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A Qualitative Analysis of Experiences of Psychiatrists and Clinical Psychologists with the Borderline Personality Disorder Patients (BPD)

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Abstract

The current study explored the experiences of psychiatrists and clinical psychologists treating borderline personality disorder (BPD) in Pakistani patients between 30 to 65 years. A purposive sample of 9 psychiatrists and 9 psychologists ($N = 18$) with experiences in treating BPD participated in the study. The author used Short Explanatory Model Interview (SEMI) to assess views and experiences about patients, diagnosis, prognosis, and therapy of BPD. A semi-structured interview (7 questions) based on anthropological perspectives and concepts investigated the health and sickness of BPD patients and the experiences participants had with them. The analysis was conducted using a framework and systematic approach that incorporates deductive and inductive thematic analysis. Five themes emerged from the framework analysis; susceptibility to misdiagnosing BPD, prevalent symptoms of BPD in women, help-seeking behavior, treatment issues and difficulties, and beliefs about mental health. The current study supports the development of standardizing symptoms and methods of treatment for BPD across psychiatrists and clinical psychologists.

Keywords: *Borderline Personality Disorder, BPD, Psychiatrists, Psychologists, Misdiagnosis, treatment issues, Beliefs about mental health in Pakistan*

Individuals with Borderline Personality Disorder (BPD) are highly sensitive, fragile, and have an unstable self-image; they suffer from fluctuating emotions and impulsive behaviors, which often lead to self-destruction (Gunderson, et al., 2018). A lifetime prevalence of 1-6% BPD if untreated results in chronic and extreme clinical courses (Gunderson, et al., 2018). It affects 20% of all psychiatric patients and is linked with high healthcare utilization, therefore, BPD has a substantial socio-economic burden (Braun & Clarke, 2019; Ludäscher et al., 2007; Witt et al., 2017). It also has high mortality rates (up to 10%) like committing suicide (Turecki et al., 2019; Zalsman et al., 2016).

There are multiple risk factors associated with BPD and including impaired social relations (Hutsebaut & Aleva, 2021), family conflicts/adversity, traumatic and stressful events in the past (Luyten et al., 2020), maternal psychopathology (or ineffective parenting) (Chapman., 2019), exposure to physical and sexual abuse, impulsivity, negative sense of self, neglect (Dunn et al., 2020), neuroticism, and low levels of childhood (Bohus et al., 2021).

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Patients diagnosed with BPD suffer intensely but their prognosis is often healthier than perceived; and the outcomes can be improved with suitable treatment choices (Herzog et al., 2022). Before 2011, clinical trials for finding an effective treatment for BPD rendered successful, which changed the perception of BPD as untreatable (Gratz et al., 2022). Such treatment included psychotherapies (dialectical behavior therapy [DBT] cf. Marsha Linehan) and adjunctive drug therapies (antipsychotics, antidepressants, lithium carbonate, and anticonvulsants) for the disorder (Bozzatello et al., 2020).

Diagnosing BPD is difficult, under-recognized, and stigmatized in mental health or primary care settings (Reed et al., 2022). General practitioners find their clinical relationship with BPD patients very challenging and their behaviors highly counterproductive for care management (Cheetham et al., 2023; Jo et al., 2022). Furthermore, mental health clinicians maintain an emotional distance from BPD patients to protect themselves from distressing behaviors (Faraji & Özarabaci, 2022). Studies from the UK, Canada, Australia, Ireland, and Greece report mental health practitioners hold a negative perception of BPD patients compared to other patients with mental disorders (Bozzatello et al., 2020; Reed et al., 2022)

The difficulties mental health professionals in the West (individualistic cultures) experience is no different from professionals in Pakistan (collectivistic culture) and report reluctance, irritability, annoyance, and sometimes helplessness in dealing with BPD patients. The purpose of this study is to explore underlying issues and to identify reasons, risk factors, and attitudes

of mental health professionals in Pakistan toward diagnostic problems, experiences, and treatment recommendations.

Method

Sample

Using a purposive sample, 22 psychiatrists and psychologists were initially approached, of which 18 (n = 9 psychologists; n = 9 psychiatrists) provided their consent to participate in the study. Six Men and twelve women *(M=6; F=12)* constituted the sample. All participants had at least six years of experience working with BPD patients. All participants had completed their graduate and post-graduate degrees and were working in the public healthcare sectors in different cities like Lahore, Karachi, Peshawar, Multan, and Islamabad.

