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PERSONALITY DISORDERS (C SCHMAHL, SECTION EDITOR)

The Stigma of Personality Disorders

Lindsay Sheehan[1] · **Katherine Nieweglowski**[1] · **Patrick Corrigan**[1]

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Abstract This article reviews the recent literature on the stigma of personality disorders, including an overview of general mental illness stigma and an examination of the personality-specific stigma. Overall, public knowledge of personality disorders is low, and people with personality disorders may be perceived as purposefully misbehaving rather than experiencing an illness. Health provider stigma seems particularly pernicious for those with borderline personality disorder. Most stigma research on personality disorders has been completed outside the USA, and few stigma-change interventions specific to personality disorder have been scientifically tested. Limited evidence suggests that health provider training can improve stigmatizing attitudes and that interventions combining positive messages of recovery potential with biological etiology will be most impactful to reduce stigma. Anti-stigma interventions designed specifically for health providers, family members, criminal justice personnel, and law enforcement seem particularly beneficial, given these sources of stigma.

Keywords Personality disorder · Stigma · Discrimination · Prejudice · Stereotypes

This article is part of the Topical Collection on *Personality Disorders*

✉ Lindsay Sheehan
lsheehan@iit.edu

Katherine Nieweglowski
knieweg1@hawk.iit.edu

Patrick Corrigan
corrigan@iit.edu

[1] Illinois Institute of Technology, 3424 S. State Street, Chicago, IL 60616, USA

Introduction

Personality disorders are among the most commonly experienced psychiatric conditions [1], with between 5 and 15 % of the population affected [2, 3]. Personality disorder is diagnosed when long-term cultural deviations in cognition, emotion, and behavior that begin in adolescence or young adulthood disrupt daily activities or cause distress [4]. Like those with other forms of mental illness, people with personality disorders experience the destructive impact of social stigma, in addition to problematic symptoms of illness [2, 5•]. In this paper, we provide a background on personality disorders, mental illness, and stigma, then explore the most current findings related to personality disorder-specific stigma.

Characteristics and Prevalence of Personality Disorder

According to the most recent national survey, personality disorders with the highest prevalence include antisocial personality (3.8 %), borderline personality (2.7 %), obsessive-compulsive personality (1.9 %), paranoid personality (1.9 %), and avoidant personality (1.2 %) [3]. The 11 distinct personality disorder diagnoses described in the DSM-5 are categorized into three clusters based on similarity of symptomology. Cluster A personality disorders, distinguished by features of eccentricity, include paranoid, schizoid, and schizotypal personality disorders. Cluster B personalities, characterized by emotionality or unpredictability include, among others, antisocial, borderline, and histrionic personality disorders. Finally, cluster C disorders are distinguished by features of anxiety. The three cluster C personalities are avoidant, dependent, and

obsessive-compulsive personality disorder. Cluster B personality disorders are most common, with about 5.5 % of the U.S. population meeting the diagnostic criteria for this cluster, whereas cluster A and C are less common with a 2.1 and 2.3 % prevalence, respectively [3]. People who experience a personality disorder are more likely to self-harm, abuse substances, and have co-occurring psychiatric problems such as mood disorders and post-traumatic stress disorder (PTSD) [6]. In fact, 67 % of individuals with personality disorder also met the diagnostic criteria for at least one other psychiatric diagnosis [7].

Defining Stigma

Sociologist Erving Goffman [8] described stigma as social rejection resulting from negatively perceived characteristics. Furthermore, Goffman wrote: this rejection leads to the "spoiled identity" of the stigmatized individual [8]. Link and Phelan [9] expanded on Goffman's conceptualization by identifying four qualities of stigma whereby (a) individual differences are recognized, (b) these differences are perceived by society as negative, (c) the stigmatized group is seen as the outgroup, and (d) the end result is loss of opportunity, power or status.

