Bl	aming and Stereotyping
and	Their Effects on Healing
for	patients with Borderline
	Personality disorder

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I. Introduction

- Ms. A: You could be dying before you got any help around here! My arm is killing me! This place is crazy!
- Therapist: Ms. A, I would like to introduce myself. I am Dr. Wheelis.
- Ms. A: Oh, no kidding! I didn't expect you.
 You're a resident? Interesting. You must be either very good or very crazy to have taken me on.
- Therapist: I can't tell if that's an invitation, a warning, or both [patient smiled at the comment], but we have an appointment tomorrow. Why don't we discuss it then.

- Ms. A: No, it's okay, just a little bang.
- **Therapist**: Are you sure? You suggested that it was giving you considerable pain.
- Ms. A: No, it's fine, really. I'll see you tomorrow. By the way, I hate being called Ms. A.
- Therapist: How would you like to be called?
- Ms. A: Lotta. That's what everyone calls me.
- Therapist: Very well, as you wish.

Already in this initial interaction with her therapist-to-be, harbingers of the therapeutic challenges are evident. Ms. A demonstrates a manipulative style that predates the first interaction by seeking help through the exaggeration of a minor physical complaint. There is also the hint that Ms. A may be taking pleasure in suggesting to the therapist-to-be that working with her will be more than a small challenge. Her final request, to be called Lotta [rather than Ms. A] betrays her desire to bypass professional formality by requesting an immediate familiarity.

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Statement of the problem

- Borderliners are the patients you think of as PIAs--pains in the ass.
- The most frequent countertransference =hate.

BPD patients	Clinicians
Manipulate, provoke	Hopeless
Bully, con	Pessimistic
Divide, complain	Angry

The view of most clinicians

- Unless a patient is deluded or hallucinating, or confused or muddled, she knows what she is doing and is therefore responsible for what she does.
- Since she is responsible for her behavior, she is to blame for it.

II. Conceptual issues	
Great suffering • Lack of connectedness • Not knowing how to correct	
their ways of behavingMore intense and longer-lasting dysphoria	
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People don't burn 'I'm a bad person' into their arm with a cigarette because they are difficult; people with BPD have a serious illness.	

But an examination of actual practices suggests that clinicians don't really believe that.	
Hard to make sense of such suffering and yet blame the patients for their symptoms	
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Willful madness	

A personality disorder is "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment."	
The Borderline Personality Disorder is viewed as an advanced form of structurally defective personality organization, with a moderate to severe level of dysfunction.	
Can you blame someone and still be empathetic to them? Apparently not—when it comes to patients diagnosed with BPD.	

What kind of thing is it?	
- Modical?	
• Medical?	
• Moral?	
Blurred boundaries between	
medical and moral kinds	
→ 'Mad' or 'bad' conflated.	
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Stereotyped perceptions play a	
crucial role in how the behavior of	
BPD patients is interpreted and responded to.	

III. Stereotyping	
Attribution Theory	
People infer (i.e. attribute) causes for events in order to gain a sense of control over their environment.	
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Negative event→	
Attribute control to Person A→	
'Person A caused'→	
Negative reaction	

Attribution theory in this context When clinicians attribute to a patient the ability to control her behavior, they experience more anger and less empathy.	
Clinicians come to clinic with a ready-made scheme of interpretation that shapes their perception.	
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Stereotype: Definition	
A cognitive structure that contains the perceiver's knowledge, beliefs, and expectations about a human group	

The difficult behavior of the patient with borderline personality disorder is often seen as "bad" and "deliberate" rather than as "sick"The schizophrenic patient, on the other hand, is not perceived as having this control.	
The lebel IDDD1 is sufficient to	1
 The label [BPD] is sufficient to diminish clinicians' empathy. 	
Clinicians and staff may believe that BPD patients "deserve" less empathetic treatment and	
that their diagnosis means that they are bad or manipulative.	
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75.0/ formula	
75 % female	

The picture of the borderline patient as a manipulative, demanding, aggressive, and angry woman is a persistent theme since the diagnosis was first included in the DSM.	
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IV. The ethics of blame and responsibility	
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It's a fundamental principle of moral philosophy that we don't blame people for things that are beyond their control.	

If one <u>cannot have done</u> <u>otherwise</u> , one cannot be said to have chosen, and therefore cannot be held responsible.	
Are the dysfunctional states, beliefs, desires, and behaviors of BPD ones that the patient has control over and, if so, which ones?	
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Impulsivity-Compulsion	
When one is forced (in this domain, by irresistible impulses or desires) to act	

Very hard-to-resist desires Choice between (1) acting on desires that one finds morally repellent and shameful; and (2) refraining, which causes one considerable distress.	
The agent is still making a choice, but (in this domain) one's choice is internally coerced.	
Problem in the structure of the will	

Being able to choose between available alternatives	
+	
Being able to choose which desires one wants to have	
If DDD maticate and unable to	
If BPD patients are unable to structure their will such that	
their second-order desires take primacy in decision-making and	
action, then responsibility for their dysfunctional behavior is at	
least mitigated.	
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Considerations for holding	
responsible 1. Fairness of attributing	
2. Effects of withholding	
3. Details of dysfunction	

V. Conclusions	
Natural kinds Indifferent kinds	
Interactive kinds Classifications that, when known by people or by those around them, and put to work in institutions, change the ways in which individuals experience themselves—and may even lead people to evolve their feelings and behavior in part because they are so classified. (Hacking 1999, 104)	

Just vision	
As moral agents we have to	
try to see justly, to overcome prejudice, to avoid temptation,	
to control and curb	
imagination, to direct reflection.	
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Implications for healing	
Clinician negativity towards	
BPD patients is often self-confirming and self-fulfilling.	
comming and sen rumming.	
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Increased dysfunction and	
higher suicide rates are correlated with negative	
clinician attitudes.	

Patients are not likely to get	
better without experiencing empathetic responses from	
clinicians.	
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If we view BPD as a mental disorder, the cluster of	
symptoms makes it less	
plausible to hold the patient responsible for expressing her	
disorder through her behavior.	
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