AUSTRALASIAN PSYCHIATRY

Editorial

Bigotry and borderline personality disorder

Australasian Psychiatry
1–2

DOI: 10.1177/10398562211045151
journals.sagepub.com/home/apy
SAGE

Andrew M. Chanen Orygen, Melbourne, VIC, Australia; and Centre for Youth Mental Health, The University of Melbourne, Melbourne, VIC, Australia

Keywords: Personality disorder, stigma, diagnosis, trauma, psychiatry

Nobody heard him, the dead man,

But still he lay moaning:

I was much further out than you thought

And not waving but drowning.

(Stevie Smith, "Not Waving but Drowning" from Collected Poems of Stevie Smith, 1972)

Stevie Smith's poem of alienation, misunderstanding, and the disjuncture between inner and outward experience speaks volumes about the experiences of those living with borderline personality disorder (BPD), including its premature mortality. BPD is a severe mental disorder by any personal, social or economic measure. Yet those living with the disorder, and those who care for them, still struggle to be taken seriously, let alone respectfully. This is especially the case among health professionals, where harmful attitudes, beliefs and practices are most common and stubbornly persist, impervious to a substantial body of scientific evidence about the aetiology, reliability, validity, severity and treatability of BPD.

Reductionistic and simplistic assumptions about the aetiology of personality disorder, especially BPD, abound and lead to flawed beliefs about diagnosis and treatment. The majority of developmental research in personality disorder has focused on distal, early childhood experiences, and how these might influence later psychopathology. Yet, two decades of evidence also indicates that these outcomes might be mediated or even reversed by later, proximal factors, such as favourable environmental influences (e.g. reparative relationships), coping mechanisms or cognitive processing of experiences. This is most evident in debate about childhood adversity and BPD. Recent meta-analytic data confirms a threefold increase in the likelihood of childhood adversity in people living with BPD, compared with other clinical populations.[1] Yet, 29% of people living with BPD reported no adverse childhood experience. This provides further support to the long-established observation that not all individuals living with BPD have a history of trauma, and not all individuals with a history of childhood trauma develop BPD. Acknowledging non-traumatic aetiological pathways to BPD should not diminish the importance of childhood adversity for victim survivors. However, it provides important validation of the lived experience of a sizable minority of people living with BPD, encouraging a more nuanced understanding of the heterogeneity and uniqueness of each individual living with BPD.

Such misconceived beliefs about aetiology often become conflated with non-scientific dogma about delayed diagnosis, non-diagnosis or substitute diagnoses. While it is widely accepted that personality disorder is a developmental disorder, with clinical onset during the transition between childhood and adulthood, few clinicians are willing to make a timely diagnosis, so as to facilitate early treatment.[2] Even among those who treat adults with BPD, it is still seen as acceptable in some settings to mutter pejoratively about a patient with BPD, yet withhold the diagnosis. Both late diagnosis and/or withholding the diagnosis are ethically dubious and clinically harmful, as they deny the person the opportunity to seek evidence-based treatment and to mitigate against poor outcomes.

Some clinicians advocate for purging the term personality disorder from the diagnostic lexicon. They argue that the assertion that something is awry with an individual's personality is distasteful and/or offensive. Yet, a wealth of evidence indicates that impairments in basic capacities essential for adaptive self- and interpersonal functioning and extreme or inflexible personality traits (both intrinsic to concepts of personality) are common and, when present, they are reliably and validly associated with poor outcomes. In the case of BPD, many of these are as severe as for mental disorders such as schizophrenia. Personality disorder might be an 'inconvenient truth' for some clinicians, but systematic review evidence

Corresponding author:
Andrew M. Chanen, Orygen, 35 Poplar Road, Parkville, VIC 3052, Australia.
Email: andrew.chanen@orygen.org.au

suggests that 'it's not what you do, it's the way that you do it'. When the diagnosis is done well and delivered in a sensitive manner, consumers find this helpful.[3]

In clinical and community samples, up to half of those diagnosed with BPD also meet the diagnostic criteria for post-traumatic stress disorder (PTSD).[4] When combined with evidence about childhood adversity, this has led some clinicians and consumers to suggest that complex PTSD (C-PTSD) should replace the BPD label.[5] The conjecture that BPD is a variant of PTSD assumes that trauma is the primary cause of the disorder. While some early life events might shape later personality and psychopathology, there is little evidence that they propel children on an inevitable trajectory towards maladjustment, perhaps with the exception of prolonged and severe experiences. The argument also ignores evidence for other important genetic and environmental aetiologic factors, such as deficits in social cognition or emotion dysregulation,[6] along with the evidence of non-traumatic pathways to BPD. Moreover, it ignores evidence from one of the principal proponents of C-PTSD that it is distinguishable from BPD.[7]

The 'BPD is a variant of PTSD' argument can also have detrimental effects upon individuals and families. Clinicians might fail to fully investigate the aetiology of the disorder once a traumatic event has been revealed, diminishing the formulation of each individual's presentation. Trauma might also be assumed, even when absent or denied. Not only is this invalidating for those living with BPD who do not have a history of trauma, but also clinical experience suggests that it increases the likelihood that families will be blamed and alienated from care.

