

2015

Borderline Personality Disorder: The Frequency of Disclosure and the Choice to Disclose

Laci Marie Rumpza
Walden University

Follow this and additional works at: <https://scholarworks.waldenu.edu/dissertations>

 Part of the [Clinical Psychology Commons](#), [Ethics and Political Philosophy Commons](#), and the [Social Work Commons](#)

This Dissertation is brought to you for free and open access by the Walden Dissertations and Doctoral Studies Collection at ScholarWorks. It has been accepted for inclusion in Walden Dissertations and Doctoral Studies by an authorized administrator of ScholarWorks. For more information, please contact ScholarWorks@waldenu.edu.

Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

Laci Rumpza

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee

Dr. Thomas Russo, Committee Chairperson, Psychology Faculty
Dr. John Agnew, Committee Member, Psychology Faculty
Dr. Tracy Mallett, University Reviewer, Psychology Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2015

Abstract

Borderline Personality Disorder: The Frequency of Disclosure and the Choice to Disclose

by

Laci Rumpza

MA, Saint Mary's University, 2005

BS, Saint Thomas University, 2000

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

Walden University

February 2015

Abstract

In the particular case of borderline personality disorder (BPD), the literature on disclosure indicates that professionals often choose not to disclose. The first purpose of the study was to identify what percentage of licensed psychologists and licensed clinical social workers disclose the diagnostic label BPD to their patients. Another purpose was to identify factors that influence disclosure and a third purpose was to gather phenomenological data about the choice to disclose or not to disclose. A sequential explanatory mixed methods design including an online survey and a telephone interview was used to collect data. The MUM effect was used as the theoretical framework. A total of 177 participants completed the survey. The majority of participants in this sample stated that they either always or usually disclose diagnostic information. Only a few stated that they rarely or never disclose. Multiple linear regression analyses were used to predict if there was a significant relationship between the independent variables concerns for self, concerns for the patient, societal norms, gender of the professional, professional occupation, theoretical orientation, and frequency of working with individuals diagnosed with BPD and the dependent variable disclosure. The results demonstrate that concerns for the patient, concerns for self, societal norms, gender of the professional, and frequency of working with individuals diagnosed with BPD impact disclosure. Participants also expressed concerns about the stigma of the diagnosis and disclosure leading to defensiveness or negatively impacting the therapeutic relationship. Disclosure has been found improve treatment outcomes. This study may stimulate future research into appropriate disclosure methods and the impact of disclosure on patients.

Borderline Personality Disorder: The Frequency of Disclosure and the Choice to Disclose

by

Laci Rumpza

MA, Saint Mary's University, 2005

BS, Saint Thomas University, 2000

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

Walden University

February 2015

Dedication

This dissertation is dedicated to my significant other, Nick. Thank you for always supporting my dreams and reminding me throughout that I am intelligent, strong, and persistent. It is also dedicated to my parents who taught me the value of education. A special thank my parents for your encouragement and for believing in me. Lastly, to my sisters who have always loved and supported me and to my nieces who I hope will successfully pursue their own dreams in the future.

Acknowledgments

I could not have completed this dissertation without the support and guidance from my dissertation committee. I would like to thank my chair, Dr. Pamela Jennings, who played a monumental role in the completion of this project. She has been a consistent source of wisdom. Dr. Jennings's expertise about the dissertation process was fundamental to my successful completion of this project. Dr. Thomas Russo served not only as a committee member but also as an excellent support. I am grateful for the attention these members provided to my study, which enabled me to remain focused on this project. Also, thank you to Dr. Tracy Mallett, my university research reviewer. She ensured I met the high standards of Walden University.

I am grateful to my employer, who has been supportive in many ways. My employer accommodated my practicum and internship. I appreciate the support from many of my colleagues who motivated me and volunteered their time and expertise. I am especially grateful to Ann Sparks, who has been a mentor for several years and played a monumental role in my decision to get my PhD.

I am forever grateful to all those who participated in the study. Lastly, thank you to everyone else I did not mention but contributed in some fashion to the successful completion of this dissertation.

Table of Contents

List of Tables	v
Chapter 1: Introduction to the Study.....	1
Problem Statement.....	4
Purpose of the Study.....	5
Research Questions and Hypotheses	6
Theoretical Framework.....	9
Nature of the Study.....	10
Definition of Terms.....	11
Assumptions and Limitations	12
Assumptions.....	12
Limitations	12
Delimitations.....	13
Significance of the Study.....	13
Summary.....	15
Chapter 2: Literature Review.....	16
Introduction.....	16
Literature Search Strategy.....	16
Review of Borderline Personality Disorder.....	17
Current Definition and Diagnostic Criteria.....	17
Prevalence of BPD.....	18
Prognosis of BPD.....	19

Validity of Diagnosis	21
Etiology of BPD.....	24
Gender Biases	28
Countertransference	30
History of Disclosure	31
Theoretical Framework.....	40
Definitions of Undesirable Information.....	41
Disclosure in Psychiatric Settings.....	41
Arguments for Diagnostic Disclosure.....	48
Arguments Against Disclosure	52
Options for Disclosure	52
Measurements of Disclosure.....	54
Summary	56
Introduction.....	57
Research Design and Rationale	61
Setting and Sample	63
Instruments.....	64
Disclosure Questionnaire	65
Breaking Bad News Questionnaire.....	65
Procedures.....	67
Data Collection and Analysis.....	68
Ethical Considerations	69

Summary	71
Chapter 4: Results	72
Introduction	72
Data Collection	72
Preliminary Analysis	73
Data Screening	73
Quantitative Results	68
Research Questions 2 and 4	68
Research Questions 2, 3, 5 and 6	70
Research Questions 7, 8 and 9	77
Qualitative Results	84
Summary	94
Chapter 5: Discussion, Conclusions, and Recommendations	96
Overview	96
Interpretation of Findings	101
Limitations	107
Implications for Social Change	108
Recommendations	110
Conclusion	111
References	114
Appendix A: Disclosure Questionnaire	125
Appendix B: Breaking Bad New Questionnaire	127

Appendix C: Demographic Questionnaire.....	130
Appendix D: Permission to use your survey.....	134
Appendix E: E-Mail Soliciting Participation.....	137
Appendix F: Consent Form.....	139
Appendix G: E-Mail Soliciting Participation-1 week.....	142
Appendix H: Thank You.....	143
Appendix I: Phase 2: E-Mail Soliciting Participation/Consent Form.....	144
Appendix J: E-Mail Soliciting Participation Phase Two-1 week	146
Curriculum Vitae	148

List of Tables

Table 1. Response Rates for Disclosure Questionnaire Items 1 and 4 69

Table 2. Response Rates Research Questions 2, 3 5, and 6..... 73

Table 3. Results for Multiple Linear Regression With Gender, Professional Occupation,
Theoretical Orientation, Frequency, and Concerns For Self Predicting Disclosure. 79

Table 4. Results for Multiple Linear Regression With Gender, Professional Occupation,
Theoretical Orientation, Frequency, and Concerns Patient Predicting Disclosure .. 81

Table 5. Results for Multiple Linear Regression With Gender, Professional Occupation,
Theoretical Orientation, Frequency, and Societal Norms Predicting Disclosure 83

Chapter 1: Introduction to the Study

Billions of dollars are spent each year on the treatment of mental health conditions. Diagnostic disclosure has the potential of improving treatment outcomes and reducing the cost associated with mental health treatment (Zanarini & Frankenburg, 2008). Yet, in the particular case of BPD, clinical data indicate that professionals often choose not to disclose, in spite of the fact that disclosing accurate diagnostic information allows patients to seek another opinion and discuss their treatment options. Diagnostic disclosure is useful in implementing evidence-based practices and appropriately predicting the patient's response to treatment.

There are ethical and legal obligations that require diagnostic disclosure. Standard 3.10 of the American Psychological Association's Ethical Standards and Codes of Conduct (APA, 2002) requires that psychologists obtain informed consent for all psychological services. Informed consent requires that the psychologist inform the patient of the nature of the treatment, possible risks and benefits of treatment, and alternative treatment options (APA, 2002). Informed consent was established to ensure patient involvement in health care. Standard 3.10 states that patients must be given an opportunity to ask questions and receive answers (APA, 2002). Withholding diagnostic information is inconsistent with informed consent because it prevents patients from being fully involved in decisions about their care. Without an understanding of their diagnosis, patients are unable to make informed decisions about their treatment options. Additionally, withholding diagnostic information places psychologists at risk of an ethical violation for failing to create these conditions.

The APA also emphasizes the importance of patient autonomy. Patients must be provided with as much information as they desire about their diagnosis and its

treatment (APA, 2002). Psychologists have an obligation to create the conditions necessary for autonomous choices in patients. If a psychologist chooses not to disclose information to a patient and the patient later finds out, it is likely that the patient will no longer trust the psychologist. A lack of disclosure destroys the therapeutic relationship, creating an environment where the patient no longer trusts the psychologist to provide appropriate information regarding diagnosis, prognosis, and treatment. A lack of disclosure also has the potential to impact the integrity of the practice of psychology if it results in a general lack of mistrust among the community. Standard 3.04 states that psychologists avoid harm and minimize harm where it is foreseeable and avoidable (APA, 2002). Diagnostic disclosure may be a necessary way of avoiding foreseeable and avoidable harm.

There are also laws that influence the decision to disclose diagnostic information. The Health Insurance Portability and Accountability Act (1996) legally permits patients access to their medical records. With increased access to health information, it is becoming more difficult to withhold information from patients. With the ethical requirement of informed consent and the obligation to promote patient autonomy and trust within the practice of psychology, a failure to disclose diagnostic information could have serious ethical and legal ramifications for mental health professionals.

Despite the ethical and legal obligation that mental health professionals have to disclose diagnostic information, little empirical research has been conducted on the topic of disclosure. Few studies have identified how often mental health professionals

inform patients of their diagnosis. Additionally, few studies have identified the reasons why mental health professionals choose to disclose or not to disclose.

BPD is one of the most commonly diagnosed personality disorders in both outpatient and inpatient settings (Paris & Zweig-Frank, 2001). There is reason to believe that clinicians are not informing patients of this diagnosis (Biskin & Paris, 2012; Lequesne & Hersh, 2004; Paris, 2007; Zanzrini & Frankenburg, 2008). Currently, there is no information in the literature regarding how often mental health professionals disclose the diagnostic label BPD. Additionally, there is only speculation in the literature regarding the factors that contribute to a lack of disclosure. In this study, I attempted to contribute to the literature by examining the disclosure practices of psychologists and clinical social workers as they relate to BPD. Because there is little currently known about this topic, the results can be used in future research to explore related topics, such as the possible effects of disclosure. The results can also be used to develop procedures for disclosure and properly educating professionals on disclosure practices.

In this chapter, I identify the problem statement and the purpose of this study. I also present the research questions and the hypotheses. The theoretical framework and its relevance to this study are reviewed. An explanation of the study procedures and a definition of terms are provided. This is followed by a review of the assumptions and limitations associated with this study. This chapter concludes with a presentation of the significance of this study.

Problem Statement

Although diagnostic disclosure has the potential to improve treatment outcomes and ultimately decrease the cost associated with mental health treatment, currently there is no data on the percentage of licensed psychologists and licensed clinical social workers who disclose diagnostic information regarding BPD. Additionally, there is no information pertaining to how these professionals choose to disclose. At this time, only one known study (McDonald-Scott, Machizawa & Satoh, 1992) has examined the prevalence of the disclosure of BPD. This study was conducted on a small sample of psychiatrists, which limits its generalizability. In addition, the survey questions were leading and psychometric data were not provided.

There has been limited research in the area of disclosure. Those studies that have been conducted have a number of limitations. Only a limited number of the studies addressing the topic of disclosure have differentiated between psychiatric illnesses. Those studies that made the distinction between psychiatric illnesses have primarily focused on schizophrenia. The studies that have focused on personality disorders have traditionally grouped all of the personality disorders together. Another problem with these studies is that the sample sizes have generally been small and the population has been limited to psychiatrists. Most of these studies excluded psychologists and clinical social workers, who often play a primary role in the diagnosis of individuals with BPD. The one known study conducted in the United States that included psychologists and social workers in addition to psychiatrists focused on the disclosure of schizophrenia (Green & Grant, 1987).

The problem that I addressed in my study is the need to identify how often licensed psychologists and licensed clinical social workers inform patients of the BPD label and the need to identify how these professionals choose to disclose or not to disclose.

Purpose of the Study

The purpose of this sequential explanatory mixed method study was to identify how licensed psychologists and licensed clinical social workers choose to disclose or not to disclose. The purpose was also to identify what percentage of licensed psychologists and licensed clinical social workers disclose the diagnostic label BPD. The MUM effect is a phenomenon whereby when faced with disclosing information, communicators are often more reluctant to disclose undesirable information (Rosen & Tesser, 1970). The MUM effect has previously been used to explain disclosure practices and was used in this study to identify whether the independent variables concerns for self, concerns for the patient, and societal norms significantly influence the reluctance to disclose diagnostic information as predicted by the MUM effect. This study also explored other variables believed to be related to disclosure including gender, theoretical orientation, professional occupation, and the frequency of working with individuals diagnosed with BPD. In the first phase, quantitative research questions and hypotheses were used to guide the data collection. In the second phase, telephone interviews were used with a subset of the participants to explore the quantitative results in more depth.

Research Questions and Hypotheses

In this study, I addressed the following research questions by analyzing the quantitative and qualitative data. There were three sets of research questions. Descriptive research data in the form of frequencies and percentages were used to answer the first set of research questions. These questions included the following

1. What percentage of licensed psychologists and licensed clinical social workers disclose the diagnostic label BPD to patients?
2. What is the relationship between the percentage of licensed psychologists and the percentage of licensed clinical social workers who disclose the diagnostic label BPD?
3. What is the relationship between the gender of the professional and the disclosure of the diagnostic label BPD?
4. What is the relationship between the gender of the patient and the disclosure of the diagnostic label BPD?
5. What is the relationship between the frequency of working with individuals diagnosed with BPD and the disclosure of the diagnostic label BPD?
6. What is the relationship between licensed psychologists' and licensed clinical social workers' theoretical orientation and the disclosure of the diagnostic label BPD?

The second set of questions was related to the MUM effect. These questions explored the relationship between the MUM effect and the disclosure of BPD. Three separate multiple regression analyses were used to predict the relationship between

the dependent variable disclosure and the independent variables concerns for self, concerns for the patient, and societal norms. As found in previous studies, it was believed that these three variables would decrease disclosure (Merker, Hanson, & Poston, 2010).

1. Is there a significant relationship between the psychologists' and clinical social workers' concerns for self and the reluctance to disclose diagnostic information, as measured by the Breaking Bad News Questionnaire?

H01: There will not be a significant relationship between the psychologists' and clinical social workers' concerns for self and the reluctance to disclose diagnostic information, as measured by the Breaking Bad News Questionnaire.

HA1: There will be a significant relationship between the psychologists' and clinical social workers' concerns for self and the reluctance to disclose diagnostic information, as measured by the Breaking Bad News Questionnaire.

2. Is there a significant relationship between the psychologists' and clinical social workers' concerns for the patient and the reluctance to disclose diagnostic information, as measured by the Breaking Bad News Questionnaire?

H01: There is not a significant relationship between the psychologists' and clinical social workers' concerns for the patient and the reluctance to disclose diagnostic information, as measured by the Breaking Bad News Questionnaire.

*HA*₁: There is a significant relationship between the psychologists' and clinical social workers' concerns for the patient and the reluctance to disclose diagnostic information, as measured by the Breaking Bad News Questionnaire.

3. Is there a significant relationship between societal norms and the reluctance to disclose diagnostic information, as measured by the Breaking Bad News Questionnaire?

*H0*₁: There will not be a significant relationship between norms and the reluctance to disclose diagnostic information, as measured by the Breaking Bad News Questionnaire.

*HA*₁: There will be a significant relationship between norms and the reluctance to disclose diagnostic information, as measured by the Breaking Bad News Questionnaire.

The third set of questions was used during the qualitative phase to expand and elaborate on the quantitative responses.

1. Those who did endorse a reluctance to disclose diagnostic information were asked, "You noted on your survey response that you rarely or never disclose diagnostic information regarding BPD to clients. Please tell me a little more about that."
2. Those who did not endorse a reluctance to disclose diagnostic information were asked, "You noted on your survey response that you always disclose diagnostic information regarding BPD. Please tell me more about that."

Theoretical Framework

The MUM effect is the theoretical framework for this study (Rosen & Tesser, 1970). The MUM effect is described here briefly. A more in-depth explanation will be provided in Chapter 2. The MUM effect is the tendency to remain mum when faced with the dilemma of communicating undesirable information (Rosen & Tesser, 1970). Several experiments were conducted over the course of several years validating the existence of the MUM effect. Rosen and Tesser (1975) found that there are several factors that contribute to the reluctance to disclose undesirable information and grouped these into three categories: (a) the communicator's self-concern, (b) the communicator's concern for the recipient, and (c) concerns for societal norms. Each of these is defined in the following paragraph.

The MUM effect was chosen because it has been found to influence clinical decision making among psychologists (Merker et al., 2010). Merker et al. (2010) used the MUM effect to study the disclosure practices of 329 licensed psychologists nationwide. Merker et al. found that the psychologists noted a fear of being blamed and being physically harmed by the patient as reasons for a lack of disclosure. The psychologists also noted wanting to avoid the negative emotional state associated with disclosing undesirable information (Merker et al., 2010). Concerns for the patient were also noteworthy and included fears about emotionally upsetting the patient, concerns for the patient's safety and the possibility of misdiagnosis leading to additional harm (Merker et al., 2010). The societal norms that impacted the disclosure of information included an ethical responsibility and the importance of preserving the therapeutic relationship (Merker et al., 2010). Several factors that prevented the

psychologists from disclosing information in this study were consistent with the earlier work of Tesser and Rosen (1970), confirming the existence of the MUM effect in the practice of psychology.

Further research and application of Rosen and Tesser's (1970) theory will potentially offer insight into clinical decision making as it relates to BPD. I expanded the current research by distinguishing between the disclosure of BPD from other undesirable information. In my study, I determined how often licensed psychologists and licensed clinical social workers disclose the diagnostic label BPD to patients. Additionally, I determined whether certain diagnostic criteria make it more or less difficult to disclose. I also identified whether concerns for self, concerns for the patient, and societal norms significantly influence the reluctance to disclose diagnostic information regarding BPD.

Nature of the Study

A sequential explanatory mixed methods design including an online survey and a telephone interview were used to collect data from participants. This method was used to explore the relationship between the independent variables concerns for self, concerns for the patient, societal norms, gender, professional occupation, theoretical orientation, and frequency of working with individuals diagnosed with BPD and the dependent variable disclosure. During the quantitative phase, licensed psychologists and licensed clinical social workers were asked to complete an online survey. During the qualitative phase of the research, telephone interviews were used with a subset of participants in order to validate and expands on the quantitative results. Merker et al., (2010) used a sequential explanatory mixed methods design to

explore the disclosure practices of psychologists. My study expanded on this approach by exploring the disclosure practices of licensed psychologists and licensed clinical social workers regarding BPD. Prior to the study conducted by Merker et al., quantitative approaches were the most common approach used to study disclosure. However, many of these studies Cleary, Hunt and Walter, (2010); Green and Grant, (1987); McDonald-Scott, Machizawa and Satoh, (1992); Shergill, Barker and Greenberg (1998) had methodological weaknesses. The sequential mixed methods approach used by Merker et al. was believed to be superior to these quantitative approaches for a number of reasons.

There are several advantages to using a mixed methods approach. Creswell (2003) noted that a mixed methods approach is useful in neutralizing or cancelling the limitations inherent in the use of a single method. Additionally, sequential designs improve the validity of results by allowing the researcher to use the results from one method to inform or expand the results of the second method. The use of a mixed methods design allowed for the collection of numeric information along with detailed perspectives from the participants. The advantages of using a mixed methods approach for this study were especially important given that limited information was known about the diagnostic disclosure of BPD.

Definition of Terms

Mental illness: A syndrome characterized by clinically significant disturbance in an individual's cognitive, emotional regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning (APA, 2013. p. 20).

Undesirable information: Also known as difficult or bad news, includes being informed that one has a mental illness, of the need for lifelong medications with side effects, unclear prognosis, and potential lifestyle consequences (Cleary et al., 2010).

Assumptions and Limitations

Assumptions

Several assumptions were made that have implications for this study. First, I assumed that a representative sample of licensees from the Minnesota Board of Social Work and the Minnesota Board of Psychology would agree to participate in the study and that this sample can be generalized to mental health professionals working in Minnesota and other Midwestern cities. In addition, I assumed that the measures used in this study were appropriate for evaluating the disclosure practices of these mental health professionals. There was an assumption that the participants would cooperate and answer all of the survey questions. Additionally, I assumed that the self-report data would accurately reflect the clinical experiences of these professionals. I am also assumed that a subset of respondents would answer the disclosure questionnaire as always, usually, sometimes, rarely, or never disclosing diagnostic information and that a subset of these individuals would be willing to participate in a telephone interview.

Limitations

This study is limited to licensed clinical social workers and licensed psychologists volunteering to complete the survey data and telephone interview. Other members of the health care profession who work with or encounter individual with BPD may have different experiences that were not included in this research. The

study is limited to the responses obtained from the survey and the telephone interviews. It is also limited by the information that was obtained by using these measures. Secondly, any limitations related to these measures apply to this study.

Delimitations

I delimited several factors in this study. These include the decision to study disclosure using the MUM effect as the theoretical framework. Although there are other theories that could have been used to study disclosure, the MUM effect was chosen because it has been thoroughly researched in both experimental and natural settings. Additionally, the MUM effect has been found to impact clinical decision making among psychologists (Merker et al., 2010). A second delimitation was the decision to study licensed clinical social workers and licensed psychologists using online survey data and follow-up telephone interviews. This design was superior to other designs because little was known about the disclosure of BPD. The mixed methods design allowed me to confirm and expand on information learned during the quantitative phase.

Significance of the Study

My study provided a better understanding of clinical practice in regard to BPD by identifying how often licensed clinical social workers and licensed psychologists disclose the diagnostic label BPD and the reasons why these mental health professionals choose to disclose or not to disclose. It has been suggested that informing patients of a diagnosis of BPD may negatively impact the patient's prognosis (Hersh, 2008; Paris, 2007). However, preliminary research in this area has demonstrated that disclosure increases compliance with treatment and generally leads

to better outcomes (Shergill, Baker & Greenberg, 1998; Zanarini & Frankenburg, 2008).

There are a variety of advantages to disclosing diagnostic information to patients. Disclosing accurate diagnostic information allows patients to seek another opinion and discuss their treatment options. Diagnostic disclosure is useful in implementing evidence-based practices in regard to the treatment of BPD and appropriately predicting the patient's response to treatment. Mental health professionals are in a position to provide hope and empower patients with BPD by providing them with reliable information combating some of the negative information patients may receive elsewhere.

There are several implications for positive social change associated with this study. Currently, there are no guidelines for psychologists to follow when disclosing undesirable information in psychiatric settings (Clearly, Hunt & Horsfall, 2009). My research contributes to this area of literature by gathering information about the frequency of the disclosure of BPD and the reasons why BPD goes undisclosed. An increased understanding of the frequency of disclosure and the reasons why BPD goes undisclosed could be used to research the possible effects of disclosure. This information could also be used to train mental health professionals in regard to proper disclosure practices. Additionally, the knowledge gained from my study has the potential to add to the ethical considerations that serve as an important guideline for clinicians.

