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Exploring Clinician Perceptions of the Clinical Utility of BPD in Aotearoa New Zealand

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Abstract

Borderline personality disorder (BPD) is a complex mental disorder marked by difficulties in emotion regulation, impulsivity, relationship issues, and identity instability (American Psychiatric Association, 2022). BPD causes great suffering to those who have the disorder, with poor outcomes in life quality, relationships, employment (Skodol et al., 2002), high rates of suicidal and non-suicidal self-injury, and high rates of death due to suicide (Oldham, 2006). BPD is associated with significant financial and emotional burdens for society as well as for the individuals with the disorder (Zanarini et al., 2001). BPD is the most commonly occurring personality disorder in clinical populations (Volkert et al., 2018). It is highly comorbid, often co-occurring with MDD, anxiety disorders, traumatic disorders, and other personality disorders (Zanarini et al., 2004).

However, BPD is a controversial and often disputed diagnosis (Leichsenring et al., 2024). This is due to the long and complex history of the diagnosis, stigma surrounding the diagnosis, gender biases of the diagnosis, its lack of a clear aetiology, the heterogeneity of symptoms, and its high comorbidity with other mental disorders (Bockian, 2002). Debate has only increased in recent decades with the development of the concept of complex post-traumatic stress disorder (CPTSD), recently included as a diagnosis in the ICD-11 (World Health Organisation, 2025). Indeed, some suggest CPTSD is a better way of understanding the symptoms of BPD (Kulkarni, 2017). This arguably has led to increased confusion in clinical practice, yet there is limited research into the perceived utility of the BPD diagnosis by clinicians.

The present study aims to investigate psychologists' perceptions of the clinical utility of the BPD diagnosis in their everyday clinical practice. Thematic analysis of interviews with practising psychologists in Aotearoa New Zealand (NZ) was conducted to examine how they perceive those seeking treatment who present with symptoms of borderline personality disorder, whether they use the BPD diagnosis, what alternative approaches they may take if not using the diagnosis, and how this would inform formulation and treatment. Five themes were identified: Alarm Bells!; Navigating a Moral Dilemma; Centring the Client; Trauma: A New Approach to BPD; and Change & Acceptance. The BPD diagnosis caused immediate concerns for clinicians due to factors such as stigma, the ‘stickiness’ of the diagnosis, gender issues with the diagnosis, and the difficulty for clinicians in treating those with BPD. Grappling with the alarming diagnosis required psychologists to discuss how they navigate the use of the diagnosis in their practice. Participants also highlighted the importance of having a client-centred approach to clinical psychology. They consistently referred to CPTSD as a potential alternative to the BPD diagnosis; however, they pointed out that there are still issues with replacing BPD with CPTSD. A final theme discussed was acceptance and change in diagnosis, including perspectives on the DSM and diagnosis, which highlighted that change is possible but complex and slow, and acknowledged the role of culture and society in diagnosis.

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Introduction

Borderline Personality Disorder (BPD) is a complex psychological disorder that is marked by severe emotional and behavioural reactivity, extreme mood swings, disturbances in perception of interpersonal interactions, and personal or interpersonal crises, self-harm, and high rates of suicidality (Lepkowsky & Yip, 2020). BPD has a reputation for being difficult to treat due to the complexity of its symptoms and the challenges to the therapeutic process due to the nature of BPD symptoms (Lepkowsky & Yip, 2020). BPD is the most commonly occurring personality disorder in clinical settings (Volkert et al., 2018). Those who have the disorder suffer immensely, with poor outcomes in life quality, relationships, employment (Skodol et al., 2002), high rates of suicidal and non-suicidal self-injury, and high rates of death due to suicide (Oldham, 2006). BPD is associated with significant financial and emotional burdens for society as well as for the individuals with the disorder (Zanarini et al., 2001). BPD is highly comorbid, often co-occurring with major depressive disorder, anxiety disorders, traumatic disorders, and other personality disorders (Zanarini et al., 2004).

BPD is highly stigmatised due to historical biases towards those with the disorder, as well as its difficult-to-treat nature, and real or perceived challenges of therapeutic management of those with the disorder (Lepkowsky, 2020). It is difficult to diagnose, and is often misdiagnosed, due to the high co-morbidity, symptom overlap, heterogeneity, and range of diagnostic criteria of the disorder (Bockian, 2002). The borderline construct itself is considered controversial, with some arguing that the trouble is in the name - ‘borderline’ - a definition predicated on bordering something else cannot be distinct (Millen et al., 2004). Consequently, the definition of borderline personality has been reinvestigated many times (Gunderson et al., 2018).

The disputed status of BPD as a diagnosis surely creates challenges for clinicians. Theories of mental disorder diagnosis highlight the importance of clinicians’ perspectives and clinical utility to inform diagnostic manuals, beyond theoretical and research psychology approaches (Reed, 2010). BPD is a highly investigated diagnosis; however, research into clinical perspectives of the diagnostic utility of BPD is limited.

This study examines the clinical utility of BPD for clinicians working with individuals presenting with BPD symptoms in Aotearoa NZ. It explores what is known about BPD, its history, theories of causes, and treatments, and challenges to the diagnosis, including stigma, gender bias, heterogeneity, symptom overlap, and the emergence of Complex Post-Traumatic Stress Disorder (CPTSD). The study compares research knowledge of BPD to the first-hand perceptions of clinicians working in Aotearoa NZ. This research aims to initiate a discussion on the clinical utility of the BPD diagnosis from the perspective of clinicians in daily practice in Aotearoa NZ.

Chapter One: The Borderline Personality Disorder

This chapter provides an overview of borderline personality disorder (BPD), starting with its historical background. It then describes how the diagnosis is established using the DSM-5 and ICD-11 criteria. The chapter further discusses the prevalence, costs, comorbidity, and heterogeneity of BPD. Prominent theories about the disorder are examined, along with research on hereditary and biological factors associated with BPD. The chapter also addresses issues related to diagnosis, such as stigma, gender bias, and symptom overlap. It concludes with a review of recent research and literature from Aotearoa NZ.

A Brief History of the BPD Diagnosis

Let us begin by discussing the word 'borderline'. Borderline, when used as a noun, refers to something that is in between two separate things; for example, the literal borderline between two countries. In this sense, it is a dividing line or a cutoff point. When borderline is used as an adjective, it describes something that is on the limit of what can be included in a particular class or group. If someone is a borderline alcoholic, they are considered to be not quite an alcoholic but very close to being one (Oxford University Press, 1989). This dual usage of the term borderline has been the case for the term 'borderline personality', and an etymology that haunts the disorder to this day.

The use of the term borderline has developed alongside the development of modern psychology and took its first shaky steps in the prisons of Italy and Germany in the 19th century. The work of Cesare Lombroso, in the 1870s, and Emil Kraepelin, at the turn of the 20th century, focused on the criminal personality. Neither Kraepelin nor Lombroso wanted to see habitual criminals as 'normal' but could not escape the fact that many criminals were not psychotic. As a solution to this problem, they began to discuss the criminal personality as being in an in-between state, in a borderland between normality and psychosis. This is believed to be the first mention of the concept of a borderline (at this time referred as a borderland) condition, the 'zwischengebiet' as Kraepelin called it, one that indicates a person who is neither psychotic nor neurotic (Stone, 2005). Thus began the controversial history of what would become BPD.

Possibly the first to mention of the concept in the English language is Irving Rosse in 1890 who described a cohort of people 'with minds trembling in the balance between reason and madness… not so sane as to be able to control themselves, nor yet so insane as to require restraint or seclusion' (Rosse, 1890, pg. 01). Rosse didn't use the word borderline; instead he referred to these people as 'pseudo-momaniacs', people in the borderland on the verge of insanity who, if left untreated, would go on to become insane. Strikingly, the cases Rosse describes are incredibly wide ranging, including a man with an uncontrollable desire to kill a family member, another complaining of pain in his right eye resulting in the inability to think for more than ten minutes at a time, and a

third who had a clawing pain in his head, an inability to concentrate, loss of will power, and again a fear of insanity. Notably, these cases are far from what the term borderline personality refers to today.

The first use of the actual word borderline is attributed to Thomas Vernor Moore in 1921. Here borderline was used to describe persons who were either 'between' psychotic and neurotic, or ´close to' being schizophrenic; at the time schizophrenia was being widely used to describe psychotic individuals, and the term 'borderline schizophrenia' was commonly used in the 1920s. By the middle of the century, most psychosis was labelled as schizophrenia, and as a result, those so-called borderline clients were labelled ´borderline schizophrenic´ (Stone, 2005).

In 1938, in his article *Psychoanalytic Investigation of and Therapy in the Border Line Group of Neuroses,* Adolph Stern described a specific pathological condition that contained within it both neurotic and psychotic features (Stern, 1938). His article drew attention to such symptoms as the simultaneous idealisation and devaluation of the analyst and other important relationships, 'psychic bleeding' (the inability of a person with the disorder to handle stressful situations), over-reactions to criticism, delusory externalising blame, depression, masochism (self-harm), and 'splitting' (the inability to integrate the good and bad aspects of the self or others). Here we begin to see the emergence of a cluster of symptoms that resemble the modern diagnosis of BPD; however, the term borderline was not used outside of psychoanalysis for a further 30 years (Stone, 2005).
Two figures that paved the way for the borderline to move from psychoanalysis into the increasingly empirical and measurable world of modern psychology are Otto Kernberg and John Gunderson.

In 1975, Otto Kernberg coined the term 'borderline personality organisation' (BPO) to describe a consistent set of behaviours and patterns of functioning 'characterised by instability and reflecting a disturbed psychological self-organisation' (Health, 2009, p. 15). The key components of BPO were adequate reality testing capacity (which separates those with the condition from psychosis) and 'identity diffusion' (which differentiates the condition from the neurotic). The symptoms and behaviours associated with BPO included fluctuations in assessment of self from despair to high confidence, unstable self-image, rapid changes in mood, fears of abandonment, suicidal thoughts, self-harm, and transient psychotic symptoms (Health, 2009). The term BPO covers a vast landscape of disorder, is highly heterogeneous, and consequently, has been widely criticised. However, Kernberg's BPO represented a more structured and clinically useful description than what preceded it.

In the 1970s, John Gunderson empirically investigated those referred to as borderline, which led to the contemporary understanding, and creation of, the diagnosis Borderline Personality Disorder (Stone, 2005). A key work was *Discriminating Features of Borderline Patients* (Gunderson & Kolb, 1978). Gunderson and his colleagues sought to establish objective and measurable criteria of the disorder. Their criteria included: lowered achievement, impulsivity, suicidal threats, disturbances in close relationships and mild or brief psychotic episodes (Stone, 2005). Like Kernberg, Gunderson's 'personality disorder' contains attributes that involve personality, such as impulsivity and anger, along with those that do not, such as lowered achievement and suicidality. Gunderson and Singer's work

was published in the American Journal of Psychiatry (Gunderson & Kolb, 1978), giving the condition a much wider audience, and helping to increase the knowledge and acceptability of the diagnosis beyond the realm of psychoanalysis.

BPD as a distinct diagnostic category was first included by the American Psychiatric Association (APA) in the DSM-III in 1980 (APA, 1980). Robert Spitzer, the editor of the DSM-III, chose to divide the borderline concept into two; schizotypal personality disorder was used to describe those who appear close to being schizophrenic, often describing those with hereditary links to people diagnosed with schizophrenia, and the rest were described by borderline personality disorder. Spitzer had for a time considered the title 'emotionally unstable personality disorder' instead of BPD but eventually chose to stick with BPD (another historical misstep that may have changed the course of the disorder). The DSM-III description of BPD was much narrower than previous attempts to describe the disorder; for example, the DSM-III diagnosis covers around a quarter of what is covered by the concept of BPO (Stone, 2005). The diagnostic criteria of BPD in the DSM-III included criteria from both Gunderson and Kernberg (Stone, 2005): impulsivity (from both Kernberg and Gunderson), identity disturbance (from Kernberg), self-harm and anger (from Gunderson), and intolerance of aloneness (from Gunderson). An issue with the BPD diagnosis was immediately apparent in that of the criteria describing the disorder, only a few are actual personality traits, echoing the flaws in the descriptions by Kernberg and Gunderson.

Further investigation of BPD didn't cease with its inclusion in the DSM. At the time of the DSM-III, many researchers, clinicians, and theorists continued to explore the terrain attempted to be covered by the BPD diagnosis. Narrower diagnoses were discussed, as were issues of comorbidity and overlap with other disorders. It was suggested that many with BPD could also be understood as having an early or dilute form of manic depression (Akiskal, 1981; Liebowitz & Klein, 1981; Stone, 1977), that BPD overlapped with depressive symptoms, and that BPD might be exaggerated forms of the hysteric personality traits and consequently, may be better labelled as ''hysteroid dysphoria'' (Liebowitz & Klein, 1981). Others argued that more subgroups of those with BPD were necessary, including dysthymic, bipolar type II, and cyclothymic (Akiskal, 1981). Despite these issues of diagnostic definition and boundaries, the BPD diagnosis has remained essentially unchanged in the DSM to this day.

Diagnosing BPD

The two most widely used diagnostic manuals for mental health in the English language are the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD). The DSM is developed by the APA and used in the US and numerous other countries, including Aotearoa NZ. The ICD is published by the World Health Organization (WHO) as part of a broader medical manual (WHO, 2025). The ICD is recognised and utilised in Europe and

other WHO member states. The latest iteration of the DSM, the DSM-5, takes a categorical approach to understanding and diagnosing BPD, and treats BPD as a distinct disorder. The most recent iteration of the ICD is the ICD-11; its release in 2022 marked a change in approach to mental diagnosis for the WHO, with a move from a categorical approach to a dimensional one. A dimensional approach, rather than seeing mental disorders as belonging to distinct categories, conceptualises them as existing on a series of spectrums (dimensions), and focuses on the severity of difficulties an individual experiences as occurring along these dimensions. The dimensional approach has been argued to allow more latitude for clinicians to assess client conditions based on severity and does not require a concrete threshold between what is considered 'normal' and what constitutes a disorder (APA, 2013).

What follows is a concise description of the diagnostic classification of BPD in the DSM-5 and the ICD-11. Of note is that both the DSM-5 and ICD-11 offer alternative or additional means of understanding BPD, which, to an extent, bridge the gap between current clinical practice and the movement toward dimensional approaches. The ICD-11 includes a pattern identifier specifically designed to address the BPD diagnosis directly, including very similar criteria to the categorical approach to BPD in the DSM-5. In the DSM-5, there is an Alternative Model of Personality Disorders, which offers clinicians the possibility to diagnose personality disorders (PDs) from a dimensional approach and aligns closely with the dimensional approach to PDs in the ICD-11.

First, let us look at the categorical approach in the DSM-5 (comparing it to the pattern specifier in the ICD-11), and then look at the dimensional approach to PDs in the ICD-11 (and compare it to the Alternative Model in the DSM-5).

DSM-5 Categorical Diagnosis of BPD vs. ICD-11 Borderline Pattern Specifier

The DSM-5 describes BPD as a "pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts" (APA, 2022, pg. 753). To be diagnosed with BPD, one must have at least five of nine criteria (see table below).

The ICD-11's Borderline Pattern Specifier is included to improve the clinical usefulness of the personality disorder classification. Specifically, using this specifier may help identify individuals who might respond to certain psychotherapeutic treatments (WHO, 2025). The borderline pattern specifier is intended to be applied to clients whose personality disturbance is characterized by "a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity" (note how closely this aligns with the DSM). Like the DSM-5, in the ICD-11, BPD also contains nine criteria, of which to meet the threshold, a person must have at least 5. The table below presents the criteria side by side; the nine criteria are essentially identical.

The ICD-11 goes further to list other possible criteria that may be present in someone with BPD: a view of the self as inadequate, bad, guilty, disgusting and contemptible; an experience of the

self as profoundly different and isolated from other people; a painful sense of alienation and pervasive loneliness; proneness to rejection hypersensitivity; problems in establishing and maintaining consistent and appropriate levels of trust in interpersonal relationships; and frequent misinterpretation of social signals (WHO, 2025).

Table 1 - Criteria of the DSM-5 Categorical Diagnosis of BPD and the ICD-11 Borderline Pattern Specifier

DSM-5 Criteria of BPD	ICD-11 Criteria of BPD
Frantic efforts to avoid real or imagined abandonment.	Frantic efforts to avoid real or imagined abandonment.
A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.	A pattern of unstable and intense interpersonal relationships, which may be characterized by vacillations between idealization and devaluation, typically associated with both strong desire for and fear of closeness and intimacy.
Identity disturbance: markedly and persistently unstable self-image or sense of self.	Identity disturbance, manifested in markedly and persistently unstable self-image or sense of self.
Impulsivity in at least two areas that are potentially self-damaging.	A tendency to act rashly in states of high negative affect, leading to potentially self-damaging behaviours (e.g. risky sexual behaviour, reckless driving, excessive alcohol or substance use, binge eating).
Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour.	Recurrent episodes of self-harm (e.g. suicide attempts or gestures, self-mutilation).
Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).	Emotional instability due to marked reactivity of mood – fluctuations of mood that may be triggered either internally or by external events, leading to intense dysphoric mood states, which typically last for a few hours but may last for up to several days.
Chronic feelings of emptiness.	Chronic feelings of emptiness.
Inappropriate, intense anger or difficulty controlling anger.	Inappropriate intense anger or difficulty controlling anger, manifested in frequent displays of temper.
Transient, stress-related paranoid ideation or severe dissociative symptoms.	Transient dissociative symptoms or psychotic-like features (e.g. brief hallucinations, paranoia) in situations of high affective arousal.

Note. Created using information from the DSM-5-TR (APA, 2022) and the ICD-11 (WHO, 2025).

ICD-11 Dimensional Approach to Personality Disorders vs. the DSM-5 Alternative Model of PDs

In the ICD-11, personality disorders are understood together. The authors state that the "central manifestations of Personality Disorder are impairments in functioning of aspects of the self… and/or problems in interpersonal functioning" (WHO, 2025, Personality disorders and related traits – Diagnostic Requirements, para. 1). Using the ICD-11 to diagnose a personality disorder, a decision needs to be made as to whether a person has a personality disorder at all, and then this needs to be determined in three levels of severity, from mild to moderate and severe. A category called

‘Personality Difficulty’ also exists to describe people whose personality is creating difficulties in their life, not severe enough to be considered a disorder. In addition to the levels of severity, the ICD-11 also has ‘Trait Domain Descriptors’, referring to five trait domains. In a diagnosis using the ICD-11, a clinician determines the severity of PD and then indicates which of the five trait domains are present; it is possible to have all of them or even none of them. The five trait domains are: negative affectivity, dissocial features, disinhibition, anankastia (compulsion / OCD), and detachment.

In Section III of the DSM-5, the APA introduces a new approach to Personality Disorders, which aims to address such things as the overlap between personality disorders, and the fact that while often an ‘other specified’ or ‘unspecified’ personality disorder is the most correct diagnosis, this lacks clarity (APA, 2022). Much like the ICD-11 dimensional approach, the alternative model in the DSM-5 is grounded in the notion that severity of PDs is the most important predictor of dysfunction (APA, 2022). The DSM-5’s General Criteria for Personality Disorder in the alternative model describes a personality disorder as being ‘moderate or greater impairment in personality (self/interpersonal) functioning’ in ‘one or more pathological personality traits’ (APA, 2022, pg. 761). Self-functioning refers to self-direction and identity. Interpersonal functioning involves intimacy and empathy (APA, 2022). The DSM-5’s five broad domains are: negative affectivity (vs. emotional stability), detachment (vs. extraversion), antagonism (vs. agreeableness), disinhibition (vs. conscientiousness), and psychoticism (vs. lucidity).

Table 2 - Criteria of the ICD-11 Dimensional Model of PDs to the DSM-5 Alternative Model

ICD-11 Dimensional Model of Personality Disorder	DSM-5 Alternative Model of Personality Disorder
Step One: Assess impairment in functioning of the self and/or problems in interpersonal functioning. Three levels of severity; mild, moderate and severe (‘Personality Difficulty’ describes people whose personality is creating difficulties in their life, not severe enough to be considered a disorder).	Step One: Assess for moderate or greater impairment in personality functioning (self and interpersonal). Self refers to identity and self-direction. Interpersonal functioning refers to empathy and intimacy.
Step Two: Indicate which of the Five Trait Domain Descriptors.	Step Two: Indicate four or more of the following trait domains.
Negative affectivity.	Negative affectivity (vs. emotional stability).
Detachment.	Detachment (vs. extraversion).
X	Antagonism (vs. agreeableness).
Disinhibition.	Disinhibition (vs. conscientiousness).
Dissocial features.	Psychoticism (vs. lucidity).
Anankastia (compulsion / OCD).	**X**

Note. Created using information from the DSM-5-TR (APA, 2022) and the ICD-11 (WHO, 2025).

X – Denotes absence of corresponding trait domain.

Summary

The authors of the DSM-5 and the ICD-11 appear to have maintained a stance in both the dimensional and the categorical diagnostic positions. In both manuals BPD is treated as a unique disorder, requiring extra attention. This may be due to the current context in psychology, where there is a growing emphasis on understanding mental health from a dimensional perspective (Hengartner & Lehmann, 2017; Kotov et al., 2017) and yet a tension may exist for the developers of diagnostic manuals between the desire to move forward and need to minimise the disruption to users of the manuals that any change may cause (Mullins-Sweatt et al., 2015).

Considering the Diagnosis

The following section highlights what is known about the BPD diagnosis including data on the prevalence, and cost of the diagnosis, and results of investigations into the co-morbidity, heterogeneity, and symptom overlap of the diagnosis.

The Prevalence of BPD

Results of research into the prevalence rates of BPD varies. The prevalence of BPD (as defined in the DSM) in the adult general population has been estimated to be between 0.7 to 3.5% (Coid et al., 2006; Grant et al., 2008; Jackson & Burgess, 2000; Lenzenweger et al., 2007; Moran et al., 2006; Quirk et al., 2017; ten Have et al., 2016; Torgersen et al., 2001). A lifetime diagnosis of BPD in primary care patients has been found to be 6.4% (Gross et al., 2002). In adult populations in mental health treatment the prevalence increases to between 9% and 18% (Ford & Courtois, 2021), between 9.3% to 14.4% in psychiatric outpatients (Zimmerman et al., 2005; Zimmerman & Mattia, 1999), 9% in psychiatric emergency services (Pascual et al., 2009), and between 12% and 18% in psychiatric inpatients (Gunderson, 2001; Koenigsberg et al., 1985; Widiger & Weissman, 1991).

Regarding prevalence rates in Aotearoa NZ, the only study known to this author examining prevalence rates of any personality disorder is a recent study by Newton-Howes et al. (2020) which sought to examine the prevalence of personality disorder among those being treated by secondary mental health services in Aotearoa NZ. The study used data from the Programme for Integration of Mental Health Data (PRIMHD), a national public mental health data set from between 1 July 2008 and 30 June 2017. The study found that of the 294,612 people aged 18-64 that had contact with mental health services for 3 months or more, 2.8% (8884) had a primary diagnosis of PD (60.4% were female). Of those, more than half (1.57 % of the total sample) had a BPD diagnosis (45.6% had a BPD diagnosis, and another 10.3% had BPD combined with another PD diagnosis). Of the PD

population, Māori[1] constituted 21.1% (18% of women and 26% of men). This is significant as only 14.5% of the population aged 15–64 years at the time identified as Māori (Newton-Howes et al., 2020). According to the study, very few Asian or Pacific peoples sought services for PD diagnoses. The total number of people in contact with services for PD increased over time from 3418 in 2009 to 5270 in 2016. The study also found that those presenting with PD almost always have either BPD or antisocial personality disorder. Due to only having one study focused on prevalence rates in Aotearoa NZ, one cannot make any strong conclusions; however, Aotearoa NZ prevalence rates from this single study align with the international range of prevalence rates, and it may be that Māori men are over represented among those with personality disorders.

The Cost of BPD

The complexity and difficulty of having borderline personality disorder places a significant cost on both the individual with BPD and society. Treatment utilisation costs of individuals with BPD exceed those of diabetes, epilepsy, depressive disorders, and Parkinson's disease (Gunderson et al., 2018; Hastrup et al., 2019; Schneider et al., 2019; Wagner et al., 2013). Research has found that an individual with BPD has worse social functioning than one with MDD or other personality disorders and increased use of mental health resources and medication for mental health disorders (Bender et al., 2001). Those with BPD are more likely to have required individual and group therapy treatment at residential and day centres, psychiatric hospitalisation, medication, and access to self-help groups. Those with BPD are younger when they access treatment, spend longer in treatment, have a significantly higher number of psychiatric hospitalisations than those with other disorders, and take larger amounts and more types of medication, taken simultaneously, than those with other personality disorders (Zanarini et al., 2001).

Mortality is also greater for those with BPD. Individuals with BPD have been found to be 2.3 times as likely to die in a two-year follow-up when compared to individuals without BPD (Schneider et al., 2019). Perhaps the most concerning cost of BPD is chronic suicidality and self-harm. One study found that more than 75% of individuals with BPD had attempted suicide (Black et al., 2004). In BPD, the rate of death by suicide is higher than in individuals with other personality disorders (5.9% versus 1.4%) (Temes et al., 2019). Another study found that suicide rates were between two and five percent, five to 14 years following up on individuals with BPD (Alvarez-Tomas et al., 2019).

Individuals with BPD have been found to have a higher prevalence of respiratory, cardiovascular, metabolic, endocrine, and infectious (i.e., HIV and hepatitis) diseases than people without BPD (Schneider et al., 2019; Tate et al., 2022). Higher mortality and increased health issues suffered by those with BPD may be attributed to either neurobiological dysregulation or the

[1] Māori are the indigenous people of Aotearoa, NZ.

compromised immune system associated with early adverse experiences and/or with the unhealthy lifestyle of those with BPD (Leichsenring et al., 2024).

The high cost of BPD has also been found in the few studies in Aotearoa NZ. The previously mentioned study by Newton-Howes et al. (2020) into personality disorders in Aotearoa NZ, found that those with PDs (of which the majority have BPD) access considerable resources. Those with PDs had greater resource utilisation per individual than people with other mental disorders (such as depression), significantly greater inpatient bed nights per person, and a greater proportion of crisis contacts and support. Another study by Tenant et al. (2023) sought to describe psychotropic polypharmacy in people with BPD in Aotearoa NZ by utilising data from the New Zealand Programme for the Integration of Mental Health Data (PRIMHD) for the years 2014 and 2019. The study found that of the 1932 people diagnosed with BPD in 2014, 1468 were dispensed psychotropic medications, of which 49.9% were dispensed three or more psychotropic medications, and 8.4% were dispensed seven or more psychotropic medications. The number of those with a BPD diagnosis increased to 2368 between 2015 and 2019, of whom 1915 were dispensed psychotropic medications. Of those dispensed medications, 55.9% were on polypharmacy, and the percentage taking seven or more medications was 10.7%. These are statistically significant increases ($P < 0.001$ and $P = 0.023$, respectively) since 2014. This is concerning due to the lack of evidence for pharmacological treatments for BPD.

The Co-Morbidity of BPD

BPD is frequently comorbid with other psychiatric conditions (Tate et al., 2022; Zanarini et al., 2004) including depression, anxiety, bipolar disorder, substance use disorders, eating disorders, autism spectrum disorders, Attention Deficit Hyperactivity Disorder (ADHD) and Post Traumatic Stress Disorder (PTSD). Mood disorders are the most common co-occurring condition for people with BPD (Shah & Zanarini, 2018), with 96% of those with BPD having a mood disorder at some point during their lifetime (Shah & Zanarini, 2018).

