COMPLEX PTSD AS A LESS PEJORATIVE LABEL: IS THE PROPOSED DIAGNOSIS LESS STIGMATIZING THAN BPD?

Susannah Miller, M.S.

Dissertation Prepared for the Degree of

DOCTOR OF PHILOSOPHY

UNIVERSITY OF NORTH TEXAS

August 2014

APPROVED:

Patricia Kaminski, Major Professor
Jennifer Callahan, Committee Member
Thomas Parsons, Committee Member
Vicki Campbell, Chair of the Department of Psychology
Mark Wardell, Dean of the Toulouse Graduate School
Clinicians’ attitudes and behaviors toward patients with borderline personality disorder (BPD) are affected by the label’s stigma. Complex posttraumatic stress disorder (CPTSD) was proposed as a comprehensive and less stigmatizing diagnostic category for clients with BPD and a history of complex trauma. Given considerable similarities across both disorders’ diagnostic criteria, the CPTSD framework holds promise as a means to improve therapists’ attitudes towards clients with BPD and a history of complex trauma. However, this quality of CPTSD had not yet been examined empirically. Using vignettes in a between-subjects experimental design, this study investigated whether CPTSD is a less stigmatizing label than BPD for trauma survivors. Participants were 322 practicing psychotherapists. Evidence of BPD stigma was found, as was an affinity for CPTSD. Results generally supported CPTSD as a less stigmatizing label than BPD; therapists presented with a CPTSD-labeled vignette were somewhat less likely to blame the client for her symptomatic behavior and expected slightly stronger working alliance with the client than therapists presented with the BPD-labeled vignette. However, therapists’ agreement with the BPD diagnosis and theoretical orientation were found to be more salient than diagnostic label in affecting concepts related to the stigmatization of BPD clients. Additionally, familiarity with CPTSD was related to more favorable attitudes toward the client and her course of treatment. Regardless of CPTSD’s recognition as a formal diagnosis, education about the construct is widely recommended for therapists.
Copyright 2014

by

Susannah Miller
ACKNOWLEDGEMENTS

I sincerely thank Dr. Patricia Kaminski for her guidance at each stage of this dissertation. Dr. Kaminski, I am grateful for your collaboration and dedication to this project, especially the encouragement, expertise, and enthusiasm you have shared with me. I look up to you in many ways. Sincere thanks also go to my dissertation committee members, Drs. Callahan and Parsons, for helping to develop and refine my dissertation. Acknowledgement and thanks to the Dallas Psychological Association for honoring the project with their 2013 dissertation award and funding the incentive to participants. Additional thanks are offered to Dr. Callahan; in her role as my clinical program advisor, she extended herself beyond what would be expected to ensure I succeeded through the program, and I am grateful for her mentorship. I am also grateful for the collegiate, cooperative atmosphere I see cultivated within the UNT Department of Psychology. Heartfelt thanks go to my very good friends, Aditi, Chelsea, and Keisha. You helped to commiserate in the hard times and celebrate in the joyful ones. I am grateful for your friendships.

I also thank my parents and siblings for their unending support. Your encouragement was so strong it spanned across the country, keeping me motivated all of these years. Finally, I thank my future husband, Brian, for his faith, patience, and reassurance. You have been my biggest cheerleader, and I appreciate the sacrifices you made so that I could pursue this dream.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>iii</td>
</tr>
<tr>
<td>LIST OF TABLES AND FIGURES</td>
<td>viii</td>
</tr>
<tr>
<td>CHAPTER 1 INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Definition of Terms</td>
<td>2</td>
</tr>
<tr>
<td>Stigmatization of BPD Patients</td>
<td>3</td>
</tr>
<tr>
<td>The History of Borderline Personality Disorder</td>
<td>6</td>
</tr>
<tr>
<td>Psychoanalytic Beginnings</td>
<td>6</td>
</tr>
<tr>
<td>Multiple Expressions of Borderline</td>
<td>8</td>
</tr>
<tr>
<td>The Split: BPD within the <em>DSM.</em></td>
<td>9</td>
</tr>
<tr>
<td>Critiques of BPD</td>
<td>17</td>
</tr>
<tr>
<td>A “Wastebasket Diagnosis”</td>
<td>17</td>
</tr>
<tr>
<td>Social Conventions in Defining Criteria</td>
<td>17</td>
</tr>
<tr>
<td>Defined by Countertransference</td>
<td>18</td>
</tr>
<tr>
<td>Trauma in BPD Formation</td>
<td>19</td>
</tr>
<tr>
<td>Empirical Evidence of BPD Stigma</td>
<td>19</td>
</tr>
<tr>
<td>Comparing BPD and PTSD</td>
<td>29</td>
</tr>
<tr>
<td>Theories to Explain the Stigma of BPD</td>
<td>31</td>
</tr>
<tr>
<td>Real Difficulties</td>
<td>31</td>
</tr>
<tr>
<td>Challenging Symptoms</td>
<td>31</td>
</tr>
<tr>
<td>Difficult Countertransference</td>
<td>32</td>
</tr>
<tr>
<td>Lack of Fit with Medical Model</td>
<td>34</td>
</tr>
</tbody>
</table>

iv
Feeling Word Checklist .......................................................................................... 61
Working Alliance Inventory – Bond Scale ............................................................. 62
Therapist attitudes questionnaire ........................................................................ 62
Balanced Inventory of Desirable Responding ....................................................... 65
Demographics ........................................................................................................ 66
Prior awareness of CPTSD .................................................................................... 66
Procedure ............................................................................................................... 66

CHAPTER 3 RESULTS ................................................................................................. 68

Data Preparation ..................................................................................................... 68

Descriptive Analyses ............................................................................................. 69
Independent Variables .......................................................................................... 69
Dependent Variables ............................................................................................. 71
Therapist Attitude Questionnaire ......................................................................... 71
Impression Management ....................................................................................... 72
Familiarity with CPTSD ......................................................................................... 72
Agreement with Diagnosis ..................................................................................... 75

Inferential Analyses ............................................................................................... 76
Therapist Characteristics and Concepts Related to BPD Stigma ......................... 76
Familiarity with CPTSD and Concepts Related to BPD Stigma ......................... 78
Diagnostic Agreement and Concepts Related to BPD Stigma ......................... 80

Analyses of Experimental Effects ......................................................................... 81
Hypothesis 1 ............................................................................................................ 81
Hypothesis 2 ............................................................................................................ 88
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypothesis 3</td>
<td>95</td>
</tr>
<tr>
<td>Hypothesis 4</td>
<td>99</td>
</tr>
<tr>
<td>Diagnostic agreement</td>
<td>101</td>
</tr>
<tr>
<td>CPTSD implementation</td>
<td>104</td>
</tr>
<tr>
<td>CHAPTER 4 DISCUSSION</td>
<td>110</td>
</tr>
<tr>
<td>Evidence of BPD Stigma</td>
<td>110</td>
</tr>
<tr>
<td>Agreement with BPD Accuracy</td>
<td>111</td>
</tr>
<tr>
<td>Hesitancy to Disclose BPD</td>
<td>113</td>
</tr>
<tr>
<td>Overview of the Experimental Effects</td>
<td>114</td>
</tr>
<tr>
<td>Dispositional Attribution</td>
<td>116</td>
</tr>
<tr>
<td>Anger Countertransference</td>
<td>118</td>
</tr>
<tr>
<td>Working Alliance</td>
<td>121</td>
</tr>
<tr>
<td>Unfavorable Attitudes</td>
<td>123</td>
</tr>
<tr>
<td>Affinity for CPTSD</td>
<td>126</td>
</tr>
<tr>
<td>Therapists’ Characteristics</td>
<td>127</td>
</tr>
<tr>
<td>Length of Clinical Experience</td>
<td>127</td>
</tr>
<tr>
<td>Theoretical Orientation</td>
<td>128</td>
</tr>
<tr>
<td>Limitations</td>
<td>129</td>
</tr>
<tr>
<td>Directions for Future Research</td>
<td>131</td>
</tr>
<tr>
<td>Conclusions and Clinical Implications</td>
<td>134</td>
</tr>
<tr>
<td>APPENDICES</td>
<td>137</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>162</td>
</tr>
</tbody>
</table>
# LIST OF TABLES AND FIGURES

## Tables

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>DESNOS Diagnostic Criteria Used in the <em>DSM-IV</em> Field Trial</td>
<td>4</td>
</tr>
<tr>
<td>2.</td>
<td><em>DSM-III</em> Diagnostic Criteria for BPD</td>
<td>14</td>
</tr>
<tr>
<td>3.</td>
<td><em>DSM-IV-TR</em> Diagnostic Criteria for BPD</td>
<td>15</td>
</tr>
<tr>
<td>4.</td>
<td><em>DSM-5</em> Alternative Dimensional Diagnostic Criteria for BPD</td>
<td>16</td>
</tr>
<tr>
<td>5.</td>
<td>Items From the Therapist Attitudes Questionnaire as Included or Excluded in an Unfavorable Attitudes Total Score</td>
<td>64</td>
</tr>
<tr>
<td>7.</td>
<td>Number of Participants Assigned to Each Experimental Group</td>
<td>70</td>
</tr>
<tr>
<td>8.</td>
<td>Inter-correlations of All Dependent Variables and Impression Management</td>
<td>71</td>
</tr>
<tr>
<td>9.</td>
<td><em>N</em>, Means, and <em>SD</em>s of Dispositional Attribution Scores Across Theoretical Orientation Groups</td>
<td>77</td>
</tr>
<tr>
<td>10.</td>
<td><em>N</em>, Means, and <em>SD</em>s of Expected Working Alliance Scores Across Theoretical Orientation Groups</td>
<td>78</td>
</tr>
<tr>
<td>11.</td>
<td>Unfavorable Attitude Scores Compared by Items Assessing Familiarity with CPTSD</td>
<td>79</td>
</tr>
<tr>
<td>12.</td>
<td><em>N</em>, Means, and <em>SD</em>s of Dispositional Attribution Scores by Diagnostic Label and Priming Condition Groups</td>
<td>83</td>
</tr>
<tr>
<td>13.</td>
<td>Tests of Between-Subjects Effects: Dependent Variable: Dispositional attributions; Exploratory Analyses with Therapists Presented with BPD and CPTSD Diagnostic Vignettes (<em>n</em> = 223)</td>
<td>86</td>
</tr>
<tr>
<td>14.</td>
<td>Dispositional Attribution Scores Across Diagnostic Agreement, Priming, and Diagnostic Label Conditions Among Therapists in the CPTSD and BPD Diagnostic Label Groups (<em>n</em> = 223)</td>
<td>87</td>
</tr>
<tr>
<td>15.</td>
<td>Tests of Between-Subjects Effects: Dependent Variable: Anger Countertransference</td>
<td>89</td>
</tr>
</tbody>
</table>
16. N, Means, and SDs of Total Anger Scores by Diagnostic Label and Priming Groups .................................................................................................................... 90

17. Tests of Between-Subjects Effects: Dependent Variable: Anger Countertransference; Exploratory Analyses with Therapists Presented with the BPD and CPTSD Diagnostic Vignettes (n = 221) ........................................................................................................ 93

18. Anger Countertransference Scores Across Diagnostic Agreement, Priming, and Diagnostic Label Conditions Among Therapists in the CPTSD and BPD Diagnostic Label Groups ........................................................................................................ 94

19. N, Means, and SDs of Expected Working Alliance by Diagnostic Label and Priming Groups .................................................................................................................... 96

20. N, Means, and SDs of Expected Working Alliance by Diagnostic Label and Priming Groups Among Cognitive-Behavioral Therapists (n = 112) ........................................................................................................ 98

21. N, Means, and SDs of Expected Working Alliance by Diagnostic Label and Priming Groups Among Psychodynamic Therapists (n = 54) ........................................................................................................ 99

22. Tests of Between-Subjects Effects: Dependent Variable: Unfavorable Attitudes; Exploratory Analysis with Therapists Presented with BPD and CPTSD Diagnostic Vignettes (n = 218) ........................................................................................................ 103

23. Unfavorable Attitude Scores Across Diagnostic Agreement, Priming, and Diagnostic Label Conditions Among Therapists in the CPTSD and BPD Diagnostic Label Groups (n = 218) ........................................................................................................ 104

24. Tests of Between-Subjects Effects: Dependent Variable: Unfavorable Attitudes; Exploratory Analysis ............................................................................................................................................ 107

25. Unfavorable Attitude Scores Across CPTSD Implementation, Priming, and Diagnostic Label Conditions Among Therapists in All Diagnostic Conditions ............................................................................................................................................ 108

Figures

1. Unfavorable attitude scores among therapists who have not implemented CPTSD ............................................................................................................................................ 109

2. Unfavorable attitude scores among CPTSD-implementing therapists ............................................................................................................................................ 109
Borderline personality disorder (BPD) is not unique among mental disorders in its evolving, controversial history. Like other Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition Text Revision (DSM-IV-TR) diagnoses, it is a reflection of society and the political climate of the field. Neither is BPD unique among mental disorders as a stigmatizing diagnosis. However, unlike other specific disorders and mental illness in general, society may not be the main proponent of the stigma of BPD (Abdullah & Brown, 2011; Couture & Penn, 2003). Rather, persons with BPD are especially vulnerable to disparagement and vilification by mental health clinicians, the very professionals charged to treat them (Aviram, Brodsky, & Stanley, 2006; Becker, 2000; Fraser & Gallop, 1993; Gallop, Lancee, & Garfinkel, 1989; Reiser & Levenson, 1984; Shaw & Proctor, 2005; Warne & McAndrew, 2007). This poses a remarkable point of reflection on the part of clinicians, a rich opportunity for researchers, and a powerful responsibility to improve our work with these clients.

The topic is not new. Researchers and theorists have investigated therapists’ reactions to the BPD patient and have proposed valiant solutions. Some call for psychodynamic approaches and better understanding of difficult countertransference (e.g., Book, Sadavoy, & Silver, 1978; Fraser & Gallop, 1993). Some have developed tailored education programs targeted to improve therapists’ knowledge and competency with this population (e.g., Krawitz, 2004; Miller & Davenport, 1996; Treloar, 2009; Wright, Haigh, & McKeown, 2007). Others demand the dissolution of the diagnosis entirely, or they ask it be housed among mood disorders or posttraumatic stress
disorder (PTSD) on Axis I (e.g., Becker & Lamb, 1994; Gunderson & Phillips, 1991; Hodges, 2003; Marshall-Berenz, Morrison, Schumacher & Coffey, 2011; Tyrer, 2009). Many have noted the prevalence of childhood trauma in persons with BPD and point to recognition of trauma as an etiological factor as the best way to develop empathy with these clients (e.g., Fallon, 2003; Nehls, 1998; Wright et al., 2007). Going a step further, there is the complex PTSD (CPTSD) or disorders of stress, not otherwise specified (DESNOS) movement, which calls for a shift in the conceptualization of clients with a history of interpersonal trauma (Courtois, 2004; Herman, 1992b; van der Kolk & Courtois, 2005). CPTSD proponents argue it is a more parsimonious and less stigmatizing conceptualization of persons with a history of complex trauma who exhibit symptoms commonly labeled as BPD (Herman, 1992b; Pearlman & Courtois, 2005). Research regarding its empirical validity, however, has been mixed; moreover, the assumption that DESNOS is a less stigmatizing diagnosis than BPD has yet to be examined.

Definition of Terms

Several of the terms used in this paper lack one clear, universal definition and are often used slightly differently across the literature. Let me begin by clarifying these specific terms. The term “borderline” has an extensive history in the fields of psychiatry and psychology. Broadly, “borderline” is used to refer to the concept before the inclusion of borderline personality disorder (BPD) in the Diagnostic and Statistical Manual of Mental Disorders – Third Edition (DSM-III; APA, 1980). “BPD” refers to the diagnosis as it is outlined by its criteria in the DSM-IV-TR (APA, 2000).
Similarly, the CPTSD literature uses a variety of terms. Here, CPTSD is used to refer to Herman’s (1992b) original conceptualization and the general research it spawned on the topic of complex reactions to trauma. DESNOS refers only to the operationalization of the CPTSD construct as it was developed in the DSM-IV field trial, that is, the diagnostic criteria outlined in Table 1 (Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997, p. 541).

For ease and simplicity, “patient” is used to refer to both inpatient and outpatient consumers of mental health services. In cases where the population of reference is solely an outpatient group, the term “client” is used.

Stigmatization of BPD Patients

Many definitions of stigma exist in the literature, likely because stigma is studied across a wide variety of circumstances and is the subject of investigation across diverse fields of study (Link & Phelan, 2001; Stafford & Scott, 1986). Most researchers broadly define stigma as a distinction that links a person with undesirable characteristics and results in discrediting or devaluing the so-labeled person (Crocker, Major, & Steele, 1998; Jones et al., 1984; Goffman, 1963). Goffman (1963) asserted that the stigmatized person is lowered “from a whole and usual person to a tainted, discounted one” (p. 3).

In a review of the subject, Link and Phelan (2001) expanded on this definition to a conceptualization of stigma as the confluence of labeling, stereotyping, separation, status loss, and discrimination occurring in a context of a differential power situation. Link and Phelan (2001) explained the process temporally. First, people determine and label differences among each other.
### DESNOS Diagnostic Criteria Used in the DSM-IV Field Trial

<table>
<thead>
<tr>
<th>I. Alteration in Regulation of Affect and Impulses (A and one of B-F required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Affect regulation</td>
</tr>
<tr>
<td>B. Modulation of anger</td>
</tr>
<tr>
<td>C. Self-destructive</td>
</tr>
<tr>
<td>D. Suicidal preoccupation</td>
</tr>
<tr>
<td>E. Difficulty modulating sexual involvement</td>
</tr>
<tr>
<td>F. Excessive risk-taking</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>II. Alterations in Attention or Consciousness (A or B required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Amnesia</td>
</tr>
<tr>
<td>B. Transient dissociative episodes and depersonalization</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>III. Alterations in Self-Perception (Two of A-F required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Ineffectiveness</td>
</tr>
<tr>
<td>B. Permanent damage</td>
</tr>
<tr>
<td>C. Guilt and responsibility</td>
</tr>
<tr>
<td>D. Shame</td>
</tr>
<tr>
<td>E. Nobody can understand</td>
</tr>
<tr>
<td>F. Minimizing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IV. Alterations in Perception of the Perpetrator (Not required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Adopting distorted beliefs</td>
</tr>
<tr>
<td>B. Idealization of the perpetrator</td>
</tr>
<tr>
<td>C. Preoccupation with hurting perpetrator</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>V. Alterations in Relations with Others (One of A-C required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Inability to trust</td>
</tr>
<tr>
<td>B. Revictimization</td>
</tr>
<tr>
<td>C. Victimizing others</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VI. Somatization (Two of A-E required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Digestive system</td>
</tr>
<tr>
<td>B. Chronic pain</td>
</tr>
<tr>
<td>C. Cardiopulmonary symptoms</td>
</tr>
<tr>
<td>D. Conversion symptoms</td>
</tr>
<tr>
<td>E. Sexual symptoms</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VII. Alterations in Systems of Meaning (One of A-B required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Despair and hopelessness</td>
</tr>
<tr>
<td>B. Loss of previously sustaining beliefs</td>
</tr>
</tbody>
</table>

**Note.** Field trial diagnostic criteria as reported in Roth et al., 1997, p. 541

Then, through mechanisms of the dominant culture, labeled persons are linked to unwanted characteristics, and negative stereotypes are created. Furthermore, the labeled persons are categorized in a separate group, distinctly separating “us” from
“them.” The result is that the labeled persons experience a loss in status and discrimination. Finally, Link and Phelan (2001) asserted that a power differential must exist for stigmatization to occur. To elaborate, they explained that though members of a disenfranchised group may stereotype those of the dominant group, stigmatization of the dominant group cannot occur because the minority group lacks the necessary power to discriminate against the dominant group.

It is within this conceptualization of stigma by Link and Phelan (2001) that the experiences of patients with borderline personality disorder (BPD) are examined in this study.

Proceeding through the model of stigma proposed by Link and Phelan (2001) clarifies the proposal that mental health clinicians stigmatize persons with BPD. Meeting the first criterion, the person is found to be different, and he or she is diagnosed with BPD. This label links the patient with “undesirable characteristics.” As is elaborated, a diagnosis of BPD is associated with a host of negative characteristics, from attention-seeking to manipulative to undeserving of care, and worse (e.g., Aviram et al., 2006; Brody & Farber, 1996). Mental health professionals socially distance themselves from their patients, and this is especially true with patients diagnosed with BPD (Markham, 2003). This effectively illustrates the separation of “us” and “them.” As is discussed further, persons with BPD face discrimination in their mental health treatment as well as in other important spheres, such as the legal system (Fallon, 2003; Herman, 1992b; Sanders, 2005; Stefan, 1998). Lastly, the power differential between a mental health professional and his or her patient or client is indisputable. Thus, all five
criteria for stigmatization put forth by Link and Phelan (2001) are met in the relationship between therapist and BPD client.

The History of Borderline Personality Disorder

BPD’s history is especially confusing due to the different names, theories and diagnostic criteria that have been used to define the umbrella term “borderline.” In fact, there has been a lack of consensus to what “borderline” refers most simply; is it a disorder, condition, state, syndrome, personality, organization, or patient (Gunderson & Singer, 1975; Raifman, 1984)? Akiskal and colleagues (1985, p. 41) famously referred to borderline as “an adjective in search of a noun.” Despite the variance in the borderline concept and confusion as to what the term precisely describes, its history can be best understood as it follows the evolution of the field of psychiatry through the 20th century and into the present.

Psychoanalytic Beginnings

Historians point to initial mentions of the borderline concept in writings as early as 1884 (Raifman, 1984), although the term “borderline” was not used until 1938 (Stern, 1938, as cited by Gunderson & Singer, 1975), and Knight (1953) was the first to use the term “borderline” to refer to patients who could not be categorized as neurotic or psychotic. Psychoanalytic theory dominated psychiatry at that time, a fact that is clearly reflected in borderline’s early conceptualization; the “border” to which borderline first referred was the tenuous “space” between neurosis and psychosis. A variety of terms were first used to describe the patient that fell into this category, most of which emphasized its closeness to schizophrenia. These terms often described a state that
either anticipated or concealed an underlying schizophrenia (Aronson, 1985; Gunderson, 2009; Gunderson & Singer, 1975; Raifman, 1984).

Deutsch’s (1942, as cited by Raifman, 1984) “as-if personality” described patients whose relationships at the surface appeared to be appropriate and meaningful, but on closer inspection were without depth or authenticity. In other words, the superficial, appropriate functioning masked an underlying dysfunction. Similarly, Rorschach (1921, as cited by Gunderson & Singer, 1975) and others (Bleuler, 1911; Federn, 1952, as cited by Gunderson & Singer, 1975) used the term "latent schizophrenic" to refer to patients whose apparently normal functioning hid an underlying schizophrenia. For instance, these patients were seemingly well-reasoned but gave responses to the Rorschach test that resembled those of schizophrenic patients. They were reported to have “micropsychotic breaks” in times of stress when their reality testing would be impaired (Aronson, 1985). These patients were further identified by their difficulty to treat in psychoanalysis; although they were initially thought to be “analyzable,” treatment was not successful and, on occasion, appeared to worsen their condition (Aronson, 1985, p. 210). Other terms that were used for this category of patients include preschizophrenia, schizophrenic character, abortive schizophrenia, pseudopathic schizophrenia, subclinical schizophrenia, and pseudoneurotic schizophrenia (Aronson, 1985; Gunderson, 2009; Raifman, 1984). Over time, “borderline” became the preferred descriptor. Thus, in its early days, borderline referred to the border of neurosis and psychosis, with an emphasis on its relatedness to schizophrenia, and was often used when patients were particularly difficult to treat in psychoanalysis.
Knight (1953) noted that certain seemingly functional patients experienced psychotic symptoms while in psychoanalysis. He described these periods of intermittent psychosis as “borderline states” and developed a list of criteria common to the patients with this experience. Knight’s (1953) criteria included neurotic symptoms, such as phobias, obsessive-compulsive behavior, psychosomatic symptoms, and ego weaknesses. The clearly observable ego weaknesses included inappropriate affect, externally triggered symptoms, lack of achievement, unrealistic planning, bizarre dreams, and inability to separate dreams from reality (Knight, 1953). Subtler ego weaknesses included impaired integration of ideas, impaired concept formation, impaired judgment, occasional blocking, peculiar word usage, lack of insight, and suspiciousness (Knight, 1953).

Kernberg (1967) expanded the concept to a personality type and generated an expansive list of characteristics associated with borderline personality organization. These characteristics included: chronic or diffuse anxiety, neurosis (e.g., phobias, obsessive-compulsive symptoms, conversion symptoms, hysterical or fugue dissociation, paranoia, hypochondriasis), perverse sexual behavior, “prepsychotic personality” (paranoid, schizoid, hypomanic or cyclothymic personality), impulse neurosis and addictions (e.g., alcoholism, drug addiction, kleptomania), and “lower-level” character disorders (hysterical, narcissistic, or depressive masochistic personality).

Multiple Expressions of Borderline

Four primary views of the borderline concept began to emerge (Aronson, 1985; Liebowitz, 1979). There were those who continued to define the concept with its
relation to schizophrenia and offered evidence of borderline as a mild schizophrenia (e.g., Hoch & Polatin, 1949; Kety, Rosenthal, Wender, & Schulsinger, 1968). Others focused on its relation with affective disturbance and proposed borderline as a subtype of affective disorder (e.g., Pope & Lipinski, 1978). There were also proponents of borderline as a distinct entity and personality disorder (e.g., Grinker, Werble, & Drye, 1968; Gunderson & Singer, 1975; Spitzer, Endicott, & Gabbon, 1979), and the psychoanalytic opinion of borderline as a psycho-structural level of functioning also continued (Akiskal et al., 1985; Aronson, 1985; Kernberg, 1967, 1971; Knight, 1953).

The Split: BPD within the DSM

The borderline concept evolved in the 1970s as the field of psychiatry became less dominated by psychoanalytic theory. In the decade leading up to the publication of the seminal *DSM-III* in 1980, psychiatry shifted from a predominantly psychoanalytic conceptualization of mental disorders to one resting on descriptive, observable features, and the challenge became to define borderline in these terms. This was not a simple task, as Spitzer and colleagues (1979) explained, because of confusion around the borderline concept and limited data on its utility and validity as a diagnosis. Gunderson and Singer (1975) summarized the divergent views of the concept at this time, noting that behaviorally oriented psychiatrists, psychoanalysts, and assessment psychologists understandably observed different characteristics of the borderline patient. They sought to integrate the observations into a comprehensive picture and described the borderline patient in terms of his or her symptoms and behavior as well as intrapsychic phenomena and ego functions. As primary characteristics, Gunderson and Singer (1975) identified the following: intense affect, a history of impulsive behavior, superficial
social adaptiveness, brief psychotic experiences, loose thinking in unstructured situations, and relationships that vacillate between superficiality and dependency.

Also over this decade there appeared a growing split in the borderline concept, with some writers continuing to note the borderline patient’s susceptibility to psychosis and emphasizing the relation to schizophrenia, and others focusing on the problematic affective and interpersonal functioning of these patients. Spitzer et al. (1979) conducted a cross-validation study to determine whether these aspects were part of a single borderline concept or if they represented independent dimensions. The term “schizotypal” was chosen to represent borderline schizophrenia, as it emphasized its likeness to schizophrenia, while the term “unstable” was used to describe the borderline personality organization, emphasizing these patients’ reported instability of affect, relationships, and sense of identity.

Spitzer et al. (1979) consulted with experts and examined case records of patients diagnosed with borderline schizophrenia in order to identify schizotypal personality items. The following items were identified as criteria: odd communication (e.g., tangential, vague, overelaborate, or circumstantial speech); ideas of reference, suspiciousness or paranoid ideation; recurrent illusions, depersonalization or derealization; magical thinking (e.g., superstitiousness, clairvoyance, telepathy); constricted or inappropriate affect; social anxiety or hypersensitivity to real or imagined criticism; and social isolation. The following unstable personality criteria were selected through a review of the literature and consultation with experts: identity disturbance evidenced by uncertainty in self-image, gender identity, long-term goals, career choice, and values; a pattern of unstable and intense interpersonal relationships; impulsivity in
at least two areas which are potentially self-damaging (e.g., spending, sex, gambling, drug or alcohol use, shoplifting); inappropriate intense anger; physically self-damaging acts (e.g., suicidal gestures, self-mutilation); work or school achievement that is unstable or below what would be expected given intelligence and opportunities; affective instability; chronic feelings of emptiness or boredom; and problems tolerating being alone, including frantic efforts to avoid being alone. In the questionnaire developed for the cross-validation study, the schizotypal and unstable items were combined and intermingled along with five unidentified, additional related items and presented in a true-false format (Spitzer et al., 1979).

Four thousand American psychiatrists were contacted to participate in the cross-validation study. Of these, a total of 808 psychiatrists responded to the request. They were instructed to consider two adult or adolescent patients they had treated, one they believed fit a diagnosis of borderline personality, borderline personality organization, or borderline schizophrenia, and the other, to serve as a control, a patient who was moderately to severely ill but did not exhibit psychosis or fit any of the borderline categories. With these patients in mind, they were asked to go through the list of items and determine whether each item was true or false for each patient. Spitzer et al. (1979) then conducted two factor analyses, first using the borderline patient group (n = 808) and then using the combined borderline and control groups (n = 1616). In both analyses, the schizotypal items loaded onto the first factor and the Unstable items onto the second. There was one exception; the schizotypal item of undue social anxiety or hypersensitivity to criticism loaded onto Factor 2 in the borderline-only factor analysis and onto Factor 1 in the borderline and control combined factor analysis. They also
looked at a five-factor model, where they found that the first and second factors mostly held the schizotypal and unstable items, respectively. The remaining three factors reflected dysphoria and affective instability, social isolation and boredom, and suspiciousness or paranoid ideation. Discriminant function analyses were conducted and found that the combined schizotypal and unstable items had sensitivity of 88% and specificity of 87% in determining borderline versus control. The combined item set was less effective at predicting borderline schizophrenia versus borderline personality organization (correct classification 64%).

The schizotypal and unstable item sets were generally upheld by the factor and discriminant function analyses. One unstable item, unstable or below expected work or school achievement, was removed as it predicted borderline schizophrenia, loaded relatively equally on the two factors, and did not help discriminate borderline from control patients. Presumably measured by Cronbach’s alpha (the authors do not report the statistic used), the item sets’ internal consistency coefficients were .54 for schizotypal and .58 for unstable; the internal consistency for the combined items was .57. Spitzer et al. (1979) acknowledged the poor internal consistency but cited the low consistency of the combined set as justification for the two as independent dimensions. The researchers further examined the item sets to determine the number of items that would reflect the best sensitivity and specificity in diagnosing either borderline schizophrenia (schizotypal items) or borderline personality organization (unstable items) from the control patients. They determined that a cut-off of five items of the unstable personality item set resulted in the best diagnostic accuracy of borderline personality organization, with sensitivity of 77% and specificity of 82%.
Despite the proposal of a change in name to “unstable personality disorder,” the label “borderline” remained. No longer representing the border between neurosis and psychosis and at that time devoid of any reference to impaired reality testing under stress, the decision was made to continue using the borderline term. It seems an affinity for the term existed by this time that was thought too entrenched to change.

