Campbell, Danielle (2025) *Considerations in the assessment and diagnosis of Borderline Personality Disorder (BPD) within minority demographics.*
D Clin Psy thesis.

# Considerations in the Assessment and Diagnosis of Borderline Personality Disorder (BPD) within Minority Demographics.

Danielle Campbell, BSc (Hons), MSc

Submitted in partial fulfilment of the requirements for the degree of

Doctorate in Clinical Psychology

School of Health and Wellbeing

College of Medical, Veterinary and Life Sciences

University of Glasgow

July 2025

# Table of Contents

# List of Tables

## Systematic Review

## Major Research project

# List of Figures

## Systematic Review

## Major Research project

# Acknowledgements

Firstly, I would like to express my deepest gratitude to all participants and experts by experience for taking the time to share your experiences and contribute to a very emotive topic.

Thank you to my wonderful research supervisor, Dr David Grinter, for his continued support and encouragement throughout this process. You not only helped me navigate challenges and develop my critical thinking skills but also empowered me to value my own lived experience.

Thank you to my field supervisor, Dr Claire Donaghey, and research advisor, Dr Ruchika Gajwani, for your enthusiasm and belief in the value of this research. Thank you to my line manager, Dr Susan Connaghan, and the Older People Psychology Service for their engagement and advocacy. I will forever be grateful to you all for going the extra mile to ensure my data collection went smoothly.

Lastly, I am forever grateful to my chosen family. All your support from the start of my journey, as an insecure undergrad embarking on an Open University degree in her spare time, has given me so much strength and I could not have gotten through this without all your unshakable faith in me (even when I had none in myself!).

Ruth, Stephen, Marc and Tania special thanks to each of you, for your unwavering support, for listening to my rants, offering words of encouragement, and being my biggest inspiration.

With love,

(Soon to be Dr!)

Danielle Campbell

# Chapter 1. Systematic Review

## Disparities in the assessment and diagnosis of Borderline Personality Disorder (BPD) among minority sexualities and gender identities: A systematic review.

Prepared in accordance with the author requirements for British Journal of Clinical Psychology: Author Guidelines

# Abstract

Title

Disparities in the assessment and diagnosis of Borderline Personality Disorder (BPD) among minority sexualities and gender identities: A systematic review.

## Background

Evidence suggests that sexual and gender minority (SGM) individuals are disproportionately diagnosed with BPD compared to heteronormative groups, raising concerns about clinician bias, minority stress, and diagnostic validity.

## Objectives

To determine whether SGM individuals are diagnosed with BPD at higher rates than heteronormative counterparts, examine the measures used in these assessments, and explore factors that researchers suggest may influence diagnostic outcomes.

## Methods

A systematic review was conducted following PRISMA 2020 guidelines. PsycINFO, MEDLINE, and Embase were searched (inception–July 2025) for peer-reviewed quantitative or mixed-methods studies comparing BPD diagnosis or symptom severity in SGM and heteronormative samples. Study quality was appraised using QualSyst. Meta-analysis synthesised odds ratios and effect sizes calculated. Measures were evaluated and a content analysis was used to explore theoretical and contextual diagnostic factors.

## Results

Nine studies met eligibility criteria. Meta-analysis showed SGM individuals had significantly higher odds of receiving a BPD diagnosis (OR ≈ 3.67), with some estimates as high as OR = 36. Symptom severity was also higher among SGM participants (Hedges' *g* = 0.29–2.08). However, few studies used validated tools for SGM populations. Key influencing factors included minority stress, trauma history, clinician bias, identity pathologisation, and unvalidated assessment tools.

## Conclusions

Findings highlight a consistent disparity in BPD diagnoses among SGM individuals. Culturally

competent, person-centred assessment practices and improved diagnostic tools are needed to reduce misdiagnosis and stigma.

### Registration

PROSPERO ID: CRD420251057221

### Funding

This research was conducted as part of a Doctorate in Clinical Psychology at University of Glasgow.

## Introduction

The phenomenology and aetiology of Borderline Personality Disorder (BPD) is often a contentious topic. The diagnostic criteria has evolved since its initial emergence when Stern (1938, cited in New & Triebwasser, 2018) coined the term "borderline" to describe patients that seemed to fall between neurosis and psychoses. Clinical features derived from these initial case studies are reminiscent of criteria still used today with descriptions including "*…narcissism, psychic bleeding, negative therapeutic reactions*, *inordinate hypersensitivity"* as well as "*Masochism; self-pity and commiseration"* which may resemble current DSM-5 descriptions of clinical features such as fear of abandonment, paranoia and dissociation, idealisation and devaluation, emotional instability and recurrent suicidality or self-harming behaviour.