Depression is comorbid with BPD at rates of between 32% and 83% (Shah & Zanarini, 2018). This includes major depression (MDD). A review by Yoshimatsu and Palmer (2014) found MDD to be highly prevalent in those with personality disorders, with 85% of those with PDs having at least one MDD episode (Gunderson et al., 2008). Individuals with BPD were more likely to have MDD at baseline, and more likely to have recurrences of MDD than other PDs (Gunderson et al., 2008; Gunderson et al., 20011). BPD was also associated with increased risk of MDD in a twin study involving 2801 individuals (Reichborn-Kjennerud et al., 2009). When examining longitudinal studies of MDD and BPD, two large prospective and longitudinal studies (Gunderson et al., 20011; Zanarini et al., 2007) found that depression combined with BPD was far more persistent and treatment

resistant, and that depression in those with BPD does not improve until the BPD associated difficulties improve.

Anxiety has also been found to be comorbid with BPD in numerous cross-sectional studies. Comorbidity of general anxiety disorder (GAD) is between 0% to 35%, panic disorder between 2% to 48%, social phobia between 3% to 46%, OCD between 0% to 20% (Shah & Zanarini, 2018). Anxiety disorders in total have been found in 88% of those diagnosed with BPD from a population found in psychiatric inpatient units (Shah & Zanarini, 2018).

BPD has been found to be comorbid with bipolar disorder (BD). A review by Frías et al. (2016) examining the studies into the co-morbidity of BPD to bipolar found a wide range of prevalence rates of between zero and 52% in 28 studies (mean=22%, median = 20.5%). The review, when looking at BD in those primarily diagnosed with BPD (13 studies), found prevalence was between 5.1% and 78.9% (mean=24.82%, median=21.4%). The prevalence rates of BP in BPD were higher than for other personality disorders, with a prevalence ratio of between 1.67 and 5.93. However, research suggests BD is less prevalent in those with BPD than those with MDD, substance abuse, eating disorders, and PTSD (Goodman et al., 1998; Grant et al., 2008; Gross et al., 2002; Sjastad et al., 2012; Skodol et al., 1999; Wang et al., 2012; Zanarini et al., 1998, 2004; Zimmerman and Mattia, 1999).

Substance use disorders have also frequently been found to be comorbid with BPD (Shah & Zanarini, 2018). Prevalence of comorbidity ranges between 23% and 84% (median 65.1%) (Shah & Zanarini, 2018). Co-occurring alcohol abuse has been found to range between 11.9% to 66% (median 47%), and drug dependence or use from 3.4% to 87% (median 44.1%) (Shah & Zanarini, 2018).

Eating disorders commonly co-occur with BPD (between 14% to 53% comorbidity (Shah & Zanarini, 2018). Comorbidity rates of zero percent to 21% have been found for anorexia nervosa (median of six percent), and three percent to 26% for bulimia nervosa (median of 10%), and between 14% and 26% (median 22%) for those diagnosed with eating disorder not otherwise specified (EDNOS) (Shah & Zanarini, 2018).

A review by Dell'Osso et al. (2023) into the comorbidity of BPD to different forms of autism spectrum disorders found that participants with BPD scored higher on measures for autistic traits compared to a non-clinical population. The authors hypothesise that ASD may be present and unrecognised in those with a BPD diagnosis, or vice versa, and that both those with ASD and BPD may have a shared vulnerability to trauma (Dell'Osso et al., 2023). The review also described significant overlaps between BPD and ASD, noting the numerous studies suggesting similarities between BPD and ASD (Da Cagna et al., 2019; Gordon et al., 2020; Lugnegård et al., 2012; Rydén et al., 2008) including superficial friendships and intense relationships, acting out, self-injury, impairment in verbal and non-verbal communications, impaired social functioning, emotional meltdowns, assumptions about the motives of others, and noting the underlying emotional

dysregulation as causal of traits and symptoms in both disorders (Dell'Osso et al., 2023) and difficulties with theory of mind (Dell'Osso et al., 2023).

Researchers have also investigated the overlap between ADHD and BPD. A review by Weiner et al. (2019) investigated recent research into the comorbidity of ADHD and BPD, and similar risk factors in both disorders. The review found that studies have reported high rates of comorbidity between BPD and ADHD, as well as shared risk factors (such as adverse childhood experiences). The review highlights two major shared dimensions of BPD and ADHD - impulsivity and emotional dysregulation. However, impulsivity was found to be higher in ADHD and combined ADHD and BPD than in BPD alone, and emotional dysregulation was higher in BPD and combined ADHD and BPD, than in ADHD alone. This may indicate phenomenological differences in the expression of impulsivity and emotional dysregulation in the disorders (Weiner et al., 2019).

Studies have also found BPD to be comorbid with PTSD. Pagura et al. (2010) found that 24% of those with lifetime PTSD also met the criteria for BPD in a nationally representative sample in the US (Pagura et al., 2010); they also found that 30% of those with BPD met the criteria for PTSD. Grant et al. (2008) in their study, utilising National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) in the US, found that 29% of individuals meeting the criteria for PTSD in the last 12 months also met the criteria for lifetime BPD, and that 32% of those with lifetime BPD could be diagnosed with PTSD in the last 12 months (Grant et al., 2008). In a more recent study, Scheiderer et al. (2015) found that 53.11% of those who met criteria for BPD also met criteria for lifetime PTSD. Interestingly, the same study found that only 14.69% of those who met the criteria for PTSD also met the criteria for BPD. That same study also investigated childhood sexual assault (CSA) as a mediator in the co-morbidity of BPD to PTSD and found that participants who had a history of CSA were significantly more likely to have comorbid BPD with PTSD rather than just BPD or PTSD (Scheiderer et al., 2015)—the rates of comorbidity increased in clinical samples.

In clinical samples with PTSD, comorbidity with BPD ranges from 28% to 68% (Heffernan & Cloitre, 2000; Zlotnich et al., 2002). In a study of 94 women with borderline personality disorder who were enrolled in a randomized controlled outpatient psychotherapy outcome study, 56.4% met diagnostic criteria for current PTSD (Harned et al., 2010). A study by Heffernan and Cloitre (2000) of 71 women with a history of childhood sexual abuse who all had PTSD found that 36.7% also met the criteria for BPD. In a study by Zanarini et al. (1998) of 379 participants who all met the criteria for BPD, 55.9% also met the criteria for PTSD. Finally, in a study by Zlotnick et al. (2002) of 1,410 treatment-seeking outpatients, a general hospital private practice found that of those in the sample who met the criteria for BPD, 32.2% also met the criteria for PTSD.

Theories and Associated Treatments of BPD

Numerous approaches exist for understanding and treating BPD. What follows is a discussion of four major theories of BPD, along with associated treatments, then a discussion of research into the role of neurobiological and hereditary factors for the disorder.

Object Relations Theory of Aggression of BPD

Kernberg (1967) posited a theory of borderline personality based on object relations theory (ORT) from psychoanalysis. ORT posits that BPD is caused when so-called 'normal' integration during childhood (the integration of the ideal object and the bad / depriving object into one good enough object /other) does not take place. The theory posits that this 'internal split' organisation continues into later life and can manifest as BPD. The internal split is maintained due to repeated interactions that reinforce the split; an individual's experiences are perceived via internal representations, the individual responds to these automatically, provoking a reaction from the other, which then reinforces the split internal system. According to ORT, aggression is the key underlying mechanism. This aggression may be due to 'inborn' temperaments (genetically determined), or due to difficult early experiences or frustrations (abuse and trauma, for example), or a combination of these factors (Fonagy et al., 2016). To protect the idealised objects (the good self and the good other), the individual alternates between aggression (to protect the good self) and defensive suppression (to protect the good other) (Fonagy et al., 2016).

Transference-focused psychotherapy (TFP) is a psychodynamic psychotherapy for BPD based on ORT (Hersh et al., 2016). TFP aims to change the psychological structures within an individual to reshape an individual's experience of the self, subjectively and interpersonally, to reduce the maladaptive emotions and behaviours of BPD. The work of TFP involves analysing the defensive processes that support the split sense of self and others that underlie BPD. The therapist attempts to constantly track the dominant affect of the client at any given moment, and use techniques such as technical neutrality (focusing on interpretation rather than side taking); transference analysis (exploring the internal object relations elucidated by the client-therapist dyad); clarification (understanding together with the client); and confrontation (presenting tactfully the contradictions in the client's experiences) to break down and integrate the rigid split between persecutory and idealised parts of relationship experiences (Hersh et al., 2016). Studies have found TFP to be effective in reducing symptoms of BPD and increasing reflective functioning (Kernberg et al., 2008).

Linehan's Biosocial Theory of BPD

Possibly the most widely accepted theory of BPD is Marsha Linehan's (1993) biosocial theory of BPD. Linehan's theory posits that BPD is primarily a disorder of emotional dysregulation caused by the interaction of biological vulnerabilities, with specific environmental influences during development (Crowell et al., 2009). Factors such as characteristics of the child, the caregiver, and the

environmental context interact to influence the development of BPD (Crowell et al., 2009). BPD results in emotional dysregulation across all aspects of emotional responding and includes heightened sensitivity, difficulty regulating intense emotional responses, and a slow return to emotional baseline. For Linehan, the development of BPD is due to an invalidating environment in which the expression of emotions, especially those relating to unobservable factors, is not tolerated. In such a setting, a child does not develop the ability to tolerate, regulate, label, or understand emotional responses, and develops instead the emotional oscillating symptoms of BPD, switching between emotional inhibition and emotional lability (Crowell et al., 2009).

Dialectical Behavioural Therapy (DBT), developed by Linehan (1993), is a treatment based on the biosocial theory of DBT. DBT was initially designed to treat highly suicidal individuals but later became the first evidence-based treatment for BPD (Dimeff & Linehan, 2001). DBT combines behavioural therapy strategies with mindfulness and is situated within a dialectical approach to understanding the world. The dialectic in DBT is the synthesis of acceptance and change, accepting the challenging behaviours and difficulties of BPD, whilst also working toward positive change. Acceptance strategies in BPD include mindfulness adopted from Zen Buddhism. Change strategies include skills training, behavioural analysis, contingency management, problem-solving techniques, and exposure therapy. Different modes of DBT include highly structured individual and group skills training, individual psychotherapy, phone consultation, and a therapist consultation team (to keep therapists motivated) (Dimeff & Linehan, 2001). Research into the efficacy of DBT when compared to treatment as usual (TAU) has found it to reduce parasuicidal episodes and reduce the severity of parasuicidal actions, reduce treatment dropout, reduce psychiatric unit visitation and inpatient psychiatric days, reduce anger, suicidal ideation hopelessness, dissociation, and hostility, reduce substance use, and improve global functioning and social adjustment both in the treatment year and one year post treatment (Dimeff & Linehan, 2001).

Mentalization Based Approach to BPD

Mentalization, a concept first introduced by Peter Fonagy (Fonagy & Bateman, 2008), refers to the ability to recognise mental states in oneself or others and to understand the relationships between them (Fonagy & Bateman, 2008). Fonagy posits that mentalization is not a given but a developmental skill dependent on early attachment relationships. Disruptions in the development of mentalization can affect the formation of a coherent self-structure (Fonagy & Luyten, 2009). An individual's ability to mentalize impacts upon affect representation, affect regulation, and attentional control. BPD may be the result of failed mentalisation, combined with disorganisation of self-structure. Fonagy and Luyten (2009) state that BPD is a consequence of "(a) the loss of mentalization in emotionally intense relationship contexts, (b) the reemergence at these times of modes of thinking about subjective experience that antedate full mentalization, and (c) the constant pressure for

externalization of internal states (projective identification), which we conceive of as the re-externalization of disorganized intolerably painful self-states (the self-destructive alien self)" (Fonagy & Luyten, 2009, p. 1357). This experience causes high levels of anger, sadness, and rejection (Leichsenring et al., 2024), leading to problematic behaviours such as substance abuse and self-harm.

Mentalization-Based Therapy (MBT) is the treatment associated with the theory of mentalization. It is a combination of group and individual therapy, developed by Bateman and Fonagy (2004). MBT is grounded in psychodynamic, attachment theory, and neurobiology. It seeks to address the vulnerability of a person with BPD to shifting into non-mentalizing modes when they find themselves in states of emotional arousal (Bateman & Fonagy, 2004). A meta-analysis of 33 RCTS supported the efficacy of MBT (Cristea et al., 2017). MBT was found to have higher-than-average effect sizes for BPD treatment when compared to TAU in a second meta-analysis of 87 studies (Rameckers et al., 2021). Furthermore, a systematic review by Vogt and Norman (2019) found that MBT was associated with significant improvements in quality of life, symptom severity, and co-morbid symptom severity in the treatment of BPD.

The Theory of Interpersonal Hypersensitivity

Gunderson and Lyons-Ruth (2008) theorise that BPD develops from a genetic predisposition for hypersensitivity to interpersonal cues interacting with adverse early caretaking experiences. This leads to a disorganised and controlling interpersonal approach, which accounts for the abandonment and relational issues in BPD, as well as problems with affect and impulsivity (Gunderson & Lyons-Ruth, 2008). Gunderson and Lyons-Ruth (2008) suggest that individuals with BPD have "a paradoxical, seemingly contradictory combination of intense needs for closeness and attention with equally intense fears of rejection or abandonment" (Gunderson & Lyons-Ruth, 2008, p. 2). Fear of abandonment is the foundational criterion of BPD. A minor verbal slight can cause someone with BPD to have profound abandonment concerns, leading to rapid dysphoria. The intolerableness of these feelings causes them to engage in self-harm, suicidality, substance abuse, promiscuity, and impulsive actions as maladaptive means to increase closeness to others or pain reduction (Zanarini, 2005).

Good Psychiatric Management (GPM) for BPD (Gunderson & Links, 2014) is the treatment associated with the theory of interpersonal hypersensitivity. This treatment modality consists of flexible guidelines of attitudes for clinicians to adopt when interacting with individuals with BPD. GPM recognises the need for flexibility and pragmatism and is intended as a guide for non-BPD-expert clinicians to approach individuals with BPD for short-term interactions, to support professionals in being "good enough" at treating most BPD cases. GPM emphasises common features from more specialised and time-intensive BPD treatments (MBT, DBT, TFP) (Gunderson & Links, 2014). Key features of GPM are case management focusing on an individual's life outside therapy;

psychoeducation; goal setting; multimodality, including the use of psychopharmacology; group therapy; family coaching; collaboration about duration and intensity of treatment; and a focus on interpersonal hypersensitivity (linking the individual's behaviours and emotions to interpersonal stressors) (Gunderson & Links, 2014). The clinical efficacy of GPM has been found in a large multisite RCT to be equal to that of DBT (McMain, 2009).

Hereditary and Biological Correlates of BPD

Research into BPD and biology has often explored links between structural and neurochemical aspects of the brain and body related to the behaviours and emotions involved in BPD. Functional impairments and specific genetic polymorphisms in the 5-HT system (the serotonin system) are linked to impulsive aggression and affective instability (Crowell et al., 2009) as well as suicidal and non-suicidal self-injury (Kamali et al., 2002). Dopamine dysfunction may contribute to behavioural, cognitive, and affective issues (Friedel, 2004; Skodol et al., 2002). Vasopressin is a neurotransmitter related to aggressive behaviour and pair bonding (Gurvits et al., 2000; Teicher et al., 2002). Differences in the MAO-A gene, when combined with high-risk development environments, increase the potential for aggressive and impulsive behaviour (Caspi et al., 2002), whereas the MAO-B gene has been negatively correlated with impulse control disorders, including BPD (Zuckerman & Kuhlman, 2000).

The Noradrenergic System (NE), a system involved in reactivity to the environment, mood regulation, social affiliation, irritability, and affect (Cloninger, 2000; Gurvits et al., 2000; Skodol et al., 2002), may also be involved in BPD. Chronic stress has been found to increase responsiveness of the hypothalamic–pituitary–adrenal (HPA) axis. Studies in animals suggest that the HPA axis and the central NE system interact, leading to dysregulated responses to stress. Chronic stress has been found to lead to NE facilitation of HPA reactivity, and this may be the mechanism by which chronic stress exposure leads to extreme dysregulation in vulnerable individuals (Pardon et al., 2003) and, therefore, may play a role in those with BPD. The HPA axis has also been found to be involved in suicidal behaviour (Coryell & Schlesser, 2001; Lester, 1992).

Studies suggest that BPD is associated with deficits of fronto-limbic circuitry (Brendel et al., 2005; Ceballos et al., 2006; Houston et al., 2005), including the ventrolateral prefrontal cortex, the orbitofrontal cortex, the hippocampus, the amygdala, the anterior cingulate cortex, the fusiform gyrus, the thalamus, and the basal ganglia (Crowell et al., 2009). Theories linking fronto-limbic dysfunction to emotion dysregulation generally suggest that prefrontal circuitry involved in inhibiting behavioural responses is insufficient, considering overpowering limbic activity (Crowell et al., 2009). The parasympathetic nervous system (PNS) may play a role in the emotional lability of those with BPD. Research into the PNS by examining respiratory sinus arrhythmia (RSA) (an index of PNS activity) has associated differences in RSA with differences in emotion regulation capabilities (Beauchaine,

2001; Katz & Gottman, 1997; Shannon et al., 2007). Lower RSA has been found in populations with severe conduct problems, poor emotion regulation (Beauchaine et al., 2001), and non-suicidal and suicidal self-injury (Beauchaine et al., 2001; Crowell et al., 2005).

Research has also sought to understand BPD through studies of heredity, with research indicating a strong genetic component of BPD. In Norway, an extensive and methodologically sound twin study involving 92 monozygotic and 129 dizygotic Norwegian twin pairs by Torgersen et al. (2000) found that 69% of the variance in BPD symptoms was attributable to additive genetic effect, whilst 31% was related to non-shared environmental effects (Torgersen et al., 2000). The study also found that the concordance rate was 38% in monozygotic twins and only 11% in dizygotic twins, indicating a strong genetic component. An older study by Silverman et al. (1991) found that affect instability and impulsivity were increased in those related to people with a BPD diagnosis than in people related to those with other PDs, suggesting a hereditary factor in BPD symptoms. A study by Beauchaine and Neuhaus (2008) indicates that impulsivity, commonly associated with BPD, is approximately 80% heritable.

Summary

Psychologists have found different ways to theorise and understand BPD. All of the theories refer to an interaction approach. Genetic vulnerabilities (which may be to hypersensitivity, aggressivity, or more broadly understood as biological vulnerabilities), combined with environmental factors (such as invalidation, or attachment ruptures) during development lead to maladaptive, sensitive or disorganised representations of the self and others (a spilt person, an aggressive person who fears abandonment and rejection, a person who has difficulty with emotional dysregulation, or interpersonal hypersensitivity). These factors then re-interact with society and people, reinforcing the disordered selves of the person with BPD. The theorists of BPD have typically focused on a standout trait of BPD (hypersensitivity, aggressivity, emotional dysregulation) and so too has research in the bio-correlates of BPD where, though inconclusive, theories are presented that link BPD to certain structural and chemical aspects of the brain and body that are related to such things as impulsivity, aggressivity, emotion lability. Finally, research into genetics shows strong hereditary links to BPD, supporting the theories of genetic vulnerabilities. Altogether, a picture emerges of a person who, due to the interaction of genetic vulnerabilities with adverse environmental factors, has developed into an adult with the emotional and behavioural traits described as BPD, and with an internal physical world to match.

BPD is a diagnosis with a contentious history, and a variety of theories have been developed to explain its tenuous set of criteria. Interventions, though shown to be effective, focus on quite different primary concerns, doing little to clarify an already confusing diagnosis. However, these are not the only challenges to BPD. The next section will explore issues with the diagnosis.

Issues with the BPD Diagnosis

Stigma & BPD

The BPD diagnosis has long been criticised due to the stigma surrounding it. This stigma can impact the physical health, self-image, and employment opportunities of those with the diagnosis and can also lead to discrimination. The stigma associated with the disorder BPD can also lead to poor identification of the illness and delayed care, negatively affecting those already experiencing distress. Additionally, the stigma around BPD impacts clinicians as well (Lepkowsky, 2020; Stiles et al., 2023).

Client Experiences of Clinicians

A study by Stiles et al. (2023) sought to synthesise studies into discrimination and stigma experienced by those with BPD. The authors identified seven studies that met their search criteria: Bonnington et al. (2014), Fromene and Guerin (2014), Veysey (2014), Horn et al. (2007), Fallon (2003), Nehls (1999), and Miller (1994). Five key concepts were uncovered: resistance from clinicians, othering by both the public and health care professionals, negative impact on self-esteem/image, hopelessness due to perceived permanency, and feeling like a burden (Stiles et al., 2023). Five of the studies in the review (those by Bonnington & Rose, 2014; Fallon, 2003; Fromene & Guerin, 2014; Horn et al., 2007; Nehls, 1999) found that BPD sufferers experienced reluctance from health care professionals to give a diagnosis of BPD, and to provide information on BPD. In the study by Bonnington and Rose (2014), health care for the participants was marked by extended periods of being left in a state of "disempowered limbo" (Bonnington and Rose, 2014, p. 13) where both diagnosis and treatment were withheld, or where a diagnosis was given but no treatment was available. Throughout the studies investigated by Stiles et al. (2023), participants expressed recurring sentiments of being left out, uninformed, and kept at a distance. Themes of othering were uncovered in five of the studies (Bonnington & Rose, 2014; Fallon, 2003; Horn et al., 2007; Miller, 1994; Veysey, 2014) with participants expressing a sense of being othered by healthcare professionals. Participants described experiences of being perceived as liars, unreasonable, difficult, manipulative (Veysey, 2014), undeserving of care (Fallon, 2003, p. 397), and attention seeking (Bonnington & Rose, 2014; Nehls, 1999; Veysey, 2014). In many of the studies, participants described a sense of being deemed untreatable by the health care providers and felt that a diagnosis of BDP meant the health care professionals could simply reject them from services (Bonnington and Rose, 2014; Horn et al., 2007; Nehls, 1999).

Client Experiences of the Public

Stiles et al. (2023) also revealed stigma felt by the participants coming from the public, including family and friends (Bonnington & Rose, 2014; Fromene & Guerin, 2014; Miller, 1994; Nehls, 1999). Participants described feeling discredited or dismissed, and even encountering physical and psychological violence, as well as a sense of a lack of public awareness (Stiles et al., 2023). In six of the studies (Fallon, 2003; Fromene & Guerin, 2014; Horn et al., 2007; Miller, 1994; Nehls, 1999; Veysey, 2014), participants reported self-image or self-esteem being negatively impacted by their diagnosis. Participants felt that a BPD diagnosis meant that they were not human (Veysey, 2014), a freak, slimy, difficult, a reject (Horn et al., 2007). In five of the studies, a general sense of hopelessness around the prospects of recovering emerged amongst participants (Bonnington & Rose, 2014; Horn et al., 2007; Miller, 1994; Nehls, 1999; Veysey, 2014), with participants not believing that change was possible. One participant stated: 'to have a diagnosis means you are just screwed' (Nehls, 1999, p. 287). Finally, four of the studies revealed themes of feeling like a burden (Fromene & Guerin, 2014; Horn et al., 2007; Miller, 1994; Nehls, 1999).

Stigma Amongst Clinicians Toward Those with BPD

The findings above support the position that BPD may be the most stigmatised personality disorder (Baker and Beazley, 2022). A historical narrative exists of the disorder being untreatable, starting in early psychoanalytic literature (Wolberg, 1952). A literature review by Hughes and Holmes (2025) concluded that in early conceptualisations of BPD, women were framed as manipulative, treatment-resistant, and high-risk clients, with therapists choosing to avoid working with female clients with BPD.

Much has been said about the difficulty for clinicians of those with borderline personality disorder (Koekkoek et al., 2006; Sulzer, 2015). The difficulty associated with BPD may in part be due to the disruptive nature of some BPD symptoms (suicidality, emotional dysregulation), which undermine the therapeutic process, and the belief that BPD is difficult to treat. The latter is not untrue, due to the complexity of the disorder, arising from the previously described multitude of difficult symptoms (including high suicidality, emotional lability, anger, etc) and difficulty of diagnosis (high co-morbidity with other disorders, high heterogeneity of symptoms) (Lepkowsky, 2020). The labelling of a client as difficult can lead to a cycle of ineffective and invalidating care, which can perpetuate and worsen symptoms (Keokkeok et al., 2011).

Baker and Beazley (2022) sought to synthesise quantitative studies that investigated the attitudes and responses of clinicians to BPD between 2000 and 2019. The systematic review included studies involving General Practitioners, psychiatrists, clinical psychologists, other medical staff, psychotherapists, social workers, mental health nurses, occupational therapists, emergency department staff, paramedics, physical health nurses, police officers, and criminal justice personnel. Thirty-seven studies were included in the review, with an estimated total number of participants of 8196. Baker and

Beazley (2022) concluded that negative attitudes in the health care community toward those with BPD continued, despite an understanding of the issue and improved efficacy of treatments (Baker & Beazley, 2022).

Regarding the impact of clinician stigma in Aotearoa NZ, the study by Veysey (2014), used interpretative phenomenological analysis of interviews with eight New Zealanders with BPD who self-identified as experiencing discrimination from healthcare professionals. All participants identified as Pākehā[2], two participants also identified with several Māori iwi[3], and one concurrently identified as Samoan. Veysey (2014) found that discrimination experiences contributed to negative self-image, with negative messages about BPD communicated by health professionals. The discrimination experienced involved a wide range of health professionals, including psychologists and psychiatrists, with most participants describing multiple experiences of discrimination across different settings.

Gender Bias & BPD

In addition to the multitude of experiences of stigma discussed above, the BPD diagnosis is often criticised for being gender biased. The APA has described BPD as impacting women at a rate three times higher than men (APA, 2013). A reason for this may be historic biases in the mental health profession, where the emotional distress experienced by women has been pathologized as irrational or excessive (Thelandersson, 2022). Women and men have also been found to present with different symptoms of BPD. According to research, women more often present with internalising symptoms of BPD (affective instability & self-harm), and men with externalising symptoms (aggression & impulsivity) (Bozzatello et al., 2024; Qian et al., 2022), further complicating gender based diagnostic issues of BPD. Holmes and Hughes (2025) argue that the widely used DSM-5-TR (APA, 2022) emphasises the internalising symptoms of BPD (affect instability, identity disturbance), which may promote the criteria of BPD that are more commonly expressed by women, and the externalising behaviours of BPD may be overlooked or misclassified.

Holmes and Hughes (2025) argue that *sampling bias* may also impact gender bias research, arguing that the overrepresentation of women in clinical populations may distort prevalence estimates and reinforce assumptions that BPD more commonly effects women (Holmes and Hughes, 2025). Holmes and Hughes believe that this overrepresentation is the result of differences in help-seeking behaviour, referral patterns, and access to care. Taken together, the history and prevalence of BPD have led researchers to discuss whether there is an inherent gender bias amongst therapists diagnosing BPD.

Numerous researchers have investigated gender bias amongst therapists when diagnosing BPD, with many results supporting a gender bias amongst clinicians (Becker & Lamb, 1994;

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[2] Pākehā is a commonly used Māori term referring to New Zealanders of European decent.

[3] Iwi is a term for the largest social units in Māori society, and is often translated as "tribe".

Braamhorst et al., 2015; Bruce & Weinraub, 2023; Liebman & Burnette, 2013; Rodriguez-Seijas et al., 2024), however, research also exists to the contrary (Özel et al., 2024; Woodward et al., 2009). Research by Bruce and Weinraub (2023) found that BPD was more often diagnosed in female "presenting" vignettes than in male "presenting" vignettes. Transgender individuals were found to be more often diagnosed as having BPD than cisgender clients with identical symptoms in research by Rodriguez-Seijas et al. (2025). More recent research into sexual and gender minorities has also found potential bias issues, with recent research indicating that non-binary and transgender clients are diagnosed with BPD more frequently than cisgender clients with identical symptoms (Rodriguez-Seijas et al., 2021; 2024).

