Exploring Mental Health Clinicians' Negative Emotions towards People with BPD

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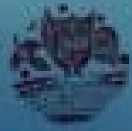

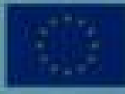

Introduction: According to research findings, a significant number of mental health clinicians show prejudices towards patients with BPD. Prejudice does not just involve negative thoughts but also negative emotions. However, clinicians' emotional reactions have only rarely been investigated. **Objective:** To record and describe the emotional reactions of mental health clinicians towards patients with BPD.

Method: A qualitative approach was used. Data were collected through: a) participant observation in a General Hospital Psychiatric Unit (October 2017-February 2018), and b) semi-structured, face-to-face, in-depth interviews with psychiatrists and psychologists (N=40). A grounded theory methodology is followed for data analysis.

Results: A variety of negative emotional reactions (NERs) were observed during the analysis of the interviews and the field notes. At the core of NERs, we identified 'fear'.

"I ***fear*** *the suicidal ideation and attempt. It scares me… that is to say, I would not want in any case someone to tell me that you did not help me and I attempted suicide. It scares me! Very much! I fear for both of us. For her (the patient with BPD) and for me, for feeling guilty… that I am inefficient, I did not help, I will feel remorse that she did something and I did not… of course for the person itself, but also for me to a greater extent to be honest. That is 60-40."* (Female Psychologist)

As we see in the previous quote, fear was based on the perceived dangerousness of the clinical encounter for the patient and for the clinician her/himself. The clinician appeared afraid of causing unwittingly harm to the patient (ALTER) (e.g. deterioration/relapse, self-injury, suicide) and to her/himself (EGO) (e.g. burnout due to frustration, problems with colleagues due to splitting, legal disputes following complaints). This 'bidirectional' fear manifested as intense anxiety. Thus, the clinician was negatively inclined in being involved in such a therapeutic relationship and tended to avoid it (e.g. refusal to accept a patient with BPD or abrupt termination of psychotherapy). This explanatory model is a variation of what Weiner called *primary appraisal* (see figure below). The lack of specialized knowledge and emotion regulation skills, the absence of clinician's own psychotherapy and supervision, the adoption of a rigid biomedical view of the disorder in the treatment plan (treatment *vs* recovery), and stereotypes about the borderline psychopathology, are some of the elements that seem to increase clinicians' fear and avoidance behavior towards patients with BPD.

Conclusions: The findings emphasize the importance of clinicians' awareness of their fear as a relevant factor for their unwillingness to work with BPD patients. Interventions aimed at reducing the prejudices among clinicians may benefit for paying more attention to emotions. More research is needed to understand the role of NERs as mediators on the clinicians' avoidant behaviour towards patients with BPD.

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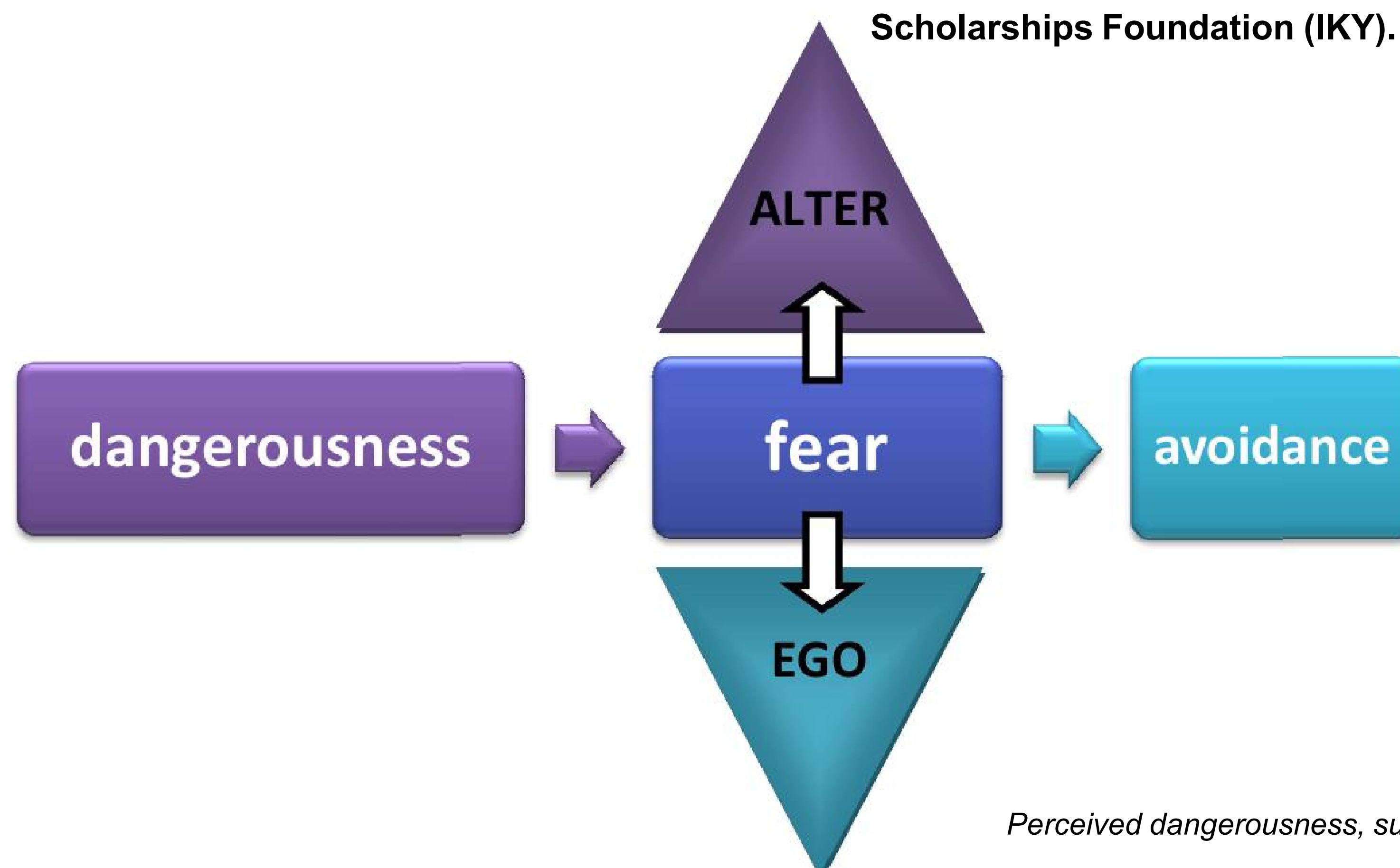

Perceived dangerousness, subsequent 'bidirectional' fear, and avoidant behaviour (Primary appraisal)