Instrument

The Short Explanatory Model Interview (SEMI) was used to assess healthcare professionals' views on BPD. This semi-structured interview is based on an anthropological perspective that investigates health and sickness (Kleinman., 2022) and consisted of seven questions (see below). Five sections of SEMI include (1) personal, cultural, social, and demographic data (2) the nature of the problem, the reason for consulting, the name of the problem, perceived causes, consequences, and overall effect (3) help-seeking, especially with non-medical or traditional healers (4) interaction with healers, the expectations, role, and satisfaction (5) Impact/ beliefs related to mental illness (Kleinman., 2022). The interviews were administered by the researchers to all participants.

1 What were your experiences of dealing with people who had borderline personality disorder?
2 What did you think were the causes that triggered you as psychological distress or possible factors of psychological distress? Prompts: In terms of ease of delivery | In terms of acceptability by the participants | Challenges | Content | Medical services.
3 How was your experience of delivering services to BPD patients when they are at the peak of their emotional symptoms? Prompts: Any emotional outburst | Specific behavior | Effect on the services.
4 What did you think were the causes that triggered you as an emotional sensitivity or possible factors of emotional sensitivity?
5 How the psychological distress and emotional sensitivity affected the services in BPD patients?
6 Do you think BPD patients think that they are having any problems? Prompts: Family | Relatives.
7 What are their behaviors towards the treatment? Specific belief? Expectations? Prompts: About traditional healers | Psychologists or psychiatrists.

Procedure

The author sought permission from the Ethical Board of the University of Management and Technology before carrying out the study. A *Participant Information Leaflet* was given to all the participants at the time of recruitment and their queries were addressed. After providing a detailed description of the study, written informed consent was obtained from all participants, and was assured confidentiality and anonymity of personal information and collected data. The interview was conducted in Urdu and the duration of the interview ranged from 30-45 minutes. The open-ended questions were asked by the researchers and respondents were encouraged to give detailed responses.

Data Analysis

An Inductive thematic analysis approach was adopted to understand the explanatory model of BPD. All researchers were trained psychologists and received additional training in qualitative research and data analysis. The five stages of framework analysis were used to analyze data. During data analysis, initial familiarization was carried out by qualitative researchers who read the assessment forms and field notes collected during the interviews several times to fully immerse themselves in the data. After a draft of the theoretical framework was developed to identify key themes. Indexing was then carried out to systematically apply the draft theoretical framework. Data from transcripts were copied and pasted alongside the relevant themes that were listed in the draft theoretical framework. Data and themes were compared again and the draft theoretical framework was revised. During the charting process, data were summarized into a table developed using MS Word software for each theme listed in the draft theoretical framework. This process provided a clear and concise overview of the data.

Analysis

Table 1

Thematic Analysis of Experiences of Psychiatrists (PTs) and Clinical Psychologists (CTs)

	Sub-themes		
Code	Psychiatrist	Clinical Psychologist	Theme
"We psychiatrists (PTs) diagnose BPD as psychosis and do not use either DSM-5 or ICD-10 for diagnosis" (*PT13, PT4). "Due to emotional instability these patients [are] diagnosed with a bipolar disorder" (PT11). "There is no accountability of [psychiatry] professionals for the diagnosis of bipolar disorder (PT15). "We clinical psychologists (CPs) diagnose BPD initially on Axis 2-NOS (not otherwise specified) disorder [largely DSM-IV, however] DSM 5 also offer[s] this [BPD] as a trait" (CP5). "Sometimes it is only considered by [psychology] professionals to get attention from the family members and fall into conversion disorder" (CP6).	No standard or clear basis for BPD diagnosis. PTs express shame, dismay, and inadequacy, in diagnosing BPD.	CPs use DSM-IV and DSM-5 for diagnosing BPD. However, the patients can be misdiagnosed under boastful pretenses.	Susceptibility of misdiagnosing BPD.
"We [PTs] found traumatic events of childhood as a root cause [of BPD]" (PT16).	Traumatic childhood events, lack of	Abusive relationships (sexual, physical,	Prevalent symptoms of BPD in women.