Research to the contrary is complex. For example, Bramhorst et al. (2015) found no evidence of gender bias in their research into BPD by comparing BPD vignettes to narcissistic personality disorder (NPD). However, when the researchers presented a combination of symptoms, women clients were more likely to be assigned BPD, whilst males were more likely to be assigned NPD. Similarly, Özel et al. (2024) found no gender bias; however, this research found that women presenting with anti-social personality disorder symptoms were more often misdiagnosed as having BPD than men were. Woodward et al. (2009) found no gender bias, but found that other factors (trauma disclosure, for example) may influence diagnostic outcomes.

Holmes and Hughes (2025) sought to clarify whether gender bias exists for BPD. Utilising full criteria vignettes, they compared the BPD diagnosis to PTSD in a sample of U.S.-based therapists. The authors stated that they chose to use the PTSD diagnosis in their study due to its gender neutrality. They found no significant gender bias. According to the researchers, this may be due to increased emphasis on ethical practices and cultural competence, leading to improved diagnostic equity. However, Holmes and Hughes (2025) did find evidence of significantly colder affect, reduced recovery optimism, and longer projected symptom duration being associated with a diagnosis of BPD, suggesting that the stigma of BPD remains.

Other Diagnostic Issues

An argument has been made that BPD is not distinct enough from other personality disorders to be considered an independent diagnosis (Leichsenring et al., 2024). Some have said that there is an absence of sound research supporting BPD as a unified syndrome (Tyrer et al., 2019). It could be that BPD is better understood as a more severe, or higher loading, form of a general personality pathology. Unlike other PDs, BPD lacks a specific factor (Leichsenring et al., 2024), and the criteria of BPD are both too broad and too heterogeneous. It has also been emphasised that there are too many criteria for BPD, and that there are too many criteria required to give a BPD diagnosis. For example, a client with self-harm, emotional lability, identity disturbances, and highly unstable relationships does not meet the diagnostic requirements for BPD due to missing a fifth criterion, even if the client is experiencing

severe impairment in functioning. Conversely, there are 256 possible ways to fulfil the criteria of BPD in the DSM-5, indicating the high heterogeneity of clients diagnosed with BPD and of the diagnosis (Leichsenring et al., 2024).

Another argument against the categorical diagnosis of BPD is the simple fact that a dimensional model for BPD already exists (Leichsenring et al., 2024). Leichsenring et al. (2024) have argued that the "clinical features typical of BPD are well represented within the ICD-11 system, with its two-step approach of firstly assigning a core personality disorder diagnosis (mild, moderate, severe) based – among others – on self and interpersonal functioning, and secondly the specification via trait dimensions, most notably negative affectivity (e.g., emotional lability, anxiety), disinhibition (e.g., reckless behaviour, impulsivity), and dissociality (e.g., hostility, aggression)" (Leichsenring et al., 2024, p. 18). Opposition to a movement away from the categorical model of BPD argue that the current categorical version of BPD is still useful, has been highly researched over the years, and has numerous interventions for BPD that have been researched. Further, research into BPD is not only useful for understanding BPD but also into understanding other vital concepts involved in BPD such as mentalization, neurobiology and trauma, and there is currently ongoing research and funding related to the DSM concept of BPD (Leichsenring et al., 2024). It is also important to note that the ICD-11, as previously discussed, contains a "borderline specifier", which allows clinicians to lean one way or the other when working with a client presenting with the symptoms associated with BPD (Leichsenring et al., 2024).

Summary

Taken together, the preceding outline presents a picture of a relatively old, consistently ill-defined, and puzzling diagnosis, with murky origins and problematic nomenclature, that has persisted to the present day. BPD is a highly heterogeneous and highly comorbid disorder, overlapping with numerous other conditions. It faces issues such as ambiguity and complex symptom presentations, which can lead to potential misdiagnosis (for example, ASD or ADHD) or wrongful diagnosis due to gender biases (such as BPD versus NPD or ASPD). BPD also carries a significant amount of stigma, which in itself can be harmful. The chapter concludes with a review of the literature on BPD in Aotearoa NZ.

A Brief Review of Literature on BPD in Aotearoa NZ

To identify what literature exists, a search of PsycINFO was conducted in July 2024 to search for published journal articles. The title keyword *borderline personality disorder* was combined with the search terms *New Zealand, NZ,* & *Aotearoa.* The publication range was limited from 2014 to 2024. The search returned 102 articles. After checking to see which articles involved research into Aotearoa NZ issues and populations, only six articles remained. An additional article was found

tangentially, as it discussed PDs and gave rise to conversations by clinicians around BPD. A Google Scholar search was also conducted, revealing 12,500 results; the first eight pages of results were investigated, revealing two additional research articles, for a total of nine articles. Three studies (Newton-Howes, Cunningham, & Atkinson, 2020; Tennant et al., 2023; Veysey, 2014) are previously mentioned. What follows is a brief review of the remaining six articles.

A study by Thabrew et al. (2018) seeking to identify the evidence-based interventions for self-harm provided by Aotearoa NZ Infant, Child and Adolescent Mental Health Services (ICAMHS) found that self-harm is a familiar presentation to ICAMHS, and that, though support is available, there is concerning variation with how treatment aligns to research-tested models.

A critical literature review by Bourke (2022) examined recovery from BPD in Aotearoa NZ. The review synthesised key themes and experiences — such as connection, hope, identity, meaning, and empowerment — in the recovery journeys of whaiora (wellness seekers). It highlighted the importance of positive therapeutic relationships, the barriers to delivery arising from a lack of compassion and empathy, and the perpetuation of negative stereotypes.

A study by Sajjadi et al. (2021) examined the relation between identity impairment, as operationalised through autobiographical memory, and features of BPD in Aotearoa NZ university students. They found evidence that narrative identity, but not narrative intimacy or coherence, was the dominant predictor of BPD features. The authors suggest that individuals with BPD are less capable of perceiving the world through cohesive stories. Their narratives often lack a clear structure (a distinct start, middle, and end), a central subject, an agentic and subjective sense of self, and object constancy.

Deborah Hill Cone (2020) published a theoretical investigation of the impact of colonialism as a collective trauma for Māori concerning the BPD diagnosis. Cone argues that BPD is a diagnosis that is embedded in social and cultural expectations and argues that in Aotearoa NZ, the differing cultural constructs of the self may lead to the potentiation of BPD amongst Māori. This theoretical essay highlights the potential of culture and social issues to play a role in both the construction of BPD and the treatment issues of the diagnosis. It should be noted that the author is non-Māori and therefore writes from an outsider's perspective, and that this essay lacks evidence.

A doctoral study by Dor (2015) used hermeneutic-phenomenological analysis to explore and describe lived-world experiences of treatment compliance in a sample of individuals with BPD from Aotearoa NZ. Themes that emerged were the importance of the relationship with the clinician, feelings of being overwhelmed, and the futility of the treatment regimen.

The only study into clinicians' perceptions and the most significant to the current research is a study by Brown et al. (2023). Brown et al. (2023) undertook a study (building on the work of Hansen et al. (2019) in Denmark) to examine the perceived clinical utility of the ICD-11 PD diagnosis (dimensional), compared with the DSM-5 categorical diagnosis for PDs in a sample of psychiatrists and clinical psychologists in Aotearoa NZ. The study utilised a mixed-methods design, including a

rating-scale questionnaire and a thematic analysis of responses to open-ended questions. Participants were asked to remember a client they had seen for at least five sessions and were then given instructions for the DSM-5 PD diagnosis and the ICD-11 PD diagnosis, respectively, and were then asked to rate the clinical utility of each model based on six questions. Clinicians were then asked to answer several questions comparing the ICD-11 to the DSM-5, and about the application of the ICD-11 in an Aotearoa NZ setting. The data analysis of the questionnaire revealed that clinicians surveyed found moderate utility in the ICD-11 model and showed a preference for the ICD-11 over the DSM-5 model. Across all six clinical utility metrics, the ICD-11 was preferred over the DSM-5 model. This is interesting as other research (Bornstein & Natoli, 2019; Hansen et al., 2019) found no preference. The authors suggest that this difference may be due to Aotearoa NZ clinicians being more formulation-focused than clinicians from other parts of the world. Themes that emerged from the qualitative part of the research were: appreciation for an alternative to DSM-5, structural barriers preventing ICD-11 PD implementation (including workplace limitations and/or reliance on DSM-5, absence of official endorsement and development opportunities, and the wide use of /or 'embedded-ness' of the DSM-5 in Aotearoa NZ), personal barriers to ICD-11 implementation (generally referring to fear of change, and lack of familiarity) and cultural safety considerations for implementation of ICD-11 PD in Aotearoa NZ (especially among Māori and Pasifika communities). The final theme is a very interesting one; clinicians surveyed held general beliefs that diagnoses have low utility and a preference for formulation. Clinicians surveyed had a general disdain for PD diagnoses regardless of the system used. Some stated that they do not diagnose PDs as they find the diagnosis unhelpful due to the diagnosis not recognising 'why' the disorders develop. One participant noted that 'these diagnoses ignore the very real and significant impact of trauma and attachment ruptures (leading to attachment disorders), and barely address emotional dysregulation' (Brown et al., 2023, p. 288). Participants felt a PD diagnosis was stigmatising, preferred not to use labels, and held a clear preference for formulation. In concluding their article, Brown et al. write that, given the positive regard for the ICD-11 model among participants, future research should investigate the 'practical clinical utility of the diagnosis in Aotearoa NZ, including its predictive utility for important clinical outcomes such as treatment outcome' (Brown et al., 2023, p. 290).

In conclusion, it is evident that research on BPD in Aotearoa NZ is very limited. This brief review identified only eight articles, and to the best of the researcher's knowledge, no research exploring clinicians' perspectives on BPD. The research that does exist points to a concerning variation in how treatment aligns with research-tested models (Thabrew et al., 2018), and the use of polypharmacy among individuals with a BPD diagnosis is alarmingly high (Tennant et al., 2023). Additionally, the number of people diagnosed with BPD in Aotearoa NZ appears to be increasing (Tennant et al., 2023). The review also highlights the challenges and needs of those with BPD, including the importance of positive therapeutic relationships and barriers to service delivery due to a lack of compassion and empathy, as well as the perpetuation of negative stereotypes (Bourke, 2022).

Discrimination involving a wide range of health professionals, including psychologists and psychiatrists, has been reported, with participants describing multiple experiences of discrimination across different settings (Veysey, 2014). Barriers to continued engagement in treatment include the relationship with the clinician, feelings of being overwhelmed, and the perceived futility of the treatment regime (Dor, 2015). Research involving Aotearoa NZ clinicians reveals a wariness of personality disorders and a general belief that diagnoses have low utility, with a preference for formulation rather than diagnosis and a disdain for PD diagnoses, which are viewed as stigmatising by participants (Brown et al., 2023).

Chapter Summary

BPD is a highly debated disorder that has been developed in the psychiatric literature for more than a century, with a problematic and confusing name. Issues with BPD include the stigma of the disorder, its high heterogeneity, high comorbidity and overlap with other disorders, a lack of a clear aetiological understanding, and the difficulty of treating it. Consequently, BPD is costly to both society and to the individuals with the disorder, most notably due to the high prevalence of suicidal and non-suicidal self-injury and completed suicide by those with the disorder.

Theories of BPD suggest that the risk for BPD is the result of biological vulnerabilities, most likely related to emotional regulation and impulsivity, interacting with challenging contextual factors during development to potentiate the development of BPD. Research into the biological dysfunctions associated with BPD has examined structural, neurochemical, and genetic perspectives. It has explored the roles of the 5-HT system and serotonin, as well as those of dopamine, monoamine oxidase (MAO), and acetylcholine. Additionally, research considers the role of the HPA axis, noradrenergic dysfunction (NE), gamma-aminobutyric acid (Crowell et al., 2009), fronto-limbic circuitry, and autonomic functioning. Evidence suggests that multiple structural biological correlates may contribute to the emotional experiences in individuals with BPD. However, these biological vulnerabilities are also linked to the risk and development of other disorders. The development of BPD involves various contextual factors, and the specific mechanisms through which these risks manifest require further investigation. Nonetheless, BPD has been found to involve a strong genetic or hereditary component.

There is, to the best of the author's knowledge, no existing research into Aotearoa NZ clinicians' perspectives of the utility of the BPD diagnosis. However, results of adjacent research reveal a scepticism amongst clinicians toward personality disorders generally. Chapter Two explores the relationship between trauma and BPD.

Chapter Two: Trauma & BPD

Over the last 50 years, research and clinical experience have evolved the psychological field's understanding of what constitutes trauma. New concepts of trauma were developed, including complex PTSD, DESNOS, and the diagnosis CPTSD. Simultaneously, the field's knowledge of the impact and relevance of trauma in the history of those with BPD has grown. Given the controversy and stigma associated with the diagnosis, arguments have been made that some clients diagnosed with BPD might be more appropriately understood through a trauma perspective. This chapter explores the development of trauma theories and evidence, and the subsequent impact on the BPD diagnosis.

The Evolution & Emergence of Complex Trauma Theories

In the late 1980s and early 1990s, numerous experts were discussing the limitations of the scope of the current PTSD diagnosis (van der Kolk et al., 2005). One researcher, Kolb, lamented in a letter to the editor in the *American Journal of Psychiatry* (1989) that ''PTSD is to psychiatry as syphilis was to medicine. At one time or another PTSD may appear to mimic every personality disorder," (Kolb, 1989, p. 811). Researchers began to discuss a more complex or multifaceted spectrum of post-traumatic disorders, and new symptoms connected to varying forms of prolonged trauma. Research began to reveal that the impact of trauma on psychological adaptation depends on when it occurs, with early trauma impacting the development of self-regulatory processes and the ability to manage future stresses (Cole & Putnam, 1992; Herman & van der Kolk, 1987; Terr, 1991). Research into children who were physically and sexually abused found them to experience aggression (Lewis & Shank, 1981), caregiver relationship difficulties (Schneider-Rosen Cicchetti, 1984), intimacy issues (Finkelhor, Hotaling, Lewis, & Smith, 1989) and extended periods of fear, guilt, and apprehension (Briere & Runtz, 1988; Crittenden & Ainsworth, 1989). Other research showed that affect regulation and self-identity were altered in adult survivors of rape (Burgess & Homstrom, 1974) and domestic violence (Walker, 1984). These new syndromes were described using various names such as post traumatic character disorder, (Horowitz, 1986), complicated PTSD, (Brown & From, 1986), complicated traumatic neurosis (Gelinas, 1983), severe post-traumatic syndrome (Goodwin, 1988), and survivor syndrome (Krystal, 1968). Other disorders resulting from specific traumas were also described, including sexually abused child's disorder (Corwin, 1988), rape-trauma syndrome (Burgess, 1974), battered woman syndrome (Walker, 1984), and childhood trauma (Terr, 1991).

The Introduction of Complex PTSD by Judith Herman

Judith Herman, who coined the term complex post-traumatic stress disorder (CPTSD) in 1992 (Herman, 1992), argued that the diagnostic conceptualisation of PTSD, based on specific, often one-off, traumatic events such as combat, natural disasters, and rape, did not fully capture the symptoms

of prolonged, repeated trauma. For Herman, repeated and prolonged trauma requires captivity and control by a perpetrator (Herman, 1992); such situations include religious cults, brothels, institutions of organised sexual exploitation, family settings, slave labour camps, concentration camps, and prisons. Captivity and contact with the perpetrator differentiate this type of traumatic exposure from classical trauma. Herman explained that 'captivity' can take the form of physical force or a combination of physical, economic, psychological, and social means (as seen in cults, abusive relationships, and situations involving children). She suggested that the psychological impact of "subordination to coercive control may have many common features, whether that subordination occurs within the public sphere of politics or within the supposedly private (but equally political) sphere of sexual and domestic relations" (Herman, 1992, p. 378). Those with Herman's complex PTSD exhibit complex, enduring symptoms that include personality changes and vulnerability to repeated harm, including self-harm (Herman, 1992). Herman described six areas of altered functioning: affect and impulses, attention or consciousness, self-perception, views of the perpetrator, relationships with others, and systems of meaning (Błaż-Kapusta, 2008). These symptoms could be interpreted as signs of BPD or various other disorders.

Contemporaneous to Herman's investigations, other clinicians such as van der Kolk and Pelcovitz were also describing a syndrome that was based on symptoms of PTSD, as well as symptoms of disorders commonly co-occurring with PTSD (Luxenberg et al., 2000).

The DSM-IV Field Trial for PTSD & DESNOS

The DSM-IV Field Trial for PTSD, undertaken between 1990 and 1992, aimed to "explore whether victims of chronic interpersonal trauma as a group tended to meet diagnostic criteria for PTSD or whether their psychopathology was more accurately captured by another constellation of symptoms" (van der Kolk et al., 2005, p. 390). The DSM-IV Field Trial task force posited that the PTSD diagnosis only captured a narrow post-traumatic psychology, and that a critical factor for the development of psychopathology after trauma is at what point during development or lifetime the trauma occurs, and whether it occurs via a caregiver or intimate partner. They believed that the clinical presentations of those who have experienced car accidents or natural disasters are different to those who have experienced neglect or abuse by caregivers (Luxenberg, 2001). The task force found that PTSD was highly interrelated with dissociation, somatisation, and affect dysregulation and that many of those diagnosed with PTSD had symptoms not included in the current PTSD diagnosis (Luxenberg et al., 2001).

These psychological problems were clustered under the working title Disorders of Extreme Stress-Not Otherwise Specified (DESNOS). The workgroup operated under the hypotheses that chronic interpersonal trauma in early life causes a higher prevalence of symptoms of DESNOS than trauma experienced later in life and that a significant number of those with childhood trauma histories

will meet DESNOS criteria whilst not meeting PTSD criteria (van der Kolk et al., 2005). This early interpersonal trauma impacts personality and social development in pervasive ways, leading to changes in six areas of function: regulation of affect and impulses, attention or consciousness, self-perception, relations with others, somatisation, and systems of meaning (Luxenberg, 2001). Specific traumatic events are not a prerequisite of DESNOS; however, research has linked DESNOS with multiple traumatic events, interpersonal victimisation, and traumatic exposure of extended duration. Those with DESNOS may have experienced chronic and ongoing exposure to "untenable environments" (Luxenberg et al., 2001, p. 375). Proponents of DESNOS argue that their clinical experiences with the DESNOS population suggest that a severe avoidance, suppression of traumatic memories, affective numbing and constriction, and an over-reliance on dissociation may mask the symptoms of PTSD required to meet a PTSD diagnosis (Luxenberg et al., 2001). In severely mentally ill clients, traumatic intrusions may be obscured by other more severe symptoms such as hallucinations, paranoid ideation, and delusions (Luxenberg et al., 2001).

Both Herman's Complex PTSD and van der Kolk and colleagues DESNOS describe enduring pervasive changes to a person after the impact of repeated trauma at the hands of a known perpetrator (repeated and prolonged trauma with captivity, control, and contact with a perpetrator for Herman; untenable events occurring during development at the hands of a caregiver or intimate partner for DESNOS), and impact on specific areas of functioning that are very similar with both involving changes to affect regulation, impulsivity, consciousness, self-perception and relationships. These areas of functioning could appear the same as, or at least confused with, some of the criteria for BPD such as unstable relationships, identity disturbances, impulsivity, affective instability, dissociation / emptiness. Not surprisingly then, in discussing DESNOS the authors (Luxenberg et al., 2000) go to great lengths to discuss the overlap and differential distinction of BPD, PTSD and DESNOS, which they say are the most confused conditions. They argue that from their clinical perspective, many clients conceptualised as 'borderline' are better characterised by DESNOS (Luxenberg et al., 2000). Luxenberg et al. (2000) also state that clients present with different symptoms depending on whether their trauma histories have been identified and incorporated into case formulations, acknowledged as etiologically important, and addressed in treatment (Luxenberg et al., 2000), highlighting the benefits of acknowledging the role of trauma. They go on to state that including trauma history in case conceptualisation and treatment planning often results in notable changes in symptom presentation for these clients. For example, typical personality features of BPD, such as hostility, deception, and emotional manipulation, may be replaced by more genuine feelings of traumatic grief, loss, and sadness (Luxenberg et al., 2000).

Luxenberg et al., (2000) do not suggest abandoning the BPD diagnosis, rather they argue that there may be a misunderstood cohort currently diagnosed as having BPD that may be better understood and treated using DESNOS. They say that DESNOS and BPD are related in terms of affect lability, attention/consciousness, identity, and relationship difficulties; but that the nature and

significance of disruptions in these domains differ between the disorders (Luxenberg et al., 2000); affect dysregulation is a hallmark feature of DESNOS, whereas in classic BPD, relational and identity disturbances are the hallmark, and BPD is a disorder of attachment, while DESNOS is a disorder of self-regulation (Luxenberg et al., 2000).

Following the field trials, the DESNOS diagnosis was not included in the DSM-IV as a formal diagnosis and was instead relegated to a paragraph in the ‘Associated descriptive features and mental disorders’ section at the end of the PTSD diagnosis (Maercker, 2021), and then completely removed in future iterations of the DSM and replaced with a dissociative specifier (APA, 2013, 2022).

The Arrival of CPTSD into the ICD-11

It was in the ICD-11 where a diagnosis intended to address a more complex response to trauma was finally officially recognised as a diagnosis under the name Complex Post Traumatic Stress Disorder (CPTSD) in 2018 (coming into effect in 2022) (Maercker, 2021). In developing the ICD-11, the WHO aimed to increase the manual's clinical utility by reducing the core symptoms of each mental disorder (Maercker, 2021) and limiting new diagnoses to those with sufficient clinical knowledge for specific therapies. A working group, comprising members from around the world and involving various NGOs, was formed to examine diagnoses in the domain of ‘Specific Stress-related Disorders’. The working group determined that the PTSD diagnosis should be complemented by a 'sibling diagnosis', which would be called Complex PTSD.

In the ICD-11, CPTSD is described as a characteristic syndrome lasting for at least several weeks following exposure to an event or series of events of an extremely threatening or horrific nature which are most often prolonged or repetitive events from which escape is difficult or impossible such as (but not limited to) torture, domestic violence, and repeated childhood sexual or physical abuse (WHO, 2025). The syndrome requires the development of all three elements of PTSD (re-experiencing, avoidance, and hypervigilance). The additional symptoms - and the ones that interest those investigating BPD - are disturbances in self-organisation (DSO) which are issues with affect regulation (heightened emotional reactivity to minor stressors, violent outbursts, reckless or self-destructive behaviour, dissociative symptoms, and emotional numbing), decreased beliefs about oneself (feeling worthless, defeated, shameful, or guilty), and relationship difficulties (relationship avoidance, or difficulty sustaining relationships) (WHO, 2025). Those with CPTSD may also have additional symptoms of suicidal ideation and behaviour, depression, substance abuse, psychosis, and somatic symptoms (WHO, 2025). The authors of the ICD-11 interestingly have presented in the CPTSD diagnosis a hybrid of sorts, a diagnosis that reflects much of the developments in trauma conceptualisation and results from research of the last 50 years whilst not completely moving away from PTSD as a foundational core of CPTSD. Table 3 presents a comparison PTSD, ICD-11 CPTSD, Herman’s Complex PTSD, DESNOS and DSM-5 BPD, all of which either must or often involve

trauma. A notable distinction between diagnoses is that absence of classic PTSD symptoms of avoidance, hypervigilance and re-experiencing for Herman's Complex PTSD, DESNOS and BPD but not for ICD-11 CPTSD. Figure 1 presents the same information as a Venn diagram.

Childhood Trauma & BPD

Studies have explicitly investigated the role of childhood trauma (CT) in the development of BPD. A review by MacIntosh et al. (2015) found that studies investigating bivariate links between CT and BPD revealed that between 30% and 90% of BPD patients reported a history of CT compared with 17% to 45% in the control groups (MacIntosh et al., 2015). The review also found studies across different populations, such as psychiatric inpatients (Bradley, Jenei, & Westen, 2005), outpatients (Golier et al., 2003), urban drug users (Bornovalova et al., 2006), and community adolescents (Rogosch & Cicchetti, 2005). These studies appeared to reveal a 'dose response' relationship between CT and BPD, with more severe CT leading to worse BPD symptoms and greater impairment (MacIntosh et al., 2015). These results are evidence that CT may be a risk factor in the aetiology of BPD. They note a meta-analysis by Fossati et al. (1999) that reviewed 21 studies over 15 years (totalling 2479 participants), all but one of which found significant associations between CSA and BPD development (MacIntosh et al., 2015). The authors conclude that because CT is present in a majority of BPD cases and there is evidence that genetics plays a role in the aetiology of BPD (via heritable personality traits), BPD is both a disorder of personality and a disorder of trauma (MacIntosh et al., 2015).

Seeking a Distinction Between the BPD & CPTSD Diagnoses

Studies and theories may help clarify the distinction between CPTSD and BPD. Some have suggested that they are distinct disorders but share common pathways, for example, neurological, as described by Amad et al. (2019), or anthropogenic, as indicated by Grant et al. (2008). It has been argued that they are not distinct (Saraiya et al., 2021), whilst others still suggest CPTSD is a combination of BPD and PTSD (Kulkarni, 2017). The introduction of CPTSD has been suggested to confuse clinicians (Karatzias et al., 2023). What follows is a summary of literature exploring the distinction between BPD and CPTSD (via latent class analysis), the role of childhood trauma in the aetiology of BPD, and the theories of phenomenological differences between the disorders.

Latent Class Analyses

Several studies utilising latent class analyses (LCAs) have been undertaken investigating the distinction between BPD, CPTSD, and PTSD. These studies utilise existing data applying up-to-date

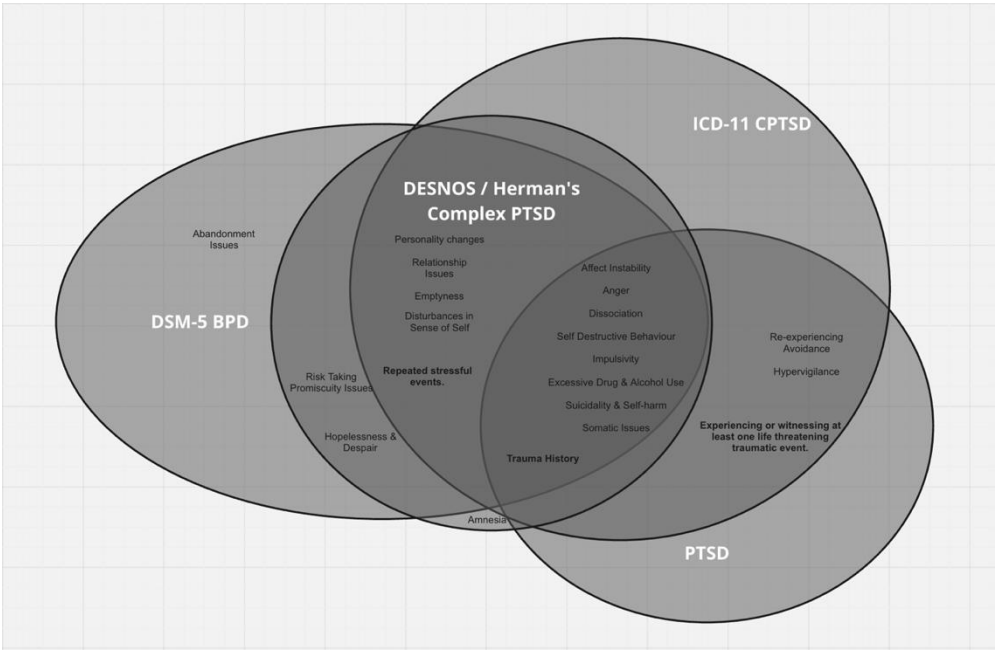
Table 3 - Comparison of PTSD, ICD-11 CPTSD, Herman's Complex PTSD, DESNOS and DSM-5 BPD

Criteria	*PTSD*	*ICD-11 CPTSD*	*Herman's Complex PTSD*	*DESNOS*	*DSM-5 BPD*
Functional Impairment	Yes	Yes	Yes	Yes	Yes
Trauma History	Yes	Yes	Yes	**Not necessary** (but likely)	**Not necessary** (but likely)
Lasting	Yes	Yes	Yes	Yes	Yes
Re-experiencing	Yes	Yes	**No**	**No**	**No**
Avoidance	Yes	Yes	**No**	**No**	**No**
Hypervigilance	Yes	Yes	**No**	**No**	**No**
Relationship Issues	**No**	Yes	Yes	Yes	Yes
Disturbances in Sense of Self	**No**	Yes	Yes	Yes	Yes
Impulsivity	May include excessive alcohol or drug use to avoid re-experiencing or manage emotional reactions.	May include substance abuse, reckless or self-destructive behaviour,	Yes	Yes	Yes
Suicidality & Self harm	May include suicidal ideation and behaviour.	May include Suicidal ideation and behaviour.	Yes	Yes	Yes
Affect Instability	May include general dysphoria.	Yes	Yes	Yes	Yes
Anger	May include anger	May include heightened emotional reactivity to minor stressors & violent outbursts.	Yes	Yes	Yes
Dissociation	May include dissociative symptoms.	May include dissociative symptoms.	Yes	Yes	Yes
Abandonment Issues	**No**	**No**	Inability to trust.	Inability to trust.	Yes

Emptiness	**No**	May include emotional numbing – particularly the inability to experience pleasure or positive emotions.	Alterations in systems of meaning – Despair, Hopelessness, Loss of beliefs	Alterations in systems of meaning – Despair, Hopelessness, Loss of beliefs	Yes.

