Podcast link:
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Annotated Bibliography

Brennan, R., & Harrell, T. (2023, December 7). *The DSM-5 Criteria for Borderline Personality Disorder*. Mind Diagnostics. https://www.mind-diagnostics.org/blog/borderline-personality-disorder/the-dsm-5-criteria-for-borderline-personality-disorder

This source was very helpful in providing the diagnostic criteria for BPD found in the DSM. I used this source instead of the DSM-V itself because I was also able to learn about other characteristics and prevalence rates of the disorder in the U.S. population. This source also discussed some of the causes and possible treatment options for individuals with BPD. I didn't use these sections as much in my podcast, but it was good to get a general overview of the whole course of the disorder. The most relevant information I got was about the diagnostic criteria, which I included in my podcast to help with the discussion about what BPD really is.

Gilbert, L. (2020). *"Borderline personality disorder: Destroying stigma and Promoting Normalization."*. Institute of Living. https://instituteofliving.org/file%20library/olin/borderline-personality-disorder_-destroying-stigma-and-promoting-normali....pdf

This source was very informative and important in my understanding of prevalent misconceptions. I learned a lot about how the media falsely portrays individuals with BPD as violent, further insinuating and reinforcing harmful stereotypes. I only briefly mention this information in my introduction, however, it was important for me to know about how stigma is spread to be able to talk about its impact and how to combat it. This source also contained relevant statistics about discrimination against individuals with BPD in the workplace,

therapeutic settings, and with medical health professionals. I used these facts to outline the different impacts that stigma can have on individuals with BPD. This source also briefly reviewed two prevalent myths, both of which I included in my podcast, and why it is important to limit the stigma regarding BPD.

Johnson, S. A. (2019). Understanding the violent personality: Antisocial personality disorder, psychopathy, & sociopathy explored. *Foresic Research & Criminology International Journal*, *7*(2). https://doi.org/10.15406/frcij.2019.07.00267

This journal article talked particularly about the difference between ASPD, psychopathy, and sociopathy. I was initially unsure about the differences between these three labels, however, this journal clearly described how they are different, and how they are portrayed and discussed in pop culture. I used the information from this article to create the section in my podcast that discusses the difference between the three in order to combat the myth that individuals with BPD or ASPD are dangerous and violent. I learned that psychopathy and sociopathy are not official diagnoses and instead can be considered more severe or specific forms of ASPD. This was important since some of the impacts of using them interchangeably include oversimplifying ASPD, trivializing the genuine emotional struggles of individuals who have a clinical diagnosis, and reinforcing incorrect stereotypes.

Ma, L. (2024). *The 10 personality disorders*. Psychology Today. https://www.psychologytoday.com/us/blog/hide-and-seek/201205/the-10-personality-disorders?msockid=3196cb0f216c63632220db9f20886220

To start my research into BPP and ASPD, I needed to learn more about personality disorders in general. This article reviewed in depth the history behind the creation of personality disorders, psychosis, and antisociality, which helped me get a basic understanding of how this diagnosis came to be. I also learned about the diagnostic criteria for personality

disorders in general, which is different from the specific diagnoses for BPD and ASPD. There are three different clusters of disorders, of which BPD and APD are in cluster B, categorized by dramatic and erratic behaviors. While I knew these two disorders were somewhat related, I understood why they are often grouped together and have high rates of co-morbidity. Lastly, this article discussed the issues of personality disorder diagnoses. This included the frequency for the disorders to blur together, the subjectivity with which they are diagnosed, and the use of diagnosing as s convenient label for undesirables and social deviants.

Meloy, J. R., & Yakeley, J. (1989). *Antisocial personality disorder*. Gabbard's Treatments of Psychiatric Disorders, Fifth Edition. https://drreidmeloy.com/wp-content/uploads/2015/12/2014_AntisocialPers.pdf

The authors discussed antisocial personality disorder in depth, including the DSM diagnostic criteria, comorbidities, intervention tactics, and impacts of biases in the therapeutic setting. One of the prevalent myths considered was that ASPD is known for having notoriously difficult treatment efforts and being 'untreatable'. This leads to psychiatrists being reluctant to treat patients with this disorder, therapeutic nihilism, helplessness and guilt, and a lack of rehabilitation efforts. I used the data and statistics presented with this information when talking about the impacts of stereotypes on those with ASPD, and when initially describing ASPD. There was also some information presented about the difference between individuals with ASPD and 'psychopathy' and those without, specifically related to their response to treatment and violence. This was informative when discussing my first misconception that individuals with BPD and ASPD are violent and dangerous.

Rao, S. (2019). Borderline personality disorder – A misunderstood disorder. *Sri Lanka Journal of Psychiatry*, *10*(2), 1–3. https://doi.org/10.4038/sljpsyc.v10i2.8217

This journal talked about the characteristics, comorbidity, misconceptions, and prognosis evidence of Borderline Personality Disorder. While there was less discussion of the specific diagnostic criteria of BPD, I found important descriptive characteristics regarding those with the disorder not mentioned in the DSM. These include self-loathing, chronic hopelessness, a loss of identity, and significant morbidity and mortality. The statistics about the frequency of self-injury and suicidality of those with the disorder increased my enthusiasm for combating the stigma against BPD, which ultimately leads to more effective, researched, and sustainable treatment methods. Additionally, the author mentioned other co-morbidities that increase and expand the symptoms of BPD such as eating disorders, substance use disorders, PTSD, and depression.