Summary

In this chapter, I introduced an area of the literature where limited empirical research has been conducted. Available research on the diagnostic disclosure of psychiatric conditions has primarily focused on schizophrenia. Additionally, these studies have focused on the views of psychiatrists excluding psychologists and clinical social workers who play a primary role in the diagnosis of mental health conditions. Additional research is needed to determine the reasons why professionals are not informing patients about their diagnosis in order to provide training in these areas.

In Chapter 2, I review information on BPD to provide the reader with an understanding of the complexity of this disorder. The history of disclosure is discussed along with a review the empirical research related to the disclosure of psychiatric illnesses. Chapter 3 includes an overview of the proposed methods for studying this topic. In Chapter 4 the results are presented and Chapter 5 is the conclusion and recommendations.

Chapter 2: Literature Review

Introduction

The disclosure practices of mental health professionals in regard to BPD and the potential impact on service delivery is an important area to address. This review begins with an overview of BPD to provide a context for understanding the controversies related to the disclosure of this illness. Specifically, I describe (a) the current definition and diagnostic criteria of BPD, (b) the prevalence of BPD, (c) the prognosis, (d) diagnostic validity, (f) what is known about the etiology, and (g) debates in the literature regarding BPD. I also provide a review of the history of disclosure. Additionally, this chapter includes an overview of a theory of disclosure entitled the MUM effect. Essentially, the definition of mum is to remain quiet. I present a review of studies related to the MUM effect to provide a conceptual framework on which my study is grounded. I will also provide an overview of the literature currently available pertaining to the disclosure of psychiatric disorders. This chapter includes a review of the arguments for and against the disclosure of BPD. I will move to a discussion of how the controversies associated with BPD are believed to contribute to a lack of diagnostic disclosure. This chapter concludes with a review of the types of disclosure that have been found in other areas of medicine.

Literature Search Strategy

The journal articles I used for this literature review were from online sources such as PsychArticles, PsycINFO, Academic Search, ERIC, and SocIndex, which I accessed through the Walden University Library. Due to the fact that psychiatry is a highly related field, research from psychological journals as well as medical journals

were used. All relevant articles were referenced regardless of the publication date in order to establish background on this topic. I also referenced lists from articles found in the literature search as a source for articles. Additional resources included scholarly books obtained through various online sources.

The terms that I used for the literature search included *borderline personality disorder*, *BPD*, *personality disorder*, *Cluster B*, *Axis II*, and *borderline*. In my quest to gather information about disclosure, I used the following words and phrases: *breaking bad news*, *truth-telling*, *controversy*, *mental illness*, *medical*, *psychologists*, *social workers*, *mental health professionals*, *borderline personality disorder*, *schizophrenia*, *bipolar disorder*, *psychiatric diagnosis*, and *psychiatric label*. I also explored the relationship between BPD and disclosure using a combination of various search terms such as personality disorders and breaking bad news.

Review of Borderline Personality Disorder

The term *borderline personality disorder* was introduced in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)*; American Psychiatric Association [APA]; 1980). Admission into the *DSM* extended BPD beyond the psychoanalytic community, increasing the frequency of its use in the general psychiatric community. Since it was first introduced in the *DSM*, BPD has undergone relatively minor changes to the diagnostic criteria.

Current Definition and Diagnostic Criteria

The APA (2013) has characterized BPD as a pervasive and persistent pattern of instability in interpersonal relationships, instability of self-image, unstable affect,

and impulsivity. According to the *DSM-5* (APA, 2013), the diagnostic criterion is indicated by five or more of the nine symptoms in the following list:

- (1) Frantic efforts to avoid real or imagined abandonment.
- (2) A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
- (3) Identity disturbances: 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 abuse, reckless driving or binge eating).
- (5) Recurrent suicidal behaviors, gestures or threats or self-mutilating behavior.
- (6) Affective instability due to a marked reactivity in mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours to 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 ideations or severe dissociative symptoms. (p. 663)

Prevalence of BPD

Personality disorders such as BPD are believed to begin in late adolescence or early adulthood (APA, 2000). The *DSM-5* estimated that BPD impacts 2% to 5.9% of the general population (APA, 2013). Torgersen (2009) has criticized these numbers,

suggesting that they are arbitrary and do not reflect empirical data. Torgersen believed that the prevalence of BPD in the general population is larger. In clinical samples, the prevalence is much higher with an estimate of 15% to 20% (APA, 2000). BPD is the most commonly diagnosed personality disorder in both outpatient and inpatient settings (Paris & Zweig-Frank, 2001).

Suicidal and self-injurious behaviors are prevalent in individuals with BPD. It is estimated that as many as 40% to 90% of patients engage in these behaviors (APA, 2000). Due to the frequency of suicide attempts and self-injurious behaviors, individuals with BPD are frequently encountered in the emergency room. The risk for suicide is highest for patients in their 20s with completed suicides occurring in 10% of patients (Paris & Zweig-Frank, 2001). Impulsivity common among individuals with this disorder is associated with other problematic behaviors such as gambling, eating disorders, sexual promiscuity, and substance abuse (APA, 2000).

Prognosis of BPD

BPD is viewed by many as a chronic and debilitating disorder; however, some studies show that the symptomology of BPD can improve with age. In one study exploring remission rates, 290 patients diagnosed with BPD were followed over the course of 6 years (Zaranini et al., 2004). Zaranini et al. (2004) defined remission as no longer meeting diagnostic criteria. Three semistructured diagnostic interviews were used to assess for the presence of BPD and other Axis I disorders, including (a) the Structural Clinical Interview for *DSM-III-R* for Axis I Disorders, (b) the Revised Diagnostic Interview for Borderlines, and (c) the Diagnostic Interview for Personality Disorders. At a 2-year follow-up, 69.6% of the participants experienced remission

(Zaranini et al., 2004). At a 4-year follow-up, 69.3% of the participants reached remission and at a 6-year follow-up, 68.9% of the participants remained in remission (Zaranini et al., 2004).

In an additional study, Grilo et al. (2004) examined the stability of BPD over 24-months. The authors recruited participants from three inpatient and three outpatient clinical programs. Participants were screened for personality disorders using the Personality Screening Questionnaire. Those identified as having a possible personality disorders were administered additional assessments, including (a) the Structural Clinical Interview for DSM-IV and (b) the Diagnostic Interview for Personality Disorders. The Diagnostic Interview for Personality Disorder was also used at 6, 12 and 24 months. These authors used a more stringent definition of remission than Zaranini et al. (2004). Remission was defined as no longer meeting diagnostic criteria for 12 consecutive months. Grilo et al. found that 28% of the participants diagnosed with BPD no longer met diagnostic criteria at the conclusion of the study.

The cause of this recovery is unknown but is believed to be associated with a decrease in impulsivity with age (APA, 2013; Paris, 2005). This decrease in impulsivity is said to result in improved interpersonal relationships and vocational functioning (APA, 2013). Despite recovery with age, research has shown that patients with BPD continue to struggle with psychosocial functioning throughout their lives (Biskin & Paris, 2012). Long-term functional impairments have been found to persist even after diagnostic criteria are no longer met (Torgersen, 2009). Grilo et al. (2004)

explained that the features of BPD are stable over time even though the severity and expression of the diagnostic criteria change.

Validity of Diagnosis

BPD is one of the most controversial diagnoses and also one of the most frequently diagnosed personality disorders. It has been argued that BPD is a diagnosis that is used most because of the vagueness and abundance of the diagnostic criteria (Becker & Lamb, 1994). According to Biskin and Paris (2012), the current diagnostic criteria for BPD allows for 256 different combinations of symptoms that could lead to a diagnosis. This complexity explains why individuals with BPD are a heterogeneous group with symptoms that vary greatly from one individual to the next. The diagnostic criteria are abundant enough that individuals receiving a diagnosis could overlap on only one diagnostic criterion (Bateman & Fonagy, 2004). This complexity has caused some to question the validity and reliability of the BPD construct.

Several authors have tried to resolve this controversy and argued that the BPD construct is both valid and reliable. Grilo et al. (2001), for example, found evidence for both convergent and discriminant validity. Johanse, Karterud, Pedersen and Falkum (2004) found that all of the criteria for BPD demonstrated diagnostic efficiency and indicated that each criterion accurately describes the BPD construct. This study was replicated several years later by Grilo et al. (2007) and resulted in similar findings. Additionally, these authors found that suicidality and self-injury along with unstable relationships were the symptoms that demonstrated the most accurate diagnostic efficiency (Grilo et al., 2007).

Others disagree that BPD is a valid diagnosis and believe that BPD would be more accurately characterized as a mood disorder or posttraumatic stress disorder (PTSD). This speculation was driven by the large number of individuals with BPD who suffer from symptoms of both depression and anxiety. Goodman et al. (2010) suggested that 37.4% to 70.9% of individuals with BPD also have major depressive disorder. In a 6-year longitudinal study of 264 patients diagnosed with BPD, Zanarini et al. (2004) found that 75% of the patients also met criteria for a mood disorder, 60% met criteria for an anxiety disorder, 34% met criteria for an eating disorder and 19% met criteria for a substance abuse disorder. The authors concluded that it is common for individuals with BPD to meet diagnostic criteria for one or more Axis I disorder (Zanarini et al., 2004). Meeting criteria for one or more Axis I disorder was found to be true even when these patients were participating in weekly individual therapy and taking psychotropic medications.

While some believe that BPD and depression are similar, supporters of BPD argue that these are distinct disorders. Goodman et al. (2010) pointed out that BPD is characteristic of frequent mood changes triggered by interpersonal difficulties while individuals with depression typically experience sustained mood problems. These authors noted that the similarity between these two disorders may be the result of an overlap between the underlying biology contributing to the disorders rather than an indication that the disorders are synonymous (Goodman et al., 2010). Another argument for the distinction between BPD and depression is related to the effectiveness of antidepressants. In support of separate diagnoses, Paris (2007) noted that antidepressants do not work as effectively in those with BPD. Paris

acknowledged that BPD overlaps with several other disorders and suggested that rather than this being a problem with BPD it reflects the current knowledge and limits of psychiatric diagnosis in general.

Some authors argue that BPD develops as a result of trauma and is a form of PTSD frequently referred to as complex posttraumatic stress disorder (C-PTSD) (Hodges, 2003; Lerman, 1993). The belief of these individuals is that BPD is more accurately explained as a chronic form of PTSD that has become integrated into the individual's personality structure (Hodges, 2003). Lewis and Grenyer (2009) have found that as many as 58% of individuals with BPD also meet diagnostic criteria for PTSD. Hodges (2003) and Lerman (1996) advocated for the use of the diagnostic term C-PTSD as opposed to BPD, believing that the former is less stigmatizing. These authors suggested that BPD has traditionally been used by psychiatrists to explain a normal response to the environmental stressors experienced by women (Hodges, 2003; Lerman, 1996). They argued that the use of the BPD label distracts from the environmental causes of the disorder and stigmatizes women (Hodges, 2003; Lerman, 1996). These authors generally avoid using the BPD construct under any circumstances (Hodges, 2003; Lerman, 1996).

Others argue that BPD develops in individuals without a history of trauma and should not be defined as C-PTSD (Lewis & Grenyer, 2009; Paris, 2007). These authors support the notion that BPD is a unique psychopathology and describe trauma as a risk factor that is common in those that have been diagnosed with BPD (Lewis & Grenyer, 2009; Paris, 2007). They argue that factors such as childhood abuse will only result in the development of BPD when genetically based predispositions are

present (Clark, 2005; Paris, 1994; Posner et al., 2003). The literature describes genetic predispositions as innate temperament dimensions that are activated by stress and place individuals at risk for psychopathology (Clark, 2005). Although childhood trauma is not a universal trait among people with BPD, it is common among this population. Childhood trauma is most accurately described as a risk factor in the development of BPD. Additionally, although there are many symptoms that overlap between BPD and PTSD, there are also defining differences. Individuals with PTSD are unlikely to use the defense mechanisms characteristic of those with BPD, such as splitting, denial, and projective identification.

Etiology of BPD

The current definition of BPD has been criticized for the absence of any reference to the etiological causes of the disorder. There has been extensive research in this area over the past several years. Researchers have explored several factors believed to contribute to the development of BPD, including abuse and neglect (Widom, Czaja & Paris, 2009), disrupted attachments (Paris; Zweig-Frank, & Paris, 1991), temperament (Hopwood, et. al, 2009) and various biological contributions. The literature indicates that modern explanations for the development of BPD are changing from single variable to multiple variable theories. The development of BPD is currently believed to be a combination of genetic vulnerability and environmental factors.

Linehan's (1993) biosocial theory focuses on the biological as well as the environmental factors believed to be associated with the development of BPD. Linehan believed that the problems with emotional regulation in those with BPD are

the result of an invalidating environment (as cited in Crowell et al., 2009). Linehan described an invalidating environment as one in which it is communicated to a child that his or her emotions are not valid, are unreasonable or irrational and should be concealed. Individuals raised in an invalidating environment fail to learn to cope with emotions and generally oscillate between emotional withdrawal and intense emotional expression (Linehan, 1993).

The biological vulnerability that contributes to the emotional regulation problems characteristic of those with BPD is believed to result from cognitive processes, biochemistry and physiology (Crowell et al., 2009). These biological vulnerabilities result in a heightened emotional sensitivity, an inability to regulate intense emotional responses and a slow return to emotional baseline (Linehan, 1993). Linehan was one of the first to believe that biological factors contribute to the development of BPD. Unfortunately, at the time that Linehan developed the model there was limited research supporting it.

Researchers have begun to discover some of the biological components that may be responsible for the genetic vulnerability first described by Linehan (1993). It was recognized several years ago that individuals with BPD are more likely to have mothers with BPD. Researchers have since confirmed these early observations, finding that those with BPD are significantly more likely to have relatives with BPD. According to the *DSM-5*, BPD is five times more common in the first-degree relatives of those with the disorder than in the general population (APA, 2013). Torgersen (2012) assessed the heritability of cluster B personality disorders in a sample of 2,794 twins from the Norwegian Medical Birth Registry. The study used the following

measures: (a) The Dysfunctional Personality Questionnaire and (b) a Norwegian version of the Structured Interview for DSM-IV Personality. Torgersen found a concordance rate of 52% to 69%. This study presents strong data for a genetic link. There is additional evidence that the personality characteristics common to individuals with BPD are inheritable.

Silverman et al. (1991) used a blind family history interview method to determine whether affective and impulsive personality traits were greater in first-degree relatives of patients with BPD when compared to patients with other personality disorders and schizophrenia. The researchers gathered information from family informants of 29 patients with BPD, 22 patients with other personality disorders and 43 patients with schizophrenia (Silverman et al., 1991). The authors found that affective and impulsive personality traits were statistically significant in the first degree relative of patients with BPD (Silverman et al., 1991). The authors concluded that there is a strong possibility that affective instability and impulsivity are inheritable personality characteristics and when combined with environmental stressors, increase an individual's vulnerability for developing BPD (Silverman et al., 1991). Linehan (1993) agreed with these observations and expanded her theory based on this research. Linehan suggested that poor impulse control and emotional sensitivity are the early biological factors that make individuals vulnerable for developing BPD (Crowell, Beauchaine & Linehan, 2009). Although studies exploring the genetics of BPD are in the early stages, the studies that have been completed suggest that some of the personality characteristics of BPD may be inheritable.

Other biological evidence is found in research on neurotransmitters such as the most frequently cited trio of serotonin, dopamine and norepinephrine (Goodman, Triebwasser & New, 2008). Of these neurotransmitters, serotonin is the most understood. Goodman et al. (2008) found that serotonin is associated with impulsive aggression and affective instability symptoms associated with BPD. There has also been an attempt to identify specific neurotransmitters sites associated with BPD. One specific neurotransmitter site that has been found to be affected is the 5-HT system. The 5-HT system is a group of protein receptors found in the central and peripheral nervous system. These neurotransmitters influence various biological and neurological processes such as aggression, anxiety and mood. Abnormalities in the 5-HT system have been found to be associated with several symptoms of BPD such as mood instability, suicide attempts, self-injurious behaviors and aggression (Kamali, Oquendo & Mann, 2001). Abnormalities in these neurotransmitters may explain several of the symptoms characteristic of individuals with BPD such as aggression, impulsivity and affective instability.

Finally, there are structural abnormalities in various brain regions that are believed to be associated with BPD. Two areas of the brain that have been identified as being impacted in those with BPD are the hippocampus and amygdala. Nunes et al. (2009) performed a meta-analysis including six studies and 104 patients with BPD and 122 healthy controls. The authors found that the right and left hippocampus and amygdala of patients with BPD was significantly smaller than healthy controls (Nunes et al., 2009). These structural abnormalities can lead to the same traits as genetic contributions including aggression, impulsivity and affective instability. According to

the research just presented, we currently have enough information to begin to accurately identify the etiology of BPD.

Gender Biases

Approximately 75% of individuals diagnosed with BPD are women (APA, 2013). Gender stereotypes are commonly cited in the literature and there is some evidence supporting the influence of these stereotypes. The term *borderline* has been found to be applied to women more than men even when both genders meet the same diagnostic criteria. Research has demonstrated that men meeting diagnostic criteria for BPD are often diagnosed with another personality disorder related to impulsivity such as antisocial personality disorder (Sansone & Sansone, 2011). These differences may be due to the opinion that aggression and impulsivity are more acceptable in men (Henry & Cohen, 1983; Nehis, 1997; Simmons, 1992; Sherwin, 1992). When these characteristics appear in women, these individuals are more likely to be diagnosed with BPD (Henry & Cohen, 1983; Nehis, 1997; Simmons, 1992; Sherwin, 1992). This theory implies that traditional gender roles and stereotyping influence diagnostic decisions of what is normal and what is abnormal for both genders. It also implies that women are inaccurately diagnosed with BPD impacting some psychologists' willingness to use the BPD diagnosis even when patients meet criteria.

Another explanation for the gender differences in the diagnosis of BPD is methodological problems. Sansone and Sansone (2011) pointed out that research studies have traditionally sampled inpatient psychiatric patients to determine the prevalence of BPD. These samples are more likely to include women. Recent research has found that there are notable gender differences in the personality traits of those

with BPD. In addition to a diagnosis of BPD, men have been found to meet diagnostic criteria for antisocial personality disorder and substance abuse disorders and end up in treatment programs or prison so they are not fully accounted for in traditional research samples (Banzhaf et al., 2012; Goodman, New, Triebwasser, Collins & Siever, 2010). Such methodological problems result in an underestimate of the number of men with BPD. These results provide evidence for the possibility that sampling problems contribute to gender differences in the diagnosis of BPD. These results also indicate that the prevalence of BPD may be more equal than originally believed.

Finally, there are individuals who argue that gender differences in the diagnosis of BPD are valid and argue based on the notion that the illness is primarily a result of trauma. This theory states that more women than men do meet the diagnostic criteria for BPD. It has been known for several years that trauma is a risk factor in the development of BPD. Researchers have found that as many as 81% to 91% of patients with BPD have experienced some type of childhood trauma (Lewis & Grenyer, 2009). This theory concludes that BPD is more prevalent in women because women are more likely to experience abuse particularly childhood sexual abuse. The research actually supports the role of gender bias in the diagnosis as opposed to real differences in the prevalence of BPD. The most recent research has found the prevalence rates of BPD in men and women are relatively equal (Lenzenweger, 2006). The literature no longer supports a refusal to use the BPD diagnosis or a lack of disclosure due to gender basis.

Countertransference

Those willing to treat individuals with BPD are likely to experience countertransference reactions. Countertransference can be defined as the psychologist's emotional reactions toward the patient. Countertransference applies to reactions that occur as a result of something that has happened to the psychologist previously. These reactions can be valid reactions elicited by the patient as well as feelings triggered by the psychologist's own history. Lequesne and Hersh (2004) noted that countertransference reactions such as anger and frustration evoked by patients have become a standard for diagnosis. Reiser and Levenson (1984) noted six ways that the BPD diagnosis is abused. These included (a) to express countertransference hate, (b) as an excuse for treatment failures, (c) to justify the therapist acting out, (d) to defend against sexual material, and (f) to avoid pharmacologic care (Reiser & Levenson, 1984). The countertransference reactions elicited by those diagnosed with BPD have resulted in some avoiding the treatment of these individuals entirely (Paris, 2007).

There is some evidence that countertransference interferes with diagnostic disclosure. BPD is characterized by affective instability, interpersonal difficulties, impulsivity, self-injurious and suicidal behavior all of which make this disorder difficult to treat. These symptoms have been found to provoke anxiety in mental health professionals (Aviram et al., 2006; Gunderson, 2008). It is believed that psychologists may fear that these symptoms will be triggered by diagnostic disclosure. In an attempt to manage their own fear about their ability to manage these symptoms, they refrain from disclosure to protect themselves as well as the patient.

Aviram et al. (2006) noted that mental health professionals manage the interpersonal difficulties associated with treating individuals with personality disorders by physically and mentally withdrawing. This withdrawal from patients, most likely results in a lack of discussion about BPD and its available treatment options. It also prevents psychologist from considering the options for disclosure.

In summary, BPD is a common diagnosis that most mental health professionals are likely to encounter at some point during their career. Over half a century of clinical observation and 25 years of empirical research has provided psychologists with significant information about the prevalence, course, and etiology of this disorder. Despite these advances, there continues to be a significant amount of controversy associated with this diagnosis. The comorbidity rates, association with trauma and perceived gender biases cause some practitioners and researchers to reject the diagnosis entirely. Others willing to use the diagnosis may prefer not to disclose diagnostic information because of these controversies. Following, I will provide a review of the history of disclosure along with the arguments for and against the disclosure of BPD.

History of Disclosure

In a patriarchal medical system in which the doctor was believed to know what was best for patients, it was a common practice to withhold information perceived to be undesirable. Patients went without any knowledge that they had been diagnosed with a terminal illness or serious psychiatric condition. This was especially true when there were limited treatment options (Buckman, 1991). It was standard to withhold information because physicians feared that the patient would lose hope or

become worse with the knowledge of their diagnosis (De Valck, Bensing & Bruynooghe, 2001). Patients were rarely included in decisions about their treatment options (Buckman, 1991).

Supporters of medical paternalism argue that it is necessary because patients frequently suffer from diminished reasoning capacity (Sherwin, 1992). Unfortunately, these beliefs have disproportionately impacted woman who historically have been viewed as irrational. Paternalistic systems are structured based on the belief that the physician often a male has better judgment than the patient. This may be especially true for a diagnosis such as BPD that has traditionally impacted more women than men. Paternalism teaches patients to trust and not question the authority of their physician. At this time in history, the decision to withhold information from patients was not based on any actual empirical research.

Research on the disclosure of undesirable information originated in the field of social psychology with Rosen and Tesser in the late 1960s and early 1970s (Rosen & Tesser, 1970). These authors were the first to describe and study empirically, a phenomenon whereby when faced with disclosing information, communicators are often more reluctant to disclose undesirable information (Rosen & Tesser, 1970). Rosen and Tesser (1970) entitled this behavior the MUM effect to emphasize the potential of communicators to remain mum when faced with the dilemma of communicating undesirable information.