"The BPD symptoms develop often to fulfill the attention needs" (PT18). "The patients get relief from an emotional outburst by harming themselves" (PT10). "Women suffer more… experiences due to the sensitivity or emotionality" (PT13). "Females have the instinct of manipulation and confusion" (PT17). "Authoritarian and single parenting has been observed among diagnosed BPD patients" (PT15). "The BPD is the reaction of any abuse [sexual or physical]" (CP7). "Poor communication skills develop [and] the emotional peak that results in the symptoms of self-harm" (CP1). "Patients show non-verbal gestures for self-harm…, which is 'crying' as they don't know how to communicate verbally" (CP7) "Females' instability/insecure emotions lead towards destructive behavior" (CP6). "Females are more vigilant to show pain through physical behavior" (CP8).	emotional control and sensitivity, harming themselves, single or authoritarian parenting. PTs also thought some women show symptoms of getting attention, manipulation, and confusion in BPD.	verbal, or emotional), emotional negligence, lack of coping skills, poor communication, and, physically destructive behaviors.	
"Patients manipulate the problem they don't want to get relief" (PT16). "Patients often feel uncomfortable due to opposite gender like female patient… male doctor" (PT17). "The lack of evidence-based treatment to fulfill the client's expectations" (PT10). "Lack of awareness often distracts to the right path of prevention/treatment" (PT12). "Some therapists take gifts, more charges, prolonged sessions that decrease help-seeking behavior" (CP9). "Sometimes transference becomes the cause of decreasing help-seeking behavior either from family or patient" (CP7).	Lack of awareness, manipulative behavior, patient-doctor gender differences, and lack of evidence-based treatment reduces patient expectations.	Patients feel clinical fees are too high, or the duration of therapy prolongs unnecessarily, and transference are reasons to reduce help-seeking behavior.	Help-Seeking Behavior.
"Only medication is not the solution to treat the cluster of BPD" (PT15). "Reduction of myth is important for utilizing new treatments approaches" (PT11). "Professionals' updated knowledge must be part of their development" (PT18). "Adaptation and knowledge about new approaches of psychotherapy should be utilized here and professionals should get training/knowledge about the updated treatments for this beautifully emotional population" (PT17). "Awareness should be raised for early detection of the problem" (CP2). "Family education must be included in the treatment plan" (CP4). "New evidence-based treatment such as CBT, and DBT should be introduced" (CP9). "Treatment should be determined with the severity of the problems" (CP7). "Practitioners must be trained as per their responsibility" (CP8).	PTs need current psychotherapy training for BPD, medicines are not enough, and other treatments should be taken into consideration.	Early awareness about BPD is needed, the family needs to be educated about the disorder, therapy should be proportional to BPD severity, psychotherapies like cognitive behavior therapy (CBT) and dialectical behavior therapy (DBT) should be used, and practitioners should be trained.	Treatment issues and difficulties.
"We psychiatrists often become reluctant to refer patients to a [psycho] therapist that's why Pakistan treatment lacks the impact of treatment" (PT17).	Collective treatment of BPD in the West, CPs not engaged by PTs.	BPD treatment lacks inpatient facilities, individualized approaches, fear of stigmatization, and lack of proper	Beliefs about BPD mental health

"In the West, the collective approach has been utilized instead of an individualized approach" (PT18). "Patients consult for medication at the time of severity" (PT14). "Inpatient treatment facilities should be introduced for BPD patients as well" (CP5). "Stigmatization has been attached to the patients and their families" (CP8). "Assessments should be done at risk level for reduction of mental health problems" (CP2).	assessments reduce the impact of mental health treatment of BPD in Pakistan

Note. *depicts aliases of the participants, where PT# = Psychiatrist Participant Number, and CP = Clinical Psychologist Participant Number.

Susceptibility of Misdiagnosing BPD

Interviews with health care professionals revealed, PTs more than CPs, did not employ standard diagnostic tools (DSM-5 or ICD-10) to diagnose BPD; they did think that BPD is a cluster of extreme emotional symptoms, which are hard to work with. It is no wonder the disorder was labeled as psychosis (PT4 and PT13) and not a personality disorder. Such misdiagnosis is not uncommon because personality disorders do have psychotic symptoms that are schizoid and paranoid in form, and for these symptoms, antipsychotic drugs are commonly used.

Symptoms of BPD in women

Both PTs and CPs thought symptoms of BPD were more common in women, or they thought about women when BPD came to their minds, men and their emotionality were not discussed; PTs correctly pointed out BPD symptoms resulted from childhood traumas, and CPs pointed them out as abusive relationships (sexual, physical, verbal or emotional) with others; like parents that developed authoritarian (insecure) attachments with children (PT15) that would result in emotional sensitivity and outbursts. These professionals also thought lack of communication lead BPD patients to use alternative ways to express their pain such as crying, self-harm, and being physically destructive.

