researcher. Participants' names were also changed on Zoom to ensure the recording identified each participant with this code. All recordings were saved on the California State University, San Bernardino cloud service (i.e., Google Drive).

Although participants had given informed consent by signing and submitting the required documents to the researcher via email, the consent form was also reiterated verbally before the interview began. Participants were reminded of their ability to withdraw from the study at any time during the interview as well as the option to skip any questions that they did not want to answer. Only one question was declined by one participant. Additionally, participants were asked to confirm that they gave their consent to have their audio recorded.

The researcher took brief notes during and then immediately after the interview to address Erlandson and colleagues' (1993, as cited in Morris, 2013) seven standard questions. This process helped identify future questions to ask during the interviews and highlighted initial themes. In addition, each interview was transcribed by the researcher and saved to the cloud service. Transcriptions and audio recordings were also uploaded to Dedoose, an application to help analyze qualitative data and support the coding process. All materials, including recordings, transcriptions, and notes, were destroyed once the study was published. This includes all data stored on Dedoose.

### Developing Constructions

After collecting data from all participants, the researcher began the analysis process using a typical constructivist approach. First, heuristic units were identified by the researcher. Examples of units identified include “women with BPD encounter negative experiences with their families and service providers,” “BPD-associated stigma,” and “importance of therapist.” Once the units were identified, they were categorized by similarity. These were also grouped, leading to two primary categories (or themes): stigma and bias associated with a BPD diagnosis and the importance of supportive treatment. These categories are discussed in greater detail below, and a final construction is presented by exploring the relationship between these two categories. However, the final construction did not include analysis or feedback from research participants, and no action plan was developed due to the researcher interpreting data independently.

### Data Interpretation

As stated above, two primary themes were identified in the data analysis process: stigma and bias associated with a BPD diagnosis and the importance of supportive treatment. Subthemes for these categories also emerged, which are explored further below.

### Stigma and Bias Associated with a BPD Diagnosis

All three participants described experiencing discrimination and biases by service providers, family and friends, and others, often due to the negative beliefs

or stigma associated with BPD. This stigma was explained by the participants in three distinctive ways, which led to the subthemes for this category. The following section explores the stigma associated with the diagnosis itself, self-disclosure, and how women with BPD feel when they encounter stigma.

Diagnosis. “When you say BPD, it’s almost like a dirty word,” stated Participant C3 when describing her experience with the diagnosis (2023). Thus, it was necessary to explore the stigma and biases women with BPD encounter when receiving their diagnosis. For Participant C3, this included acknowledging the challenges of getting a BPD diagnosis, calling it “a journey.” She goes on to state:

I have been through many therapists, and they were giving me random diagnoses...and every single time, it just seemed like they were kind of shying away from what it was. I got just anxiety disorder, I got undiagnosed mood disorder, I had gotten I think it’s [complex Post-Traumatic Stress Disorder] cPTSD, I had gotten many diagnoses (Participant C3, 2023).

This bias against BPD was further addressed as she described one specific therapist who diagnosed her with cPTSD: “it felt like he was holding back” (Participant C3, 2023). Unsurprisingly, Participant B2 described a similar experience with a provider:

I didn’t even have the diagnosis at the time...and when I got evaluated, the psychiatrist did not want to give me a BPD diagnosis. He gave me a

PTSD diagnosis instead. I think this happens often because they know how harmful the label is, and there is so much stigma and discrimination systemically (2023).

Although Participant A1 did not encounter challenges with receiving a diagnosis, stating she had been diagnosed “a number of different times by a number of different sources,” she did experience similar biases. She described one therapist who “said very despairingly things about people with BPD” (Participant A1, 2023). She continued by stating, “her exact words were, ‘I don’t normally work with cluster Bs because they’re just too much to handle’” (Participant A1, 2023). Participant B2 had a similar experience:

When I first found out about BPD, I was in a counselor’s office. First of all, she only knew me for about 10 minutes before diagnosing me...I didn’t have an issue, I didn’t know there was a stigma attached to it...but the more that our sessions went on, I found that her goal switched from helping me to getting me to realize that I am manipulative as a person. She would say things like, ‘well, don’t you see how that’s manipulating this person?’ (2023).