Although the proponents of the borderline schizophrenia concept appear to be satisfied with the term “schizotypal,” the investigators and clinicians who have used the borderline personality concept are far from satisfied with the term “unstable personality disorder.” They argue that the term “unstable” is a misnomer because the personality is in fact quite stably unstable. They assert that clinicians will never abandon the term “borderline” in favor of the term “unstable.” (Spitzer et al., 1979; p. 24)

Thus, schizotypal personality disorder and borderline personality disorder, as their diagnostic criteria were identified and confirmed in the cross-validation study (Spitzer et al., 1979), entered the official nomenclature in the *DSM-III* (APA, 1980). The BPD diagnostic criteria as they were put forth in the *DSM-III* are presented in Table 2 (APA, 1980, p. 347). The separation of BPD and schizotypal personality disorder is generally confirmed (Rosenberger & Miller, 1989; Spitzer & Endicott, 1979) and the diagnostic criteria of each were changed only slightly in the publication of the *DSM-IV* (APA, 1994). Specifically, “intolerance of being alone” was changed to “frantic attempts to avoid real or imagined abandonment,” and a ninth criterion, transient, stress-related paranoid ideation or severe dissociation symptoms, was added. The criteria were not further updated in the *DSM-IV-TR* (APA, 2000). The BPD criteria outlined in the *DSM-IV-TR* are presented in Table 3 (APA, 2000, p. 710).

The *DSM-5* presented another opportunity for changes to the BPD diagnostic criteria. The *DSM-5* introduced an alternative, dimensional model for BPD (APA, 2013),
the criteria of which are presented in Table 4, but it also retained the categorical model, with no changes to the BPD criteria listed in the *DSM-IV*.

Table 2

*DSM-III Diagnostic Criteria for BPD*

The following are characteristic of the individual's current and long-term functioning, are not limited to episodes of illness, and cause either significant impairment in social or occupational functioning or subjective distress.

A. At least five of the following are required:

1. impulsivity or unpredictability in at least two areas that are potentially self-damaging, e.g., spending, sex, gambling, substance use, shoplifting, overeating, physically self-damaging acts
2. a pattern of unstable and intense interpersonal relationships, e.g., marked shifts of attitude, idealization, devaluation, manipulation (consistently using others for one's own ends)
3. inappropriate, intense anger or lack of control of anger, e.g., frequent displays of temper, constant anger
4. identity disturbance manifested by uncertainty about several issues relating to identity, such as self-image, gender identity, long-term goals or career choice, friendship patterns, values, and loyalties, e.g., “Who am I?”, “I feel like I am my sister when I am good”
5. affective instability: marked shifts from normal mood to depression, irritability, or anxiety, usually lasting a few hours and only rarely more than a few days, with a return to normal mood
6. intolerance of being alone, e.g., frantic efforts to avoid being alone, depressed when alone
7. physically self-damaging acts, e.g., suicidal gestures, self-mutilation, recurrent accidents or physical fights
8. chronic feelings of emptiness or boredom

B. If under 18, does not meet the criteria for Identity Disorder.

Table 3

DSM-IV-TR Diagnostic Criteria for BPD

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.
(2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
(3) identity disturbance: markedly and persistently unstable self image or sense of self
(4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance use, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.
(5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
(6) affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
(7) chronic feelings of emptiness
(8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
(9) transient, stress-related paranoid ideation or severe dissociative symptoms

Note. From the DSM-IV-TR (APA, 2000, p. 710).
### Table 4

**DSM-5 Alternative Dimensional Diagnostic Criteria for BPD**

A. Moderate or greater impairment in personality functioning, manifested by characteristic difficulties in two or more of the following four areas:

1. **Identity**: Markedly impoverished, poorly developed, or unstable self-image, often associated with excessive self-criticism; chronic feelings of emptiness; dissociative states under stress.
2. **Self-direction**: Instability in goals, aspirations, values, or career plans.
3. **Empathy**: Compromised ability to recognize the feelings and needs of others associated with interpersonal hypersensitivity (i.e., prone to feel slighted or insulted); perceptions of others selectively biased toward negative attributes or vulnerabilities
4. **Intimacy**: Intense, unstable, and conflicted close relationships, marked by mistrust, neediness, and anxious preoccupation with real or imagined abandonment; close relationships often viewed in extremes of idealization and devaluation and alternating between overinvolvement and withdrawal.

B. Four or more of the following seven pathological personality traits, at least one of which must be (5) Impulsivity, (6) Risk taking, or (7) Hostility:

1. **Emotional lability** (an aspect of Negative Affectivity): Unstable emotional experiences and frequent mood changes; emotions that are easily aroused, intense, and/or out of proportion to events and circumstances
2. **Anxiousness** (an aspect of Negative Affectivity): Intense feelings of nervousness, tenseness, or panic, often in reaction to interpersonal stresses; worry about the negative effects of past unpleasant experiences and future negative possibilities; feeling fearful, apprehensive, or threatened by uncertainty; fears of falling apart or losing control.
3. **Separation insecurity** (an aspect of Negative Affectivity): Fears of rejection by – and/or separation from – significant others, associated with fears of excessive dependency and complete loss of autonomy.
4. **Depressivity** (an aspect of Negative Affectivity): Frequent feelings of being down, miserable, and/or hopeless; difficulty recovering from such moods; pessimism about the future; pervasive shame; feelings of inferior self-worth; thoughts of suicide and suicidal behavior.
5. **Impulsivity** (an aspect of Disinhibition): Acting on the spur of the moment in response to immediate stimuli; acting on a momentary basis without a plan or consideration of outcomes; difficulty establishing or following plans; a sense of urgency and self-harming behavior under emotional distress.
6. **Risk taking** (an aspect of Disinhibition): Engagement in dangerous, risky, and potentially self-damaging activities, unnecessarily and without regard to consequences; lack of concern for one’s limitations and denial of the reality of personal danger.
7. **Hostility** (an aspect of Antagonism): Persistent or frequent angry feelings; anger or irritability in response to minor slights and insults.

*Note.* From the *DSM-5* (APA, 2013, p. 766-767).
Critiques of BPD

Criticism of the BPD diagnosis began in its inception in the DSM-III with the decision to separate schizotypal symptoms from BPD (Grinker, 1979). Siever and Gunderson (1979) used their review of borderline’s genetic determinants as a platform to denounce the decision, calling it “premature” and based on incomplete genetic evidence. Others criticized the DSM-III’s emphasis on observable or reportable symptoms. Aronson (1985) explained that the psychodynamic theories of defenses and ego functioning were important in understanding the borderline concept and that to dismiss these was a mistake.

A “Wastebasket Diagnosis”

As far back as 1953, Knight deemed borderline a “wastebasket diagnosis” as it seemed to account for a widely heterogeneous group of patients that were so-labeled because they were difficult to diagnose and did not readily fit into established diagnostic categories. Despite the attempt to limit and operationalize BPD criteria, critics continue to argue that clients diagnosed with BPD are more dissimilar than similar and too diverse to constitute a single diagnostic category. Many have noted the numerous different constellations of symptoms that could meet the diagnosis for BPD based on the requirement that only five of the nine symptoms must be present (Hersh, 2008; Hodges, 2003; Lenzenweger & Cicchetti, 2005; Lewis & Grenyer, 2009).

Social Conventions in Defining Criteria.

BPD is condemned by feminists and others who believe the diagnostic criteria serve to pathologize women who do not meet cultural gender norms (Becker & Lamb, 1994; Hodges, 2003; Shaw & Proctor, 2005; Warne & McAndrews, 2007). Perhaps
more so than Axis I disorders, personality disorders rely on social conventions and society’s idea of what it means to be “normal” (Becker & Lamb, 1994; Shaw & Proctor, 2005; Warne & McAndrew, 2007), and decisions of whether a patient meets the BPD diagnostic criteria, particularly regarding interpersonal functioning, require a significant degree of subjective judgment.

Defined by Countertransference

Although some recommended using countertransference to confirm BPD diagnoses (Book et al., 1978; Gunderson & Singer, 1975), others have criticized the practice, explaining that it leads to a “looseness” in the use of the term as referring to any patient that evokes anger or dislike and relies on an irrational, circular argument (Aronson, 1985; Becker, 2000; Hodges, 2003; Lequesne & Hersh, 2003; Raifman, 1984). That is, the argument that a client is demanding because she has BPD or that the BPD diagnosis is accurate because she is demanding is illogical and impossible to prove. Becker (2000) noted it is suspicious when therapists’ countertransference reactions are considered as evidence of the validity of the diagnosis. Gunderson and Sabo (1993) asserted that countertransference and therapists’ subjective like or dislike of a client unduly influence their diagnostic decisions, and Reiser and Levenson (1984) cited using the term as an expression of “countertransference hate” as one of the common ways the borderline diagnosis is abused. Aronson (1985) explained the implications: “As an expression of countertransference hate, borderline explains away the breakdown in empathy between therapist and patient and becomes an institutional epithet in the guise of pseudoscientific jargon” (p. 217).
Trauma in BPD Formation

Though BPD’s diagnostic criteria in the *DSM-IV* were left relatively unchanged from its original criteria in the *DSM-III*, the *DSM-IV* introduced a modification that had significant implications for many diagnosed with BPD: a change in the definition of trauma in the PTSD diagnosis. Previously stipulated in the *DSM-III* as having to be “outside the range of normal human experience” (APA, 1980, p. 236), trauma in the *DSM-IV* included “an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or to others” (APA, 1994, p. 467). This brought the tragically prevalent sexual and physical abuse of women into the class of traumatic experiences that were acknowledged could lead to PTSD (Hodges, 2003).

The relation of BPD and trauma has been studied extensively. Herman, Perry, and van der Kolk (1989) found high rates of childhood abuse among patients diagnosed with BPD or exhibiting BPD traits, with 81% of participants with BPD reporting trauma histories. Ogata et al. (1990) compared the trauma histories of BPD and depressed patients and found significantly higher rates of sexual abuse among BPD patients (71%) compared to the depressed group (22%). Numerous studies have confirmed high prevalence of childhood abuse in patients diagnosed with BPD (Barnard & Hirsh, 1985; Courtois, 1988; Gunderson & Sabo, 1993; Herman, 1992; McLean, 2004; Rieker & Carmen, 1986; Stone, Unwin, Beacham & Swenson, 1988; Surrey, Swett, Michaels & Lewvin, 1990; Wheeler & Walton, 1987; Yen & Shea, 2001; Zanarini et al., 1997).

Empirical Evidence of BPD Stigma

Stigmatization of those with BPD by mental health clinicians, as realized by dislike, diminished empathy, and social distancing, among other manifestations, has
been observed in a variety of environments. Book et al. (1976) provide anecdotal evidence of hospital staff’s hostile dislike of patients with BPD with the following, rather disturbing example:

Shortly after a number of patients with the diagnosis of borderline personality disorganization were rapidly admitted to the ward, an intriguing object appeared speared to the staff bulletin board. It was a small wool doll. Underneath was the word “border” and underneath that word was a thick black “line.” This, we took as a symbolic representation of “borderline” patients. The doll was skewered to the bulletin board by six shiny syringes. (Book et al., 1976, p. 525)

Lewis and Appleby (1988) examined the topic empirically. The researchers presented 240 British psychiatrists with a randomly assigned vignette describing a patient presenting for hospital admission. The vignettes were identical except for the mention of a previous diagnosis; the vignettes either did not mention a previous diagnosis, provided a previous diagnosis of personality disorder, or provided a previous diagnosis of depression. Lewis and Appleby (1988) also manipulated the patient’s sex and social status in the vignettes, but in analysis collapsed groups and simply compared the responses of psychiatrists who read the personality disorder vignette with the remaining groups. The psychiatrists were asked to rate how much they agreed with 22 statements about the patient.

Significant differences were found between the personality disorder vignette and other vignettes for 16 of the statements. Psychiatrists reacting to the patient labeled with personality disorder responded with higher agreement to the following statements: patient is manipulating hospital admission, unlikely to arouse sympathy, suicidal behavior is “attention-seeking,” should be discharged, would not like to have in one’s care, difficult to manage, likely to annoy, unlikely to improve, debt is under patient’s control, not mentally ill, does not merit psychiatrist’s time, unlikely to complete
treatment, unlikely to comply with treatment, condition not severe, not a suicide risk, and antidepressants not indicated. Lewis and Appleby (1988) conceptualized the primary factor resulting in these differences as the belief that personality disorder is not a mental illness. They assert that failing to consider personality disorder as illness causes clinicians to reject these patients and consider them more in control of their behavior and less deserving of treatment.

Gallop, Lancee, and Garfinkel (1989) studied the BPD label as it influences psychiatric nurses’ empathy toward the patient. The researchers hypothesized that the BPD label alone was enough to diminish the nurses’ expressed empathy with the patient. They used a within-subjects design to compare 113 registered nurses’ responses to hypothetical clients with a diagnosis of schizophrenia or BPD. Participants were presented with four short vignettes describing the patients, two diagnosed with BPD and two with schizophrenia. They were given hypothetical statements from the patient (e.g., “I just want to stay in bed – please,” “Life’s not worth living. There is nothing anyone can do,” and “Go away – get off my case – don’t you ever give up?”), then were asked to write what they would respond to each statement. The nurses’ responses were categorized into three levels of empathic care: no care, solution based, or affective involvement. Responses in the “no care” group were considered the least empathic and included statements that were belittling to the patient or which offered platitudes or clichés. Responses in the “solution” category included responses that focused on explaining the hospital rules to the patient, told the patient what to do, or otherwise offered solutions to the patient. Responses in the “affective involvement”
group, judged to be the most empathic, included responses that expressed care or concern for the patient or addressed the patient’s feelings.

Gallop et al. (1989) found that nurses were more likely to give affective involvement responses to patients diagnosed with schizophrenia than with BPD. Nurses were also more likely to give responses in the “no care” category to the patient with BPD than the patient with schizophrenia. The researchers hypothesized that nurses may respond with belittling or contradictory comments to patients labeled with BPD as a way to remain affectively distant and protect themselves from the difficult countertransference they predict the BPD patient may evoke. Gallop et al. (1989) argued that the label alone is enough to evoke this behavior in nurses, as they concluded that a BPD diagnosis stereotypes the patient and creates in nurses the expectations of negative interactions with them.

Parting from the vignette design, Fraser and Gallop (1993) examined the stigmatization of BPD patients through in vivo observation of psychiatric nurses and patients. The researchers observed 20 45-minute process groups with psychiatric inpatients led by a registered nurse ($N = 17$ nurses and 164 inpatients). The inpatients were grouped by diagnosis: schizophrenia ($n = 21$), BPD ($n = 34$), affective disorder ($n = 91$), and other ($n = 18$). An author blind to patient diagnosis rated the nurses’ responses during group as confirming or disconfirming using Heineken’s Confirmation/Disconfirmation Rating Instrument (Heineken, 1982). Fraser and Gallop (1993) found significant differences between the BPD and affective disorder groups and between the BPD and “other” diagnoses groups, where nurses responded with more disconfirming responses to the BPD group. These results provide evidence of actual
differential treatment of BPD patients, giving credence to the extension of results from hypothetical vignette studies to real events.

Brody and Farber (1996) surveyed psychology graduate student therapists and practicing psychologists to compare their countertransference reactions to patients diagnosed with depression, schizophrenia, and BPD. The researchers presented 336 therapists (21% graduate students, 12% on internship, and 65% licensed psychologists) with three vignettes describing patients with each of the three diagnoses. The sex and order of the vignettes were randomly assigned so that participants received either male or female versions of each case in varying orders. Participants were asked to rate how likely they imagined the patient to evoke feelings related to positive countertransference and negative countertransference, and to evoke countertransference-related behaviors. Feelings related to positive countertransference included: liking the patient, gratification, empathy, nurturance, compassion, helpfulness, challenge, and engagement. Negative countertransference items were feelings of boredom, anger, anxiety, hopelessness, irritation, frustration, and depression. The countertransference-related behaviors included temptation or tendency to give advice, to think about the patient in one’s leisure time, refer patient, let sessions run over time, and let the patient know you value and/or like him or her.

With the exception of two items, “challenged” and “gratified,” Brody and Farber (1996) found the borderline patients were expected to evoke the least positive feelings, whereas depressed patients were expected to evoke the most positive feelings. In fact, the lowest rated item of all positive countertransference items was for the BPD patient on the item “liking the patient.” Additionally, the BPD patient was expected to arouse
the most anger and greatest irritation and was least likely to evoke acknowledgement
that he or she is liked, to tempt therapists to run over session time, and to be thought of
in the therapist’s leisure time. This research raises the question of whether therapists’
anticipations about how they will interact with clients are based, in part, on their
expected countertransference reactions and not solely on what is best for the clients’
treatment.

Markham (2003) studied the effect of the BPD label on psychiatric nurses’ and
health care assistants’ social rejection, beliefs about dangerousness, optimism for
treatment, and overall ratings of work experience with BPD patients. In this repeated
measures design, 71 registered psychiatric nurses and health care assistants
completed all measures with three psychiatric label conditions: BPD, schizophrenia, and
depression. A modified version of the Social Distance Scale (Trute & Loewen, 1978, as
cited in Markham, 2003) measured staff’s social acceptance or rejection of patients with
the three psychiatric labels by asking them to rate their agreement with statements such
as “If you had children you would strongly discourage them from marrying a man or
woman who had been diagnosed with BPD,” “You would agree to providing board and
lodgings for a man or woman with BPD,” and “You would be willing to work on the same
job with a man or woman who had BPD,” where “BPD” was replaced with schizophrenia
and depression in the various conditions.

Additionally, Markham (2003) incorporated the social rejection scale developed
by Link, Cullen, Frank, and Wozniak (1987) to measure the staff’s perception of
patients’ dangerousness. This scale asked participants to rate their agreement with
statements such as “If a man or woman with BPD lived nearby I would not hesitate to
allow young children under my care to play near their residence,” “If a man or woman with BPD applied for a teaching job at a junior school and was qualified for the job I would recommend hiring him or her,” and “The main purpose of psychiatric hospitals should be to protect the public from men and women with BPD.” Again, the statements were repeated to inquire about all three diagnostic labels. Optimism for change was measured by agreement with statements such as, “A man or woman with this disorder will always have problems once they have developed” and “Their problems are so ingrained their behavior will not be responsive to treatment.” The staff were also asked to indicate the quality of their personal experience working with each type of patient on a scale from extremely positive to extremely negative.

Markham (2003) found significant differences between the three diagnostic labels on all measures. In comparison with the schizophrenia and depression labels, participants rated the BPD label as lower in optimism for change and higher in social distance, dangerousness, and negative overall work experience. Markham (2003) examined differences between the registered nurses ($n = 50$) and health care assistants ($n = 21$), but these results should be interpreted with caution because of low statistical power in the latter group. Examined separately, the registered nurses’ ratings supported the hypothesis that staff would be more socially rejecting towards patients with BPD label, while the health care assistants’ ratings were often not significantly different across the groups. These results may suggest that staff with more experience and training are more likely to reject BPD patients, but may be simply a result of lower statistical power due to the smaller sample size of health care assistants. Markham (2003) points out that the perception that patients with BPD are more dangerous to
others than patients with schizophrenia or depression is without demonstrated empirical evidence. Although some research suggests patients with BPD have biological markers correlated with impulsive aggression to others (Trestman, 1997), empirical comparisons of actual, committed violence by members of this diagnostic group is lacking, and most experts agree that patients with BPD are more likely to hurt themselves than others (Linehan, 1993).

Exploring a potential cause for their stigmatization, Markham and Trower (2003) studied psychiatric nurses’ perceptions of BPD patients through their causal attributions for patients’ behavior. They evaluated 48 registered psychiatric nurses’ beliefs about the cause of patients’ behavior using the modified Attributional Style Questionnaire (Peterson, Semmel, Von Baeyer, Abramson, Metalsky, & Seligman, 1982). Participants were asked to imagine a patient with a particular diagnosis (BPD, schizophrenia, or depression) and presented with six written examples of common challenging behaviors (e.g., refusing to follow staff’s instructions). Participants rated the controllability of the behavior, then developed one possible cause for each behavior and rated the internality, stability, globality, and controllability of their expected cause. Participants also rated their level of sympathy with the patient on a 7-point scale.

The challenging behaviors were considered more stable for BPD patients than for patients with schizophrenia or depression. BPD patients were also thought to be more in control of both their behavior and the cause of the behavior than patients with schizophrenia or depression. There were no significant differences among the three diagnoses on the internality or globality dimensions. Importantly, the nurses had
significantly lower levels of sympathy for BPD patients than for patients with schizophrenia or depression.

The differences in attributions examined in this study could be a reflection of defining differences between Axis I and II disorders. For example, the diagnostic criteria explicitly describe BPD's traits as stable and enduring. Therefore, these results might be more compelling if BPD was compared with other Axis II disorders. Nevertheless, the nurses' reported diminished sympathy for BPD patients, and the belief that the BPD patient is in control of his or her behavior is relevant to the stigmatization of these patients as it may relate to a distinction in their perception as “immoral or bad” rather than ill or troubled (Markham & Trower, 2003, p. 245).

Researchers have also used qualitative studies to better understand clinicians’ perceptions of BPD patients and the BPD patient’s experience. Fallon (2003) analyzed hour-long unstructured interviews with seven persons diagnosed with BPD. Six of the seven interviewed spontaneously discussed negative attitudes from mental health workers; specifically, they identified feeling undeserving of inpatient care. One interviewee described it this way: “Yeah, the attitudes can be quite difficult because they can’t place you, it’s not like I’m a schizophrenic or you’ve got this very definite problem or perhaps you’re just there to be dried out or detoxed or whatever, erm and I think that they think that you’re being difficult most of the time, I know they think ‘Oh god she’s playing up’” (Fallon, 2003; p. 397). This interviewee effectively connected the feeling of being undeserving of care with the ambiguity of the BPD symptoms and the staff’s beliefs that the patient’s behavior is within their control.
In a qualitative analysis of six psychiatric nurses working with BPD patients, Woollaston and Hixenbaugh (2008) discovered a core theme in the nurses’ perception of these clients as a “destructive whirlwind” (p. 705). This overarching theme summarizes the nurses’ descriptions of BPD patients as powerful, dangerous, and unrelenting (Woollaston & Hixenbaugh, 2008). The analysis also found commonalities across the nurses' interviews describing BPD patients as manipulative and threatening. On a positive note, they also found that the nurses indicated a desire to improve their relationships with BPD patients.

Newton-Howes, Weaver, and Tryer (2008) found that mental health workers perceived patients with personality disorder as more globally difficult to manage, more aggressive, and less compliant than patients without personality disorder. These researchers further examined differences between “overt” personality disorder patients (i.e., patients clinically diagnosed with personality disorder) and “covert” personality disorder patients (i.e., patients who were not clinically diagnosed as having a personality disorder but who met criteria for a personality disorder in a structured interview); those with “overt” personality disorder were considered more difficult to manage, more chaotic, and more aggressive than the “covert” personality disorder patients. This finding suggests a bias in the way personality disorders are diagnosed in a clinical setting; personality disorders are more likely to be diagnosed in challenging patients, while personality disorders of less challenging patients go undetected, or at least undiagnosed.

The stigmatization of patients with BPD does not escape the mental health clinician’s awareness (Koekkoek, van Meijel, Schene, & Hutschemaekers, 2009). There
is evidence that nurses acknowledge that the care BPD inpatients receive is inadequate (James & Cowman, 2007), and some psychiatrists are wary of disclosing a diagnosis of BPD because of its stigma (Fallon, 2003; Lequesne & Hersh, 2003). Recognition of the BPD stigma has led many experts in the field to argue for a fundamentally different approach to conceptualizing these patients (Herman, 1992b; Pearlman & Courtois, 2005; Reiser & Levenson, 1984).

Comparing BPD and PTSD

BPD has been studied in its relation to PTSD (e.g., Gunderson & Sabo, 1993; Hodges, 2003; Woodward, Taft, Gordon, & Meis, 2009). Becker and Lamb (1994) used a vignette study to compare clinicians’ patterns of diagnosing BPD and posttraumatic stress disorder (PTSD) and examine possible sex bias. Participants were 311 clinicians, roughly equally made up of clinical social workers (39%), psychologists (36%), and psychiatrists (24%). The participants were presented with one of six vignettes, which described male and female versions of three patients exhibiting BPD and PTSD symptoms with a history of sexual abuse. The vignettes were designed to be diagnostically ambiguous; the patient presented with an approximately equal number of PTSD and BPD symptoms, and only the minimum criteria requirements were met for each diagnosis (i.e., six symptoms of PTSD and five symptoms of BPD). After reading the vignettes, participants were asked to rate how well the case met diagnostic criteria for seven Axis I disorders (dysthymic disorder, intermittent explosive Disorder, PTSD, schizophrenia, generalized anxiety disorder, delusional disorder, jealous type, and adjustment disorder) and seven Axis II disorders (narcissistic, schizoid, dependent, histrionic, antisocial, borderline, and self-defeating personality disorders).
BPD was rated highest as the best fit, followed by dysthymic disorder, self-defeating personality disorder, and PTSD. Becker and Lamb (1994) determined that vignettes of female patients were rated higher for BPD than were identical vignettes that identified the patients as male, confirming a sex bias in the clinicians’ diagnostic practices. To explain this bias, the authors hypothesized that clinicians use knowledge of base rates to make diagnoses, particularly when the diagnostic picture is ambiguous. In other words, when a patient presents with symptoms that make a diagnosis of PTSD or BPD equally reasonable, clinicians may base their diagnostic decision on the base rates of gender for either diagnosis, leading them to choose BPD as a better fit for the female patient and PTSD for the male. Interestingly, Becker and Lamb (1994) discovered a difference in the ratings of male and female clinicians. Female clinicians rated PTSD as a better diagnostic fit for vignettes of male and female patients than did male clinicians, which suggests female clinicians may be less likely to bias diagnostic decisions based on the patient's gender.

Based on their findings, Becker and Lamb (1994) concluded that a perpetuating cycle might exist for the gender base rates of BPD. Especially in ambiguous cases, clinicians may use gender base rates to determine diagnoses, which ultimately results in more women diagnosed with BPD. This may inflate the unequal gender frequencies of BPD, which then continues to affect clinicians’ future diagnostic practices. In light of the stigma endured by those with BPD, Becker and Lamb (1994) recommended that clients with borderline characteristics who have histories of trauma “would be better served by a less stigmatizing diagnosis that reflects the traumatic etiology of their symptoms and points the way toward treatment approaches” (Becker and Lamb, 1994;
Theories To Explain the Stigma of BPD

Why has BPD become particularly stigmatized among mental disorders? A review of the literature yields many attempts to explain BPD’s stigma. These explanations can be roughly grouped into four categories, those arising from the real difficulties faced by clinicians working with this population, a lack of fit with the medical model of disease, and various forms of bias. Additionally, a compelling feminist perspective clarifies the formation and maintenance of the BPD stigma.

Real Difficulties

*Challenging symptoms.* Realistically, some of the defining symptoms of BPD can be dangerous (i.e., self-harming behavior) and difficult to treat. Clients that have a higher incidence of self-harm, suicide attempts, and completed suicide bring with them a higher risk of anxiety and emotional pain for the clinician, not to mention risk of legal action, which may understandably cause clinicians to be cautious or wary in their interactions with patients with BPD. Patients with BPD also have a high incidence of relapse and repeated hospitalization (Fallon, 2003). As has been true for serious medical illnesses (e.g., cancer), the poorer the prognosis, the greater the stigma associated with the illness (Goldin, 1990; Markham, 2003). Thus, the pathology of the illness and its stigma become “intertwined” (Aviram et al., 2006, p. 254). The perception that BPD symptoms are difficult to treat and the fact that patients with BPD are at a higher risk of causing themselves physical harm or death are aspects that contribute to its stigma (Fraser & Gallop, 1993).
Difficult countertransference. Another category of realistic difficulties is the countertransference encountered in work with borderline patients, which has been noted in the literature for decades. Traditionally defined in psychodynamic terms, countertransference refers to the responses, conscious and unconscious, of the therapist to the patient’s transference. More modern discussions of sources of countertransference include the therapist’s total emotional response to the patient (Brody & Farber, 1996). These responses can originate from the clinician’s accurate or inaccurate assumptions about the client and his or her intentions, or may simply be a therapist’s genuine response to who the client is as a person.

Lequesne and Hersh (2003) emphasized the defining role of countertransference in BPD, explaining that the interpersonal expression of BPD symptoms differentiates BPD from other psychiatric disorders with similar challenging behaviors (e.g., suicidal behavior, rage). Indeed, the extraordinarily interpersonal environment of therapy creates a context in which interpersonal BPD symptoms are inevitably expressed.

Book et al. (1978) grouped the common countertransference responses they noted in their work with borderline patients into five patterns. First, they identified the mistaken tendency for staff to conceptualize these patients as “bad” rather than “troubled.” The second pattern is the result of adoration and idealization of the staff by the patient, leading to the staff feeling they “can do no wrong,” and the third reaction is fragmentation and conflict among staff and other patients. Fourth, the authors reported that hopelessness or desperation is common. The last countertransference pattern described by these authors is difficulty setting appropriate limits; staff are pulled to extremes of being either too lax or “controllingly sadistic” with borderline patients (p. 32).
The first and fourth of these patterns (i.e., seeing the patient as “bad” rather than “troubled” and staff’s feelings of hopelessness) have received the most attention in the literature as contributing to the stigma of BPD.

In fact, researchers have identified numerous negative feelings evoked in therapy with borderline patients, including anger, hostility, helplessness, ineffectiveness, anxiety, frustration, guilt, and feeling “drained,” frightened, provoked, and intolerant (Colson et al., 1986; Fraser & Gallop, 1993; Gallop, Lancee, & Garfinkel, 1989; Gallop & Wynn, 1987; Hodges, 2003; Kelly & May, 1982). These feelings are thought to be a powerful contributor to the stigmatization of BPD patients. They reinforce the stereotype that patients with BPD are “difficult” to work with (Fraser & Gallop, 1993; Hersh, 2008; Kelly & May, 1982; Reiser & Levenson, 1984), and in trying to avoid or protect themselves from experiencing these painful feelings, clinicians may distance themselves emotionally from patients with BPD (Aviram et al., 2006; Gallop et al., 1989; Nehls, 1998).

Unfortunately, this emotional retreat is particularly harmful for BPD patients, who are especially sensitive to interpersonal rejection. The clinician’s distance thus may cause an exacerbation of symptomatology in the patient, which in turn may further harden the clinician, promoting a damaging cycle and ultimately perpetuating the stigma of BPD (Aviram et al., 2006). Once clinicians have experienced these uncomfortable countertransference reactions or witnessed other professionals’ experience, the BPD label alone may be enough to lead clinicians to raise their guard in anticipation of difficult countertransference (Gallop et al., 1989).
The significance of the role of countertransference in the creation and perpetuation of BPD’s stigma may be best understood in the many calls for clinicians to better recognize, understand, and manage their countertransference as a primary method to improve care of these patients and reducing BPD’s stigma (Book et al., 1978; Fraser & Gallop, 1993; Pearlman & Courtois, 2005; Williams & Day, 2007).