The link between identity and the condition was introduced by Schmideberg (1959, p27) who stated that borderline patients often show "*sexual perversions, homosexuality… eccentricities, peculiar behaviour, and vegetarianism*" alongside substance misuse and risk-taking behaviours. This correlation between nonconformity or "eccentricities" and a BPD diagnosis features throughout research and has informed subsequent diagnostic criteria for the condition. *Emotionally Unstable Personality Disorder* was added to the first DSM in 1952, which featured the inclusion of anger, reactivity, relational difficulties, depression and inconsistent self-identity, (Grinker, Werble, & Drye, 1968, cited in New & Triebwasser, 2018).

This inclusion of perceived "identity disturbance" may suggest a high risk of gender and cultural biases informing the assessment, which leads to concerns about the disregard of important cultural and social confounding factors as well as possible pathologisation of minority groups, (Nyquist Potter, 2013). Despite homosexuality being removed from the DSM in 1973, there were still legal, social and cultural implications, particularly during the 1980s AIDS epidemic, which negatively impacted public perceptions of homosexuality. The impact of historical contexts still perpetuates stigma and discrimination today which adversely impacts minority sexualities and gender identities. (Hectors, 2023, Porter, 2023)

Testa et al.'s (2015) development of Meyer's (2013) minority stress model highlights that sexual and gender minorities (SGM) are more likely to experience minority stressors such as discrimination, rejection and victimisation which often leads to a stress response such as internalised shame, emotional dysregulation and maladaptive coping strategies i.e. risk taking, self-harm and substance misuse. SGM may feel the need to conceal their gender identity or sexuality as a safety precaution and may also experience identity confusion during the early stages of their identity development process. This confusion can arise from the initial awareness of same-sex attractions and the questioning of one's sexual orientation or may be due to the impact of societal norms and heteronormative (cisgender, heterosexual) expectations this can perpetuate feelings of being different and disconnected from others, which can lead to distress and uncertainty. These factors taken without the appropriate context may lead to a diagnosis of BPD. (Hall et al. 2021, Porter, 2023).

A growing body of evidence underscores the central role of trauma in the development of BPD, Porter et al.'s (2019) meta-analysis found that individuals with BPD were nearly 14 times more likely to report childhood adversity than non-clinical controls, with emotional abuse and neglect showing the strongest associations. This is particularly salient for minority sexualities and gender identities, who are disproportionately exposed to trauma. Marchi et al. (2023) found that LGBTQ+ individuals are more than twice as likely to develop Post Traumatic Stress Disorder (PTSD) compared to heteronormative peers, with transgender and bisexual individuals facing the highest risk. These elevated trauma exposures align with findings from Cano-Gonzalez et al. (2025), who demonstrated that complex PTSD (C-PTSD) particularly disturbances in self-organisation (DSO), which includes affective dysregulation and negative self-concept, mediate the relationship between minority stress and suicide risk among LGBTQ+ adults. These findings align with Denning et al. (2022), who found that abuse, neglect, and stigmatising events were significantly associated with increased BPD symptoms in SGM, and with Rodriguez-Seijas et al. (2023), who reported that transgender and gender diverse patients (TGD) were significantly more likely to be diagnosed with both PTSD and BPD. There is a strong symptom overlap between C-PTSD and BPD, namely emotional instability, identity disturbance, and relational difficulties, these findings suggest that SGM individuals may be more vulnerable to misdiagnosis.

Research (Ritter & Terndrup, 2002, Wanta et al. 2019 and Rodriguez-Seijas et al. 2023) supports a predilection among clinical criteria to diagnose TGD individuals that appears disproportionate to the BPD-specific pathology reported among these patients. TGD patients have been found to be three times more likely to be diagnosed with BPD than cisgender patients (50% vs 17.31%, Rodriguez-Seijas et al., 2023). Similar findings appear in many studies examining the prevalence of BPD within minority sexualities and gender identities that suggest a large disparity in BPD prevalence between sexual minority and heterosexual populations. However, there is a need to critically examine the quality of these studies and synthesise the findings in such a way as to effectively evidence the true extent of a possible disparity. The possibility of clinician bias, potential issue with the validity of measures utilised in diagnoses or examination of which factors may contribute to a suspected disparity have rarely been explored within the literature.

This systematic review sought to further explore the diagnosis of BPD in minority sexualities and gender identities. It aimed to answer the primary research question:

Q1. Are minority sexualities and gender identities diagnosed with BPD at a different rate than heteronormative groups?

Secondary questions were:

Q2. How are BPD traits measured within these studies?

Q3. What factors do researchers consider may influence the diagnoses of BPD amongst minority sexualities and gender identities?