Indeed, the research participants found that they were either too difficult for a therapist or not difficult enough to receive a diagnosis. The stigma associated with BPD – this dirty word – led to biases from service providers who then delivered inadequate treatment. However, this interpretation is to be expected, considering the current research.

Self-Disclosure. The research participants also described their experience with self-disclosure, with some limiting how often they disclosed due to the negative connotations of a BPD diagnosis. For example, Participant C3 stated, “I would rather not say anything and keep that to myself” after describing that others view women with BPD like “a walking time bomb” (2023). Participant A1 reported a similar experience:

I don't disclose that I have BPD anymore, so I don't know that you would see discrimination in my day-to-day life because I made the conscious decision after, you know, it happened x number of times that I trusted people with like this really personal information and they started treating me very differently very quickly (2023).

Although Participant B2 stated that she continues to disclose, she also recognized that doing so can lead to issues:

I guess I am a bit of an outlier when it comes to being open about it. I am super not ashamed, I am not one to keep it hidden, especially now. But when it first happened, I didn't know about the stigma, so I told everybody. Well, that didn't help me (2023).

In other words, the stigma associated with the diagnosis directly impacted whether the research participants were comfortable disclosing. Two of the three participants were not, while the third highlighted how self-disclosing had created issues for her.

Strong Emotions. Furthermore, the biases associated with a BPD diagnosis directly impact the emotions of women who have the diagnosis. “Crappy is an understatement,” stated Participant B2 (2023) when describing how she felt, but all three participants highlighted their feelings after experiencing this stigma. She goes on to describe how these experiences cause a “depth of sadness” (Participant B2, 2023). She reported feeling “absolutely hopeless” and further stated:

It’s like an abyss of despair, I would say. This is a feeling I have experienced my whole life, it’s chronic, it’s not acute. It’s not like you experience discrimination, and then that’s the first time you’ve felt that sadness. It’s more like you get discriminated against, and it opens up a can of every time in your life you have felt that way. And so, when we get rejected and maybe say we are told our feelings are not correct or the way we reacted was not correct... it’s a rejection of our entire person because we don’t have a sense of self... it’s a global rejection, and that makes you want to die, disappear, not be here because you don’t feel accepted (Participant B2, 2023).

Participant A1 felt similarly, describing it as “such a letdown” (2023). She continued:

I think what really really hurts about it is, especially on a personal relationship basis, is like in between, let’s say today and yesterday – yesterday when you didn’t know I had BPD and today when you do –



you're treating me like a completely different person, but it's not as if like in between yesterday and today...I didn't do anything dramatically horrifying that would make you treat me like a completely different person... it's really upsetting. For psychiatric providers, I will never get over feeling like they should know better (Participant A1, 2023).

Participant C3 also experienced a strong emotion in these situations, but the emotion itself was different. It was anger. In addition, to feeling "very angry," she stated, "it just makes me feel less like a person. It makes me feel not worth being treated well...it makes me feel a little bit more despaired" (Participant C3, 2023). According to the participants, these strong emotions are triggered by the stigma and negative beliefs they have encountered in their lives.

#### Importance of Supportive Treatment

Participant B2 described her current therapist as "the best thing to ever happen to" her (2023). Thus, it became necessary to consider how treatment providers could support the well-being of women with BPD. This exploration led to the second significant theme from the data: the importance of supportive treatment. Two subthemes were identified within this category: stability and solidarity, as well as advocacy and autonomy. It is important to note that Participant A1's interview sparked additional questions about current treatment providers which led to this theme. As such, she did not have an opportunity to contribute to these topics.

Stability and Solidarity. Participants B2 and C3 described the positive experiences with their treatment providers, specifically highlighting the importance of stability and solidarity. Participant C3 reported that she and her therapist are a team (2023). She defined their relationship as “open and transparent” and acknowledged that the “freedom” she experienced in therapy made her “embrace [her] diagnosis more” and “also feel like [she] can get better” (Participant C3, 2023). She further stated:

My current treatment provider has actually been a beautiful, wonderful provider. They are the one who gave me my diagnosis. They are the one who talked openly about the discrimination within providers themselves. They have their colleagues who have this like notion that BPD is untreatable, BPD is terrible, walking time bomb, treatment resistant, etc., and they are trying to break that boundary. This is something that needs to be treated, this is something that needs to be given care to folks like me...My current provider actually gives me the tools, has given me so many book recommendations about BPD, whereas my other ones would not even talk about it (Participant C3, 2023).