Rosen and Tesser (1970) conducted their first study of the MUM effect by recruiting students from an introductory psychology course. Participants were recruited to participate in a “consumer preference study.” While completing a

fictitious task they overheard a message from another individual that contained either some very bad or good news. Shortly after overhearing the message, the individual appeared. The dependent measure consisted of whether or not the communicator conveyed all or part of the message and whether the communicator did so spontaneously or after a probe from the recipient. Participants were asked to complete a post-experimental questionnaire to investigate their desire, obligation and perceived responsibility to communicate. In support of the MUM effect, the authors concluded that the more pleasant the message for the recipient, the more likely the recipient is to receive it (Rosen & Tesser 1970).

In an attempt to elaborate on the MUM effect and explain its existence, Rosen and Tesser (1970) discussed possible consequences incurred by the communicator as a result of having the responsibility of delivering undesirable information. Rosen and Tesser believed that a reluctance to deliver undesirable information could be associated with a fear that the recipient will have a negative emotional reaction or a fear of being evaluated negatively by the recipient. The authors also believed that the possibility of the communicator being infected with the emotional distress of the recipient prevented disclosure (Rosen & Tesser 1970). Lastly, Rosen and Tesser considered that communicators may withhold information as a result of feeling guilty for not having the same fate as the recipient.

In a study exploring whether communicators withheld information as a result of feeling guilty for not having a similar fate as the recipient, Tesser and Rosen (1972) asked 48 female undergraduate students from a large university to participate in an experiment to earn credit in their introductory psychology course. The participants

were told that they would be participating in an experiment evaluating the effects of shock stimulation on learning. While waiting for the second participant (recipient) to arrive, the first participant was given a test shock and found that it was harmless. The first participant was given one of four scenarios: (a) both she and the recipient would be shocked, (b) neither she or the recipient would be shocked, (c) she would be shocked while the recipient would not, or (d) the recipient would be shocked and she would not. When the second participant arrived, that individual was also administered the shock and found that it was painful. The first participant was given an opportunity to inform the recipient of the recipient's fate. The amount of guilt that the first participant experienced about the situation was measured with a post-experimental questionnaire. The authors found that participants in the dissimilar fate-bad news condition experienced the most guilt and communicated less frequently (Tesser & Rosen, 1972).

In a similar experiment, Johnson and Conlee (1974) determined how a fear of being negatively evaluated by the recipient impacted communication. Sixty-four female undergraduate students from a large university participated in the experiment for course credit. The participants were informed that they were participating in an experiment to determine the impact of electrical shock on learning. Before the study began, the recipient was administered a test shock and screamed loud enough for the participant to hear that it was painful. While waiting for the study to begin, a male informant that has just completed the experiment entered the room and disclosed to the participant that the experiment consisted of one of three situations: (a) both parties get shocked, (b) neither gets shocked, and (c) one person gets shocked while the other

does not. Just before the experiment began the experimenter, who was blind to what was on the card, gave the participant a card indicating who was to get shocked. The experimenter also admitted that she forgot to inform the other person (recipient) if she would be shocked. During the experiment, the participant is given an opportunity to inform the recipient of her fate. The amount of guilt that the participant experienced and a fear of being negatively evaluated were measured with a post-experimental questionnaire. The authors found that the participants were significantly more concerned with what the recipient would think of them in conditions where they did not share the same fate (Johnson & Conlee, 1974). Additionally, the results indicated that undesirable information was communicate more frequently in situations where the participant believed that they shared the same fate as the recipient (Johnson & Conlee, 1974).

In a role play extension several other variables believed to be associated with the MUM effect were evaluated. The dependent variables were (a) assignment of responsibility for communicating, (b) the recipient's mood, (c) gender of the receipt, and (d) type of news good or bad. The researchers also controlled for (a) perceived message importance, desire to communicate, and (c) perceived urgency of the message. Tesser, Rosen and Batchelor (1972) recruited 120 females and 120 males from an introductory psychology course. After reading 1 of 24 variations of a news passage, participants were asked to record what they thought they would do or feel under the conditions noted in the assigned passage. The results of this study replicated earlier finding in support of the MUM effect. Participants indicated that they would disclose good news more often than bad news (Tesser et al., 1972). The authors

hypothesized that good news would be more likely to be communicated to a sad person while bad news would be less likely to be communicated to this person. The role of mood in the communication of undesirable information was contradictory to what was anticipated. The results indicated that participants felt more obligated to communicate undesirable information to sad recipients. The authors also found several significant findings related to gender. Female communicators felt more obligated than male communicators to communicate both good and bad news and female recipients also saw the message as more urgent (Tesser et al., 1972). Additionally, the authors found that participants felt more obligated to communicate both good and bad news when the recipient was a female (Tesser et al., 1972). The results of this research suggest that there may be gender differences in the societal norms regarding the disclosure of undesirable information.

In an attempt to determine if a recipient's desire to hear information impacted disclosure, Conlee and Tesser (1973) tested the following hypotheses: (a) communicators assume that recipients want to hear desirable news and do not want to hear undesirable news, (b) communicators are more likely to communicate news to those that are perceived as having a desire to hear news than those who are not, and (c) when the communicator is not aware of the recipients desire, desirable information is communicated more frequently than undesirable information. In order to test this, Conlee and Tesser (1973) recruited 60 male students from classes at a large university. The participants were told that they would observe a group discussion and evaluate a chosen member's (the potential recipient's) communication skills. The participants were provided information that the potential recipient had either scored

high (desirable information) or poor (undesirable information) on an aptitude test. Two thirds of the participants were also provided with information as to whether the student they were evaluating desired to know the results of their aptitude test. The remaining third of the participants were not provided with information on the desire to know. All of the participants were given an opportunity to inform the student they were evaluating of their results.

Conlee and Tesser (1973) found that those participants that were unaware of the desire to know believed that the recipient would prefer not to be told. The authors concluded that communicating news was done more frequently to a recipient perceived as having a high desire for information than one perceived as having a low desire for information (Conlee & Tesser, 1973). Interestingly, the MUM effect was still present to some extent even when the recipient's desires were known to be high (Conlee & Tesser, 1973). Based on the results of this research, the communicator should become aware of their own assumptions regarding the recipient's desire in order to prevent their assumptions from interfering with the communication of undesirable information.

In an article reviewing all of the MUM effect research, Tesser and Rosen (1975) grouped the results of these studies into three categories. The first is the communicator's self-concern. In this category, Tesser and Rosen (1972) found that guilt for not having a similar fate as the recipient, a fear of being negatively evaluated by the recipient, and a fear of being blamed by the recipient are all reasons that prevented the communicator from relaying undesirable information. Another reason for the unwillingness to disclose undesirable information is the communicator's desire

to avoid the negative mood that is believed to accompany the process of disclosing undesirable information (Tesser, Rosen & Conlee, 1972).

The second category includes the communicator's concern for the recipient. The authors reported that communicators consider the costs to the recipient prior to relaying bad news (Tesser & Rosen, 1975). One explanation for the reluctance to disclose undesirable information is that it might upset the recipient emotionally (Tesser & Rosen, 1975).

The third category that is believed to impact the participant's willingness to disclose undesirable information is concerns for societal norms. Tesser, Rosen and Batchelor (1972) evaluated whether beliefs about personal responsibility, type of relationship between the individuals and the norm to help impacted the willingness to disclose undesirable information. They found that the norms for disclosing undesirable information were ambiguous (Tesser et al., 1972). The participants in their research had a difficulty agreeing on times when it is required to communicate undesirable information (Tesser et al., 1972). More specifically, individuals are less likely to agree on circumstances such as urgency of the message or the obligation to share the message in bad news situations (Tesser et al., 1972).

In a more recent study, Merker et al. (2010) used the MUM effect to study the disclosure practices of 329 licensed psychologists nationwide. In the first phase of their research, psychologists were asked to answer the Breaking Bad News Questionnaire, a 28-item survey instrument developed by the authors. The participants were also asked to complete a 29-item survey developed by Eberhardt, McKee and Ptacket (2001). Both questionnaires were developed to gather information about

factors believed to affect the participants' willingness to disclose undesirable information (Merker et al., 2010). In a second phase, qualitative interviews were used to help determine the accuracy of results and reinforce possible explanations for the reluctance in disclosing undesirable information (Merker et al., 2010). The authors concluded that a significant difference was found between the respondents' willingness to disclose undesirable information versus desirable information (Merker et al., 2010). There were several factors that contributed to these results.

Merker et al. (2010) found that the psychologists noted a fear of being blamed and being physically harmed by the patient as reasons for a lack of disclosure. The psychologists also noted wanting to avoid the negative emotional state associated with disclosing undesirable information (Merker et al., 2010). Concerns for the patient were also noteworthy and included fears about emotionally upsetting the patient, concerns for the patient's safety and the possibility of misdiagnosis leading to additional harm (Merker et al., 2010). The societal norms that impacted the disclosure of information included an ethical responsibility and the importance of preserving the therapeutic relationship (Merker et al., 2010). Several factors that prevented the psychologists from disclosing information in this study were consistent with the earlier work of Tesser and Rosen (1970) confirming the existence of the MUM effect in the practice of psychology.

Despite the understandable and even unavoidable human tendency to withhold information that is perceived to be undesirable, contemporary psychiatry and psychology require some degree of disclosure. For example, in order to get reimbursed by insurance companies patients must give their health care providers

permission to disclose their diagnosis. Thus, at a minimum a high number of patients will see their diagnosis on insurance forms. Additionally, there is less tolerance for paternalism and a push to protect the autonomy of the patient.

Theoretical Framework

Rosen and Tesser's MUM effect was chosen for the theoretical framework for this study. As discussed earlier in this chapter, the MUM effect is the tendency to remain mum when faced with the dilemma of communicating undesirable information (1970). The MUM effect was chosen because it has been found to influence clinical decision making among psychologists (Merker et al., 2010).

Prior to the work of Merker et al. (2010) studies on the disclosure of psychiatric information have not used a theoretical framework to ground the research. Merker is one of the first known studies to use the MUM effect to explore the disclosure practices of psychologists. This study was useful because it provided valuable information about why psychologists do not disclose undesirable information. However, there were limitations associated with this study. The authors did not differentiate between different types of undesirable information. There is no evidence supporting the idea that all psychological diagnoses are treated equally in regard to disclosure. In fact, in an earlier study McDonald-Scott, Machizawa and Satoh (1992) found significant differences in the likelihood of disclosure among the various psychiatric diagnoses. Further research and application of Rosen and Tesser's theory offered insight into clinical decision making as it relates to BPD. My study attempted to expand and build on this research by distinguishing between the disclosure of BPD from other undesirable information.

Definitions of Undesirable Information

Within the medical field, the disclosure of undesirable information has been referred to as “breaking bad news” (Buckman 1991; Ptacek & Eberhardt, 1996). Bad news has been defined in the literature in a variety of ways, none of which accurately define the disclosure of psychiatric information. The one that comes closest is Ptacek and Eberhardt (1996) definition which defines bad news as a threat to an individual’s psychological or physical well-being. This definition includes news that results in cognitive, emotional or behavioral changes in the person receiving the news that last beyond the bad news encounter (Ptacek & Eberhardt, 1996)

Cleary et al. (2010) argued that the definitions of bad news as defined in the medical literature do not satisfactorily define the disclosure of psychological information and as a result these authors have chosen to use the term “difficult news” as opposed to bad news. These authors noted that difficult news can include being informed of the need for lifelong medications with side effects, unclear prognosis and potential lifestyle consequences (Clearly et al., 2010). The literature also suggests that what constitutes bad news is highly subjective and dependent upon ones roles as the communicator or the recipient (Buckman, 1991; Ptacek & Eberhardt, 1996; Tesser & Rosen, 1972).

Disclosure in Psychiatric Settings

Due to the paucity of research on disclosure practices with BPD, I included research on schizophrenia and other personality disorders. In one of the first known studies to explore the disclosure practices of mental health professionals, researchers asked 60 psychiatrists, 53 social workers and 10 psychologists whether they would

disclose an affective disorder or schizophrenia to the patient or their family (Green & Grant, 1987). The participants were asked to choose from one of five responses: *always, usually, sometimes, rarely, or never*. The results indicated that 75% of the psychiatrists would tell the patient's family and 80% would tell the patient if diagnosed with an affective disorder (Green & Grant, 1987). The researchers found that only 56% of the psychiatrists were comfortable informing the family of a diagnosis of schizophrenia and 37% were comfortable informing the patient (Green & Grant, 1987). Green and Grant found that 52% of the social workers and 40% of the psychologist would inform the patient's family if diagnosed with an affective disorder. Fifty-nine percent of social workers and 35% of the psychologists would inform the patient (Green & Grant, 1987). When this was compared to schizophrenia, only 25% of the social workers and 20% of the psychologists would inform the family of the diagnosis. Additionally, only 15% of the social workers and 20% of the psychologists would inform the patient (Green & Grant, 1987). These researchers found several reasons for this lack of reporting. The professionals expressed concerns about labeling clients due to the stigma associated with schizophrenia (Green & Grant, 1987). There were also concerns that patients would not understand the diagnosis and that diagnostic disclosure would cause unnecessary harm (Green & Grant, 1987). Green and Grant is the first known study to find that the disclosure practices of mental health professionals may depend on the psychiatric diagnosis. Schizophrenia and BPD have been two of the psychiatric conditions that have traditionally gone undisclosed. Although researchers have only speculated about the

possible reasons why BPD has gone undisclosed, they are believed to be similar to those of schizophrenia.

Past studies on BPD disclosure practices include only one study. In this study, the authors wanted to gain a better understanding of psychiatric diagnostic disclosure practices. They provided 112 psychiatrists at a large university with six case vignettes based on actual patient histories. The first described a young man with a five-year history of psychosis requiring hospitalization and meeting criteria for schizophrenia according to the *DSM-III-R*. The second vignette depicted a woman in her late 20s experiencing a recurrence of non-affective psychotic symptoms lasting for three months and meeting criteria for schizophreniform disorder. A woman with bipolar disorder was described in the third vignette. The fourth vignette described a middle-aged man presenting with symptoms of depression which lasted a year but did not meet criteria for major depression or dysthymia. The fifth vignette described a person (gender unknown) with panic disorder and the sixth vignette gave a summary of a woman with BPD. The participants were asked to complete a four question survey. Each question had four multiple choice answers associated with it. The questions were as follows: “(a) What would you tell patients, (b) Why wouldn’t you tell the patient the diagnosis, (c) If the patient asked, “Do I have . . .?” What would you say?, and (d) What would you tell this patient’s family?” (McDonald-Scott, Machizawa & Satoh, 1992, p. 149).

Those surveyed reported the greatest reluctance when informing patients that they had been diagnosed with BPD (McDonald-Scott, Machizawa & Satoh, 1992). The researchers found that only half of the respondents would inform patients of a

diagnosis of BPD (McDonald-Scott et al., 1992). These numbers increased to 70% to 80% when the patient asked directly about their diagnosis (McDonald-Scott et al., 1992). Regardless of the patients desire to know, 25% of the respondents indicated that they would not inform the patient of a diagnosis of BPD (McDonald-Scott et al., 1992). The respondents indicated that they would not provide diagnostic information due to a belief that doing so would lead to misunderstandings, confusion and possibly harm the patient (McDonald-Scott et al., 1992). Interestingly, the amount of clinical experience that the psychiatrists had did not play a role in whether the psychiatrists disclosed information (McDonald-Scott et al., 1992). When BPD was compared to other psychiatric disorders such as bipolar disorder, minor depression and panic disorder all of the psychiatrists surveyed indicated that they would inform the patient of their diagnosis (McDonald-Scott et al., 1992). These results are interesting given that at the time of this research the American Psychological Association's Ethical Standards and Code of Conduct (APA, 1992) required that patients be provided with the results of any assessments. One explanation for poor disclosure may be that BPD is a difficult diagnosis to understand and explain to patients.

In another study, Shergill, Barker and Greenberg (1998) surveyed the disclosure practices of psychiatrist and explored the perceptions of both inpatients and outpatients regarding their experience with disclosure. The authors were interested in how disclosure is impacted by a diagnosis of schizophrenia or personality disorders. They were also interested in determining how often psychiatric patients were informed of their diagnosis, the significance they attached to it and the impact of being informed. The researchers asked consulting psychiatrists working at an

inpatient psychiatric unit located in London to complete a questionnaire about whether they told patients their diagnosis. The participants were given the option of answering *always*, *sometimes* or *rarely* to this question (Shergill et al., 1998). The researchers also asked the psychiatrists to identify which characteristics interfered with disclosure from a list provided. The participants were also asked to indicate if they felt psychiatric diagnoses were as “real” as physical illnesses (Shergill et al., 1998). Twenty-four of the 28 psychiatrists contacted replied (Shergill et al., 1998). Of those that replied, 83% said that they inform patients of their diagnosis (Shergill et al., 1998). Although many of the participants indicated a willingness to disclose psychiatric diagnoses, they were less inclined to do so when the diagnosis was organic, schizophrenia or a personality disorder (Shergill et al., 1998). The authors concluded that the participants were influenced by their confidence in the diagnosis, how well they knew the patient and whether the patients insisted on being informed (Shergill et al., 1998). The authors noted that the participants may not view personality disorders as “real” influencing their likelihood of being disclosed (Shergill et al., 1998).

The study for inpatients ($N = 126$) included a self-report survey focused on what they had been told about their diagnosis and their attitude toward this. The patients were also asked what they wanted to be told and by whom. The authors found that 59% of the patients had been informed of their diagnosis and 67% had not (Shergill et al., 1998). In regard to those with personality disorders, 7% of the patients were informed of their diagnosis while 2% were not. Shergill et al. found that most of the patients wanted to know their diagnosis and wanted to be informed by their

physician. Seventy-five percent of the patients believed that knowing their diagnosis was helpful and 45% believed that their diagnosis was as “real” as a physical diagnosis (Shergill et al., 1998).

The self-report measure was administered to day patients ($N = 23$) at admission and again at 6 weeks. The researchers found that at admission most of the patients wanted to know their diagnosis and wanted to be informed by their primary doctor (Shergill et al., 1998). Ninety-one percent of the patient believed that knowing their diagnosis was helpful and 25% believed that the diagnosis was as “real” as a physical diagnosis (Shergill et al., 1998). After 6-weeks, 98% of the patients had been given their diagnosis and 96% reported that the information was helpful (Shergill et al., 1998). This research supports the idea that patients want to know their diagnosis and find this information helpful.

Cleary et al. (2010) expanded on previous studies by asking a sample of inpatient psychiatrists and psychiatric nurses working in a hospital located in Australia their views of disclosing diagnostic information. The participants were asked to indicate the patient characteristics considered when making a decision to disclose a psychiatric diagnosis (Cleary et al., 2010). One weakness of this study was the authors did not distinguish between psychiatric diagnoses; however, they did ask participants if the patient’s diagnosis is considered when disclosing information. Participants were asked to rate these characteristics on a scale ranging from *always*, *usually*, *occasionally* and *rarely, or never* (Cleary et al., 2010). Of the 247 questionnaires that were mailed out, 33% of the psychiatrists and 29% of the nurses responded (Cleary et al., 2010). The results indicate that 90% of the participants

believed that patients should be informed of their diagnosis (Cleary, et al., 2010). However, 46% of respondents also believed that full disclosure of diagnosis and treatment could have negative consequences on patients (Cleary, et al, 2010). Although a high percentage of respondents believed patients should informed of their diagnosis, several of these respondents also believed that full disclosure could be harmful. The authors neglected to ask the respondents how often they disclose information and given this information there is reason to believe that not all who believe it is important actually disclose. The results of this research were similar to previous findings. Once again the patient's diagnosis was found to influence the disclosure of information (Cleary et al., 2010). More specifically, these authors found that the stigma associated with the diagnosis and whether the patient could become distressed were factors that influenced disclosure (Cleary et al., 2010). Given the nature of BPD and the findings that a patient's distress is taken into consideration, it is possible that these factors would have a significant impact on the disclosure of this illness.

To summarize, studies about disclosure practices have generally demonstrated that professionals consider the psychiatric diagnosis when disclosing information. Those diagnoses associated with more stigma are disclosed less frequently. This may reflect a lack of confidence in the diagnostic process. Psychologists do not have any concrete evidence as would be the case with lab tests supporting one diagnosis over another. Professionals can improve the validity of their diagnosis by administrating psychological tests but even these have a certain amount of error associated with them. Although the existing studies do not address this

directly, it is possible that disclosure is impacted by the tendency to avoid giving a patient an inaccurate diagnosis.

There are a number limitations associated with the existing studies including the sample sizes have generally been small and the population has generally been limited to psychiatrists. Most of these studies excluded psychologists and clinical social workers who often play a primary role in the diagnosis of individuals with BPD. Only one known study has been conducted in the United States that included psychologists and social workers in addition to psychiatrists (Green & Grant, 1987). Only a limited number of these studies have differentiated between psychiatric illnesses. Those that made this distinction have primarily focused on schizophrenia. The studies that have focused on personality disorders, have traditionally grouped all of the personality disorders together. Although paternalism in medical care is more likely to adversely impact women, none of the completed studies controlled for the gender of the patient. This study contributed to the literature by exploring the disclosure practices of psychologists and clinical social workers as it relates to a specific personality disorder. In this research study, BPD was distinguished from other personality disorders.

Arguments for Diagnostic Disclosure

There are a variety of arguments in favor of diagnostic disclosure in the case of BPD. Researchers in the field argue for diagnostic disclosure and suggest that there is no evidence that diagnostic disclosure is harmful to patients (Biskin & Paris, 2012; Gunderson, 2011). It is posited that disclosure is helpful in improving the patient's understanding and is far superior to leaving the patient with the unknown (Biskin &

Paris, 2012; Gunderson, 2011). Diagnostic disclosure gives the patient's experience a name and lets them know they are not alone. Biskin and Paris noted that in their clinical experience when the diagnosis is disclosed, patients often feel that the diagnosis "finally makes sense." (p. 1793). Biskin and Paris suggest that it can be helpful to review the diagnostic criteria with the patient and explain the reason for the diagnosis. Gunderson agreed with these authors and suggested that asking patients whether the diagnostic criterion characterizes them improves acceptance of the diagnosis. These authors believe that disclosure reduces the stigma associated with BPD rather than increase it as others believe (Biskin & Paris, 2012; Gunderson, 2011).

Studies that have explored the topic of disclosure from the patient's perspective have found that patients want full disclosure (Buckman, 1991; Tuckett, 2004). These studies have found that patients want information about a number of medical conditions including those most serious conditions such as cancer, Alzheimer's disease and human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) (Buckman, 1991; Tuckett, 2004). In a sample of outpatient psychiatric patients diagnosed with major mental illness including a small sample of individuals with personality disorders, most patients wanted to know their diagnosis (Shergill et al., 1998). Although the authors did not specify how many of the individuals in the sample were diagnosed with BPD, there is no logical reason to expect that individuals with BPD would differ from the sample in terms of wanting to be informed of their diagnosis. A failure to disclose information based on a belief that patients prefer not to know is unsupported. In fact, one study found that patient

satisfaction is correlated with the amount of information that is shared by their physician (Devine, 1992).