# Methods

## Experts by experience involvement

Consultation with experts by experience (EbE) from LGBTQ+ charity, Pride Proms, was undertaken at the proposal and results synthesis stages of this review to ensure accurate and sensitive representation as well as guide the inclusion of various terms into the search strategy.

## Registration

In accordance with PRISMA guidelines, this systematic review protocol was registered with the International Prospective Register of Systematic Reviews (PROSPERO) on 23 June 2025. (CRD420251057221)

## Search Strategy

EBSCOhost: PsycINFO, Ovid Embase and Medline were searched from inception to 5th July 2025. The search terms included a variety of terms for borderline personality disorder. Descriptions that encompass the condition included "(borderline personality disorder or bpd or emotionally unstable personality disorder or eupd ) OR borderline state" OR "Cluster B" OR "F60.3" etc. Common criteria associated with the condition were also utilised with traction to maximise the results such as "(unstab* or instab* or poor or disturb* or fail* or dysregulat* or self* or impuls* or interperson* or identit* or relationship* or emotion* or affect)".

A range of terms to capture the target population were utilised such as; "(LGBTQ or lesbian or gay or asexual or bisexual or transgender or homosexual or queer or sexual minority) OR (transgender or transsexual or transexual or gender variant or gender non-conforming)" To successfully capture historic research, some of the terms were outdated references that were commonly used within that time period such as "transvestite OR Cross-dress*" Full search strategies for each database can be found in *appendix 2*.

## Screening

The screening of literature was conducted in five stages:

1. Duplicates, non-peer reviewed, and non-English papers were disregarded.
2. The titles and abstracts were then screened by two researchers to ensure they featured assessment of BPD *and* had a focus on individuals with minority sexualities and gender identities.
3. Full papers were then screened to ensure they met the full eligibility criteria, see *Table 1*.
4. A sample of ten papers were independently screened by a second reviewer to ensure reliability.

A full PRISMA flow diagram (Page et al. 2020) was completed alongside this process to ensure transparency, *see figure 1*.

*Table 1. Eligibility Criteria*

| **Inclusion Criteria** | **Exclusion Criteria** |
|---|---|
| • Quantitative or mixed-methods methodology.<br>• Comparative analysis with control group.<br>• Peer reviewed.<br>• Focus on the assessment and diagnosis of BPD/EUPD.<br>• Focus on LGBTQ+ individuals.<br>• Includes a clinical measure and/or interview for BPD<br>• Includes discussion of factors impacting potential diagnosis. | • Qualitative methodology<br>• Systematic or meta-analysis reviews<br>• Languages other than English.<br>• Grey/ non-peer-reviewed literature<br>• Exclusively heteronormative participants. |

## Critical Appraisal

QualSyst (Kmet et al. 2004) standardised checklists are particularly useful for systematic reviews, as it provides a systematic and reproducible method for assessing the quality of both quantitative and qualitative research papers. These tools include specific guidance for evaluating key aspects of research quality, such as study design, sample size, data collection methods, analysis and risk of bias which helps to identify strengths and weaknesses of each study. Scoring guidelines are provided to calculate a quality assessment score based on the internal validity. This provides a clear quality rating of high (0.75- 1.00.), moderate (0.50 - 0.74) and low (<0.50), which helps ensure that only high-quality studies are included. The tool itself has good inter-rater reliability, and a large sample of the studies (n=6) were independently appraised by a second reviewer with 90% agreement.

## Data analysis

Following quality appraisal, a narrative synthesis of the findings in line with the Centre for Reviews and Dissemination, (2009) guidance, key descriptive information such as,

- Study characteristics (author, year, location, design, sample size)
- Methodology and analysis (Measures, tests)
- Key findings (outcomes, statistical results)

were extracted and presented in *Table 4*, to provide an overview of the evidence-base and explore the statistical findings, which included reported or calculated effect sizes i.e. odds ratios (ORs).

### Q1: Meta-analysis

A meta-analysis was conducted to quantitatively synthesise the odds of receiving a BPD diagnosis among minority sexualities and gender identities compared to heteronormative controls. Studies were eligible for inclusion in the meta-analysis if they reported, or provided sufficient data such as group sample sizes, diagnostic percentages, means, standard deviations or reported effect sizes. A binary raw data meta-analysis was run for studies where event counts were calculated.

A random-effects model was used to account for anticipated heterogeneity in sample characteristics, diagnostic methods, and study designs. Odds ratios were log-transformed, pooled using inverse-variance weighting, and then exponentiated for interpretation.