Participant B2 described a similar experience of teamwork with her current therapist, specifically highlighting the strength her provider gave her. She stated:

Usually, for those of us with BPD, our very first safe relationship is one with a therapist...I have this stability, and she is available 24/7, which is what we need because you just never know when something is going to

bring you down to the point where you don't want to be here anymore. But just knowing that she's there makes me stronger, makes me feel stronger (Participant B2, 2023).

These experiences suggest that service providers who offer stability and solidarity for their BPD clients are more likely to see positive results in treatment. This can be assumed, as the participants had to attest to being in treatment without recent self-harm or hospitalization.

Advocacy and Autonomy. In addition to stability and solidarity, advocacy and autonomy were highlighted by Participants B2 and C3 when describing their current service providers. Indeed, Participant B2 described her therapist as her “number one advocate,” stating:

She advocated for me in the face of my family, and she will advocate for me in relationships. And she teaches me how to advocate for myself, which is something that a lot of therapists miss. Like connecting me to my agency. I have a choice, I have a say. A lot of us feel like we have no control over our lives. But we do, we just have never had the opportunity to explore that (2023).

When asked if her current therapist advocates on her behalf, Participant C3 responded by stating that her therapist was “definitely on [her] team” (2023). She further stated:

Definitely giving me transparency but also the autonomy to kind of outline my treatment and my goals, what I want to do. And if I ask is there

something maybe perhaps I am missing that she sees that I can't, she'll let me know 'hey, I feel like we need to work on this,' but it's still my full control, there's never anything pressured on me (Participant C3, 2023).

Thus, advocacy and autonomy were also identified by the research participants as requirements for having positive experiences with treatment providers. In combination with stability and solidarity, these four attributes lead to positive outcomes for women with BPD, suggesting the importance of supportive treatment for this population. Future studies should consider the length of time each participant has been with their current provider to determine whether these characteristics lead to longevity.

#### Final Construction and Discussion

"There's fear to seek treatment. You call us treatment resistant, well, make us feel safer," Participant B2 stated as she closed out her interview (2023). This statement alone sums up the final construction of this study. As identified by the research participants, women with BPD experience bias and discrimination due to their diagnosis, which leads to a lack of self-disclosure and intense emotions of sadness and anger. However, this can be challenged by supportive treatment providers who offer stability, solidarity, advocacy, and autonomy to this population. In other words, this study suggests that by creating safer treatment options for women with BPD – ones without negative beliefs, biases, and discrimination – it is possible that women with this diagnosis will receive better treatment outcomes.

Furthermore, this construction aligns with what limited literature is available on this topic from this perspective, such as Goldstein's (2020) research. As described above, Goldstein found that women with BPD not only needed positive connections with their treatment providers, but they also needed providers who were competent, actively listened, validated their experiences, and offered safety, humanity, and flexibility in their sessions (Goldstein, 2020). Although categorized differently, the three participants in this study had similar requirements for their providers (i.e., stability, solidarity, advocacy, and autonomy).

For example, the autonomy identified among participants is very similar to the balance between structure and flexibility discussed by Goldstein (2020). In both studies, women with BPD needed to feel in control as well as cared for by their service providers. Likewise, solidarity identified within this study is similar to the need for validation expressed by participants in Goldstein's (2020) research, and stability is akin to safety. Indeed, one participant even described the relationship between therapist and client as the first safe relationship an individual with BPD might have. Advocacy can also be compared to a provider's humanity. Demonstration of a provider's humanity was described differently by each of the participants in Goldstein's (2020) research; however, in all cases, there was a need to confirm that a provider's "caring was real and not just a service provided" (p. 144). For participants in this study, advocacy was a way for providers to demonstrate their genuine interest in supporting their clients.

Lastly, these findings verify that, at least in the case of these three participants, biases and negative perspectives of service providers impact women with BPD in a significant and adverse way. As Sulzer (2015) argues, the “difficult” descriptor often given to individuals with BPD “operates as the code word to legitimize clinicians dismissing some patients,” which feeds into the stereotype that this population is “untreatable” (p. 86-87). However, when mental health clinicians challenge these stereotypes, it can be assumed that individuals with BPD are more likely to experience successful treatment (Sulzer, 2015). Sulzer’s (2015) assumption is demonstrated in this study, as the participants described their experiences with service providers who believed these stereotypes and those who did not.