Several years ago, a minority of the mental health professionals surveyed by Green and Grant (1987) noted the possibility that diagnostic disclosure could positively impact treatment outcomes. This reasoning has become more popular in recent years. Preliminary research in this area has demonstrated that disclosure increases compliance with treatment and generally leads to better outcomes. Zanarini and Frankenburg (2008) found that when patients were provided with psychoeducation about BPD shortly after being diagnosed, they demonstrated an improvement in general impulsivity and interpersonal conflict. Diagnostic disclosure is useful in implementing evidence-based practices in regard to the treatment of BPD and appropriately predicting the patient's response to treatment.

There is research demonstrating that patients agree that disclosure has positive treatment outcomes. Ninety one percent of the patients surveyed by Shergill et al. (1998) believed that receiving their diagnosis was helpful to their treatment and recovery. Disclosing accurate diagnostic information allows patients to seek another opinion and discuss their treatment options. Chapman and Sonnenberg (2000) noted that patients feel they have a right to understand their health care and to participate in decisions making.

There are ethical and legal obligations that require diagnostic disclosure. The American Psychological Association's Ethical Standards and Codes of Conduct (APA, 2002) emphasize the importance of patient autonomy. Patients must be provided with as much information as they desire about their diagnosis and its

treatment (APA, 2002). Psychologists are ethically required to respect the self-determination of patients (APA, 2002). This implies that patients have a right to play a role in decisions regarding their medical care. Psychologists have an obligation to create the conditions necessary for autonomous choice in patients with BPD. When psychologists make the choice to withhold diagnostic information, it inhibits patient autonomy by rendering patients unable to make a personally meaningful decision.

APA Ethical Standards also indicate that psychologists are required to establish relationships of trust with those with whom they work (APA, 2002). Trust is accomplished by the promotion of accuracy, truthfulness, and honesty in their work (APA, 2002). If a psychologist chooses not to disclose information to a patient and the patient later finds out, it is likely that the patient will no longer trust the psychologist. This destroys the therapeutic relationship creating an environment where the patient no longer trusts the psychologist to provide appropriate information regarding diagnosis, prognosis, and treatment. A lack of disclosure also has the potential to impact the integrity of the practice of psychology if it results in a general lack of mistrust among the community.

There are also laws that influence the decision to disclose diagnostic information. Legally, patients have a right to access their medical records. The Health Insurance Portability and Accountability Act (HIPAA) (1996) allows patients access to their health information. This law gives patients the right to make sure their medical record is accurate (HIPAA, 1996). These federal laws require that upon request, a psychologist supply to the patient complete and current information concerning any diagnosis, prognosis, and treatment (HIPAA, 1996). With increased

access to health information, it is becoming more difficult to withhold information from patients. As stated previously, a lack of disclosure has the potential to compromise the integrity of the practice of psychology.

Arguments Against Disclosure

Many of the arguments against disclosure have revealed themselves in previous sections of this chapter. However for the sake of clarity, I will explicitly state them here. Research exploring the general practices of psychologists has provided insight into the reasons for a lack of disclosure and include: (a) a fear of being blamed, (b) a fear of misdiagnosis, (c) a fear of emotionally upsetting the patient, (d) a fear of being physically harmed by the patient, (e) a fear for the patient's safety, and (f) to avoid the development of negative transference (Merker et al., 2010).

Additional reasons include a general resistance in diagnosing personality disorders and disagreement regarding the reliability and validity of BPD (Lequesne & Hersh, 2004 & Paris, 2007). Given the nature of BPD, one may argue that these fears would be greater when compared to other psychiatric diagnoses. While these fears may be valid, they do not justify a lack of disclosure and would be more appropriate topics for clinical supervision or consultation.

Options for Disclosure

There are three models of disclosure frequently cited in the literature. These models include: non-disclosure, full-disclosure, and patient-centered disclosure (De Valck, Bensing & Bruynooghe, 2001). According to De Valck et al. these three disclosure models represent attitudes toward the doctor-patient relationship and impact decision-making regarding disclosure, illness management and doctor-patient

communication. The traditional model of non-disclosure is paternalistic characterizing the relationship between the psychologist and patient where it is believed that the psychologist knows best (De Valck et al., 2001). Consistent with this model, the psychologist decides how much and which information is shared with patients. This allows the psychologist to maintain an emotional distance from the patient and minimizes their potential of experiencing intense emotions (De Valck et al., 2001).

Evidence suggests that the disclosure of undesirable information can have a significant impact on the individual communicating the news. Stress, fear, and anxiety are the most commonly cited reactions (Alexander & Klein, 2000; Buckman, 1991; Dosanjh, Barns & Bhandari, 2001; Radziewicz & Baile, 2001). Ptacek, Ptacek and Ellison (2001) found that 42% of physicians reported experiencing stress following the disclosure of undesirable information and the effects lasted from several hours to more than 3 days. Non-disclosure may continue to be practiced by psychologists possibly as a self-protective mechanism (Biskin & Paris, 2012; Lequesne & Hersh, 2004; Paris, 2007; Zanmarini & Frankenburg, 2008).

Models of full-disclosure stress the importance of providing patients with total information based on their ethical and legal right to know the truth (De Valck et al., 2001). This model emphasizes the rights of the patient and places the patient in control of their health information and decisions regarding their medical care (De Valck et al., 2001). This model was once the preferred model of disclosure in medical care and continues to be practiced by most. However, researchers have found that although most patients want information about their diagnosis, there are some that would prefer to decide how much information is disclosed (De Valck et al., 2001). As

a result of this information, a new model was created that takes each patient's preferences into consideration.

The literature indicates that models of full-disclosure are becoming less acceptable when compared to patient-centered models. An individualized approach emphasizes the importance of disclosing information based on the patient's preferences (Arber & Gallagher, 2003; Baile et al., 2012; Buckman, 2005; De Valck et al., 2001; Thistlethwaite, 2009). This model is focused on the relationship between the psychologist and the patient and empathizes the importance of understanding the patient's preferences and argues for the disclosure of information based on these preferences (De Valck et al., 2001). This model also takes into consideration each client's cultural background and accounts for differences related to an individual's culture (De Valck et al., 2001). I argue for the disclosure of BPD and agree that the patient's preferences should be taken into consideration.

Measurements of Disclosure

Questionnaires have been the most common method for measuring the attitudes of mental health professionals in regard to diagnostic disclosure (Cleary et al., 2010; Green & Grant, 1987; Merker et al., 2010; McDonald-Scott et al., 1992; Shergill et al., 1998). Each of these authors has created their own survey targeting different variables. The variables of interest have varied considerably from one study to the next and have been dependent upon what is believed to interfere with disclosure. However, there have been some common themes among these studies. Most notably, all the researchers have asked how often the participants inform patients of their diagnosis (Cleary et al., 2010; Green & Grant, 1987; Merker et al.,

2010; McDonald-Scott et al., 1992; Shergill et al., 1998). Secondly, many of the authors have inquired into how the belief that diagnostic disclosure is harmful impacts how often professionals chose to disclose (Cleary et al., 2010; McDonald-Scott et al., 1992; Shergill, Barker & Greenberg 1998). Lastly, all of the researchers have explored the reasons believed to be associated with a lack of disclosure (Cleary et al., 2010; Green & Grant, 1987; Merker et al., 2010; McDonald-Scott et al., 1992; Shergill et al., 1998). Researchers have gathered this information in one of two ways: (a) by asking participants to think about their clinical work and answer the questionnaire accordingly or (b) by providing a hypothetical clinical case vignette and asking participants how they would respond.

The established measures are limited in several ways. The questions associated with them were not based on a theoretical framework and seemed to have been arbitrarily created. Additionally, the questionnaires are often limited in the amount of data collected. Most of them simply asked how often information is disclosed without elaborating on the possible variables believed to impact disclosure. Unfortunately, many of these researchers failed to publish the reliability and validity data associated with these established measures. As a result, there is no way to know whether the established questionnaires are actually measuring what they intended to measure. As a result of these methodological errors, these measures were not considered for this study.

For my own research, I eliminated the previous methodological weaknesses by using a two-phase, sequential explanatory mixed methods design. During the quantitative phase of the study, I used the only previously established questionnaire

that is based on a theoretical framework and has satisfactory reliability and validity. Participants were asked to answer the questionnaire according to how they typically behave in their clinical practice. The measure chosen was created by Eberhardt and Ptacek (2001) and is entitled the Breaking Bad News Questionnaire. In an additional study conducted by Merker et al. (2010) this measure was modified and found to have satisfactory reliability and validity. This questionnaire was selected because it measures a variety of variables associated with the MUM effect which was the theoretical framework for my study. This measure was used to determine if the nature of BPD or the psychologists' and clinical social workers' concerns for self, concerns for the patient, and societal norms negatively influence their reluctance to disclose diagnostic information. In the qualitative phase of the study, telephone interviews were used to verify and expand on the results of the questionnaire. This method will be described more thoroughly in Chapter 3.

Summary

In this chapter, I introduced the gap in the research on BPD and diagnostic disclosure. I also reviewed the known empirical studies addressing the disclosure of psychological information. Additionally, I reviewed research studies, peer-reviewed articles and other relevant information pertaining to the relationship between BPD and disclosure. I presented the controversies associated with BPD and how they are believed to be related to a lack of disclosure.

This chapter demonstrates that little is known about the disclosure practices of mental health professionals. The psychological research has defined some of the variables that influence the disclosure of undesirable information. In one empirical

study, these variables were found to impact general decision making among psychologists (Merker et al., 2010). However, what remains unknown is whether the disclosure of a controversial diagnosis such a BPD would differ from other psychiatric diagnosis. A review of the literature suggests that this may in fact have a significant impact on diagnostic disclosure practices and is in need of additional research.

In Chapter 3, I provide an overview of the research design and rationale, including a discussion of the sample, testing instruments, data collection, and statistical analysis.

Chapter 3: Research Method

Introduction

The purpose of this study was to identify how often licensed psychologists and licensed clinical social workers inform patients that they have a diagnosis of BPD and to identify the reasons why these professionals choose to disclose or not to disclose. Licensed clinical social workers and licensed psychologists were chosen because each has a significant role in diagnosing individuals with BPD. In this chapter, I explain the research design and provide justification for the methods used. Following that, I discuss the sample. A review of the instruments and their reliability and validity is

presented. Data collection and analysis is discussed. A consideration of ethical issues will conclude this chapter. I outline the research methods used to test three sets of research questions. Descriptive research data in the form of frequencies and percentages were used to answer the first set of research questions. These questions included the following

1. What percentage of licensed psychologists and licensed clinical social workers disclose the diagnostic label BPD to patients?
2. What is the relationship between the percentage of licensed psychologists and the percentage of licensed clinical social workers who disclose the diagnostic label BPD?
3. What is the relationship between the gender of the professional and the disclosure of the diagnostic label BPD?
4. What is the relationship between the gender of the patient and the disclosure of the diagnostic label BPD?
5. What is the relationship between the frequency of working with individuals diagnosed with BPD and the disclosure of the diagnostic label?
6. What is the relationship between licensed psychologists' and licensed clinical social workers' theoretical orientation and the disclosure of the diagnostic label BPD?

The second set of questions is related to the MUM effect. These questions explored the relationship between the MUM effect and disclosure of BPD. Three multiple regression analyses were used to predict the relationship between the dependent variable disclosure and the independent variables concerns for self,

concerns for the patient, and societal norms. As found in previous studies, it was believed that these three variables would negatively impact disclosure (Merker et al., 2010). Three multiple regression analyses were also used to predict the relationship between the dependent variable disclosure and the independent variables gender, professional occupation, theoretical orientation, and frequency of working with individuals diagnosed with BPD.

1. Is there a significant relationship between the psychologists' and clinical social workers' concerns for self and the reluctance to disclose diagnostic information, as measured by the Breaking Bad News Questionnaire?

*H0*₁: There will not be a significant relationship between the psychologists' and clinical social workers' concerns for self and the reluctance to disclose diagnostic information, as measured by the Breaking Bad News Questionnaire.

*HA*₁: There will be a significant relationship between the psychologists' and clinical social workers' concerns for self and the reluctance to disclose diagnostic information, as measured by the Breaking Bad News Questionnaire.

2. Is there a significant relationship between the psychologists' and clinical social workers' concerns for the patient and the reluctance to disclose diagnostic information, as measured by the Breaking Bad News Questionnaire?

*H0*₁: There is not a significant relationship between the psychologists' and clinical social workers' concerns for the patient and the reluctance to

disclose diagnostic information, as measured by the Breaking Bad News Questionnaire.

*HA*₁: There is a significant relationship between the psychologists' and clinical social workers' concerns for the patient and the reluctance to disclose diagnostic information, as measured by the Breaking Bad News Questionnaire.

3. Is there a significant relationship between societal norms and the reluctance to disclose diagnostic information, as measured by the Breaking Bad News Questionnaire?

*H*₀₁: There will not be a significant relationship between norms and the reluctance to disclose diagnostic information, as measured by the Breaking Bad News Questionnaire.

*HA*₁: There will be a significant relationship between norms and the reluctance to disclose diagnostic information, as measured by the Breaking Bad News Questionnaire.

The third set of questions was asked during the qualitative phase to expand and elaborate on the quantitative responses.

1. Those who did not endorse a reluctance to disclose diagnostic information were asked, "You noted on your survey response that you always disclose diagnostic information regarding BPD. Please tell me more about that."
2. Those who did endorse a reluctance to disclose diagnostic information were asked, "You noted on your survey response that you never or rarely

disclose diagnostic information regarding BPD. Please tell me more about that.”

3. All of the participants were also asked, “How does explaining any of the 9 BPD diagnostic criteria to patients impact your willingness to disclose?”

Research Design and Rationale

A two-phase, sequential explanatory mixed methods design was used for this study. This two-phase methodological approach consisted of an initial quantitative data collection and analysis phase followed by a qualitative data collection and analysis phase. The use of a single method limits the responses, while using both approaches maximizes the potential of gathering an abundance of information about this topic (Creswell, 2003). The advantages of using a mixed methods approach for this study was especially important given that limited information was known about the diagnostic disclosure of psychiatric illnesses. The qualitative interviews were used to confirm and expand on information learned during the quantitative phase. A similar design was used by Merker et al. (2010) to study the attitudes of psychologists in regard to the general practice of breaking bad news. My study expanded on this research by exploring the disclosure practices of psychologists and clinical social workers specific to BPD.

There are several advantages to using a mixed methods approach. Creswell (2003) noted that a mixed methods approach is useful in neutralizing or cancelling the limitations inherent in the use of a single method. Additionally, sequential designs improve the validity of results by allowing the researcher to use the results from one method to inform or expand the results of the second method. The use of a mixed

methods design allowed for the collection of numeric information along with detailed perspectives from the participants. This approach was appropriate because limited information was available regarding the disclosure of diagnostic information.

During the quantitative phase of the study, licensed psychologists and licensed clinical social workers were asked to complete an online survey. There are a variety of advantages to using surveys each contributing to why it was the chosen method for this research. Surveys are an efficient means of gathering information about the attitudes of participants by surveying a sample of the population (Creswell, 2003). Surveys offer the possibility of anonymity and privacy that encourages respondents to answer honestly to sensitive issues (Babbie, 2007). Anonymity was especially important for this research because participants were asked to answer questions regarding their attitudes toward disclosing a controversial diagnosis. Babbie noted that an advantage of surveys is that respondents may feel more comfortable reporting controversial or deviant attitudes. Additionally, surveys are a convenient way of gathering a significant amount of data in a timely manner. Surveys are also relatively inexpensive when compared to other methods making them both time efficient and cost effective (Babbie, 2007). Surveys have been the primary method used by other researchers exploring this topic and were an appropriate method for this research. The advantages of using a survey for this research also included the fact that it was cost effective and time efficient.

An online survey is a self-administrated questionnaire that uses the Internet to collect data from participants. Online surveys offer several advantages including a high response rate and increased data quality (Evans & Mathur, 2005; Tuten et al.,

2010; Wright, 2006). Tuten et al. noted that online surveys can be especially useful when requesting information on attitudes that may be subject to socially desirable responding. Online surveys provide additional anonymity that allows respondents to provide honest answers to sensitive questions (Tuten et al., 2010). Online surveys are also cost effective and more efficient when compared to other methods.

SurveyMonkey was used for this research because it is a secure and private method for collecting data. In addition to completing demographic information, the participants were asked to take a short survey at the same time.

During the qualitative phase of the research, purposeful sampling was used to identify a subset of participants meeting criteria to participate in a telephone interview in order to validate and expands on the quantitative results. The inclusion criteria will be discussed in the setting and sample section of this paper. There are several advantages of telephone interviews. Questions can be refined and changed as additional information is learned (Creswell, 2003). When compared to survey research, interviews are more flexible allowing participants to provide a variety of views and options in response to the research questions. Interviews were useful for this study since limited information was available explaining why psychologists and clinical social workers choose to disclose or not to disclose diagnostic information.

Setting and Sample

In order to identify the reasons why psychologists and clinical social workers do or do not inform patients when they have diagnosed BPD, the participants of this study were recruited from a random sample of licensees from the Minnesota Board of Psychology and the Minnesota Board of Social Work.

The Minnesota Board of Social Work provided a random sample of 999 of the approximate 10,000 licensed clinical social workers in the state of Minnesota. The Minnesota Board of Psychology provided a complete list of the 3,783 licensed psychologists in the state of Minnesota. Online surveys generally have a 30% response rate and it was expected that approximately 30% of these professionals would respond to my survey. Since I chose to contact these professionals via e-mail to complete the online survey, those who did not provide a public e-mail address were eliminated from the sample. Additionally, those psychologists and clinical social workers who listed their address as a school or other agency such as a rehabilitation center where it is unlikely that individuals have been diagnosed with BPD were eliminated. The remaining psychologists and clinical social workers were included in the study.

Instruments

The survey measure chosen for the quantitative phase of this research is the Breaking Bad News Questionnaire (Eberhardt-McKee & Ptacek, 2001). Though originally used with college students, Merker et al. (2010) modified this measure to use with licensed psychologists. Merker (personal communication, November 7, 2012) gave permission to use the modified instrument and to make any necessary changes deemed appropriate for my study. The original author was also contacted to receive permission to use the modified version in my study. Eberhardt McKee (personal communication, October 8, 2013) provided permission to use the survey and make any necessary changes for my research. I chose to slightly alter the instructions changing the words breaking bad news to diagnostic disclosure. In

addition to completing the Breaking Bad News Questionnaire, the participants were asked to answer six questions from the Disclosure Questionnaire I created that are associated with the disclosure of BPD. Demographic information was also collected.

Disclosure Questionnaire

The Disclosure Questionnaire (Appendix A) is a six-item survey I developed to measure how often licensed psychologists and licensed clinical social workers disclose the diagnostic label BPD. Gender is another variable that the survey measures. Examples of survey questions include (a) “how often do you inform patients that they have been diagnosed with BPD and (b) to what extent does the patient’s gender (male) influence your decision to disclose diagnostic information regarding BPD?” Answers to how often licensed psychologists and licensed clinical social workers disclose diagnostic information were given on a 5-point Likert scale ranging from *always* to *never*. The remaining answers were given on a 7-point Likert scale ranging from *not at all* to *a great extent*.

Breaking Bad News Questionnaire

The Breaking Bad News Questionnaire (Appendix B) was created by Eberhardt-Mckee and Ptacek (2001) assessed undergraduate students’ recollection of a time they had broken bad news. The survey essentially measures the three areas associated with the MUM effect that are believed to moderate the disclosure of undesirable information (Eberhardt-Mckee & Ptacek, 2001). These three areas include (a) psychological costs to the communicator, (b) concerns for the recipient, and (c) societal norms. Seventy-two statements assess the characteristics believed to be associated with delivering difficult news. Answers are given on a 7-point Likert

scale ranging from *made easier* to *made harder*. The authors did not provide the psychometric data associated with this questionnaire.

In a later study, Merker et al. (2010) reduced the Breaking Bad News Questionnaire to 29 questions and used it to survey psychologists about breaking bad news. Their modified survey also measures the three areas associated with the MUM effect believed to moderate the disclosure of undesirable information including: (a) psychological costs to the communicator, (b) concerns for the recipient, and (c) societal norms. The psychological costs to the communicator that apply to my study include (a) a fear of being blamed, (b) being physically harmed by the patient, and (c) wanting to avoid the negative emotional state associated with disclosing undesirable information. The concerns for the recipient include (a) fears of upsetting the patient, (b) concerns for the patient's safety, and (c) misdiagnosis leading to additional harm. Lastly, the societal norms include (a) an ethical responsibility, (b) the importance of preserving the therapeutic relationship, and (c) disagreement regarding when disclosure is required. The modified version demonstrated good internal consistency using Cronbach's alpha: .891. Validity evidence was obtained using exploratory factor analysis. A three-factor solution was chosen and included concerns for self and the process of disclosing undesirable information, concerns for client, and societal norms. These three factors are consistent with the categories first described by Tesser and Rosen (1972) that were discussed in Chapter 2. This modified version was the version used for my research.

Demographic Questionnaire

In addition to the questionnaires previously mentioned, participants were asked to complete a demographic questionnaire developed for this study (Appendix C). I used the demographic questionnaire to provide information on the respondents' gender, theoretical orientation, and frequency of working with individuals diagnosed with BPD.

Procedures

The Walden University's Institutional Review Board (IRB) approved all aspects of this study before data collection began. An e-mail was sent to all potential participants explaining the purpose of the study, estimated time to complete the survey and assurance that their participation was confidential and voluntary. Participants were informed that they could withdraw from the study at any time during the data collection period. Those interested in participating were instructed to click on the direct link to SurveyMonkey. Upon entering SurveyMonkey, participants were provided with an informed consent statement. This provided potential participants with a statement regarding confidentiality, ethical issues and my contact information. After reading the informed consent statement, if they agreed to participate the participants were asked to click on the Agree to Participate icon. If they decide not to participate in the survey, they were instructed to exit the webpage.

The participants that provide consent proceeded to the survey portion of the research. The survey questions are designed to allow respondents to point-and-click with a mouse on their desired response on a Likert scale. The demographic portion of the survey includes multiple-choice questions. After completing the study, participants had the option of providing their e-mail address to receive the results.

Following the initial data collection and analysis phase, purposeful sampling was used to select those psychologists and clinical social workers who during the first phase of the research identified that they either *rarely* or *never* disclose diagnostic information regarding BPD by endorsing a 4 or 5 on the survey or that they *always* or *usually* disclose information regarding BPD by endorsing a 1 or 2 on the survey. A random sample from this subgroup was sent an additional e-mail requesting their consent to contact them and ask additional information about their survey responses. During the telephone interview, participants reporting that they rarely or never disclose were asked, “You noted on your survey response that you rarely or never disclose diagnostic information regarding BPD. Please tell me a little more about that.” This group of participants was also asked, “How does explaining any of the nine BPD diagnostic criteria to patients impact your willingness to disclose? Those that did not endorse a reluctance to disclose diagnostic information were asked, “You noted on your survey response that you always disclose diagnostic information regarding BPD. Please tell me more about that.” The telephone interviews were audio recorded. Following the interviews, the telephone conversations were transcribed in their entirety and general themes were developed through a content analysis.