Heterogeneity was assessed using the $I^2$ statistic and Cochran's Q test, with $I^2$ values of 25%, 50%, and 75% interpreted as low, moderate, and high heterogeneity respectively (Higgins et al., 2003). A forest plot was included to visualise effect sizes across studies, and all calculations were performed using SPSS software. Sensitivity analysis was considered if high heterogeneity emerged ($I^2 > 75\%$) or if outlier effect sizes were detected. No funnel plot was conducted due to the small number of included studies.

### Missing data

The lack of available standard deviations from Cavale et al. (2024),  Reuter et al. (2016) and Denning et al. (2022) meant the data required to run a continuous data meta-analysis was incomplete. Authors were contacted by emails, whilst there was 100% response rate, the requested data was not available due to the original dataset being inaccessible. Instead, effect sizes were calculated via online calculator (Wilson, 2023), based on an estimate derived from the reported t-tests. These estimated effects should be taken with caution.

### Q2.

The measures used in each paper, their psychometric properties were extracted, and the sampling norms were extracted from the corresponding research into the initial development of the measure. This was presented in *Table 8.*

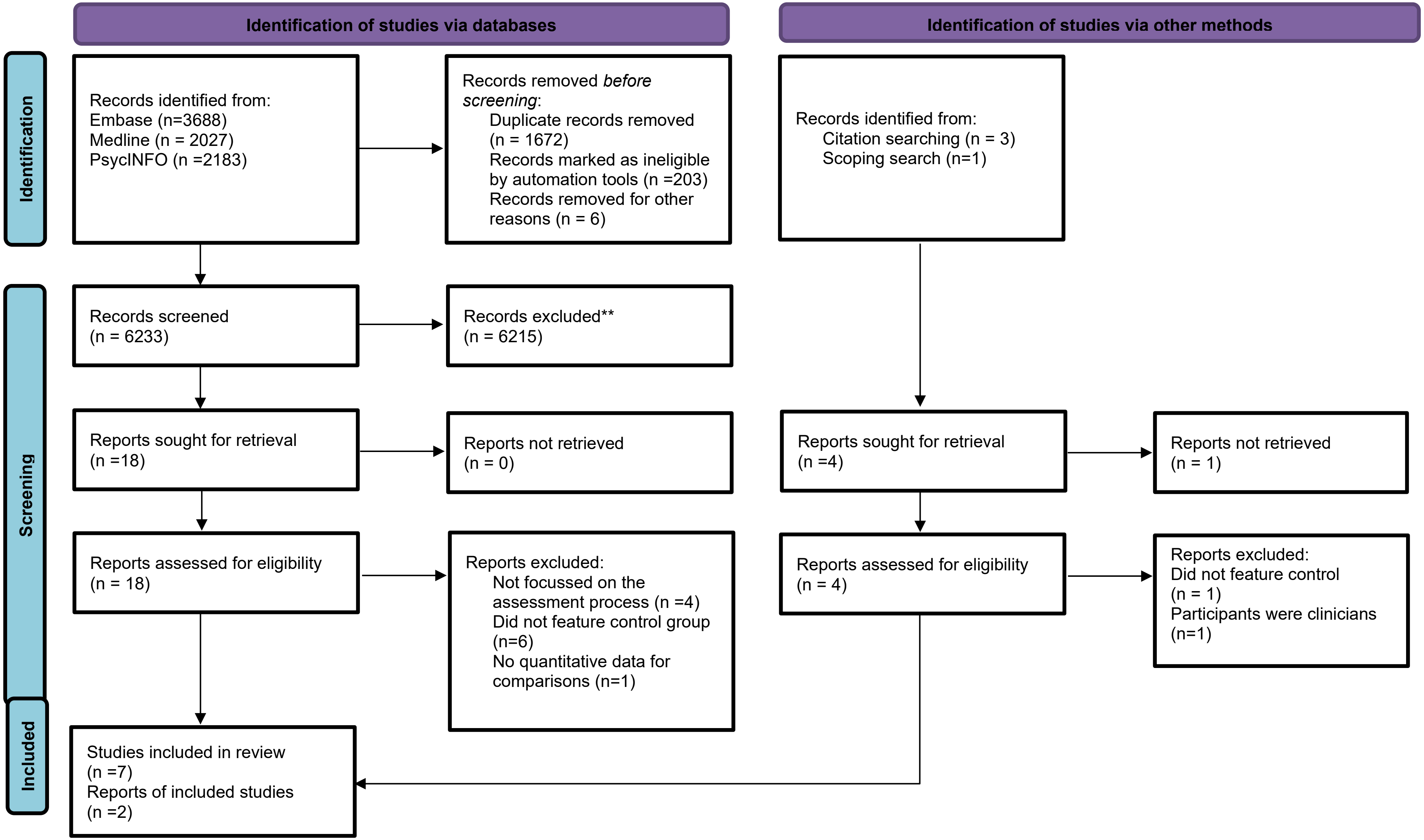
### Q3.