Lack of Fit with Medical Model

The difficulties clinicians encounter in work with patients with BPD is one theorized explanation for the disorder’s stigma. A second explanation is its lack of fit with the medical model. In 1988, Lewis and Appleby asserted a supposed consensus that a personality disorder is not a mental illness. Whether or not this is the current opinion, it can be argued that personality disorders have a poorer fit within the medical model of disease than Axis I disorders. The medical model focuses solely on the physical and biological causes of a disease (Taylor, 1976). Causes of the enduring personality traits that constitute personality disorders are unable to be identified with certainty, and what happens often with symptoms of mental illnesses in general occurs even more persistently with personality disorders: the ill person is assumed the cause of his symptoms. Further complicating the issue, “personality” is a nebulous concept that lacks a single definition and can refer to one’s character, temperament, self, or traits (Markham & Trower, 2003). Particularly within the community of mental health clinicians, this draws an important distinction between patients with personality disorders and patients with Axis I mental disorders, who are more widely considered to be “ill” (Lequesne & Hersh, 2003; Lewis & Appleby, 1988).
Several consequences follow the fact that personality disorders do not fit well in the medical model of disease. First, the patient is understood as responsible for and, therefore, in control of her symptoms. This assumption of controllability is fundamental in shaping the clinician’s perception of the patient. It is likely the reason patients with BPD are mistaken as “bad” rather than “troubled” (Book, Sadavoy, & Silver, 1978; Gallop et al., 1989; Markham & Trower, 2003). Consider a classic social psychology experiment, in which passersby were more likely to help and were more sympathetic to those who appeared ill (uncontrollable) rather than drunk (controllable; Weiner, 1980). Likewise, the belief that a patient with BPD is in control of her behavior is instrumental in creating blame, judgment, and a lack of sympathy for the patient (Lewis & Appleby, 1988). In their study of psychiatrists, Lewis and Appleby (1988) found that the item “not mentally ill” was positively correlated with a lack of sympathy and negatively correlated with willingness to help. Belief in the control and responsibility of the patient over her behavior causes undesirable behavior, even behavior subsumed in the BPD diagnostic criteria, to be considered attention-seeking and manipulative and the patient herself to be considered immoral or bad (Markham & Trower, 2003). This has grave effects on the therapeutic relationship and perpetuates the disorder’s stigma (Nehls, 1998).

Recalling the origins of the borderline concept helps to elucidate another aspect of the challenge in accepting BPD as an illness or disease. The borderline patient was defined by his apparent high functioning in many aspects (recall the so-called “as if” personality) along with a propensity to experience psychotic-like thought and disturbed behavior in times of stress. This apparent high functioning disguised underlying
difficulties, particularly within relationships. As reviewers of Aviram et al. (2006) summarized,

Therapists may find it difficult, emotionally if not intellectually, to accept the reality that people who are intermittently charming and capable cannot control their behavior even when they want to. It’s too easy to interpret symptoms as personal rejection and to judge rather than sympathize. (Harvard Mental Health Letter, p. 6)

With creative license, the “borderline” once referring to the edge between psychosis and neurosis may be used loosely as a metaphor for the gap between illness and health, between compassion and judgment. Those diagnosed with BPD are burdened with the stigma of mental illness but often refused sympathy and the medical, legal, or financial assistance entitled to those with mental illness (Stefan, 1998). They are also declined the acceptance that their symptomatic behavior is beyond their control. Though not considered to be “normal,” these patients are also denied the concessions of illness (Lewis & Appleby, 1998).

Bias

Fundamental attribution error. The fundamental attribution error, that is, the powerful tendency to overestimate dispositional factors and underestimate situational factors to explain others’ behavior, is also theorized to contribute to the stigmatization of individuals with BPD. This explanation is similar in end result to the one above. A clinician unwilling to consider BPD as an illness blames the patient for his behavior rather than a disease; a clinician committing the fundamental attribution error blames the patient for her behavior rather than the situation the patient is in. In either case, the patient is judged to be both responsible for and in control of his behavior. Warne and McAndrew (2007) suggested that the very act of diagnosing a mental illness indicates
that the problem lies within the individual and fails to consider environmental factors or the wider context.

As mentioned previously, the core of BPD symptomatology is interpersonal in nature, and the highly relational aspect of psychotherapy creates an intense and dynamic context in which BPD symptoms are sure to emerge. It is a grave mistake for a therapist to ignore context – that is, to deny or downplay her own role and the role of the therapeutic relationship – in the symptoms and behaviors expressed by the client with BPD. Forget the unconditional positive regard deemed necessary for therapeutic change to occur (Rogers, 1957): “If an individual comes to be seen as the problem, he or she is less likely to be regarded with neutrality, and more likely to be condemned” (Aviram et al., 2006, p. 249).

Labeling theory. As summarized by Markham (2003), labeling theory posits that psychiatric labels negatively influence social attitudes, which cause patients to act out and engage in further abnormal behavior, in turn causing additional social rejection. This theory would suggest that the use of the BPD diagnosis is detrimental to the patient and perpetuates the stigma of the disorder. Labeling effects may cause therapists to distance themselves from the client (Wolfe, 1989) or bias the way they conceptualize a client (Langer & Abelson, 1974). Research suggests fear of labeling effects influences practitioners’ diagnostic decisions (Hersh, 2008; Fallon, 2003; Lequesne & Hersh, 2003; Paris, 2007).

In a study of 112 American psychiatrists, McDonald-Scott, Machizawa, and Satoh (1992) detected that 55% reported they would voluntarily disclose a diagnosis of BPD to the patient, with an additional 16% who reported they would disclose a
diagnosis of BPD if they were asked directly by the patient. Twenty-nine percent reported they would not disclose the diagnosis, even if the patient directly asked for his or her diagnosis. The rate of psychiatrists who reported they would not disclose a diagnosis of BPD was significantly higher than the rate of non-disclosure for bipolar disorder (1.8%), dysthymia (7.5%), and panic disorder (1.8%). The rate of non-disclosure for BPD was statistically similar to that of schizophrenia (18.3%) and schizophreniform disorder (27.9%).

There is controversy over the decision to disclose a diagnosis of BPD. Some note that providing a diagnosis helps patients make sense of their symptoms (Fallon, 2003; Lequesne & Hersh, 2003) and argue that withholding the diagnosis fortifies its stigma by conveying the impression that the diagnosis to “too awful to discuss” (Lequesne & Hersh, 2003, p. 171). However, there are also the realistic fears that knowledge of the diagnosis may exacerbate symptoms (Aviram et al., 2006).

Regardless, it remains important to acknowledge the power of labels such as BPD. “Language within mental health is more than ‘just’ semantics. Words such as ‘disorder’ have the power to obstruct further understanding and can in themselves shape thought and practice” (Shaw & Proctor, 2005, p. 487).

**Feminist Perspective**

Feminist theorists identify societal influences that provide an explanation of how the stigma of BPD came to be and why it persists. These researchers propose that the BPD diagnosis is by its purpose stigmatizing; it is used by the paternalistic psychiatric field to punish women who fail to comply with social gender norms (Hodges, 2003; Shaw & Proctor, 2005; Stefan, 1998; Warne & McAndrew, 2007). Essential to this
perspective is the disorder’s relation to childhood sexual abuse. Feminist theorists argue that certain behaviors (e.g., anger and fear of abandonment), although justifiable given a woman’s history of violation or oppression, are judged to be deviant and threatening in order to conceal the profound scope and impact of sexual abuse (Herman, 1992b). Shaw and Proctor (2005) contend that BPD is the most recent attempt to pathologize certain women rather than recognize the effects of their oppression, citing BPD as a modern extension of the 17th century witch-hunts and 19th century concept of hysteria.

Propositions to Resolve BPD Stigma

With mounting empirical evidence supporting the notion that BPD is a pejorative and stigmatizing label, researchers and clinicians have called for various measures to reduce or eliminate the stigma and improve care for this population.

Targeted Training and Education

The most enduring appeal over the decades has been for better training and education of clinicians. Although individual researchers and clinicians emphasize different areas in which to increase education and awareness, the general intentions are to promote understanding of BPD development, to increase clinicians’ empathy with patients with BPD, and to foster confidence in their competency to treat patients with BPD. Many have underscored the necessity for clinicians to recognize countertransference reactions as such (Book et al., 1978; Fraser & Gallop, 1993; Pearlman & Courtois, 2005; Williams & Day, 2007). Early psychoanalytic theorists and researchers contended that acknowledging one’s emotional reaction as arising from the patient’s projections, rather than from a personal attack, is essential in working with
borderline patients (Book et al., 1978). More recent researchers also argue that better understanding of countertransference is critical in developing clinicians’ empathy and reducing the BPD stigma (Fraser & Gallop, 1993; Pearlman & Courtois, 2005) and some recommend knowledge of object relations theory for those working with BPD patients (Fraser & Gallop, 1993). In addition to acknowledging and appropriately understanding countertransference rather than denying or attempting to escape these emotions, clinicians treating patients with BPD are also encouraged to seek specific support (Langley & Klopper, 2005; Pearlman & Courtois, 2005; Warne & McAndrew, 2007).

Others highlight the importance of recognizing the role of childhood trauma in BPD formation (Fallon, 2003; Herman, 1992b; Lequesne & Hersh, 2003; Nehls, 1998; Pearlman & Courtois, 2005). Increasing awareness of the high prevalence of childhood abuse in patients with BPD serves several purposes: it encourages a thorough assessment, informs treatment, and of most importance to lessening stigma, is expected to foster the clinician’s empathy for her patient (Courtois, 2004; Hodges, 2003; Wright et al., 2007). Understanding the patient’s most difficult symptoms and behavior within the context of developmental trauma is an antidote to the fundamental attribution error. When external factors are acknowledged, dispositional factors are deemphasized. The shift then can be made to consider the patient’s symptoms “not the result of defective personality but the expression of active defenses against…unbearable intra-psychic tension and pain” (Warne & McAndrew, 2007, p. 159).
There are those that call for increased, up-to-date knowledge of the disorder’s complex biological, psychological, and social etiology in order to decrease the stigma and improve the quality of treatment for this population (Lenzenweger & Cicchetti, 2005; Nehls, 1998; Siever & Gunderson, 1979). Crowell, Beauchaine, and Linehan (2009) advocate a biosocial model in which BPD develops through the interaction of biological dispositions (i.e., emotion dysregulation and impulsivity) and an invalidating environment. Highlighting biological and genetic factors, like data from an extensive twin study finding that genetic factors account for 42% of the variance in BPD symptoms (Distel et al., 2007), may help reduce BPD’s stigma by increasing its fit with the medical model of disease.

Personality disorders are generally considered inherently different from Axis I disorders because the latter are believed to be primarily a result of biological processes and predispositions (Lequesne & Hersh, 2003). Therefore, increasing awareness of these factors in BPD may bolster its status as an illness and adjust the blame for symptomatic behavior from the character of the person to biological aspects outside of the person’s immediate control.

There is initial evidence that specific education programs do work to reduce clinician’s stigmatization of patients with BPD (Krawitz, 2004; Krawitz & Jackson, 2007; Miller & Davenport, 1996; Wright et al., 2007). For example, Miller and Davenport (1996) found that a 31-page booklet educating psychiatric nurses about BPD etiology, BPD symptoms and common staff reactions, and treatment for BPD effectively increased the nurses’ knowledge and improved their attitudes towards patients with BPD. Similarly, Krawitz (2004) found support for sustained improvement in attitude and
increased knowledge and feelings of competence in a sample of nurses, psychologists, and clinical social workers after a two-day workshop. The workshop, which focused on informing clinicians about the etiology, prognosis, and treatment of BPD, improved the participants’ optimism, enthusiasm, confidence, and willingness to work with patients with BPD (Krawitz, 2004).

In a comparison of education programs, Treloar (2009) found that both cognitive-behavioral and psychoanalytic education programs showed an immediate effect of improved attitude toward self-harm behavior and willingness to work with BPD patients over a no-education control. However, the effect was maintained at six months only in the psychoanalytic group. In Treloar’s (2009) study, each education program was an hour and a half long and covered research findings on attitudes toward BPD, prevalence rates and diagnostic criteria, etiological factors, and therapeutic responses, and discussed three case studies using cognitive-behavior or psychoanalytic conceptualizations and treatment. These studies support the proposal to use tailored training and education to reduce the stigmatization of BPD patients.

Withdraw or Reclassify the BPD Diagnosis

Others insist a more radical approach is needed and call for the dissolution of BPD altogether or fundamental changes to the way it is classified. Lewis and Appleby (1988) charged the psychiatric classification system with the responsibility to “encourage a sympathetic approach to treatment” (p. 49) and suggested that all personality disorders should be withdrawn due to the inherent moral judgments within their conceptualization. Those who propose to discard the term “borderline” do so in large part because of its stigma, and some cite the abandonment of other stigmatizing
terms (e.g., “hysteria”) to justify their argument (Herman, 1992; Hodges, 2003; Nehls, 1998). Of course, this argument is not specific to BPD; some argue the importance of understanding context and focusing on the individual as justification for ceasing to use all DSM-IV diagnoses (Beutler, 1989; Warne & McAndrew, 2007).

Before its classification as BPD, Kernberg (1967) conceptualized borderline personality organization as a level of functioning, rather than a discrete disorder, which is a view that was continued by some (Aronson, 1985; Akiskal et al., 1985). Also advocated is the reclassification of BPD as a subset of Axis I disorders. BPD is now most commonly proposed as a subset of affective disorders (Gunderson & Phillips, 1991; Kroll, 1993; Hodges, 2003; Tyrer, 2009) or PTSD (Becker & Lamb, 1994; Hodges, 2003; Marshall-Berenz et al., 2011), though its relations to other Axis I disorders (e.g., schizophrenia, impulse control disorders) have also been noted historically (Gunderson, 1979; Lewis & Grenyer, 2009).

Among calls for BPD to be subsumed under PTSD came the proposal for a new trauma spectrum disorder: Complex PTSD.

Complex PTSD/DESNOS

**Rationale**

The proposed complex PTSD (CPTSD; also referred to as disorders of extreme stress, not otherwise specified, DESNOS) summarizes the characteristics of those distressed by having experienced prolonged, repetitive trauma. Proponents of CPTSD assert that the symptoms outlined in the traditional PTSD diagnostic criteria, developed initially to portray the distress of combat veterans, are limited and inadequately describe the symptomatology of survivors of chronic, interpersonal trauma, such as those who
experienced childhood sexual abuse or were prisoners of war (e.g., Courtois, 2004; Herman, 1992; van der Kolk & Courtois, 2005). Although others noted the need for an expanded understanding of PTSD (e.g., Horowitz, 1986), it was Herman in 1992 who articulated the rationale and symptoms of Complex PTSD, spurring research and advocacy for the concept that continues today.

Patients with a history of chronic, interpersonal trauma exhibit a variety of symptoms and, in the absence of a comprehensive diagnostic category like CPTSD, are commonly diagnosed with multiple, comorbid conditions (Courtois, 2004; Ford & Kidd, 1998; Herman, 1992). Along with traditional PTSD symptoms, this population is frequently observed to experience depression, anxiety, dissociation, substance abuse, self-destructive behaviors, revictimization, interpersonal problems, medical problems, self-hatred, and despair (Courtois, 2004). Proponents of CPTSD argue that conceptualizing these symptoms as “comorbid” in this population essentially obscures or separates them from their traumatic etiology and leads to deleterious consequences (van der Kolk et al., 2005). Not only would CPTSD capture the total clinical picture of these patients in one rather than multiple comorbid disorders, it would lead the way to appropriate treatment, acknowledge the etiological role of trauma, and, presumably, separate the patient from stigmatizing labels.

Specifically, survivors of childhood abuse are more likely to be diagnosed with somatization disorder, borderline personality disorder, and multiple personality disorder (Herman, 1992). Together, these disorders represent symptoms comprising the former hysteria diagnosis, and individually, each communicates significant negative connotations, the “most notorious” being BPD (Herman, 1992).
Herman (1992) argued that the enduring effects of chronic trauma are so profound they are often misattributed to defects in the survivor’s character. She explained,

Concepts of personality organization developed under ordinary circumstances are applied to victims, without any understanding of the corrosion of personality that occurs under conditions of prolonged terror. Thus, patients who suffer from the complex aftereffects of chronic trauma still commonly risk being misdiagnosed as having personality disorder. (Herman, 1992b, p. 117)

In its conception, CPTSD aimed to more accurately and comprehensively account for the symptomology of survivors of complex trauma in order to both improve treatment for this population and lessen the stigma these patients endured from pejorative diagnoses, specifically BPD. “Thus the way is opened to the creation of a new meaning in experience and a new, unstigmatized identity” (Herman, 1992b, p. 127). It should be noted that DESNOS was not proposed to replace the BPD diagnosis or to provide a new diagnostic category under which all patients previously diagnosed with BPD would fall. However, given the prevalence of childhood abuse in patients diagnosed with BPD and noticeable similarities in the diagnostic criteria of the two disorders, it was conceived to be an applicable and preferable diagnosis for a large subset of those diagnosed with BPD (McLean & Gallop, 2003; van Dijke et al., 2012). Similarly, some have described DESNOS as an attempt to integrate traditional PTSD and BPD (McLean & Gallop, 2003; Pearlman & Courtois, 2005; Laddis, 2010).

**Symptom Overlap with BPD**

Herman (1992) identified three broad categories of the additional effects of complex trauma: symptomatic sequelae (including somatization, dissociation, and affective lability), characterological sequelae (including changes in the survivors’
relationships with others and changes in their identity), and repetition of harm. Herman
and other experts (Pelcovitz et al., 1997) generated a list of symptoms that were
frequently observed in survivors of child abuse, domestic violence, and concentration
camps but were not included in DSM-III-R PTSD criteria. These symptoms constituted
DESNOS and were assessed in the PTSD field trial conducted by the American
Psychological Association (APA) between 1990 and 1992 (van der Kolk, Roth,
Pelcovitz, Sunday, & Spinazzola, 2005). The DESNOS symptoms were grouped into
seven criteria for the purposes of the field trial: a) difficulties regulating affect and
impulses, b) disturbances in attention and consciousness, c) abnormalities in self
perception, d) abnormal perception of the perpetrator, e) difficulties in relationships with
others, f) somatization, and g) disrupted systems of meaning (Roth et al.; 1997). See
Table 1 for the complete list of DESNOS criteria and symptoms.

A comparison of the DESNOS and BPD criteria finds marked similarities in five
major areas: dysregulated affect, impulsivity, impairments in reality testing, identity
disturbance, and difficulties in interpersonal relationships (Lewis & Grenyer, 2009).
Common difficulties in affect regulation found in both disorders include depression,
intense anger and rage, irritability, and feelings of emptiness. Impulsivity is also
common to both DESNOS and BPD and includes behaviors such as substance abuse,
self-mutilation, suicidal behavior, and excessive risk-taking. Transient paranoid ideation
and dissociation are impairments in reality testing described in both disorders. An
unstable identity and sense of self are integral criteria to both, as are interpersonal
relationships marked by intense vacillations between dependency and withdrawal
(Lewis & Grenyer, 2009).
Empirical Support for DESNOS

Among other objectives, the APA field trial for PTSD investigated the validity of DESNOS and its feasibility for inclusion in the *DSM-IV* (Roth et al., 1997). DESNOS supporters claimed the results from the field trial supported the validity of DESNOS as a discrete diagnosis, as it showed DESNOS to be highly comorbid with PTSD, found DESNOS to be most strongly related to more severe interpersonal trauma (i.e., early-onset childhood sexual abuse), and demonstrated that while most who meet criteria for DESNOS also meet criteria for PTSD, traditional PTSD does not explain the full extent of their symptoms (Roth et al., 1997; van der Kolk et al., 2005; Zucker, Spinazzola, Blaustein, & van der Kolk, 2006). Nevertheless, DESNOS was not included as a diagnosis in the *DSM-IV*. Rather, many of the DESNOS symptoms were listed as associated features of PTSD in the text of the *DSM-IV* (Roth et al., 1997). The decision not to include DESNOS in the *DSM-IV* may have hindered research due to a lack of consensus on CPTSD criteria (Bryant, 2012), but it did not end the CPTSD movement and research on the subject continued.

In the decade following the *DSM-IV* (APA, 1994) publication, research on the topic focused on establishing CPTSD’s link with chronic trauma, particularly childhood abuse. Support for CPTSD came from research with a variety of samples: female inpatient survivors of sexual abuse (McLean & Gallop, 2003; Zlotnick et al., 1996), mixed gender inpatient and community samples of childhood abuse survivors (Roth et al., 1997; van der Kolk et al., 2005), male inpatient combat veterans (Ford, 1999; Ford & Kidd, 1998), college students (Ford, Stockton, Kaltman, & Green, 2006), substance abusers (Ford & Smith, 2008), the seriously mentally ill (Ford & Fournier, 2007) and
cross-cultural survivors of war (de Jong, Komproe, Spinazzola, van der Kolk, & Ommeren, 2005). CPTSD continued to be relevant in the traumatic stress literature, as evidenced by a special section on CPTSD in the October, 2005 edition of the International Society for Traumatic Stress Studies’ *Journal of Traumatic Stress*. The special section cited articles from proponents of the CPTSD construct arguing its diagnostic validity and underscoring its clinical utility in informing treatment approaches for survivors of complex trauma (Ford & Kidd, 1998; van der Kolk & Courtois, 2005), while others criticized the construct’s lack of conclusive empirical evidence as a discrete disorder and called for more research on the subject (Kilpatrick, 2005). Critics also cautioned against confusing factors of risk (e.g., histories of childhood abuse) with etiology (Lewis & Grenyer, 2009).

Despite the lack of consensus on the subject, research continued and began to focus on specific distinctions in treatment of patients with CPTSD versus traditional PTSD (Blaz-Kapusta, 2008; Cloitre et al., 2011; Courtois, 2004; Laddis, 2010; Pearlman & Courtois, 2005). Again, CPTSD was proposed for inclusion in the forthcoming *DSM-5* (Friedman, Resick, Bryant & Brewin, 2011). In their review of elements of PTSD under consideration for the *DSM-5*, Friedman and colleagues (2011) dedicated a section in their paper on the topic and noted that CPTSD may be valuable in clarifying the relationship between trauma, BPD, and dissociative disorders. In light of decisions being made for the *DSM-5*, the continued controversy and interest in CPTSD warranted another special section in the June 2012 *Journal of Traumatic Stress* (Weiss, 2012).

Resick et al. (2012) contributed an extensive overview of the research on CPTSD to date and concluded with their recommendation to exclude it as a diagnostic category.
from the *DSM-5*. Acknowledging its importance in broadening the variety of symptoms now understood to result from trauma, the authors nevertheless judged CPTSD to be lacking in its empirical support as a discrete and valid construct and recommended further research be done. Specifically, they criticized CPTSD’s lack of a consistent, universal set of symptom criteria, absence of a valid measure, and significant symptom overlap with other disorders (i.e., PTSD, BPD, and major depressive disorder) and pointed to these areas as most in need of research (Resick et al., 2012). Of the rebuttals made in comments to Resick et al. (2012), perhaps the most compelling was articulation of the dilemma of conducting scientific research on a subject that is not officially recognized (Herman, 2012). Herman (2012) acknowledged the need for more research but pointed out that research would be considerably limited without widespread recognition of CPTSD. It was also mentioned that the stringent requirements for *DSM-5* inclusion imposed on CPTSD were not imposed on other disorders (e.g., PTSD) before they entered the official nomenclature (Weiss, 2012).

The bulk of research on CPTSD has been on establishing its reliability and validity as a parsimonious diagnosis, demonstrating its relation to complex trauma, and highlighting treatment concerns with patients exhibiting CPTSD symptoms. The calls for further research by Resick et al. (2012) and others (e.g., Friedman et al., 2011) predict studies designed to develop and test a set of CPTSD criteria, establish diagnostic reliability and validity, determine complex trauma as primary etiology, and investigate efficacious treatment will be conducted in the coming years. No research to date has focused on the efficacy of CPTSD to reduce the stigmatization of patients with a history of complex trauma diagnosed with BPD. Although it was a core element of the
rationale for CPTSD (Herman, 1992b; Pearlman & Courtois, 2005), it appears the aspect of CPTSD as a less stigmatizing and pejorative label has been either ignored or assumed in the literature. This study proposes to investigate this aspect of the CPTSD rationale.

The Current Study

The demonstrated stigma of the BPD label and its consequences for psychotherapy treatment necessitate efforts to determine and enact methods to improve therapists’ attitudes towards these patients. The conceptualization of clients with BPD symptoms and a history of complex trauma (a majority of the clients meeting criteria for BPD) within the CPTSD framework holds promise as a means to do so. The current study investigated whether CPTSD succeeds in its proposed quality as a less stigmatizing label than BPD for this population. This was examined with a vignette methodology in which practicing, licensed clinical and counseling psychologists and master’s level licensed psychological counselors considered their attitudes toward a hypothetical client labeled with BPD, CPTSD, or given no diagnosis.

A secondary aim of the study was to compare the effectiveness of the CPTSD label to affect therapists’ attitudes about the client in the vignette with a brief paragraph that explicitly asked therapists to consider the potential long-term effects of the client’s complex trauma. Finally, the study proposed to broadly survey the participants’ prior knowledge and awareness of CPTSD to gather a sense of the concept’s acceptance and clinical utility among practicing therapists.
Hypotheses

The study’s specific hypotheses were:

1) Therapists presented with the vignette of a hypothetical client labeled with CPTSD would attribute the client’s symptomatic behavior less to dispositional factors than therapists presented with the hypothetical client labeled with BPD. This was predicted when neither group was asked explicitly to consider the client’s trauma history. When therapists were asked explicitly to do so, it was predicted that there would be no difference in degree to which therapists attributed the client’s symptomatic behavior to dispositional factors whether they were presented with the diagnostic control (no diagnosis given), CPTSD, or BPD vignettes.

2) Therapists presented with the CPTSD-labeled vignette would expect to have less intense anger countertransference in therapeutic work with the hypothetical client than therapists presented with the BPD-labeled vignette. Again, this was predicted to occur when neither group was prompted to consider the client’s complex trauma. When therapists were prompted to do so, it was predicted there would be no differences in therapists’ expectations of anger countertransference across diagnostic label (no diagnosis, CPTSD, BPD) groups.

3) Therapists presented with the CPTSD-labeled vignette would expect to have stronger working alliance with the hypothetical client than therapists presented with the BPD-labeled vignette when not explicitly asked to consider the client’s trauma history. When primed to consider her trauma, no differences were predicted in therapists’ expected working alliance with the client across diagnostic label groups.
4) Therapists presented with the CPTSD-labeled vignette would have a more favorable impression of the hypothetical client and a more positive outlook for her course of treatment than therapists presented with the BPD-labeled vignette. Again, this was predicted to occur in the absence of the request to consider her trauma history. When prompted to consider the potential long-term effects of the client’s developmental trauma, no differences were predicted in the attitudes of the therapists toward the client and her course of treatment across diagnostic label groups.

In order to assess the climate of the field and determine possible covariates, this research also proposed to examine the following broad research questions:

1) Are therapists’ professional characteristics (e.g., theoretical orientation, years of experience) related to differences in attributions of the client’s symptomatic behavior, expected anger countertransference, expected working alliance, and attitudes toward the hypothetical client and her course of treatment?

2) How widespread is knowledge, acceptance, and use of the CPTSD construct among practicing therapists? What is the opinion of practicing therapists on the merit of CPTSD as a diagnostic entity?

3) What types of therapists (e.g., theoretical orientation, years of experience) are more likely to use the CPTSD conceptualization?

4) Is prior awareness or education of CPTSD related to differences in attribution of the client’s symptomatic behavior, expected anger countertransference, expected working alliance, and attitudes toward the hypothetical client and her course of treatment?
CHAPTER 2

METHOD

Design

The study employed a between-subjects experimental design. The two independent variables were priming paragraph describing complex trauma sequelae and requesting the therapist to consider the long-term effects of the hypothetical client’s developmental trauma: paragraph not presented, presented, and diagnostic label provided in the vignette: no diagnosis, complex posttraumatic stress disorder (CPTSD), borderline personality disorder (BPD). Thus, six groups were compared: priming/no diagnosis, no priming/no diagnosis, priming/CPTSD, no priming/CPTSD, priming/BPD, and no priming/BPD. Participants were randomly assigned to one of these six conditions. The dependent variables were the participants’ beliefs about the attributions of the client’s symptomatic behavior, anger countertransference expected to be evoked in working with the client, expectations about the therapeutic alliance, and unfavorable attitudes toward the client and her course of treatment. These variables were measured by the Clinical Attribution Scale (Chen, Froehle, & Morran, 1997), Feeling Word Checklist-25 (Hoffart & Friis, 2000), Working Alliance Inventory – Bond scale (Horvath & Greenberg, 1989), and the therapist attitudes questionnaire adapted from similar research (i.e., Giacalone, 1997; Lewis & Appleby, 1988), respectively. Participants’ degree of socially desirable responding was measured by the Impression Management subscale of the Balanced Inventory of Desired Responses (BIDR-IM; Paulhus, 1989) and was held constant as a covariate in relevant analyses. Participants were also
asked to provide demographic and professional information and were assessed on their prior knowledge of the CPTSD construct.

Participant Recruitment

Participants were recruited between May 2013 and December 2013 through random sampling of the state-licensed members of the American Psychological Association (APA) on-line membership directory and participant referral. Of the 48,413 state-licensed members of the APA on-line membership directory, 4,552 were randomly selected to receive an e-mail request to participate. The e-mail invitation is presented in Appendix A. A follow-up e-mail was sent to contacts who had not yet responded at two weeks after the original e-mail request was sent. Upon completion of the survey, participants were asked to consider referring colleagues to the study by providing their e-mail addresses. The 44 e-mail addresses provided were also contacted with an e-mail invitation to participate.

Three hundred forty-nine (8%) first contact e-mails were returned as undeliverable. The remaining 4,247 e-mails are presumed to have reached the intended recipients. Of these, 596 (14%) responded to the request stating they were unable to participate because they did not meet the inclusion criteria or were otherwise unable or unwilling, and 332 (8%) completed the survey. Those who responded to the request either by replying to the e-mail or completing the survey represented a response rate of 22%. This is comparable to the 10 – 20% response rate that was expected based on the response rates of studies using similar sampling procedures with volunteer samples of psychologists (Blashfield & McElroy, 1989; Crosby & Sprock, 2004; Knowles, 2009).
A total of 445 persons followed the link to the survey start page. Of these, 374 began the survey. The 332 therapists who completed the survey (89% of those who started) comprise the sample examined in the analyses.

Sample

Participants were 332 masters and doctoral level psychotherapists currently practicing psychotherapy with an average of at least four adult individual therapy clients per week. The sample was composed of 187 women (56%), 140 men, and 5 of unreported gender. Participants ranged in age from 27 to 88 years ($M = 55.40$, $SD = 11.15$). The sample’s ethnic composition was 92.7% White/Caucasian ($n = 306$), 2.4% Hispanic/Latino ($n = 8$), 1.8% Asian/Pacific Islander ($n = 6$), 1.8% other ethnicity ($n = 6$), 1.2% multiracial/multiethnic ($n = 4$). Demographically, the sample is representative of the APA membership (APA Center for Workplace Studies, 2011).