When working with providers who believed these stereotypes, the participants reported feeling overwhelming sadness and anger. These emotions, which can be considered extreme by others, could be read as challenging in a treatment setting. Participants also reported difficulties in receiving the diagnosis, potentially limiting their ability to receive appropriate treatment options. Indeed, even after receiving the diagnosis, participants had a decreased interest in self-disclosing due to the stigma associated with BPD, which may have also created barriers to treatment access. Collectively, the adverse effects on women with BPD due to poor treatment received by service providers further enforce the “untreatable” label given to this population.

However, when service providers reject the idea of the “difficult” BPD client, they are more likely to provide treatment (Sulzer, 2015). In other words, when providers report enjoyment in working with this population and/or focus on how treatment is possible, these adverse effects on women with BPD are mitigated. As demonstrated in this study, not only did participants report having positive and strong therapeutic relationships with their current providers, but they also had to attest to no recent self-harm or hospitalizations. This suggests that supportive treatment providers help reduce symptoms for this population and decrease the adverse experiences these women encounter in treatment settings.

#### Limitations

There were several limitations to this study, with the most significant being the inability to generalize the study’s findings. Due to the constructivist paradigm as well as the small sample size, the results of the study are unable to be applied neither to the general population nor broadly to women with BPD. Additionally, only women who could attest to being currently stable (i.e., had a therapist, had not self-harmed in the past four weeks, and had not been hospitalized in the past six months) were able to participate in the study. This, in combination with using only two mental health forums as field sites, greatly limited those who could participate. Although the researcher received additional interest from possible participants, two individuals had to be denied participation due to not meeting requirements. Moreover, several individuals reached out with interest in participating but did not follow up once the researcher had provided the informed

consent form and screener. Lastly, due to time constraints, this research did not follow the complete constructivist model, as no member check meetings were conducted, and participants were treated less like partners in the research than initially anticipated.

#### Implication of Findings for Micro and Macro Practice

Despite these limitations, this study provides several implications for micro and macro social work practice. First, it acknowledges the importance of a positive therapeutic relationship for this population and identifies the need for social workers at the micro level to both be advocates and instill self-advocacy in their clients. It also suggests the need for continued education and training for service providers, including social workers, to understand their clients with BPD. Lastly, it encourages social workers at the micro level to challenge their biases and treat their clients with dignity and respect. In combination, this will ensure that women with BPD who are in treatment receive adequate and appropriate services.

Furthermore, it invites the opportunity for future research to highlight the lived experiences of women with BPD. Due to the limited research on this population and even less from their perspective, this is a necessary endeavor for social workers in macro practice. Further exploration is also needed on how providers can lead to positive treatment outcomes for women with BPD, as described by those with the diagnosis. Ideally, future research should be conducted with a larger sample. A mixed methods approach may also be



valuable to obtain quantitative data while also engaging directly with this population through qualitative research. In addition to further research, this study also suggests the need to reduce the stigma this population encounters. Social workers who engage in community organizing can support the work needed to eliminate the stigmatization women with BPD throughout the United States encounter on a day-to-day basis.

### Summary

Chapter Four began by describing the data analysis and interpretation processes. This included how data is typically analyzed within the constructivist paradigm as well as what aspects were not included in this study (e.g., member check meetings and the development of a joint construction). Instead, data was interpreted by the researcher, independent of the research participants. This interpretation led to the final construction of the study: women with BPD are considered treatment resistant because they lack safe and supportive treatment options. Additionally, this chapter addressed the limitations of the research, including the inability to carry out a true constructivist study due to time constraints. This chapter concluded with the implications for micro and macro social work practice.

## CHAPTER FIVE

### TERMINATION AND FOLLOW UP

#### Introduction

The final chapter – Chapter Five – describes the termination of the study and final follow up. Typically, in the constructivist model, this includes ensuring research partners are able to continue this work without the researcher. However, since this study was unable to be completed using constructivism, it will not include such efforts. Nevertheless, this chapter examines final termination and the dissemination plan, including how the findings will be communicated to research participants. To conclude, it will review any ongoing relationship with the study's participants.