To address *what factors do researchers consider may influence the diagnosis of BPD among minority sexualities and gender identities?* A content analysis (Prior, 2020) was conducted. Although the included studies were primarily quantitative in design, relevant qualitative content (e.g., discussion sections, limitations, theoretical framing) was extracted and analysed, see *Table 9.* A hybrid deductive-inductive coding framework was applied, incorporating both theory-informed categories (e.g., clinician bias, minority stress, intersectionality) and emergent concepts (e.g., identity pathologisation, epistemic injustice). Each study was systematically reviewed to determine the presence or absence of these conceptual factors. The goal was not to interpret participant data, but to map how the authors themselves conceptualise and articulate influences on diagnostic outcomes.

# Results

A total of 7,898 articles were identified; 1,672 duplicates were removed. The remaining 6,233 articles were then screened, reviewing the title and abstracts (6,215 removed). 18 articles remained for full-text review. A backward and forward citation search was then completed for seven eligible papers, and two further articles that met the eligibility criteria was found. In addition, web-based searches were conducted using Google Scholar and ResearchGate which yielded no further papers. The full papers were then independently screened against the inclusion/exclusion criteria by two researchers with 90% corroboration. A discussion took place between researchers with agreement reached that the paper did not fully meet the criteria. In total, 9 articles were included in the synthesis. A PRISMA (2020) diagram details this process within *Figure 1.*

*Figure 1. PRISMA 2020 flow diagram for new systematic reviews which included searches of databases, registers and other sources.*



## Critical Appraisal

As shown in *Tables 2 and 3*, each paper was critically appraised using Qualsyst, and their internal reliability scored to check for quality. A breakdown of these scores as well as the identified strengths and limitations can be found in *Table 3.* Overall, the included papers are of high quality, however, some limitations include small sample sizes, a lack of detailed reporting as well as little exploration of confounding factors that may impact the result. This is important to note when considering if the papers provide representation that can be generalised to the wider population.

Characteristics of included publications and descriptions of each sample can be found in *Table 4.* However, there are limited available demographics of intersectional identities such as ethnicity, nationalities and education level.

*Table 2. Qualsyst checklist.*

| Paper | Question / objective sufficiently described? | Study design evident and appropriate? | Method of subject/comparison group … described and appropriate? | Subject… characteristics described? | Outcome and exposure measure(s) well defined and robust to measurement / misclassification | Sample size appropriate? | Analytic methods described /justified and appropriate? | Some estimate of variance is reported for the main results? | Controlled for confounding? | Results reported in sufficient detail? | Conclusions supported by the results? |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Kerridge et al. 2017 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Rodriguez-Seijas et al. 2023 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Zimmerman et al. 2022 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Carsten et al. (2024) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | Partial | ✓ | ✓ |
| Rodriguez-Seijas et al. 2021 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | Partial | ✓ |
| Reuter et al. 2016. | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | Partial | ✓ |
| Cavale et al. (2024) | ✓ | ✓ | ✓ | ✓ | ✓ | Partial | ✓ | ✓ | Partial | Partial | ✓ |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Denning et al. 2022 | ✓ | ✓ | ✓ | ✓ | ✓ | Partial | ✓ | ✓ | Partial | Partial | ✓ |
| Wanta et al. 2019 | ✓ | ✓ | ✓ | Partial | Partial | ✓ | ✓ | x | Partial | ✓ | ✓ |

*Table 2* provides a detailed breakdown of each study's methodological quality as assessed using the QualSyst tool (Kmet et al., 2004). Most studies performed well across domains, particularly in clearly defined objectives, appropriate design, and analytic transparency. However, areas of weakness included limited demographic detail, underreporting of variance estimates, and minimal control for confounders particularly in studies using archival or secondary datasets. These methodological inconsistencies must be considered when interpreting findings across the evidence base.