The participants’ years of full-time clinical experience ranged from 0 to 47 years ($M = 20.15$, $SD = 11.03$). The majority of the sample (73.5%, $n = 244$) held a doctorate of philosophy (Ph.D.); 19.3% a doctorate of psychology (Psy.D; $n = 64$), 2.1% a doctorate of education (Ed.D.; $n = 7$), 3.0% a master of science ($n = 10$), and 0.6% a master of social work ($n = 2$).

The theoretical orientation of the sample was assessed: 32.5% identified a cognitive behavioral orientation ($n = 108$), 21.1% eclectic ($n = 70$), 17.2% psychodynamic ($n = 57$), 7.8% humanistic/existential ($n = 26$), 7.2% integrative ($n = 24$), 5.4% interpersonal ($n = 18$), 3.9% systemic ($n = 13$), 1.5% behavioral ($n = 5$), 0.3% biological ($n = 1$), and 3.01% “other” orientation or failed to specify ($n = 10$).
Sixty percent of the sample ($n = 200$) spent more than half of their professional time in a private practice setting, 11.1% in a hospital setting ($n = 37$), 4.5% in an academic setting ($n = 15$), 4.5% in a community mental health center ($n = 15$), 3.6% in a university counseling center ($n = 12$), 2.4% in a school setting ($n = 8$), 1.8% at a health maintenance organization ($n = 6$), 1.5% in a psychiatric facility ($n = 5$), and 1.5% in a correctional facility ($n = 5$). An additional 14 participants (4.2%) reported the majority of their professional time in an unspecified setting and 15 participants (4.5%) split their time exactly evenly between two settings. Nearly 80% of participants ($n = 264$) reported more than half of their professional time spent in direct clinical work. The majority of participants (83.4%, $n = 277$) reported their clinical work to be primarily with an adult population. Participants reported seeing an average of 18 ($SD = 11.17$) adult, individual clients in therapy per week. Approximately 63% of the sample ($n = 210$) reported they currently work with at least one client diagnosed with BPD; 96% ($n = 318$) reported they had worked in the past with at least one client diagnosed with BPD.

**Materials**

*Priming Paragraph*

Participants in the priming condition were presented with the following paragraph before being instructed to read the case vignette:

In a moment, you will be presented with a vignette of an adult therapy client who has a history of childhood neglect and sexual abuse. As you read the vignette, please consider how the client’s early traumatic experiences may contribute to her current psychological problems. Research suggests chronic childhood maltreatment increases the risk for a variety of problematic behaviors and
psychological symptoms in adulthood, including low self-esteem, dysphoria, anxiety, suicidal behavior, somatization, revictimization, and substance abuse.

The purpose of the priming paragraph was to remind (or educate) participants about the risk of long-term effects after complex trauma and to prompt therapists to consider the trauma history of the client in the vignette.

Case Vignette

All participants were provided the same case vignette, with the only difference being the diagnosis given at the beginning of the vignette (i.e., “borderline personality disorder,” “complex posttraumatic stress disorder,” or no diagnosis listed). The intent of the case vignette was to describe a client with symptoms creating an ambiguous diagnostic picture that made meeting diagnostic criteria for BPD and CPTSD equally plausible. A case vignette presented by Luxenberg, Spinazzola, Hidalgo, Hunt, and van der Kolk (2001) in a DESNOS training program was modified for use in this study. The vignette was chosen for its representativeness of DESNOS, as it was developed by key researchers and proposers of the CPTSD/DESNOS construct and offered in a program to help clinicians diagnose and treat DESNOS. Moreover, the vignette included overlapping BPD criteria intended to assist trainees in differential diagnosis.

The vignette described a woman with a trauma history of neglect and strongly implied sexual abuse who exhibits problems in affect regulation, dissociative symptoms, somatic symptom, and problematic interpersonal relationships, along with suicidal and self-harming behavior and sleep difficulties. Luxenberg et al. (2001)’s vignette was modified in the following ways for use in the current study:
1) selected background information was removed to reduce the vignette’s length and thus the time burden on participants;

2) certain symptoms were removed (i.e., exaggerated startle, panic attacks, claustrophobia) to reduce the number of traditional PTSD and anxiety disorder symptoms exhibited in the vignette;

3) reference to past therapy experience (i.e., “she reports that none of the therapists truly understood her, and that she ultimately left therapy each time, feeling disappointed and betrayed again;” p. 401) was modified to describe her relationships with friends so as not to unduly influence therapists’ expectations for treatment.

It should be noted that although a few of the traditional PTSD symptoms were deleted, there were still sufficient traditional PTSD symptoms included so that the client also met criteria for the PTSD diagnosis, as is common in most persons meeting DESNOS criteria (Roth et al., 1997). Knowles (2009) found that slightly over half (53%) of psychologists provided with the Luxenberg et al. (2001)'s DESNOS vignette assigned a diagnosis of PTSD to the case, and 31% assigned a diagnosis of BPD. Removing traditional PTSD symptoms and anxiety disorder symptoms was intended to make the CPTSD and BPD diagnoses given in the vignettes more plausible.

The vignette modified from Luxenberg et al. (2001) was piloted for use in this study. Five upper-level clinical and counseling psychology doctoral graduate students and three practicing clinical psychologists read the case vignette and rated their agreement of the accuracy of the BPD and CPTSD diagnoses (1 Strongly disagree, 5 Strongly agree). Agreement with the accuracy of the CPTSD diagnosis ($M = 4.13$, $SD =$
0.64) was stronger than agreement with the BPD diagnosis \( (M = 3.25, SD = 1.04), t(7) = 2.97, p = .021, d = 1.02 \). The pilot participants also rated the demonstration of each of the CPTSD and BPD diagnostic criteria in the vignette (1 Not at all demonstrated, 3 Moderately demonstrated, 5 Clearly demonstrated). The means of six of the nine BPD criteria were greater than 3.00, indicating at least moderate demonstration of these six criteria in the vignette. The mean demonstration of individual BPD criteria \( (M = 3.40, SD = 0.20) \) was statistically equivalent to the mean demonstration of individual CPTSD criteria \( (M = 3.27, SD = 0.24), t(6) = 0.72, p = .502, d = 0.59 \).

Data from the vignette pilot study supported the desired ambiguity of the vignette while demonstrating that both diagnoses were plausible. Although the pilot participants agreed more strongly with the accuracy of the CPTSD diagnosis, the individual CPTSD and BPD diagnostic criteria were endorsed roughly equally. As a result of the pilot, three edits were made to the case vignette to increase the plausibility of the BPD diagnosis. To indicate unstable interpersonal relationships, the client in the vignette was reported to have left threatening messages for her ex-boyfriend while intoxicated. Additionally, an edit was made so that she was reported to have stated she was “tired of conflict with coworkers,” instead of “tired of conflict among coworkers,” as the vignette had originally included. To indicate identity disturbance, a statement was added noting that the client had changed religious affiliations and has held jobs in a variety of fields. When the vignette was piloted again in a sample of four doctoral psychology interns, the mean demonstration of BPD criteria was 3.94 \( (SD = 0.84, 1 \text{ Not at all demonstrated, 3 Moderately demonstrated, 5 Clearly demonstrated}) \), with the mean of eight of the nine
BPD criteria 3.50 or greater. The final vignette, as it was presented in the larger study, is presented in Appendix B.

Diagnostic Criteria and Manipulation Check

After reading the vignette, study participants were presented with the BPD or DESNOS diagnostic criteria and asked to rate their agreement with the accuracy of the diagnosis for the client provided in the vignette (BPD or CPTSD; see Appendix C). This served as a manipulation check for the accuracy of the vignette to portray the disorders’ diagnostic criteria and as a method of providing the proposed DESNOS criteria to participants in the CPTSD group who may not have been aware of the CPTSD construct. Participants in the diagnostic control group proceeded without this step.

Measures

Clinical Attribution Scale

Chen, Froehle, and Morran (1997) developed the Clinical Attribution Scale (CAS) to measure dispositional bias among mental health practitioners. Its 18 items assess a clinician’s tendency to explain a client’s actions as the result of dispositional characteristics (e.g., personality) or external, situational factors. Participants rated their agreement with each item using a 5-point Likert-type scale (1 = strongly disagree, 5 = strongly agree). Ten of the items represent dispositional attributions. The remaining eight items represent situational attributions, which are reverse-scored. Total scores range from 18 to 90; high overall scores indicate more dispositional clinical attribution and low overall scores reflect a more situational attribution.

The CAS has been found to have good internal consistency, with Cronbach’s alphas of .87 (Chen et al., 1997) and .81 (Dougall, 2010). In the current study, the CAS
also demonstrated good internal consistency (Cronbach’s alpha = .81). Chen and colleagues (1997) assessed the measure’s construct validity with rater judgments; three judges blind to the study’s objectives rated the items as to where they fell along a 7-point dispositional-situational continuum. In this manner, Chen et al. (1997) found strong inter-rater reliability ($r = .96$).

**Feeling Word Checklist**

A modified version of Holmqvist’s (1996) Feeling Word Checklist (FWC) was used to assess therapists’ expected emotional reaction to the client in the vignette. The FWC assesses countertransference by asking therapists to consider the extent of 25 adjectives to describe their feelings in therapy with their patient. The instructions to participants were modified in this study to assess the extent they expect to experience each feeling in therapy with the hypothetical client on a 4-point scale (0 = not at all, 4 = very much). Several versions of the feeling checklist (i.e., with 30 and 58 items) have been examined empirically. This version was chosen for its relative brevity and demonstrated psychometric properties (Hoffart & Friis, 2000).

Hoffart and Friis (2000) examined the factor structure of the FWC-25 and found evidence of three factors described as interest, insecurity, and anger. Cronbach’s alpha of the subscales was determined to be .90, .72, and .81, respectively (Hoffart & Friis, 2000). The Anger subscale (angry, manipulated, disappointed, suspicious, and frustrated) was used in the current study, and it demonstrated good internal consistency (Cronbach’s alpha = .80). The FWC has been found to have stable test-retest reliability (Holmqvist, 2001), and the three facture structure demonstrated criterion validity in its relatedness to patient characteristics and theoretically-derived expectations of
countertransference with different diagnostic groups (Hoffart & Friis, 2000).
Additionally, similar versions of the Feeling Word Checklist have been examined and
found to be related to treatment outcome measures (Holmqvist, 2000) and aspects of
the therapeutic process (Tobin, 2006).

**Working Alliance Inventory – Bond Scale**

The Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) has been
widely used in psychotherapy process studies. It contains 36 items across three
factors: therapeutic bond, tasks, and goals. Three versions of the scale are available to
measure the patient’s, therapist’s, and observer’s perceptions, respectively, of the
therapeutic alliance. The Bond scale from the therapist form was used in the current
study. Participants rated their assessment of each item on a 7-point scale from 1
(\textit{strongly disagree}) to 7 (\textit{strongly agree}). The Bond scale alone was chosen for use in
this study as it was expected to be less challenging for therapists to generate
expectancies about bonding than about agreement on goals and tasks. The three
subscales are highly correlated. In a review of 25 studies, Hanson, Curry, and
Bandalos (2002) found the WAI Bond scale to have an internal consistency coefficient
in the range of .68 to .92. In the current study, the WAI Bond scale was internally
consistent, Cronbach’s alpha = .86.

**Therapist Attitudes Questionnaire**

Participants were asked to respond to a questionnaire of 25 items relating to the
participant’s anticipated attitudes toward the hypothetical client and work with her in
therapy (see Appendix D). Participants rated their agreement with statements about the
client and their expectations as the client’s therapist on a 7-point Likert scale (1 =
strongly disagree, 7 = strongly agree). The statements were designed to assess aspects theorized in the literature to be related to the stigma of the BPD label, specifically, the therapist’s confidence in treating the patient, therapist’s fear or expected risk working with client, severity of client’s condition and prognosis, therapist’s regard for the client, and therapist’s willingness to accommodate the client versus maintain strict boundaries.

The items, presented in Table 5, were modeled after those used by Lewis and Appleby (1988) and Giacalone (1997) in similar research assessing psychiatrists’ and psychologists’ attitudes towards a hypothetical patient. Three upper-level clinical and counseling psychology doctoral graduate students and two licensed psychologists completed independent Q sorts with these 25 items, wherein they grouped items into conceptually related factors. There was agreement across raters to group together general favorable attitudes about the hypothetical client and the course of her treatment and to group general unfavorable attitudes. However, raters differed in how to group items regarding the motivations of the client’s suicidal and self-harming behavior, severity of the client’s condition, therapists’ willingness to accommodate the client, relation of current difficulties to history of trauma, thinking of client outside of therapy, and informing client of her diagnosis.
Table 5

*Items from the Therapist Attitude Questionnaire as Included or Excluded in an Unfavorable Attitudes Total Score*

<table>
<thead>
<tr>
<th>Items included in Unfavorable Attitudes total score</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I anticipate an overall positive experience working with this person.*</td>
<td></td>
</tr>
<tr>
<td>I am confident in my ability to treat this person.*</td>
<td></td>
</tr>
<tr>
<td>This person poses a legal risk.</td>
<td></td>
</tr>
<tr>
<td>This person is unlikely to improve in therapy.</td>
<td></td>
</tr>
<tr>
<td>It would be difficult to identify this person’s strengths.</td>
<td></td>
</tr>
<tr>
<td>This person is likely to terminate therapy prematurely.</td>
<td></td>
</tr>
<tr>
<td>It would be easy to empathize with this person.*</td>
<td></td>
</tr>
<tr>
<td>I would be willing to change this person a reduced fee if needed.*</td>
<td></td>
</tr>
<tr>
<td>This person is mentally ill.</td>
<td></td>
</tr>
<tr>
<td>This person’s self-harm is primarily attention-seeking.</td>
<td></td>
</tr>
<tr>
<td>This person is likely to annoy me.</td>
<td></td>
</tr>
<tr>
<td>I would not like to see this person in therapy.</td>
<td></td>
</tr>
<tr>
<td>This person is at risk for suicide.</td>
<td></td>
</tr>
<tr>
<td>This person is exaggerating her symptoms.</td>
<td></td>
</tr>
<tr>
<td>I expect to like this person.*</td>
<td></td>
</tr>
<tr>
<td>This person is likely to make deliberate attempts to manipulate me.</td>
<td></td>
</tr>
<tr>
<td>I am likely to enjoy meeting with this person.*</td>
<td></td>
</tr>
<tr>
<td>I would refer this person to another therapist.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Items excluded</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>This person’s current difficulties are directly related to her history of trauma.†</td>
<td></td>
</tr>
<tr>
<td>I would inform this person of her diagnosis.†</td>
<td></td>
</tr>
<tr>
<td>This person’s self-harming urges are under her control.</td>
<td></td>
</tr>
<tr>
<td>This person’s condition is not severe.</td>
<td></td>
</tr>
<tr>
<td>It would be important to maintain strict boundaries with this person.</td>
<td></td>
</tr>
<tr>
<td>I would not be willing to extend my usual hours to accommodate this person’s schedule.</td>
<td></td>
</tr>
<tr>
<td>I would think about this person in my leisure time.</td>
<td></td>
</tr>
</tbody>
</table>

*Note.* Items with an asterisk were reverse-scored. Items with † were examined individually.

In exploratory factor analysis, these seven items also did not fit with others. The most parsimonious solution was to exclude these seven items and examine the remaining 18 items as one factor labeled unfavorable attitudes. Items reflecting positive expectations of therapeutic work with the hypothetical client were reverse-scored, so
that higher total scores reflected more unfavorable attitudes toward the hypothetical client and her course of treatment. The unfavorable attitudes scale demonstrated good internal reliability consistency in the current sample, Cronbach’s alpha = .82. Two of the excluded items, “This person’s current difficulties are directly related to her history of trauma,” and “I would inform this person of her diagnosis” were examined individually as they are uniquely important to the hypotheses of the study.

**Balanced Inventory of Desirable Responding**

The 20-item Impression Management (IM) subscale of the Balanced Inventory of Desirable Responding (BIDR; Paulhus, 1989) measures the extent an individual presents himself or herself in an exaggeratedly positive manner. The IM subscale presents behaviors that are desirable but uncommon. If an individual endorses a high number of these behaviors, he or she may be responding in a way to intentionally impress the assessor. Respondents rated their agreement with each item on a 5-point scale (1 = not true to 5 = very true). After odd-numbered items were reverse-scored, responses of a 6 or 7 were scored one point. Thus, the total score can range from 0 to 20, with high scores representing a higher total of exaggerated desirable responses. Paulhus (1998) identifies protocols from persons with IM scores higher than 12 as “probably invalid” (p. 10). The participants’ total scores on this measure were used as a covariate in relevant analyses.

Regarding its reliability, the IM subscale has evidenced good internal consistency, with Cronbach’s alphas ranging from .75 to .86, and test-retest correlations of .65 (Paulhus, 1991). In the current study, the obtained Cronbach’s alpha was .75. The subscale’s validity is demonstrated by its strong correlation with other measures of
desirable responding (e.g., the Marlowe-Crowne scale) and lie scales (e.g., MMPI lie scale; Paulhus, 1991).

Demographics

Participants were asked to provide basic demographic information, including their age, gender, and ethnic identity. They were also asked to provide information regarding their professional training, clinical experience, and theoretical orientation (see Appendix E).

Prior Awareness of CPTSD

This form collected specific data about the participants’ prior knowledge of the CPTSD construct, use of CPTSD in case conceptualization, and opinion as to whether CPTSD should be included as a separate diagnosis in the DSM-5 (see Appendix F). Participants were also given the opportunity to provide their opinion about the clinical utility of CPTSD and its relationship to BPD in a free response format.

Procedure

The study was conducted via an on-line survey hosted by Qualtrics Survey Software. Participants were sent an e-mail with an invitation to participate and the survey link (Appendix A). Each aspect of the online survey is presented in Appendices D through N. Upon clicking on the survey link, participants were directed to the survey website, where the survey software randomly assigned participants to one of the six experimental conditions.

Once directed to the survey website, participants were first presented with the consent form explaining the purpose and procedures of the study (Appendix G). If they agreed to participate following informed consent, they began the survey. Participants in
the priming conditions were then directed to a page with the paragraph priming them to consider the trauma history of the client in the vignette, followed by the case vignette (see Appendix B.) Participants in the priming control conditions, wherein the priming paragraph was not presented, were directed firstly to a page with the case vignette. After reading the vignette, participants in the two diagnostic label conditions (CPTSD or BPD) were presented with the respective diagnostic criteria asked to rate their agreement with the accuracy of the diagnosis (see Appendix C). Participants in the diagnostic control group skipped this step.

Next, participants were asked to provide responses to the following measures: CAS, Feeling Word Checklist, WAI – Bond scale, therapist attitude questionnaire (see Appendix D), and the IM subscale of the BIDR. These five measures were presented in one of three randomly-assigned orders to counter possible order effects. All participants then provided demographic information (see Appendix E), and lastly, provided information about their knowledge of CPTSD (see Appendix F).

Once they had completed the survey, participants were directed to a page that thanked them for their participation, debriefed them of the research hypotheses, and offered them the opportunity to provide their email addresses to be included in the raffle and/or to be provided with results of the study. If they chose to enter the raffle and/or be provided with results of the study, participants were redirected to a separate survey to input their contact information.
CHAPTER 3
RESULTS

Data Preparation

All data were downloaded from the online survey and imported into the Statistical Package for the Social Sciences (SPSS) software. Of the 374 participants who began the online survey, 42 (11%) exited the survey before completing all measures. The proportion of participants who completed versus failed to complete the survey was statistically equivalent across experimental groups. Data were screened for missing values and outliers, and the assumptions of the MANCOVA, ANCOVA, t-test, and chi-square analyses were assessed. Participants missing no more than one item per measure were retained in all analyses, and the participant’s mean score for the scale replaced the missing data point. Participants missing more than one item per measure were excluded from analyses with that measure.

Data were examined to screen for univariate outliers. Values disconnected from the distribution with z scores greater than 3.3 were considered univariate outliers. One outlier was detected on the WAI scale score, three outliers were detected on the FWC Anger subscale, and one outlier was detected on the TAQ total score. No other univariate outliers were detected. The raw scores of these outliers were adjusted to reduce the outlier’s influence while preserving the sequential order of the values.

The distribution of each dependent variable was examined via skew and kurtosis values, histograms, and box plots to test the normality assumption. With one exception, the dependent variables’ distributions were considered normal. The FWC Anger subscale was significantly positively skewed and was subsequently transformed. A
square root transformation brought the FWC Anger subscale total to an acceptable
distribution, as determined by examining the transformed variables’ skew and kurtosis.
This transformed Anger variable was used in the analyses. Means, standard
deviations, skew, and kurtosis of the original variables and transformed Anger subscale
are reported in Table 6.

Table 6
N, Means, Standard Deviations, Skew, and Kurtosis for Original and Transformed
Variables

<table>
<thead>
<tr>
<th>Original</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>Skew (SE)</th>
<th>Kurtosis (SE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dispositional Attribution</td>
<td>331</td>
<td>59.28</td>
<td>8.48</td>
<td>-0.38 (.13)</td>
<td>0.16 (.27)</td>
</tr>
<tr>
<td>Anger</td>
<td>329</td>
<td>4.29</td>
<td>2.86</td>
<td>0.46 (.13)</td>
<td>-0.28 (.27)</td>
</tr>
<tr>
<td>Working Alliance Bond</td>
<td>330</td>
<td>53.17</td>
<td>10.65</td>
<td>-0.27 (.13)</td>
<td>-0.08 (.27)</td>
</tr>
<tr>
<td>Unfavorable attitudes</td>
<td>330</td>
<td>77.33</td>
<td>12.86</td>
<td>0.09 (.13)</td>
<td>0.24 (.27)</td>
</tr>
<tr>
<td>Impression Management</td>
<td>332</td>
<td>8.29</td>
<td>3.79</td>
<td>0.05 (.13)</td>
<td>-0.68 (.27)</td>
</tr>
<tr>
<td>Transformed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anger</td>
<td>329</td>
<td>2.20</td>
<td>0.65</td>
<td>-0.17 (.13)</td>
<td>-0.57 (.27)</td>
</tr>
</tbody>
</table>

Homogeneity of variance was examined in each analysis. When homogeneity of
variance was not confirmed, the Welch’s $F$ or $t$ statistic was reported as a robust
alternative (Welch, 1947; Welch, 1951).

Descriptive Analyses

Independent Variables

Participants were randomly assigned to one of the six experimental groups. The
numbers of participants in each group is presented in Table 7.
Table 7

Number of Participants Assigned to Each Experimental Group

<table>
<thead>
<tr>
<th>Vignette Condition</th>
<th>Priming Condition</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Control</td>
<td>Primed</td>
</tr>
<tr>
<td>Control</td>
<td>54</td>
<td>54</td>
</tr>
<tr>
<td>CPTSD</td>
<td>55</td>
<td>58</td>
</tr>
<tr>
<td>BPD</td>
<td>56</td>
<td>55</td>
</tr>
<tr>
<td>Total</td>
<td>165</td>
<td>167</td>
</tr>
</tbody>
</table>

Chi-square and $F$ test analyses were conducted to determine whether the random assignment of participants to experimental condition resulted in groups approximately equal across participants’ demographic and professional characteristics variables and prior awareness of CPTSD. The experimental groups were approximately equal with regard to participants’ demographic variables (sex, race) and professional characteristics (e.g., degree obtained, type of graduate program, theoretical orientation, professional setting). The experimental groups also did not differ by whether or not they had learned about CPTSD before beginning the survey or by their opinion of CPTSD being included in *DSM* nomenclature.

Demographic variables, professional characteristics, and prior awareness of CPTSD were also examined across the groups of each independent variable separately. These analyses revealed that a higher percentage of the female participants were randomly assigned to prime control condition (55.1% of female participants) while a higher percentage of the male participants were randomly assigned to read the priming paragraph (58.6% of male participants), $\chi^2 (1, N = 327) = 5.97, p = .015$, Cramer’s $V = .14$. The dependent variables did not vary across participants’ sex, however, and participants’ sex was not statistically controlled in the analyses. All other
demographic variables, professional characteristics, and familiarity with CPTSD were evenly distributed across the three diagnostic label groups and both priming conditions.

**Dependent Variables**

Means and standard deviations of the dependent variables are presented in Table 6. Inter-correlations among the dependent variables are shown in Table 8.

Table 8

*Inter-correlations of All Dependent Variables and Impression Management*

<table>
<thead>
<tr>
<th></th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Dispositional Attribution</td>
<td>.19**</td>
<td>-.05</td>
<td>.29**</td>
<td>.07</td>
</tr>
<tr>
<td>2. Anger</td>
<td></td>
<td>-.31**</td>
<td>.55**</td>
<td>-.18**</td>
</tr>
<tr>
<td>3. Working Alliance</td>
<td></td>
<td></td>
<td>-.44**</td>
<td>.02</td>
</tr>
<tr>
<td>4. Unfavorable Attitudes</td>
<td></td>
<td></td>
<td></td>
<td>-.09</td>
</tr>
<tr>
<td>5. Impression Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* *p < .05, **p < .01. CT = countertransference

**Therapist Attitude Questionnaire**

The mean and standard deviation of the total unfavorable attitudes score is presented in Table 6. Two individual items were not included in the unfavorable attitude score but are relevant to the BPD stigma and are examined individually. These items were rated on a scale of 1 (*strongly disagree*) to 7 (*strongly agree*). The first of these items is “This person’s current difficulties are directly related to her history of trauma.” Seventy-one percent of the sample responded that they agree (*n* = 90, 27.1%) or strongly agree (*n* = 147, 44.3%) with this statement. The mean response was 6.01 (*SD* = 1.19). The second TAQ item examined individually is “I would inform this person of her diagnosis.” Fifty percent of the sample responded that they agree (*n* = 117, 35.2%) or strongly agree (*n* = 48, 14.5%) with this statement, and the mean response was 5.00 (*SD* = 1.61).
Impression Management

The Impression Management (IM) scale of the BIDR was presented to participants to be used as a covariate to control for participants’ desirable responding. The mean and standard deviation of the BIDR-IM scale is presented in Table 6, and its correlations with the dependent variables are presented in Table 8. Impression Management was significantly negatively correlated with countertransference feelings of anger. Therefore, impression management response style was controlled as a covariate in analyses of anger countertransference.

Familiarity with CPTSD

Participants were asked the following series of seven questions to gauge their familiarity with the CPTSD construct in order to understand how widespread is knowledge and use of the CPTSD among practicing therapists. Their opinion on the merit of CPTSD as a diagnostic entity was also examined.

1) Before beginning this survey, had you heard of CPTSD or DESNOS? Approximately 58% of the sample reported they had heard of CPTSD or DESNOS before beginning the survey ($n = 193$). Participants’ identified theoretical orientation was related to whether or not they had heard of CPTSD, $\chi^2 (7, N = 319) = 17.32, p = .015$, Cramer’s $V = .23$. Approximately 75.5% of psychodynamic therapists, 69.6% of integrative therapists, 59% of cognitive-behavioral therapists, and 44.8% of eclectic therapists had heard of CPTSD before beginning the survey. No other demographic or professional variables were significantly related to having previously heard of CPTSD.

2) Have you read articles or books about CPTSD/DESNOS? Nearly 41% of the sample reported they had read articles or books about CPTSD or DESNOS ($n = 135$).
No demographic or professional variables were significantly related to having read about CPTSD.

3) Did you learn about CPTSD/DESNOS in your graduate coursework or training? Approximately 10% of the sample reported learning about CPTSD or DESNOS in their graduate training \( (n = 34) \). No demographic or professional variables were significantly related to having learned about CPTSD in graduate training.

4) Did you learn about CPTSD/DESNOS through continuing education? Thirty-nine percent of the sample learned about CPTSD or DESNOS through continuing education \( (n = 130) \). Participants who had learned of CPTSD in continuing education were older \( (M = 57.49 \text{ years}, \ SD = 10.98) \) than those who did not learn about CPTSD in continuing education \( (M = 54.17, \ SD = 11.14) \), \( t(302) = 2.55, p = .011, d = 0.30 \). Participants who had learned of CPTSD in continuing education also had more years of experience \( (M = 21.94, \ SD = 10.80) \) than those who did not \( (M = 19.04, \ SD = 11.08) \), \( t(316) = 2.31, p = .022, d = 0.27 \). Forty-five percent of those currently working with at least one client diagnosed with BPD reported learning about CPTSD through continuing education, which is significantly higher than the 29.4% of those not currently working with a client diagnosed with BPD who reported learning about CPTSD through continuing education, \( \chi^2 (1, N = 321) = 7.68, p = .006, \) Cramer’s \( V = .15 \). No other demographic or professional variables were significantly related to having learned about CPTSD through continuing education.

5) Have you ever used CPTSD/DESNOS to conceptualize a client? Approximately 37% of the sample reported they have used CPTSD or DESNOS to conceptualize a client \( (n = 124) \). Forty-three percent of those currently working with a
client diagnosed with BPD reported having used CPTSD to conceptualize a client, which is significantly higher than the 29.5% of those not currently working with a client with BPD who reported they had used CPTSD to conceptualize a client, \( \chi^2 (1, N = 318) = 5.26, p = .022, \) Cramer’s \( V = .13. \) No other demographic or professional variables were significantly related to whether the participants had previously used CPTSD to conceptualize a client.

6) Do you believe CPTSD/DESNOS should be included as a diagnostic category in the \textit{DSM} nomenclature? Of the entire sample, nearly 43% answered yes, they believe it should be included \((n = 141)\), five percent answered no, they believe it should not be included \((n = 17)\), and 51% reported they were undecided or did not know enough to make a decision on the issue \((n = 172)\).

Prior awareness of CPTSD was related to participants’ opinion of CPTSD’s inclusion in the \textit{DSM} nomenclature, \( \chi^2 (2, N = 321) = 55.00, p < .001, \) Cramer’s \( V = .41. \) The percentage of those who had heard of CPTSD opining it should be included in the \textit{DSM} nomenclature (60%) was higher than the percentage of those who had not heard of CPTSD but nonetheless indicated that it should be included in the \textit{DSM} (19%). The percentage noting CPTSD should not be included in the \textit{DSM} was equivalent among those who had (4.7%) and had not (5.4%) heard of CPTSD.

Participants’ years of experience was significantly related to their opinion on this issue; \( F(2, 321) = 7.58, p = .001, \) partial \( \eta^2 = .05. \) Those who believed CPTSD should not be included had significantly more years of experience \((M = 28.00, SD = 8.70)\) than those who indicated CPTSD should be included \((M = 21.39, SD = 10.98, p = .021, d = 0.67)\) and those who were undecided \((M = 18.32, SD = 10.79, p = .001, d = 0.99)\).
Additionally, those who believe CPTSD should be included in the DSM had more years of experience than those who were undecided on the issue, $p = .013$, $d = 0.28$. No other demographic or professional variables were significantly related to participants’ opinions of whether CPTSD should be included in the DSM nomenclature.