#### Termination of Study

Termination in constructivism is a process. For this study, the first step to termination was after each interview, where the researcher provided a debriefing statement, ensuring that participants were aware of next steps and resources. Participants were also encouraged to reach out if they had any questions or concerns about the study. Once the study was published, participants received a final email, which shared the final report and findings via an infographic. Additionally, the mental health forums that were used as field sites throughout this study also received the final report and infographic; these items were both

posted to the sites and shared with the moderators. All materials related to the study, such as recordings, transcripts, and notes, have been destroyed.

#### Communication of Findings and Dissemination Plan

Once the research paper was completed and published, findings were communicated and distributed to research partners and field sites. The researcher presented the study's outcomes and findings via direct email to the participants. In addition, the researcher posted the findings on the mental health forums used to collect participants for this study. These served as the researcher's final form of involvement and communication with the participants and field sites.

During this termination process, the researcher also decided how to disseminate the study's findings. Since it is essential for the participants, field sites, other online mental health forums, clinicians, other people with BPD, and their loved ones to have access to the study and its results, accessibility and availability were necessary to consider. Research briefs and infographics were used over other methods to distribute findings to a broader audience. This ensured that the populations described above, specifically others with BPD who are experiencing similar situations, had access to this information.

#### Ongoing Relationship with Study Participants

Typically, the termination process under constructivism occurs over time, where the researcher and the research partners have an opportunity to reflect,

discuss implementing next steps for the project, and explore follow-up needs. However, as noted above, this study was unable to be entirely completed using the constructivist paradigm. Thus, there was not and will not be an ongoing relationship with the study's participants. There were no member check meetings, so the researcher did not need to organize any follow up meetings for them to continue without the researcher's presence. In other words, the researcher was not required to reduce availability to the participants or field sites. Instead, final communication occurred over email to distribute the findings of the study.

APPENDIX A  
INFORMED CONSENT

**RESEARCH PARTICIPANT INFORMED CONSENT**

**INVITATION TO PARTICIPATE:** You are invited to participate in a study designed to investigate the effects of discrimination on women with Borderline Personality Disorder (also known as BPD). This study is being conducted by Cassidy Acosta under the supervision of Dr. Carolyn McAllister, Department Chair of the School of Social Work at California State University, San Bernardino. This study has been approved by the Institutional Review Board, California State University, San Bernardino.

**PURPOSE:** The purpose of this research is to explore how discrimination affects women with BPD. Women with BPD are often described as manipulative, difficult, and treatment-resistant by family members and service providers. This research hopes to provide an alternative perspective by asking women with BPD how these biases and discrimination affect them.

**DESCRIPTION:** If you agree to participate, the researcher will schedule a virtual one-on-one interview with you by email. The researcher will also interview other participants. After all interviews are completed and results are finalized, the researcher will send a direct email to share the research findings with you.

**PARTICIPATION:** Your participation is voluntary, and you do not have to answer any questions you do not wish to answer. You may skip or not answer any questions and can freely withdraw from participation at any time. You can withdraw consent at any time without penalty.

**CONFIDENTIALITY:** The researcher will handle all information you share as confidentially as possible. The researcher will keep all recordings, documents, and notes in the California State University, San Bernardino, cloud service (Google Drive), which has a protected firewall. If the results of this study are published or presented, personally identifiable information will not be used and you will be assigned a pseudonym. The researcher will destroy all recordings three years after the project has ended.

However, there are risks to confidentiality. Research participants will all be users of the same online public forum. Due to the small sample size, you may know some of the other participants.

**DURATION:** If you agree to participate, you will complete a one-on-one virtual interview with the researcher. The interview will take about 45 minutes to complete. It can be longer or shorter depending on your responses to the interview questions. If the interview runs long, we will schedule a second interview.

**RISKS:** Some interview questions may be difficult to answer and cause distress. You may be asked questions that could potentially trigger memories of events in your life that were traumatic or upsetting. You may be asked to describe how these experiences affected you.