From a social-cognitive perspective, stigma includes the cognitive, affective, and behavioral components called stereotypes, prejudice, and discrimination [10]. Table 1 provides definitions and examples of each of these three components that together create social stigma [10]. Public stigma manifests in a variety of forms, ranging from lack of eye contact to complete ostracization of an individual based on his or her membership in the stigmatized group [11]. This public stigma becomes internalized into self-stigma, if the person believes that negative societal attitudes imposed upon them are true [12]. Self-stigma might lead to low self-esteem, depression, or lack of motivation. An additional type of stigma, structural stigma, occurs when stigmatizing beliefs and attitudes lead to unfair social institutions and policies for the stigmatized group [11]. Legislation such as the Americans with Disabilities Act [13] combats structural stigma by protecting people with disabilities from systematic workplace exclusion because of perceived inferiority.

Stigma of Mental Illness

Specific stereotypes and prejudices towards those with mental illness incite discriminatory treatment against these individuals. For example, when a person with schizophrenia is stereotyped as incompetent, employers doubt her ability to perform on the job (prejudice) and avoid hiring her (discrimination). The stereotype of incompetence can also lead to coercive behavior such as forced hospitalization, guardianship, or restriction of independent living options. Along with incompetence, dangerousness and responsibility are among the most commonly endorsed stereotypes applied to people with mental illness [10]. Media reports that exaggerate the link between mental illness and violence perpetuate the "dangerous" stereotype, leading to a public fear of the "mentally ill." This fear fuels behaviors including segregation of people with mental illness in poor neighborhoods, avoidance, or withdrawal [10]. Likewise, with the stereotype of responsibility, people with mental illness are viewed as to blame for the illness. That is, the public believes these individuals have made choices that led to their symptoms or have not made sufficient recovery efforts.

Table 1 A model for understanding mental illness stigma

Stigma components	Types			
	Definition	Public stigma	Self-stigma	Structural stigma
Stereotype (cognitive)	Overgeneralization about a person based on group membership	People with mental illness are irresponsible		
Prejudice (affective)	Agreement with the stereotype and negative emotions toward the person	It's true. People with mental illness are irresponsible—they annoy me	I have a mental illness, so I'm destined to be irresponsible and depressed	Treatment center doubts patient ability to make decisions
Discrimination (behavioral)	Unfair acts toward groups or group members	I will not hire anyone with mental illness	I give up trying to make a recovery	Clinicians fail to involve patients in decisions about treatment

Despite attempts to combat the stigma of mental illness, a meta-analysis by Schomerus and colleagues [14] indicates that attitudes towards mental illness have not improved over time. Indeed, recent research highlights continued prejudice and discrimination experienced by those with mental illness [15, 16]. Individuals with mental illness who have internalized the public stigma may feel shame or have low self-esteem [17, 18]. Other individuals with mental illness experience the "why try" effect [19] in which recovery efforts stall when the person has fully incorporated the stigmatized mentality of incompetence. Additionally, those who fail to seek treatment for fear of being seen as "crazy" may miss out on health care opportunities [20]. People with personality disorder are likely subject to both the general stigma of mental illness and the stigma attached to the particular personality disorder. Thus, we next examine the literature specific to personality disorders.

Public Stigma of Personality Disorder

Evidence suggests that personality disorders might be even more stigmatized than other psychiatric diagnoses [21•, 22], with both fear and frustration among the common public reactions to personality disorders [2]. The belief that people with personality disorders should be able to exhibit control over behavior results in symptoms being viewed as manipulations or rejections of help [23]. This can cause people to be seen as difficult and misbehaving rather than sick. In fact, the public reacts less sympathetically to individuals described as having a personality disorder and is less likely to think these individuals need professional help than those with other psychiatric disorders [24•].

The general public has less knowledge about personality disorders than about other mental illnesses [24•, 25]. When presented with a vignette describing someone with borderline personality disorder (BPD), only 2.3 % of respondents recognized the symptoms as BPD, whereas 72.5 % recognized depression and 65.6 % recognized schizophrenia [24•]. This public knowledge, often termed mental health literacy, has been connected with both treatment-seeking behavior and public stigma. The limited mental health literacy about personality disorders could mean that individuals with personality disorder are ostracized rather than referred to treatment and are less likely to recognize their own behaviors as symptoms of illness [24•]. However, there are diagnostic-specific variations in the way that personality disorders are perceived by the public.