Help-seeking Behaviors

Help-seeking behaviors and maintaining therapeutic relationships are difficult for BPD patients, most patients discontinue their therapies early, and convincing them to seek help is difficult. Pakistani context is no different, in many cases according to participants, BPD is not considered a psychological problem until severe symptoms emerge, so no help is sought for extended periods. Female BPD patients and male healthcare professionals are another reason for not seeking help; male professionals find it difficult to deal with women patients for their attention-seeking behaviors (positive transference?, CP7), the prevalence of the symptoms, avoidance has been considered to consult male doctors. In addition, longer duration therapies, higher costs and fees, and reduced motivation also become the cause of reluctance to get help from professionals.

Treatment Issues and Difficulties

A few PTs thought that psychiatrists need psychotherapy training for BPD and added that medicines were not enough to treat these patients (PT15); CPs on the other hand emphasized awareness and education about BPD, especially to the family members of the patient; they also proposed therapy should be proportional to BPD severity (CP7). Psychotherapies like cognitive behavior therapy (CBT) and DBT should be used, and practitioners should be trained with refresher courses with newer therapies (CP8).

Beliefs about BPD Mental Health

Inpatient treatment for BPD patients should be introduced in hospitals (CP5), and the hospitals should engage CPs in a collective milieu to treat BPD, PTs' resistance against CPs to joining combined therapeutic forums would retard BPD mental health (PT17). In addition, healthcare professionals suggested stigma against BPD needs to be addressed (CP8) and psychological assessment for BPD should be introduced (CP2).

Discussion

The current study explored the experiences of mental health professionals, PTs, and CPs with patients with BPD. Their experiences suggested these professionals did have susceptibilities to misdiagnosing BPD patients in Pakistan, which would complicate issues for the patients and their families. Misdiagnosis of personality disorders is common (Johansson & Werbart, 2020), for it shares symptoms with other disorders and co-occurs with them (Fornaro et al. 2016; Ha et al., 2013; Joshi & Wilens, 2008); prognosis becomes worse if appropriate treatment is unavailable (Campbell et al., 2020; Lester et al., 2020) or delayed. The current study suggests, healthcare professionals had difficulties diagnosing BPD. One recommendation especially for psychiatrists is to consult standard criteria (DSM-5 and/or ICD-10) of diagnosis for BPD patients.

The authors are unsure why healthcare professionals talked about women BPD patients more than men; this could be because women with BPD are more prevalent in the clinical context (APA, 2000), or they express their emotional behaviors more dramatically than men, or they could be recalled more by male professionals in our study. Differences in gender prevalence of BPD are controversial, but generally, it is believed that epidemiological prevalence rates of BPD across women and men are equal (Busch et al., 2015) though higher (3:1) in clinical samples (APA, 2000). Patients with BPD are notorious for not seeking professional help largely because the therapy is long duration, does not help much in the long run, and has quick remission; however, things have changed since the seminal study (Linehan et al., 1991) that suggested DBT could be successfully used for BPD. Participants in our study did not list these reasons and reported BPD patients did not seek help because of low motivation, stigma (see Braga et al., 2020), and gender-differential between female patients and male practitioners (see Jo et al., 2022) which may hinder female patients to get married, and higher medical costs (see Iliakis et al., 2019); some middle-income patients cannot use professional consultants for high fees and costs.

Several treatment issues and difficulties were highlighted by healthcare professionals in our study, for example, PTs suggested the inclusion of psychotherapy in their training and CPs thought that various psychological therapies like CBT and DBT should be part of the practitioner's armamentarium. In addition, a lack of awareness about BPD and other mental health problems (Tay et al., 2019) needs to be addressed, including educating the family about BPD. And though inpatient recruitment of BPD patients in hospitals, psychological testing, and collective treatment engaging professionals could be listed under treatment issues we thought that

these were more peripheral ideas about BPD mental health and not treatment issues and therefore listed as a separate theme.

Conclusion

The study concluded that BPD is a cluster of symptoms and for treating the complex symptoms evidence-based practice requires practice by mental health professionals. Furthermore, the capacity and capability building of mental health professionals provides them with the data and modern knowledge, which is essential for the healthcare sector in Pakistan.

Limitations

One limitation of the current study is the diversity of BPD patients (age and gender) that were tapped by healthcare professionals when they were giving their responses to interview questions. We think asking the participants to focus on a narrow age range or a particular gender would have helped with the analysis. In addition, we think more interview questions and more prompts could have been included in the study for a more comprehensive and detailed analysis.

Future Research

Future studies could carry out quantitative surveys from healthcare professionals that are carved out of this thematic analysis. Such a study could corroborate, replicate and validate this study.

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