Sheehan, L., Nieweglowski, K., & Corrigan, P. (2016). The stigma of personality disorders. *Current Psychiatry Reports*, *18*(1). https://doi.org/10.1007/s11920-015-0654-1

This journal article discussed the stigma against personality disorders in general, with sections specifically discussing those against individuals with BPD and ASPD. I learned about the prevalence rates of personality disorders in general and in regards to ASPD and BPD, which have the highest prevalence out of the personality disorders. The authors went into depth about the stigmas that arise from misconceptions about ASPD, BPD, and personality disorders, which come about especially because of low public mental health literacy. There was discussion about different types of stigma that arise, including provider stigma, self-stigma, and structural stigma, especially in the justice system. This helped round out my discussion of the impacts of harmful myths of ASPD and BPS. Lastly, the authors mentioned anti-stigma interventions such as educating providers and allowing members of stigmatized groups to connect to one another. Unfortunately, a lot of these tactics are not well-researched or scientifically proven to be helpful.

Talking Points

A. Introduction

a. Definitions and Diagnostic Criteria

i. Personality Disorders

1. Prevalence: 5 - 15% of population
   a. Among the most commonly experienced psychiatric conditions
2. Diagnostic Criteria:
   a. Significant impairments in self and interpersonal functioning with 1 + pathological personality traits
   b. Stable across time and situations
   c. Not normative for developmental stage or socio-cultural environment
   d. Not due to effects of substance or medical condition
3. Three 'clusters' of personality disorders:
   a. Cluster A: Odd, bizarre, eccentric
      i. Paranoid PD
      ii. Schizoid PD
      iii. Schizotypal PD
   b. Cluster B: Dramatic, erratic
      i. Antisocial PD
      ii. Borderline PD
      iii. Histrionic PD
      iv. Narcissistic PD
   c. Cluster C: Fearful, anxious
      i. Avoidant PD
      ii. Dependent PD
      iii. Obsessive-compulsive PD

ii. Borderline Personality Disorder (2.7%)

1. Characteristics
   a. Emotional instability
   b. Fear of abandonment
   c. Lacking a sense of self
   d. Comorbidity - ED, SU, PTSD, depression, chronic pain
   e. Suicidal threats and acts of self-harm
      i. 85% of patients self-injure
      ii. 10% diagnosed die by suicide
      iii. Contributes to 95% of all PD-related suicides
2. Diagnostic Criteria
   a. A pervasive pattern of instability in relationships, self-image, and affect, marked by impulsivity starting in early adulthood, present in different contexts
   b. At least 5 of the following:
      i. Frantic efforts to avoid abandonment

ii. unstable and intense relationships
iii. identity disturbance
iv. impulsivity in at least 2 areas (spending, sex, SU)
v. recurrent suicidal or self-harming behavior
vi. affective instability
vii. chronic feelings of emptiness
viii. inappropriate, intense anger or difficulty controlling anger
ix. Stress-related paranoid ideation or severe dissociative symptoms

iii. <u>Antisocial Personality Disorder</u> (3.8%)
1. Characteristics
   a. Callous unconcern for the feelings of others
   b. Disregard for social rules and obligations
2. Diagnostic Criteria
   a. Pervasive pattern of disregard for and violation of the rights of others
   b. Occurring since age 15, being at least 18
   c. Evidence of conduct disorder before age 15
   d. Not exclusively during schizophrenia or bipolar disorder
   e. At least 3 of the following:
      i. failure to conform to social norms/lawful behavior
      ii. Decietfulness - lying, aliases, conning
      iii. Impulsivity/failure to plan ahead
      iv. Irritability and aggressiveness
      v. Reckless disregard for the safety of self or others
      vi. Consistent irresponsibility
      vii. Lack of remorse - indifferent to/rationalizing having hurt, mistreated, or stolen

b. Explanations for Misconceptions

i. <u>Lack of Education/Knowledge</u>
1. The general public knows less about PD than other MI
   a. When given a description, only 2.3% of respondents recognize symptoms of BPD whereas 72.4% recognized depression and 65.6% recognized schizophrenia
2. Public knowledge, aka mental health literacy, has been correlated to influence both treatment-seeking behavior and public stigma

ii. <u>Portrayal in the Media</u>

1. ASPD are generally portrayed as being sociopaths and/or psychopaths while BPD is generally shown as individuals being violent or manipulative