Borderline Personality Disorder BPD is among the most stigmatized of all personality disorders and is the most researched in terms of stigma [26, 27]. Characterized by mood instability, extreme sensitivity to abandonment, impulsivity, self-mutilating behavior, and difficulty controlling anger [4], BPD can lead to severe limitations in social relationships and functioning. People with BPD are often seen as annoying and undeserving, which results in inadequate treatment and help [23]. People with BPD can have frequent contact with law enforcement due to anger and suicidality, leading police to feel frustrated, angry, and powerless in interactions with BPD individuals [28•]. While negative emotions from police can be understandable responses to disruptive behavior, they may also reflect stigma. That is, an officer's frustration might be intensified when he endorses the stereotype that people with personality disorders are intentionally troublesome. When people with BPD are seen as deliberately wasting valuable police time, they could experience harsher treatments and services that are not particularly well-designed to serve their unique needs [28•].

Antisocial Personality Disorder People with a diagnosis of antisocial personality disorder (ASPD) often exhibit symptoms such as lack of remorse and empathy, aggressiveness, and recklessness that begin in childhood [29]. Tufts [30] explains that children with ASPD are often labeled as delinquents by their parents, teachers, and even peers. This leads to a self-fulfilling prophecy where the child believes he/she is a bad person and ultimately engages in a future life of crime [30]. As adults, a significant number of individuals with ASPD are involved in the criminal justice system [31].

The stigma of dangerousness that is associated with ASPD can lead individuals to be denied the prospects of treatment and recovery, especially within the justice system. Individuals with ASPD are referred to as psychopaths or sociopaths and are sometimes stigmatized as being evil [29]. Smith and colleagues [32] surveyed 400 individuals on jury duty and found that the people with ASPD were viewed as more violent, but generally sane and responsible for their actions [32]. In fact, most court officials do not consider ASPD to be a mental illness at all [29]. In the justice system, an ASPD diagnosis may cause the person to be labeled as dangerous and untreatable, ultimately affecting sentencing and possibility for death penalty. Partly due to these attitudes, people with ASPD are unable to complete rehabilitation while in the prison system [29]. However, recent neurological evidence suggests that ASPD is associated with specific brain abnormalities, which may eventually lead the criminal justice system to re-evaluate the legal process, sentencing and treatment of offenders with ASPD in the future [33].

Obsessive-Compulsive Personality Disorder Obsessive-compulsive personality disorder (OCPD) is characterized by perfectionism and over-emphasis on order and interpersonal control [4]. Presumably because of the similarity to obsessive-compulsive disorder (OCD), OCPD is a

particularly well-understood personality disorder by the general public [34]. In contrast to other researched personality disorders, the public views people with OCPD as quite amenable to treatment. In a British survey of 342 individuals, OCPD was thought to be caused by childhood experience, parenting styles, and stress/anxiety, with cognitive behavior therapy often endorsed as a treatment option [34]. Although this study explored public understanding rather than stigma per se, this data suggests that attitudes and behaviors towards people with OCPD would be more favorable than other personality disorders.

Narcissistic Personality Disorder Unlike OCPD, narcissistic personality disorder (NPD) is not as familiar to the general public [25]. People with NPD lack empathy, exhibit a high need for admiration, and have an over-developed sense of self-importance [4]. Although no research explicitly examines stigma related to NPD, a recent survey found that people with NPD are seen as being fragile, lacking self-esteem, and experiencing problematic social relationships. However, NPD was also viewed as a potential advantage in business contexts [25]. The lack of public understanding of NPD suggests potential stigma and need for further rigorous exploration.

Provider Stigma

While lack of public awareness serves as an initial barrier to seeking care, once individuals with personality disorder begin treatment, they are confronted by a label that may be more stigmatizing within the treatment setting than outside it [26]. Recent studies highlight the negative attitudes and behaviors of health care professionals towards people with personality disorders, particularly those with BPD. Psychiatric nurses, social workers, psychologists, and psychiatrists are all sources of harmful attitudes towards people with BPD [35••, 36, 37]. In Israeli psychiatric hospitals, nurses had more negative attitudes towards people with BPD than towards any other mental illness [35••]. According to a research review, psychiatric nurses have the most stigmatizing attitudes [37]. In another study, psychiatrists had the lowest empathy towards people with BPD in comparison to other providers including nurses, social workers, and psychologists [35••].