7) What is your opinion about the utility of CPTSD/DESNOS diagnostic label and its relationship, if any, to BPD (free response)? Sixty-four percent ($n = 212$) of the sample chose to leave responses to this question. Forty percent of the responses reflected general support of CPTSD ($n = 85$) as a diagnostic entity and approximately 12% questioned the utility of CPTSD. The remainder of the responses reflected ambivalence about the topic. Examples of responses are provided in Appendix H. Thirteen percent ($n = 28$) noted the stigma of BPD in their response.

Agreement with Diagnosis

Participants were asked to rate their agreement (1 strongly disagree to 7 strongly agree) with the accuracy of the diagnosis, CPTSD or BPD, noted in the vignette. Therapists were only asked to rate their agreement with the accuracy of the diagnosis presented in the vignette that they read, and therapists in the diagnostic control group did not rate their agreement with the accuracy of either diagnosis. Considered together, mean agreement with either CPTSD or BPD was 5.58 ($SD = 1.45$). Mean agreement with the CPTSD diagnosis was 5.87 ($SD = 1.21$). Ninety percent of those presented with the CPTSD vignette indicated that they somewhat agreed, agreed, or strongly agreed that the client met criteria for the CPTSD diagnosis, with 76.1% indicating that they agreed or strongly agreed. Of those presented with the BPD vignette, mean agreement with the BPD diagnosis was 5.28 ($SD = 1.60$). Seventy-six percent of those
presented with the BPD vignette indicated that they somewhat agreed, agreed, or strongly agreed that the client met criteria for the BPD diagnosis; 57.6% indicated they agreed or strongly agreed. Participants’ agreement with the BPD diagnosis was significantly lower and more variable than agreement with the CPTSD diagnosis, Welch’s $t(202.89) = -3.06, p = .003, d = 0.39$.

Inferential Analyses

**Therapist Characteristics and Concepts Related to BPD Stigma**

The current study posed a research question to examine if therapists’ demographic or professional characteristics account for differences in dispositional attribution, expected anger countertransference, working alliance, and attitudes toward therapy with the hypothetical client. The participants’ number of years in clinical practice was significantly positively correlated with dispositional attribution ($r = .20, p < .001$), such that the longer therapists have been in clinical practice, the more likely they are to attribute the hypothetical client’s symptomatic behavior to dispositional factors. Attitudes toward therapy with the hypothetical client also were more unfavorable with more years of clinical experience ($r = .11, p = .048$).

Professional setting was significantly related to expected working alliance; participants whose primary professional setting was independent practice expected lower working alliance ($n = 199, M = 51.90, SD = 10.41$) than those whose primary professional setting was not independent practice ($n = 131, M = 55.10, SD = 10.76$), $t(328) = -2.69, p = .007, d = 0.30$.

Dispositional attributions and expected working alliance differed by theoretical orientation. The means and standard deviations of these two variables by each
theoretical orientation group are presented in Tables 9 and 10. Dispositional attribution scores varied significantly by theoretical orientation, $F(7, 320) = 2.40, p = .021$, partial $\eta^2 = .05$. Psychodynamic therapists attributed the client’s symptomatic behavior to dispositional factors more often than integrative ($p = .005, d = 0.70$) and interpersonal therapists ($p = .002, d = 0.83$). Cognitive behavioral therapists were also more likely to attribute her symptomatic behavior to dispositional factors than were integrative ($p = .020, d = 0.55$) and interpersonal therapists ($p = .007, d = 0.69$).

Expected working alliance also varied significantly by theoretical orientation group, $F(7, 319) = 3.11, p = .003$, partial $\eta^2 = .06$. Cognitive behavioral therapists expected stronger working alliance than interpersonal ($p = .001, d = 0.77$), psychodynamic ($p = .015, d = 0.38$), and systemic therapists ($p = .040, d = 0.58$).

Table 9

N, Means, and SDs of Dispositional Attribution Scores Across Theoretical Orientation Groups

<table>
<thead>
<tr>
<th>Theory</th>
<th>n</th>
<th>M</th>
<th>(SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Behavioral</td>
<td>112</td>
<td>59.89</td>
<td>a 7.35</td>
</tr>
<tr>
<td>Eclectic</td>
<td>67</td>
<td>59.22</td>
<td>(8.14)</td>
</tr>
<tr>
<td>Humanistic/Existential</td>
<td>26</td>
<td>59.81</td>
<td>(9.72)</td>
</tr>
<tr>
<td>Integrative</td>
<td>24</td>
<td>55.50</td>
<td>b 8.69</td>
</tr>
<tr>
<td>Interpersonal</td>
<td>17</td>
<td>53.94</td>
<td>b 9.71</td>
</tr>
<tr>
<td>Psychodynamic</td>
<td>54</td>
<td>61.37</td>
<td>a 8.81</td>
</tr>
<tr>
<td>Systemic</td>
<td>13</td>
<td>59.77</td>
<td>(10.16)</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
<td>56.21</td>
<td>(8.40)</td>
</tr>
</tbody>
</table>

*Note.* Means with different superscripts indicate that those means are statistically different from one another.
Table 10

N, Means and SDs of Expected Working Alliance Scores Across Theoretical Orientation Groups

<table>
<thead>
<tr>
<th>Group</th>
<th>n</th>
<th>M</th>
<th>(SD)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Behavioral</td>
<td>112</td>
<td>54.56</td>
<td>a(10.30)</td>
<td></td>
</tr>
<tr>
<td>Eclectic</td>
<td>67</td>
<td>53.64</td>
<td>(9.30)</td>
<td></td>
</tr>
<tr>
<td>Humanistic/Existential</td>
<td>25</td>
<td>56.12</td>
<td>(9.01)</td>
<td></td>
</tr>
<tr>
<td>Integrative</td>
<td>24</td>
<td>54.46</td>
<td>(7.97)</td>
<td></td>
</tr>
<tr>
<td>Interpersonal</td>
<td>17</td>
<td>45.88</td>
<td>b(12.08)</td>
<td>.001</td>
</tr>
<tr>
<td>Psychodynamic</td>
<td>54</td>
<td>50.35</td>
<td>b(12.66)</td>
<td>.015</td>
</tr>
<tr>
<td>Systemic</td>
<td>13</td>
<td>48.31</td>
<td>b(11.12)</td>
<td>.040</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
<td>56.86</td>
<td>(9.40)</td>
<td></td>
</tr>
</tbody>
</table>

Note. Means with different superscripts indicate that those means are statistically different from one another.

Participants who reported they currently work with a client diagnosed with BPD reported more favorable attitudes toward the hypothetical client \( (n = 209, M = 76.17, \text{SD} = 13.06) \) than those who reported they currently do not work with a client diagnosed with BPD \( (n = 111, M = 80.08, \text{SD} = 11.86) \), \( t(318) = -2.63, p = .009, d = 0.31 \).

Familiarity with CPTSD and Concepts Related to BPD Stigma

Participants’ dispositional attribution, expected anger countertransference, expectations of working alliance, and unfavorable attitudes in therapy with the hypothetical client were explored in relation to the participants’ knowledge and use of CPTSD. Familiarity with CPTSD was related to unfavorable attitudes toward the client and her course of treatment.
### Table 11

*Unfavorable Attitude Scores Compared by Items Assessing Familiarity with CPTSD*

<table>
<thead>
<tr>
<th>CPTSD Familiarity Question</th>
<th>Response</th>
<th>n</th>
<th>M</th>
<th>(SD)</th>
<th>t</th>
<th>df</th>
<th>p</th>
<th>d</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Heard of CPTSD?</td>
<td>Yes</td>
<td>191</td>
<td>76.13</td>
<td>(13.56)</td>
<td>-2.08*</td>
<td>318</td>
<td>.038</td>
<td>0.24</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>129</td>
<td>79.10</td>
<td>(11.79)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Read books or articles about CPTSD?</td>
<td>Yes</td>
<td>134</td>
<td>75.62</td>
<td>(13.28)</td>
<td>-2.07</td>
<td>323</td>
<td>.040</td>
<td>0.23</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>191</td>
<td>78.59</td>
<td>(12.35)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Learned about CPTSD in graduate training?</td>
<td>Yes</td>
<td>34</td>
<td>77.71</td>
<td>(10.37)</td>
<td>0.17</td>
<td>322</td>
<td>.867</td>
<td>0.03</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>290</td>
<td>77.32</td>
<td>(13.08)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Learned about CPTSD in continuing education?</td>
<td>Yes</td>
<td>128</td>
<td>75.66</td>
<td>(13.27)</td>
<td>-2.08</td>
<td>320</td>
<td>.039</td>
<td>0.23</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>194</td>
<td>78.66</td>
<td>(12.29)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Used CPTSD to conceptualize a client?</td>
<td>Yes</td>
<td>122</td>
<td>74.50</td>
<td>(13.65)</td>
<td>-3.16*</td>
<td>319</td>
<td>.002</td>
<td>0.37</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>199</td>
<td>79.21</td>
<td>(11.75)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* *Welch’s t* reported due to unequal variance. Those who responded “I don’t know” were excluded.
Across most items gauging familiarity with CPTSD, those who had heard of, learned about, or implemented CPTSD to conceptualize a client had less unfavorable attitudes than those who had not. These results are presented in Table 11. Familiarity with CPTSD was not related to dispositional attribution, expected anger countertransference, expected strength of working alliance, or strength of agreement with the accuracy of the presented diagnosis. There were no significant differences on dependent variables among the sample based on their opinion of whether CPTSD should be included in the DSM nomenclature.

*Diagnostic Agreement and Concepts Related to BPD Stigma*

Agreement with the accuracy of the BPD diagnosis was significantly positively correlated with clinical dispositional attributions ($r = .24, p = .014$), countertransference feelings of anger ($r = .31, p = .001$), and unfavorable attitudes for treatment ($r = .30, p = .003$). This indicates that the more strongly therapists agreed with the accuracy of the BPD diagnosis for the client, the more likely they were to attribute her symptomatic behavior to dispositional factors. These correlations also indicate that the stronger therapists’ agreement with the accuracy of the BPD diagnosis for this client, the stronger their expected anger countertransference, and the less favorable attitudes toward the client and her course of treatment. Agreement with the CPTSD diagnosis was significantly positively correlated with impression management ($r = .21, p = .025$), indicating that the more strongly they agreed with the accuracy of the CPTSD diagnosis for the client, the more likely they were to attempt to present themselves in an exaggeratedly positive manner.
It should be noted that agreement with the accuracy of each diagnosis did not vary by whether or not therapists were asked explicitly to consider the client’s trauma history. Of the therapists presented with the BPD-labeled vignette, their agreement with the accuracy of the BPD diagnosis for the client was equivalent whether they were asked to consider her trauma history (mean rank = 57.97, M = 5.37, SD = 1.65) or not asked to do so (mean rank = 53.12, M = 5.20, SD = 1.57), U = 1378.50, z = 0.57, p = .572. Of the therapists presented with the CPTSD-labeled vignette, agreement with the accuracy of the CPTSD diagnosis for the client also did not vary significantly between those who were asked to consider her trauma history (mean rank = 59.58, M = 6.05, SD = 0.93) and those who were not asked (mean rank = 53.19, M = 5.67, SD = 1.44), U = 1387.50, z = 1.12, p = .265.

Analyses of Experimental Effects

Hypothesis 1. The first hypothesis predicted that stigma associated with a BPD diagnosis would be revealed when diagnostic label and priming condition interacted to affect participants’ dispositional attributions of the hypothetical client’s difficulties. Specifically, it was predicted that when not asked explicitly to consider the client’s trauma history, the therapists presented with a CPTSD-labeled vignette would be less likely to overestimate dispositional factors to explain the client’s current difficulties than the therapists who were presented with a BPD-labeled vignette. When asked explicitly to consider the client’s trauma history, no differences were expected between the CPTSD and BPD diagnostic label conditions in the extent therapists attributed the client’s symptomatic behavior to dispositional factors. The therapists’ number of years
of clinical experience was significantly correlated with the manner they attributed the client’s symptomatic behavior and was held as a covariate.

This hypothesis was tested with a two-way analysis of covariance (ANCOVA) with diagnostic group (diagnostic control, CPTSD, and BPD) and priming condition (not presented, presented) as independent variables, and CAS total dispositional attribution score as the dependent variable. Therapists’ number of years of clinical experience was included as a covariate. The interaction of diagnostic label and priming condition was not significant, $F(2, 318) = 1.76, p = .175$, partial $\eta^2 = .01$. There were no main effects of diagnostic label, $F(2, 318) = 1.53, p = .218$, partial $\eta^2 = .01$, or priming condition, $F(1, 318) = 0.35, p = .557$, partial $\eta^2 < .01$.

After controlling for therapists’ years of clinical experience, the hypothesized interaction was not confirmed. When not primed to consider the client’s trauma history, therapists presented with the CPTSD-labeled vignette were not significantly less likely than therapists given the BPD vignette to attribute the client’s symptomatic behavior to dispositional factors, although the hypothesized pattern was observed to a small effect, $p = .184, d = 0.26$.

Interestingly, when asked explicitly to consider the client’s trauma history, a trend was observed that was quite different from what was predicted. When therapists were asked explicitly to consider the client’s trauma history, a small effect was found such that therapists in the BPD group were somewhat less likely to attribute the client’s symptomatic behavior to dispositional factors than therapists in both the CPTSD ($p = .087, d = 0.37$) and diagnostic control ($p = .067, d = 0.30$) groups. Means and standard
deviations of dispositional attribution scores across the experimental groups are presented in Table 12.

Table 12

N, Means and SDs of Dispositional Attribution Scores by Diagnostic Label and Priming Condition Groups

<table>
<thead>
<tr>
<th>Priming Condition</th>
<th>Diagnostic Label Group</th>
<th>n</th>
<th>M</th>
<th>(SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Presented</td>
<td>Control</td>
<td>54</td>
<td>60.09</td>
<td>(9.76)</td>
</tr>
<tr>
<td></td>
<td>CPTSD</td>
<td>55</td>
<td>58.18</td>
<td>(6.59)</td>
</tr>
<tr>
<td></td>
<td>BPD</td>
<td>54</td>
<td>60.15</td>
<td>(8.49)</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>163</td>
<td>59.47</td>
<td>(8.37)</td>
</tr>
<tr>
<td>Presented</td>
<td>Control</td>
<td>53</td>
<td>60.21</td>
<td>(7.75)</td>
</tr>
<tr>
<td></td>
<td>CPTSD</td>
<td>55</td>
<td>59.67</td>
<td>(8.31)</td>
</tr>
<tr>
<td></td>
<td>BPD</td>
<td>54</td>
<td>56.94</td>
<td>(9.68)</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>162</td>
<td>58.94</td>
<td>(8.69)</td>
</tr>
<tr>
<td>Total</td>
<td>Control</td>
<td>107</td>
<td>60.15</td>
<td>(8.78)</td>
</tr>
<tr>
<td></td>
<td>CPTSD</td>
<td>110</td>
<td>58.93</td>
<td>(7.50)</td>
</tr>
<tr>
<td></td>
<td>BPD</td>
<td>108</td>
<td>58.55</td>
<td>(9.21)</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>325</td>
<td>59.20</td>
<td>(8.52)</td>
</tr>
</tbody>
</table>

Exploratory analyses were conducted to better understand the results. The impact of therapists agreeing with the accuracy of the diagnosis (BPD or CPTSD) for this client was explored as it related to dispositional attribution. This exploration was warranted because the more strongly therapists agreed with the accuracy of the BPD diagnosis for the client, the more likely they were to attribute her symptomatic behavior to dispositional factors \((r = .24, p = .014)\). However, there was no correlation between agreement with the accuracy of the CPTSD diagnosis and dispositional attribution \((r = .006, p = .950)\). For this exploratory analysis, therapists were grouped by the strength of their agreement with the accuracy of the diagnosis presented in their vignette (BPD or CPTSD) into a dichotomous variable referred to below as “diagnostic agreement.” Those indicating they “agreed” or “strongly agreed” with the accuracy of the BPD or
CPTSD diagnosis for the client were grouped separately from those indicating lower agreement with the accuracy of the BPD or CPTSD diagnosis.

To explore how therapists' agreement with the accuracy of the diagnosis presented may have impacted the experimental effects on dispositional attribution scores, a three-way ANCOVA was conducted with diagnostic agreement (low, high), diagnostic label (CPTSD, BPD), and priming condition (not presented, presented) as independent variables, and dispositional attribution total score as the dependent variable. Therapists' number of years of clinical experience was included as a covariate. Because participants in the diagnostic control condition did not rate their agreement with either diagnosis, the diagnostic control group was excluded from this analysis. Results of the ANCOVA are presented in Table 13. Means and standard deviations of dispositional attribution scores across the three independent variables are presented in Table 14. A three-way interaction of diagnostic agreement, diagnostic label, and priming condition was not found. There was also no interaction between diagnostic agreement and priming condition affecting dispositional attribution scores.

A two-way interaction of diagnostic agreement and diagnostic label approached significance and demonstrated a small effect on therapists' dispositional attribution scores, as did a two-way interaction of diagnostic label and priming condition. Although the loss of power due to unequal cell sizes made it more difficult to find statistical significance, both two-way interactions are examined because the small but present effects are important in understanding the results of Hypothesis 1. The \( p \) values and effect size of mean differences relevant to these interactions are presented in Table 13.
Diagnostic agreement and diagnostic label affected dispositional attribution scores such that among therapists given the BPD-labeled vignette, after controlling for the therapists’ years of clinical experience, therapists who agreed strongly with the accuracy of the BPD diagnosis were more likely to attribute the client’s symptomatic behavior to dispositional factors than therapists in low agreement with the accuracy of the BPD diagnosis for this client ($p = .049$, $d = 0.38$). Among therapists given the CPTSD-labeled vignette, there were no differences between those that had high or low agreement with the accuracy of the CPTSD diagnosis ($p = .470$, $d = 0.07$).

Diagnostic label and priming condition affected dispositional attribution scores such that, after controlling for therapists’ years of clinical experience and when asked explicitly to consider the long-term effects of the client’s trauma history, therapists given the BPD vignette were less likely to attribute the client’s symptomatic behavior to dispositional factors than therapists given the CPTSD vignette ($p = .063$, $d = 0.30$). An opposite trend was observed when therapists were not asked to consider the client’s trauma history, such that therapists given the BPD vignette demonstrated the hypothesized pattern of higher dispositional attribution than therapists given the CPTSD vignette ($p = .553$, $d = 0.26$). The $p$ values reported above were estimated holding therapists’ years of clinical experience constant.
Table 13

Tests of Between-Subjects Effects: Dependent Variable: Dispositional attributions; Exploratory Analysis with Therapists

Presented with BPD and CPTSD Diagnostic Vignettes (n = 223)

<table>
<thead>
<tr>
<th>Source</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
<th>Partial η²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrected Model</td>
<td>1419.98</td>
<td>8</td>
<td>177.50</td>
<td>2.69</td>
<td>.008</td>
<td>.09</td>
</tr>
<tr>
<td>Intercept</td>
<td>139659.42</td>
<td>1</td>
<td>139659.42</td>
<td>2116.96</td>
<td>&lt;.001</td>
<td>.91</td>
</tr>
<tr>
<td>Covariate Years of Clinical Experience</td>
<td>626.28</td>
<td>1</td>
<td>626.28</td>
<td>9.49</td>
<td>.002</td>
<td>.04</td>
</tr>
<tr>
<td>Diagnostic Agreement (DxAgree)</td>
<td>37.05</td>
<td>1</td>
<td>37.05</td>
<td>0.56</td>
<td>.454</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Diagnostic Label (DxLabel)</td>
<td>61.94</td>
<td>1</td>
<td>61.94</td>
<td>0.94</td>
<td>.334</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Trauma History Primed or Not (Prime)</td>
<td>61.72</td>
<td>1</td>
<td>61.72</td>
<td>0.94</td>
<td>.335</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>DxAgree * DxLabel</td>
<td>226.75</td>
<td>1</td>
<td>226.75</td>
<td>3.44</td>
<td>.065</td>
<td>.02</td>
</tr>
<tr>
<td>DxAgree * Prime</td>
<td>45.70</td>
<td>1</td>
<td>45.70</td>
<td>0.69</td>
<td>.406</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>DxLabel * Prime</td>
<td>208.17</td>
<td>1</td>
<td>208.17</td>
<td>3.16</td>
<td>.077</td>
<td>.02</td>
</tr>
<tr>
<td>DxAgree * DxLabel * Prime</td>
<td>2.61</td>
<td>1</td>
<td>2.61</td>
<td>0.04</td>
<td>.843</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Error</td>
<td>13788.12</td>
<td>209</td>
<td>65.97</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>767355.00</td>
<td>218</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrected Total</td>
<td>15208.10</td>
<td>217</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 14

Dispositional Attribution Scores Across Diagnostic Agreement, Priming, and Diagnostic Label Conditions Among Therapists in the CPTSD and BPD Diagnostic Label Groups (n = 223)

<table>
<thead>
<tr>
<th>Diagnostic Agreement</th>
<th>Priming Condition</th>
<th>Diagnostic Label</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>p</th>
<th>d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Not Presented</td>
<td>CPTSD</td>
<td>16</td>
<td>59.31</td>
<td>6.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>26</td>
<td>58.96&lt;sup&gt;a&lt;/sup&gt;</td>
<td>9.00</td>
<td>&lt;sup&gt;a-b&lt;/sup&gt;.046</td>
<td>0.53</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>42</td>
<td>59.10</td>
<td>8.06</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Presented</td>
<td>CPTSD</td>
<td>11</td>
<td>59.73&lt;sup&gt;c&lt;/sup&gt;</td>
<td>7.17</td>
<td>&lt;sup&gt;c-d&lt;/sup&gt;.072</td>
<td>0.67</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>21</td>
<td>53.76&lt;sup&gt;b, d&lt;/sup&gt;</td>
<td>10.45</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>32</td>
<td>55.81</td>
<td>9.76</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CPTSD</td>
<td>27</td>
<td>59.48</td>
<td>6.65</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>47</td>
<td>56.64&lt;sup&gt;e&lt;/sup&gt;</td>
<td>9.92</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>74</td>
<td>57.68</td>
<td>8.92</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>Not Presented</td>
<td>CPTSD</td>
<td>39</td>
<td>57.72</td>
<td>6.66</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>29</td>
<td>61.14</td>
<td>7.87</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>68</td>
<td>59.18</td>
<td>7.34</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Presented</td>
<td>CPTSD</td>
<td>47</td>
<td>59.96</td>
<td>8.48</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>34</td>
<td>59.29</td>
<td>8.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>81</td>
<td>59.68</td>
<td>8.57</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CPTSD</td>
<td>86</td>
<td>58.94</td>
<td>7.74</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>63</td>
<td>60.14&lt;sup&gt;f&lt;/sup&gt;</td>
<td>8.37</td>
<td>&lt;sup&gt;e-f&lt;/sup&gt;.049</td>
<td>0.38</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>149</td>
<td>59.45</td>
<td>8.01</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not Presented</td>
<td>CPTSD</td>
<td>55</td>
<td>58.18</td>
<td>6.59</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>55</td>
<td>60.11</td>
<td>8.42</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>110</td>
<td>59.15</td>
<td>7.59</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Presented</td>
<td>CPTSD</td>
<td>58</td>
<td>59.91</td>
<td>8.19</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>55</td>
<td>57.18</td>
<td>9.75</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>113</td>
<td>58.58</td>
<td>9.05</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CPTSD</td>
<td>113</td>
<td>59.07</td>
<td>7.47</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>110</td>
<td>58.65</td>
<td>9.19</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>223</td>
<td>58.86</td>
<td>8.35</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* The p values are estimated based on holding years of clinical experience constant.

The effect of diagnostic label and priming condition were strongest among therapists who were in low agreement with the accuracy of the presented diagnosis.
Among therapists in low agreement with BPD, those who read the priming paragraph were less likely to attribute her symptomatic behavior to dispositional factors ($p = .046, d = 0.53$). Also within the group of therapists in low agreement with the presented diagnosis, when reminded to consider the client’s trauma history, those in the BPD group were less likely to attribute her symptomatic behavior to dispositional factors than those in the CPTSD group ($p = .072, d = 0.67$).

**Hypothesis 2.** The second hypothesis predicted that diagnostic label and priming condition would interact to affect participants’ expected countertransference feelings of anger with the hypothetical client. Specifically, it was predicted that when not asked explicitly to consider the client’s trauma history, the therapists presented with a CPTSD-labeled vignette would expect to have less intense anger countertransference in therapeutic work with the client than therapists presented with the BPD-labeled vignette, but that this difference would not be significant when primed diagnostic groups were compared. Participants’ attempts at Impression management were significantly negatively correlated with participants’ reported expectations of anger countertransference, so impression management was controlled as a covariate in this analysis.

This hypothesis was tested with an ANCOVA with diagnostic group (control, CPTSD, and BPD) and priming condition (not presented, presented) as independent variables, and countertransference anger total score as the dependent variable. The BIDR total score was included as a covariate to control for impression management. Results of the ANCOVA are presented in Table 15.
Table 15

*Tests of Between-Subjects Effects: Dependent Variable: Anger Countertransference*

<table>
<thead>
<tr>
<th>Source</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
<th>Partial $\eta^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrected Model</td>
<td>7.09</td>
<td>6</td>
<td>1.18</td>
<td>2.85</td>
<td>.010</td>
<td>.05</td>
</tr>
<tr>
<td>Intercept</td>
<td>334.12</td>
<td>1</td>
<td>334.12</td>
<td>807.19</td>
<td>&lt;.001</td>
<td>.72</td>
</tr>
<tr>
<td>Covariate Impression Management</td>
<td>4.27</td>
<td>1</td>
<td>4.27</td>
<td>10.31</td>
<td>.001</td>
<td>.03</td>
</tr>
<tr>
<td>Diagnostic Label of Vignette (DxLabel)</td>
<td>0.31</td>
<td>2</td>
<td>0.16</td>
<td>0.38</td>
<td>.684</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Trauma History Primed or Not (Prime)</td>
<td>2.12</td>
<td>1</td>
<td>2.12</td>
<td>5.13</td>
<td>.024</td>
<td>.02</td>
</tr>
<tr>
<td>DxLabel * Prime</td>
<td>0.07</td>
<td>2</td>
<td>0.03</td>
<td>0.08</td>
<td>.925</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Error</td>
<td>133.29</td>
<td>322</td>
<td>0.41</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1739.00</td>
<td>329</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrected Total</td>
<td>140.37</td>
<td>328</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 16

N, Means and SDs of Total Anger Scores by Diagnostic Label and Priming Groups

<table>
<thead>
<tr>
<th>Diagnostic Label</th>
<th>Priming Condition</th>
<th>n</th>
<th>M</th>
<th>(SD)</th>
<th>p</th>
<th>d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control Group</td>
<td>Presented</td>
<td>54</td>
<td>2.31</td>
<td>(0.60)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not Presented</td>
<td>54</td>
<td>2.15</td>
<td>(0.75)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>108</td>
<td>2.23</td>
<td>(0.68)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPTSD Group</td>
<td>Presented</td>
<td>57</td>
<td>2.28</td>
<td>(0.61)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not Presented</td>
<td>55</td>
<td>2.08</td>
<td>(0.59)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>112</td>
<td>2.18</td>
<td>(0.61)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BPD Group</td>
<td>Presented</td>
<td>54</td>
<td>2.30</td>
<td>(0.65)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not Presented</td>
<td>55</td>
<td>2.11</td>
<td>(0.70)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>109</td>
<td>2.20</td>
<td>(0.68)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>Presented</td>
<td>165</td>
<td>2.29&lt;sup&gt;a&lt;/sup&gt;</td>
<td>(0.62)</td>
<td>a-b</td>
<td>.024</td>
</tr>
<tr>
<td></td>
<td>Not Presented</td>
<td>164</td>
<td>2.11&lt;sup&gt;b&lt;/sup&gt;</td>
<td>(0.68)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>329</td>
<td>2.20</td>
<td>(0.65)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* Means with different superscripts indicate that those means are statistically different from one another.

Means and standard deviations of anger countertransference scores across the experimental groups are presented in Table 16. The interaction of diagnostic label and priming condition was not significant, nor was there a main effect of diagnostic label affecting countertransference feelings of anger. The hypothesis was not confirmed; after controlling for attempts at impression management, therapists in the CPTSD label group did not expect to have less intense anger countertransference than those in the BPD label group. A main effect of priming condition, however, was significant. Participants presented with the priming paragraph, which asked therapists to consider the possible long-term effects of the client’s trauma history, expected to have more intense anger countertransference than those not presented with the priming paragraph,
regardless of whether therapists were told the client was diagnosed with BPD, CPTSD, or not given a diagnosis.

Exploratory analyses were conducted to better understand these results. The impact of therapists’ agreement with the accuracy of the diagnosis (BPD or CPTSD) for the hypothetical client was explored as it related to expected anger countertransference. This exploration was warranted because the more strongly therapists agreed with the accuracy of the BPD diagnosis for the client, the more intensely they expected to feel anger countertransference with her in therapy, \( r = .31, p = .001 \), but the correlation between agreement with the accuracy of the CPTSD diagnosis and expected anger countertransference was not significant \( r = -.079, p = .412 \).