B. Misconception #1: Individuals with BPD and ASPD are violent and dangerous

a. **Difference between ASPD, sociopath, and psychopath**
   i. Sociopath and psychopath are NOT formal diagnoses - they are pop culture terms for people perceived to be cold-hearted, serial killers, or lacking empathy and emotions but do not describe people with the actual clinical condition
      1. Sociopath - described as a subtype of ASPD that includes more impulsive, erratic behavior with emotional outbursts
      2. Psychopath - a more severe or specific form of ASPD that is cold, calculating, manipulative, and lacking empathy
   ii. ASPD is a clinical diagnosis
      1. About 3-15% of those with ASPD likely have psychopathy and another 30% likely have sociopathy
      2. Generally, sociopathy and psychopathy are more extreme forms of ASPD
   iii. You can have a diagnosis of ASPD but not have the characteristics of the labels ‘sociopath’ or ‘psychopath’
   iv. Impact:
      1. Oversimplifies ASPD
      2. Trivializes the genuine emotional struggles of those with ASPD
      3. Reinforces incorrect stereotypes that individuals with ASPD are inherently evil or violent

b. **BPD by itself is not significantly associated with violence** (2016 study in the UK)
   i. Violence in individuals with BPD can be explained by other common comorbidities like ASPD or substance abuse which does increase the risk of aggression and violence

c. **Impact**
   i. Often labeled as delinquents and troublesome which can become a self-fulfilling prophecy that they live up to in their adulthood
   ii. Discrimination and abuse in the justice system
      1. There are a significant number of people with ASPD who are involved in the criminal justice system
      2. Smith and colleagues - 400 people on jury duty found people with ASPD to be more violent but generally sane and responsible for their actions
         a. Most court officials don’t consider ASPD to be a mental illness which leads to them being given long sentences or even the death penalty
      3. Lack of rehabilitation efforts

            a. Interventions that focus on control and surveillance may increase the risk of recidivism if not combined with rehabilitative efforts
    iii. <u>Fear and discrimination to patients with ASPD and BPD</u>
        1. Fear of assault or harm by therapists
        2. Denial of prospects of treatment and recovery

C. Misconception #2: Individuals with BPD or ASPD are manipulative and controlling
  a. **Individuals with PD are perceived as purposefully misbehaving**
    i. People with ASPD are perceived as being sane and responsible for their actions compared to those suffering from a mental disorder
    ii. Belief that those with PD should be able to exhibit control over their behavior, so when they can't it is instead manipulation and misbehaving
    iii. Individuals with BPD aren't acting negatively on purpose, it is the only way they know how to care for themselves especially since their disorder makes them rigid and inflexible and they don't know other ways to act that are more adaptive
        1. A fate worse than death is being alone/abandoned, so behavior allows them to maintain the presence of important people
        2. Suicide attempts are seen as attention-seeking
        3. NOT manipulation, a last-ditch attempt to get emotional needs met
  b. **Impact**
    i. <u>Discrimination and prejudice from professionals in healthcare</u>
        1. Negative attitudes and behaviors toward people with PD, especially BPD from psychiatric nurses, social workers, psychologists, and psychiatrists
            a. Longer wait times, and earlier discharge in the ER
            b. Frequent misdiagnoses which could lead to inappropriate medications given
        2. Over half (57%) of people with BPD in an Australian study felt that their providers shunned them, compared to only 29% of people with other mental diagnoses
        3. Issues with insurance coverage for PD
        4. Denial and disbelief that the patient has ASPD or BPD
        5. People with BPD report feeling shunned by a treating health professional due to self-harm and being perceived to be lying, manipulative, attention-seeking, and resource-wasting
    ii. <u>Public Stigma/Discrimination in the Workplace</u>
        1. The public reacts less sympathetically to individuals having a PD and are less likely to think they need professional help compared to people with other psychiatric disorders
        2. Ostracized rather than referred to treatment
        3. Employers see PD as a threat to business

            a. Only 50% of individuals with BPD manage to find employment
            b. Only 20% in employment are capable of maintaining their job and becoming financially independent
            c. 20% of the homeless population have BPD
    iii. Self Stigma
        1. Less likely to recognize their behaviors as symptoms
        2. Exacerbate problems of depression self-esteem, and identity
        3. Experience shame, leading to staying away from treatment to avoid self-labeling
        4. Shown to have more 'existential shame' than other diagnoses

D. Misconception #3: BPD and ASPD are untreatable
  a. Only 1 in 3 individuals in prison with ASPD have severe psychopathy and those that do have significantly lower prognosis than others with ASPD
  b. Prognosis evidence - most people with BPD will eventually achieve a life worth living, find their place in the world, and stop wanting to kill themselves
    i. scientifically and clinically proven to be successful treatments
        1. Psychiatrists are reluctant to treat patients
        2. Therapeutic nihilism - rejection of patients with ASPD as being completely untreatable, and devalued as 'untouchables'
    ii. Differential treatment
        1. Reduced amount of services available
        2. Reduced quality of services available
        3. Discourage people from seeking and continuing treatment
    iii. Self-Stigma
        1. 'Why try' effect of stalling recovery because the person incorporates stigma

E. Conclusion
  a. By limiting stigma, more people with BPD will seek a diagnosis and professional help = decreased suicide rate and a more optimistic society
  b. How to combat stigma
    i. Adequate education to dispel misconceptions - aimed at providers
    ii. Unfortunately, one of the impacts of these misconceptions and lack of public knowledge is that few stigma-changing interventions have been scientifically tested
    iii. There is some limited evidence that shows that health provider training can improve stigmatizing attitudes