Ultimately, negative provider attitudes can lead to differential treatment of people with personality disorders. Stigma may reduce the amount of services available, reduce the quality of those services, and discourage people from seeking and continuing treatment ("Why go see my psychiatrist when he's just going to treat me like dirt."). In the case of BPD, a diagnosis can even cause exclusion from treatment when mental health professionals refer out upon diagnosis [26]. Over half (57 %) of people with BPD in an Australian study reported that providers shunned them, compared with only 29 % of people with other mental diagnoses [5•]. More poor decisions to hospitalize and assign negative traits were made for BPD than for those who had depression or anxiety [35••]. Perceived discrimination is a common occurrence for patients with personality disorders when they are seeking hospital admission in times of crisis [5•]. Suicide attempts among this group are even, at times, viewed as attention-seeking rather than a sign of illness [23]. People with BPD were discharged more quickly from an emergency room than those with other diagnoses [28•]. In a study by Lawn and colleagues [5•], three-fourths of participants with BPD said that they had waited for care in an emergency room for more than 4 h following self-harm.

Self-Stigma

People self-stigmatize, accepting the public stereotypes not only about mental illness in general but also those more specific to BPD. This can lead to problems with self-esteem, depression, and identity. Self-stigma is an established problem for people with BPD; they may feel shame about their diagnosis and stay away from treatment to avoid self-labeling as sick, weak, or incapable of handling problems independently [5•]. Indeed, people with BPD have more "existential shame" than those with other diagnoses (e.g., anxiety, depression, ADHD) [38].

Structural Stigma

Structural stigma can impact availability of services, quality of services, insurance coverage, and research on personality disorders. Clinicians have encountered hurdles in billing insurance companies for a personality disorder diagnosis [39]. Although personality disorders are as prevalent, or more prevalent, than other diagnoses, there is less funding, research, and services available for them. Zimmerman [40•] maintains that there is less funding from the National Institute of Mental Health for BPD than for bipolar disorder and thus, much less research devoted to understanding the disorder and crafting treatments. Stigma influences diagnosis and assessment as well, specifically for BPD. Diagnostic and screening tools are absent or not sufficient enough to accurately assess this population [40•], presumably because of lack of funding for research or lack of interest. People with BPD report trouble getting services and information about their diagnosis [5•]. Due to considerable overlap between symptoms of BPD and other mental health diagnoses, such as bipolar disorder and PTSD, people with BPD are frequently misdiagnosed and may receive inappropriate treatments such as overuse of medications rather than psychotherapy [2, 41]. Psychiatrists might avoid a diagnosis of personality disorder to protect people

from stigma perpetrated by the system, or avoid telling the person of their diagnosis altogether [2, 41].

Anti-stigma Interventions for Personality Disorders

Given the stigma perpetrated by the mental health system, crafting interventions to change the stigma about personality disorders is an important endeavor [42••]. Education is one strategy meant to change stigma by correcting misperceptions about mental illness and providing information. A second commonly used strategy to combat stigma involves members of the stigmatized group engaging in personal contact with others, such as through an interactive presentation about their story of recovery from mental illness. A meta-analysis of stigma-change interventions for mental illness in general finds that both interventions that educate and provide meaningful interpersonal contact with people with the mental illness are most effective, but contact interventions have a distinct advantage [43]. Findings are mixed in terms of contact with health providers. Bodner and colleagues [35••] found that health professionals who have more experience working with BPD have more negative attitudes, while a study by Egan and colleagues [42••] found more positive attitudes. However, very few studies have examined stigma-change interventions specific to personality disorder.