Data Collection and Analysis

Subsequent to the quantitative data collection phase, all responses were downloaded from SurveyMonkey into Software Package for the Social Sciences (SPSS) for data analysis. Descriptive statistics such as frequencies and percentages were used to analyze the data. Three separate multiple regression analyses were used to determine the relationship between the dependent variable disclosure and

independent variables concerns for self, concerns for the patient, societal norms, gender, theoretical orientation, professional occupation, and years of experience working with individuals with BPD. A multiple regression analysis was chosen because it can be used to predict the relationship between several variables. Multiple linear regression analysis allows for the control of a third variable, which will be used to explore the relationship each independent variable and the dependent variable disclosure (Gravetter & Wallnau, 2007). Statistical power refers to the probability of accurately rejecting the null hypothesis when it is false (Gravetter & Wallnau, 2007). A power analysis for a multiple regression with nine predictor variables was conducted to determine the minimum number of participants needed to achieve sufficient power for my study. Based on a power size of .80, which is typical for this type of study and an effect size of .15, the minimum sample size needed was 113 (Soper, 2015).

In the second phase of the research, results from the statistical analysis were used to provide direction for the qualitative phase. The results of the statistical and qualitative analysis are presented in Chapter 4.

Ethical Considerations

Prior to their participation in the study, participants received an informed consent statement explaining the purpose of the study, confirmation that their participation in the study is completely voluntary and permission to withdraw at any time during the data collection period. Participants were informed that data collected will be stored in a password protected computer hard drive accessible to me. The consent clearly stated that by clicking on the agree to participate icon, they are

providing informed consent and confirmation that they understand their rights. Participants were also provided with my contact information for questions. They were informed that they can contact me following the completion of the study if they desire a copy of the results. The consent guaranteed participants that any contact with me will remain confidential.

SurveyMonkey was used to collect and manage data during the quantitative phase and offers an explicit guarantee of security and privacy of all research files. Responses were collected through the use of a web link collector. A web link collector is a versatile method of gathering data that allows the creator to generate a survey URL that can be posted in an e-mail to participants. The web collector was constructed in a manner that allowed e-mail addresses to be tracked for follow up in the qualitative phase of the research. The survey did not ask respondents to provide additional identifying information. Subsequent to being downloaded from the SurveyMonkey website, raw data is stored on my secure hard drive and kept for a period of 5 years. Following 5 years, I will permanently destroy the data deleting it from my hard drive.

The survey concluded with a message thanking participants for their participation and contribution to the research. While there is no reason to believe that the survey would cause harm or distress to the participants, the thank you page also included my telephone number for additional questions or concerns.

Those participants meeting criteria for the second phase of the study were notified via e-mail requesting their consent to contact them and ask additional information about their survey responses. The email reminded participants of the

purpose of the study, estimated time to complete the interview and assurance that their participation is voluntary. Participants were reminded they can withdraw from the study at any time during the data collection period. The consent clearly stated that by returning an e-mail with their phone number, they are providing informed consent and confirmation that they understand their rights. Participants were provided with my contact information for questions. They were reminded that they can contact me following the completion of the study if they desire a copy of the results. The consent guaranteed participants that any contact with me will remain confidential. The raw data generated from the telephone interviews will be stored on my secure hard drive and kept for a period of 5 years. Following 5 years, I will permanently destroy the data deleting it from my hard drive.

Summary

This mixed methods study employed a survey design during the initial phase of data collection and analysis followed by a telephone interview in the second phase. The focus of the investigation was to identify how often licensed psychologists and licensed clinical social workers inform patients of the diagnostic label BPD and to identify how these professionals choose to disclose or not to disclose. Of further interest was the impact of the diagnostic criteria, gender, theoretical orientation, professional occupation, and frequency of working with individuals diagnosed with BPD. In Chapter 4, I present the results of this analysis and in Chapter 5 I discuss the results of this study and the insights gained about diagnostic disclosure as it relates to BPD.

Chapter 4: Results

Introduction

In Chapter 4, I begin first with a review of the data collection with an emphasis on the recruitment, sampling, data screening, and interview processes. Followed by a presentation of descriptive statistics for demographic variables including theoretical orientation, professional occupation, gender, and how frequently participants work with individuals diagnosed with BPD. Secondly, I present the frequency data for how often licensed psychologists and licensed clinical social workers inform patients that they have a diagnosis of BPD. I also present the multiple linear regression analyses results for Questions 2,3,5,7, 8, 9 and their associated hypotheses. Included are the results for the relationships involving the independent variables of concerns for the self, concerns for the patient, societal norms, gender, professional occupation, theoretical orientation, frequency of working with individuals diagnosed with BPD, and their relationship to the dependent variable of disclosure. Thirdly, I present the qualitative data analysis regarding the choice to disclose or not to disclose. This chapter concludes with a summary of the results.

Data Collection

Participants were recruited in two phases. The first data collection phase lasted for 2 weeks and was focused on recruitment for the quantitative phase of my research. The target population for the first phase was all licensed psychologists and a random sample of licensed clinical social workers in the state of Minnesota, which when combined included a total of 4,782 potential participants. After excluding participants

who did not provide an e-mail address, as well as participants working in schools, rehabilitation centers, and primarily with children, the total sample size was 3,359.

Recruitment for the second phase lasted an additional 3 weeks. Purposeful sampling was used to select those psychologists and clinical social workers who during the first phase of my study identified that they either *rarely* or *never* disclose diagnostic information regarding BPD by endorsing a 4 or 5 on the Disclosure Questionnaire (Appendix A) or that they *always* disclose diagnostic information regarding BPD by endorsing a 1 on the survey. All members from this subgroup were sent an additional e-mail requesting their consent to contact them by telephone and gather additional information about their survey responses. A total of 75 participants met criteria for the second phase of my study. Data collection proceeded as planned in Chapter 3.

Preliminary Analysis

Data Screening

SurveyMonkey was used to collect and record responses from the 240 participants that partook in the first phase. All participants who responded to the survey indicated agreement to the statement of consent. Data were screened for accuracy and missing information. Responses with missing data were removed and 63 responses were removed for nonresponsive data. A total of 177 participants completed the survey for a response rate of 5%, which is significantly lower than what is expected for online surveys (Creswell, 2003). Although this response rate was lower than anticipated, a power analysis for a multiple regression with nine predictor variables was conducted to determine the minimum number of participants needed to

achieve sufficient power for my study. Based on a power size of .80, which is typical for this type of study and an effect size of .15, the minimum sample size needed was 113 (Soper, 2015).

For the second phase, telephone interviews of a total of 13 subjects were audio recorded and immediately transcribed. The 13 subjects fell into two groups. The first group ($n = 7$) consisted of Phase 1 participants who responded that they *always* disclose diagnostic information regarding BPD on the Disclosure Questionnaire. Two additional participants in this category agreed to participate in a telephone interview but were unavailable at the agreed upon time. The second group of interviews ($n = 6$) consisted of participants who responded that they *never or rarely* disclose diagnostic information on the Disclosure Questionnaire. One additional member in this category expressed interest via e-mail but did not respond to voice mail messages to schedule an interview.

Descriptive Statistics

All demographic data were collected from the self-report demographic measure that each participant completed (Appendix C). The majority of participants were female ($n = 120, 70\%$) and licensed psychologists ($n = 125, 74\%$). Many of the participants cited cognitive behavioral therapy as their primary theoretical orientation ($n = 83, 49\%$) and seven ($n = 34, 19.88\%$) with ten being highest was the most common response for how frequently participants worked with individuals diagnosed with BPD. Frequencies and percentages for participant demographics are presented in Table 1.

Table 1

Frequencies and Percentages for Participant Demographics

Variables	<i>N</i>	%
Gender		
Female	120	70
Male	51	30
Professional occupation		
Clinical social worker	45	26
Licensed Psychologist	125	74
Theoretical Orientation		
Behavioral	5	3
Eclectic/Integrative	50	30
Humanistic/Existential	4	2
Interpersonal	11	7
Psychodynamic or Psychoanalytic	12	7
Cognitive Behavioral Therapy	83	49
Systems	3	2
How often do you work with		
1 Not frequently	16	9
2	8	5
3	17	10
4	10	6
5	15	9
6	19	11
7	34	20
8	24	14
9	7	4
10 Frequently	21	12

Note. Due to rounding error, percentages may not add to 100.

Quantitative Results

Research Questions 2 and 4

2. What percentage of licensed psychologists and licensed clinical social workers in the state of Minnesota disclose the diagnostic label BPD to patients?
4. What is the relationship between the gender of the patient and the disclosure of the diagnostic label BPD?

The frequency of disclosing diagnostic information regarding BPD was collected using the Disclosure Questionnaire. Possible responses included *always*, *usually*, *sometimes*, *rarely*, and *never*. The frequency data for those who *always* disclose ($n = 51$, 30%) and those who *usually* disclose ($n = 52$, 31%) were very close in number. The next most common response was *sometimes* ($n = 39$, 23%). The least popular responses included *rarely* ($n = 18$, 11%) and *never* ($n = 6$, 4%).

Data examining the relationship between gender of the patient and disclosure of the diagnostic label BPD were also collected using the Disclosure Questionnaire. Participant responses were ranked on a 7-point scale ranging from *not at all* to *a great extent*. The majority of participants indicated that the gender of the patient did not impact disclosure, women, 104 (62%) and men, 105 (63%). Only one participant indicated that a patient being male would impact disclosure to *a great extent*. Frequencies and percentages for research questions 2 and 4 are presented in Table 2.

Table 2

Response Rates for Disclosure Questionnaire Items 1 and 4

Disclosure survey item	<i>N</i>	%
Frequency of disclosure		
Always	51	30
Usually	52	31
Sometimes	39	23
Rarely	18	11
Never	6	4
Patient's Gender (female) Impact Disclosure		
Not At All	104	62
2	33	20
3	11	7
To Some Extent	10	6
5	7	4
6	0	0
A Great Extent	0	0
Patient's Gender (male) Impact Disclosure		

	Not At All	105	63
	2	33	20
	3	10	6
	To Some Extent	11	7
	5	4	2
	6	2	1
	A Great Extent	1	1

Note. Due to rounding error, percentages may not add up to 100.

Research Questions 2, 3, 5 and 6

2. What is the relationship between the percentage of licensed psychologists and the percentage of licensed clinical social workers that disclose the diagnostic label BPD?
3. What is the relationship between the gender of the professional and the disclosure of the diagnostic label BPD?
5. What is the relationship between the frequency of working with individuals diagnosed with BPD and the disclosure of the diagnostic label BPD?
6. What is the relationship between licensed psychologists' and licensed clinical social workers' theoretical orientation and the disclosure of the diagnostic label BPD?

Frequencies and percentages are presented for research questions 2, 3, 5, and 6 from the Disclosure and Demographic Questionnaires. The licensed psychologists

indicated that they *usually* disclose ($n = 36, 30\%$) most frequently while *always* ($n = 35, 29\%$) was the second most common response. This was also true for licensed clinical social workers; *always* ($n = 16, 36\%$) and *usually* ($n = 15, 34\%$) were the most common responses. None of the licensed clinical social workers stated that they *never* disclose and only ($n = 6, 5\%$) of the licensed psychologists stated that they *never* disclose.

A multiple linear regression analysis was performed to explore the relationship between the independent variable professional occupation and the dependent variable disclosure, $r = .31, p = .087$. The results showed that professional occupation did not make an independent contribution to the prediction of disclosure when the variables of concerns for self, concerns for the patient, societal norms, gender, theoretical orientation, and frequency of working with individuals diagnosed with BPD were controlled for. The results are presented in Table 4.

The majority of male participants ($n = 19, 40\%$) indicated that they *always* disclose diagnosed information regarding BPD. The second most common response for males was *usually* ($n = 14, 30\%$). The majority of female participants ($n = 38, 32\%$) stated that they *usually* disclose diagnostic information while $n = 32 (27\%)$ stated that they *always* disclose.

A multiple linear regression analysis was performed to explore the relationship between the independent variable gender of the professional and the dependent variable disclosure. The results showed that gender of the professional was a significant independent predictor of disclosure, $r = 0.49, p < .008$, suggesting that males had

disclosure scores that were 0.49 units lower than the female participants when the other variables of concerns for self, concerns for the patient, societal norms, professional occupation, theoretical orientation, and frequency of working with individuals diagnosed with BPD were controlled for. Results are presented in Table 4.

Participants were asked to indicate how frequently they work with individuals diagnosed with BPD by choosing 1 through 10 on a scale with 10 being highest. Those subjects that responded with a 10 reported disclosing *always* ($n = 14$, 28%) most frequently and *never* ($n = 2$, 4%) least frequently. Of the participants that responded by choosing 1, none of them stated that they *always* disclose and $n = 3$ (50%) stated that they *never* disclose.

A multiple linear regression analysis was performed to assess the relationship between the independent variable frequency of working with individuals diagnosed with BPD and the dependent variable disclosure. The results showed that frequency of working with individuals diagnosed with BPD was a significant independent predictor of disclosure, $r = .14$, $p < .001$, suggesting that for every one unit increase in frequency, disclosure decreased by 0.12 units when the other variables of concerns for self, concerns for the patient, societal norms, gender, theoretical orientation, and professional occupation were controlled for. The results are presented in Table 4.

Those who indicated that cognitive behavioral therapy was their primary theoretical orientation chose *always* ($n = 31$, 38%) most frequently and *never* ($n = 2$, 3%) least frequently. Those who chose behavioral therapy as their primary theoretical

orientation chose *always* ($n = 2, 50\%$) most frequently and *never* ($n = 0, 0\%$) least frequently. *Usually* and *sometimes* were the most common responses for the remaining theoretical orientations. Frequencies and percentages for research questions 2, 3 5 and 6 are presented in Table 3.

A multiple linear regression was conducted to assess the relationship between the independent variable theoretical orientation and the dependent variable disclosure. The results showed that theoretical orientation did not make an independent contribution to the prediction of disclosure, cognitive behavior therapy and behavioral therapy ($r = .08, p = .881$), eclectic/integrative ($r = .22, p = .671$), humanistic/existential ($r = -.36, p = .672$) interpersonal ($r = .17, p = .773$), psychodynamic/psychoanalytic ($r = .58, p = .308$), systems ($r = .07, p = .030$) when the other variables of concerns for self, concerns for the patient, theoretical orientation, societal norms, professional occupation, gender, and frequency of working with individuals diagnosed with BPD were controlled for. The results are presented in Table 4.

Table 3

Response Rates Research Questions 2, 3 5 and 6

	Male		Female	
	<i>N</i>	%	<i>N</i>	%
Frequency of Disclosure				
Always	19	40	32	27

Usually	14	30	38	32
Sometimes	7	15	31	26
Rarely	5	11	13	11
Never	1	2	5	4

Frequency of Disclosure	Clinical Social Worker		Licensed Psychologist	
	<i>N</i>	%	<i>N</i>	%
Always	16	36	35	29
Usually	15	34	36	30
Sometimes	9	21	29	24
Rarely	3	7	15	12
Never	0	0	6	5

Theoretical Orientation	<i>n</i>	%
Cognitive Behavioral Therapy		
Always	31	38
Usually	26	32
Sometimes	13	16

	Rarely	9	11
	Never	2	3
Behavioral			
	Always	2	50
	Usually	0	0
	Sometimes	2	50
	Rarely	0	0
	Never	0	0
Humanistic / Existential			
	Always	1	25
	Usually	2	50
	Sometimes	0	0
	Rarely	0	0
	Never	1	25
Psychodynamic or Psychoanalytic			
	Always	1	8
	Usually	4	33
	Sometimes	4	33
	Rarely	2	17
	Never	0	0
Interpersonal			

	Always	2	20
	Usually	3	30
	Sometimes	3	30
	Rarely	1	10
	Never	1	10
Systems			
	Always	1	33
	Usually	1	33
	Sometimes	1	33
	Rarely	0	0
	Never	0	0
Eclectic / Integrative			
	Always	12	24
	Usually	16	32
	Sometimes	14	28
	Rarely	6	12
	Never	1	2

Disclosure Responses for Each Level of Frequency of Working with Individuals with BPD

	Disclosure				
	Always	Usually	Sometimes	Rarely	Never

Frequency	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%	<i>n</i>	%	<i>N</i>	%
1	2	4	2	4	3	8	4	22	3	50
2	0	0	2	4	3	8	2	11	1	17
3	5	10	5	10	4	10	2	11	0	0
4	2	4	4	8	2	5	1	6	1	17
5	6	12	3	6	4	10	1	6	0	0
6	3	6	9	17	4	10	2	11	1	17
7	8	16	14	27	9	23	3	17	0	0
8	9	18	11	21	2	5	2	11	0	0
9	2	4	2	4	2	5	0	0	0	0
10	14	28	0	0	6	15	1	6	0	0

Note. Due to rounding error, percentages may not add up to 100.

Research Questions 7, 8 and 9

7. Is there a significant relationship between the psychologists' and clinical social workers' concerns for self and the reluctance to disclose diagnostic information, as measured by the Breaking Bad News Questionnaire?

*H0*₁: There will not be a significant relationship between the psychologists' and clinical social workers' concerns for self and the reluctance to disclose diagnostic information, as measured by the Breaking Bad News Questionnaire.

*HA*₁: There will be a significant relationship between the psychologists' and clinical social workers' concerns for self and the reluctance to disclose diagnostic information, as measured by the Breaking Bad News Questionnaire.

8. Is there a significant relationship between the psychologists' and clinical social workers' concerns for the patient and the reluctance to disclose diagnostic information, as measured by the Breaking Bad News Questionnaire?

*H0*₁: There is not a significant relationship between the psychologists' and clinical social workers' concerns for the patient and the reluctance to disclose diagnostic information, as measured by the Breaking Bad News Questionnaire.

*HA*₁: There is a significant relationship between the psychologists' and clinical social workers' concerns for the patient and the reluctance to disclose diagnostic information, as measured by the Breaking Bad News Questionnaire.

9. Is there a significant relationship between societal norms and the reluctance to disclose diagnostic information, as measured by the Breaking Bad News Questionnaire?

*H0*₁: There will not be a significant relationship between norms and the reluctance to disclose diagnostic information, as measured by the Breaking Bad News Questionnaire.

*HA*₁ There will be a significant relationship between norms and the reluctance to disclose diagnostic information, as measured by the Breaking Bad News Questionnaire.

To examine research questions 7, 8 and 9 a separate multiple linear regression analyses was conducted for each question to assess if the independent variables concerns for self, concerns for the patient, societal norms, gender, professional occupation, theoretical orientation, and frequency of working with individuals diagnosed with BPD predicted the disclosure of the diagnostic label BPD. The gender of the patient was not included in the multiple regression analyses since it is clear from the descriptive statistics that gender of the patient does not impact disclosure.

A multiple linear regression analysis was conducted to assess the relationship between the independent variable concerns for self and the dependent variable disclosure. The results showed that concerns for self did not make an independent contribution to the prediction of disclosure, $r = .02$, $p = .120$ when the other variables of gender, professional occupation, theoretical orientation, and frequency of working with individuals diagnosed with BPD were controlled for. Therefore, the null hypothesis could not be rejected.

Results of the multiple linear regression are presented in Table 4.

Table 4

Results for Multiple Linear Regression With Gender, Professional Occupation, Theoretical Orientation, Frequency, and Concerns For Self Predicting Disclosure

Source	<i>B</i>	<i>SE</i>	β	<i>T</i>	<i>P</i>
--------	----------	-----------	---------	----------	----------

Concerns For Self	-0.02	0.01	.00	-1.56	.120
Licensed Psychologist (ref: Clinical Social Worker)	0.31	0.18	.13	1.72	.087
Cognitive Behavioral Therapy (ref: Behavioral)	-0.08	0.51	-.04	-0.15	.881
Eclectic/Integrative (ref: Behavioral)	0.22	0.51	.10	0.43	.671
Humanistic/Existential (ref: Behavioral)	-0.36	0.75	-.05	-0.49	.627
Interpersonal (ref: Behavioral)	0.17	0.59	.04	0.29	.773
Psychodynamic or Psychoanalytic (ref: Behavioral)	0.58	0.57	.14	1.02	.308
Systems (ref: Behavioral)	0.07	0.75	.01	0.09	.930
Frequency	-0.14	0.03	-.35	-4.57	.001

Note. $F(10,146) = 3.64, p < .001, R^2 = 0.20$

A second multiple linear regression analysis was conducted to assess the relationship between the independent variable concerns for the patient and the dependent variable disclosure. The results showed that concerns for the patient did not make an independent contribution to the prediction of disclosure, $r = .02$, $p = .56$ when the other variables gender, professional occupation, theoretical orientation, and frequency of working with individuals diagnosed with BPD were controlled for. Therefore, the null hypothesis could not be rejected. Results of the multiple linear regression analysis are presented in Table 5.

Table 5

Results for Multiple Linear Regression with Gender, Professional Occupation, Theoretical Orientation, Frequency, and Concerns For Patient Predicting Disclosure

Source	<i>B</i>	<i>SE</i>	β	<i>t</i>	<i>P</i>
Concerns For Patient	-0.02	0.01	.00	-1.93	.056
Male (ref: Female)	-0.46	0.18	-.20	-2.57	.011
Licensed Psychologist (ref: Clinical Social Worker)	0.30	0.18	.13	1.71	.090
Cognitive Behavioral Therapy (ref: Behavioral)	-0.17	0.50	-.08	-0.35	.730
Eclectic/Integrative (ref: Behavioral)	0.14	0.51	.06	0.29	.776

Humanistic/Existential (ref: Behavioral)	-0.50	0.74	-.07	-0.67	.505
Interpersonal (ref: Behavioral)	0.06	0.58	.01	0.10	.922
Psychodynamic or Psychoanalytic (ref: Behavioral)	0.55	0.56	.13	0.97	.331
Systems (ref: Behavioral)	0.11	0.74	.01	0.14	.885
Frequency	-0.14	0.03	-.34	-4.53	.001

Note. $F(10,146) = 3.80, p < .001, R^2 = 0.21$

A third multiple linear regression analysis was conducted to explore the relationship between the independent variable societal norms and the dependent variable disclosure. The results showed that societal norms were a significant independent predictor of disclosure, $r = 0.08, p < .001$, suggesting that for every one unit increase in societal norms, disclosure decreased by 0.08 units when the other variables gender, professional occupation, theoretical orientation, and frequency of working with individuals diagnosed with BPD were controlled for. Societal norms include an ethical responsibility and the importance of preserving the therapeutic relationship (Merker et al., 2010). Therefore, the null hypothesis was rejected. Results of the multiple linear regression analysis are presented in Table 6.