Note. Created using information from the DSM-5-TR (APA, 2022) and the ICD-11 (WHO, 2025), Luxenberg et al. (2000) and Herman (1993). Criteria are an amalgamation of PTSD and BPD diagnoses from DSM-5; the criteria of diagnoses in the manuals are not identical, where unclear criteria descriptions from particular diagnoses have been added.

Figure 1 - Overlap of DSM-5 BPD with PTSD, ICD-11 CPTSD and DESNOS / Herman's Complex PTSD – A Venn Diagram



Note. Created using information from DSM-5-TR (APA, 2022), ICD-11 (WHO, 2025), Luxenberg et al. (2000), and Herman (1993).

measures of BPD and CPTSD to the data. The studies covered in this brief review are six studies by Cloitre et al. (2014), Frost et al. (2018), Saraiya et al. (2020), Jowet et al. (2019), Cyr et al. (2021), and Lee and Choi (2023). The results of the studies are as follows.

Studies by Cloitre et al. (2014), Jowet et al. (2019) and Cyr et al. (2021) clearly distinguished BPD, CPTSD and PTSD. Cloitre et al. (2014) distinguished CPTSD from PTSD and BPD. They found that symptoms strongly linked to the BPD class were an unstable sense of self, desperate

attempts to avoid abandonment, impulsiveness, and unstable and intense interpersonal relationships. Jowet et al. (2019) also found BPD to be a distinct class; however, they concluded that BPD and CPTSD overlap considerably (33.7% of the CPTSD class endorsed seven or more of the BPD characteristics). Of note is that a criterion the authors found to differentiate BPD from CPTSD and PTSD was temper outbursts, which appeared to be linked to more severe BPD. Results from Cyr et al. (2021) found distinct BPD and CPTSD classes, as well as a CPTSD and BPD combined class. The authors suggest that, because their sample was less traumatised or clinical, a high BPD class, independent of ICD-11 PTSD symptoms, was possible. However, they also note that both the high BPD and high CPTSD classes contained symptoms associated with their respective disorders and highlight apparent similarities between them. Additionally, classes with high CPTSD, high BPD, and a combination of both, included individuals with dissociation symptoms, higher levels of cumulative childhood trauma, and lower life satisfaction compared to the low symptom and high PTSD classes. The authors conclude that their findings support the distinction between BPD, PTSD, and CPTSD. However, they acknowledge that the profiles are not clear-cut, and emphasise that, in childhood trauma survivors, BPD, CPTSD, and a co-occurrence of both are all possible clinical profiles.

Studies by Frost et al. (2018), Saraiya et al. (2020) and Lee and Choi (2023) did not clearly distinguish BPD from CPTSD. In their study Frost et al. (2018) did not find a distinct BPD class; however, they confirmed a distinction between PTSD and CPTSD. They state that their results do not indicate that CPTSD is representative of the combination of BPD and PTSD symptoms, but is instead a distinct disorder, and conclude that phenomenological distinctions are what distinguish BPD from CPTSD. Notably, BPD did not appear distinct from a history of trauma in their sample; however, this may be due to the trauma status of their sample, and the authors argued that it is still possible for BPD to emerge independent of trauma. Results from Saraiya et al. (2020) could not distinguish CPTSD or BPD from each other or from PTSD in a non-treatment-seeking, racially and ethnically diverse sample of young adults. The authors noted that the combination classes (including BPD, PTSD and CPTSD) showed higher levels of interpersonal dysfunction and shame than those in the PTSD and healthy classes (Saraiya et al., 2020). Lee and Choi (2023) could not distinguish CPTSD from BPD. Their study found four classes: a high comorbid class (high scores on all symptoms), an externalising BPD class, an avoidant BPD class (with high BPD symptom of loneliness, low on other BPD symptoms, and an avoidant attachment style and personality) and a low symptomology class. The study did not show a distinct CPTSD class, and the authors suggest that this is due to the common risk factor of child abuse in their sample population and the high comorbidity of CPTSD and BPD. Class one, the comorbid class, was also the largest (37.9%) and had the highest probability for all symptoms and higher scores on invalidating environment and childhood abuse. The authors state that this supports the notion that increased risk factors lead to increased comorbidity. Worth noting is that the study identified two subclasses of BPD, an externalising subclass and an internalising subclass. Also worth noting is that the avoidant BPD class reported much higher levels of physical and emotional

abuse, and emotional neglect, than the externalising class, which makes sense as emotional neglect has been shown to lead to social anxiety and avoidance (Müller et al., 2019). The 'externalising BPD' subclass scored higher on grandiosity, callousness, and risk-taking in the pathological personality traits, indicating that those in this class have lower empathy, an exaggerated sense of self, and act out their urges. Considering these two subgroups, the authors conclude that, in addition to assessing CPTSD and BPD symptoms, dimensional approaches to assess pathological personality traits and attachment style should also be used (Lee & Choi, 2023).

The results of these LCAs were mixed; split down the middle regarding finding distinct BPD and CPTSD classes. However, the authors generally support a distinction between CTPSD and BPD, whilst simultaneously providing evidence of much overlap between the disorders, particularly regarding specific criteria, and particularly among traumatised populations. The authors consistently emphasised the significance of the populations sampled in their research for impacting results as well as symptom severity, with more severe symptoms leading to higher comorbidity, and the severity of trauma history impacting relationships between disorder overlap. These results highlight the need for caution when using the BPD and CPTSD diagnoses to ensure that a given diagnosis is appropriately differentiated from other potential diagnoses. These sentiments align with the authors of the ICD-11, who state the need to differentiate CPTSD from a personality disorder diagnosis, stating that given the broad definition of disturbances involved in personality disorders, and their similarities to the criteria of CPTSD, both diagnostic requirements may be met requiring an assessment of the clinical situation before an additional diagnosis are made (WHO, 2025).

Phenomenological Differences

So how can one distinguish between BPD and CPTSD? An article published in the British Journal of Psychiatry (Karatzias et al., 2023) provides a clinical guide for distinguishing between the two. At first, the authors recognise that traumatic events can precipitate both BPD and CPTSD, and that affect dysregulation appears to link CPTSD to BPD (Owczarek et al., 2023) (although it is worth noting that emotional regulation issues in CPTSD are argued to be due to difficulties with emotional equilibrium, whereas in BPD, they involve self-harming and suicidal behaviour (Frost et al., 2020)). The authors argue that impulsive, suicidal and self-injurious behaviours are characteristics that are more central to BPD than to CPTSD (Cloitre et al., 2014). Karatzias et al. (2023) suggest that in the authors' experience, difficulties in affect regulation are ego dystonic (i.e. incompatible with one's beliefs and personality), stressor specific and variable over time" (Karatzias et al., 2023, p. 404), whereas in BPD "affect dysregulation and unstable mood seem to be ego syntonic (i.e. compatible with one's beliefs and personality) and persistent over time" (Karatzias et al., 2023, p. 404). Regarding self-concept in CPTSD, this involves a stable, consistent negative evaluation of the self, whereas in BPD, self-concept difficulties are due to unstable, alternating self-evaluations (with

changing goals and beliefs). The authors argue that a changing view of self would rule out a CPTSD diagnosis in favour of a BPD diagnosis (Karatzias et al., 2023). The interpersonal difficulties in CPTSD are due to problems establishing connections or trusting others, whilst for BPD, these are a sign of volatile patterns of interactions with others (Frost et al., 2020; Hyland et al., 2019).

Chapter Summary

Over the past fifty years, advancements in research and experiences of trauma have led to the inclusion of a CPTSD diagnosis in ICD-11. CPTSD shares many criteria with the BPD diagnosis. Research has also shown that trauma is common in the histories of those with BPD. All of this has potentiated confusion in clinical practice. Further investigations seeking distinctions between BPD and CPTSD have found both a high overlap and comorbidity (especially with severe symptom presentations and trauma histories) between the two disorders; however, research also suggests that the CPTSD and BPD diagnoses are diagnostically distinct. Discussions around the distinction of BPD and CPTSD in clinical practice highlight the need to cautiously differentiate BPD from CPTSD and PSTD, as well as to consider an additional diagnosis. Understanding the characteristics of symptoms in each diagnosis is an important means to differentiate CPTSD from BPD (Karatzias et al., 2023). For example, impulsive, suicidal and self-injurious behaviours, are more characteristic of BPD, affect regulation difficulties are ego dystonic in CPTSD and ego syntonic in BPD, self-concept in BPD is alternating whereas in CPTSD self-concept difficulties are stable, and there are differences in relational difficulties between the disorders (trust issues and avoidance for CPTSD vs volatile patterns of interactions for BPD).

Chapter One outlined the history of the BPD diagnosis, its problematic origins, lack of a clear aetiology, high cost, high comorbidity, overlap and heterogeneity, as well as high stigma surrounding the disorder and history of gender bias. Chapter Two shows both a strong presence of trauma in those with BPD and a significant overlap with CPTSD. Researchers could spend significant amounts of time understanding and comparing BPD to other diagnoses to find its distinct features. However, if the diagnosis itself is problematic or if the results are ambiguous, we may need to look elsewhere for answers. This raises the question: Where does the current state of psychology's understanding of BPD leave clinicians? Chapter Three will discuss diagnostic classification systems, clinical utility and diagnosis.

Chapter Three: Clinical Utility

This research project seeks to understand psychologists' perceptions of the 'clinical utility' of the BPD diagnosis. But what exactly is clinical utility? This chapter provides an overview of diagnostic manuals, then a discussion of clinical utility and diagnosis.

Diagnostic Manuals

Diagnostic Manuals & their Users

In the preface to the DSM-5, the authors state that the "DSM is intended to serve as a practical, functional, and flexible guide for organizing information that can aid in the accurate diagnosis and treatment of mental disorders. It is a tool for clinicians, an essential educational resource for students and practitioners, and a reference for researchers in the field." (APA, 2013, p. xli). It is obvious that a diagnostic manual is intended for diagnosis; however, what is not immediately obvious is the array of users of diagnostic manuals and the factors involved in their development. These factors include scientific evidence for its validity, ease of clinical use, avoiding excessive prevalence rates, maximising access to effective treatment, minimising stigma and unnecessary or harmful treatment, encouraging research and increasing research funding, and providing continuity with previous manuals (Lilienfeld, 2010; Mullins-Sweatt et al., 2015). Another challenge in the development of diagnostic manuals is the wide range of parties who utilise them. In the U.S, the DSM-5 is used by numerous different agencies, organisations, companies, and professionals (Mullins-Sweatt et al., 2015). Diagnostic categories can impact decisions involving public healthcare policy, insurance coverage, disability, incarceration, and access to support. Developers of diagnostic manuals must balance the needs of "clinicians, researchers, trainees and students, administrators, record room librarians, lawyers, disability boards and insurance companies" (Frances et al. 1991, p. 410).

Earlier in Chapter Two, the field trial for the DSM-IV was explicitly discussed in relation to the development of DESNOS. Interestingly, the developers of DESNOS have highlighted issues with diagnostic manuals, referring specifically to the DSM-IV, stating that it (the DSM-IV) is used to guide both research and treatment, and utilises incremental advances in research to revise the constructs that were theoretically derived at the *first* edition of the manual (Luxenberg et al., 2001). This implies that what is possible to change in the DSM is limited to what already exists in the manual. This is a slight overstatement, as the manuals have added new constructs (CPTSD in the ICD-11 being a prime example); however, the sentiment is somewhat accurate: the manuals change slowly and are likely to prioritise the status quo, or at least only incremental advancements.

Going further, Luxenberg et al. (2001) postulate that, because the DSM is non-etiological, it can only draw arbitrary distinctions between clinical phenomena to construct a manual that can be

widely used. Luxenberg et al. (2001) admit that this approach to creating a manual results in efficiency and a common language across users. However, they argue that a cost of the system is that

> "practitioners can become overly reliant on artificial distinctions between disorders, and thereby fail to account for symptomatology that is not readily summed up under existing diagnostic formulations. The challenge thus becomes to work within the existing system to characterize as precisely as possible what we know about the statement of psychopathology in various clinical populations" (Luxenberg et al., 2001, p. 383).

Luxenberg et al. (2001) argue that this issue becomes salient when differential diagnosis is considered. Luxenberg et al. (2001) are speaking of DESNOS, which they state has high comorbidity and symptom overlap with other disorders (specifically, they mention PTSD and BPD), and that these issues can lead to misdiagnosis or multiple diagnoses, or that some aspects of a client's difficulties are overlooked entirely (Luxenberg, 2001).

Diagnostic manuals are intended to serve a variety of users, they exist in a dynamic relationship with said users where the manuals are both influenced by and impact upon those that they are intended for. The attributes that make diagnostic manuals so valuable are also what put them in danger of having diminished use. On the one hand we need manuals that are useful for communication, are stable across environments and time, and are standardised. Unfortunately, these positive attributes can lead to manuals that are too broad, contain arbitrary distinctions, avoid aetiological considerations, slow to change, and may not accurately reflect the traits and symptoms of the individuals they seek to describe.

Clinician Perspectives of Diagnostic Manuals

A study by Evans et al. (2013) sought to understand the use and perceptions of diagnostic classification systems (DCSs) amongst psychologists. The multilingual survey, including 2155 psychologists from 23 countries, found that 60% of participants routinely used DCSs (51% used the ICD, 44% used the DSM), and that the most important factor for participants when evaluating DCSs was their use in informing treatment decisions and facilitating communication. Participants also preferred flexible diagnostic guidelines to strict criteria and raised concerns about cross-cultural applicability and cultural bias (Evans et al., 2013).

To the best of this researcher's knowledge, there is no research into what psychologists in Aotearoa NZ think of the diagnostic manuals; however, research with Aotearoa NZ psychiatrists exists. A study by Mellsop et al. (2007) sought to describe the perspectives of Aotearoa NZ psychiatrists on what they desire from a classificatory system, and their opinions of current classification systems. Results from the 235 respondents showed that psychiatrists in Aotearoa NZ

primarily used the DSM-IV (this survey was conducted prior to the release of the DSM-5). As to why they use the DSM, the overwhelming answer was that it was the manual used during their education and the system most widely used in textbooks. Other common reasons were that their employer health provider systems used the DSM, or that 'everybody' used it. Respondents noted that what they value most in a DCS is its use for reliable inter-clinician communication and to inform client management planning. In response to the qualities or attributes they need or want from a psychiatric classification, respondents most prominently stated simplicity of use, reliability and usefulness to guide treatment. Other reasons included being less rigid, allowing for more individuality, greater use and context flexibility, greater emphasis on dimensions, a system that is more reliable and valid over time, and fewer, broader categories (Mellsop et al., 2007).

It appears that mental health workers frequently utilise diagnostic manuals, and what they perceive as being most important is their usefulness for informing treatment decisions and planning, and for communication; these are two key aspects of clinical utility.

Clinical Utility

As far back as 1966, it has been argued that clinical utility must be a significant factor in the development of diagnostic manuals (Rorer et al. 1966) and an essential goal for classification systems (Reed 2010). The developers of the DSM and the ICD reiterate these sentiments. The developers of the DSM-IV stated that their 'highest priority has been to provide a helpful guide to clinical practice' (APA, 2000, p. xxiii). In the DSM-5, it states that 'efforts were directed toward the goal of enhancing the clinical usefulness of DSM-5' (APA, 2013, p. 5). The developers of the ICD-11 have stated that 'clinical utility deserved to be a major guiding principle for the revision process as an organising priority for the revision as long as it does not sacrifice validity as established by the best science available' (First et al. 2015; Reed 2010).

The first definition of clinical utility in the literature appeared surprisingly recently, in 2004, by First et al. (2004). The authors attempted to find prior definitions in the psychological literature, but although the term clinical utility appeared relatively frequently, no definition was found (First et al., 2004). First et al. (2004) define clinical utility, in the context of diagnostic manuals, as 'the extent to which (a diagnostic manual) assists clinical decision makers in fulfilling the various clinical functions of a psychiatric classification system' (First et al., 2004, p. 947). For First et al. (2004), these functions include: conceptualising diagnostic entities, communicating clinical information to practitioners, patients, and their families, using diagnostic categories and criteria sets in clinical practice, choosing effective interventions to improve clinical outcomes, and predicting future clinical management needs (First et al., 2004). The WHO sees clinical utility similarly, and argues that, for a diagnostic manual to have clinical utility, it must be useful for communication among all involved, for implementation (including accuracy, ease, and speed of use), and for selecting interventions and

making clinical management decisions (Reed 2010, p. 461). Mullins-Sweatt and Widiger (2009) align with the WHO in suggesting that there are three primary components of clinical utility: communication, ease of usage, and treatment planning.

Though classification developers often state that clinical utility is essential, historically little research has been conducted on clinical utility during the development of diagnostic manuals, with research focusing more on construct or diagnostic validity than on clinical utility (First et al., 2015), and a distinction between validity and utility is important. First et al. (2004) suggest that at times clinical utility and diagnostic validity overlap, and at other times they are distinct. This is because diagnosis can have excellent validity but can still, unfortunately, be difficult for clinical practice in the real world (First et al, 2004). For example, a completely valid diagnostic manual will have extremely poor clinical utility if it becomes so complex and time-consuming that it is not used in clinical practice (First, 2005). Conversely, shortening sets of diagnostic criteria may improve the ease of use of a diagnosis, but may decrease its descriptive validity. Similarly, shorter instruments may facilitate faster assessment but may also provide less clarity or certainty in diagnosis, thereby reducing trust in and therefore use of a diagnosis.

Clinical utility is essential because it affects clinicians' ability to identify and treat mental health issues. Improving clinical utility leads to reduced burden of mental disorders to the individuals who suffer from them and to society at large (Reed, 2010), however improvements to clinical utility are not straightforward. One must determine whether advantages in diagnostic criteria do not outweigh other negative consequences, such as increased burden on users due to changes, the need to develop new instruments and measures, and new difficulties for researchers (Mullins-Sweatt et al., 2015). This is evident in the inclusion of CTPSD in the ICD-11, which, on the one hand, has increased its diagnostic validity by improving specificity. On the other hand, it may lead to confusion among clinicians and clients, require the use of new instruments, and increase assessment time for already resource-limited health care providers.

It is worth exploring the crucial aspects of clinical utility further. One such critical aspect of clinical utility outlined by First et al. (2004) is of impact on use, and specifically user acceptability; this aspect of clinical utility focuses on whether the diagnostic system is used *at all* by its intended end population (user acceptability) and whether it is used *correctly* (accuracy in the application of the diagnostic criteria). Achieving adequate levels of user acceptability is critically vital, as non-use of the diagnostic system eliminates any potential benefits that might result from DCS (Mullins-Sweatt et al., 2015). Simply put, if clinicians do not accept the diagnosis and therefore avoid using it, any other aspect of clinical utility is nullified. Equally, if a diagnosis is difficult to apply, it may be incorrectly applied and negatively impact treatment outcomes.

Another aspect previously mentioned is communication. Communication involves relaying information to government agencies, public health providers, and among service providers, not all of whom are mental health experts. This communication between professionals is essential if a diagnosis

is to have any clinical utility within an organised psychological system. Communication also involves communication with the public; a key issue in public communication is stigma. As previously stated, the BPD diagnosis has been historically highly stigmatised.

A third aspect of clinical utility is impact on use. An argument can be made that classification manuals are designed for use by researchers rather than clinicians, partly due to the lengthy criteria sets for different disorders. While researchers may have time to investigate lengthy criterion sets, this may prove more challenging in a clinical setting (Mullins-Sweatt et al., 2015). In the field trial for the DSM-5, studies focused on feasibility, face validity, and reliability (Clarke et al., 2013; Mullins-Sweatt et al., 2015). It is encouraging that feasibility was investigated, as this relates to ease of use; however, no improvements in ease of use emerged from the trials (Clarke et al., 2013; Mullins-Sweatt et al., 2015). What is more encouraging is that the development of the ICD-11 involved several internet-based field trials to assess utility. These field trials found that the criteria in the ICD-11 were easier to apply and yielded more accurate results than those in previous iterations (First et al., 2015; Mullins-Sweatt et al., 2015). Other factors to consider include available public health resources and whether the prevalence of disorders aligns with the resources needed for treatment. It has been argued that prevalence rates are too high given the limited availability of treatment resources (Mullins-Sweatt et al., 2015).

Finally use for treatment planning is important. It has been argued that the development of diagnostic manuals should be governed more strongly and specifically by either aetiology or treatment implications (Charney et al., 2002; Helzer & Hudziak, 2002; Phillips et al., 2003; Tsuang et al., 2003) and that a manual without clear treatment implications is fundamentally flawed (Kupfer et al., 2002). The use of ‘unspecified’ or ‘not otherwise specified’ diagnoses can suggest that clinicians find diagnostic categories difficult to use or inefficient (Reed, 2010).

Beyond Diagnosis & Diagnostic Manuals

Any discussion of the utility of a psychological diagnosis needs to extend beyond the diagnosis itself to consider the approaches psychologists use in their daily practice to provide information to, and inform the treatment of, the clients they work with. A clinical diagnosis, via a manualised framework such as the DSM-5 or the ICD-11, is not the only way to understand the issues a client is dealing with.

There are many reasons why a psychologist might be wary of a diagnosis. Many psychologists resist the use of diagnosis and may even be critical of it, seeing it as being within a ‘medical paradigm’ (Love, 2018), and in danger of assuming a person’s distress is a form of pathology with biological roots, with symptoms clustered into a single category (Meyers & Agnew, 2019). This may oversimplify the challenges a person faces and run the risk of ignoring important contributing factors such as trauma or discrimination. Diagnoses have been criticised at an

epistemological level for failing to acknowledge or focus on social issues such as poverty or trauma history as factors influencing a person's current behaviours and emotions; as a result, they may fail to truly reflect peoples' lived experiences (Meyers & Agnew, 2019).

Ambivalence toward diagnosis is not only at the clinician level. Emeritus Professor Anthony Love, in his article for the Australian Psychological Society (Love, 2018), stated that a benefit of diagnosis for psychologists is that it provides a framework for ongoing development of knowledge, reflection, and decision-making, especially within peer supervision. However, if the diagnosis is not sufficiently informative, it can have the opposite effect (Love, 2018). Love (2018) emphasised the importance of being able to rule out competing diagnoses, consider personality style, other personality factors, as well as physical health, and social, cultural, and spiritual aspects. In 2013, during a public address, Tom Insel, the head of the US National Institute of Mental Health, criticised the DSM-5's validity, stating that in the future, no research would be funded if it focused solely on diagnostic categories. The UN Special Rapporteur stated that mental health policies should, instead of focusing on 'chemical imbalances', address 'power imbalances' (Meyers & Agnew, 2019).

There is more to what psychologists do than using diagnostic manuals. In discussing the role of psychologists, Mayers and Agnew (2019) provide a helpful description of the various practices of a psychologist. The authors use the terms 'scientist-practitioner', 'reflective-practitioner' and 'activist-practitioner'. As scientist-practitioners, psychologists use evidence-based approaches to support their clients. As reflective practitioners, they consider the impacts of biases, assumptions, and prejudices on the therapeutic process. As activist-practitioners (Psychologists for Social Change, 2017), psychologists must use their 'understanding of cultural-political factors and their professional power to lobby for social change alongside communities, to impact psychological wellbeing at both an individual and population level' (Meyers & Agnew, 2019, p. 9).

Chapter Summary

Chapter One reviewed literature and presented BPD as a controversial and often disputed diagnosis (Leichsenring et al., 2024) due to the stigma surrounding the diagnosis, gender bias of the diagnosis, its lack of a clear aetiology, the heterogeneity of symptoms, and its high comorbidity and symptom overlap with other mental disorders (Bockian, 2002). Chapter Two outlined developments in trauma conceptualisation, the development of the concept of complex post-traumatic stress disorder (CPTSD), recently included as a diagnosis in the ICD-11 (World Health Organisation, 2025), the common presence of trauma in the histories of those with BPD, and discussions concerning the significant overlap between CPTSD and BPD.

The current chapter presented a discussion of diagnostic manuals, clinical utility, and diagnosis, highlighting the competing forces at play in the development of diagnostic manuals, including scientific evidence, usability, the preventing overdiagnosis, improving treatment access,

reducing stigma, encouraging research, and ensuring continuity, alongside the needs of the wide range of parties that use diagnostic manuals (Lilienfeld, 2010; Mullins-Sweatt et al., 2015). As a result, diagnostic manuals risk changing too slowly, prioritising the status quo, and reducing mental health difficulties to arbitrary categories (Luxenberg et al., 2001). Clinical utility was discussed; it refers to how useful a manual is in clinical practice, including its role in communication, treatment planning, and ease of use (impact on use, user acceptability, and correct use) (Reed 2010). Literature also suggests that many psychologists resist the use of diagnosis, viewing it as part of a medical model, over-simplifying a client's challenges, and risking the neglect of essential factors like trauma or social issues (Meyers & Agnew, 2019).

The disputed status of BPD as a diagnosis, and the arrival of CPTSD as an official diagnosis surely creates challenges for clinicians. Theories of mental disorder diagnosis highlight the importance of clinicians' perspectives and clinical utility to inform diagnostic manuals, beyond theoretical and research psychology approaches (Reed, 2010). BPD is a highly investigated diagnosis; however, research into clinical perspectives of the clinical utility of BPD is limited. To date there is no research existing into the perceptions of clinicians working in Aotearoa NZ of the clinical utility of the BPD diagnosis. This study aims to bridge the gap in knowledge by asking the question: What is the perception of the clinical utility of the BPD diagnosis for clinicians working with individuals presenting with BPD symptoms in Aotearoa NZ.

In the next chapter, Chapter Four, the research methodology is explained.

Chapter Four: Methodology

The current study is qualitative, utilising reflexive thematic analysis from a critical realist theoretical framework. This chapter describes the methodological and theoretical orientation of this study, the approach to data collection and analysis, participant recruitment, research reflection and ethics of this research project.