Anti-stigma interventions targeting providers may benefit from designs that combat diagnostic-specific stigma. In one intervention, health professionals completed 2 days of BPD anti-stigma training. Professionals were assigned to either self-management (using acceptance and commitment therapy) or skills training (using dialectical behavior therapy) [44••]. In comparison to pre-test, clinicians in both groups had more positive attitudes, improved relationship with clients, and lower desire for social distance from their clients after the intervention. Additionally, stigma reduction was maintained at the 6-month follow-up [44••].

Recent research suggests another approach to stigma change. Current brain imaging studies provide evidence that personality disorders have visible neurobiological differences and challenge widespread ideas that personality disorders are merely a character flaw or the intentional actions of the person [45–48]. Critics of the neurological approach suggest that seating the cause of mental illness with brain structure and function increases the notions of differentness and downplays the possibility for change and recovery [50]. In fact, a brief training that stressed the neurology of PD showed change in knowledge and attitudes, but not empathy of healthcare staff [49]. Using an experimental vignette, Lebowitz and Ahn [51••] found that combining neurobiological information about the causes of personality with recovery-orientated information was more effective in reducing stigma than the neurobiological approach or treatment information alone [51••].

Gaps in the Literature

Our review of the current literature on the stigma of personality disorders reveals a focus on BPD and ASPD, with the majority of studies on personality disorder stigma conducted outside of the USA [37]. Future research could explicitly explore the stigma experienced by people with other personality disorders such as paranoid, schizoid, and avoidant personality disorders. Although Catthoor and colleagues [21•] surveyed 214 patients referred for personality disorder treatment and found that level of experienced stigma did not vary significantly between those with different personality disorder diagnoses, identifying specific stigmas attached with diagnoses will aid in addressing these stigmas. Researchers might also develop more sensitive measurements of stigma unique to personality disorders and compare stigma experienced from mental illness in general with personality disorder-specific stigma. While attitudes towards BPD have been measured on general stigma scales, the BPD-specific components of stereotypes, prejudice, and discrimination have not been empirically identified. Research might also examine how stigma varies by DSM-5 personality disorder clusters. For example, people with cluster A personality disorders might be viewed as more dangerous, whereas those with cluster B could be seen as more responsible for their illness.

Despite the fact that health provider stigma is an established problem, few concerted efforts towards changing stigma of personality disorders have been mounted [40•]. Anti-stigma interventions for law enforcement personnel, criminal justice workers, and family members, in addition to health providers, seem essential as these individuals are most likely to interact with affected individuals. Careful research could examine the development of stigma directed at individuals upon initiation of mental health treatment systems and explore how provider stigma manifests within the context of services. In contrast to past findings, Catthoor and colleagues [21•] concluded that participants experienced relatively a low level of stigma that was no greater than that experienced by those with other mental health diagnoses. Although this study was limited by the inclusion of the control group with high prevalence of personality disorder traits and sample of treatment-seekers, further research can help clarify this contradictory finding. In particular, the study authors suggest that participants had merely initiated contact for mental health treatment and thus may not have been subjected to stigmatizing treatment of providers.

Personality disorder stigma might also interact with other co-occurring stigmatizing conditions, and further energies could investigate the impact of multiple stigmas.

In particular, personality stigma might be amplified for individuals who belong to a highly stigmatized ethnic or sociocultural group. Additionally, cross-cultural research may reveal important cultural difference in personality stigma and disclosure decisions (i.e., deciding whether to disclose a personality disorder diagnosis to friends, family, and colleagues).

Conclusions

Clearly, stigma experienced by individuals with a personality disorder threatens to compound psychiatric symptoms and compromise treatment, especially when that stigma is perpetrated by health professionals or social institutions. Although longitudinal research shows that people with personality disorders do benefit from treatment and recovery [52], the misconception of personality disorders as untreatable may seriously limit efforts of service providers and development of comprehensive programs. Given the high suicide and self-harm rates of people with BPD, endeavors to reduce stigma for this population are especially imperative. Contact-based anti-stigma interventions that emphasize recovery possibilities and educate about biological underpinnings of personality disorders seem most promising. Finally, structural changes in the health and criminal justice system, including increased funding for research and services, might help reduce disparate treatment of those with personality disorders.

Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no competing interests.

Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subjects performed by any of the authors.

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