Another variant of this theme is the argument that BPD is better described as a form of attachment disorder. This seems to be based in the misplaced belief that disorganised attachment reliably indicates maltreatment and that it is a strong predictor of pathology, neither of which is supported by the evidence. Even more pernicious is the idea that disorganised attachment represents a fixed trait in an individual, that is impervious to development or help.[8]

The question remains, then, as to why some clinicians and patients are so heavily invested in the hypothesis that BPD is a variant of PTSD or a matter of attachment style. One answer might be the perceived reduction in stigma associated with re-labelling BPD.[5] Discrimination against people with personality disorder is widespread, and the stigma associated with BPD is greater than for other psychiatric disorders.[9] Indeed, people with BPD are more often stigmatised by mental health professionals than by members of the general public. Some well-meaning clinicians also argue that the diagnosis should be withheld in order to protect individuals from the negative attitudes, beliefs and behaviours of their colleagues. Whether re-labelled or withheld, surely colluding with ignorance, prejudice and discrimination against people with BPD should be opposed? Such bigotry in our colleagues should be challenged, not avoided, especially when it is clear that it will diminish the quality of care. No one would accept the non-diagnosis of HIV/AIDS in the modern era in order to avoid stigma or discrimination. This would be a death sentence, denying people access to life-saving treatment. Why should we tolerate this for personality disorder?

The diagnosis of BPD has few friends.[10] However, both the ICD-11 and DSM-5 Alternative Model for Personality Disorder have addressed this by recognising that personality disorder is a unitary construct, with varying levels of severity and that BPD is largely synonymous with its most severe form. Adopting and rehabilitating the term 'severe personality disorder', early diagnosis and treatment and parity of access to the mental and general health systems are vital planks of reform. Most importantly, the ignorance, prejudice and discrimination surrounding personality disorder must be challenged among clinicians to ensure appropriate and timely care. Rather than renaming personality disorder, experiences of developmental adversity at any age should be respected in their own right and in the context of the formulation of that individual's presenting problems. Using substitute diagnoses as a 'trojan horse' for achieving a more humane response for people with BPD is misleading, likely to have unintended consequences, and unlikely to succeed. Stigma is likely to metastasise to any new term because it is the interpersonal dysfunction associated with BPD that generates negative attitudes and behaviours among clinicians.

Acknowledgement

The author acknowledges Dr Katie Nicol and E/Prof. Henry Jackson for their comments on an earlier version of this manuscript.

Disclosure

The author reports no conflict of interest. The author alone is responsible for the content and writing of the paper.

References

1. Porter C, Palmier-Claus J, Branitsky A, et al. Childhood adversity and borderline personality disorder: a meta-analysis. *Acta Psychiatr Scand* 2020; 141: 6–20.
2. Chanen AM and Nicol K. Five failures and five challenges for prevention and early intervention for personality disorder. *Curr Opin Psychol* 2021; 37: 134–138.
3. Lester R, Prescott L, McCormack M, et al. Service users' experiences of receiving a diagnosis of borderline personality disorder: a systematic review. *Personal Ment Health* 2020; 14: 263–283.
4. Frías Á and Palma C. Comorbidity between post-traumatic stress disorder and borderline personality disorder: a review. *Psychopathology* 2015; 48: 1–10.
5. Kulkarni J. Complex PTSD - a better description for borderline personality disorder? *Australas Psychiatry* 2017; 25: 333–335.
6. Winsper C. The aetiology of borderline personality disorder (BPD): contemporary theories and putative mechanisms. *Curr Opin Psychol* 2018; 21: 105–110.
7. Cloitre M, Garvert DW, Weiss B, et al. Distinguishing PTSD, complex PTSD, and borderline personality disorder: a latent class analysis. *Eur J Psychotraumatol* 2015; 15: 5.
8. Granqvist P, Sroufe LA, Dozier M, et al. Disorganized attachment in infancy: a review of the phenomenon and its implications for clinicians and policy-makers. *Attach Hum Dev* 2017; 19: 534–558.
9. Sheehan L, Nieweglowski K and Corrigan P. The Stigma of Personality Disorders. *Curr Psychiatry Rep* 2016; 18: 11
10. Tyrer P. Why borderline personality disorder is neither borderline nor a personality disorder. *Personal Ment Health* 2009; 3: 86–95.