*Table 3. Critical Appraisal.*

| Quality rating | Papers | Strengths | Weaknesses |
|---|---|---|---|
| 22/22<br>1 (High) | Kerridge et al. 2017<br>Rodriguez-Seijas et al. 2023<br>Zimmerman et al. 2022 | Large diverse sample sizes; robust analytic methods; controlled for confounding variables; detailed reporting of results; conclusions are all supported by results. | None found using Qualsyst. |
| 21/22<br>0.95 (High) | Carsten et al. 2024<br>Reuter et al. 2016.<br>Rodriguez-Seijas et al. 2021 | Large diverse sample sizes; robust analytic methods; conclusions are all supported by results. | Minimal controls for confounding variables.<br>Or lack of detailed reporting of results. |
| 20/22<br>0.91 (High) | Cavale et al. 2024<br>Denning et al. 2022 | Clear objectives; appropriate study design; conclusions supported by results. | Small sample sizes; some missing data in reporting of results Minimal controls for confounding variables. |
| 15/22<br>0.68<br>(Moderate) | Wanta et al. 2019 | Clear research objective, Robust sample size, appropriate study design, detailed statistical methods and results reporting. | Limited control for confounding factors, Lack of variance estimates, Limited demographic detail, *potential miscalculations |

**Suspected limitation not included in the Qualsyst guidance.*

*Table 3* synthesises the strengths and weaknesses from the Qualsyst checklist into an overall appraisal rating. Eight studies were rated high quality (scores ≥ 0.90), with strong internal validity, appropriate statistical analyses, and well-supported conclusions. These include Kerridge et al. (2017), (Rodriguez-Seijas et al. (2023) and Zimmerman et al. (2022) who achieved perfect scores using the checklist. Carsten et al. (2024), Cavale et al. (2024), Reuter et al. (2016), Rodriguez-Seijas et al. (2021), and Denning et al. (2022), all received a high rating but with minor issues such as small sample size, lack of detailed reporting of statistics and limited reporting on confounders. The only study of moderate quality was Wanta et al. (2019) (score = 0.68), largely due to the use of EHR diagnostic codes. It is unclear what diagnostic process was undertaken, which may have resulted in miscalculations, lack of variance estimates, and limited demographic reporting.

Overall, the risk of bias across the included studies was moderate to low. Common strengths included use of validated BPD measures, transparent analytic strategies, and adequate sample descriptions. However, several studies lacked detailed demographic data, particularly relating to ethnicity, socioeconomic status, or intersectional identities, which may limit generalisability. In addition, only five studies explicitly controlled for confounding variables such as trauma history or comorbid conditions, and most relied on cross-sectional designs, introducing the potential for selection and recall bias. The absence of blinding in diagnostic assessments, particularly in studies using unstructured clinical interviews or electronic health records, further contributed to diagnostic bias risk. These methodological limitations should be considered when interpreting the strength and applicability of the findings.

*Table 4. Data extraction*

| Study (Author, Year) | Design / Country | Sample Details | Measure Used | BPD Diagnosis Rate (SM/ TGD vs. Control) | Key Statistical Results | Odds Ratios / Effect Sizes |
|---|---|---|---|---|---|---|
| Carsten et al. (2024) | Cross-sectional, USA | SM: 1,351; Het: 34,644 | AUDADIS -5 | SM: 15.1%; Het: 5.1% | $\chi^2 = 128.67$, $p < 0.001$ | Reported OR = 3.21 |
| Rodriguez-Seijas et al. (2021) | Population-based, USA | SM: 1,500; Het: 34,809 | AUDADIS -5 | Individual BPD criterion reported | **see Table 7.* | See Table 7. |
| Cavale et al. (2024) | Cross-sectional India | Gay: 45, Bi: 43, Het: 28 | BSL-23, MSI-BPD | MSI-BPD Scores (possible range: 0–10)<br>Gay: Mean = 3.84<br>Bisexual: Mean = 3.37<br>Heterosexual: Mean = 1.82.<br>BSL-23 scores (possible range: 0–92)<br>Gay: Mean = 21.78<br>Bisexual: Mean = 15.56<br>Heterosexual: Mean = 9.29 | $p < .017$ | Calculated Hedges g = 0.34 (Gay vs. Het), g= 0.26 (Bi v het)<br>BSL-23, g=2.08 (Gay vs. Het), g= 1.04 (Bi v het) |

| | | | | | | |
|---|---|---|---|---|---|---|
| Reuter et al. (2016) | Cross-sectional, USA | SM: 152; Het: 683 | BPFS-C | SM: 58.7 (mean); Het: 52.3 (mean) | t = 3.38, p = .001<br>t = -5.15, $\chi^2$ = 20.18 | Calculated Hedges g= 0.29 |
| Denning et al. (2022) | Cross-sectional, USA | SGD: 218;<br>Het/Cis: 809 | BPQ | SGD Mean: 35.69; Control Mean: 21.06 | t = 12.58 | Reported Cohen's d = 0.95<br>Calculated Hedges g= 0.96 |
| Kerridge et al. (2017) | Cross-sectional epidemiological survey / USA | N = 36,309 adults (NESARC-III); nationally representative non-institutionalized U.S. population; included: Het (96.7%) gay/lesbian (1.5%), bisexual | AUDADIS-5 | 12 months; Lifetime prevalence<br>Lesbian Women: 3.6%; 8.9%<br>Bisexual Women: 6.8%; 15.0%<br>"Not Sure" Women: 6.0%; 13.1%<br>Heterosexual Women: 1.1%; 2.9%<br>Gay Men: 1.6%; 4,5%<br>Bisexual Men: 2.1%; 6.1%<br>"Not Sure" Men: 2.6%; 6.7% | P value <.05 | Reported ORs<br>12month; Lifetime<br>Lesbian Women: 3.78; 3.38<br>Bisexual Women: 2.62; 2.62<br>Women "Not Sure": 3.3; 3.3 |