Table 6

Results for Multiple Linear Regression with Gender, Professional Occupation, Theoretical Orientation, Frequency, and Societal Norms Predicting Disclosure

Source	<i>B</i>	<i>SE</i>	β	<i>T</i>	<i>P</i>
Societal Norms	-0.08	0.02	.00	-3.42	.001
Male (ref: Female)	-0.44	0.17	-.19	-2.50	.013
Licensed Psychologist (ref: Clinical Social Worker)	0.25	0.17	.10	1.41	.162
Cognitive Behavioral Therapy (ref: Behavioral)	-0.13	0.48	-.06	-0.26	.793
Eclectic/Integrative (ref: Behavioral)	0.10	0.49	.05	0.21	.834
Humanistic/Existential (ref: Behavioral)	-0.35	0.72	-.05	-0.49	.626
Interpersonal (ref: Behavioral)	-0.00	0.57	-.00	-0.01	.995
Psychodynamic or Psychoanalytic (ref: Behavioral)	0.60	0.55	.15	1.09	.277
Systems (ref: Behavioral)	-0.19	0.72	-.03	-0.27	.789

Frequency	-0.12	0.03	-.30	-3.98	.001
-----------	-------	------	------	-------	------

Note. $F(10,146) = 4.78, p < .001, R^2 = 0.25$

Qualitative Results

Following the completion of the quantitative phase, those participants that met criteria for participation in the second phase of my research were sent an e-mail requesting their participation. A total of 13 out of 75 respondents agreed to participate in the qualitative portion. The 13 subjects fell into two groups. The first group ($n = 7$) consisted of Phase 1 participants who responded that they *always* disclose diagnostic information. The second group ($n = 6$) consisted of phase one participants who responded that they *never* or *rarely* disclose diagnosed information. Since there were so few participants in the *never* category, this category was combined with participants that responded with *rarely*. I divided respondents into two groups, based upon their response to Question 1 of the Disclosure Questionnaire (Appendix A). Question 1 of this questionnaire asked, "How often do you inform patients that they have been diagnosed with BPD?" Respondents were allowed to choose from one of five response options on a Likert Scale. The response options were *always*, *usually*, *sometimes*, *rarely*, and *never*. Participants who responded *usually* and *sometimes* were not included in the qualitative portion of my study.

The participants in each of the groups were asked to respond to a set of two open-ended prompts. These prompts were as follows:

1. “You noted on your survey response that you *never/rarely or always* disclose diagnostic information regarding BPD to clients. Please tell me more about that.”
2. “How does explaining any of the nine BPD diagnostic criteria to patients impact your willingness to disclose?”

I examined the responses of each group to assess for commonalities or themes that emerged from the data. A content analysis design was used with emphasis on constant comparison. The constant comparison method is used to assess participant responses for themes with an emphasis on comparing developing themes with each additional participant's response to compile support for each theme. This method was chosen as it is the most appropriate method to discover how participants tended to respond to questions regarding the disclosure of the BPD diagnostic label. As each participant's responses were gathered, they were compared with previous responses and assessed for similarities or differences (Glaser, 1965). Data were constantly compared with previously collected responses by means of coding or categorization into a series of themes. Any response which could be categorized into an existing theme was coded as such, while responses that did not correspond with any existing themes were considered a potential new theme into which future responses could fall. Upon completion of this phase, responses were re-assessed to determine if any of the data could be categorized into the themes which emerged after the initial reading. As increasing amounts of textual data were examined, commonalities in meaning from interviewee to interviewee became

apparent and were considered to follow a similar general idea. This methodological model allowed an examination of experiences, techniques, and opinions that the sample reported overall. I will present these themes in the sections to follow, organized by respondent group.

Rarely or Never Respondents

Six respondents reported that they *rarely* or *never* disclose the diagnostic label BPD to their clients. These respondents were asked to provide additional information to two open-ended prompts. The first prompt was, “You noted on your survey response that you rarely or never disclose diagnostic information regarding BPD to clients. Please tell me a little more about that.” The second prompt was, “How does explaining any of the nine BPD diagnostic criteria to patients impact your willingness to disclose?” Several themes were identified among the responses. Themes were identified based on responses to both prompts overall, as the first prompt alone did not provide sufficient data for independent analyses. The themes identified from these responses were the following:

- Several participants modified their initial response to the questionnaire item.
- Disclosure of a BPD diagnosis can lead to defensiveness and other negative client reactions.
- The stigma attached to the BPD diagnosis is an important consideration.
- Explaining the diagnostic criteria is not a factor in the decision to disclose, and can be a helpful tool.

These themes will be explained in detail in the sections to follow.

Negative case analysis. Three of the six respondents modified or contradicted their responses concerning their preference to never or rarely disclose the BPD diagnosis to a client. Respondent 10 clarified that a diagnosis should be explained within a larger behavioral therapeutic context, saying, “I would try to explain [the diagnosis] in a context that they would understand rather than just say well here is your diagnosis.” Respondents 11 and 12 both expressed disagreement with their previously offered responses. Respondent 11 stated, “You know that’s probably not accurate that it’s rarely or never.” Respondent 12 similarly asked, “Did I say rarely or never? Well you know that’s odd because I do um disclose it sometimes but I might have picked rarely because I don’t you know I don’t know why I picked that.” These participants were still considered a part of the *rarely* or *never* group of respondents.

Stigma of diagnosis. Several respondents discussed the stigma associated with the BPD diagnosis as an important implication of disclosing the diagnosis to clients. The respondents indicated that they preferred to de-emphasize the label to the client. Respondent 5 reported, “It has a really bad reputation borderline personality and clients usually by the time they fit the criteria for that diagnosis, they have been through enough psychotherapy they know what a bad reputation [BPD] has.” Respondent 12 supported this point saying, “Because some people just think borderline personality means difficult patient you know and I, that’s not my opinion, but the thing is because of all that bad press of borderline um I don’t bring that up right away.” Respondent 5 explained further:

I feel like I don't need clients looking up what their disorder is so they can feel more labeled or feel more like this is a condition that I have that I am never gonna be able to get rid of. I feel like it is more of kind of looking at the behaviors as behaviors and so I am more careful with borderline but just that is my general rule.

Respondent 10 similarly reported, "Rather than say here is your diagnosis, I would probably talk to somebody like, 'Some of the behaviors that you're talking about are on a continuum of what would be called um borderline.'" To this point, Respondent 9 reported greater interest in explaining to the client "the substructures of [BPD] or what are the symptoms of that, more so than I would be concerned about the diagnostic label its self."

Respondent 13 similarly explained,

Often times I will talk to the person about the symptoms they have ... I will talk to them about you're an emotional kind of person that feels things very strongly and that can cause some problems for you, let's work on that.

Respondent 13 added, "That sort of approach [allows me] to get around saying, 'Well, you're borderline.'" "

Diagnostic disclosure can lead to client defensiveness. Several respondents raised the point that disclosure of a BPD diagnosis can lead to defensiveness and other negative reactions from clients. Respondent 13 offered the following explanation:

Well it's something I struggle with because a part of me says a person needs to know what they are dealing with, they have every right to know what their

diagnosis is. On the other hand, for many people a personality disorder diagnosis is pejorative and they don't want to hear it, don't like the implications of hearing that diagnosis.

Respondent 5 argued that disclosure of the BPD diagnosis “perpetuates the behaviors and I feel like it also can damage the relationship between the client and me because then they think that I think they are really screwed up because no one wants to be a borderline client.” Respondent 10 described the negative reaction that some clients have to the diagnosis as “kinda more aggressive not physical but emotionally upset, loud.” Respondent 10 continued saying, “For me personally, [my response to defensiveness] is an area that I continue to strengthen like not to back pedal when they are upset or not to back pedal like oh my God I upset them.”

Diagnostic criteria not a factor in disclosure. Despite any expressed reluctance to disclose a BPD diagnosis to clients, the majority of respondents did not cite explanation of the diagnostic criteria as a factor in their reluctance or confidence to disclose. Respondent 12 reported, “I use the DSM. I mean it's not perfect but it's, I am okay with those nine diagnostics.” However, Respondents 12 and 13 both noted that they would typically not explain the diagnostic criteria to clients on a line by line basis. Respondent 12 stated, “I don't run off a sheet from the DSM. I will look at them and talk about them with the person.” Respondent 13 likewise stated, “I usually don't go over the criteria for any diagnosis one item at a time with my clients. It doesn't require labeling the person so much as addressing something that they may see as a problem also.”

Several respondents pointed to the diagnostic criteria as a helpful educational tool by which to initiate a dialogue with the clients, though it did not factor into their reluctance or confidence to disclose. Respondent 9 stated,

I would talk about well, ‘This is why you have been called a borderline personality. You have these characteristics, you have these problems, and that’s what causes you to qualify for this diagnosis’ if we need to talk like that. I wouldn’t be too uncomfortable with that I guess.

Respondent 11 offered the following explanation:

No, [explaining the criteria] does not negatively impact my willingness to disclose. Um when I do have that situation with clients, I um actually again because of the severity of the client sometimes, it’s actually a relief for them to hear that. Um you know, it kind of explains some of the challenges they have had... So I may not even be the first person to share it with them but I may be the first person to educate them about it. When I do the education, they are actually grateful for that. It can be helpful for them to better understand who they are.

Always or Usually Respondents

Seven respondents reported that they always disclose the diagnostic label BPD to their clients. These respondents were asked to provide additional information to two open-ended prompts. The first prompt was, “You noted on your survey response that you always disclose diagnostic information regarding BPD. Please tell me more about that.” The second prompt was, “How does explaining any of the nine BPD diagnostic criteria to

patients impact your willingness to disclose?” Several themes were identified among the responses. The themes identified from these responses were the following:

- Full disclosure of a BPD diagnosis is clinically beneficial.
- Diagnostic disclosure contributes to the development of a collaborative treatment relationship.
- Respondents vary in the degree to which they utilize the diagnostic criteria to explain BPD to clients.
- Explanation of the affective components of BPD are favored in aiding client understanding of the disorder.

These themes will be explained in detail in the sections to follow.

Disclosure clinically beneficial. Among the respondents who reported that they always disclose a BPD diagnosis to their client, the majority expressed the belief that full disclosure is best. To this point, Respondent 7 shared, “I don’t know what the secret is. I don’t understand why you wouldn’t tell somebody [their diagnosis].” Respondent 4 argued that disclosure of a BPD diagnosis is clinically appropriate. Respondent 1 echoed this theme saying, “There is seldom a time in which I found it clinical appropriate not to share information with clients.” Respondent 6 added, “I always disclose the diagnosis no matter what diagnosis my client has, so that is certainly not any different than any other disorder.”

Disclosure and development of the treatment relationship. Several respondents argued that the disclosure of the diagnosis contributes to the development of

a collaborative treatment relationship between the therapist and client. Respondent 1 stated, “It’s wise to let them know what the diagnosis is and what my clinical impressions are so that we are able to work together.” Respondent 4 similarly shared, “It clinically seems good for them to be informed so then we can come with treatment goals related to that.” To this point, Respondent 8 opined, “I don’t hide anything because the most important part of working with a borderline and also being a counselor/therapist is the relationship and if I am hiding something, what kind of relationship do I have?”

Using diagnostic criteria to explain disorder. Concerning the process of explaining BPD to clients, some respondents reported use of the diagnostic criteria as a tool in explaining the disorder. Respondents 7 and 8 made reference to explaining the diagnostic criteria to clients in detail. Respondent 8 reported, “I go through the diagnostic points in the DSM-V and um you know and ‘you meet this, you meet this and you meet this’ and I tell them right there.” Respondent 7 similarly shared, “They need to know the details or the definition of their disorder and the behaviors that go along with the disorder.” Respondent 3 reported, “I usually don’t go over all nine of them [diagnostic criteria] but just the ones that particularly apply to the client.”

Explaining affective components of disorder. The other respondents tended to report alternative methods of explaining BPD to clients. These respondents placed an emphasis on describing the affective components of the disorder to the clients, rather than listing the diagnostic criteria. This process allowed clients to recognize their own symptoms and identify with the diagnosis. Respondent 6 explained, “Clients have the

right number one to have their diagnosis and to have it explained in terms they can understand.” Respondent 6 added, “I phrase it in language first of all that they can understand and um I guess soften the blow a little bit.” Respondent 2 similarly reported, “I don’t usually describe the disorder in terms of the DSM criteria.” Respondent 2 offered the following description of the approach:

I have a particular way of describing that disorder consistent with Marsha Linehan’s theory... I explain that for various reason some people developed affective reactions that are stronger than other people um the way I often it explain it to them is saying some people’s feelings are like a puppy they are usually fun, they are inconvenient when they wet on the floor. Some people’s emotions are more like lions and you know even when they are happy and purring, they rub their face on you and they are so heavy they can be difficult. They go to stretch and scratch a little and oh my gosh they ruined the sofa. So basically you need to learn to be a lion tamer in managing your affect.

Respondent 3 offered further explanation of this concept saying that “[clients] realize that their emotional reactivity and their emotional dis-control gets them into a lot of trouble and so they are looking for solutions but they don’t understand the concept of a personality disorder.” Respondent 3 continued, explaining that clients are better able to “understand that their emotions are um way out of proportion to the...situation.”

Respondent 4 similarly stated, “I usually start with the initial personality disorder symptoms just how it’s overarching with emotions and the way interacting with people so

they can usually agree that they do feel different in those ways from the majority of people.”

Summary

One purpose of this study was to identify how often licensed psychologists and licensed clinical social workers inform patients that they have a diagnosis of BPD. Another purpose was to identify factors that influence disclosure such as concerns for self, concerns for the patient, societal norms, gender, professional occupation, theoretical orientation, and frequency of working with individuals diagnosed with BPD. A third purpose was to gather phenomenological data about the choice to disclose or not to disclose. Participants were recruited from the Minnesota Board of Psychology and the Minnesota Board of Social Work. It was hypothesized that the MUM effect a phenomenon whereby when faced with disclosing information, communicators are often more reluctant to disclose undesirable information would impact the disclosure of BPD. There are several factors that contribute to the reluctance to disclose undesirable information and each can be grouped into three main categories: (a) concerns for self, (b) concerns for the patient, and (c) societal norms (Rosen & Tesser, 1970). Responses were collected using the Disclosure Questionnaire and the Breaking Bad New Questionnaire. Demographic information was also collected in order to understand the relationship between professional occupation, theoretical orientation, gender, frequency of working with individuals diagnosed with BPD, and disclosure.

The majority of participants were female ($n = 120$, 70%) and licensed psychologists ($n = 125$, 74%). Many of the participants fell into the category of cognitive behavioral therapy as their primary theoretical orientation ($n = 83$, 49%) and seven with ten being highest ($n = 34$, 19.88%) was the most common response for how frequently participants work with individuals diagnosed with BPD.

In response to the percentage of licensed psychologists and licensed clinical social workers in the state of Minnesota that inform their patients of the diagnostic label BPD, data for those that *always* disclose ($n = 51$, 30%) and those that *usually* disclose ($n = 52$, 31%) were very close in number. The next most common response was *sometimes* ($n = 39$, 23%). The least popular responses included *rarely* ($n = 18$, 11%) and *never* ($n = 6$, 4%). The results of the multiple linear regression analyses exploring the relationship between disclosure and concerns for self, concerns for the patient, and societal norms found that societal norms such as an ethical responsibility and the importance of preserving the therapeutic relationship have a significant relationship with disclosure, while concerns for self and concerns for the patient were not found to have a significant relationship with disclosure. In Chapter 5, includes the results, conclusions and recommendations pertaining to this study.

Chapter 5: Discussion, Conclusions, and Recommendations

Overview

Diagnostic disclosure has the potential of improving treatment outcomes and reducing the cost associated with mental health treatment (Zanarini & Frankenburg, 2008). Yet, in the particular case of BPD, the literature on this topic indicates that professionals often choose not to disclose even though there has been little to no data on the number of mental health professionals who choose to disclose (Lequesne & Hersh, 2004). Failure to disclose is true in spite of the fact that disclosing accurate diagnostic information allows patients to seek another opinion and discuss their treatment options. Diagnostic disclosure is useful in implementing effective treatment practices and appropriately predicting the patient's response to treatment.

There are ethical and legal obligations that require diagnostic disclosure. Standard 3.10 of the American Psychological Association's Ethical Standards and Codes of Conduct (APA, 2002) requires that psychologists obtain informed consent for all psychological services. Informed consent requires that the psychologist inform the patient of the nature of the treatment, possible risks and benefits of treatment, and alternative treatment options (APA, 2002). The APA also emphasizes the importance of patient autonomy. Patients must be provided with as much information as they desire about their diagnosis and its treatment (APA, 2002). Psychologists have an obligation to create the conditions necessary for autonomous choices in patients.

There are also laws that influence the decision to disclose diagnostic information. The Health Insurance Portability and Accountability Act (1996) legally permits patients access to their medical records. With increased access to health information, it is becoming more difficult to withhold information from patients. With the ethical requirement of informed consent and the obligation to promote patient autonomy and trust within the practice of psychology, a failure to disclose diagnostic information could have serious ethical and legal ramifications for mental health professionals.

Despite the ethical and legal obligation that mental health professionals have to disclose diagnostic information, little empirical research has been conducted on the topic of disclosure. Few studies have identified how often mental health professionals inform patients of their diagnosis. Additionally, few studies have identified the reasons why mental health professionals choose to disclose or not to disclose. BPD is one of the most commonly diagnosed personality disorders in both outpatient and inpatient settings (Paris & Zweig-Frank, 2001). In Chapter 2, I highlighted the theoretical reasons why it is believed that this diagnosis goes undisclosed.

The first purpose of the study was to identify what percentage of licensed psychologists and licensed clinical social workers in the state of Minnesota disclose the diagnostic label BPD to their patients. Another purpose was to identify factors that influence disclosure such as concerns for self, concerns for the patient, societal norms, gender, professional occupation, theoretical orientation, and frequency of working with individuals diagnosed with BPD. A third purpose was to gather phenomenological data

about the choice to disclose or not to disclose. A sequential explanatory mixed methods design including an online survey and a telephone interview was used to collect data from participants. During the quantitative phase, licensed psychologists and licensed clinical social workers were asked to complete an online survey. During the qualitative phase of the research, telephone interviews were used with a subset of participants in order to validate and expands on the quantitative results. There were three sets of research questions. These questions included the following

1. What percentage of licensed psychologists and licensed clinical social workers in the state of Minnesota disclose the diagnostic label BPD to patients?
2. What is the relationship between the percentage of licensed psychologists and the percentage of licensed clinical social workers who disclose the diagnostic label BPD?
3. What is the relationship between the gender of the professional and the disclosure of the diagnostic label BPD?
4. What is the relationship between the gender of the patient and the disclosure of the diagnostic label BPD?
5. What is the relationship between the frequency of working with individuals diagnosed with BPD and the disclosure of the diagnostic label BPD?

6. What is the relationship between licensed psychologists' and licensed clinical social workers' theoretical orientation and the disclosure of the diagnostic label BPD?

The second set of questions was related to the MUM effect. The MUM effect is the tendency to remain mum when faced with the dilemma of communicating undesirable information (Rosen & Tesser, 1970). There are several factors that contribute to the reluctance to disclose undesirable information and each can be grouped into three main categories: (a) concerns for self, (b) concerns for the patient, and (c) societal norms (Rosen & Tesser, 1970). These questions explored the relationship between the MUM effect and the disclosure of BPD. Three separate multiple linear regression analyses were used to predict the relationship between disclosure and concerns for self, concerns for the patient, and societal norms. Multiple linear regression analyses were also used to explore the relationship between gender of the professional, professional occupation, theoretical orientation, frequency of working with individuals diagnosed with BPD, and disclosure.

7. Is there a significant relationship between the psychologists' and clinical social workers' concerns for self and the reluctance to disclose diagnostic information, as measured by the Breaking Bad News Questionnaire?
8. Is there a significant relationship between the psychologists' and clinical social workers' concerns for the patient and the reluctance to disclose diagnostic information, as measured by the Breaking Bad News Questionnaire?

9. Is there a significant relationship between societal norms and the reluctance to disclose diagnostic information, as measured by the Breaking Bad News Questionnaire?

The third set of questions was used during the qualitative phase to expand and elaborate on the quantitative responses.

10. “You noted on your survey response that you *rarely* or *never* disclose diagnostic information regarding BPD to clients. Please tell me a little more about that.”
11. Those that did not endorse a reluctance to disclose diagnostic information were asked, “You noted on your survey response that you *always* disclose diagnostic information regarding BPD. Please tell me more about that.”
12. All of the participants in the second phase were also asked, “How does explaining any of the nine BPD diagnostic criteria to patients impact your willingness to disclose?”

In Chapter 4, I presented the results of my study and found that the majority of participants indicated that they *usually* or *always* disclose diagnostic information. Only a small percentage of respondents indicated that they *never* or *rarely* disclose. Societal norms such as an ethical responsibility and the importance of preserving the therapeutic relationship were found to decrease disclosure.

In regard to the other variables included in the multiple regression analyses such as gender, professional occupation, theoretical orientation, and frequency of working

with individuals diagnosed with BPD, female participants were more likely than male participants to disclose diagnostic information to their clients $r = 0.49, p < .008$. The more frequently participants reported working with individuals diagnosed with BPD, the less likely they were to disclose $r = .14, p < .001$. None of the other variables were found to have a significant relationship with disclosure.

Interpretation of Findings

Although the literature has indicated that mental health professionals under disclose diagnostic information in regard to BPD, my study indicates otherwise, in that most of the subjects reported that they do disclose, the percentage of people who never disclose was only 11%, and only 23% said they only sometimes disclose. It is difficult to interpret the meaning of these findings without more information about how much psychologists and clinical social workers disclose other diagnoses. Without that information, it is not possible to determine whether they are disclosing information about BPD any less than they are disclosing information about other disorders, making this potentially a problem about diagnostic disclosure in general and not just the specific problems associated with the disclosure of BPD.

Nonetheless, it was surprising to find that although the literature has suggested that there is insufficient disclosure of the BPD diagnosis, many professionals in this sample reported that it is their practice to disclose. My results were consistent with a previous study that indicated that half of the psychiatrists participating from two university-affiliated medical schools would inform patients of a diagnosis of BPD

(McDonald-Scott et al., 1992). These numbers increased to 70% to 80% when the patient asked directly about his or her diagnosis (McDonald-Scott et al., 1992).

While the McDonald-Scott et al. (1992) research excluded psychologists and clinical social workers, my study added to the literature in demonstrating that these professionals disclose diagnostic information to patients more often than not. Those respondents who participated in the second phase of my research cited several reasons for disclosure including a belief that diagnostic disclosure is clinically beneficial and a belief that it contributes to a collaborative treatment relationship.

Perhaps one complicating factor in ascertaining more widespread data regarding the number of professionals who disclose the diagnosis of BPD has to do with who has the authority to disclose. In the patriarchal medical system in which the doctor was believed to know what was best for patients, not only was it a common practice to withhold information perceived to be undesirable but more importantly psychologists and social workers may not have had primary responsibility for disclosure. In future research on this topic, it would be advisable to add level of responsibility for patient care as an independent variable in order to get a better handle on how the medical hierarchical arrangement of psychiatrists at the top affects how much psychologists and social workers report.

Although withholding diagnostic information from patients was less common than anticipated, it was important to explore the dynamics associated with the 23% of participants in my study who stated that they only disclose sometimes and the 11% who

stated that they rarely disclose. This was addressed more specifically by the results regarding factors that influence disclosure as discussed in the following section.

The theoretical framework for this study was informed by the MUM effect (Rosen & Tesser, 1970). The MUM effect explains why communicators are often reluctant to disclose undesirable information. The MUM effect provided the theoretical framework that was used to guide my decisions regarding the selection of the independent variables thought to influence disclosure. Specifically these included concerns for self, concerns for the patient, and societal norms. Additional independent variables included gender, professional occupation, theoretical orientation, and frequency of working with individuals diagnosed with BPD. It was reasoned that these may mediate or work in concert with some of the MUM effect variables. Three separate multiple linear regression analyses were conducted to test the relationship between the independent variables and the dependent variable disclosure.