To explore how therapists’ agreement with the accuracy of the diagnosis presented may have impacted the experimental effects on anger countertransference, a three-way ANCOVA was conducted with diagnostic agreement (low, high), diagnostic label (CPTSD, BPD), and priming condition (not presented, presented) as independent variables, and countertransference anger total score as the dependent variable. Impression management was controlled as a covariate. Because participants in the diagnostic control condition did not rate their agreement with either diagnosis, the diagnostic control group was excluded from this analysis. Results of the ANCOVA are presented in Table 17. Means and standard deviations of expected anger countertransference scores across the three independent variables are presented in Table 18. A three-way interaction of diagnostic agreement, diagnostic label, and priming condition was not found.
The two-way interaction of diagnostic agreement and diagnostic label was significant. Among therapists with low agreement with the presented diagnosis and after controlling for impression management, a medium effect was found therapists presented with the BPD vignette expected to have less intense anger countertransference than therapists presented with the CPTSD vignette ($p = .098, d = 0.48$). Among therapists with strong agreement with the presented diagnosis and after controlling for impression management, a small effect was found that therapists in the BPD group expected to have more intense anger countertransference than therapists in the CPTSD group ($p = .079, d = 0.29$). Among therapists in the BPD group, expected anger countertransference varied significantly between those in high and low agreement with the accuracy of BPD for the client; therapists who agreed strongly with the BPD diagnosis expected to have significantly more intense anger countertransference with the client ($p = .007, d = 0.50$). As in the exploratory analyses of Hypothesis 1, these results suggest therapists who hesitated to agree with the accuracy of the BPD diagnosis for this client were importantly different from both the therapists in strong agreement with the BPD diagnosis and the therapists in low agreement with the CPTSD diagnosis.
Table 17

Tests of Between-Subjects Effects: Dependent Variable: Anger Countertransference; Exploratory Analysis with Therapists

Presented with BPD and CPTSD Diagnostic Vignettes (n = 221)

<table>
<thead>
<tr>
<th>Source</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
<th>Partial $\eta^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrected Model</td>
<td>9.46</td>
<td>8</td>
<td>9.46</td>
<td>3.08</td>
<td>.003</td>
<td>.10</td>
</tr>
<tr>
<td>Intercept</td>
<td>264.37</td>
<td>1</td>
<td>264.37</td>
<td>688.26</td>
<td>&lt;.001</td>
<td>.77</td>
</tr>
<tr>
<td>Covariate Impression Management</td>
<td>3.79</td>
<td>1</td>
<td>3.79</td>
<td>9.86</td>
<td>.002</td>
<td>.04</td>
</tr>
<tr>
<td>Diagnostic Agreement (DxAgree)</td>
<td>0.53</td>
<td>1</td>
<td>0.53</td>
<td>1.37</td>
<td>.243</td>
<td>.01</td>
</tr>
<tr>
<td>Diagnostic Label (DxLabel)</td>
<td>0.06</td>
<td>1</td>
<td>0.06</td>
<td>0.16</td>
<td>.686</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Trauma History Primed or Not (Prime)</td>
<td>1.50</td>
<td>1</td>
<td>1.50</td>
<td>3.90</td>
<td>.049</td>
<td>.02</td>
</tr>
<tr>
<td>DxAgree * DxLabel</td>
<td>2.13</td>
<td>1</td>
<td>2.13</td>
<td>5.55</td>
<td>.019</td>
<td>.03</td>
</tr>
<tr>
<td>DxAgree * Prime</td>
<td>0.11</td>
<td>1</td>
<td>0.11</td>
<td>0.28</td>
<td>.601</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>DxLabel * Prime</td>
<td>0.21</td>
<td>1</td>
<td>0.21</td>
<td>0.54</td>
<td>.465</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>DxAgree * DxLabel * Prime</td>
<td>0.04</td>
<td>1</td>
<td>0.04</td>
<td>0.09</td>
<td>.763</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Error</td>
<td>81.43</td>
<td>212</td>
<td>0.38</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1154.00</td>
<td>221</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrected Total</td>
<td>90.89</td>
<td>220</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 18

*Anger Countertransference Scores Across Diagnostic Agreement, Priming, and Diagnostic Label Conditions Among Therapists in the CPTSD and BPD Diagnostic Label Groups (n = 221)*

<table>
<thead>
<tr>
<th>Diagnostic Agreement</th>
<th>Priming Condition</th>
<th>Diagnostic Label</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>$p$</th>
<th>$d$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Not Presented</td>
<td>CPTSD</td>
<td>16</td>
<td>2.16</td>
<td>0.56</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>25</td>
<td>1.93</td>
<td>0.73</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>41</td>
<td>2.02</td>
<td>0.67</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Presented</td>
<td>CPTSD</td>
<td>11</td>
<td>2.51</td>
<td>0.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>20</td>
<td>2.10</td>
<td>0.56</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>31</td>
<td>2.25</td>
<td>0.57</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>CPTSD</td>
<td>27</td>
<td>2.30</td>
<td>0.55</td>
<td>a-b</td>
<td>.098</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>45</td>
<td>2.01</td>
<td>0.66</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>72</td>
<td>2.12</td>
<td>0.63</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>Not Presented</td>
<td>CPTSD</td>
<td>39</td>
<td>2.05</td>
<td>0.61</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>30</td>
<td>2.26</td>
<td>0.65</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>69</td>
<td>2.14</td>
<td>0.63</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Presented</td>
<td>CPTSD</td>
<td>46</td>
<td>2.23</td>
<td>0.63</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>34</td>
<td>2.41</td>
<td>0.68</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>80</td>
<td>2.31</td>
<td>0.65</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>CPTSD</td>
<td>85</td>
<td>2.15</td>
<td>0.62</td>
<td>c-d</td>
<td>.079</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>64</td>
<td>2.34</td>
<td>0.67</td>
<td>e-f</td>
<td>.007</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>149</td>
<td>2.23</td>
<td>0.65</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>Not Presented</td>
<td>CPTSD</td>
<td>55</td>
<td>2.08</td>
<td>0.59</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>55</td>
<td>2.11</td>
<td>0.70</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>110</td>
<td>2.10</td>
<td>0.65</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Presented</td>
<td>CPTSD</td>
<td>57</td>
<td>2.28</td>
<td>0.61</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>54</td>
<td>2.30</td>
<td>0.65</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>111</td>
<td>2.29</td>
<td>0.63</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>CPTSD</td>
<td>112</td>
<td>2.18</td>
<td>0.61</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>109</td>
<td>2.20</td>
<td>0.68</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>221</td>
<td>2.19</td>
<td>0.64</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* The $p$ values are estimated based on holding impression management scores constant.

As in the preliminary analysis, a significant, small main effect of priming condition on expected anger countertransference continued. Regardless of which diagnostic label was presented in the vignette, and regardless of therapists’ strength of agreement...
with the accuracy of the diagnosis presented, after controlling for impression management, therapists who were asked explicitly to consider the long-term effects of the client’s trauma history before reading the vignette expected to experience more intense anger countertransference than did therapists who were not asked to consider the client’s trauma history ($d = 0.30$).

**Hypothesis 3.** The third hypothesis predicted that diagnostic label and priming condition would interact to affect participants’ expectations of working alliance with the hypothetical client. Specifically, it was predicted that when not explicitly asked to consider the client’s trauma history, the therapists presented with the CPTSD-labeled vignette would expect to have a stronger therapeutic alliance with the client than therapists presented with the BPD-labeled vignette.

This hypothesis was tested using a two-way ANOVA with diagnostic label (control, CPTSD, and BPD) and priming condition (prime presented, not presented) as independent variables and WAI Bond total score as dependent variable. The interaction of diagnostic label and priming condition was not significant, $F(2, 324) = 1.80, p = .167$, partial $\eta^2 = .01$, nor was there a main effect of diagnostic label on expected working alliance, $F(2, 324) = 2.20, p = .113$, partial $\eta^2 = .01$. The hypothesis was not confirmed; the CPTSD label did not result in significantly stronger expected working alliance than the BPD label. An inspection of group means, however, revealed an interesting finding; the hypothesized difference between CPTSD and BPD diagnostic label groups approached significance when the diagnostic control group is excluded, $p = .066$, $d = 0.25$. There was also no main effect of priming condition on working alliance, $F(1, 320)$
= 0.42, \( p = .518 \), partial \( \eta^2 < .01 \). Means and standard deviations of expected working alliance across experimental groups shows are presented in Table 19.

Table 19

| Therapists' agreement with the diagnosis presented in the vignette was not associated with the strength of their expected working alliance with the client, so the exploratory analyses conducted for Hypotheses 1 and 2 were not conducted for Hypothesis 3. Therapists' expected working alliance with the hypothetical client, however, did vary across theoretical orientation. Cognitive-behavioral and psychodynamic orientations are each frequently discussed in relation to BPD stigma in the literature (e.g., Fraser & Gallop, 1993; Treloar, 2009). Thus, the experimental effects were uniquely examined in these two theoretical orientations to better understand the results of Hypothesis 3. ANCOVAs with priming condition (not presented, presented) and diagnostic label (control, CPTSD, and BPD) as independent

---

**Table 19**

**N, Means and SDs of Expected Working Alliance by Diagnostic Label and Priming Groups**

<table>
<thead>
<tr>
<th>Priming Condition</th>
<th>Diagnostic Label</th>
<th>n</th>
<th>M</th>
<th>(SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Presented</td>
<td>Control</td>
<td>53</td>
<td>52.75</td>
<td>(10.73)</td>
</tr>
<tr>
<td></td>
<td>CPTSD</td>
<td>55</td>
<td>53.96</td>
<td>(11.67)</td>
</tr>
<tr>
<td></td>
<td>BPD</td>
<td>56</td>
<td>54.02</td>
<td>(9.22)</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>164</td>
<td>53.59</td>
<td>(10.53)</td>
</tr>
<tr>
<td>Presented</td>
<td>Control</td>
<td>53</td>
<td>51.92</td>
<td>(10.27)</td>
</tr>
<tr>
<td></td>
<td>CPTSD</td>
<td>58</td>
<td>55.74</td>
<td>(10.59)</td>
</tr>
<tr>
<td></td>
<td>BPD</td>
<td>55</td>
<td>50.42</td>
<td>(10.95)</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>166</td>
<td>52.76</td>
<td>(10.79)</td>
</tr>
<tr>
<td>Total</td>
<td>Control</td>
<td>106</td>
<td>52.34</td>
<td>(10.46)</td>
</tr>
<tr>
<td></td>
<td>CPTSD</td>
<td>113</td>
<td>54.88</td>
<td>(11.12)</td>
</tr>
<tr>
<td></td>
<td>BPD</td>
<td>111</td>
<td>52.23</td>
<td>(10.23)</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>330</td>
<td>53.17</td>
<td>(10.65)</td>
</tr>
</tbody>
</table>
variables and working alliance scores as the dependent variable were conducted separately among cognitive-behavioral and psychodynamic therapists.

Among cognitive-behavioral therapists, the interaction of priming condition and diagnostic label was not significant, $F(2, 106) = 1.52, p = .225$, partial $\eta^2 = .03$. Observed power in this analysis was low (.32), however, suggesting the small interaction effect, although not statistically significant, may be important in understanding how diagnostic label and the explicit consideration of the client’s trauma history affected cognitive-behavioral therapists expectations to form a strong working alliance with the client. Cognitive-behavioral therapists’ means and standard deviations of expected working alliance scores across experimental conditions are presented in Table 20. Medium effect sizes were found to suggest that among cognitive-behavioral therapists not asked explicitly to consider the client’s trauma history, those given no diagnosis in the vignette expected stronger working alliance with the client than those given either a BPD ($d = 0.67$) or CPTSD ($d = 0.54$) diagnosis. To a lesser degree, the pattern also emerged that among cognitive-behavioral therapists who were asked to consider the client’s trauma history, those presented with the CPTSD-labeled vignette had slightly higher expectations of working alliance than those in the diagnostic label control ($d = 0.25$) and BPD ($d = 0.30$) groups.
Table 20

N, Means and SDs of Expected Working Alliance by Diagnostic Label and Priming Groups Among Cognitive-Behavioral Therapists (n = 112)

<table>
<thead>
<tr>
<th>Priming Condition</th>
<th>Diagnostic Label</th>
<th>n</th>
<th>M</th>
<th>(SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Presented</td>
<td>Control</td>
<td>17</td>
<td>58.82</td>
<td>(9.13)</td>
</tr>
<tr>
<td></td>
<td>CPTSD</td>
<td>21</td>
<td>53.00</td>
<td>(12.29)</td>
</tr>
<tr>
<td></td>
<td>BPD</td>
<td>19</td>
<td>52.95</td>
<td>(8.28)</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>57</td>
<td>54.72</td>
<td>(10.34)</td>
</tr>
<tr>
<td>Presented</td>
<td>Control</td>
<td>16</td>
<td>53.81</td>
<td>(10.86)</td>
</tr>
<tr>
<td></td>
<td>CPTSD</td>
<td>15</td>
<td>56.60</td>
<td>(11.40)</td>
</tr>
<tr>
<td></td>
<td>BPD</td>
<td>24</td>
<td>53.42</td>
<td>(9.52)</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>55</td>
<td>54.40</td>
<td>(10.34)</td>
</tr>
<tr>
<td>Total</td>
<td>Control</td>
<td>33</td>
<td>56.39</td>
<td>(10.17)</td>
</tr>
<tr>
<td></td>
<td>CPTSD</td>
<td>36</td>
<td>54.50</td>
<td>(11.90)</td>
</tr>
<tr>
<td></td>
<td>BPD</td>
<td>43</td>
<td>53.21</td>
<td>(8.89)</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>112</td>
<td>54.56</td>
<td>(10.30)</td>
</tr>
</tbody>
</table>

The same ANOCVA was conducted among psychodynamic therapists. Among psychodynamic therapists, a strong interaction of diagnostic label and priming condition on expected working alliance was found, $F(2, 48) = 2.90, p = .065$, partial $\eta^2 = .11$. When presented with the CPTSD vignette, psychodynamic therapists’ expectations of working alliance were somewhat higher when they were asked explicitly to consider the long-term effects of the client’s trauma than when they were not asked to consider the client’s trauma history ($d = 0.31$). When presented with the BPD vignette, psychodynamic therapists’ expectations of working alliance were much higher when they were not asked to consider trauma history than when they were ($d = 0.72$).

When not requested to consider the client’s trauma history, psychodynamic therapists in the BPD group expected somewhat stronger working alliance than those in the CPTSD group ($d = 0.33$) and much stronger working alliance than those in the diagnostic control group ($d = 0.68$). When primed to consider her trauma history,
medium and large effect sizes were found between psychodynamic therapists in the BPD, CPTSD, and diagnostic control label groups. Psychodynamic therapists in the BPD group expected poorer working alliance than those in the CPTSD ($d = 0.64$) and much poorer working alliance than in the diagnostic control group ($d = 1.04$)

Psychodynamic therapists’ means and standard deviations of expected working alliance scores across experimental conditions are presented in Table 21.

Table 21

| N, Means and SDs of Expected Working Alliance by Diagnostic Label and Priming Groups Among Psychodynamic Therapists ($n = 54$) |
|---|---|---|---|
| Priming Condition | Diagnostic Label | $n$ | $M$ (SD) |
| Not Presented | Control | 13 | 45.92 (11.74) |
| | CPTSD | 4 | 49.50 (15.42) |
| | BPD | 11 | 54.18 (12.45) |
| | Total | 28 | 49.68 (12.65) |
| Presented | Control | 6 | 56.33 (9.16) |
| | CPTSD | 9 | 54.22 (15.25) |
| | BPD | 11 | 45.64 (11.32) |
| | Total | 26 | 51.08 (12.87) |
| Total | Control | 19 | 49.21 (11.83) |
| | CPTSD | 13 | 52.77 (14.82) |
| | BPD | 22 | 49.91 (12.41) |
| | Total | 54 | 50.35 (12.66) |

**Hypothesis 4.** The fourth hypothesis predicted that diagnostic label and priming condition would interact to affect participants’ unfavorable attitudes towards the hypothetical client and her course of treatment. Specifically, when not explicitly reminded to consider the client’s trauma history, therapists presented with the CPTSD-label vignette were hypothesized to have a more favorable impression of the client and a more positive outlook for her course of treatment than therapists presented with the BPD-label vignette. The therapists’ number of years of clinical experience was
significantly correlated with unfavorable attitudes towards the client and her course of treatment and was held as a covariate.

This hypothesis was tested using a two-way ANOVA with diagnostic label (control, CPTSD, and BPD) and priming condition (prime presented, not presented) as independent variables and total unfavorable attitude score as the dependent variable. Therapists’ years of clinical experience was controlled as a covariate. The interaction of diagnostic label and priming condition was not significant, \( F(2, 324) = 1.50, p = .226 \), partial \( \eta^2 = .01 \), nor was there a main effect of diagnostic label on unfavorable attitudes toward the hypothetical client and her course of treatment, \( F(2, 324) = 0.96, p = .383 \), partial \( \eta^2 = .01 \). The hypothesis was not supported; the CPTSD label did not result in more favorable attitudes than the BPD label. There was also no main effect of priming condition on unfavorable attitudes, \( F(1, 324) = 0.22, p = .638 \), partial \( \eta^2 < .01 \).

Two individual items from the TAQ were examined with nonparametric tests (Kruskal-Wallis) to determine whether the diagnostic label presented to therapists in the vignette affected their ranked agreement with statements that 1) the client’s current difficulties are directly related to her history of trauma and 2) they would inform the client of her diagnosis. Neither the presented diagnostic label nor request to consider trauma history were significant in affecting agreement that her difficulties were trauma-related; therapists responded with strong agreement to this statement regardless of whether therapists were told the client was diagnosed with BPD, CPTSD, or not given a diagnosis, and regardless of whether they were primed to consider her trauma history.

The second item examined individually was, “I would inform this person of her diagnosis.” There was a significant difference among diagnostic label groups, \( \chi^2 (2, N = \)
The CPTSD group expressed higher agreement to disclose the diagnosis (mean rank = 191.09) than both the diagnostic control group (mean rank = 154.27; $z = 2.98, p = .003$) and BPD group (mean rank = 149.26; $z = 3.37, p = .001$).

Exploratory analyses were conducted to understand how therapists’ agreement with the accuracy of the diagnosis presented and their familiarity with the CPTSD construct may have impacted the experimental effects on therapists’ impression of the client and attitudes towards her treatment. This exploration was warranted because the more strongly therapists agreed with the accuracy of the BPD diagnosis for the client, the more they viewed the client and her course of treatment unfavorably ($r = .30, p = .003$), but there was no correlation between agreement with the accuracy of the CPTSD diagnosis and unfavorable attitudes ($r = -.064, p = .502$). Additionally, therapists who reported they have previously used CPTSD/DESNOS to conceptualize a client had a more favorable impression of the client and her course of treatment than therapists who have not conceptualized a client with CPTSD ($p = .002, d = 0.37$).

**Diagnosis agreement.** To explore how therapists’ agreement with the accuracy of the diagnosis presented may have impacted the experimental effects on unfavorable attitudes, a three-way ANCOVA was conducted with diagnostic agreement (low, high), diagnostic label (CPTSD, BPD), and priming condition (not presented, presented) as independent variables, and unfavorable attitudes total score as the dependent variable. Therapists’ number of years of experience was controlled as a covariate. Because participants in the diagnostic control condition did not rate their agreement with either diagnosis, the diagnostic control group was excluded from this analysis. Results of the
ANCOVA are presented in Table 22. Means and standard deviations of unfavorable attitude scores across the three independent variables are presented in Table 23. A three-way interaction of diagnostic agreement, diagnostic label, and priming condition was not found.

The two-way interaction of diagnostic agreement and diagnostic label was significant, such that agreement with the BPD diagnosis was associated with the highest unfavorable attitudes while low agreement with the BPD diagnosis was associated with the lowest unfavorable attitudes ($p = .023, d = 0.52$). Moreover, the effect of agreement with diagnosis on therapists’ attitudes functioned differently for the two diagnoses. While one’s agreement with BPD affected unfavorable attitudes, one’s agreement with CPTSD did not ($p = .499, d = 0.13$).

Among those in moderate to strong agreement with the presented diagnosis, therapists in the BPD group demonstrated more unfavorable attitudes than their colleagues who read the CPTSD vignette ($p = .034, d = 0.36$). Among those who disagreed or were in low agreement with the presented diagnosis, unfavorable attitudes across both diagnostic groups were statistically equivalent ($p = .330, d = .31$) after controlling for years of experience; however, a small effect size was found such that therapists in the BPD group had more favorable attitudes than those in the CPTSD group.
Table 22

Tests of Between-Subjects Effects: Dependent Variable: Unfavorable Attitudes; Exploratory Analysis with Therapists

Presented with BPD and CPTSD Diagnostic Vignettes (n = 218)

<table>
<thead>
<tr>
<th>Source</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
<th>Partial η²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrected Model</td>
<td>2683.32</td>
<td>8</td>
<td>335.41</td>
<td>2.31</td>
<td>.022</td>
<td>.08</td>
</tr>
<tr>
<td>Intercept</td>
<td>243520.41</td>
<td>1</td>
<td>243520.41</td>
<td>167.44</td>
<td>&lt;.001</td>
<td>.89</td>
</tr>
<tr>
<td>Covariate Years of Clinical Experience</td>
<td>716.71</td>
<td>1</td>
<td>716.71</td>
<td>4.93</td>
<td>.028</td>
<td>.02</td>
</tr>
<tr>
<td>Diagnostic Agreement (DxAgree)</td>
<td>140.48</td>
<td>1</td>
<td>140.48</td>
<td>0.97</td>
<td>.327</td>
<td>.01</td>
</tr>
<tr>
<td>Diagnostic Label (DxLabel)</td>
<td>19.05</td>
<td>1</td>
<td>19.05</td>
<td>0.13</td>
<td>.718</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Trauma History Primed or Not (Prime)</td>
<td>24.70</td>
<td>1</td>
<td>24.70</td>
<td>0.17</td>
<td>.681</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>DxAgree * Prime</td>
<td>249.79</td>
<td>1</td>
<td>249.79</td>
<td>1.72</td>
<td>.192</td>
<td>.01</td>
</tr>
<tr>
<td>DxAgree * DxLabel</td>
<td>595.13</td>
<td>1</td>
<td>595.13</td>
<td>4.09</td>
<td>.044</td>
<td>.02</td>
</tr>
<tr>
<td>Prime * DxLabel</td>
<td>253.62</td>
<td>1</td>
<td>253.62</td>
<td>1.74</td>
<td>.188</td>
<td>.01</td>
</tr>
<tr>
<td>DxAgree * Prime * DxLabel</td>
<td>261.11</td>
<td>1</td>
<td>261.11</td>
<td>1.79</td>
<td>.182</td>
<td>.01</td>
</tr>
<tr>
<td>Error</td>
<td>30413.80</td>
<td>209</td>
<td>145.52</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1318852.00</td>
<td>218</td>
<td>103</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrected Total</td>
<td>33097.12</td>
<td>217</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 23

Unfavorable Attitude Scores Across Diagnostic Agreement, Priming, and Diagnostic Label Conditions Among Therapists in the CPTSD and BPD Diagnostic Label Groups (n = 218)

<table>
<thead>
<tr>
<th>Diagnostic Agreement</th>
<th>Priming Condition</th>
<th>Diagnostic Label</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>p</th>
<th>d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Not Presented</td>
<td>CPTSD</td>
<td>16</td>
<td>77.75</td>
<td>9.21</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>26</td>
<td>70.81</td>
<td>11.18</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>42</td>
<td>73.45</td>
<td>10.91</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Presented</td>
<td>CPTSD</td>
<td>11</td>
<td>76.18</td>
<td>8.64</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>21</td>
<td>77.90</td>
<td>9.72</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>32</td>
<td>77.31</td>
<td>9.26</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>CPTSD</td>
<td>27</td>
<td>77.11</td>
<td>8.84</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>47</td>
<td>73.98a</td>
<td>11.04 a-b</td>
<td>.023</td>
<td>0.52</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>74</td>
<td>75.12</td>
<td>10.34</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>Not Presented</td>
<td>CPTSD</td>
<td>39</td>
<td>76.38</td>
<td>11.28</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>29</td>
<td>81.38</td>
<td>14.30</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>68</td>
<td>78.51</td>
<td>12.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Presented</td>
<td>CPTSD</td>
<td>43</td>
<td>74.95</td>
<td>14.13</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>33</td>
<td>79.42</td>
<td>12.69</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>76</td>
<td>76.89</td>
<td>13.62</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>CPTSD</td>
<td>82</td>
<td>75.63c</td>
<td>12.79 c-d</td>
<td>.034</td>
<td>0.36</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>62</td>
<td>80.34b, d</td>
<td>13.39</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>144</td>
<td>76.89</td>
<td>13.22</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not Presented</td>
<td>CPTSD</td>
<td>55</td>
<td>75.63</td>
<td>10.65</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>55</td>
<td>80.34</td>
<td>13.87</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>110</td>
<td>77.66</td>
<td>12.31</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Presented</td>
<td>CPTSD</td>
<td>54</td>
<td>76.78</td>
<td>13.13</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>54</td>
<td>76.38</td>
<td>11.55</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>108</td>
<td>76.58</td>
<td>12.45</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>CPTSD</td>
<td>109</td>
<td>76.00</td>
<td>11.92</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>109</td>
<td>77.60</td>
<td>12.77</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>218</td>
<td>76.80</td>
<td>12.35</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. The p values are estimated based on holding number of years of clinical experience constant.

CPTSD implementation. The way in which the experimental conditions affected therapists’ impression of the client and their attitudes toward her treatment was also explored in relation to the therapists’ familiarity with CPTSD. This exploration was
warranted because therapists who reported they have previously used CPTSD/DESNOS to conceptualize a client had a more favorable impression of the client and her course of treatment than therapists who reported they have not \((p = .002, d = 0.37)\). Therapists who reportedly had heard of CPTSD prior to beginning the survey and who have used CPTSD to conceptualize a client are considered to not only know of CPTSD, but to have also implemented CPTSD into their clinical work. Such therapists comprise a sizable minority \((n = 115, 36\%)\) of the current sample.

To explore how therapists’ implemented use of CPTSD may have impacted the experimental effects on unfavorable attitudes, a three-way ANCOVA was conducted with CPTSD implementation (have not, have conceptualized a client with CPTSD), diagnostic label (control, CPTSD, BPD), and priming condition (not presented, presented) as independent variables, and unfavorable attitudes total score as the dependent variable. Therapists’ number of years of experience was controlled as a covariate. Results of the ANCOVA are presented in Table 24. Means and standard deviations of unfavorable attitude scores across the three independent variables are presented in Table 25. The three-way interaction of CPTSD implementation, diagnostic label, and priming condition was significant.

The vignette’s diagnostic label and the request to explicitly consider the client’s trauma history affected therapists’ unfavorable attitudes towards the client differently if they have used CPTSD to conceptualize a client than if they have not. Among therapists who have not implemented CPTSD into their clinical practice, there was no interaction of diagnostic label and priming condition. A graph of these therapists’ unfavorable attitude scores across experimental conditions is presented in Figure 1.
However, among therapists who have implemented CPTSD, there was a strong interaction effect of diagnostic label and priming condition on unfavorable attitude scores. A graph of CPTSD-implementing therapists’ unfavorable attitude scores across experimental conditions is presented in Figure 2.

Among these therapists who have implemented CPTSD in their clinical work, referred to below as “CPTSD-implementing,” the request to explicitly consider this client’s trauma history had a large impact on therapists’ attitudes toward the client and her course of treatment when presented with the BPD-labeled vignette. CPTSD-implementing therapists given the BPD-labeled vignette had much more unfavorable attitudes when asked explicitly to consider her trauma than when not asked to do so ($d = 1.03$). Additionally, the diagnostic labels presented in the vignette affected CPTSD-implementing therapists’ attitudes toward the client and her treatment differently by whether or not they were asked to consider her trauma history. When not asked explicitly to consider her trauma history, CPTSD-implementing therapists presented with the BPD-labeled vignette had lower unfavorable attitudes toward the client than therapists in the diagnostic control condition ($d = 0.68$). When asked to consider her trauma history, however, CPTSD-implementing therapists presented with the BPD-labeled vignette had much higher unfavorable attitudes than therapists in the diagnostic control ($d = 0.78$) and CPTSD-labeled ($d = 0.95$) conditions.
Table 24

Tests of Between-Subjects Effects: Dependent Variable: Unfavorable Attitudes; Exploratory Analysis

<table>
<thead>
<tr>
<th>Source</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
<th>Partial $\eta^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrected Model</td>
<td>5141.92</td>
<td>12</td>
<td>428.49</td>
<td>2.81</td>
<td>.001</td>
<td>.10</td>
</tr>
<tr>
<td>Intercept</td>
<td>392097.08</td>
<td>1</td>
<td>392097.08</td>
<td>2571.64</td>
<td>&lt;.001</td>
<td>.89</td>
</tr>
<tr>
<td>Covariate Years of Clinical Experience</td>
<td>489.14</td>
<td>1</td>
<td>489.14</td>
<td>3.21</td>
<td>.074</td>
<td>.01</td>
</tr>
<tr>
<td>CPTSD Implementation (CPTSD_Imp)</td>
<td>1584.40</td>
<td>1</td>
<td>1584.40</td>
<td>10.39</td>
<td>.001</td>
<td>.03</td>
</tr>
<tr>
<td>Trauma History Primed or Not (Prime)</td>
<td>1.09</td>
<td>1</td>
<td>1.09</td>
<td>0.01</td>
<td>.933</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Diagnostic Label (DxLabel)</td>
<td>465.39</td>
<td>2</td>
<td>465.39</td>
<td>1.53</td>
<td>.219</td>
<td>.01</td>
</tr>
<tr>
<td>CPTSD_Imp * Prime</td>
<td>184.67</td>
<td>1</td>
<td>184.67</td>
<td>1.21</td>
<td>.272</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>CPTSD_Imp * DxLabel</td>
<td>104.32</td>
<td>2</td>
<td>104.32</td>
<td>0.34</td>
<td>.711</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Prime * DxLabel</td>
<td>914.76</td>
<td>2</td>
<td>914.76</td>
<td>3.00</td>
<td>.051</td>
<td>.02</td>
</tr>
<tr>
<td>CPTSD_Imp * Prime * DxLabel</td>
<td>1846.54</td>
<td>2</td>
<td>1846.54</td>
<td>6.06</td>
<td>.003</td>
<td>.04</td>
</tr>
<tr>
<td>Error</td>
<td>46960.61</td>
<td>308</td>
<td>152.47</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>321</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrected Total</td>
<td>320</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table 25

**Unfavorable Attitude Scores Across CPTSD Implementation, Priming, and Diagnostic Label Conditions Among Therapists in All Diagnostic Conditions**

<table>
<thead>
<tr>
<th>CPTSD Implementation</th>
<th>Priming Condition</th>
<th>Diagnostic Label</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>p</th>
<th>d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not implemented</td>
<td>Not Presented</td>
<td>Control</td>
<td>33</td>
<td>79.97</td>
<td>11.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CPTSD</td>
<td>39</td>
<td>78.64</td>
<td>10.39</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>36</td>
<td>80.50</td>
<td>11.52</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>108</td>
<td>79.67</td>
<td>11.14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presented</td>
<td>Control</td>
<td>Control</td>
<td>32</td>
<td>80.38</td>
<td>13.60</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CPTSD</td>
<td>34</td>
<td>77.94</td>
<td>12.38</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>32</td>
<td>76.53</td>
<td>11.59</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>98</td>
<td>78.28</td>
<td>12.52</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>Control</td>
<td>Control</td>
<td>65</td>
<td>80.17</td>
<td>12.62</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CPTSD</td>
<td>73</td>
<td>78.32</td>
<td>11.29</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>68</td>
<td>78.63</td>
<td>11.64</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>206</td>
<td>79.00</td>
<td>11.81</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implemented</td>
<td>Not Presented</td>
<td>Control</td>
<td>20</td>
<td>79.15(^a)</td>
<td>15.75</td>
<td>a-b</td>
<td>.014</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CPTSD</td>
<td>14</td>
<td>72.71</td>
<td>10.85</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>19</td>
<td>68.58(^b, g)</td>
<td>14.85</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>53</td>
<td>73.66</td>
<td>14.75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presented</td>
<td>Control</td>
<td>Control</td>
<td>20</td>
<td>72.80(^c)</td>
<td>12.94</td>
<td>c-d</td>
<td>.030</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CPTSD</td>
<td>20</td>
<td>70.55(^e)</td>
<td>13.37</td>
<td>e-f</td>
<td>.009</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>22</td>
<td>82.18(^d, f, h)</td>
<td>10.90</td>
<td>g-h</td>
<td>.002</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>62</td>
<td>75.40</td>
<td>13.24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>Control</td>
<td>Control</td>
<td>40</td>
<td>75.96</td>
<td>14.58</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CPTSD</td>
<td>34</td>
<td>71.44</td>
<td>12.27</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>41</td>
<td>75.88</td>
<td>14.45</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>115</td>
<td>74.60</td>
<td>13.92</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>Not Presented</td>
<td>Control</td>
<td>53</td>
<td>79.66</td>
<td>13.28</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CPTSD</td>
<td>53</td>
<td>77.08</td>
<td>10.74</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>55</td>
<td>76.38</td>
<td>13.87</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>161</td>
<td>77.69</td>
<td>12.72</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presented</td>
<td>Control</td>
<td>Control</td>
<td>52</td>
<td>77.46</td>
<td>13.34</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CPTSD</td>
<td>54</td>
<td>75.20</td>
<td>13.13</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>54</td>
<td>78.83</td>
<td>11.55</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>160</td>
<td>77.16</td>
<td>12.83</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>Control</td>
<td>Control</td>
<td>105</td>
<td>78.57</td>
<td>13.49</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CPTSD</td>
<td>107</td>
<td>76.13</td>
<td>11.99</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BPD</td>
<td>109</td>
<td>77.60</td>
<td>12.77</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>321</td>
<td>77.43</td>
<td>12.76</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* The *p* values are estimated based on holding number of years of clinical experience constant.
Figure 1

*Unfavorable Attitude Scores Among Therapists Who Have Not Implemented CPTSD*

Figure 2

*Unfavorable Attitude Scores Among CPTSD-Implementing Therapists*
CPTSD’s quality as a less stigmatizing diagnostic label than BPD, one of several rationales for the CPTSD construct (Herman, 1992b), had yet to be tested. The purpose of the present study was to examine whether the proposed CPTSD diagnosis succeeds as a less stigmatizing diagnosis than BPD for patients with a history of complex trauma exhibiting BPD symptoms. Additionally, the present study examined the effect of a priming paragraph that provided a reminder about the sequelae of chronic childhood trauma and explicitly asked the therapist to consider the potential long-term effects of the client’s trauma, which has also been proposed as a solution to lessen BPD stigma (Courtois, 2004; Fallon, 2003; Herman, 1992b; Hodges, 2003; Lequesne & Hersh, 2003; Nehls, 1998; Pearlman & Courtois, 2005; Wright et al., 2007). Over 20 years since the CPTSD construct was introduced, the current study also included a survey of practicing therapists’ familiarity with CPTSD and their opinion of its utility as a diagnosis.