Method

Thematic analysis (TA), a widely used approach to qualitative psychological research, was used to identify and analyse patterns of meaning in the dataset for this research (Braun & Clarke, 2006). TA helps elucidate the 'specific nature of a given group's conceptualisation of the phenomenon under study' (Joffe, 2012, p. 212). The result of a TA should highlight the most salient constellations of meaning in the dataset (Joffe, 2012). There are many forms that a TA can take. This study utilised reflexive thematic analysis. A reflexive approach to TA emphasises the inevitable subjectivity in the research's data coding and analysis, and the role of the researcher as active during encoding (Braun & Clarke, 2021).

Theoretical Orientation

Because TA is a trans theoretical method, it is important for the research to recognise a theoretical position (Braun & Clarke, 2006). This research takes the constructivist position that meaning and experience are socially produced and reproduced (Burr, 1995). Knowledge involves, or is predicated by, social processes and the social construction of meaning (Gergen, 2015). When one undertakes constructionist thematic analysis, the language used is not treated as straightforward information to be taken at face value but rather as something to be interrogated, as something that creates rather than reflects meaning (Braun & Clarke, 2021).

Self-Reflection

Thematic analysis involves the researcher's interpretation of data and, therefore, involves subjectivity. A thoughtful, reflective research approach is crucial to quality TA (Braun & Clarke, 2021). As a researcher, my experiences and understanding impact my interpretation of the data.

I am a 43-year-old male born in Aotearoa NZ of Irish, Swedish, and Dutch descent. I currently live in Copenhagen, Denmark. There is a history of mental illness in my family; my grandmother on my father's side was institutionalised due to mental health issues, the details of which are unknown, and there is a history of dementia on my mother's side of the family. My grandmother had severe dementia all the time I knew her. I have cousins with learning disabilities and addiction

problems. I have struggled with anxiety and mild depression. I recognise in myself issues with abandonment, hypersensitivity, relational difficulties, and emotional reactivity. I grew up in the deep rural south of the South Island. Though I didn't realise it at the time, looking back, I think it was a pretty violent place. I have spent much of my adult life in Scandinavia and, as a result, have experienced a completely different culture and society —one that appears less aggressive but is also less open.

The impact of colonialisation on Aotearoa is something I reflect upon. Firstly, due to the largely unresolved damage it has done to our indigenous people, but also due to the psychological damage it has done and may continue to do to all of Aotearoa NZ society. To me, colonialism is a force that makes everyone homeless, both the colonised and the coloniser. The impact of this must take a psychological toll on future generations. I always feel odd in Aotearoa NZ, due to the cognitive dissonance of being both 'of the place' and a trespasser. It reminds me of the double bind of BPD.

All of this is to say that I have both an insider and an outsider perspective on Aotearoa NZ, a deep empathy for the suffering of those with mental health issues, both at the individual and societal levels, and a suspicion that Aotearoa NZ is a very unique environment for practising psychology. I am fascinated with the concept of BPD and believe that there is something there that is there; on the other hand, I am wary of the history of psychology and diagnosis, and the role that external cultural, economic, and political pressures have played in the development of mental health conceptualisations and diagnostic manuals. I bring all this with me to my research. My particular subjectivity is something I was aware of, worked with, and reflected upon as I undertook the thematic analysis of this research.

The Research Question

The broad research question of this project is: What do clinical psychologists in Aotearoa NZ think about the clinical utility of the BPD diagnosis for Aotearoa NZ? Additional questions connected to the broader question include: What is the role of trauma in borderline personality disorder? Do clinicians consider there to be differences between complex PTSD and BPD? Do they believe that the Aotearoa NZ population presents differently from other populations, specifically regarding BPD? The broad research question was intended as an open starting point. The analysis in this research involves a 'dialogue' between the interpretation of the patterned meaning and the research question (Braun & Clarke, 2021).

Ethical Considerations

Good ethics are essential to good research practice and concern both the procedures of the research and its politics (Braun & Clarke, 2021). In Aotearoa NZ, the New Zealand Psychological Society has a Code of Ethics, and Massey University has a process of approving research to ensure

that it is ethically sound. The code of ethics was consulted prior to the commencement of the research. Ethical approval for this study was obtained through Massey University Human Ethics Committee (see Appendix E).

The subject of mental illness and trauma can be distressing for participants. This risk was acknowledged in the information sheet provided to participants (see Appendix B). Participants were also given a list of available counselling resources and helplines, along with contact information for the researcher and supervisor. No participants appeared distressed or emotional during the interviews, and no one subsequently reached out to the researcher or supervisors with concerns.

Guidelines for conducting TA research encourage researchers to utilise a reflexive approach to research ethics (Braun & Clarke, 2021). Reflexivity was utilised when considering encounters with and representations of participants. The utmost consideration was given to conducting research in a genuinely inclusive and culturally and politically sensitive manner.

Trustworthiness

Trustworthiness is essential for establishing the reliability and credibility of qualitative research (Ahmed, 2024). Trustworthiness comprises credibility, transferability, dependability, and confirmability (Nowell et al., 2017).

Credibility refers to the fit between participants' responses and the researcher's representation of those views (Tobin & Begley, 2004). In this project, credibility was supported by involving my supervisor (an expert researcher) at all stages of the process to corroborate methods and findings. Prolonged engagement with the data (Lincoln & Guba, 1985) was also used during transcription, coding, and theme generation. Data were read and re-read, and interpretations were re-examined multiple times throughout the coding and theme-naming process. A third technique, persistent observation, was also utilised, involving remaining open-minded, engaging in self-reflection, and interrogating personal biases (Ahmed, 2024). Reflexivity before the commencement of research is described above; this reflexivity was continued throughout.

Transferability is the degree to which a research finding can be generalised from the sample to the population under study (Nowell et al., 2017). A technique for aiding transferability is to provide thick descriptions to help readers judge the transferability of a piece of qualitative research (Lincoln & Guba, 1985). A detailed discussion of the methodology is provided here to aid transferability.

Dependability requires a research process that is logical, traceable, and well-documented (Nowell et al., 2017). An audit trail (Koch, 1994), including documentation of decision-making, record-keeping, a reflexive journal, and raw data and transcripts, was saved for future reference. Thorough methodological documentation provided in this section and the appendix also supports dependability by ensuring transparency and aiding replication (Ahmed, 2024). Finally, the

presentation of the analysis is supported by extensive quotations from participants, allowing the reader to see how the analysis was made.

Confirmability refers to providing evidence that the interpretations and findings are derived from the data (Nowell et al., 2017). Key to this confirmability is the inclusion of numerous quotes throughout the analysis as evidence. To aid confirmability, an external auditor (my supervisor), who is experienced and impartial, followed the research project to review and confirm this researcher's decisions throughout the research process (Lincoln & Guba, 1985).

Recruitment & Sampling

The four-step 'pan-paradigmatic' guide to sampling (Robinson, 2013) was used to consider the aspects of sampling in the current study. A sampling universe was defined using inclusion criteria. In the current study, the inclusion criteria were that participants must be actively working as a registered clinical psychologist in Aotearoa NZ, with professional experience with BPD. A sample size was determined by reflecting on what is ideal and practical (Braun & Clarke, 2021). In the current study, the aim was for a rich, detailed analysis of the data, which required considerable time in the coding and analysis phases. Consequently, due to recruitment and resource limitations, the number of participants was set to seven. The sample in this study was sourced using purposive, convenience, and snowball sampling to find participants willing to participate, utilising a research advertisement (see Appendix A) distributed digitally via existing relationships and personal networks, the NZ Psychology Society newsletter email, and psychology clinics (via email). Those who responded and met the inclusion criteria were sent a more detailed information sheet and consent form (see Appendix C) and invited to a 50-minute online interview.

Participants

The participants were seven clinical psychologists currently working in Aotearoa NZ, including five women and two men. Of the participants, five identified as Pakeha, one as French, and one as African British. The participants ranged in age from 32 to 58.

Data Collection

TA research aims for rich, complex, nuanced, and detailed data (Braun & Clarke, 2021). In alignment with what is standard for reflexive TA, a verbal semi-structured interview was used (Wilkinson et al., 2004) (see Appendix D). The aim of the interview was to promote a real-world conversation to enable the interaction and co-construction of meaning between researcher and participant (Braun & Clarke, 2021). Close attention was paid to prompting and probing for data, and

to avoid ‘at-surface interviewing’ (Conelly & Peltzer, 2016) and to the relationship between participant and researcher (Braun & Clarke, 2021).

Procedure

All seven participants were interviewed over Google Meet. Length of interviews ranged from 50 to 70 minutes. Prior to interview commencement, written informed consent was collected during which participants were asked if they wanted to receive a copy of their transcript for review and /or a copy of the analysis once completed. Interviews were conducted at agreed-upon times, utilising the interview schedule as a starting point. Interviews were recorded and stored on two password-protected hard drives. Identifying information of the participants was replaced with numbers to ensure confidentiality. Transcription was made using the transcription tool within the Google Meet application, and then personally checked against the video recordings.

Thematic analysis was used to construct themes from the interview data. Coding in reflexive TA is not just about identifying data but also interpreting it through the researcher's subjectivity and requires prolonged and in-depth engagement with the data (Braun & Clarke, 2021). The approach taken in this research was both inductive and deductive. Deductive analysis is a top-down, theoretically driven approach that is more explicitly analyst-driven (Braun & Clarke, 2006). In contrast, inductive thematic analysis is a data-driven, bottom-up approach; here, themes identified are strongly linked to the data themselves (Braun & Clarke, 2006). Data was approached with the researcher’s preconceived understanding of the subject derived from the literature review, and the research sought to remain open to new themes, concepts, and ideas (Joffe, 2012). During analysis familiarisation was made by listening to, reading and re-reading transcripts, sorting and labelling data into codes (reflecting what is perceived to be meant by the segments of data), further sorting the codes into clusters of codes, and finally generating broader themes that connect various linked codes. This process involved coding and recoding, reading and re-reading, reflection, then generating and questioning themes. Outlying codes were also noted and considered. Finally, a set of themes was decided upon for discussion.

Chapter Summary

This study aims to explore how clinical psychologists in Aotearoa NZ view the clinical utility of the BPD diagnosis in Aotearoa NZ. Seven clinical psychologists with experience in the BPD diagnosis were recruited via purposive, convenience, and snowball sampling. Semi-structured interviews were conducted via Google Meet. Reflexive thematic analysis was used to generate themes from the data. The next chapter presents the results of the data analysis.

Chapter Five: Analysis

The following chapter presents the results of the thematic analysis of this research project.

Analysis

Five themes were identified in the data set: Alarm Bells!; Navigating a Moral Dilemma; Centring the Client; Trauma: A New Approach to BPD; and Change & Acceptance. Each theme contained numerous subthemes (presented in Table 4). Names and identifying information have been removed from the data used throughout this chapter. The acronym DSM will be used throughout the following analysis and is used interchangeably to refer to both the DSM-5 and the broader concept of the DSM as a ubiquitous diagnostic manual used throughout the 20th century to today. If participants refer specifically to the DSM-5 then DSM-5 will be used.

Table 4 - Summary of Thematic Analysis of Aotearoa NZ Clinician Perspectives of the BPD Diagnosis

Theme	Subordinate Theme
1. Alarm Bells!	1.1 The Stigma of "Borderline"
	1.2 The Gender Problem
	1.3 The "Sticky-ness" of BPD
	1.4 The "Mongrel" Diagnosis
2. Navigating a Moral Dilemma	2.1 Wariness and Frustration about the Diagnosis
	2.2 The "Game" of Psychology
	2.3 It's Not All Bad
	2.4 There is a "There" There
3. Centring the Client	3.1 Begin With What Matters Most to the Client
	3.2 Collaboration & Communication Facilitated by Expertise
4. Trauma – A New Approach to BPD	4.1 Everyone has Trauma.
	4.2 What are We Talking About When We Say "Trauma"?
	4.3 CPTSD is Here
	4.4 A Diagnosis that is Positive
5. Change & Acceptance	5.1 Caution… CPTSD May Not Be BPD
	5.2 Grappling with Change
	5.3 Reflecting on How Psychology meets Society

Theme One: Alarm Bells!

The first theme was one that all participants spent a considerable amount of time talking about. They reflected experiencing a sense of alarm bells, danger or caution arising from the BPD diagnosis. Four subthemes associated with these alarm bells were: 1. the stigma of "borderline", 2. the gender problem, 3. the "sticky-ness" of BPD, and 4. the "mongrel" diagnosis.

The Stigma of "Borderline"

The alarm bells felt by clinicians were primarily due to their perceptions that BPD was a highly stigmatised diagnosis. Concerns about stigma began with the name of the disorder itself, which many clinicians thought was a problem both for clients and the public.

> *ITV5 - "I think there's been talk for a while about renaming it and calling it something like emotional dysregulation disorder or something. I don't know. But, yeah, I don't really think that's (BPD) a very nice term, personally, I don't think it's very nice."*

> *ITV6 - "You'll hear it in meetings and community health, like it will get shortened to "borderline", you know, which we don't do with anything else."*

This reduction of a client down to one word was, for Interviewee Six, indicative of the issue of the BPD diagnosis as a whole; a poorly named diagnosis that leads to reinforced negative attitudes amongst healthcare workers.

> *ITV6 - "There's still lots of, yeah… lots of disparaging comments about these clients, you know? "Difficult", "manipulative", umm, "revolving door clients". We should just discharge, you know, like a kind of quick decision-making around these clients. And so, you're kind of, that term is just, it's a hard one because it's really it's sucked all that up, you know, into one word."*

Interviewee Six's perception that the term borderline is loaded with negative stigma, which is then expressed toward clients by healthcare workers, was a common view among participants and supported by research (Stiles et al., 2023). Participants expressed concern that the stigmatisation of the diagnosis meant that those diagnosed with BPD were treated differently by health professionals, and that the bias is so embedded in the culture of health professionals that they may not be aware of it.

ITV2 - "I think that there's still people who, they eye roll. It's horrible… they just think you're being naughty. They just think you're being a pain in the ass and making our lives difficult for us. And don't have a working formulation about why does this behaviour seem to be most workable for this person at this time?"

ITV1 - "I know historically it was often seen as like a "Oh, well, they've got BPD". It's kind of like, they're, you may as well write them off. You know? They can't be helped. So, yeah, the stigma of that and being a difficult case, or a ´heart sink´ client. All of that is kind of encapsulated in this label."

Such phrases as "manipulative", "heart-sink client", "naughty", "write off", or "pain in the ass" clearly illustrate a judgmental and dismissive attitude that participants felt is present amongst healthcare professionals regarding those with BPD, leading to increased caution at best, or treatment refusal at worst. Concerningly, research supports these concerns. In their review, Stiles et al., (2023) found themes of othering, with participants describing experiences of being perceived as liars, unreasonable, difficult, manipulative (Veysey, 2014), undeserving of care (Fallon, 2003), and attention seeking (Bonnington & Rose, 2014; Nehls, 1999; Veysey, 2014). In many of the studies in the review, participants described a sense of being deemed untreatable by health care providers and felt that a diagnosis of BDP meant the health care professionals could simply reject them from services (Bonnington & Rose, 2014; Horn et al., 2007; Nehls, 1999).

It is also in the discussion of stigma where there is the first mention of complex trauma; Interviewee One points to a difference in the perception of someone diagnosed with BPD compared to someone with a CPTSD diagnosis, foreshadowing discussions to come about the potential applicability of less stigmatising diagnoses for someone presenting with BPD traits.

ITV1 - "Two people walk into the ward on the same day, they are admitted to the ward, and one of them has a borderline diagnosis and one has a complex trauma diagnosis. I think unwittingly, I'm guessing it's not consciously, how that person is perceived is different, especially by the nursing team."

Although participants express awareness of the dangers of stigma, they also, conversely, highlighted an either real or internalised sense of alarm within themselves (and other psychologists) at the prospect of encountering a client with BPD, or with BPD traits, due to the reputation of those with BPD as being more challenging. This was discussed as particularly challenging with regards to the therapeutic relationship.

ITV5 - "I do think it influences the way that professionals might approach people or might see people. So, people might think, "Oh, that person might be really difficult to work with." Which is really unfortunate because they might not be as well, right? They might be, you know… really, you know, committed to their recovery and wanting treatment."

ITV4 - "They (BPD clients) tend to flip between, you know, classic BPD. "You're really, really, wonderful. I can't believe I found such an amazing therapist," and "You're terrible. What are your credentials? How could you possibly suggest that and disappear?" You know?" and "Because they have difficulties with relationships, and that relationship with the therapist is so key to actually being able to do therapy, a lot of their difficulties then play out in that relationship with the therapist."

An historical narrative exists of BPD being untreatable, starting in early psychoanalytic literature (Wolberg, 1952). Much has been written about the difficulty for clinicians of those with BPD (Koekkoek et al., 2006; Sulzer, 2015). The difficulty associated with BPD, from a clinician perspective, may in part be due to the disruptive nature of some BPD symptoms (suicidality, emotional dysregulation) which undermines the therapeutic process, the belief that BPD is difficult to treat due to the complexity of the disorder (due to multiplicity of difficult symptoms, including high suicidality, emotional lability, anger etc) and difficulty of diagnosis (high co-morbidity and overlap with other disorders and high heterogeneity of symptoms) (Lepkowsky, 2020). What is evident from this subtheme concerning stigma is that on the one hand, clinicians are aware of and concerned about the stigma toward those diagnosed with BPD, particularly by health professionals, whilst at the same time reckoning with the reality that these clients cause alarm for them. Indeed, the participants were included in the health professionals who have complicated preconceptions of clients with BPD.

The Gender Problem

Another alarm bell raised about the BPD diagnosis by participants is that it is extremely gendered. Participants were quick to point out concerns that BPD is diagnosis historically applied most commonly to women and often what was considered to be in a controlling way. According to Interviewee One, who laughed from frustration, this bias is an "open-secret"; women are given BPD and men Anti-Social Personality Disorder.

ITV1 - "(laughs) I guess from like a gender perspective. I mean, that's I think quite clearly like the first thing that comes to my mind because it's a hugely gendered diagnosis… It's kind of an open secret, right? That we kind of diagnose women with BPD and men with antisocial personality disorder."

These sentiments were echoed by Interviewee Two and Interviewee Six.

ITV2 - "Umm, well, we haven't talked about the whole sexism, there's a sexist aspect to it, the way women have been diagnosed with it and not men."

ITV6 - "Everyone (with BPD) in our program at the moment and for nearly 99% of the time is a woman or, or a trans woman. Umm, ah, occasionally you get trans men, but rarely do you get men."

BPD impacts women three times more than men (American Psychiatric Association, 2013). The exact reason for this difference in prevalence remains unclear. Researchers have suggested that this may be due to historic biases (Holmes & Hughes, 2025; Thelandersson, 2022), sampling bias or the overrepresentation of women in clinical populations which may distort prevalence estimates and reinforce assumptions that BPD more commonly affects women (Holmes and Hughes, 2025). Research into gender bias amongst clinicians is mixed, with some research confirming gender bias (Becker & Lamb, 1994; Braamhorst et al., 2015; Bruce & Weinraub, 2023; Liebman & Burnette, 2013; Rodriguez-Seijas et al., 2024), and other research disconfirming it (Özel et al., 2024; Woodward et al., 2009). More recent research into transgender individuals found them to be more often diagnosed with BPD than cisgender clients with identical symptoms (Rodriguez-Seijas et al., 2025). Research into sexual and gender minorities has found that non-binary and transgender clients are diagnosed with BPD more frequently than cisgender clients with identical symptoms (Rodriguez-Seijas et al., 2021; 2024).

Other research suggests that BPD may have different symptom presentations for men and women, with women more often presenting with internalising symptoms (affective instability & self-harm), and men with externalising symptoms (aggression & impulsivity) (Bozzatello et al., 2024; Qian et al., 2022). It has also been argued that the DSM-5-TR places too much emphasis on the internalising symptoms of BPD, which again may lead to increased female prevalence and decreased male prevalence (Holmes and Hughes, 2025). Research by Bruce and Weinraub (2023) found that BPD was more often diagnosed in female presenting vignettes than in male presenting vignettes; similarly, research by Bramhorst et al. (2015) found that females were more likely to be assigned BPD, and males Narcissistic Personality Disorder (NPD) when clinicians were presented with a combination of symptoms.

Regardless of the reason the BPD diagnosis is not neutrally gendered, participants perceive it as biased, and this perception is another reason to be wary of the diagnosis.

The "Sticky-ness" of BPD

Not only did participants point to BPD as being stigmatising and gendered, but they also expressed alarm about the disturbing 'sticking quality' of the diagnosis. Unlike other diagnoses that are generally considered to be more temporary, there is a sense that the BPD diagnosis can be like a 'black mark' that follows those with the diagnosis long after the diagnosis is useful, or the client's presentation meets clinical criteria for the disorder. This sense of being 'stuck' with BPD forever was perceived to be both an issue within the mental health field and for clients with the diagnosis.

Interviewee Three expressed the toll of the permanence of the BPD diagnosis from the point of view of the client, who may be impacted long after they themselves feel that symptoms have improved.

> *ITV3 - "I got the flu. Maybe next week I don't have the flu. I got BPD. Fuck. I'm stuck with it for the rest of my life. Even if I feel better, I know at the back of my mind that this thing is still part of defining me… When people are told "this is what you are", it becomes an identity."*

For Interviewee Two, the concept of personality included in the diagnosis name, which is so linked to the underlying "person", almost makes it impossible for a person to progress away from a connection to the BPD diagnosis, even going so far as to refer to BPD as a "death sentence".

> *ITV2 - "Well, that's in the name, right? The way we think about personality is that it's something that's there forever… it implies just sort of in a stronger way than anything else. There's something wrong with you. And that's why it's a death sentence. Something wrong with (you). Nothing we can do. We just kind of try and manage as best we can."*

Research has found a general sense of hopelessness around the prospects of recovery amongst those with BPD (Bonnington & Rose, 2014; Horn et al., 2007; Miller, 1994; Nehls, 1999; Veysey, 2014), as well as a belief that change is impossible. Shockingly the "sticky-ness" of BPD can impact a person even without a formal diagnosis. Here, the spectre of BPD acting as if it is some monster of urban legend can work its way up out of a client's notes and, mysteriously, assert itself as a full-blown diagnosis.

> *ITV5 - "When I worked at (clinic name removed)… you have to be really careful with what you say because on that system you can, like, browse through, years and years of a person's notes and if somebody has written "they might have symptoms" or "my impression is they might have symptoms of BPD" that can really stick even if the person hasn't got a formal diagnosis."*

ITV1 - "I've done so many file reviews in my years where someone you're working with has like, ages and ages ago, someone's made a comment about kind of borderline traits or emerging borderline traits, when they were like a teenager and then the next person who's assessed them is kind of, and then it's just gotten lost, and all of a sudden they've been diagnosed with BPD and that's never actually happened, and it's like a mark I guess on their file."

It is crucial to emphasise the significance of this information. To reiterate; BPD traits can be mentioned regarding a client, and later, without an official diagnosis, this person is referred to as having BPD, a diagnosis that is gendered and highly stigmatised.

The "Mongrel" Diagnosis

The previously mentioned, concerns participants had with the dangers of the BPD label led participants to a final alarm bell about the risk of misdiagnosis. Contributing to this concern was the belief that BPD is difficult to diagnose. All participants were familiar with the DSM-5 description and criteria of BPD and tended to discuss those criteria when discussing someone with BPD. However, participants felt that the BPD diagnosis is poorly demarcated from other diagnoses (especially other personality disorders), that the diagnosis is too broad, and that the presentation of BPD is highly heterogeneous. All these issues led to doubts and concerns about giving the diagnosis, particularly in the context of the problems mentioned above.

Interviewee Three described BPD as a category "built from thin air", and concerningly, created to capture people who were not understood within other conditions. The lack of understanding of these clients appeared to both contribute to them being diagnosed with BPD and then this was perpetuated by the diagnosis acting as a barrier to fully knowing the person and the functions of their behaviour.

ITV3 - "It's really a category that was built out of thin air to fit in people that didn't fit into anywhere else."

Perhaps Interviewee Seven put things most simply when they referred to BPD as a "mongrel" category, where case presentation can vary a lot and some clients seemingly better explained by other disorders.

ITV7 - "Borderline is kind of a mongrel category, and actually they (clinicians) need to tease (the BPD diagnosis) out, like probably 70% of cases are like complex PTSD, more, umm, and

> *kind of what (are) more close to what the actual borderline diagnostic criteria are. But then there's like antisocial personality disorder, narcissistic personality disorder in there as well, and they all sort of get lumped in the same category a lot."*

Similarly, Interviewee Five described the variety of symptom presentations involved in the diagnosis of BPD, meaning that clients with the same diagnosis could have very different challenges and be very different from each other.

> *ITV5 - "So, some people can have outbursts of anger. Some people feel chronically empty. Umm, quite often, pretty much everyone I've known that (has) BPD has had problems in interpersonal relationships. So (it) can be fear of abandonment, re the whole, umm, idealisation and devaluing of people, and that real swing of how they see people, and that can really affect relationships. Umm, yeah, problem, well, disturbances in identity. So, some people just don't really know who they are. Yeah, it could be dissociation there as well."*

The variety of presentations that come under the umbrella of BPD, as well as the overlap of BPD with other diagnoses (both personality disorders and other completely distinct diagnoses), was often expressed as one of the challenges of making a BPD diagnosis.

> *ITV4 - "… there is quite a lot of crossover. So, there's traits that are similar to ADHD, there are traits similar to sort of like more of a mood disorder, there are traits similar to more from a trauma disorder… I do find that it has quite a lot of crossover with quite a number of diagnoses. Not to say that it is completely the same, but it does share a lot of similar traits with others."*

> *ITV6 - "if you meet the criteria for one personality disorder, you've got a pretty hefty chance of meeting the criteria for a couple. Right."*

> *ITV5 - "Bi-polar can often be confused with BPD. They can look quite similar. Umm, there's some research I've read recently that says even autistic people can get, umm, it seems like they could have BPD when actually underneath everything it's actually autist-, being autistic."*

Not only did participants express an alarm bell due to overlap between BPD and other disorders, which led to fears of misdiagnosis, but they also spoke of difficulties parsing out the complexity and overlap of presentations. This was expressed by Interviewee One, along with experiences of encountering misdiagnosis (ITV4).

ITV4 - "I can find it difficult to differentiate some of that, particularly when there's a more complicated presentation. If there are a lot of other comorbidities, which more often than not in my experience there have been, is that it is more difficult to find reliable ways to differentiate that."

ITV1 - "We recently had someone… who had been diagnosed as a teenager as having borderline and had gone through treatment but later, I don't know how this was missed, but we realized that she had autism, had a massive family history of it, but because she was a young woman back in the times when I guess that wasn't recognized and the way that, you know, when she was, over stimulated or having kind of like a sensory meltdown or really struggling interpersonally that was labelled as borderline."

Other alarm bells with the diagnosis noted by participants include a lack of validity of criteria (ITV6) of the diagnosis, a lack of evidence to support the diagnosis (ITV2), that the diagnosis lacks a core symptom (ITV1), or that the descriptions in the DSM don't align well with clinical experience (ITV1).

These sentiments are supported by the research, particularly because of the high co-morbidity with other disorders and the high heterogeneity of symptoms (Lepkowsky, 2020), as well as symptom overlap (Bockian, 2002) and BPD has frequently been found to be comorbid with other psychiatric conditions (Tate et al., 2022; Zanarini et al., 2004).