Of the three components of the MUM effect, only societal norms were found to have a significant relationship with disclosure. Societal norms were found to decrease disclosure while concerns for self and concerns for the patient were not found to significantly impact disclosure. Societal norms include an ethical responsibility and the importance of preserving the therapeutic relationship (Merker et al., 2010). These results provide partial support for the MUM effect in the practice of psychology and suggest that psychologists and clinical social workers believe that disclosing information about BPD could disrupt the therapeutic relationship.

The results of all three multiple linear regression analyses indicated that female participants were more likely than male participants to disclose diagnostic information to their clients, $r = 0.49$, $p < .008$. This was actually consistent with a previous study conducted by Tesser et al. (1972) who also explored how gender contributes to the MUM effect. These authors found that women communicators felt more obligated than male communicators to communicate both good and bad news (Tesser et al., 1972). These results would imply that the female psychologists and clinical social workers in my study feel more obligated to disclose diagnostic information to their patients and thus reported disclosing more frequently than males.

Tesser, et al. (1972) also found that their participants had difficulty agreeing on times when it is required to communicate undesirable information. More specifically, these researchers found that individuals are less likely to agree on circumstances such as urgency of the message or the obligation to share the message in bad news situations (Tesser et al., 1972). It would appear from the result of my study that the norms for disclosing undesirable information in clinical settings are ambiguous. There is evidence that psychologists and clinical social workers have a difficult time agreeing on when disclosure is necessary and this ambiguity may contribute to why the females in my study were more likely to disclose than the males. Although the results of my research suggest that there may be gender differences in the societal norms regarding the disclosure of undesirable information, they should be interpreted with caution given that the sample included twice as many females ($n=120$) than males ($n=51$) and it is possible that this

statistic would not have been significant if the sample were evenly distributed (Tabachnick & Fidell, 2012).

There was an interesting relationship between frequency of working with individuals diagnosed with BPD and disclosure. The results of the three multiple linear regression analyses indicated that the more frequently participants reported working with individuals diagnosed with BPD, the less likely they were to disclose, $r = .14$, $p < .001$. These results would suggest that those confronted with disclosing diagnostic information regarding BPD most frequently have a greater reluctance. Since there is currently nothing in the literature relevant to the MUM effect to explain this relationship, it would be advisable that future research explore the relationship between frequency of communicating undesirable information and disclosure.

The results of my study and previous research suggest that the stigma associated with BPD and concerns about the patient's reaction are factors that inhibit disclosure. Previous studies have found that the patient's diagnosis influences the disclosure of information (Cleary et al., 2010). More specifically, these authors found that the stigma associated with the diagnosis and whether the patient could become distressed were factors that influenced disclosure (Cleary et al, 2010). These findings are consistent with the qualitative results and suggest that respondents consider the stigma associated with BPD and the patient's reaction when making decisions about disclosure. Although there is some evidence that this stigma has improved over time, it continues to be a barrier to disclosure.

In fact, there is some evidence that the stigma associated with BPD prevented some professionals from participating in my research. As one potential participant stated, “I have to say that I think BPD is way over-diagnosed and so often what we are really seeing is a complex PTSD.” Another potential participant replied, “I believe most ‘borderline personality disorder’ is better understood as ‘complex PTSD.’ I prefer that frame for it because its way less stigmatizing, probably more accurate, and leads nicely to a hopeful treatment outcome.” A third potential participant indicated that she was unwilling to take the survey because she does not diagnose her clients with personality disorders. She stated, “I rarely if ever gave a personality disorder diagnosis.” Many of the licensed psychologists and licensed clinical social workers referenced above refused to take the survey but chose to e-mail information about why they made this decision.

Some of those participating in the qualitative phase indicated that they describe the behaviors associated with BPD to avoid the diagnostic label. Another participant indicated that she uses the diagnostic label BPD with her clients but avoids documenting it in her notes as way of minimizing potential stigma. She indicated that she explains this to her clients and uses another less stigmatizing diagnosis for billing purposes.

Mental health professionals may be justified in their concerns about the stigma associated with BPD. In a study exploring how stigma among mental health professionals influences the treatment of individuals with BPD, Baldwin (2013) found that stigma existed across groups of professionals including social workers, nurses, psychologists and marriage and family therapists. These individuals endorsed a greater adherence to

stereotypes of dangerousness toward individuals diagnosed with BPD but also expressed optimism in the ability of these individuals diagnosed to make changes (Baldwin, 2013). While these fears may be valid, they do not justify a lack of disclosure and would be more appropriate topics for clinical supervision or consultation.

To summarize, the quantitative results demonstrated that societal norms was the only component of the MUM effect found to impact the disclosure of BPD. However, the qualitative results indicate that licensed psychologists and licensed social workers consider all three components of the MUM effect when choosing to disclose diagnostic information regarding BPD. Several of the participants in my study expressed concerns about diagnostic disclosure leading to defensiveness and disclosure negatively impacting the therapeutic relationship. My study provides additional support for the impact of the MUM effect on clinical decision making among psychologists and clinical social workers in regard to the disclosure of BPD. Consistent with the general population, psychologists and clinical social workers are more reluctant to disclose undesirable information.

Limitations

This study was limited to licensed clinical social workers and licensed psychologists in Minnesota volunteering to complete the survey data and telephone interview. The majority of professionals willing to participate in this research cited cognitive behavioral therapy as their primary theoretical orientation. There is some evidence that professionals practicing from other theoretical orientations may approach the disclosure of BPD differently. As one participant pointed out, “I took your survey but

found the questions difficult to answer as I don't really believe in the diagnostic criteria of BPD. I'm a trauma therapist and see many diagnosed with BPD or who 'fit the criteria' but I look at it as a dissociative disorder NOS, thus see it and treat it in a much different light.”

Since most of the participants in this study were women psychologists citing cognitive behavioral therapy as their primary theoretical orientation, these results should not be generalized to professionals outside of these demographics. The study included twice as many licensed psychologists ($n = 125$) than licensed clinical social workers ($n = 45$) therefore, caution should be used when generalizing the results to licensed clinical social workers in the state of Minnesota and elsewhere.

My study was limited to the responses obtained from the survey and the telephone interviews. It was also limited by the information that was obtained by using the Disclosure Questionnaire and the Breaking Bad News Questionnaire and any limitations related to these measures apply to this study.

Implications for Social Change

There are several implications for positive social change associated with my study. The first implication for positive social change includes academic and professional awareness that most licensed psychologists and licensed clinical social workers are sharing this controversial diagnosis with their clients. These professionals believe that patients have a right to know their diagnosis and they believed that disclosure is necessary for building a therapeutic relationship and treatment goals.

A second implication is knowledge about the reasons why a minority of professionals choose not to disclose. The study findings suggest that a fear of emotionally upsetting the patient, a fear of disclosure negatively impacting the therapeutic relationship, and avoiding the stigma associated with the diagnosis are reasons for a lack of disclosure. Societal norms including an ethical responsibility and the importance of preserving the therapeutic relationship was also found to impact disclosure.

Those who currently disclose the diagnostic label BPD to patients reported some use of the diagnostic criteria while others choose to focus on the affective components of the disorder. Biskin and Paris (2012) suggest that it can be helpful to review the diagnostic criteria with the patient and explain the reason for the diagnosis. Gunderson (2011) agreed with these authors and suggested that asking patients whether the diagnostic criterion characterizes them improves acceptance of the diagnosis. These authors believe that disclosure reduces the stigma associated with BPD rather than increase it as others believe (Biskin & Paris, 2012; Gunderson, 2011).

Despite these recommendations, there are no current guidelines for psychologists to follow when disclosing undesirable information in psychiatric settings (Clearly et al., 2009). My research may stimulate future research into the impact of disclosure on clients and appropriate methods of disclosing psychiatric information. The study showed that education and additional training is needed to reduce stigmatizing attitudes associated with BPD and to train professionals on how to work with individuals diagnosed with BPD. These trainings, in turn, may increase compliance with treatment among patients

and decrease the overall cost associated with treating this disorder. My study also demonstrated that professionals find the guidelines for diagnostic disclosure ambiguous and supports the creation of specific guidelines to increase disclosure among mental health professionals.

Recommendations

Future research may expand on current findings on several levels. The first recommendation is an increase in sample size could potentially increase the power and the likelihood of finding significance if there is significance. There were inconsistencies in the results between the quantitative and qualitative phases. The quantitative results indicated that societal norms were the only component of the MUM effect to impact disclosure while the qualitative results suggested that all three components impact disclosure. These inconsistencies are evidence of the value of a mixed methods study and the value of gathering phenomenological data. The phenomenological approach in this study was able to capture information that the Breaking Bad New Questionnaire was ineffective in measuring. When asking mental health professionals about clinical decision making it may be more effective to use qualitative methods.

Although the MUM effect provided some evidence for why females disclose more frequently than males, additional research is needed to determine if other variables contribute to these differences. Increasing the sample size may be one solution in answering this question. Thirdly, additional research is needed to determine why those working most frequently with individuals diagnosed with BPD disclose less often.

Additional research is also needed to determine if professionals from theoretical orientations less represented in the current study approach the disclosure of the BPD diagnostic label differently.

While all of the participants in my study believe that preserving the therapeutic relationship is important, they disagree as to how this should be done. Some believe that disclosure builds the therapeutic relationship while others believe that disclosure could destroy this relationship. Lastly, additional research is needed to explore the impact of diagnostic disclosure on patients and to determine the most clinically effective way of disclosing diagnostic information to patients. My research results indicate that several psychologists use the specific diagnostic criteria while others prefer to focus on the affective component of the disorder.

Conclusion

Although the literature has indicated that mental health professionals under disclose diagnostic information in regard to BPD, the majority of professionals in this sample reported that it is their practice to disclose. There was however a small percentage of psychologists and clinical social workers that stated that they rarely or sometimes disclose. It is difficult to interpret the meaning of these findings given that so little is currently known about diagnostic disclosure making this potentially a problem about diagnostic disclosure in general and not just the specific problems associated with the disclosure of BPD.

Many variables were found to contribute to why professionals choose not to disclose these include a fear of emotionally upsetting the patient, a fear of disclosure negatively impacting the therapeutic relationship, and avoiding stigma associated with the diagnosis. Societal norms including an ethical responsibility and the importance of preserving the therapeutic relationship was also found to impact disclosure. My findings provide additional support for the impact of the MUM effect on clinical decision making among psychologists and clinical social workers in regard to the disclosure of BPD. Consistent with the general population, psychologists and clinical social workers are more reluctant to disclose undesirable information in their clinical practice.

Patients have a right to know their diagnosis. Ninety one percent of the patients surveyed by Shergill et al. (1998) believed that receiving their diagnosis was helpful to their treatment and recovery. The current research suggests that there is an ongoing need for education and training focused on effective methods of disclosure among mental health professionals. Preliminary research in the area of disclose has demonstrated that disclosure increases compliance with treatment and generally leads to better outcomes (Shergill et al., 1998; Zanarini & Frankenburg, 2008). There are a variety of other advantages to disclosing diagnostic information to patients. Disclosing accurate diagnostic information allows patients to seek another opinion and discuss their treatment options. Diagnostic disclosure is useful in implementing effective treatment practices in regard to the treatment of BPD and appropriately predicting the patient's response to treatment. Mental health professionals are in a position to provide hope and empower

patients with BPD by providing them with reliable information combating some of the negative information patients may receive elsewhere.

References

- Alexander, D., & Klein, D. (2000). Bad news is bad news: Let's not make it worse. *Trauma, 2*, 11-18. doi: 10.1177/146040860000200102
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- American Psychological Association. (2010). Ethical principles of psychologists and code of conduct.
- Aviram, R., Brodsky, B., & Stanley, B. (2006). Borderline personality disorder, stigma and treatment implications. *Harvard Review Psychiatry, 14*(5), 249-256.
doi:10.1080/10673220600975121
- Babbie, E. (2007). *The practice of social research* (11th ed.). Belmont, MD: Thomson Learning.
- Banzhaf, A., Ritter, K., Merkl, A., Schulte-Herbruggen, Claas-Hinrich, L., & Roepke, S. (2012). Gender differences in a clinical sample of patients with borderline personality disorder. *Journal of Personality Disorders, 26*(3). 368-380.
doi: 10.1521/pedi.2012.26.3.368
- Becker, D., & Lamb, S. (1994). Sex bias in the diagnosis of borderline personality disorder and posttraumatic stress disorder. *Professional Psychology: Research and Practice, 25*, 55-61. doi:10.1037/0735-7028.25.1.55

- Baldwin, E. (2013). *Stigmatizing attitudes among mental health professionals regarding borderline personality disorder* (Unpublished doctoral dissertation). Walden University, Minnesota.
- Biskin, R. & Paris, J. (2012). Diagnosing borderline personality disorder. *Canadian Medical Association, 184*(6), 1789-1794. doi: 10.1503/cmaj.045281
- Bradley, R., & Westen, D. (2005). The psychodynamics of borderline personality disorder: A review from developmental psychopathology. *Development and Psychopathology, 17*, 927-957. doi:10.1017/S0954579405050443
- Buckman, B. (1992). *How to break bad news*. Baltimore, MD: Johns Hopkins University Press.
- Chapman, G. &. (2000). *Decision Making in health care*. New York, NY: Cambridge University Press.
- Cleary, M., Hunt, G., & Horsfall, J. (2009). Delivering difficult news in psychiatric settings. *Harvard Review of Psychiatry, 17*(5), 315-321.
doi: 10.3109/10673220903271780
- Creswell, J. (2003). *Research design: Qualitative, quantitative and mixed methods approaches*. Thousand Oaks, CA : Sage Publications.
- Crowell, S., Beauchaine, T., & Linehan, M. (2009). A biosocial developmental model of borderline personality: elaborating and extending Linehan's theory, *Psychological Bulletin, 135*(3), 495-510. doi:10.1037/a0015616
- Conlee, M., & Tesser, A. (1973). The effects of recipient desire to hear the news on

- transmission. *Sociometry*, 36, 588 doi: 10.2307/2786254
- De Valck, C., Bensing, J. & Bruynooghe, R. (2001). Medical students' attitudes towards breaking bad news: An empirical test of the world health organization model. *Psychological Oncology*, 10, 398-409. doi: 10.1002/pon.520
- Distel, M., Rebollo-Mesa, I., Willemsen, G., Derom, C., Trull, T., Martin, N., & Boomsma, D. (2009). Familial resemblance of borderline personality disorder features: Genetic or cultural transmissions? *PLoS One*, 4(4), 1-8.
doi:10.1371/journal.pone.0005334
- Eberhardt-Mckee & Ptacek, J. (2001). I'm afraid I have something bad to tell you: Breaking bad news from the perspective of the giver. *Journal of Applied Social Psychology*, 31(2), 246-273. doi:10.1111/j.1559-1816.2001
- Evans, J. & Mathur, A. (2005). The value of online surveys. *Internet Research*, 15(2), 195-219. doi:10.1108/10662240510590360
- Glaser, B. G. (1965). "The Constant Comparative Method of Qualitative Analysis". *Social Problems*. Chicago, IL: Aldine
- Glaser, B. G. & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Piscataway, New Jersey: Transaction.
- Green, R. & Ganett, A. (1987). Telling patients and their families the psychiatric diagnosis: A survey of psychiatrists. *Hospital and Community Psychiatry*, 38, 666-6668. <http://psycnet.apa.org/psycinfo/1988-24621-001>
- Gravetter, F. & Wallnau, L. (2007). *Statistics for the behavioral sciences* (7th ed.).

Belmont, CA: Thomson Higher Education.

- Grilo, C., Sanislow, C., Skodol, A., Gunderson, J., Stout, R., Bender, D. McGlashan, T. (2007). Longitudinal diagnostic efficiency of DSM-IV criteria for borderline personality disorder. A 2-year prospective study. *Canadian Journal of Psychiatry*, 52(6), 357-362. http://works.bepress.com/charles_sanislow/100
- Grilo, C., Shea, T., Sanislow, C., Skodol, A., Gunderson, J., Stout, R., McGlashan, T. (2004). Two-year stability and change of schizotypal, borderline, avoidant and obsessive compulsive personality disorders. *Journal of Consulting and Clinical Psychology*, 72(5), 767-775. doi:10.1037/0022-006X.72.5.767
- Grilo, G., McGlashan, L., Morey, L., Gunderson, J., Skodol, A., Sanislow, T....Stout, R. (2001). Internal consistency, intercritera, overlap and diagnostic efficiency of criteria sets for DSM-IV schizotypal, borderline, avoidant and obsessive-compulsive personality disorders. *Scandinavian Psychological Association*, 104, 264-272. doi: 10.1111/j.1600-0447.2001.00436.x
- Goodman, M., Triebwasser, J., & New, A. (2008). Biological underpinnings of borderline personality disorder. *Social Work in Mental Health*, 6, 33-47. doi:10.1300/J200v06n01_04
- Goodman, M., New, A., Triebwasser, J., Collins, K., & Siever, L. (2010). Phenotype, endphenotype and genotype comparisons between borderline personality disorder and major depressive disorder. *Journal of Personality Disorders*, 24(1), 38-59. doi: 10.1521/pedi.2010.24.1.38

- Goodman, M., Patil, U., Steffel, L., et al. (2010). Treatment utilization by gender in patients with borderline personality disorder. *Journal of Psychiatry Practice, 16*, 155-163. doi: 10.1097/01.pra.0000375711.47337.27
- Gunderson, J. (2011). Borderline personality disorder. *New England Journal of Medicine, 364*(21), 2037-2042. doi:10.1176/appi.books.9781585625048.gg70
- Henry, K., & Cohen, C. (1983). The role of labeling processes in diagnosing borderline personality disorder. *American Journal of Psychiatry, 140*(11), 1527-1529.
<http://psycnet.apa.org/psycinfo/1984-06917-001>
- Hodge, S. (2003). Borderline personality disorder and posttraumatic stress disorder: Time for integration? *Journal of Counseling and Development, 81*, 409-417.
doi: 10.1002/j.1556-6678.2003.tb00267.x
- Hursh, R. (2008). Confronting myths and stereotypes about borderline personality disorder. *Social Work and Mental Health, 6*, 13-32.
doi:10.1300/J200v06n01_03
- Johansen, M., Karterud., S., Pedersen, G., Gude., T. Falkrum, E. (2004). An investigation of the prototype validity of the borderline DSM-IV construct. *Scandinavian Psychological Association, 109*, 289-298. doi: 10.1046/j.1600-0447.2003.00268.x
- Johnson, R. & Conlee, M. (1974). The effects of similarity of fate on bad news transmission: A reexamination. *Journal of Personality and Social Psychology, 29*(5), 644-648. doi:10.1037/h0036619
- Kamali, M., Oquendo, M. and Mann, J. (2001). Understanding the neurobiology of

- suicidal behavior. *Depression and Anxiety*, 14, 164-176. doi: 10.1002/da.1062
- Kernberg, O. (1985). *Borderline Conditions and Pathological Narcissism*. New Jersey: Jason Aronson Inc.
- Lenzenwegar, M. (2006). The longitudinal study of personality disorders: history, design, considerations and initial findings. *Journal of Personality Disorders*, 20(6), 645-666 doi: 10.1521/pedi.2006.20.6.645
- Lerman, H. (1996). *Pigeon Holing Women's Misery*. New York: HarperCollins Publishers.
- Lewis, K, & Grenyer, B. (2009). Borderline personality or complex posttraumatic stress disorder? An update on the controversy. *Harvard Review Psychiatry*, 17(3), 322-328. doi:10.3109/10673220903271848
- Lequesne, E. & Hersh, R. (2004). Disclosure of a diagnosis of borderline personality disorder. *Journal of Psychiatric Practice*, 10(3), 170-176.
http://journals.lww.com/practicalpsychiatry/Abstract/2004/05000/Disclosure_of_a_Diagnosis_of_Borderline.5.aspx
- Linehan, M. (1993). *Skills Training Manual for Treating Borderline Personality Disorder*. New York: The Guilford Press.
- Nehis, N. (1998). Borderline personality disorder: gender stereotypes, stigma and limited systems of care. *Issues in Mental Health Nursing*, 19, 97-112.
doi:10.1080/016128498249105
- Nunes, P., Wenzel, A., Borges, K., Porto, C., Caminha, R., Olivetra, R. (2009). Volumes

of the hippocampus and amygdale in patients with borderline personality disorder: a meta-analysis. *Journal of Personality Disorders*, 23(4), 333-345.

doi: 10.1521/pedi.2009.23.4.333

McDonald-Scott, P., Machizawa, S. & Satoh, H. (1992). Diagnostic disclosure: a tale in two cultures. *Psychological Medicine*, 22, 147-157.

doi:10.1017/S0033291700032803

Merker, B., Hanson, W., & Postin, J. (2010). National survey of psychologists' training and practice in breaking bad news: A mixed methods study of the MUM effect. *Journal of Clinical Psychology in Medical Settings*, 17, 211-219.

doi:10.1007/s10880-010-9197-0

Paris, J. & Zweig-Frank, H. (2001). The 27-year follow-up of patients with

borderline personality disorder. *Comprehensive Psychiatry*, 42, 482-487

doi:10.1053/comp.2001.26271

Paris, J. (1994). *Borderline personality disorder: A Multidimensional approach*.

Washington, DC: American Psychiatric Association.

Paris, J. (2007). The nature of borderline personality disorder: Multiple dimensions, multiple symptoms, but one category. *Journal of Personality Disorders*, 21(5),

457-473. doi: 10.1521/pedi.2007.21.5.457

Ptacek, J., Ptacek, J. & Ellison, N. (2001). I'm sorry to tell you...physicians' reports of breaking bad news. *Journal of Behavioral Medicine*, 24(2), 205-216.

doi:10.1023/A:1010766732373

- Radziewicz, R. & Baile, W. (2001). Communication skills: breaking bad news in the clinical setting. *Leadership and Professional Development*, 28(6), 951-953.
<http://europepmc.org/abstract/med/11475881>
- Reiser, D. & Levenson, H. (1984). Abuses of the borderline diagnosis: A clinical problem with teaching opportunities. *American Journal of Psychiatry*, 141, 1528-1532.
<http://psycnet.apa.org/psycinfo/1985-12951-001>
- Rosen, S., & Tesser, A. (1970). On reluctance to communicate undesirable information: The MUM effect. *Sociometry*, 33(3), 253-263.
[doi 10.2307/2786156?sid=21105850835623](https://doi.org/10.2307/2786156?sid=21105850835623)
- Sansone, R. & Sansone, L. (2011). Gender patterns in borderline personality disorder. *Innovations in Clinical Neuroscience*, 8(5), 16-19.
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3115767>
- Shergill, S., Baker, D., & Greenberg, M. (1998). Communication of psychiatric diagnosis. *Social Psychiatry & Psychiatric Epidemiology*, 33, 32-38.
[doi: 10.1007/s001270050019](https://doi.org/10.1007/s001270050019)
- Sherman, S. (1992). *No longer patient: Feminist ethics & health care*. Philadelphia: Temple University Press.
- Silverman, J., Pinkham, L., Hovath, T., Coccaro, E., Klar, H., Scheer, S. Siever, L. (1991). Affective and impulsive personality disorder traits in the relatives of patients with borderline personality disorder. *American Journal of Psychiatry*, 148(10), 1378-1385. [doi:10.1176/ajp.148.10.1378](https://doi.org/10.1176/ajp.148.10.1378)

- Simmons, D. (1992). Gender issues and borderline personality disorder: Why do females dominate the diagnosis? *Archives of Psychiatric Nursing*, 4, 219-223.
doi:10.1016/0883-9417(92)90063-O
- Soper, D. (2015). Statistic Calculators [Software]. Available from
www.danielsoper.com.
- Sullivan, K. & O'Connor, F. (2001). Should a diagnosis of Alzheimer's disease be disclosed? *Aging & Mental Health*, 5(4), 340-348.
doi:10.1080/13607860120080297
- Tabachnick, B. G. & Fidell, L. S. (2012). *Using multivariate statistics* (6th ed.). Boston, MA: Pearson.
- Tesser, A. & Rosen, S. (1972a). On the reluctance to communicate bad news (the mum effect): A role-play extension. *Journal of Personality*, 40, 88-103.
doi:10.2307/2786156?sid=21105850835623
- Tesser, A., & Rosen, S. (1972b). Similarity of objective fate as a determinant of the reluctance to transmit unpleasant information: The MUM effect. *Journal of Personality and Social Psychology*, 23, 46-53. doi:10.1037/h0032881
- Tesser, A. & Rosen, S. (1975). The reluctance to transmit bad news. In L. Berkowitz (Ed). *Advances in experimental social psychology* (Vol. 8, pp. 193-232). New York: Academic Press.
- Tesser, A., Rosen, S. & Batchelor, T. (1972). On the reluctance to communicate bad news (the mum effect): A role-play extension. *Journal of Personality*, 40, 88-103.