Evidence of BPD Stigma

The profound stigmatization of BPD patients by mental health clinicians has been noted in empirical studies of psychiatric nurses, nurses’ assistants, and hospital staff (Book et al., 1976; Fraser & Gallop, 1993; Gallop et al., 1989; Markham, 2003; Markham & Trower, 2003; Woollaston & Hixenbaugh, 2008), psychiatrists (Lewis & Appleby, 1988), social workers (Newton-Howes et al., 2008), and psychology graduate students and licensed psychologists (Brody & Farber, 1996). This study offers further
evidence of the stigma of the BPD diagnosis among practicing masters and doctoral-level psychotherapists.

Agreement with BPD Diagnostic Accuracy

Participants in the BPD vignette group were asked to rate the strength of their agreement with the accuracy of the BPD diagnosis for the hypothetical client. The participants’ strength of agreement with BPD was related to concepts promoting stigma, including attributing symptomatic behavior to dispositional factors, expecting intense anger countertransference, and having unfavorable attitudes toward the client and therapeutic work with her.

Research shows evidence that clinicians react negatively to patients already diagnosed with BPD (e.g., Book et al., 1976; Brody & Farber, 1996; Fraser & Gallop, 1993; Gallop et al., 1989; Markham, 2003; Markham & Trower, 2003). Examining participants’ agreement with the diagnostic conceptualization is uniquely interesting; this finding suggests clinicians more likely to confirm a diagnosis of BPD are also more likely to believe the client is the cause of her symptoms, to expect to have difficult countertransference, and to be pessimistic about treatment outcomes. This finding suggests the act of diagnosing BPD may be both a result and catalyst of BPD’s stigma, and it gives credence to the idea that BPD may be diagnosed by subjective, and largely negative, reactions of the therapist, rather than adherence to objective, behavioral criteria (Lequesne & Hersh, 2003).

Relatedly, there was a hesitancy to agree with diagnostic accuracy of BPD for the client within this sample. Mean agreement indicated participants generally “somewhat agreed” (i.e., 5.28 on a scale 1 strongly disagree to 7 strongly agree) with
the accuracy of BPD for this client, but agreement with BPD was less strong and more variable than participants’ agreement with CPTSD as an accurate conceptualization. The comparative hesitance to agree with BPD observed in this sample may be due to the controversy of BPD as a diagnosis (Lewis & Grenyer, 2009). Additionally, hesitance to agree with BPD may be a result of clinicians’ doubt as to whether the client’s symptoms are a “normal” or “abnormal” reaction to the developmental trauma she experienced. Shaw and Proctor (2005) noted diagnosing BPD is a judgment that the patient’s symptoms are not rationally appropriate reactions to her experience. If deemed appropriate, or at the least understandable given her history, participants may have been wary to diagnose the hypothetical client’s symptoms, particularly with a stigmatizing diagnosis. As Hersh (2008), explained, “Clinicians may recognize BPD, but for philosophical reasons stress alternative explanations for certain symptom constellations” (p. 16).

The therapists in the sample demonstrated an awareness of the BPD stigma, with thirteen percent of the participants’ comments regarding the utility of CPTSD and its relation to BPD spontaneously noting BPD as a pejorative and/or stigmatizing diagnostic label. Clinicians are aware of the stigma BPD holds for those diagnosed (Fallon, 2003; Herman, 1992b; James & Cowman, 2007; Koekkoek et al., 2009; Lequesne & Hersh, 2003; Pearlman & Courtois, 2005; Reiser & Levenson, 1984). Given the extensive literature describing BPD’s stigma, it is not surprising that these masters- and doctoral-level clinicians are aware of the BPD stigma and that this awareness may influence their diagnostic practices. The observed correlation of agreement with BPD conceptualization with several concepts proposed to foster
stigmatization suggests, in its reverse, that a hesitancy to diagnose BPD may be related to a desire to avoid stigmatization of these patients.

_Hesitancy to Disclose BPD_

Participants presented with the BPD vignette were less willing than those presented with the CPTSD vignette to tell the hypothetical client her diagnosis. This finding is similar to previous research documenting the reluctance of clinicians to disclose a diagnosis of BPD to the patient (Lequesne & Hersh, 2003; McDonald-Scott et al., 1992). Despite its lack of formality as a diagnosis, clinicians may believe CPTSD is more appropriate to discuss with the client in order to help her understand her symptoms and options for treatment.

It has been suggested that withholding disclosure of a BPD diagnosis may be in part due to the clinician’s desire to avoid stigmatizing the patient (Lequesne & Hersh, 2003; Paris, 2007); however, withholding a BPD diagnosis may inadvertently perpetuate the BPD stigma and may negatively impact treatment. A therapist who withholds disclosure of a BPD diagnosis to the client fails to include the client in decision-making for her care and limits the therapeutic options open to the client (e.g., Dialectical Behavior Therapy groups; Lequesne & Hersh, 2013). Once the client’s constellation of symptoms has been named, however, psychoeducation can occur that may empower the client and his family (Lequesne & Hersh, 2013). Indeed, the APA practice guidelines for the treatment of patients with BPD recommends informing patients with BPD of their diagnosis (APA, 2001).
Overview of the Experimental Effects

Stigma was further examined by assessing (1) beliefs about the attributions of the client’s symptomatic behavior, (2) expected feelings of anger countertransference, (3) expected working alliance with the client, and (4) unfavorable attitudes toward the client and her course of treatment. As would be expected, concepts proposed to be related to stigma and to have a negative impact on the therapeutic relationship were positively correlated with each other and negatively correlated with expected working alliance. The salient findings from each hypothesis are noted here, with further discussion following.

Hypothesis 1 predicted that therapists presented with the CPTSD-labeled vignette would be less likely than therapists in presented the BPD vignette to attribute the client’s symptomatic behavior to dispositional factors when neither were explicitly asked to consider her complex trauma history. Hypothesis 1 was not confirmed. There were no differences across diagnostic label groups when not asked to consider her trauma history. Additionally, it seemed that when therapists were asked to consider her trauma history, therapists presented with the CPTSD-labeled vignette were actually more likely to attribute her symptomatic behavior to dispositional factors. Examining this effect more closely, however, revealed that therapists who were reluctant to agree with the BPD diagnosis were driving this apparent difference. That is, therapists who read the BPD vignette but did not agree strongly with the diagnostic accuracy of BPD for the client were much less likely to attribute her symptomatic behavior to dispositional factors than the other therapists in the sample.
Hypothesis 2 predicted that therapists presented with the CPTSD-labeled vignette would expect to have less intense anger countertransference than therapists in the BPD group when neither were asked to explicitly to consider the client’s trauma history. The hypothesis was not confirmed. However, further examination suggested therapists’ reluctance to agree with the BPD diagnosis interacted with the way the diagnostic labels affected expected anger countertransference. Regardless, no matter which diagnostic label was presented in the vignette or the therapists’ agreement with diagnosis, therapists who were explicitly asked to consider the client’s trauma history expected to feel more intense anger countertransference than therapists who were not given the instruction to consider her trauma history.

Results supported but did not confirm Hypothesis 3, which predicted that therapists presented with the CPTSD-labeled vignette would expect to have stronger working alliance with the client than therapists in the BPD group when neither were asked explicitly to consider the client’s trauma history. Interestingly, it was found the experimental conditions affected psychodynamic therapists directly opposite from what was predicted for the general sample. When not primed to consider the client’s trauma history, psychodynamic therapists expected stronger working alliance when presented with the BPD-labeled vignette than when presented with the CPTSD vignette. When primed to consider the long-term effects of trauma, however, psychodynamic therapists expected stronger working alliance when presented with the CPTSD vignette.

The fourth hypothesis predicted that therapists presented the CPTSD-labeled vignette would have a more favorable impression of the client and more optimistic expectations of her course of treatment than therapists presented with the BPD vignette.
when neither were asked explicitly to consider the client’s complex trauma. This hypothesis was not supported. Further examination of the data suggested, again, that agreement with the accuracy of the diagnosis interacted with the effects of the diagnostic label. Additionally, therapists’ familiarity with CPTSD affected their impression of the client and attitudes toward her course of treatment. Overall, therapists who reportedly had implemented CPTSD to conceptualize a client had more favorable attitudes than therapists who had not. The experimental conditions, however, affected these CPTSD-implementing therapists’ attitudes toward the hypothetical client. When not explicitly requested to consider her complex trauma, CPTSD-implementing therapists exhibited more favorable attitudes toward the BPD client than the CPTSD client, but when they were primed to consider her trauma history, CPTSD-implementing therapists demonstrated less favorable attitudes toward the BPD client than the CPTSD client.

Dispositional Attribution

Attributing a client’s symptomatic behavior to dispositional factors, that is, essentially blaming the client for her difficulties, has been related to the stigma of BPD (Aviram et al., 2006; Markham & Trower, 2003; Nehls, 1998), and CPTSD was proposed to de-emphasize dispositional explanations for the enduring difficulties of complex trauma survivors.

The explicit request for therapists to consider the client’s trauma history was effective in de-emphasizing dispositional explanations for symptomatic behavior within the BPD diagnostic label group, particularly when therapists were hesitant about diagnosing the client with BPD. This result supports research showing targeted
education to be effective in mitigating the stigma of BPD (Krawitz, 2004; Miller & Davenport, 1996; Treloar, 2009) and suggests even very short, educational interventions are successful in acknowledging context and deemphasizing dispositional factors. Among participants not asked explicitly to consider the client’s trauma history, therapists in the CPTSD group were somewhat less likely to blame the client for her difficulties, but this difference was not statistically significant, and it was certainly not as large as the effect of the reminder to consider the client’s trauma history.

It seems, therefore, the proposed change in diagnostic label from BPD to CPTSD would not substantially change therapists’ beliefs about the attributions of a client’s behavior. Becker (2000) expressed doubt in the assumed influence of CPTSD to affect the degree to which therapists hold a client responsible for her difficulties, and in the practical relevance if it could, stating,

The case is frequently made that the PTSD diagnosis helps to create a more beneficial treatment context for women currently labeled borderline, since it rids the term of the disagreeable connotations that continue to cling to BPD, while offering the possibility for a situationally focused rather than a more blaming, intrapsychically focused psychotherapy. The notion that construing the client’s situation as trauma-based is more likely to elicit from the therapist feelings of warmth and empathy, along with a greater willingness to identify with the client and believe in her ability to change, is indeed a happy thought. The reality, however, may be far different. (p. 427)

The reality, in the present study, is different, but it is not far different. A few sentences reminding participants of the enduring effects of complex trauma produced a relatively small ($d = 0.32$) yet meaningful effect on the way clinicians perceived the BPD client’s difficulties. Therapists’ beliefs about the causes of a client’s behavior are particularly important as they engage with clients in therapy; if dispositional factors are emphasized, blaming, judging, or experiencing a lack of sympathy for the patient may
result (Lewis & Appleby, 1988). People in general (Weiner, 1980) and mental health clinicians specifically (Lewis & Appleby, 1988) are more likely to be sympathetic and willing to help when they believe symptoms are out of the person’s control. Attributing difficulties to dispositional factors makes problematic behavior seem attention-seeking or manipulative (Markham & Trower, 2003), and fear of being manipulated disrupts the therapeutic alliance (Nehls, 1998). Therefore, even a small effect in lowering dispositional attribution may be clinically meaningful in its potential to positively impact therapeutic work with survivors of complex trauma.

Anger Countertransference

Anger is agreed to be common countertransference in therapeutic work with BPD patients (Brody & Farber, 1996; Colson et al., 1986; Fraser & Gallop, 1993; Gallop, Lancee, & Garfinkel, 1989; Gallop & Wynn, 1987; Hodges, 2003; Kelly & May, 1982) and survivors of complex trauma (Dalenberg, 2004; McCann & Pearlman, 1990; Neumann & Gamble, 1995; Pearlman & Courtois, 2005). The diagnostic label presented in the vignette did not affect participants’ expected anger countertransference. The explicit request for therapists to consider the client’s trauma history, however, resulted in more intense expected anger countertransference. In other words, therapists primed to consider the potential long-term effects of the client’s complex trauma anticipated feeling more angry, manipulated, disappointed, suspicious, and frustrated in therapeutic work with the hypothetical client than therapists not primed. This effect occurred across diagnostic label groups and across high and low agreement with BPD’s diagnostic accuracy for the client. This effect is contrary to what was hypothesized; the encouragement to consider that the client’s developmental
trauma likely contributes to her presenting problems was expected to increase feelings of empathy, acceptance, and warmth, and to lessen expected negative countertransference. Initial reflection on this finding seems to give credence to Becker’s (2000) cynicism that acknowledging traumatic etiology does not engender warmth. Other, nuanced reasons for this finding are explored.

The paragraph reminding therapists of the long-term effects of complex trauma not only prompted therapists to consider the client’s trauma history; it made her trauma history definitive. Whereas the case vignette strongly implied the client experienced childhood sexual abuse, the priming paragraph stated it outright. Although the priming paragraph succeeded in lessening the degree to which therapists held the client responsible for her difficulties, the priming paragraph may have raised expected anger countertransference because it alerted clinicians to the severity of the case and the realistic challenges inherent in therapy with a client who has experienced complex trauma. Additionally, participants in the priming condition, because they were told unequivocally of the hypothetical client’s trauma, were uniquely aware that the client had trauma that she is reluctant or unable to disclose. Undisclosed trauma may represent an even more challenging, frustrating, or long-term course of therapy (McCann & Pearlman, 1990).

It should be noted that the Feeling Word Checklist, which was used to assess anger countertransference, did not specify to whom the therapists’ expected anger was directed. Psychotherapy with survivors of trauma is known to evoke difficult countertransference. Therapists may experience helplessness as they witness the complex trauma survivor’s suffering, both in relation to the client’s past traumatic
experiences and her current self-injury or re-victimization (Neumann & Gamble, 1995). Therapists may feel guilt and frustration from not being able to help these clients, as well as profound sadness and rage in response to evidence of previously unfathomable evil perpetrated in our society (Neumann & Gamble, 1995). Therapists may also identify with the survivor's rage at the perpetrator and failings of others to protect her (McCann & Pearlman, 1990).

Experiencing difficult countertransference in therapeutic work with survivors of trauma contributes to the phenomenon of vicarious traumatization (McCann & Pearlman, 1990). The priming paragraph may have provoked realization of these realistic challenges and the vulnerability to vicarious traumatization in therapy with this hypothetical client, resulting in anticipated frustration, disappointment, and anger. It is also possible the priming paragraph increased participants' empathy with the hypothetical client, leading participants to feel particularly vulnerable to vicarious traumatization.

Anger in reaction to the BPD patient may be expected, particularly among therapists expecting projective identification from BPD patients (Adler, 1993), and if recognized, may promote successful outcomes in psychotherapy (Book, Sadavoy, & Silver, 1978). However, unrecognized countertransferential anger is potentially harmful. Therapists may increase emotional distance between themselves and the patient in order to avoid or protect themselves from unpleasant countertransference (Aviram et al., 2006; Gallop et al., 1989; Nehls, 1998). Neumann and Gamble (1995) explain, “This distancing buffers the therapist from the pain engendered in authentic human relating with traumatized clients, but is usually experienced by survivors as
disengaged and countertherapeutic” (p. 342). If the unrecognized anger is expressed in indirect or displaced ways, harm to the patient is more detrimental as therapist’s expressed anger risks reenacting abuse in treatment (Aviram et al., 2006) or blaming the victim for her abuse (Herman, 1992b).

The CPTSD label did not affect therapists’ expected anger countertransference compared to the BPD group, and prompting therapists to consider the potential enduring effects of the client’s trauma actually resulted in more intense expected anger. This is discouraging as it suggests using the CPTSD label and increasing awareness of complex trauma histories may neither engender the warmth and acceptance that proponents of the CPTSD construct hoped (Hodges, 2003; Woodward et al., 2009) nor diminish the BPD stigma. Alternatively, anticipated frustration and anger are perhaps a result of the realistic challenges in working with survivors of complex trauma or collateral damage from perceived empathic closeness. If recognized and resolved, negative countertransference may not be detrimental and may even be beneficial to treatment.

**Working Alliance**

The Working Alliance Inventory Bond scale assessed the mutual like, trust, and respect therapists anticipated with the hypothetical client, as well as their expectations of the client’s felt concern, genuineness, appreciation, and importance within the therapeutic relationship. Although not statistically significant, therapists presented with the CPTSD-labeled vignette expected somewhat stronger working alliance than therapists presented with the BPD vignette ($d = 0.26$), particularly if they were primed to consider the client’s trauma ($d = 0.37$). Even a small effect on working alliance is likely
to be clinically significant, given the well-documented importance of working alliance in treatment outcomes (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000), particularly with reducing BPD pathology (Barnicot, Katsakou, Bhatti, Savill, Fears, & Pribe, 2012; Spinhoven, Giesen-Bloo, Van Dyck, Kooiman, & Arntz, 2007; Yeomans, Gutfreund, Seizer, Clarkin, Hull, & Smith, 1994). This finding is important as it demonstrates some success of CPTSD as a preferred alternative to BPD.

Specifically, this finding provides preliminary evidence that the CPTSD diagnostic label may improve clinicians’ expectations to form a therapeutic relationship with adult survivors of chronic trauma, an idea hypothesized in this study and previously assumed in CPTSD literature (Pearlman & Courtois, 2005). Previous research has shown that a BPD diagnostic label lowered nurses’ felt and demonstrated empathy for the patient (Fraser & Gallop, 1993; Gallop, Lancee, & Garfinkel, 1989). The breakdown in empathy between clinician and patient with BPD is critical. As it is in all therapeutic work, perceived empathy is especially important in therapy with clients with BPD as it protects against premature termination (Yeomans et al., 1994) and promotes positive therapeutic outcome (Fallon, 2003; Krawitz, 2004; Shearin & Linehan, 1992; Spinhoven et al., 2007). Contributing to BPD stigma is the idea patients with BPD are “difficult” to treat, which is due, in large part, to difficulty establishing a therapeutic relationship with these patients (Langley & Klopper, 2005; Nehls, 1998). Although preliminary, the importance of therapeutic alliance to treatment outcomes makes this effect promising, as it suggests a shift in name could powerfully affect treatment outcomes with survivors of complex trauma exhibiting BPD symptoms.
Unfavorable Attitudes

The items used to assess therapists’ impression of the client described in the case vignette and therapists’ outlook for her treatment were developed for this study. The unfavorable attitudes scale items were modeled after those used in similar research assessing psychiatrists’ and psychologists’ attitudes towards a hypothetical client (Giacalone, 1997; Lewis & Appleby, 1988) and were uniquely suited to assess for therapists’ subjective dislike of the client and poor expectations for treatment. Not being a standardized measure, however, results utilizing the unfavorable attitudes scale must be interpreted with caution and considered preliminary.

In the general sample of therapists, the CPTSD diagnostic label did not result in a more favorable impression of the client or more optimistic expectations for treatment, suggesting a change in name from BPD to CPTSD would not be effective at improving therapists’ regard for survivors of complex trauma who exhibit BPD symptoms. However, knowledge of CPTSD/DESNOS did; therapists who reported they had previously learned about CPTSD had more favorable impressions of the client, particularly if they had also reportedly implemented CPTSD to conceptualize a client. This suggests that an understanding of the CPTSD construct improves therapists’ regard for a survivor of complex trauma, regardless of whether the client is actually given a CPTSD diagnosis. This finding is encouraging, as it indicates education about CPTSD is successful in combatting the BPD stigma.

However, it is interesting to note that therapists who had implemented CPTSD were not immune from the experimental effects in the current study. In fact, although these therapists exhibited more favorable attitudes toward the BPD client than CPTSD
client when not requested to consider her complex trauma, they demonstrated less favorable attitudes toward the BPD client when they were primed to consider her trauma history. This interaction effect was not found among therapists who had not implemented CPTSD to conceptualize a client.

It is proposed that the experimental variables affected unfavorable attitudes in therapists familiar with the CPTSD construct differently than therapists unfamiliar with CPTSD due to differences in their clinical experiences and professional interests. Therapists who have sought education and training in complex trauma reactions are likely more interested in and curious about the topic. Only approximately 10 percent of the sample reported learning about CPTSD in graduate training, indicating the majority of those familiar with CPTSD were self-directed in learning about the subject. Therapists aware of CPTSD may have more experience working with survivors of complex trauma and/or clients with borderline traits. In this sample, those familiar with CPTSD were more likely to endorse having at least one current therapy client diagnosed with BPD, supporting the idea that those familiar with CPTSD may have more experience treating BPD.

Therapists familiar with the CPTSD construct, if they have more experience working with clients with BPD and/or complex trauma histories, may have a more personal understanding of the challenges inherent in working with this population. They may be intimately familiar with the legal and emotional risks (e.g., suicide and self-harm, difficult countertransference) and high cost (e.g., repeated hospitalization) associated with BPD patients (Fallon, 2003; Fraser & Gallop, 1993; Markham, 2003). These clinicians may also have personal experience of vicarious traumatization in therapeutic
work with survivors of complex trauma (McCann & Pearlman, 1990). However, these experiences do not fully explain why the priming paragraph and BPD label together, and neither separately, created these negative outcome effects.

It is hypothesized that the CPTSD-familiar clinicians’ professional experience created a different internal context in which the experimental conditions activated affect over cognition. Rather than simply providing a rational explanation of the etiology for the hypothetical client’s presenting problems, as it was intended and as it may have occurred in clinicians unfamiliar with CPTSD, the priming paragraph may have activated an unpleasant emotional response in CPTSD-familiar clinicians. For example, the priming paragraph may have reminded the CPTSD-familiar clinicians of a client they have worked with in the past, which may have activated emotional memories of therapeutic work with that client.

It could also be that more experience with BPD patients has made CPTSD-familiar clinicians more susceptible to the stereotype of the BPD label. The more frequently an evaluation has been made (e.g., that BPD patients are difficult to work with), the more accessible it is in implicit memory (Judd & Bauer, 1995), and once a stereotype has become associated with a particular group, “it is immediately activated on perception of a characteristic of the group, regardless of the individual’s conscious attitude or judgment,” (Stoycheva & Weinberger, 2014, p. 112). Perhaps the stereotype and resulting stigma of BPD is not as strong in clinicians who do not as regularly treat these clients.
Affinity for CPTSD

A secondary goal of the current study was to survey practicing therapists about their knowledge, use, and opinion of the CPTSD construct. Overall, results suggest an affinity for CPTSD among practicing psychotherapists. Agreement with the accuracy of a CPTSD diagnosis for the hypothetical client was strong, with over three-quarters of those in the CPTSD group indicating they agreed or strongly agreed with this conceptualization. In fact, participants were in agreement with the accuracy of the CPTSD diagnosis even if they had not previously been aware of the CPTSD construct. Therapists’ strength of agreement with the accuracy of a CPTSD diagnosis for the client was related to impression management, however, suggesting it is possible therapists agreed with the CPTSD diagnosis because they felt they ought to.

Regardless, more than 40% of the sample expressed the opinion that CPTSD should be included in the *DSM* nomenclature, and the majority of the remaining participants stated only that they were undecided or did not know enough about the subject to form an opinion; very few participants (5%) expressed the outright opinion it be excluded. Importantly, the opinion to include CPTSD in the *DSM* was not related to therapists’ attempts at impression management. Additionally, a plurality of free response comments expressed support of the CPTSD construct. The affinity for CPTSD observed in this sample may be related to an awareness of the BPD stigma. Therapists, particularly psychologists or others with doctoral degrees, are aware of the stigma associated with BPD and likely want to rectify that.
Therapists’ Characteristics

The current study also sought to examine if certain of therapists’ demographic or professional characteristics were related to differences in dispositional attribution, expected countertransference reactions, working alliance, and attitudes toward the hypothetical client.

Length of Clinical Experience

Reported number of years of clinical experience was positively correlated with higher dispositional attribution and stronger unfavorable attitudes toward the hypothetical client and her treatment. This finding was across experimental conditions, and it is similar to findings in related research that more experienced psychiatric nurses were more likely to socially reject BPD patients, estimate higher dispositional attribution, and respond with belittling responses (Gallop, Lancee, & Garfinkel, 1989; Markham, 2003) than younger or less experienced nurses. However, it is contrary to other research that found psychiatrists with more years of experience have less critical attitudes toward patients (Lewis & Appleby, 1988).

The finding that more years in clinical work related to less favorable impressions of the client and her course of treatment could be due to a realistic understanding of difficulties of therapeutic work with complex trauma survivors (i.e., less experienced clinicians may be more naïve), or it could be due to cynicism related to burnout. Those with more experience in the field may attribute patients’ behavior and symptoms to dispositional factors so as to protect themselves from negative feelings (e.g., ineffectiveness, helplessness) that may accompany responsibility for poor treatment outcomes with these patients (Markham, 2003; Reiser & Levenson, 1984).
Theoretical Orientation

The attribution of the client’s symptomatic behavior to dispositional factors and the expected strength of working alliance were found to vary by theoretical orientation. Theoretical orientation has been suggested as relevant to the BPD stigma. Specifically, the psychodynamic orientation is debated in its relation to this subject. Some authors proposed object relations or psychodynamic training would help to reduce BPD stigma by encouraging clinicians to focus on recognizing and resolving countertransference (Book, Sadavoy, & Silver, 1978; Fraser & Gallop, 1993), while others found psychodynamic clinicians more likely to blame the patient presumably because of the orientation’s emphasis on dispositional characteristics (Langer & Abelson, 1974; Plous & Zimbardo, 1986). Interestingly, in the current study, psychodynamic and cognitive behavioral therapists responded with equivalent, relatively high dispositional attribution. This suggests psychodynamic therapists are not unique in emphasizing dispositional characteristics. However, cognitive behavioral therapists anticipated overall stronger working alliance with the hypothetical client than did psychodynamic therapists.

Psychodynamic-oriented therapists reacted in a unique way to the experimental conditions with respect to their expectations of working alliance with the hypothetical client. When not primed to consider her trauma history, psychodynamic therapists expected stronger alliance with the BPD-labeled client than the CPTSD client. When primed to consider her trauma history, however, psychodynamic therapists expected stronger alliance with the CPTSD-labeled client. There is a long history of psychoanalytic contributions to understanding and treating the primitive intrapsychic development in borderline psychopathology (Aronson, 1985; Gunderson, 2009). In light
of this history and recent research that suggests transference-focused treatment is more successful with BPD patients than dialectical behavior or supportive therapy (Clarkin, Levy, Lenzenweger, & Kernberg, 2007), psychodynamic therapists may feel confident in establishing strong therapeutic alliance with BPD patients. When chronic developmental trauma becomes explicit in the etiology of BPD traits, however, the traditional psychoanalytic conceptualization of BPD is complicated, and psychodynamic therapists may expect treatment to take a less predictable course.

Limitations

The study’s limitations must be considered to appreciate the results and their implications. Utilizing a vignette methodology limits the applicability of the findings, as it is unclear whether clinicians’ responses to a vignette accurately represent how they would respond to a real client. It is impossible to condense the complex history and presenting symptomology of a real person into a brief, written description, and expecting therapists to anticipate such highly personal experiences as their countertransference and therapeutic alliance with a hypothetical client from a vignette may have been particularly difficult. However, extrapolating from vignettes engages the use of stereotypes (Lewis & Appleby, 1988), which made this methodology attractive to the purposes of this study. There is also an extensive body of literature that uses vignette methodology in social science research (e.g., Becker & Lamb, 1994; Crosby & Sprock, 2004) to begin understanding a phenomenon and to point the way for future research. Examples in the literature, such as Fraser and Gallop’s (1993) in vivo replication confirming previous analogue results (i.e., Gallop, Lancee, & Garfinkel, 1989), support the generalizability of similar vignette research. Moreover, in clinical practice, therapists
are often presented with written descriptions of a therapy patient (e.g., intake reports, previous therapist’s progress notes), and it is important to understand how diagnostic labels contained in these documents may influence the clinician’s expectations of therapy with the patient.

Another potential limitation in the current study was the particular vignette chosen for use. Although it was piloted and carefully edited to include symptoms intended to make the diagnostic picture ambiguous but equally plausible as BPD or CPTSD, the sample agreed more strongly with the CPTSD conceptualization. Mean agreement of the sample suggested moderate agreement with the BPD conceptualization, and it is hypothesized that the discrepancy in agreement may be due to a hesitancy to agree with the BPD diagnosis, even when the diagnostic criteria are met. However, the discrepancy could have been the result of a vignette that did not portray BPD as realistically as it did DESNOS/CPTSD.