|  |  |  |  |  |  |  |
|---|---|---|---|---|---|---|
|  |  | (1.3%), and “not sure” (0.5%) orientations. |  | Heterosexual men 1.2% 2.5% |  | Gay Men 1.35 1.84<br>Bisexual Men 1.7 1.7<br>Men “Not Sure” 0.9 0.9 |
| Rodriguez-Seijas et al. (2023) | Clinical, USA | TGD: 200; Cis: 920 | SIDP-IV | TGD: 50%; Cis: 17.3% | $\chi^2 = 19.39$, $p < .0001$ | Reported OR = 4.05 (unadjusted) 2.98 (adj.) |
| Wanta et al. (2019) | EHR data, USA | Trans: 10,270; Cis: 53,449,400 | DSM-5 via EHR | Trans: 3.1%; Cis: 0.09% | Chi$^2$ $p < 0.0005$ | Calculated OR = 36 *estimate |
| Zimmerman et al. (2022) | Psychiatric sample, USA | TGD: 69; Cis: 2,143 | SCID | TGD: 36.2%; Cis: 18.8% | $t = 2.37$, $p = .02$ | Calculated OR = 1.87 |

***Key**: SM= Sexual minority, TGD= Transgender or Gender diverse, SGD Sexual minority or Gender diverse, Het= Heterosexual, Cis= Cisgender (Born and identify as the same gender).*

*Table 4* presents the core characteristics of the studies included in the synthesis. Most studies relied on cross-sectional designs and USA based samples. A range of psychometric measures were used and are explored within *table 8.*

Across these studies, sexual and gender minority (SGM) participants were found to have higher rates of BPD diagnoses or elevated symptom severity compared to cisgender and/or heterosexual controls.

Several studies, (Carsten et al. 2024, Denning et al. 2022, Kerridge et al. 2017 and Rodriguez-Seijas et al. 2023) reported the effect sizes. However, the reported or calculated ORs (calculated using percentages, events, means, estimated standard deviations based on t-test data) ranged from 0.9 to 4.05, with one study estimating an OR as high as 36 in large-scale EHR data (Wanta et al., 2019). Whilst the cisgender diagnostic rate of 0.09% reported by Wanta et al. (2019) appears lower than in other studies (e.g., 17.3% Rodriguez-Seijas et al., 2023; 18.8% Zimmerman et al., 2022), the sample size is considerably larger at over 54 million and it is unclear if this was a mental health service user population or general population. However, the reported rate appears lower than known prevalence rates so should be interpreted with caution.

Hedges g effect sizes ranged from a small (0.26) to very large (2.08) effect size when comparing between-group samples. The reported comparative data seemed to highlight a substantial disparity in diagnostic patterns. However, few studies adjusted for confounding variables, limiting the ability to draw causal inferences.

## Q1. Are minority sexualities and gender identities diagnosed with BPD at a differential rate than heteronormative groups?