In summary, in Theme One, participants express alarm bells at the BPD diagnosis, describing a diagnosis that is highly stigmatising, tends to attach itself to clients long after it is useful, has a history of gender bias, and has numerous diagnostic issues. The next theme deals with the moral dilemma caused for psychologists as they try to integrate their concerns about the BPD diagnosis into their clinical practice.

Theme Two: Navigating a Moral Dilemma

The alarm bells of the BPD diagnosis place clinical psychologists in a moral dilemma. The moral dilemma arises from working with a diagnosis one might not feel good about using, or even acknowledging. As participants discussed what to do, they expressed wariness and frustration about the diagnosis (Subtheme 1) about the position they find themselves in, which is the emotional or psychological outcome of the dilemma they face. What follows is a search for a way to process or understand more deeply what to do. Additionally, psychologists may not have a choice about whether to work with the BPD diagnosis, as a client may be referred with a preexisting BPD diagnosis. At least part of the grappling with the BPD diagnosis involves coming to terms with working with the

diagnosis in the absence of a choice (Subtheme 2: The "Game of Psychology). Given that the realities of the job may require psychologists to encounter, at the very least, clients with a history of BPD and a previously existing diagnosis, participants acknowledged that despite the many issues with the BPD diagnosis, it still holds some value for them, and that it is not all bad (Subtheme Three). Finally, participants reckoned with the reality that there is a 'there' that is there (Subtheme Four), meaning that there is a cohort of clients that are covered by the criteria and descriptions of BPD that may not be better covered by other diagnoses, and that do need psychological support.

Wariness & Frustration about the Diagnosis

Participants showed reluctance or wariness to diagnose or expressed frustration with having to use the BPD diagnosis. Some participants recognised that, because they were concerned about the diagnosis, they either did not use it or did not want to. Their concerns focused on stigma, the potential harm to a person already in distress, and challenges to using the diagnosis for those with less experience. Interviewee One was hesitant to give any personality disorder diagnosis due to stigma and potential harm.

> *ITV1 - "Personally, I would feel very, very hesitant to give anyone a personality disorder diagnosis because, I just, the utility of that diagnosis versus the kind of potential harms when they come into the health system again… I think would, yeah, I don't think those would be equal. Yeah."*

Interviewee Four noted that concern around giving the BPD diagnosis could lead practices to refer people on, and that they themselves, due to limited experience diagnosing BPD, would also consider referring a client who could meet a BPD diagnosis onwards.

> *ITV4 - "There is more hesitancy. In fact, I have seen and… been at some places where they have, their general policy is (that) they refer people with a personality disorder to other places just because they - their presentation tends to be more complex… if somebody came to me to ask for a diagnosis of it uhm, then I normally, just because I guess, like I said to you in my email I am wary of my limited experience in the area, so I tend to, refer them onwards…"*

Those with BPD often report reluctance from health care professionals to give a diagnosis of BPD and to provide information on BPD (Styles et al., 2023). Additionally, a downside of not being given a diagnosis can mean extended periods of being left with no support, where both diagnosis and treatment are withheld (Bonnington & Rose, 2014). A complex diagnosis like BPD requires experience and knowledge; it may be difficult for inexperienced or new psychologists to be sure of

how to assess and treat BPD effectively. This hesitation to use the diagnosis poses a problem for clinical practice. A critical aspect of clinical utility is impact on use, and specifically user acceptability (First et al., 2004). If a diagnosis is perceived as so problematic that its use is avoided, or if it is challenging to apply correctly, this can lead to underutilisation of the diagnosis, eliminating potential benefits (Mullins-Sweatt et al., 2015).

Difficulty coming to terms with whether to use the BPD diagnosis was also expressed in a broader frustration around the expectations of the psychologist's job – a job that requires practitioners to simultaneously treat the individual, to meet them where they are, whilst also requiring clinicians to put clients into categories.

> *ITV5 - "I think it (psychology) should be based on 'Is this person experiencing extreme or significant distress or disability or problems?' Then if they are, of course, they should have access to therapy or to support, yeah, I totally agree with that. Rather than trying to fit things into a neat little box… it seems kind of ridiculous to me that you need to fit, because these things aren't discreet. The more you work with people, it's like, you can't always fit things into a nice little neat box even though our human minds like to have a category-based system… because it's easier to conceptualise."*

This desire to go beyond diagnostic categories and utilise the full range of knowledge, skills, and assessment approaches available to psychologists was repeatedly raised by participants. It involved conversations around client-centredness, formulation, and moving beyond diagnosis, all of which are interpreted as themes discussed later. Meyers and Agnew (2019) state that a criticism of the medical model is that it assumes that a person's distress is a form of pathology with biological roots. Symptoms are clustered together in a single category, over-simplifying the challenges a person faces and running the risk of ignoring important contributing factors such as trauma, discrimination or societal factors. BPD has been linked to trauma, and yet it does not include trauma in its diagnosis.

The "Game" of Psychology

Psychology is a field that has been shaped over decades, involving many actors, organisations, and interested parties. When a single psychologist enters an institution or organisation or encounters a new client, those interactions occur in the context of the history of the organisation, individual, and field of psychology. The context within which psychologists work is unavoidable. The reality of 'the game' of psychology is the second subtheme produced in this analysis. Participants spoke of what they considered to be inevitable realities of the job for a psychologist practicing in Aotearoa NZ, including: the ubiquitousness of the DSM and the required use of it within particular organisations (ITV3, ITV1, ITV6); that the diagnosis of BPD already exists and is unavoidable, with

some clients having a pre-existing BPD diagnosis (ITV5, ITV6); and the reality that diagnosis may be necessary for access to resources (ITV5).

Interviewee Six reflected on the reality that many clients with BPD symptoms have been engaged with mental health services for many years and have already come across the diagnosis.

> *ITV6 - "I think that's more of a reflection of the system pathway, which is, - by the time they come to DBT and therapy work, they've often, you know, especially the clients in adult services have been in child services usually. And so, they've had engagement with mental health services often for like a decade by the time they see me. And so, at that stage, there's been many psychiatrists who have either said they've got BPD traits or have given a diagnosis."*

This interaction among institutions, research, practice, and tools such as evidence-based interventions and diagnostic manuals constitutes a complex network of which clinical psychologists are merely one component. To access supports or find ways to support clients in a way that psychologists believe will work best for each individual requires "playing along" with all stakeholders in the collective mental health sector and, at times, utilising the power of the diagnosis.

> *ITV2 - "There's a sort of a game part to it, if I can get you this diagnosis, you can access resources."*

> *ITV6 - "For me, as a clinician, it's like, how can I hold it (BPD) and use it and still be critical of it as it develops, not abandon it, but then also not become like "this is the only way I see the psychology world"? So that there's space for other stuff to come in, again at that kind of pluralist kind of perspective."*

Interviewee Five described the way the BPD diagnosis can have a "life of its own", outside of the wishes of a clinician. By its very existence, BPD has become embedded in the history of psychology, and the actors and factors involved—research, identification, funding models, and evidence-based treatments—maintain it.

> *ITV5 - "It seems like then that that's kind of taken on a life of its own. Partly because people identify with the label, but partly also because I guess there's funding models and stuff for treatments, and so it just becomes so difficult (to avoid)."*

Even if a psychologist would want to reject the BPD diagnosis outright, they may not be able to, due to the realities of the job and the diagnosis's embeddedness; for example, it may be as simple

as a clinician needing to use the diagnosis to access treatment, or the diagnosis might exist within the communication occurring between the psychologist and other involved parties. Clinicians can manage their own communication, but they may not be able to manage the communication they receive.

The slowness of change in diagnostic manuals is also a factor. Diagnostic manuals tend to be adjusted incrementally and forward from the first edition (Luxenberg et al., 2001). If a manual then becomes widely used, the diagnosis exists in the world with a life of its own, making it difficult to avoid either encountering it or referring to it. In this way, given the lifespan of a human, it is difficult to escape the impact of earlier diagnoses and understandings within the field on clients. Given the number of people who need to use diagnostic manuals as part of their job, diagnoses—even those with stigma—may need to be used. There is a double bind: the diagnosis has existed for decades, and many parties use the diagnostic manual for various reasons, making it difficult to avoid; however, using it perpetuates this situation. If a psychologist does engage with the diagnosis, they risk reinforcing its future use.

However, participants also described positively the independence they have in their work, and that the job of a psychologist encompasses more than just diagnosis. They illustrated ways to work with BPD symptoms without diagnosing it, and they shared a belief in the benefits of formulation. Participants reported having ample scope to tailor their approach to a client's needs. They can utilise other methods that don't involve diagnosis, including the ability to access resources without giving a diagnosis, or focusing on different aspects of a person's psychology (traits and behaviours), by adding notes or details to a report to provide a richer description of a client, and by articulating what is happening for a client in a specific way. This tailored approach to the job enables psychologists to "play the game" of psychology and address their concerns about the diagnosis, while also providing care and access to resources for clients.

> *ITV1 - "It would be more like the person is presenting with these problems, they're extreme, they're experiencing a lot of distress. And then, yeah, I would refer them and find some funding for them."*

> *ITV6 - "More generally, we talk about personality traits, rather than getting too hung up on one specific disorder."*

> *ITV3 - "It's something that they have been experiencing, these crazy moods and these crazy difficulties with people around them. Umm, and… there's plenty that we can do to fix it without giving them a diagnosis that we can't erase afterwards."*

> *ITV7 - "Ah, we didn't talk about that like a huge amount (a BPD diagnosis). We talked much more about behaviours and emotion regulation."*

Participants also highlighted ways they can mitigate stigma, such as by providing more context and history about a client rather than just the diagnosis. Interviewee Six discussed strategies for reducing stigma and fostering empathy and understanding when referring to a client with BPD, utilising context and aetiology to explain current concerns.

> *ITV6 - "If I do use it, or refer to a client with that diagnosis, I'll always try, even if briefly, to just give like a little bit more of the context of the person (laughs) so that it kind of helps buffer the kind of…. yeah, so, you know, it'll be like "so and so has borderline personality disorder", you know, and then it might be like a sentence or two "they've gone through a very traumatised past with lots of difficulties of validation and so really seek support from people". Right. So, you're kind of naming that, yeah, this is where it's come from, but like still using the term."*

Probably the most often highlighted aspect of a psychologist's role, and a means to circumnavigate the moral conundrum of the BPD diagnosis, was by emphasising formulation over diagnosis as the primary speciality of a psychologist.

> *ITV1 - "I work in teams where it's quite small teams and very psychologically minded teams, that very much value psychology and formulation. One of my roles in the team…. I'm often asked by the psychiatrist to meet with people and just kind of formulate kind of do more of an assessment and help the team understand what's going on for this person. So very much even though there would be diagnoses on the file that's not really what drives our practice as much."*

> *ITV7 - "I think that's baked into our clinical psychology training anyway… because yeah, we do diagnosis… but this thing we really specialise in is formulation, which, it's much more like, "how does this show up in your life and what kind of treatment options or whatever fall out of that?""*

> *ITV2 - "(Formulation) is actually not about statistics. It's just about how do we put together you and the formulation reflects you. It's not "you had five out of eight of the criteria that you have to have to get this diagnosis". Yeah." AND "By and large, people find it incredibly validating because it's like, I make sense, and my story is all pulled together in a way. People find it really helpful to see it there in some words and to see that it's kind of connected. So that's what a formulation is."*

Formulation can take various forms, draw on different therapeutic models and consider the social aspects of mental illness. Participants expressed positive regard for formulation's strengths and its central role in their work of understanding clients. As previously mentioned, clinical utility involves the will to use, because if a diagnosis isn't used, how can it have utility? This begs the question: Do clinicians' preferences for formulation as a tool that is more clinically useful than diagnosis supersede the concerns about the utility of a diagnosis such as BPD? Or does their ability to weave what they know about BPD, evidence-based research, and combine it with their expert clinical judgement increase the clinical utility of BPD? Could it be that even without being used to give a diagnosis, the diagnosis can still have utility as a description, just not in the most obvious way of making a literal diagnosis? Either way, participants expressed a strong preference for formulation over diagnosis, at least regarding BPD. This will be reflected on later, in Theme Five, when participants discuss the future of diagnosis.

It's Not All Bad

Some participants shared that despite the many issues with the BPD diagnosis, it still holds some value for them, and that it is not all bad. Recognising this was part of their processing of the moral dilemma. Participants discussed the value of the BPD diagnosis for communication amongst mental health workers and within teams.

> *ITV6 - "When you say that word (BPD) like yes, there might be different interpretations of it, but there's a general understanding of what that, you know, you're pointing towards or what you're speaking about…"*

> *ITV2 - "There's this thing (BPD) that is a short-term handy way for me to say to you, "Wow, this person really struggles with their thoughts and feelings, is probably doing tension reduction behaviours by hurting themselves. They find relationships difficult and they're not quite sure who they are as a person". It's much easier just to be able to say BPD, right?"*

An essential aspect of negotiating the difficulties of the BPD diagnosis is the development of effective treatments of BPD and theories around aetiology. Many participants referred to treatments that they would be thinking about when considering a BPD diagnosis, including DBT, eye movement desensitisation and reprocessing (EMDR), acceptance and commitment therapy (ACT), mindfulness-based treatment and mentalisation-based treatment (MBT). They also often discussed Linehan's biopsychosocial model of BPD, which can provide an explanation to clients of the influences of experiences, inherited biological sensitivities, and the invalidating environment.

ITV4 - "For some people, yes, (a BPD diagnosis is good) because they like to have an understanding of what it is, that is going on for them, as well as feeling like they're not alone because at least then they can find, you know, other people (who) have the same label. Uhm, and there are, you know, treatment groups for people with that label."

ITV5 - "Guess the one thing with it is the access to support, so you know, getting into DBT programs. So, at (name of healthcare provider), there's a DBT program which is usually about a year long. And so, the person would usually go to a group a couple of times a week and then get individual therapy with a psychologist or another therapist, and that's really great. So, I guess a lot of people see if we give that diagnosis, then that can access a whole lot of support that the person might not otherwise get."AND "We know that if people do get the right treatment and if they're engaged in therapy, people, you know, I think it's nearly 80% of people that go through DBT put it in remission. So, it is actually treatable. Yeah, with the right, with the right circumstances."

Once considered a 'death sentence', there are now numerous treatment approaches to BPD, all of which are effective in improving outcomes for BPD clients (DBT, Linehan, 1993; MBT, Bateman & Fonagy, 2004). A key aspect of clinical utility is a diagnosis's ability to inform treatment; this aspect has been advocated by the WHO and the authors of the DSM (APA, 2013; First et al., 2004; Reed, 2010). The ability to inform treatment was identified as one of the most important aspects of a diagnostic manual for psychologists (Evans et al., 2013). It has also been argued that diagnostic manuals should be governed more strongly and specifically by treatment implications (Charney et al., 2002; Helzer & Hudziak, 2002; Phillips et al., 2003; Tsuang et al., 2003) and that a manual without clear treatment implications is fundamentally flawed (Kupfer et al., 2002). So, although there are numerous downsides to the BPD diagnosis outlined by participants, it does appear to have use for informing treatment.

There is a "There" There

Participants were asked if there was a particular disorder, cluster of symptoms or traits, or client they could imagine, that could be considered distinct and specific to their understanding of what BPD was. The response was a resounding yes. Participants felt that there is a type of client that is particularly challenging, which brings to mind BPD. Whether this client is conceptualised via the DSM as having BPD or in other ways, clinicians still need to be able to help a client with complex behaviours, and one that is challenging therapeutically. All participants were able to describe a very complex client type with a unique clinical presentation.

ITV6 - "The way it can switch very quickly from crisis, to like feeling fine, to like "I hate you. You're the worst psychologist I've ever had," to, by the end of the session, "I can't do this without you."... I do think that unique quality about this significant kind of push and pull and how quickly that can change is not always understood just through a complex trauma lens."

ITV1 - "... that kind of interpersonal instability, like conflict and changing friends and things like that. So that would probably in my head be more BPD... When people are on the ward, they're around people constantly. So, you do see that more kind of prickly difficult behaviour, like, I guess, the splitting behaviours or having difficulty with the nursing staff."

ITV2 - "Maybe (referring to BPD) that's just a way of saying there's a group of people that its really difficult, it's difficult work... There is a group of people with whom the work is hard in a particular way. Now, you know, I know who those people are in my full experience. There's definitely a group of people for whom the work feels hard in a particular way."

ITV7 - "Mhmm. Right. Yeah. Yeah. I think there is something there. I don't think, and this is where I think it's more the severe end of people who would meet criteria. Umm, there's a kind, ah, of what's the word? Stuck-ness or just level of defen-defended-ness that feels like ah, I can't really connect with this person in the same way or the connection feels tenuous maybe, umm, yeah, and so that's a big part of it like what I'd be looking for or like, sort of on the lookout for a little bit of, umm I'm not sure."

What participants are describing is very often related to the experience of working with a particular kind of person, or a person who behaves in a way that creates a reaction in the clinician that is expressed using words like "prickly", "defended-ness", and "stuck-ness", with moods and ways of relating that push and pull and change quickly, for whom working with is uniquely difficult.

However, this presentation of a person who is perceived by others as difficult to reach may not necessarily constitute a set of criteria that can be considered a distinct diagnosis, and there was still scepticism that the "there", that is there, is best described as BPD.

ITV2 - "I am sceptical about diagnosis. I can't say to you that I've done a study, and they better meet the criteria for complex PTSD, CPTSD or BPD. So, I could say to you, yes, there's these people that I just have a feeling for, and there can be described like there is a "there" there. But I actually can't say to you whether they're the borderline people because actually to be honest, I don't know. But if I were a more psycho-dynamically trained person, then I understand that what you're saying about the feel of there's a "there" there. And so,

you see what I mean? I get the feeling part and yes people, but I don't know if that maps on to what we're talking about."

The perception that there is a "there" there is supported both theoretically and by the research. There are numerous accepted theories of BPD (Linehan's biosocial theory of BPD (1993); the Mentalization-based approach to BPD (Bateman & Fonagy, 2006); the theory of Interpersonal Hypersensitivity (Gunderson, 2008); the Object Relations Theory of Aggression in BPD (Kernberg, 1967). The current paper's literature review focused on the distinction of BPD from PTSD and CPTSD, with numerous studies revealing the overlap between the disorders, but also finding a distinction between the phenomenological nature of the symptoms of each disorder (Cloitre et al., 2014; Cyr et al., 2021; Frost et al., 2018; Jowet et al., 2019; Lee & Choi, 2023; Saraiya et al., 2020).

An argument for the distinction of BPD from other disorders can be discussed in terms of phenomenological differences. For example, it has been argued that the behaviours central to BPD are impulsivity, suicidality and self-injury (Karatzias et al., 2023). In BPD, unstable mood and affect dysregulation are ego-syntonic and persistent over time (Karatzias et al., 2023). Self-concept issues stem from unstable, alternating self-evaluations (with changing goals and beliefs). Interpersonal difficulties in BPD are a sign of volatile patterns of interactions with others (Frost et al., 2020; Hyland et al., 2019).

So, if there is a type of client that is not better described by other diagnostic approaches than BPD, yet BPD is an alarming conundrum of a diagnosis, where does this leave clinicians? Themes Three, Four, and Five continue this line of enquiry by emphasising client concerns (Theme Three), exploring alternatives to the BPD diagnosis (Theme Four), and considering the future of BPD (Theme Five).

Theme Three: Centring the Client

In the maelstrom of dealing with an imperfect and stigmatising diagnosis, participants expressed the significance of centring the client in any decision-making process around the use of the BPD diagnosis. This is the third theme interpreted from the dataset. For participants, centring the client involved two key aspects: starting with the client's concerns (Subtheme One: Begin with What Matters Most to the Client), and collaborating with and involving the client in understanding the pros and cons of a BPD diagnosis and decision-making about the diagnosis (Subtheme Two: Collaboration & Communication Facilitated by Expertise).

Begin with What Matters Most to the Client

Participants strongly believed that psychologists should focus on a client's specific concerns in the present. Interviewee Seven emphasised the importance of treating clients presenting with BPD

symptoms the same as any other client, which involved avoiding assumptions, listening to their perspective, providing validation, and building rapport.

> *ITV7 - "I mean, I think it'd be the same as any first encounter with the client. You're trying not to make any big assumptions. Even if you've got some referral information, you want to hear it from them and what their perspective is on it, and you want to build a relationship with them and have them feel safe, feel heard, validated and understood. I'm just really trying to understand them." (ITV7)*

Interviewee One, who works in an inpatient setting, emphasised the importance of understanding the client's situation, even if they initially appear more aggressive than others.

> *ITV1 - "Speaking from my experience, if I'm working with someone on the ward, I guess especially in an inpatient setting, it's more about addressing what's kind of going on right now… I guess, and it's again more understanding the context where on our inpatient ward someone might come across as more aggressive or more, like, needing support. But it's kind of to understand what's going on for that person."*

For Interviewee Six, understanding the client included any diagnoses they might have; still, this information must be considered as part of a larger understanding that involves "where they are at" and "what might be helpful" for them, as well as formulation. For Interviewee Five this involved casting a wide net in terms of assessment and providing a differential diagnosis.

> *ITV6 - "We do try and make an informed decision based on the client, and where they're at, and what might be helpful, and their formulation and the diagnosis as well."*

> *ITV5 - "Sometimes clients come in and they've already done some reading around what BPD is. So they'll come to you and say, "yeah, I think I might have BPD," and then you still have to, you know, do quite a wide assessment just to rule out everything else… because if you're going to give someone a diagnosis like that, you want to be pretty sure that you're on, on the money. You don't want to get that sort of a diagnosis wrong. So, not that you'd want to get any of them wrong, but yeah, you want to be really certain about what you're doing."*

Here, participants emphasise that if they encounter clients with a preexisting BDP diagnosis or traits in their referral notes, or who are exhibiting some of the markers of BPD, their first task is to understand the client. For participants, an indication of BPD is not a fire door extinguishing other

tools, training, and experience a psychologist offers during client interactions; nor does it stifle the principle of understanding the client.

Collaboration & Communication Facilitated by Expertise

Discussing BPD with a client is a complex undertaking that involves psychologists paying particular attention to the wishes of the client, as well as ensuring that they have a complete understanding of the implications of using or not using the BPD diagnosis. Client centring is not just about what the client wants; it is also about utilising tools and expertise to support the client in a collaborative decision-making process, involving psychoeducation, assessing the client's needs, and assisting them to recognise challenges that they may not initially want to address, as well as past experiences of stigmatisation and needs for communication and validation.

Interviewee Four discussed how past stigmatisation impacts the willingness of some clients to discuss a BPD diagnosis, echoing what was mentioned earlier in Theme One and Theme Two. Often, clients have previous experiences of the diagnosis, as well as earlier experiences of stigmatisation, both of which require working through in collaboration with the client.

> *ITV4 - "Whether they think that it's a really important thing for me to know depends on how much luck they've had with finding another therapist. So, if I'm the fourth or the 10th one they've tried, then that can sometimes change when they bring it up, depending on the feedback they've received."*

Clients without prior experience of the BPD diagnosis can have different impressions of the diagnosis. Some find the diagnosis helpful, validating, useful for communicating to others, and for understanding themselves, whilst for others, a BPD diagnosis can be intimidating and labelling. Because of this participants emphasized the need for care when communicating with clients about BPD.

> *ITV4 - "I'd tread carefully, because like I say, some people they really do want to know, if they have probably researched it and said, "I think this sounds like me." And some people are, if it's the first time they've heard it, then they can feel a little bit more, either like it's given them an answer for what's going on, or kind of feel like they've just been labelled. So, it kind of just depends on the person."*

Interviewee Six described the difficult interactions that some clients with BPD symptoms have had with mental health services in the past, especially those exhibiting traits in childhood and adolescence. Researchers have challenged the validity of diagnosing personality disorders in children

or adolescents due to the fluidity of personality during development, and BPD specifically has been found to lack stability across adolescence (Miller et al., 2008). Given this, as well as the stigma and stickiness of the diagnosis described by participants in Theme One, and the moral dilemma of Theme Two, clinicians may seek out alternatives to giving a BPD diagnosis, including applying other diagnoses, causing clients to feel misunderstood and invalidated and resulting in delayed treatment for those with BPD.

> *ITV6 - "There are clients I've had, though, that really are fine with it (the BPD label) and actually quite like having it, I think, because they see themselves in it so clearly that that can feel very, can feel very validating in that sense. It's yeah, and in that way, it can be, yeah, very helpful because they just, ah, like when they read it off the paper, they're like, "yep, that's me", you know? And like, they finally found some sense of comfort in that because often for a long time, especially if you go through child services, like there'll be so much hesitation in using it with people, you know, children or teenagers, because, you know, it's a personality disorder. So, the idea being you've got to wait until people are 18, usually. And so, in that sense, like, you know, they often then will get told they're just depressed or anxious, but they can tell that there's something missing, like that's not enough. That can feel very invalidating."*

Centring the client does not mean abandoning one's expertise as a psychologist and leaving the client to decide everything on their own; instead, it highlights the essential role psychologists play in a collaborative process. In this process, psychologists bring their expertise and experience, and clients bring their lived experience. Participants described this as a collaborative approach that considers the client's history of stigmatisation, past experiences with the diagnosis, the client's current perspective on what is essential to address, and the psychologist's professional assessment of what might help. It also involved not rushing to conclusions, even if the client wants a diagnosis; instead, participants pointed to the need to be mindful of all aspects of the diagnosis, including stigma. This was achieved by utilising tools such as motivational interviewing, encouraging cautiousness and careful consideration, and ensuring that the positives outweigh the negatives.

> *ITV6 - "Often, people come to me with a diagnosis already. But even if they don't, I'll sort of talk about these things in general terms, without giving them a diagnosis unless they specifically want it, and then it would be a discussion about what are the pros and cons of that." AND "I just want to hold that part of this decision making is also around the like, what's most helpful for the clients and working around the stigma."*

> *ITV5 - "If someone's a little bit on the fence, or if you're not really too sure, like, sometimes I'll actually do a bit of motivational interviewing. So, I'll weigh up the pros and cons with the person. And sometimes, sometimes, they've thought of things like they'll be like, "yeah, I really want this as a diagnosis because it will help me understand myself." And they think… it will give other people more understanding about themselves. And then when you kind of talk to them about what, you know, might not be the bright side of giving a diagnosis like that that they sort of might understand, "Okay we have to weigh this up a little bit more and tread with a bit of caution as well"."*

One of the most significant issues of BPD is that clients can be highly suicidal and self-injurious, and centring the client also involves client safety. Interviewee Seven explained this rather irreverently, perhaps channelling the work of Masha Linehan.

> *ITV7 - "I think it's done collaboratively. Like, obviously, what the client is there for is pretty important. And at the same time, if they're acutely suicidal, then that's going to be one of the first priorities, whether they think it's a priority or not. Because, and sometimes you have to kind of, yeah, talk about that with the client and be like okay so you want to be a software engineer and you want to do all this, but, if we don't get this under control, the next time you have an impulsive episode like you might die and then all those dreams go out the window so if you're not here then we can't do treatment successfully (laughs)."*

Interviewee Four pointed out that the collaboration between the client and the psychologist can be complicated by challenges to the therapeutic alliance caused by some of the traits of BPD. They highlighted the need for psychologists to utilise their expertise to support a client's wishes while maintaining a perspective on what the client needs rather than what they want, especially with clients who may not be able or ready to recognise some of their challenges.