**BENEFITS:** There is little to no direct benefit to you from taking part in this research. It may allow you to share your story, express concerns, advocate for yourself, or find similarities among other women with BPD. These opportunities can be therapeutic for some. But this study will hopefully lead to further education to better understand how negative beliefs impact people with BPD.

**AUDIO:** Interviews will be held online via Zoom. If you agree, the interview audio will be recorded and a transcription of the audio will be saved to the California State University, San Bernardino's cloud service. Please state whether you agree to have your audio recorded:

Yes  No

It is not required for your audio to be recorded to participate in this study. If you would prefer your audio not be recorded, the researcher will take digital notes instead. These will also be saved to the cloud service.

**CONTACT:** If you have questions or comments about this research, please contact my advisor, Dr. Carolyn McAllister. Dr. McAllister is the Department Chair of the School of Social Work and can be reached at (909) 537-5501 or [cmcallis@csusb.edu](mailto:cmcallis@csusb.edu)

**RESULTS:** The researcher will share results with participants via email once the study is complete. Additionally, the results will be posted on the university's master thesis database.

**I understand that I must be 18 years of age or older to participate in the study. I have read and understand the consent document and agree to participate in the study.**

**Participant's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

APPENDIX B  
PRE-SCREENING SURVEY



**PRE-SCREENING QUESTIONS**

1. Are you currently in active treatment for your borderline personality disorder (e.g., regularly meet with a therapist or mental health professional, taking psychiatric medications such as mood stabilizers, etc.)?  
 Yes                       No
  
2. Have you actively engaged in self-harm in the past 4 weeks (e.g., cutting, scratching, burning, hitting oneself, pulling out one's hair, overeating/undereating, engaging in risky situations, excessive use of alcohol or drugs, or engaging in other self-destructive behaviors including attempting suicide)?  
 Yes                       No
  
3. Have you been hospitalized for your borderline personality disorder in the past 6 months?  
 Yes                       No

APPENDIX C  
SAMPLE INTERVIEW QUESTIONS

### SAMPLE INTERVIEW QUESTIONS

1. What is your age, race/ethnicity, highest education level?
2. Are you married, or do you have a significant other? Are you close with your family?
3. Where are you from?
4. When did you receive your diagnosis of BPD?
5. How long have you used the online public forum? Have you used other mental health forums as well?
6. Have you experienced discrimination or have others treated you differently because you have BPD? If yes, when, how, by whom?
7. Have you experienced discrimination from your mental health treatment provider?
8. Have you experienced discrimination from your family and friends?
9. If I were to observe you in your day-to-day life, what discrimination would I see you experience or how would you be treated differently? Who would be the person who treated you differently?
10. Do you think other women with BPD experience discrimination regularly? What kind of discrimination do you think they face?
11. Do you think the people who discriminate against women with BPD are being held accountable?
12. How do you feel when you experience discrimination?
13. Do you advocate for yourself when you experience discrimination? Do others advocate on your behalf? What do you or they do or say?
14. Are there any other questions or concerns about this issue that you would like to add or address?

APPENDIX D  
SAMPLE DEBRIEF

**SAMPLE DEBRIEF SCRIPT – AFTER INTERVIEWS**

Thank you so much for the opportunity to interview you. If this interview caused any distress, there are resources to help you. This includes the National Suicide Prevention Lifeline, which you can call 24/7 at 1-800-273-8255 or you can chat online at <https://suicidepreventionlifeline.org/>. You can also find local resources by contacting SAMHSA's Treatment Referral Helpline at 1-877-726-4727 or the NAMI HelpLine at 1-800-950-6264.

If you have additional questions about the study, please contact my advisor, Dr. Carolyn McAllister. Dr. McAllister is the Department Chair of the School of Social Work and can be reached at (909) 537-5501 or [cmcallis@csusb.edu](mailto:cmcallis@csusb.edu) I will include her contact information in the Zoom chat as well.

Again, thank you so much for participating. It's been a pleasure, and I wish you the best.