DOI: 10.1111/j.1467-6494.1972.tb00651.x

- Torgersen, S. (2000). Genetics of patients with borderline personality disorder. *Psychiatry Clinical North American*, 23, 1-9.
doi:10.1016/S0193-953X(05)70139-8
- Torgersen, S. (2009). The nature (and nurture) of personality disorders. *Scandinavian Journal of Psychology*, 50, 624-632. doi: 10.1111/j.1467-9450.2009.00788.x
- Tuckett, A. (2004). Truth-telling in clinical practice and the arguments for and against: A review of the literature. *Nursing Ethics*, 11(5), 501-513.
doi: 10.1191/0969733004ne728oa
- Tuten, T. L., Gosling, S. D., & Johnson, J. A. (2010). *Conducting online surveys. Advanced methods for conducting online behavioral research*. Washington, DC: American Psychological Association.
- White, C., Gunderson, J., Zanarini, M., & Hudson, J. (2002). Family studies of borderline personality disorder: A review. *Harvard Review Psychiatry*, 11(4), 8-19.
doi:10.1080/10673220303937
- Widom, C., Czaja, S., & Paris, J. (2009). A Prospective Investigation of Borderline Personality Disorder In Abused Children and Neglected Children Followed-up into Adulthood. *Journal of Personality Disorder*, 23(5).433-446.
doi: 10.1521/pedi.2009.23.5.433
- Wright, K. (2006). Researching internet-based populations: Advantages and disadvantages of online survey research, online questionnaire authoring software

packages and web survey services. doi: 10.1111/j.1083-6101.2005.tb00259.x

Zahedi, F. (2011). The challenge of truth telling across cultures: a case study. *Journal of Medical Ethics and History of Medicine*, 4(11), 2-9.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3713926>

Zanarini, M., Frankenburg, F., Hennen, J., Reich, D. & Silk, K. (2004). Axis I comorbidity in patients with borderline personality disorder: 6-year follow-up and prediction time to remission. *American Journal of Psychiatry*, 161(11), 2108-2114. doi.org/10.1176/ajp.155.12.1733

Zanarini, M. & Frankenburg, F. (2008). A preliminary randomized trial of psychoeducation for women with borderline personality disorder. *Journal of Personality Disorders*, 22(3), 284-290. doi: 10.1521/pedi.2008.22.3.284

Appendix A: Disclosure Questionnaire

In order to understand licensed social workers' and licensed psychologists' practices regarding the diagnostic disclosure of borderline personality disorder, please answer the following questions. It will take approximately 20 minutes. Your participation is very much appreciated.

1. How often do you inform patients that they have been diagnosed with BPD?

1	2,	3	4	5
Always	Usually	Sometimes	Rarely	Never

2. To what extent, do you feel confident, in general in your ability to disclose diagnostic information regarding BPD?

1	2	3	4	5	6	7
Not at all		To some extent				A great extent

3. To what extent, do you feel confident in general, in your ability to detect and respond to a client's reaction to hearing their diagnosis of BPD?

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Not at all

To some extent

A great extent

4. To what extent does the patient's gender (female) influence your decision to disclose diagnostic information regarding BPD?

1 2 3 4 5 6 7

Not at all

To some extent

A great extent

5. To what extent does the patient's gender (male) influence your decision to disclose diagnostic information regarding BPD?

1 2 3 4 5 6 7

Not at all

To some extent

A great extent

6. To what extent are you involved in disclosing diagnostic information regarding BPD in your practice?

1 2 3 4 5 6 7

Not at all

To some extent

A great extent

12. At the time I delivered the news, I believed the receiver
trusted me. -3 -2 -1 0 1 2 3
13. I recognized that the news would impact the relationship
I had with the receiver. -3 -2 -1 0 1 2 3
14. I knew the person receiving the news quite well. -3 -2 -1 0 1 2 3
15. I believed I was respected by the person receiving the news. -3 -2 -1 0 1 2 3
16. I knew the person receiving the news would be able to turn
to me for help and guidance after the news was delivered. -3 -2 -1 0 1 2 3
- Next we would like some information about the thoughts and feelings you might have
had and the actions you might have taken as you prepared yourself to deliver the news.
17. I thought about my own needs prior to the transaction. -3 -2 -1 0 1 2 3
18. I talked to others about how best to deliver the news. -3 -2 -1 0 1 2 3
19. I thought the receiver would consider this to be bad news. -3 -2 -1 0 1 2 3
20. I developed a plan/strategy to deliver the news. -3 -2 -1 0 1 2 3
21. I feared being blamed by the receiver. -3 -2 -1 0 1 2 3
22. I thought about the needs of the receiver prior to the transaction -3 -2 -1 0 1 2 3
23. I worked out a script in my mind about how best to convey
the news. -3 -2 -1 0 1 2 3
24. I had a choice of informing the receiver of the news. -3 -2 -1 0 1 2 3
25. I anticipated that the receiver would take the news hard. -3 -2 -1 0 1 2 3

26. I tried to prepare myself for the receiver's response. -3 -2 -1 0 1 2 3
27. I recognized that the news I was giving was fixable,
able to be changed -3 -2 -1 0 1 2 3
28. I tried to determine what the receiver already knew about the bad
news situation. -3 -2 -1 0 1 2 3
29. I considered preparing the receiver for the news. -3 -2 -1 0 1 2 3
30. I thought about where to give the news. -3 -2 -1 0 1 2 3
31. I tried to determine the other events in the person's life. -3 -2 -1 0 1 2 3
32. I considered when would be the best time to deliver the news. -3 -2 -1 0 1 2 3
33. I encouraged the receiver to have another person.
(friend or family member) present while I gave the news. -3 -2 -1 0 1 2 3
34. I thought about how I could protect myself from
psychological harm. -3 -2 -1 0 1 2 3
35. I thought about my goals for the transaction. -3 -2 -1 0 1 2 3

Appendix C: Demographic Questionnaire

1. What is your sex?
 - (a) Male
 - (b) Female

2. What professional license do you have?
 - (a) Clinical Social Worker
 - (b) Psychologist

3. What is your primary theoretical orientation? (Please select one)
 - (a) Cognitive Behavioral Therapy
 - (b) Behavioral
 - (c) Humanistic/Existential
 - (d) Psychodynamic or Psychoanalytic
 - (e) Interpersonal
 - (f) Systems

(g) Eclectic/Integrative

(h) Other (Please specify)

4. How often do you work with individuals with BPD?

1 2 3 4 5 6 7 8 9 10

(not frequently)

(frequently)

Appendix D: Permission For Measures

**Permission From Bradley Merker to use the Breaking Bad New
Questionnaire**

Subject : RE: Survey

Date : Wed, Nov 07, 2012 06:15 AM CST

From : **"Merker, Bradley" <BMERKER1@hfs.org>**

To : **"Laci Rumpza" <laci.rumpza@waldenu.edu>**

Hi Laci,

Thank you for contacting me. It sounds like your dissertation may provide further evidence of the MUM Effect. I have no problem with you using/modifying my survey. Unfortunately, I no longer have the survey in either electronic or hard copy. It was destroyed in a fire after completion of the dissertation. You could likely get a copy through dissertation abstracts. I hope this helps. Please feel free to contact me if you have any other questions.

Sincerely,

Brad

From: Laci Rumpza [mailto:laci.rumpza@waldenu.edu]

Sent: Saturday, November 03, 2012 8:30 PM

To: Merker, Bradley

Subject: Survey

Hello Dr. Merker,

I am a graduate student in the clinical psychology program at Walden University. I am currently working on my dissertation and came across an article you wrote entitled: National Survey of Psychologists Training and Practice in Breaking Bad News: A Mixed Methods Study of the MUM Effect.

My dissertation is exploring the disclosure practices of psychologists as it relates to borderline personality disorder. I am trying to gather information on how frequently psychologists are disclosing this diagnosis to patients and the reasons why they may choose not to disclose. I believe that their anxiety is related to the lack

of disclosure.

I am wondering if it would be possible to review the survey that you used to gather your data. I was hoping to get your permission to modify your survey slightly and use it for my own research.

Thank you for your time,

Laci Rumpza

**Permission from original author, Tara McKee to use the
Breaking Bad News Questionnaire**

Subject : Re: Permission to use your survey

Date : Tue, Oct 08, 2013 12:27 PM CDT

From : [Tara McKee <tmckee@hamilton.edu>](mailto:tmckee@hamilton.edu)

To : [Laci Rumpza <laci.rumpza@waldenu.edu>](mailto:laci.rumpza@waldenu.edu)

Laci,

Sure, you are welcome to use the modified version. I don't recall Dr. Merker asking for permission to use/modify it in the first place! In general, my understanding is that if measures are published in journal articles that they are fair game for others to use and/or

change. Thanks anyway for asking me about it. It is nice to know that this research has extended from physicians to psychologists/clinicians.

Best of luck with your dissertation,

Tara

Tara E. McKee, PhD
Associate Professor of Psychology
Hamilton College
198 College Hill Road
Clinton, NY 13323
(Work) 315-859-4216
(Fax) 315-859-4807

On Tue, Oct 8, 2013 at 11:36 AM, Laci Rumpza <laci.rumpza@waldenu.edu> wrote:

Hello Dr. Eberhardt-Mckee,

I am currently completing my doctorate in clinical psychology at Walden University. My dissertation is looking at the disclosure practices of psychologists and clinical social workers in regard to borderline personality disorder. I am interested in the reasons why professionals do and do not disclose.

I reviewed your article, I'm afraid I have something bad to tell you: breaking bad news from the perspective of the giver and found it relevant to my own research.

Merker, Hanson and Poston (2010) used a modified version of your survey in their article National survey of psychologists' training and practice in breaking bad news: a mixed methods study of the MUM effect.

I would like to use the modified version created by these authors for my own research and was hoping that you would grant me permission to do so. I have received permission from Dr. Merker as well.

Please let me know if you would like any additional information,

I appreciate your time,

Laci Rumpza, M.A., LP

Appendix E: E-Mail Soliciting Participation

Dear Colleagues,

My name is Laci Rumpza and I am working on my dissertation for my PhD in Clinical Psychology. I am writing to request your participation in a short survey examining the diagnostic disclosure of borderline personality disorder. There is relatively no research in this area and your contribution would be greatly appreciated.

If you choose to participate in this study. Participation is voluntary and will require approximately 15 minutes of your time. You are free to exit the survey at any time. There are no known potential risks to you as a participant and all efforts will be made to preserve the confidentiality of your responses.

If you have any questions, please feel free to contact me at laci.rumpza@waldenu.edu.

If you agree to participate in the study, please visit the following address to take the

Questionnaire: <https://www.surveymonkey.com>

The first page of the survey consists of an informed consent page that provides additional information about the survey. Please be sure to "agree" to the informed consent form if you wish to participate, and then you will be able to access the survey.

Thank you in advance for your willingness to contribute to research in the field of mental health.

Sincerely,

Laci Rumpza, M.A., LP

Doctoral Candidate

Walden University

laci.rumpza@waldenu.edu

Appendix F: Consent Form

You are invited to take part in a research study examining the disclosure practices of mental health professionals in regard to borderline personality disorder (BPD). The study will invite all licensed psychologists and a random sample of licensed clinical social workers in the state of Minnesota to participate. This form is part of a process called “informed consent” to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Laci Rumpza, who is a doctoral student at Walden University. You may already know the researcher as a Licensed Psychologist or Licensed Professional Counselor but this study is separate from that role.

Background Information

The purpose of this study is to identify how licensed psychologists and licensed clinical social workers choose to disclose or not to disclose the diagnostic label BPD.

Procedures

If you agree to this study, you will be asked to respond to items via an online survey website. It is anticipated that this process will take approximately 15 minutes. The second phase of the study involves a purposeful sample of questionnaire respondents and includes a brief 10-15 minute interview. Respondents selected for the second phase of the study will be emailed a separate consent form. Those respondents willing to participate will be contacted by phone and again asked for their verbal consent.

Risks and Benefits of Being in the Study

There is minimal risk associated with this research. You may feel some distress or discomfort in answering questions that are personal in nature, and are free to discontinue your participation at any time. If you choose to participate your responses will be confidential. There are no direct benefits regarding study participation. You may benefit from this study through the opportunity to reflect on your perception towards BPD. The benefit to society is that this study will add to our knowledge regarding the disclosure of BPD.

Voluntary Nature of the Study

This study is voluntary. Your decision of whether or not you choose to be in the study will be respected. You are free to refuse to participate or to withdraw your consent to participate in this research at any time before completing the survey without penalty or prejudice: your participation is entirely voluntary. If you choose to withdrawal after you have submitted your responses, you may contact me at Laci.Rumpza@waldenu.edu and ask that your responses be eliminated. Once the study has ended, you will not be able to withdrawal your responses.

Privacy

Your privacy will be protected. Any information you provide will be kept confidential. Audio recorded interviews conducted during the second phase of the study will be immediately transcribed and the audio recordings will be destroyed. All of the data will be stored on the student researcher's computer. All files will be password protected. The

files will be maintained for 5 years following the closure of the project, as required by the university, at which point the files will be erased.

Contacts and Questions

You may contact the researcher via e-mail with any questions, at

Laci.Rumpza@waldenu.edu. If you would like a copy of the research results, please e-mail the researcher and a copy will be e-mailed to you upon completion of the study.

Confidentiality will be maintained. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Her phone number is 612.312.1210. Walden University's approval number for this study is 08-22-14-0161767 and it expires on 08-21-2015.

Please print or save a copy of this informed consent for your records.

Appendix G: E-Mail Soliciting Participation-1 week

Dear Colleagues,

One week ago I sent you an invitation to take a survey examining the diagnostic disclosure of borderline personality disorder. If you have not already done so, would you please take approximately 15 minutes to complete the survey? It would greatly help me to research this important and understudied topic.

For your convenience, the survey can be accessed by following the address listed below.

Questionnaire: <https://www.surveymonkey.com>

Thank you so much for taking the time to assist me with my dissertation research study.

Sincerely,

Laci Rumpza, M.A., LP

Walden University

Doctoral Candidate

laci.rumpza@waldenu.edu

Appendix H: Thank You

You have completed the survey.

Thank you for your participation in the study, as your participation will be helpful to this research area.

Appendix I: Phase 2: E-Mail Soliciting Participation/Consent Form

Dear Colleagues,

Thank you for completing the questionnaire regarding disclosure and borderline personality disorder. In order to further our understanding, I would greatly appreciate if you would take 10 to 15 minutes to participate in the second phase of the research, which includes a telephone interview. Your name was selected based on your responses to the survey and your responses will be strictly confidential. Audiotapes will be immediately transcribed and then destroyed. Transcriptions will not be directly associated with any particular individual and will be stored on the student researcher's computer. All files will be password protected. The files will be maintained for 5 years following the closure of the project, as required by the university, at which point the files will be erased.

Benefits to participants include contributing to the knowledge base in this important and understudied area. There are no known risks associated with participation. You have a right to ask questions about this research and to have those questions answered. If you have any questions, feel free to contact me at laci.rumpza@waldenu.edu. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Her phone number is 612.312.1210.

Walden University's approval number for this study is 08-22-14-0161767 and it expires on 08-21-2015. Please keep a copy of this consent for your records.

Your help is greatly appreciated and your participation is voluntary. You are free to decide whether or not to participate in the study. Your decision of whether or not you choose to be in the study will be respected. You are free to refuse to participate or to withdraw your consent to participate in this research at any time before completing the survey without penalty or prejudice: your participation is entirely voluntary.

I have read the above information and I feel I understand the study well enough make a decision about my involvement. By indicating your agreement with this consent form, you agree that you understand the procedures and any risks and benefits involved in this research. Simply reply to this email with your phone number. By replaying with your phone number you are consenting to participate and be auto recorded.

Appendix J: E-Mail Soliciting Participation Phase Two-1 week

Dear Colleagues,

One week ago I sent you an invitation to take a survey examining the diagnostic disclosure of borderline personality disorder. I would greatly appreciate if you would take 10 to 15 minutes to participate in the second phase of the research, which includes a telephone interview. Your name was selected based on your responses to the survey and your responses will be strictly confidential. Audiotapes will be immediately transcribed and then destroyed. Transcriptions will not be directly associated with any particular individual and will be stored on the student researcher's computer. All files will be password protected. The files will be maintained for 5 years following the closure of the project, as required by the university, at which point the files will be erased.

Benefits to participants include contributing to the knowledge base in this important and understudied area. There are no known risks associated with participation. You have a right to ask questions about this research and to have those questions answered. If you have any questions, feel free to contact me at laci.rumpza@waldenu.edu. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Her phone number is 612.312.1210.

Walden University's approval number for this study is 08-22-14-0161767 and it expires on 08-21-2015. Please keep a copy of this informed consent for your records.

Your help is greatly appreciated and your participation is voluntary. You are free to decide whether or not to participate in the study. Your decision of whether or not you choose to be in the study will be respected. You are free to refuse to participate or to withdraw your consent to participate in this research at any time before completing the survey without penalty or prejudice: your participation is entirely voluntary.

I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By indicating your agreement with this consent form, you agree that you understand the procedures and any risks and benefits involved in this research. Simply reply to this email with your phone number. By replying with your phone number you are consenting to participate and be auto recorded.

Curriculum Vitae

Laci Rumpza, M.A., LP**EDUCATION****Walden University Minneapolis, Minnesota****June 2009 – Current**

Degree: Doctor of Psychology

Major Field of Study: Clinical Psychology

Saint Mary's University Minneapolis, Minnesota**September 2001 – June 2005**

Degree: Master of Arts

Major Field of Study: Counseling Psychology

Saint Thomas University Saint Paul, Minnesota**September 1996 – May 2000**

Degree: Bachelor of Arts

Major Field of Study: Criminal Justice

Minor Field of Study: Psychology

CLINICAL PROFESSIONAL EXPERIENCE**North Point Health & Wellness Center, Hennepin Count****January 2007 – Present**

Minneapolis, MinnesotaPsychologist

- Provide assessment and treatment to children, adolescents, adults and their families in a multidisciplinary community health center.
- Conduct psychological assessments that include the evaluation of academic, intellectual, behavioral, adaptive and personality functioning.
- Facilitate a chemical health education group for adolescents.
- Facilitate a cognitive skills group for adult women
- Facilitate a domestic abuse psychoeducation group for males
- Provide culturally competent therapeutic services to individuals with diverse backgrounds in north Minneapolis.
- Participate in weekly case consultation meetings with a multidisciplinary team.
- Collaborate with the medical, dental, and other departments in the clinic, as well as community corrections officials, schools, and community agencies to provide optimal services to clients and families.

Neighborhood Involvement Program**September 2012 to August 2014****Minneapolis, Minnesota**Doctoral Psychology Internship

- Provided assessment and treatment to adults in the Rape and Sexual Violence Center, Counseling Clinic and Sexual Health Clinic.

- Participated and completed training the Sexuality Training Program.
- Facilitated a short-term psychoeducational group for survivors of sexual violence.
- Facilitated a long-term process group for survivors of sexual violence.
- Supervised master's level and doctoral level practicum students.
- Served as on-call for student questions and emergencies.

NorthPoint Inc Renaissance Program

September 2011-May 2012

Minneapolis, Minnesota

Doctoral Psychology Practicum

- Provide assessment and treatment to adults participating in a dual diagnosis treatment program.
- Facilitate group psychotherapy.
- Conduct psychological assessments that include the evaluation of academic, intellectual, behavioral, adaptive and personality functioning.
- Provide culturally competent therapeutic services to individuals with diverse backgrounds.
- Attend weekly case consultation meetings with a multidisciplinary team regarding chemical health and provide mental health treatment recommendations.

Project Support, Juvenile Probation

July 2004 – January 2007

Hennepin County, Department of Community Corrections

Senior Social Worker

- Conducted mental health screenings at the juvenile court with court ordered youth.

- Provided assessment and treatment to individuals, families and groups court-ordered by Hennepin County Juvenile Court.
- Provided individual, family and group therapy to adolescents with a diagnosis of fetal alcohol spectrum disorder (FASD).
- Provided culturally competent therapeutic services to individuals with diverse backgrounds.
- Collaborated with probation officials, schools, and community agencies to provide optimal services to clients and families.
- Assisted families in scheduling FASD Diagnostic Evaluation appointments and helped remove any barriers the family may be experiencing in getting to the evaluation.
- Attended the family consultation and reading of the recommendations with the multidisciplinary team at the University of Minnesota.
- Helped families and stakeholders select appropriate ongoing resources for case management services.
- Made referrals to interventions including special education, mental health treatment and other interventions as appropriate.
- Assisted with data collection efforts as needed.
- Developed and conducted community and professional trainings to increase capacity of various provider groups to provide effective interventions to youth with an FASD diagnosis.

Project Support, Juvenile Probation

May, 2004-November 2005

Hennepin County, Department of Community Corrections

Masters Counseling Practicum

- Conducted mental health screenings at the juvenile court with court ordered youth.
- Conducted mental health diagnostic assessments.
- Provided individual, family and group psychotherapy.
- Provided case management for identified clients by identifying resources in the community based on insurance and individual needs.
- Monitored progress of referrals and provided updates to the Juvenile Court.

RESEARCH EXPERIENCE**National Institute of Mental Health “RAISE” Project****August 2010- Present**Clinical Researcher

- Deliver structured “Individuals Resiliency Training” treatment protocol to individuals with early onset schizophrenia/psychosis.
- Audio record therapy sessions and submit therapy sessions to ensure adherence to treatment protocol to the lead researchers.
- Participate in weekly multidisciplinary team meetings.
- Participate in biweekly clinical supervision via telephone conference call with the lead researchers.

Saint Mary’s University**May, 2005**Master’s Thesis

- Completed a literature review on posttraumatic stress disorder as it applies to the juvenile

delinquent population.

LICENSURE

- Licensed Psychologist, August 2009