> *ITV4 - "It's one of those things where it depends on the level of insight that the person has because… some come through with a diagnosis already, and they really want to work on it, which is great. Some come with a diagnosis, but they either just go, that's not one I want to work on. It's this other big thing, which is actually wrapped up in part of the borderline personality disorder. And then some people, uh, just- they deny it. They deny that there is an issue with how they connect with other people."*

By the end of Theme Three, a picture is emerging of the challenge BPD poses for clinicians. Firstly, due to issues around stigmatisation, a moral dilemma ensues, as discussed in Theme One. Participants emphasised focusing on the client, collaborating with them, considering their point of

view, whilst utilising professional expertise to arrive at the best decisions about BPD together with the client. Having arrived here, the discussion naturally turns to discussing alternatives to BPD, particularly CPTSD. Can CPTSD be an adequate substitute for describing and addressing the experiences of those with the symptoms historically covered in the BPD diagnosis? If so, could the CPTSD diagnosis mitigate many of the previous concerns raised by participants? This is discussed in Theme Four.

Theme Four: Trauma - A New Approach to BPD

Throughout the interviews, participants consistently brought up CPTSD, as well as other terms for trauma, as something that they use and would like to prioritise over giving a BPD diagnosis. Questions about the arrival of CPTSD into the ICD-11 and the aetiology of BPD sparked conversations about the overlap between BPD and CPTSD. This conversation included discussions of the relevance of trauma in the lives of those with BPD, or in the development of the disorder, and the potential of a diagnosis like CPTSD to replace BPD. Subthemes that were revealed are: 1. everyone has trauma, 2. what are we talking about when we say "trauma"?, 3. CPTSD is here, and 4. a diagnosis that is positive. Participants used the terms trauma and CPTSD broadly, liberally and at times interchangeably. The terms were often used to refer to events that had happened to clients, which were either additional difficulties they faced or aetiological factors in the development of their current psychological challenges and a barrier to treatment.

Everyone has Trauma

All participants were emphatic that nearly everyone they see with BPD traits has a history of trauma. The significance of trauma for those with BPD traits was not just an additional factor for participants but was front of mind, and a primary factor to be considered for understanding causes of a clients present psychological challenges.

> *ITV4 - "Pretty much every time I meet with somebody who has a diagnosis of BPD, I'm already thinking, okay, so what kind of traumatic things have they gone through? ... I haven't personally come across anybody who has a diagnosis of BPD who doesn't have some form of trauma."*

> *ITV6 - "I've, personally, I've never had a client who's met BPD criteria or at least been described as having traits… that's not had any kind of significant long-standing kind of trauma."*

ITV3 - "Most of the… difficulties and emotional turmoil that I find, and that clients are suffering from, has to do with trauma."

In their response Interviewee Two used a phrase "awful stuff" as a proxy for trauma, which is indicative of the broad understanding of what is traumatic amongst participants. They then go on to posit that if clients don't have trauma, then they may not recognise events in their lives as traumatic.

ITV2 - "I have never worked with somebody with this feel where there isn't awful stuff. They can't always see it though. I mean I don't know anybody who doesn't meet, like, how could you not meet both of those (both BPD and CPTSD), like if you don't meet both of them it's because you can't remember what it is that's happened to you, or what's happened to you, you don't think it is so bad because of your experience."

Central to Interviewee Two's position is the question: What do we mean by trauma (or CPTSD)? And specifically for the client; How does the client understand their experiences? For Interviewee Two, reasons why trauma would be invisible to a client were a lack of memory of the event or a lack of awareness of the gravity of an event.

ITV2 - "Like, you sometimes see it before they see it because people's expectations of what it's like to grow up in a family are, like, "it must have been fine because my mother was a doctor" or "it must have been fine because we both had two parents, and they were there all the time". So, they dismiss their own experiences because of these kind of external features. But everybody with that feel (sic) has had shit happen. So why would you use a personality disorder diagnosis rather than- which is saying there's something wrong with you that- because that's…why you do all these things- rather than, this is this combination of you perhaps having a sensitive temperament, and then this stuff happening that people didn't understand, and didn't know how to respond to."

Interviewee Two has struck at the core of an issue that lies beneath the discussion of trauma and BPD. One needs to know what is meant by trauma to recognise it in their lives. Clients may not know or feel it important to describe certain challenging events that may have impacted their emotions, identity and relationships. Psychologists themselves surely need robust understanding of trauma themselves to be able to support these clients. What is meant when we say trauma is the next subtheme.

What are We Talking About When We Say "Trauma"?

Knowing if someone has trauma depends on how we define trauma. But what do we mean by trauma? Interviewee Two, above, was not the only participant with a broad concept of "trauma". All participants used the term liberally and broadly in their accounts. For Interviewee Five, it could be both classic trauma (PTSD) and chronic invalidation.

> *ITV5 - "Usually, a lot of the time people with BPD do have the sort of classic trauma as well… it's, usually, the main triggering event is either trauma or… yeah, that chronic invalidation. So, that can look different in different people."*

For Interviewee Three, the range of traumatic experiences was broad, from uncomfortable school experiences to torture.

> *ITV3 - "Whether it's the teacher who pulled them up at the front of the class to recite a poem that they didn't learn well enough, and they couldn't do it, and it was all shame. You know, whether their parents told them they were stupid or whether the really-really bad shit and torture happened to them."*

For Interviewee Seven, it was early childhood trauma, as well as neglect, or impossible-to-navigate situations.

> *ITV7 - "I think if we talk about it in terms of early childhood trauma or neglect, or like really kind of impossible to navigate situations that they were placed in kind of early in their development, it makes sense that there'd be overlapping disorders because I think they're just different coping strategies that then get turned into really core aspects of how they are in the world."*

Here, Interviewee Seven sees the symptoms of CPTSD and BPD as overlapping expressions of early coping that become core aspects of personality. The notion that BPD and CPTSD are comparable as they both function as coping mechanisms in response to trauma was reiterated by Interviewee Four, who also referred to the significance of sexual assault as a form of trauma involved in BPD, whilst acknowledging that "more general" events can also play a role.

> *ITV4 - "It (BPD) feels like a way of coping in this world around them in response to trauma, normally repeated trauma, normally not just a one-off and that trauma more often than not*

will be of a sexual nature, but there can be this, more general developmental trauma as well, less common, but that's there too."

Interviewee Two deepened the conversation, discussed some of the key figures in increasing the awareness of the role of difficult experiences in the development of BPD, as well as the historic debate about what constitutes "trauma", including discussion of the primacy of sexual assault and the role of invalidation, which both occur simultaneously throughout the history of psychology.

ITV2 - "I can remember in the '90s that John Brier was arguing with Marsha Linehan about whether, I think he actually thought sexual abuse was a requirement to develop borderline personality, and she thought it was about invalidation, so an interesting kind of debate to be happening. And Marsha is right that you don't have to have had sexual abuse, but most people who meet these criteria have experienced, really difficult things."

Interviewee One reiterated the point that the field's understanding of trauma has expanded to recognise the traumatising power of an early invalidating environment and referred to "little t" trauma. They discussed the sense of traumatic event/s is shifting from the "old school" conceptualisation, as something that literally is life-threatening, to also include the impact of accumulated smaller events.

ITV1 - "It is quite tricky because coming back to the kind of DBT, like Linehan, conceptualisation of borderline is having that early invalidating environment, that is traumatic. It's just, I guess, what we would call little t trauma rather than someone who was, say, sexually assaulted or physically abused, which kind of crosses this threshold into being like an actual trauma that we could diagnose complex trauma… So, I guess yeah, that idea of trauma shifting from a very old school kind of something that threatened your life, like a war or a car accident or a rape, to this concept of little t trauma where the traumas that build up across our life that have an impact."

The concept of an early invalidating environment, or other "little t" traumas accumulating to constitute complex trauma, aligns with Judith Herman's (1992) conception of CPTSD, which was a topic other participants also addressed. Interviewee Five explained that invalidation can be a form of trauma and described invalidation as repeated negative messages during early childhood.

ITV5 - "And so early childhood experiences, umm, in this training I'm doing at the moment… they talk about invalidation as a form of trauma. So, when you've got that message over and over again that no, you're wrong or your opinion doesn't matter, or I'm going to ignore you,

or whatever that is. That is basically like a trauma… I was talking to somebody the other day, and they were saying with people that have gone through what we think of traumatic experiences, quite often the invalidation is as traumatic… if not more traumatic than some of the, like, really traumatic, yeah, what we kind of think of as traumatic experiences."

In Theme Four, participants affirmed that the field's understanding of trauma (used broadly here) has changed over time and can include what can be called classic or "big T" trauma, the kind that is most often understood as aetiological in PTSD. Trauma can also be "small t" trauma, which may be repeated, frequently occurring in early childhood, and is perhaps more likely to be a factor in Complex PTSD (as described by Judith Hermann) and for BPD. Participants also stated that invalidation can be as impactful as, or more impactful than, a classic life-threatening trauma.

CPTSD is Here

If there is a 'there' there for BPD, then there is a 'here' here for CPTSD. Although Aotearoa NZ clinicians primarily refer to the DSM-5 (rather than the ICD-11) when considering diagnosis, and although CPTSD is not currently recognised in the DSM-5, participants all acknowledged that they are already working with a concept of CPTSD. Regardless of how trauma and complex trauma are explicitly defined, there is an everyday use of the terms CPTSD and trauma, which are interchangeable, broad, overarching terms that are a framework for formulation and communication. Here, the terms are used to place an emphasis on past experiences and aetiology for understanding many clients, including those with symptoms of BPD.

ITV1 - "It (CPTSD) is kind of something we see every day and… and it makes so much sense with all the presentations we see… I guess in that way, although we have the DSM framework, we do think outside of that, and I think probably complex trauma is just something we all accept… So, I guess, our team, even though there isn't such a thing as complex trauma in the DSM, we speak about it openly and we diagnose it."

ITV6 - "In the New Zealand context, like, the majority of psychologists won't be using the ICD, they'll be using the DSM, and so when these terms are borrowed from ICD, they're not often borrowed. I mean, I could be wrong, but I don't know many people who will be going into ICD and looking through their criteria and saying this is complex t- Like they're almost just used, like, as a turn of phrase and I think complex trauma is often used that way not even as a strict diagnosis that you meet the criteria for complex trauma. It's just saying this person has complex trauma, almost they've just gone for what it simply is rather than, they meet the criteria for complex trauma."

For Interviewee Seven, in their practice, this extended beyond communication to informing treatment and to actually integrating complex trauma interventions into their treatment approaches in what is a primarily BPD-focused clinic.

> *ITV7 - "So, at (name of clinic) we've been in this kind of interesting transition phase… where we're integrating trauma treatment much more as an integral part of the treatment. It used to be just a purely stage one DBT service where focus is on skills training in the present moment mostly, and that a big part of that is learning to validate yourself as the client and you give the client a lot of validation and that I guess is overturning some of those past patterns of chronic invalidation that they've got from their environment or gaslighting or abuse or whatever it is. But yeah, then I guess we've found, and in line with literature as well, that just that isn't going to heal the past. So, you actually need to go in, and the main two methods we were using for that were prolonged exposure and EMDR, or eye movement desensitisation and reprocessing. Then that further breaks down between traumatic events like big T traumas like sexual abuse, physical assault or whatever it is, and then social and relational trauma as well."*

Interviewee Seven described the value of a broader understanding of trauma as being both helpful and integral to their work with BPD clients. For them, Stage One DBT (developed for BPD) can only go so far to address BPD symptoms and cannot address some of the underlying symptoms that are trauma-related. It is also noteworthy that in the treatment of the trauma, a further breakdown occurred between classic "big T" trauma and relational, and social, "small t" trauma. Not only is CPTSD widely used as an umbrella term amongst psychologists in Aotearoa NZ, but awareness of it appears to be also informing treatment, even at a BPD-specific intervention centre.

A Diagnosis that is Positive

Contrary to expressions of "alarm bells" for BPD, participants all focused on the positive perceptions they had of a trauma-informed approach to those with BPD symptoms. Reasons for this included that a trauma-informed approach is more empathic, points to a cause, is less stigmatising and is helpful in validating trauma symptoms in the absence of big T trauma (ITV5, ITV6, ITV2, ITV7, ITV1). This broad understanding of trauma functions as a framework for formulation, something participants highlighted as being a specialist skill that they prefer over diagnosis.

> *ITV1 - "…in my experience, people when you formulate with them how their trauma has informed how they see the world and how they show up in the world and how, that is then*

kind of coming up and impacting them in the here and now, that's a much more validating way of understanding themselves."

ITV7 - "I think pairing it (BPD) with the trauma narrative is actually really validating. So, I'll say like "Look, these are the things that we know from how human psychology and physiology is impacted by trauma. So, a lot of these things that you've struggled with are because of what you've experienced. You know, it's not because you're inherently bad". You know, that's actually part of the thing. Like, it'll tell you you're inherently bad, but that's also a result of trauma most of the time. I'll add that in with clients, I guess, over the top of the non-etiological DSM symptom list."

Interview Seven saw value in the interventions used with trauma-informed approaches to those with BPD symptoms. A trauma-informed approach to BPD is helpful at the start of treatment for stabilising a client. It is also validating and builds rapport and trust, crucial for a client with BPD. Additionally, the trauma-informed approach remains useful once the trauma issues have been stabilised in the future, for emotional dysregulation or for dealing with current distress that is not necessarily traumatic.

ITV7 - "Not everyone's ready to go there straight away, and they can't all tolerate it, but the ones that can…like, that's the kind of the most useful thing once the suicidality is under control. You can also use that for current distress as well. So just sometimes just bringing down the distress that they've come from that week, and then they sort of build trust in the therapy and the therapist… you're balancing those up dialectically, I think. Umm, and that's where I found, the trauma treatment and EMDR particularly really helpful because that both validates why they've been struggling and also gets at the root of it quite quickly."

Theme Five: Change & Acceptance

Thus far, themes have been interpreted concerning BPD as a diagnosis that causes alarm bells and a dilemma around whether to use or how best to use the diagnosis. Participants have emphasised the value of formulation and a client-centred approach, and client collaboration when negotiating the BPD diagnosis. Participants were also positive about using complex trauma, CPTSD or a broader understanding of trauma as useful concepts when considering clients with BPD symptoms. Considering the implications of these themes for the future of the BPD diagnosis occurred toward the end of the conversations and constitutes Theme Five: Change & Acceptance. Subthemes include: 1. caution… CPTSD may not be BPD, 2. grappling with change and 3. reflecting on how psychology meets society.

Caution… CPTSD May Not Be BPD

Participants expressed that thinking about trauma for someone with BPD traits is positive, validating, valuable in informing treatment, and an approach to BPD that psychologists use and feel positive about. However, participants still described the need for caution when thinking about CPTSD (or something similar) as a replacement for BPD. Discussions focused on the kind of trauma that is a factor in BPD, as well as the way symptoms appear in those with BPD versus those with CPTSD.

For example, Interviewee Seven emphasised relational trauma and invalidation, rather than other traumatising experiences, as more likely to lead to BPD.

> *ITV7 - "I think borderline generally is more the social relational trauma. They might have sexual abuse or other things as well, but we sort of characterise that between, and then we see people with more just a PTSD diagnosis that was often complex and had co-occurring conditions and all that kind of stuff. So, I think if we distinguish between big T trauma and little t trauma, or like the kind of events versus the chronic invalidation and relational trauma, I think relational trauma and chronic invalidation is more likely to lead to more BPD kind of presentation."*

Here, Interviewee Seven linked the type of trauma experienced and future symptom presentation based on their real-world experience. They highlighted the significance of invalidation and relational trauma for BPD presentation in clients and indicated that there may be a distinct BPD presentation post-trauma, one that is more involved with relationships and invalidation, and is distinct from CPTSD or PTSD. Interviewee Five talked through the behaviours or coping responses of someone who is perhaps better understood as having BPD versus someone with CPTSD.

> *ITV5 - "So, you've got trying to avoid abandonment. So those frantic efforts to avoid abandonment which, that's quite, when you're assessing somebody that's quite a particular thing. It's like plea-ing (sic) or actually blocking access, or it's you know, it's quite a particular thing… You know, unstable and intense relationships in BPD. So, I guess that could be a little bit different to the relationship disruptions in complex trauma. So, with somebody with BPD, like we were saying before, that whole idealisation, devaluing somebody, and that, that can shift around. I have worked with somebody with complex trauma who, yeah, their relationships… they had problems in relationships… but it wasn't like that, kind of like that swinging thing."*

Interviewee Five described the “swing” of BPD that isn’t quite the same as their experience of a client with CPTSD. Interviewee Six did the same, referring to the “flavour in the room” of someone with BPD that is not there with someone with CPTSD.

> *ITV6 - “(A diagnosis of) complex trauma might explain that these clients might be, yeah, more avoidant in general or might be more hypervigilant or might be distrusting or fear abandonment, but it doesn't fully kind of capture that flavour in the room that you sometimes get… (with someone with BPD).”*

Interviewee One pointed out that in their experience, they do not see the re-experiencing symptoms of PTSD as part of a BPD presentation[4].

> *ITV1 - “Thinking about borderline personality disorder, how we think about it. I guess maybe some of the differences in my mind between BPD and complex trauma. I mean people with I guess if you're thinking if it's such a thing pure BPD don't necessarily have those PTSD reexperiencing symptoms like the nightmares, the flashbacks, but then other than that, it is quite tricky because coming back to the kind of DBT, like Linehan, conceptualisation of borderline is having that early invalidating environment, that is traumatic.”*

These differences in symptoms, or presentation, can lead to concerns regarding confusion created by a new diagnosis of CPTSD. Interviewee One suggested that, in difficult diagnostic situations, having the alternative of CPTSD may make diagnosis more difficult and could lead to incorrect or multiple diagnoses.

> *ITV1 - “So, I think, if you're really stuck on diagnosis, I guess it would make it more confusing because you're like, “How do I make sense of this person?””… “I know that there's some kind of statistical analyses out there looking at the diagnoses and where the overlaps are and stuff but I guess if we as a profession start to get more of an understanding of when we do or when we don't diagnose BPD if there's trauma present, because that's the part that I guess is a bit more confusing or unclear and that's where my colleagues and…I have sometimes had discussions too. This person has trauma, and they've got PTSD*

[4] It is worth noting that in the ICD-11 CPTSD is defined using the symptoms of classic PTSD of hypervigilance, re-experiencing and avoidance, which are not the criteria set out by Herman in her initial description of Complex PTSD (Herman, 1992; WHO, 2025).

symptoms, but they've also got loads of other stuff which doesn't quite fit, looks a lot more like BPD. Should we give both, should we just call it complex trauma?"

Participants' cautiousness about replacing BPD with CPTSD, and their nuanced descriptions of the particular ways symptoms are exhibited by different clients, align with theories and research into BPD and CPTSD. Research suggests that CPTSD and BPD overlap considerably; however, they can also be distinct (Cloitre et al., 2014; Cyr et al., 2021; Frost et al., 2018; Jowet et al., 2019; Lee & Choi, 2023; Saraiya et al., 2020). Trauma or difficult experiences most likely play a role in the potentiation of BPD (Zanarini et al., 2004) and are required for the diagnosis of CTPSD (WHO, 2025). Still, phenomenologically, the symptoms in BPD and CPTSD appear differently and for different reasons (the previously mentioned relational volatility in BPD versus relational avoidance or trust issues in CPTSD, for example). Finally, the need to exercise caution in properly differentiating BPD from CPTSD is reiterated in much of the research (Cloitre et al., 2014; Cyr et al., 2021; Frost et al., 2018; Jowet et al., 2019; Lee & Choi, 2023; Saraiya et al., 2020), with the ICD-11 emphasising the need to differentiate ICD-11 CPTSD from personality disorders and to decide whether it is in the client's interest to have multiple diagnoses or not (WHO, 2025).

Grappling with Change

Participants' caution about replacing the BPD diagnosis with CPTSD prompted reflection on a dialectic of psychology—a desire for improvement through change versus caution about change—highlighting the tension between making the right changes and avoiding the wrong ones, as well as the rigidity often found in psychology, especially concerning diagnosis and diagnostic manuals. Thoughts around diagnostic change coexist with participants' concerns about diagnosis in general. The issue is that if psychological diagnosis more generally raises concerns, it can create problems for concluding whether or not to replace one diagnosis with another. Some participants expressed the view that diagnosis is harmful, has no use, and should be abandoned (ITV2) or that it is flawed and just a list for labelling things we see (ITV1, ITV7). Issues with the DSM specifically include that it has been "an over-dominating force historically" (ITV6), that it focuses on just one aspect of human psychology (symptom criteria over aetiology or social context) (ITV6), and that those developing it have conflicts of interest (ITV2). The perspective that diagnostic manuals and diagnoses are flawed leads to acceptance that, by its very nature, a single diagnostic manual could never do everything (ITV6), as well as an acceptance of the pervasiveness of the DSM and the slowness of change in psychology. Participants discussed the future of what could come of both the BPD diagnosis and manualized diagnosis more generally, leading to mixed feelings. A sense of hope meets despair, progress meets caution, working with and around the DSM, moving towards less stigmatising ways of working, alongside concerns about increasing stigma.

Interviewee Two reflected on both “hope” and “despair” at the slowness of change in the field of psychology regarding the BPD diagnosis.

> *ITV2 - “Jeepers it’s been… It’s been a slow ship to turn around… I guess I feel hopeful on the one hand that there's really exciting things happening here and despairing at the other.”*

For Interviewee Six, change was happening; still, the DSM felt so ubiquitous and embedded that it was difficult to imagine escaping it.

> *ITV6 - “So, what we're seeing now is that, like, yeah, people are trying alternatives. You know, there's RDoC[5], which is a dimensional-based model and a few others. The DSM, even itself, is kind of doing a more dimensional-based model. But then there is still this… it's very hard to escape the shadow of the DSM because of how ubiquitous it is in all the work we do.”*

Whilst Interview Seven wondered “who” would make the changes.

> *ITV7 - “Yeah, I think it's one of those, kind of, ‘chicken and egg’ scenarios, where I think we need to change as a field…but who actually initiates that? It's not like there's some master of the mental health field that's going like, "Okay, we're all going to change now.””*

The chicken-and-egg of diagnostic change, or changes in the field of psychology, was echoed by Interviewee Six.

> *ITV6 - “There's a natural tension here, I think, which is that, and I don't know what the answer is, which is that, on one hand, probably what we're doing a lot in services, at least from a psychology lens, is moving away from BPD, and thinking all these things around being of, you know, pointing more to the formulation or more to traits or, ah, as a way to manage this. Whereas, but I think that, I imagine there are some people arguing that, we- maybe the answer is to still keep the diagnosis, but speak more to that so that there's less stigma around those words, you know, because avoiding talking about it or finding new terms for it might end up, you know, you're only pathologizing it more.”*

Here, Interviewee Six highlighted a “natural tension” that excessive change may further pathologize those with a BPD diagnosis or transfer the pathologisation to new terms.

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[5] Research Domain Criteria (RDoC) is an alternative classification framework mental disorders providing a multidimensional conceptualization of psychiatric disorders with neurobiological roots (Hakak-Zargar et al., 2022).

ITV6 - "There's a real kind of absence of, like, radicalism in these kind of, like, to really propose something just completely different… There's probably lots of reasons for that. It might be the nature of the psychologist, but it also might be the way that research is funded, and it's got to have some kind of utility or be used by lots of people…"

For Interviewee Six, this slowness to change stems from a broad absence of radicalism in psychology as a field of study. They pointed to factors inhibiting change, including funding and the psychologist's personality. The tensions reassert themselves when considering the utility of a widely known diagnosis versus a new, more valid but lesser-known diagnosis, as well as the ease of accessing research funding for an established diagnosis versus a new diagnosis. This anti-radicalism is not without warrant; changes to diagnosis must be useful and used by many different people.

Other participants reflected on the dangers of change, highlighting some valuable aspects of diagnostic manuals. Interviewee One pointed out that, as flawed as it is, the DSM-5 has value, particularly in the early stages of a psychologist's career, as it provides guidelines for understanding clients. Interviewee Four cautioned against abandoning standardisation completely, as it can lead to over-individualisation, which may pose its own issues.

ITV1 - "I think there's safety, especially if you're an early practitioner in kind of being able to formulate, or to use a diagnostic manual, and there's always a place for it, obviously diagnostic manuals, especially if we're thinking of general kind of classes of difficulties."

ITV4 - "How do we kind of help (without a DSM)? Otherwise, it almost has to be individualised for everybody. And how do you do that? You know? Maybe somebody else has a good answer for that. I don't know."

So, participants made the argument that there is a place for the DSM-5, and it has utility, whether as documentation to support clinicians with less experience or as a helpful tool in standardising psychological practice. Interviewee Six resolved the dialectic of acceptance and change by recognising that the key is not to expect the DSM-5, the BPD diagnosis, or any aspects of the work psychologists do to be perfect, and to reckon with the complexity and messiness of understanding human psychology.

ITV6 - I don't think the answer is to find, at least from my perspective, that there's going to be one thing that does everything for us (laughs). I'm not expecting the DSM to ever get to a point where it can do all of this work, because it's just much more complex or messy than that."

Interviewee Seven reached a similar acceptance and a sense that things make sense, despite an imperfect set of diagnoses, with enough wiggle room for the job to work. Interestingly, this sense of acceptance has changed with experience.

> *ITV7 - "I don't know. I feel like we've kind of got to a point that makes sense to me… I think maybe a couple of years ago or when I didn't know as much, I wanted to delete the BPD diagnosis altogether, but now I'm sort of a bit more middle path about it, of like I think it does describe something that's not the same as complex PTSD."*

Here, the validity of a new diagnosis may not be as strong as first thought, and may inadvertently lead to other issues, with a subset of clients not being understood as well by a CPTSD diagnosis. Coming to terms with a diagnosis may be more about how psychologists use the DSM-5 and how they integrate it into their work. Interviewee Six highlighted how the DSM-5 can serve as just one tool among many within a scientifically plural approach to human psychology.

> *ITV6 - "It's okay, it's actually a really good thing in science to have like, um, pluralism, so to have, like, lots of different models at once, it's all right, we don't have to have one thing."*

In earlier themes, participants discussed their pluralistic and dynamic approach to understanding the issues that their clients face including such things as; the client's wants, the client's needs, managing stigma through communication, psychoeducation about diagnoses, formulation, being etiologically grounded, finding a reason why, and being trauma-focused, utilising resources and planning interventions without diagnosis, and diagnosis workarounds within and between organisations. Participants were already being ecological, holistic, or pluralistic in their approaches to understanding their clients, and they may have reduced the negative impact of the BPD diagnosis simply by working the way they do, without the need for radical changes. The diagnostic system and all the interested parties can catch up, but clinicians in Aotearoa NZ may already be doing the job in the way they need to.

Reflecting on How Psychology Meets Society

Thinking more abstractly about the future of psychology naturally led to reflection about the relationship between psychological practice, culture, and society, which was important for the participants. Psychological practice is adaptable, and there remains the option to use a diagnosis, or aspects of one, while also working with different models of health. However, culture must always be taken into consideration when engaging with a client.

ITV5 - "I think with any clinical work, you always need to take the person's culture into consideration, and that needs to inform every part of treatment. So, if I'm working with a person from a different culture, I'll, you know, think of models of health and that will underpin the formulation and the treatment plan. So, umm, you could still have a dia-, you know, be thinking of this person, they have a cluster of symptoms that looks like BPD and then I think you could still use different models of health underpinning all of that to sort of explain what's going on. So, you could use Te Whare Tapa Whā[6] or something holistic, and then look at okay in Taha Hinengaro we've got this stuff going on, and this is how it's impacting Whanau and Wairua and Tinana. So yeah, I think you could definitely do that."

ITV4 - "While I think, New Zealand is probably at least able to have a bit more of a shared understanding across a diagnostic sphere, it does mean that there is definitely sort of like a- a working around working with let's just say families, uh, in terms of their different cultural understandings, different acceptance and different… different things that they are okay for us to proceed with from a therapeutic point of view depending on what their interpretation is."