**SAMPLE DEBRIEF EMAIL TO SHARE FINDINGS**

Greetings,

I hope you're doing well. I am following up to share our research findings with you. As a reminder, this study was designed to investigate the effects of discrimination on women with Borderline Personality Disorder. Here are the results of our study:

- *Share results of the study, which could include a research brief and/or infographics.*

If you have additional questions about the study, please contact my advisor, Dr. Carolyn McAllister. Dr. McAllister is the Department Chair of the School of Social Work and can be reached at (909) 537-5501 or [cmcallis@csusb.edu](mailto:cmcallis@csusb.edu)

Lastly, if you experienced any distress after participating in this study, there are resources to help you. This includes your personal treatment provider and other mental health services. This includes the National Suicide Prevention Lifeline, which you can call 24/7 at 1-800-273-8255 or you can chat online at <https://suicidepreventionlifeline.org/> You can also find local resources by contacting SAMHSA's Treatment Referral Helpline at 1-877-726-4727 or the NAMI HelpLine at 1-800-950-6264.

Thank you again for participating in the study.

I wish you all the best,  
Cassidy Acosta

APPENDIX E  
INSTITUTIONAL REVIEW BOARD LETTER OF APPROVAL



May 20, 2022

**CSUSB INSTITUTIONAL REVIEW BOARD**

Full Board Review

IRB-FY2022-189

Status: Approved

Prof. Carolyn McAllister and Cassidy Acosta  
CSBS - Social Work  
California State University, San Bernardino  
5500 University Parkway  
[San Bernardino, California 92407](#)

Dear Prof. Carolyn McAllister and Cassidy Acosta:

Your application to use human subjects, titled "The effects of discrimination on women with borderline personality disorder" has been reviewed and approved by the Institutional Review Board (IRB) of CSU, San Bernardino. The CSUSB IRB has weighed the risk and benefits of the study to ensure the protection of human participants. The study is approved from May 20, 2022 through May 20, 2023 and requires IRB annual continuing review and approval. The Cayuse system is automated and will send you email reminders 90, 60, and 30 days before the study comes due for renewal or annual administrative check-in.

This approval notice does not replace any departmental or additional campus approvals which may be required including access to CSUSB campus facilities and affiliate campuses. Investigators should consider the changing COVID-19 circumstances based on current CDC, California Department of Public Health, and campus guidance and submit appropriate protocol modifications to the IRB as needed. CSUSB campus and affiliate health screenings should be completed for all campus human research related activities. Human research-related activities conducted at off-campus sites should follow CDC, California Department of Public Health, and local guidance. See CSUSB's [COVID-19 Prevention Plan](#) for more information regarding campus requirements.

If your study is closed to enrollment, the data has been de-identified, and you're only analyzing the data - you may close the study by submitting the Closure Application Form through the Cayuse Human Ethics (IRB) system. The Cayuse system automatically reminds you at 90, 60, and 30 days before the study is due for renewal or submission of your annual report (administrative check-in). The modification, renewal, study closure, and unanticipated/adverse event forms are located in the Cayuse system with instructions provided on the IRB Applications, Forms, and Submission Webpage. Failure to notify the IRB of the following requirements may result in disciplinary action. Please note a lapse in your approval may result in your not being able to use the data collected during the lapse in the application's approval period.

- **Ensure your CITI Human Subjects Training is kept up-to-date and current throughout the study.**
- **Submit a protocol modification (change) if any changes (no matter how minor) are proposed in your study for review and approval by the IRB before being implemented in your study.**
- **Notify the IRB within 5 days of any unanticipated or adverse events are experienced by subjects during your research.**

- **Submit a study closure through the Cayuse IRB submission system once your study has ended.**

Failure to notify the IRB of the above requirements can result in disciplinary action. You are required to keep copies of the IRB approval letter, informed consent forms, and maintain the data for at least three years. The stored data should be stripped of all personal identifiers to ensure the protection and security of all participant information.

The CSUSB IRB has not evaluated your proposal for scientific merit, except to weigh the risk to the human participants and the aspects of the proposal related to potential risk and benefit. If you have any questions regarding the IRB decision, please contact Michael Gillespie, the IRB Compliance Officer. Mr. Michael Gillespie can be reached by phone at (909) 537-7588, by fax at (909) 537-7028, or by email at [mjillesp@csusb.edu](mailto:mjillesp@csusb.edu). Please include your application approval identification number IRB-FY2022-189 in all correspondence.

Best of luck with your research.

Sincerely,

*Nicole Dabbs*

Nicole Dabbs, Ph.D., IRB Chair  
CSUSB Institutional Review Board

ND/MG



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