There are also limitations related to the sample used in this study. The garnered 21% response rate, wherein 7% of those contacted completed the survey and 14% responded to the email to explain they were ineligible, was comparable to similar research (Brody & Farber, 1996; Crosby & Sprock, 2004; Knowles, 2009) but low. It may be difficult to generalize from this largely self-selected sample to the general population of American psychologists. However, Blashfield and McElroy (1989) compared a volunteer sample of psychologists and psychiatrists (15% response rate) with a paid sample (67% response rate). They found no differences in the two samples’ demographic variables and diagnostic opinions of vignettes, suggesting generalization from self-selected clinicians to the general population of clinicians may be reasonable.
Additionally, ethnic minority clinicians were woefully underrepresented in this sample. However, the sample’s ethnic composition was representative of APA membership, which estimates its members to be 90% white (APA Center for Workplace Studies, 2011).

Stigma is an elusive concept to measure, and there is no “gold standard” to measure effects of stigma in psychotherapy. Measures used in the current study were chosen to quantify concepts theorized to be related to stigma of the BPD patient. Participants expressed confusion about the instructions of the Clinician Attribution Scale (CAS); 12 participants noted in comments that they were unclear if questions referred to the client’s current or past environments. The instructions were clarified after 85 participants (25%) completed the survey, but it is unknown if the initial respondents’ confusion over these instructions impacted the results. Also, because the unfavorable attitudes scale is not a standardized measure, interpretations with this scale must be made cautiously.

Lastly, CPTSD is not a diagnosis recognized in the DSM nomenclature, which limits the ability to examine its proposed quality as a less pejorative diagnostic label. It is unclear whether the same effects would have been found if CPTSD was a recognized diagnostic entity, or if the entire sample had been familiar with the construct.

Directions for Future Research

The current study’s results and limitations illuminate directions for future research to understand the influence of CPTSD as a diagnostic label and determine the most effective methods for eliminating the BPD stigma.
The current study found therapists who were reluctant to agree with the diagnostic accuracy of BPD for the client differed meaningfully from therapists who agreed with BPD to a moderate or strong degree. Future research may help illuminate the clinical significance of this difference. Are these therapists also more reluctant to diagnose BPD? If so, what diagnosis might they choose for the client instead? It would also be beneficial to understand if these therapists differ in the mode of treatment they offer similar clients or in treatment outcomes.

The current study found therapists expect to feel more intense anger countertransference when primed to consider the client’s trauma history. Future research could further examine this finding to distinguish whether the anger countertransference differs in type or direction by the client’s diagnostic label. For example, do therapists expect to feel angrier towards the BPD client, but more diffuse frustration with the CPTSD client? It will also be important to understand how a therapist’s anger countertransference is resolved. Future research examining how different therapists manage difficult countertransference in therapy with complex trauma survivors, whether or not they are diagnosed with BPD, would also be beneficial to understand how best to support therapists in this work.

The current study found therapists who were familiar with the CPTSD construct and had implemented it in their clinical work were different from other therapists in the impression they had for the client and their expectations for her course of treatment. The BPD label, however, negatively influenced these CPTSD-implementing therapists, suggesting the BPD stigma has not been eliminated by knowledge and use of CPTSD.
Further research is recommended to understand how therapists familiar with the CPTSD construct distinguish between CPTSD and BPD in conceptualizing their clients.

It is also recommended the current experiment be replicated with psychiatric nurses and staff, as much of the earlier research on BPD stigma was conducted with nurses, and in order to determine if the current results are generalizable to other mental health professions.

The current study compared the CPTSD and BPD diagnostic labels’ effect on attitudes and expectations for treatment. Comparing the CPTSD label’s effect with co-diagnosed BPD and PTSD is important to determine if CPTSD is necessary to reduce BPD stigma, or if including an additional PTSD diagnosis, if warranted, is sufficient in improving attitudes toward the patient and expectations for therapy. It would also be interesting to compare the CPTSD and PTSD label in a similar vignette design to examine whether there has been any transfer of the BPD stigma to CPTSD.

It will be important for future research to study the potential effects of CPTSD to influence the experience of the client in therapy. Fewer studies have examined self-stigma related to BPD, which may be an area of BPD stigma that CPTSD is best suited to improve. The current study focused on the therapists’ reactions to the label; however, arguably more important to treatment outcome is the client’s perception of the therapist’s reaction. Future in vivo studies will be necessary to determine the felt effects of diagnostic label for both therapist and client. Naturalistic comparisons of working alliance and treatment outcomes of therapists treating similar clients, with some therapists choosing to conceptualize the client with CPTSD and others with BPD, may be starting point to understand the effect of CPTSD to lessen BPD stigma.
The priming paragraph in the current study reminded clinicians to consider the client’s complex trauma history in affecting her presentation. An emphasis on the biological determinants of BPD has also been recommended to lessen BPD stigma. A comparison of reminding clinicians of the relation of trauma to BPD presentation with educating clinicians of the biological determinants of BPD may provide conclusions as to the best next step to remedy BPD stigma.

Conclusions and Clinical implications

Clients with BPD represent a significant portion of those seeking psychotherapy (Hodges, 2003; Stefan, 1998). Indeed, 96% of the current sample of therapists reported having treated a client with BPD in the past, with 63% reporting current psychotherapy with a client meeting criteria for BPD. The majority of empirical studies of BPD stigma examined psychiatric nurses’ perceptions and interactions with BPD patients; the current study provides further evidence of the BPD stigma with masters- and doctoral-level psychotherapists, because even highly educated professionals prided to be highly empathetic and non-judgmental are susceptible to stigmatizing clients given a BPD diagnosis, particularly if they agree that BPD is an accurate diagnosis for the client. This is not a problem alone to psychiatric nurses, nurses’ assistants, or hospital staff. All mental health professionals, including psychologists, are charged with working to rectify the BPD stigma, both at individual and policy levels.

When reminded of her complex trauma history, participants in the current study expected anger, disappointment, suspicion, and frustration would be provoked in therapeutic work with the hypothetical client. This anticipation of negative countertransference emphasizes the need for substantial personal and institutional
support for therapists treating survivors of complex trauma, as well as the need for adequate training in management of strong, difficult countertransference for all therapists, regardless of their primary theoretical orientation.

The complicated presenting problems described in the vignette reflect the ambiguity of many therapy clients. Diagnosing such clients is difficult. Data from the current study indicate the BPD diagnosis may be confirmed by negative, subjective perceptions of the client, and not by behavioral criteria alone, as the *DSM-5* criteria would suggest. In diagnostically complex cases, clinicians may be more susceptible to bias in diagnosing (Becker & Lamb, 1994). The increased likelihood of bias in diagnosing BPD, as well as the observed hesitancy to disclose the BPD diagnosis to the client, suggest the BPD diagnosis is not as useful as CPTSD to clinicians or clients when a history of complex trauma is known. Regardless of whether CPTSD is recognized as a formal diagnosis, it may be generally considered the better conceptualization for both the clinician and client to understand the etiology and indicated treatment for her current difficulties.

Similarly, regardless of CPTSD’s recognition as a formal diagnosis, education about the construct is widely recommended for psychotherapists. Familiarity with CPTSD was related to more favorable attitudes toward the client and her course of treatment in the current study. Knowledge of the variety of sequelae from complex trauma is important in order to recognize when a client’s presenting problems are trauma-related. It is also important in developing therapists’ confidence to treat these clients and maintaining their hope for treatment success with these clients.
However, knowledge and use of the CPTSD construct is not enough to end the stigmatization of clients with BPD. Therapists familiar with CPTSD had less favorable impressions of the BPD client when reminded to consider her complex trauma history. This finding is eerily reminiscent of the warning made by critics of CPTSD that discriminating CPTSD from BPD may further stigmatize those diagnosed with BPD (Becker & Lamb, 1994; Becker, 2000). In the reality of the continued existence of BPD as a diagnosis and growing awareness of the CPTSD construct, it will be increasingly important to ensure the CPTSD conceptualization is not used to benefit one segment of patients meeting criteria for BPD only to further disparage another.
APPENDIX A

EMAIL INVITATION TO PARTICIPATE IN SURVEY
Dear Dr. X,

Hi. I am Susannah Miller, a doctoral student in the clinical psychology program at the University of North Texas (UNT), and I am conducting my dissertation research project under the supervision of Dr. Patricia Kaminski. I am seeking volunteer participants for this project, which examines therapists’ perceptions of a hypothetical client and expectations for the client’s treatment. This study has been reviewed and approved by the Institutional Review Board at UNT.

You were randomly selected from among the state-licensed members of APA. Your participation would entail reading a description of a client and completing questionnaires about your perceptions of the client and your expectations for therapy with this client. You would also be asked basic demographic information about yourself. The study is expected to take 20 to 30 minutes of your time.

Given the focus of this study, only individuals currently licensed to practice psychotherapy at a master’s or doctoral level are eligible to participate. Additionally, to be eligible, you must currently see an average of four or more adult, individual therapy clients per week.

If you meet the above requirements, I ask you to thoughtfully consider participating. Your participation is voluntary, and your responses would be anonymous. There are no known risks associated with participating in this study. You may be compensated a $25 gift card to Amazon.com or $20.00 Visa gift card (your choice), if upon completing the study you choose to enter the raffle by providing your name and e-mail or mailing address. The odds of winning a gift card are one in 25. Your participation is not expected to benefit you directly, but greater benefits may include contributing to our field’s knowledge about how the description of a client’s history and presentation relates to therapists’ perceptions of the client, expectancies for treatment, and other variables related to the course of psychotherapy.

Please feel free to contact my faculty supervisor or me if you have questions regarding the study.

If you would like to participate, click on the link below and proceed.

https://unt.qualtrics.com/SE/?SID=SV_5zlEod9cpsxKwhn

Sincerely,

Susannah Miller, M.S.
Doctoral Candidate

Patricia Kaminski, Ph.D.
Associate Professor
APPENDIX B

CASE VIGNETTE
Melissa is a 34-year-old single, European American woman who was referred to your therapy practice from a psychiatrist, Dr. Turpin. Dr. Turpin explained that Melissa was recently hospitalized after attempting to kill herself by taking several medications she had on hand and consuming a bottle of wine. Dr. Turpin was her treating psychiatrist in the hospital. Dr. Turpin spoke briefly to you regarding Melissa’s treatment.

This was her fourth hospitalization in the last two years. The previous hospitalizations had all been precipitated by similar suicide attempts, or self-injury in the form of burning herself with a cigarette lighter. Melissa explained to hospital staff that she had to burn herself sometimes, because otherwise she would “go crazy” or start crying and never stop. Indeed, she was observed to get extremely upset for extended periods of time over what appeared to be relatively minor stressors in the hospital. After one conflict with another patient who called her a “whore,” Melissa banged her head against the wall until staff restrained her.

During the restraint, Melissa appeared to be experiencing a childhood memory, crying out that she wouldn’t take her underwear off and asking repeatedly for her grandmother, who had raised her for several years during her childhood. Melissa reported that her childhood had been a “nightmare,” with her bouncing between relatives and foster homes as her mother went in and out of drug treatment programs and lived with a series of abusive men. Melissa refused to talk about any of her mother’s boyfriends or her experiences with them, simply stating, “I hope they all rot in hell.” Melissa insists that her mother did the best she could, but acknowledges that she was often without food or heat as a young girl, and she was frequently left to care for her two younger siblings when her mother would disappear for several days at a time. Melissa has memories, over which she experiences intense shame, of going through the neighbors’ trashcans, looking for food for herself and her siblings.

As an adult, Melissa used drugs heavily until she entered a detoxification program, which she successfully completed. Prior to her entering the program, Melissa’s ex-boyfriend changed his number and told her never to contact him again after she left several threatening messages for him while she had been intoxicated. Melissa reported that she no longer abuses drugs or alcohol to the same extent as previously but finds she sometimes drinks and uses marijuana to temporarily escape. Melissa reported significant sleep problems, often not falling asleep until two or three in the morning because she “can’t turn [her] mind off and stop remembering stuff.” Melissa has frequent nightmares, the content of which she cannot remember upon waking. Melissa also reports that “everything” scares her, and she screams at any sudden noise or movement.

Melissa is significantly overweight and reported feeling depressed about this. She experiences chronic heartburn, which she reports was not helped by her medication, so she discontinued taking it and has not sought other solutions, stating that “nothing will help.” She also reported frequent chronic, unexplained headaches. Melissa reported that the only thing that helps her feel better is “stuffing” herself with food.

Melissa has a few friends, but she described difficulty trusting them. She believes that none of her friends truly understand her, and she often feels disconnected from them. Melissa has changed her religious affiliation several times over the years and
has held jobs in a variety of fields, explaining that she has never found a religion or career in which she feels “at home.” She currently works part-time, but she does not find it fulfilling and often has difficulty focusing on her work, which has caused her to be fired on several occasions. Other times, she has quit, stating that she was tired of conflict with coworkers. Melissa also reported conflict with romantic partners, resulting in a series of failed relationships. When asked what she does to help herself cope with the difficulties in her life, Melissa replied, “Just not think about things, I guess.”
APPENDIX C

VIGNETTE MANIPULATION CHECK BPD AND CPTSD CONDITIONS
DSM-IV-TR Diagnostic Criteria for Borderline Personality Disorder

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.
(2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
(3) identity disturbance: markedly and persistently unstable self image or sense of self
(4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance use, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.
(5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
(6) affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
(7) chronic feelings of emptiness
(8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
(9) transient, stress-related paranoid ideation or severe dissociative symptoms

Given the diagnostic criteria provided above, please indicate your agreement with the accuracy of the conceptualization of the client in the vignette.

1 = Strongly Disagree

7 = Strongly Agree

1 2 3 4 5 6 7
Proposed Diagnostic Criteria for Complex Posttraumatic Stress Disorder

I. Alteration in Regulation of Affect and Impulses (A and one of B-F required)
   A. Affect regulation
   B. Modulation of anger
   C. Self-destructive
   D. Suicidal preoccupation
   E. Difficulty modulating sexual involvement
   F. Excessive risk-taking

II. Alterations in Attention or Consciousness (A or B required)
   A. Amnesia
   B. Transient dissociative episodes and depersonalization

III. Alterations in Self-Perception (Two of A-F required)
   A. Ineffectiveness
   B. Permanent damage
   C. Guilt and responsibility
   D. Shame
   E. Nobody can understand
   F. Minimizing

IV. Alterations in Relations with Others (One of A-C required)
   A. Inability to trust
   B. Revictimization
   C. Victimizing others

V. Somatization (Two of A-E required)
   A. Digestive system
   B. Chronic pain
   C. Cardiopulmonary symptoms
   D. Conversion symptoms
   E. Sexual symptoms

VI. Alterations in Systems of Meaning (One of A-B required)
   A. Despair and hopelessness
   B. Loss of previously sustaining beliefs

Given the diagnostic criteria provided above, please indicate your agreement with the accuracy of the conceptualization of the client in the vignette.

1 = Strongly Disagree  7 = Strongly Agree
APPENDIX D

THERAPIST ATTITUDES QUESTIONNAIRE
The statements below refer to the case study you have just read. Please read each statement and indicate your agreement.

1 = Strongly Disagree

7 = Strongly Agree

1  2  3  4  5  6  7

_____ 1. I anticipate an overall positive experience working with this person.
_____ 2. I am confident in my ability to treat this person.
_____ 3. This person poses a legal risk.
_____ 4. This person is unlikely to improve in therapy.
_____ 5. It would be important to maintain strict boundaries with this person.
_____ 6. It would be difficult to identify this person’s strengths.
_____ 7. This person’s current difficulties are directly related to her history of trauma.
_____ 8. I would not be willing to extend my usual hours to accommodate this person’s schedule.
_____ 9. This person is likely to terminate therapy prematurely.
_____ 10. It would be easy to empathize with this person.
_____ 11. I would be willing to charge this person a reduced fee if needed.
_____ 12. This person is mentally ill.
_____ 13. This person’s self-harm is primarily attention-seeking.
_____ 14. This person is likely to annoy me.
_____ 15. I would not like to see this person in therapy.
_____ 16. This person’s self-harming urges are under her control.
_____ 17. This person’s condition is not severe.
_____ 18. This person is at risk for suicide.
_____ 19. I would inform this person of her [BPD or CPTSD] diagnosis.
_____ 20. This person is exaggerating her symptoms.
_____ 21. I expect to like this person.
_____ 22. This person is likely to make deliberate attempts to manipulate me.
_____ 23. I am likely to enjoy meeting with this person.
_____ 24. I would think about this person in my leisure time.
_____ 25. I would refer this person to another therapist.
APPENDIX E

DEMOGRAPHICS QUESTIONNAIRE
1) Age: __________

2) Sex:
   1) ☐ Female
   2) ☐ Male
   3) ☐ Transgender

3) Ethnic/racial background:
   1) ☐ Asian/Pacific Islander
   2) ☐ Black/African American
   3) ☐ Hispanic/Latino
   4) ☐ Native American
   5) ☐ White/Caucasian
   6) ☐ Multiracial/Multiethnic
   7) ☐ Other, please specify __________

4) What is the highest degree you have earned?
   1) ☐ Ed.D.
   2) ☐ M.S. or M.A.
   3) ☐ Ph.D.
   4) ☐ Psy.D.
   5) ☐ Other, please specify __________

5) What type of graduate program did you attend?
   1) ☐ Clinical psychology
   2) ☐ Clinical health psychology
   3) ☐ Counseling psychology
   4) ☐ Social work
   5) ☐ Other, please specify __________

6) Was your graduate program accredited at the time you graduated?
   1) ☐ Yes
   2) ☐ No
   3) ☐ I don’t know

7) How many years of full-time clinical experience have you had since licensure? (If half-time, divide number of years by two.) __________
8) What is your primary theoretical orientation?

1) ☐ Behavioral
2) ☐ Biological
3) ☐ Cognitive Behavioral
4) ☐ Eclectic
5) ☐ Humanistic/Existential
6) ☐ Integrative
7) ☐ Interpersonal
8) ☐ Psychodynamic/Psychoanalytic
9) ☐ Systemic
10) ☐ Other, please specify __________

9) Indicate the percent of time spent working in each type of setting (total should equal 100%):

1) Academic Teaching ______
2) Community Mental Health Center ______
3) Consortium ______
4) Correctional Facility ______
5) Health Maintenance Organization ______
6) Hospital/Medical Center ______
7) Independent Practice ______
8) Psychiatric Facility ______
9) School District or System ______
10) University Counseling Center ______
11) Other, please specify: __________

10) Indicate the percent of your time spent in each of the following activities (total should equal 100%):

1) Administrative services ______
2) Clinical services ______
3) Consultation ______
4) Research ______
5) Teaching _____
6) Other _____

11) Indicate the percent of your clinical work with the following groups (total should equal 100%):
   1) Children (12 and under) _____
   2) Adolescents (13-17) _____
   3) Young Adults (18-29) _____
   4) Adults (30-64) _____
   5) Older Adults (65+) _____

12) Approximately how many adult individual therapy clients do you see in a typical week? ___________

13) Which types of disorders do you commonly encounter in your clinical practice? (select all that apply)
   1) ☐ Disorders Usually Diagnosed in Infancy, Childhood, or Adolescence
   2) ☐ Delirium, Dementia, Amnestic and Other Cognitive Disorders
   3) ☐ Mental Disorders Due to a General Medical Condition
   4) ☐ Substance-Related Disorders
   5) ☐ Schizophrenia and Other Psychotic Disorders
   6) ☐ Mood Disorders
   7) ☐ Anxiety Disorders
   8) ☐ Somatoform Disorders
   9) ☐ Factitious Disorders
   10) ☐ Dissociative Disorders
   11) ☐ Sexual and Gender Identity Disorders
   12) ☐ Eating Disorders
   13) ☐ Sleep Disorders
   14) ☐ Impulse-Control Disorders Not Elsewhere Classified
   15) ☐ Adjustment Disorders
   16) ☐ Personality Disorders
APPENDIX F

PRIOR AWARENESS OF CPTSD QUESTIONNAIRE
1) Before beginning this survey, had you heard of Complex PTSD or Disorders of Extreme Stress, Not Otherwise Specified (DESNOS)?
   1) ☐ Yes
   2) ☐ No
   3) ☐ I don’t know
2) Have you read articles or books about Complex PTSD or DESNOS?
   1) ☐ Yes
   2) ☐ No
   3) ☐ I don’t know
3) Did you learn about Complex PTSD or DESNOS in your graduate coursework or training?
   1) ☐ Yes
   2) ☐ No
   3) ☐ I don’t know
4) Did you learn about Complex PTSD or DESNOS through continuing education?
   1) ☐ Yes
   2) ☐ No
   3) ☐ I don’t know
5) Have you ever used Complex PTSD or DESNOS to conceptualize a client?
   1) ☐ Yes
   2) ☐ No
   3) ☐ I don’t know
6) Do you believe Complex PTSD or DESNOS should be included as a diagnostic category in the DSM-5?
   1) ☐ Yes
   2) ☐ No
   3) ☐ Undecided
   4) ☐ I do not know enough to make a decision
7) What is your opinion about the utility of a Complex PTSD/DESNOS diagnostic label and its relationship, if any, to borderline personality disorder? (Free response)
APPENDIX G

UNIVERSITY OF NORTH TEXAS INSTITUTIONAL REVIEW BOARD

INFORMED CONSENT NOTICE
Before agreeing to participate in this research study, it is important that you read and understand the following explanation of the purpose, benefits and risks of the study and how it will be conducted.

**Title of Study:** Client Description and Therapists’ Expectancies for Treatment

**Supervising Investigator:** Patricia Kaminski, Ph.D.

**Student Investigator:** Susannah Miller, M.S., University of North Texas (UNT) Department of Psychology.

**Purpose of the Study:** You are being asked to participate in a research study, which involves examining how the description of a client’s history and presentation relates to therapists’ perceptions of the client, expectancies for treatment, and other variables related to the course of psychotherapy.

**Study Procedures:** You will be asked to read a vignette describing a hypothetical client and to answer questions about the client, your expectations for therapy with this client, and basic demographic information about yourself that will take 20 to 30 minutes of your time. All procedures will be completed on-line.

**Foreseeable Risks:** No foreseeable risks are involved in this study.

**Benefits to the Subjects or Others:** This study is not expected to be of any direct benefit to you, but we hope to learn more about how communication about a client may impact variables related to the course of psychotherapy.

**Compensation for Participants:** If you choose, you will be entered in a drawing to receive a $25.00 Amazon.com gift card or a $20.00 Visa gift card. A drawing for a gift card will occur after every 25 completed surveys. Thus, your chance to win a gift card will remain at 1 in 25.

**Procedures for Maintaining Confidentiality of Research Records:** Your answers to the study’s survey questions will remain anonymous. Once you have completed the study’s survey, you will be redirected to a second survey that is not connected in any way to the study’s survey. On this second survey, you may choose to provide your name and an e-mail or mailing address in order to be included in the drawing for a gift card and/or to receive the results of the study. If you choose to provide this information, your name and contact information will not be connected to your responses to the study survey in any way. The confidentiality of your individual information will be maintained in any publications or presentations regarding this study.

**Questions about the Study:** If you have any questions about the study, you may contact the Student Investigator, Susannah Miller, at [redacted] or [redacted] or the Supervisory Investigator, Dr. Patricia Kaminski, at [redacted] or [redacted].
Review for the Protection of Participants: This research study has been reviewed and approved by the UNT Institutional Review Board (IRB). The UNT IRB can be contacted at (940) 565-3940 with any questions regarding the rights of research subjects.
APPENDIX H

SAMPLES OF RESPONSES FROM CPTSD UTILITY FREE RESPONSE PROMPT
Samples of responses from the free response prompt: What is your opinion about the utility of a CPTSD/DESNOS diagnostic label and its relationship, if any, to borderline personality disorder?

**Sample of responses reflecting general support of CPTSD**
I hate the diagnosis of BPD. It doesn’t convey an accurate picture of the persons [sic] problems. I much prefer the proposed diagnoses.

I think the BPD label should be abolished. A trauma diagnosis would be more appropriate.

It is a more useful dx [sic] for understanding how to be helpful.

...BPD has become a prejudicial stereotype among psychotherapy professionals rather than a simple diagnostic conceptualization...the stereotype overwhelms the useful conceptual framework of the diagnosis...In this we find part of the utility of the DESNOS conceptualization because it imparts hope, to therapist and client.

This thing about “borderline” I always found to be victimizing wimmin [sic].

BPD is over diagnosed and patients tend to be forced into the diagnostic label. This is especially so for all women and more so for women of color.

It would help in forming a treatment plan and prognosis.

The pejorative nature of the BPD diagnosis is a problem so I only use it after considerable time with a client, and with great caution. Anything to describe these patients in a less pejorative manner would be an improvement.

Less pejorative.

I tend to see BPD diagnosis as saying more about the treater than client-i.e, the treater is exasperated or dislikes the client.

Separation from stigma of BPD at least in terminology.

I do believe that most borderline personality disorders suffered a great deal of trauma and treatment of the trauma has to happen or else the borderline will never truly get better. And that nobody signed up to be a borderline. S there but the grace of God go all of us.

The concept of CPTSD fits very well within the scope of my understanding of women who are misdiagnosed as BPD.

...I suspect it would likely be a label which might have the potential to generate more therapist empathy than the BPD label.
I think that using the CPTSD diagnosis captures the complexity of both the etiology of the patient’s difficulties as well as what needs to happen therapeutically. The BPD label is very pejorative and tends to blame the patient and validate the anger or disturbing feelings that are typically stirred up in the therapist…Because of the impact on the developing personality, by the time the person comes for treatment the source is both in the patient and in the environment.

It’s sort of the same thing, perhaps more accurate, certainly less stigmatizing

I would love to have this be an official diagnosis, because I believe it would avoid the label of borderline personality disorder as a way of dismissing the seriousness of trauma and attachment disruptions in the presentation.

I think it is very useful as it offers a more positive treatment outlook and ability to conceptualize a difficult client that frequently comes having been treated badly in the mental health system.

Trauma-related conceptualizations are not only more accurate, they are more therapeutic as they provide clients and therapists with a framework that make sense of symptoms without blaming the victim.

I dislike giving someone who has clearly been traumatized a diagnosis that is as pejorative as BPD. The trauma should be the focus of treatment, not the unfortunate side effects.

Some therapists see borderline personality disorder as forever and the client picks up these cues and begins to see themselves as hopeless. Using CPTSD diagnosis helps the client to develop a better understanding of what stimuli trigger her affect, thoughts, an behavior.

I avoid the diagnosis of BPD where possible because I believe it has the suggestive power to influence professionals to expect trouble and untreatability.

BPD is a description of behavior; CPTSD speaks of causes and has less “blaming” quality to it.

**Samples of responses questioning the utility of CPTSD**
The word complex does not add anything to post traumatic stress disorder. I do not believe there is a need for DESNOS.

It is complex. CPTSD does not eliminate the reality of BPD.

I think the PTSD diagnosis is sufficient. The C simply relates to how long you may have to treat the patient.
While having an accurate label is important, beneficial treatment regimen is equally so. Even if you called it CPTSD/DESNOS, wouldn’t DBT still be the preferred treatment for her symptoms?

Oh boy…Have you read some of the garbage that the APA passes off as contributions to science which are basically the addition of fancy statistics to something anyone’s grandmother could tell them? All in the name of glorifying and promoting the profession, a clearly political move. So, will establishing another diagnostic category benefit the client? The drug company? The psychotherapy industry? You choose.

…Given the track record for diagnosis I’m afraid it will only add to the determent of our clients. Instead of there being pejorative comments about “borderline” clients, there will be pejorative comments about “complex” clients.

Although the discrimination of these disorders is likely useful for research purposes and in communicating differences in expression, the difference in the actual diagnosis would likely have very little utility in helping the client as the approach to treatment would likely be similar, if not identical.

Always concerned that a label closes the therapist’s eyes to other issues. Emerging research indicates a good many PTSD sufferers do so, in part, because of other issues. Does this make them all complex?

Not sure how CPTSD differs from PTSD or why a distinction would be made…It’s unclear to me what purpose a diagnosis of CPTSD/DESNOS would serve that a diagnosis of PTSD and/or BPD wouldn’t serve.

BPD is BPD. While trauma can certain [sic] exacerbate this and/or cause it to be manifested, it is NOT the etiology of this disorder in my view.

Not sure but do believe more diagnoses are not warranted

I believe the vast majority of clients diagnosed with BPD have had multiple traumas throughout their lives. In the rare cases where there appears to have been no trauma, it turns out that I didn’t have enough history to learn of the trauma…As for the CPTSD/DESNOS diagnosis, I’m unclear as to whether this would clarify or muddy the waters.

**Sample of ambivalent responses**

No patient is a “garden variety.” Each one deserves to be heard completely prior to makin [sic] diagnostic judgments…If there were a diagnostic category like “very troubled individual, risk of suicide and/or self-mutilization [sic],” that would be what I would choose. I must [sic] prefer descriptions, rather than labels.

I’m a trauma psychologist by training and have mixed feelings. I think there are many people who meet criteria for Borderline and do not have a trauma history.
We should be able to hold more than one conceptualization of a client in our minds at any time and be able to work on different fronts.

I believe it helps the therapist view the patient in a more compassionate manner. However, I do not necessarily see them as separate.

In practical terms, what looks like borderline or schizophrenia or bipolar often turns out to be PTSD and is treatable. My vote is to treat the PTSD effectively and see what is left.

I do not know where that line of demarcation is to be found between these two diagnostic labels...Will it free “personality disorder” label? Will mental health insurance help pay for treatment or readily?

Consider BPD label as punitive and that the descriptors are not uncommon in individuals who have diagnoses other than BPD.

I suppose I’m really on the fence. I get that people with “complex trauma” react differently to the world, but I’m just not sure we need another label to best conceptualize this.

CPTSD seems remarkably similar to BPD, probably too similar...which makes me question whether it is needed. As the saying goes, “A rose by any name would smell just as sweet”...One upside may be that as an Axis I diagnosis, CPTSD patients may not have to deal with the same barriers that borderline patients routinely have to deal with (e.g., getting insurance companies to pay for treatment, stigma).

Not certain. This vignette, however, strongly suggests “borderline personality disorder.”
REFERENCES


attributional biases and objective countertransference reactions. [Doctoral dissertation]. Available from ProQuest Dissertations and Theses database. (UMI No. 3407711)


    Robinson, P. Shaver, & L.S. Wrightsman (eds.), Measures of Personality and

    framework: Relational treatment of complex trauma. Journal of Traumatic
    Stress, 18, 449-459.

Pelcovitz, D., van der Kolk, B., Roth, S., Mandel, F., Kaplan, S., & Resick, P.
    (1997). Development of a criteria set and a structured interview for disorders of
    extreme stress (SIDES). Journal of Traumatic Stress, 10, 3-16.

Peterson, C., Semmel, A., Von Baeyer, C., Abramson, L., Metalsky, G., &
    Therapy and Research, 6, 287-299.

    comparison of psychoanalysts and behavior therapists. Journal of
    Consulting and Clinical Psychology, 54, 568 - 570.

Pope, H., & Lipinski, J. (1978). Diagnosis in schizophrenia and manic-depressive
    illness: A reassessment of the specificity of schizophrenia symptoms in the light

    Psychology, 1, 301-318.

    problem with teaching opportunities. American Journal of Psychiatry, 141, 1528-
    1532.


118.


Welch, B. (1947). The generalization of 'Student's' problem when several different population variances are involved. *Biometrika Trust*, 34, 28-35.