Interviewees One and Six stated that psychology does not do a good job of recognising or seeing pathology in society. They referred to the fact that, in their view, psychologists focus on the individual and what is happening for them. They expressed that this is often done using formulation, which can include the person's life story, history, and experiences, as well as support networks, but it still often misses a broader investigation of social factors that can impact a person's psychology. Such factors could include the ways that various sociocultural and historical contexts impact the individual.

ITV6 - "We're very good as psychologists… because of how we're trained to look for the pathology in the internal world, right. To look at it in the mind. And we're a bit better at looking at it in the physical brain, you know, with what that manifests, in terms of dopamine changes or whatever it is. But we're still very poor at looking at pathology as it sits in other places, like pathology in the social system and pathology in the cultural system. I think it's a very hard thing for us to kind of understand."

ITV1 - "I think there's still, across the board, a lot more work that needs to be done to fully reckon with how things show up in a New Zealand context."

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[6] Te Whare Tapa Whā is a Māori health model developed by Sir Mason Durie based on the Māori concepts of whānau (family), tinana (physical), hinengaro (mental) and wairua (spiritual) health (Mental Health Foundation of New Zealand, 2025).

In addition to this idea is that there are factors in a society that can contribute to symptoms of a disorder, for example, the invalidation often seen in BPD, or that diagnoses are 'forced' upon cultures that might not be the best fit. Participants expressed a sense of sorrow, engagement and wariness about the utility of diagnosis for Māori and what to do to improve it.

> *ITV2 - "Māori have suffered the imposition of diagnoses on them. This western model that's- and there's horrible stories about people, especially with voice hearing stuff. There's lots of stories about people being locked up and whatnot because of that."*

> *ITV1 - "What's more invalidating than colonial racism and marginalization, so yeah, I mean it's not something that I've kind of reckoned with a lot, but I guess that's where I'm thinking, like, because obviously we started this conversation talking about the gender differences, but I don't know too much about the kind of the racial differences and diagnosis and stuff in New Zealand, but I can imagine that, that's probably at play and probably needs a lot more thinking about."*

> *ITV6 - "I don't know if the answer is to do research on diagnosis in this group… because it also feels like that comes from a colonial mindset, right to apply a Western model to these groups. So, like, um, yeah, and so I don't know if we will gather the data necessarily because maybe that's not the actual kind of response that's needed, right?"*

Although the current study is not Kaupapa Māori research, it is clear that the need to address historical wrongs and the danger of imposing Western psychological approaches on Māori and other populations are important to participants. Investigating the utility of the BPD diagnosis across different cultural and ethnic groups was beyond the scope of this research. However, participants have raised concerns about the "invalidation of colonial racism" and have expressed wariness about identifying the correct, necessary steps to address such issues.

Chapter Summary

This chapter presented the results of the thematic analysis of this research project. Five themes were identified in the data set: Alarm Bells!; Navigating a Moral Dilemma; Centring the Client; Trauma: A New Approach to BPD; and Change & Acceptance. Chapter Six discusses the results of the research, considering the extant body of literature and knowledge, describes the strengths and limitations of the study, and provides future research directions.

Chapter Six: Discussion

This chapter discusses the research results, considering the extant body of literature and knowledge, examines the study's strengths and limitations, and outlines future directions for exploration.

Discussion

This research's reflexive thematic analysis investigates the clinical utility of the BPD diagnosis for psychologists in Aotearoa NZ. At face value, the clinical utility of any given diagnosis appears relatively straightforward; however, with BPD, the communication and use aspects of clinical utility are impacted by social and institutional stigma, gender bias, a convoluted history, its poor name, aetiological ambiguity, and an absence of intervention until recent decades. This has all occurred in the context of new ideas around diagnosis, contestation of categorical diagnoses, the broadening of theorising and research into what constitutes trauma, and the role of developmental challenges and trauma in potentiating future psychological problems, such as BPD.

There is a gap in research into psychologists' perspectives on the utility of the BPD diagnosis in Aotearoa NZ. This study was the first of its kind. Seven participants described BPD as a diagnosis that is both unwanted, dilemma-inspiring, overly stigmatising and confusing, whilst simultaneously deeply embedded within the field of psychology and the public imagination. Participants also described a unique type of client with a specific set of needs, requiring interventions that are currently understood using the BPD diagnosis and are not covered by another diagnosis. For participants the BPD diagnosis presents complex challenges that involves many aspects of their job, including working with a previously existing BPD diagnosis, working within structured institutional systems with requirements for communication and funding, wrestling with the best ways of involving clients in the decisions about what is impacting them, as well as using psychological expertise to support clients to address the difficulties they face.

Participants expressed alarm bells about the BPD diagnosis, reporting that it is a diagnosis that causes many concerns, primarily due to stigma. For participants, the diagnosis is perceived negatively by society, but especially by health care professionals, with professionals using words such as "naughty" and "manipulative" to describe those with a BPD diagnosis. Those with BPD may be dismissed by health care professionals and treated differently from other clients. BPD also has a reputation of being a "death sentence", which continues to this day. Participants were concerned about the stickiness of the BPD diagnosis reporting examples of the diagnosis following a client around, even long after it is helpful, and the danger of describing a client with BPD traits resulting in a diagnosis without this officially occurring. Participants also reckoned with the historic gender bias of the diagnosis, stating that the diagnosis is often applied to women and, more recently, to transgender

clients. Participants also expressed alarm bells raised due to the perceived difficulty of those with BPD, due to symptoms that impact the therapeutic process, as well as difficulty making a BPD diagnosis accurately due to the high comorbidity, symptom overlap, and heterogeneity of the disorder.

This alarming diagnosis posed a moral dilemma for participants about whether to make the diagnosis and how to use it. Participants expressed frustration at having to deal with the diagnosis and wrestling with ways to mitigate stigma. They discussed the game psychologists play, which is essentially an ongoing negotiation between the need to use the diagnosis for accessing support and for communication, whilst side-stepping the worst aspects of the diagnosis. They acknowledged the reality that the BPD diagnosis already exists in the field and that often a psychologist will encounter a client with a preexisting BPD diagnosis, meaning that encountering the diagnosis is unavoidable. Participants acknowledged that there does seem to be a cohort of clients who are currently not adequately described by anything other than BPD. Yet, they questioned whether the current BPD diagnosis is the best way to describe such "difficult" clients.

In discussing the challenge of treating such a diagnosis as BPD, participants consistently emphasised the importance of a client-centred approach to psychological practice. This includes understanding the client's wants, the client's perspective on the BPD diagnosis, and supporting them to analyse the pros and cons of a BPD diagnosis, while ensuring the psychologist's expertise is utilised to meet the client's best interests. They noted that a client may lack insight into their needs. A key example of this is client safety, considering the high suicidality and self-harm present in clients with BPD traits. Participants consistently referred to formulation as a key part of the psychologist's job and a valuable tool for understanding the client and presenting a picture of the client's situation without necessarily requiring a diagnosis.

In discussing clients with BPD symptoms or previous BPD diagnoses, participants were adamant that trauma was a factor for this cohort. Participants often lamented that the DSM was non-aetiological and that the BPD diagnosis lacks a clear aetiological foundation. This certainty of the role of trauma in the aetiology of BPD led to a discussion of what trauma is. This included a discussion of CPTSD, classic trauma, the difference between "little t" and "big T" trauma, as well as expanding the conceptualisation of trauma to include invalidation and relational trauma. Throughout the conversations, when participants referred to CPTSD, they were not referring to the diagnosis of CPTSD described in the ICD-11, but rather to a broader concept that is often interchangeable with trauma and encompasses such concepts as "little t" trauma, relational trauma or invalidation. The term trauma itself was also used broadly and could include the previous concepts as well as the classical life-threatening traumatic experiences and associated symptoms.

When participants spoke of complex trauma and CPTSD outside of strict diagnostic circumstances, they were referring to an umbrella term for understanding a set of experiences that can be relational in nature and more closely aligned with the invalidation spoken about by Marsha Linehan (1993). For participants, these experiences can symptomatically take the form of a person's

difficulty in relationships, it can impact their sense of self, it may manifest as the disturbances of self-organisation of CPTSD, and it may have led to coping mechanisms which can present similarly to some of the symptoms of BPD. These can also manifest as emotional dysregulation issues, splitting, dissociation and self-harm. Participants were also adamant that this broader understanding of traumatic experiences, often referred to as CPTSD or chronic or complex trauma, is commonly used amongst clinical psychologists and health care teams in Aotearoa NZ. Participants discussed the term positively, noting its aetiological focus, the treatment it informs, as validating for clients, helpful in building the therapeutic alliance and trust, useful to help clients understand better the "why" of their psychological challenges, useful for communication amongst healthcare workers, and that it is more empathetic and less stigmatising than BPD. Whether officially endorsed or not, there appears to be, among the participants in this research, a movement toward a broader understanding of traumatic events, and awareness of the importance of addressing those events to validate the experiences of their clients, understand the behaviours of their clients, and to address the current challenges their clients face.

Perceived issues with BPD and the positive feelings toward a broader term that includes a "why", such as CPTSD, led to a discussion of change in psychology. Many participants cautioned against the total replacement of BPD with CPTSD, referring to phenomenological differences in symptoms, and positing that the difficult experiences of one with BPD may be more relational in nature, rather than classically traumatic. Mixed feelings were interpreted in which participants, on the one hand, expressed frustrations around the slowness of psychology to change, negative feelings toward the BPD diagnosis, personality disorders, and diagnosis in general, as well as concerns around issues of validity for a new diagnosis, the danger of creating new stigmas, or simply shifting current issues onto a new diagnosis, concerns around what happens to those already diagnosed, and acknowledging the fact that there's a "there" there for BPD. Participants grappled with the issues of BPD diagnosis and the positive aspects of CPTSD, as well as the belief that there are some things that the BPD diagnosis can address that CPTSD cannot right now. They also acknowledge the utility of diagnostic manuals, despite their shortcomings. Participants arrive at a resolution that involves recognising their own skills to negotiate the good and bad aspects of the BPD diagnosis, and diagnosis more broadly, as well as their ability to draw on other research and other diagnoses or theories of mental health, as well, along with client collaboration and an integrative approach to interventions to help clients thrive.

Much of what participants said about the BPD diagnosis mirrored what is found in the literature on BPD. This included concerns around the diagnosis being highly stigmatising (Lepkowsky, 2020), gender biased (Becker & Lamb, 1994; Braamhorst et al., 2015; Bruce & Weinraub, 2023; Liebman & Burnette, 2013; Rodriguez-Seijas et al., 2024), BPD clients being perceived as difficult (Koekkoek et al., 2006; Sulzer, 2015), and that BPD clients are difficult for practitioners (Lepkowsky & Yip, 2020), the heterogeneity of symptoms of BPD and that BPD is

highly overlapping with other disorders (Bockian, 2002), and that BPD is comorbid with other disorders (Bockian, 2002; Tate et al., 2022; Zanarini et al., 2004). The literature on whether BPD is a distinct diagnosis is mixed; however, most researchers acknowledge differences between BPD and CPTSD, and participants expressed this, first by saying there is a "there" to be found and later by expressing caution about abandoning the diagnosis. Latent class analyses have shown that BPD is both distinct and highly overlapping (Cloitre et al., 2014; Cyr et al., 2021; Jowet et al., 2019), and theorists have posited that BPD and CPTSD are phenomenologically different (Karatzias et al., 2023). Participants perceived the BPD diagnosis as useful for informing treatment. Though initially considered untreatable, numerous effective treatments for BPD now exist (Dimeff & Linehan, 2001; Kernberg et al., 2008; McMain, 2009; Vogt & Norman, 2019). Participants' awareness of trauma backgrounds in those with BPD traits also aligns with the literature (Luxenberg et al., 2000; MacIntosh et al., 2015).

Beyond being the only study of its kind focused on Aotearoa NZ, the current study adds to the knowledge base by providing thick descriptions of how participants managed to work with a diagnosis they were wary of and concerned about, yet not ready to do away with completely. Participants reflected on a holistic approach to understanding clients with BPD traits, including such things as the client's wants, the client's needs, managing stigma through communication, psychoeducation about diagnoses, formulation, being etiologically grounded, finding a reason why, being trauma-focused, utilising resources and planning interventions without diagnosis, and diagnosis workarounds within and between organisations. All aspects of trauma are considered without the need for an official CPTSD diagnosis. Participants' statements also highlight the complexity of the job, the advocacy role psychologists take seriously, and the prioritisation of formulation by Aotearoa NZ psychologists. This study also provides insight into the complexity of clinical utility and the dynamic way in which psychologists practising in Aotearoa NZ balance the challenges of working with imperfect diagnostic tools in an environment with numerous stakeholders, obstacles, and goals. Participants, by being ecological, holistic, or pluralistic in their approaches to understanding their clients, may have reduced the negative impact of the BPD diagnosis simply by working the way they do, without the need for radical changes.

Strengths & Limitations

Convenience sampling means that the participants, by their interest in discussing BPD, may be self-selecting as a cohort of the psychological community that is biased against manualized diagnosis and more focused on formulation. It may be that there is another cohort of psychologists in Aotearoa NZ who believe strongly in the value of manualised diagnosis and in personality disorders. Exactly how to address this limitation may require new methodological considerations.

A strength of reflexive qualitative TA is that it enables the gathering of rich data sets. This study contained almost seven hours of audio. Participants were given the freedom to discuss the subject as they wished, allowing for data that the researcher did not initially consider. The participants were also experts in the field and experienced in discussing the topic at hand, and therefore well-positioned to provide data on the subject.

Although TA offers rich data, the researcher interprets and analyses it through their thoughts, feelings, and personal experience. The researcher's opinion of the BPD diagnosis and personal feelings about approaches to diagnosis and trauma may have had an impact on the focus and analysis of the research. Due to this and to the desire to produce a trustworthy piece of research, techniques were utilised, including prolonged engagement with the data, persistent observation, reflexivity, providing thick descriptions and detailed discussion of the methodology, the use of an audit trail, extensive use of participant quotations during analysis reporting, and the involvement of an experienced external auditor.

A further weakness of the study concerns the sample's representation. The majority of participants identified as European / Pākehā. Future research would benefit from a more diverse and representative sample. None of the participants in the current research identified as Māori. However, participants expressed a keen awareness of the WEIRD-ness of the DSM, and sorrow at the persecution of Māori who have had Western models of psychology imposed upon them. Although this study is not Kaupapa Māori research or particularly socially or culturally focused, it seeks to understand perceptions of clinical psychologists. The applicability of the BPD diagnosis across cultures was a concern for the participants and warrants further culturally appropriate investigation, given the need for psychologists to be committed to ethical and culturally inclusive practices (Code of Ethics Review Group, 2012). There is a need for psychological practices that are effective not only for Māori but for all cultures that may fall outside of WEIRD science. This is a significant concern and an essential issue for psychologists practising in Aotearoa NZ, warranting further and ongoing study.

Future Implications & Closing Thoughts

At the outset of this research, the researcher sought clinicians' perspectives in Aotearoa NZ on the clinical utility of the BPD diagnosis, particularly in relation to CPTSD. The intention was to answer the broad question: What do they think about BPD? Aotearoa NZ clinicians perceive of BPD as a highly problematic, complex and troubling diagnosis. Yet one that also has some utility in terms of available treatments, as well as for clients who feel best represented by the diagnosis. Participants acknowledged that there may be a particular client who is not currently better described by other diagnoses, for them the diagnosis has some utility. However, BPD remains a conundrum and raises additional questions.

One such question that would require future research is: How vital are diagnostic manuals like the DSM and the diagnoses within them for practising psychologists in Aotearoa NZ? Specifically, in the context of the clear preference for formulation, as well as emerging alternatives to diagnosis, ease of access to emerging research, and the ability to plan treatment outside of giving a diagnosis. The proximity of this researcher to academic study may have led him to place a greater value on diagnostic manuals than necessary, prompting him to ask the wrong questions. As a result, the research question of this study may overemphasise the primacy of diagnosis to psychologists.

Striking down a specific diagnosis and abandoning it, expecting a new diagnosis to fix all the problems of a previous diagnosis, or abandoning diagnoses altogether, may not be the answer to the challenge of imperfect diagnoses. This is particularly true in a field that is slow to change and anti-radical. Instead, a new way of incorporating the different aspects of a psychologist's job, along with the skills, knowledge, and experience a psychologist has, into a pluralistic and flexible approach to psychological practice in Aotearoa NZ may be the way forward. Rather than abandoning or expecting too much from the DSM or the ICD, we could instead lower our expectations of diagnostic manuals or diagnoses. As such, other questions raised and implications for future research could include: What is the role of diagnostic manuals in day-to-day practice for clinical psychologists? Is there a discrepancy between the emphasis placed in diagnostic manuals versus the independent work of emerging research? For what reasons do psychologists in Aotearoa NZ make diagnoses? How can psychology as a field reduce the public focus on diagnosis or diagnostic concepts when discussing their mental health?

Though the position of BPD as a concerning diagnosis that still has some use leaves it with a somewhat ambiguous status, there are positive takeaways to draw from this research. The TA results extend beyond merely highlighting the challenges of a troubling BPD diagnosis. They reflect a sample of Aotearoa NZ clinicians who recognise the difficulties that a BPD diagnosis can pose to mental health practice. These clinicians have the freedom to independently question the diagnosis. They can work with the diagnosis if they choose to, and navigate obstacles, such as stigma, by shifting their focus to traits, using formulation, and collaborating with clients. They also acknowledge and communicate the importance of contextual, social, and aetiological factors, including those related to traumatic experiences. They find ways to utilise funding, interventions, and support systems without necessarily assigning a new diagnosis, and they understand the importance of holding space for clients who either have an existing BPD diagnosis or find the diagnosis meaningful. Though it may not be possible to achieve a perfect diagnosis, it is possible to work with expertise to utilise what a diagnosis can provide to deliver the best care for clients.

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Appendix A: Research Advertisement



MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND



Seeking practicing clinical psychologists to participant in Master's research project.



Kia ora, my name is Daniel Borgman; I am a student conducting a qualitative research project for my Master of the Arts in Psychology at Massey University and I would greatly appreciate your input.

The project is focused on exploring the perceptions of the clinical utility of the BPD diagnosis for psychologists working in Aotearoa NZ.

The research involves a conversation focusing on your experience as a psychologist of the BPD diagnosis. This includes what you think of the diagnosis, how you use the diagnosis, what steps you take to better understand someone presenting with symptoms of the diagnosis, as well as what alternative formulations or diagnoses you would use, or consider using.

The findings of this analysis will form the basis for a discussion on the clinical utility of the BPD diagnosis for psychologists working in Aotearoa NZ.

I am looking for:

Practicing clinical psychologists (with experience of clients presenting with symptoms of BPD) who are willing to spend an hour or so to take part in my project.

- The research will be conducted via a semi-structured interview over video chat online, which should take approximately one hour.
- As a thank you for your time for your time, a Koha of a 40 GiftPay Voucher is offered to each participant.

If you are interested in taking part or have any questions, please reach out via email to
dborgman@gmail.com.

Your contribution will be greatly appreciated.

Appendix B: Information Sheet

Information Sheet

The clinical utility of the Borderline Personality Disorder (BPD) diagnosis for psychologists in Aotearoa NZ.

My name is Daniel Borgman; I am a student conducting a qualitative research project in partial completion of my Master of the Arts in Psychology at Massey University and I would greatly appreciate your input.

I am seeking practicing psychologists (with experience of clients presenting with symptoms of BPD) who are willing to spend an hour or so to take part in my project. The project is focused on exploring the perceptions of the clinical utility of the BPD diagnosis for psychologists working in Aotearoa NZ. The research will be conducted via a semi-structured interview over Zoom, which should take approximately one hour.

The aim of the interview is to have a conversation focusing on your experience as a psychologist of the BPD diagnosis. This includes what you think of the diagnosis, how you use the diagnosis, what steps you take to better understand someone presenting with symptoms of the diagnosis, as well as what alternative formulations or diagnoses you would use, or consider using.

Discussion will also take into consideration your thoughts around the recent inclusion of CPTSD as a diagnosis in the ICD-11 and any implications this may have for the BPD diagnosis. The role of trauma in the aetiology of BPD will also be discussed.

The findings of this analysis will form the basis for a discussion on the clinical utility of the BPD diagnosis for psychologists working in Aotearoa NZ.

If you are interested in taking part or have any questions, please reach out via email to dborgman@gmail.com.

Participant Information:
I am recruiting participants via professional organisations, who are sharing information about the research on my behalf, as well as snowball sampling/word of mouth. The only criteria are that you are a practicing psychologist with experience of BPD and you are willing to participate in an interview with me online. Once the interview has been completed, it will be transcribed and you will have the option to review and edit your own transcript if you wish. You will have two weeks to do this, after which time the transcript will be taken as accurate if not returned.

You will be talking about professional issues and your professional opinions; thus, it is not expected that participating would cause you distress. However, should you feel you need to, we can pause the interview at any time, and you would be encouraged to discuss your experience with your supervisor and usual support systems.

Appendix C: Consent Form



MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

HEALTH PROFESSIONAL CONSENT FORM
Interviews

Aotearoa NZ psychologists' perspectives of the clinical utility of the borderline personality disorder (BPD) diagnosis.

I have read and I understand the Participant Information Sheet. I have had the chance to ask Daniel questions about this study and I am happy with the information I have been given. I have been given a copy of the Participant Information Sheet and Consent Form to keep.

I understand that taking part in this study is my choice, and that I may withdraw from this study at any time up until one month after I have been sent the transcript of my interview to have a look over.

I understand that this study involves meeting once with Daniel to discuss my experiences of the clinical utility of the BPD diagnosis. I understand that I can also choose to connect with Daniel to get to know each other before the interview.

I understand that I may bring along a support person(s) to the interview.

I understand that if I have any cultural needs, Daniel will seek to meet these as best he can. I am also aware that Daniel will ask for cultural advice about any cultural information I share with him.

I understand that my name and any other potentially identifying information will be changed in all reports of this research.

I agree to have the interview with Daniel sound recorded.

I understand that I can contact Daniel or his supervisors if I have any questions about the study:

Daniel Borgman (Doctoral student)
Telephone: [redacted]
Email: dborgman@gmail.com

Dr Kirsty Ross (Supervisor)
Telephone: +64 (06) 356 9099 ext. 84968
Email: K.J.Ross@massey.ac.nz

I _____ (name)

☐ Agree to be interviewed

Signature _____ Date _____

The best way to get hold of me is:

Telephone ☐ Contact telephone number: _____

Email ☐ Contact email address: _____

Letter (post) ☐ If so, please give the best address to send a letter to:

_____

_____

_____

_____

I would like a summary of the main results sent to me at the end of the study:

Yes ☐

No ☐

If you are willing to share the following demographic information, please specify:

Age: _____

Ethnicity: _____

Appendix D: Interview Schedule

Interview Schedule

Name:

Age:

Ethnicity:

Qualifications:

Years as a practicing psychologist:

Proportion of BPD cases in workload:

Intro:

Thank you so much for agreeing to this interview. I've invited you here today to discuss the BPD diagnosis in the context of clinical psychological practice in Aotearoa New Zealand. I have some questions around your perception of the diagnosis, its relationship to other diagnoses, and its usefulness for psychologists working in New Zealand.

Opening: Do not rush - provide the opportunity for participants to open the space with some words, a prayer or karakia or other procedure - be prepared to open the space with a karakia and/or pepeha - use an ice breaker question for example: 'Tell me about where you work?'

Warm up.

1. Can you describe your understanding of what the Borderline Personality Disorder diagnosis is?
    a. Is this description based on the DSM-V or something else?

Perceptions of the Diagnosis.

2. More generally, what is your perception of the BPD diagnosis?
    a. Personality disorders generally.
    b. Fit in NZ context.
3. What are your thoughts on the impact of stigma on those diagnosed with BPD?
    a. What about for clinicians, family, or society at large?
    b. Does stigma play a role in your use of the diagnosis?
4. How useful do you believe the diagnosis to be?
    a. For communication to families, clients, and other involved parties.

   b. For ease of application.
   c. For informing treatment.
   d. How willing are you to make the diagnosis?

Encountering BPD symptoms.

5. Can you discuss your experience of an encounter with a client presenting with symptoms that are included in the criteria of BPD (i.e., aggressivity, suicidality, relational troubles, abandonment issues, self-harm, identity disturbance, impulsivity and difficulties with emotional regulation).
6. Can you describe how the person presented?
   a. Do you think there is a quality or affect that triggers your instincts to see if this person has BPD?
7. And what was the eventual formulation or diagnostic indication that you made? How did you come to that conclusion?
   a. Did you consider making a BPD diagnosis?
   b. What other diagnoses did you rule out, and what process did you take to do so?

Trauma & BPD.

8. How important are early childhood experiences in your understanding of a client who presents with symptoms of BPD?
   a. If you encounter someone with BPD symptoms, and a trauma history what do you do?
9. Since the late 80s our understanding and conceptualization of trauma has developed to include what has come to be called 'complex trauma'. Recently the WHO has included CPTSD as a separate diagnosis in the ICD-11. What implications has this inclusion had to your practice, especially regarding those with symptoms of BPD?
   a. Has it made things clearer easier or more confusing?
   b. Has the CPTSD diagnosis created additional issues for diagnosing BPD?

On Diagnosis.

10. Reflecting on what we've discussed, what would you consider important in future diagnostic manuals, especially considering a diagnosis such as BPD?

Wrap Up.

11. Is there anything else you would like to add, or that you think is worth mentioning given what we have discussed in this interview?

Closing.

Provide the opportunity for participants to close the space in a manner of the choosing, or close the space with a karakia of your own if appropriate.

Appendix E: Ethics Approval

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

22/11/2024

Dear: Daniel Borgman

Re: Low Risk Notification - 4000029276 - Qualitative research into Aotearoa NZ psychologists' perspectives of the clinical utility of the borderline personality disorder (BPD) diagnosis.

Thank you for submitting a low risk notification for your research/teaching/evaluation.

This email is to acknowledge receipt of the low risk notification and to inform you that the details of your project have been recorded in our database for inclusion in the annual reports to the Health Research Council Ethics Committee (HRCEC) and the Massey University Research Committee (URC).

You may proceed with your research, though it is advisable to provide a couple of weeks before commencing, as all low risk notifications are checked for completeness and clarity by a Research Ethics Advisor. You may be contacted if your application is incomplete and/or further clarification is required.

The low risk notification for this project is valid for a maximum of three years.

Please notify me if situations subsequently occur which cause you to reconsider your initial ethical analysis.

If a sponsoring organisation, funding authority (e.g., the Health Research Council) or a journal require evidence of ethical approval from a Human Ethics Committee (with an approval number), you need to complete a full Massey University Human Ethics application to be reviewed and approved by one of our Human Ethics Committees. Applications must be submitted and approved prior to the commencement of the research.

Please note that travel undertaken by students must be approved by the supervisor and the relevant Pro Vice-Chancellor and be in accordance with the Policy and Procedures for Course-Related Student Travel Overseas. In addition, the supervisor must advise the University's Insurance Officer.

If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher(s), please contact the Research Ethics Office, email humanethics@massey.ac.nz. "

Please include the following statement on all public documents (e.g., information sheet, consent form) related to your project:

> ***This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research.***
>
> ***If you have any concerns about the ethical conduct of this research that you want to raise with someone other than the researcher(s), please contact Massey University Human Ethics by email: humanethics@massey.ac.nz.***

I wish you all the best in your research, teaching or evaluation activities and appreciate your thoughtful consideration of ethics principles and practices.

Ngā mihi nui,



Professor Tracy Riley
Acting Chair, Research Ethics Chair's Committee

Research Ethics Office, Research and Enterprise
Massey University, Private Bag 11 222, Palmerston North, 4442, New Zealand T 06 951 6841; 06 951 6840
E humanethics@massey.ac.nz; animalethics@massey.ac.nz; gtc@massey.ac.nz