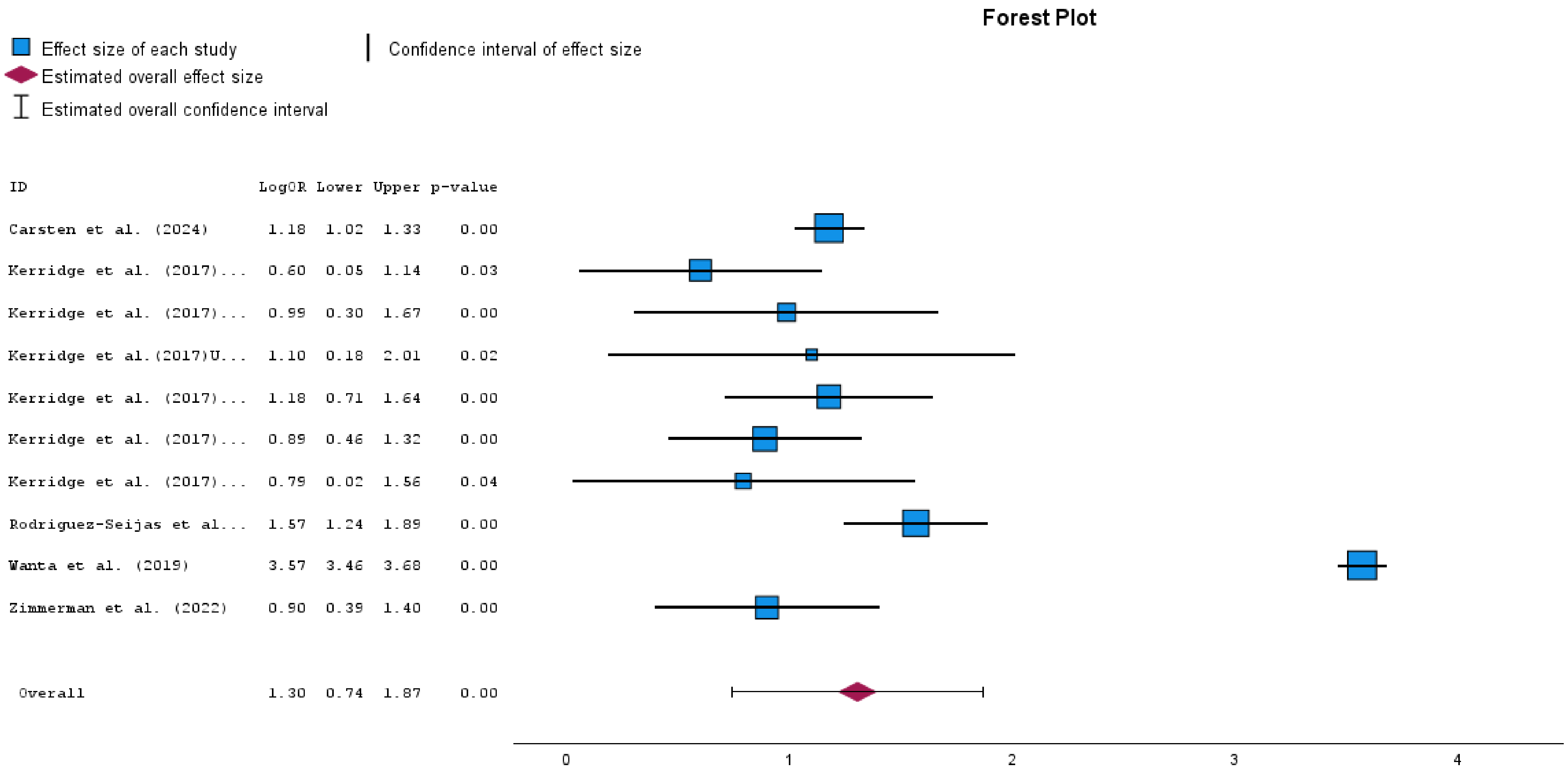
As shown in Table 4, Across nine cross-sectional studies (N ≈ 116 –53 million), SGM participants consistently exhibited higher BPD diagnosis rates (3.1–58.7%) than heterosexual/cisgender controls (0.09–21.1%). Effect sizes ranged from OR = 1.76 up to an estimated OR ≈ 36, with continuous measures yielding Hedges' g = 0.26–2.08. Meta-analytic pooling (*Figure 2*) confirmed a significant overall effect (logOR = 1.30, 95% CI [0.74, 1.87], p = .001; OR ≈ 3.67) alongside substantial heterogeneity (Q = 869.50, p < .001).

Five studies, Carsten et al. (2024), Kerridge et al. (2017), Rodriguez-Seijas et al. (2023) Wanta et al. (2019) and Zimmerman et al. (2022) provided percentages of SGM groups diagnosed with BPD compared to heterosexual or cisgender controls, these were converted into numerical data for the purpose of meta-analysis, *see table 5.*

*Table 5. Rates of BPD diagnosis in each paper (event counts).*

| Study | SGM groups | Control group |
|---|---|---|
| Carsten et al. (2024) | Diagnosed- 204<br>Not Dx- 1147 | Diagnosed- 1801<br>Not Dx- 32842 |
| Kerridge et al. (2017) | **Gay men**<br>Diagnosed- 14<br>Not Dx-300 | **Heterosexual men**<br>Diagnosed-423<br>Not Dx- 16502 |
| | **Bisexual men**<br>Diagnosed-9<br>Not Dx-131 | |
| | **Unsure men**<br>Diagnosed-5<br>Not Dx-65 | |
| | **Lesbian women**<br>Diagnosed- 20<br>Not Dx-206 | **Heterosexual women**<br>Diagnosed-528<br>Not Dx- 17632 |
| | **Bisexual women**<br>Diagnosed- 23<br>Not Dx-316 | |
| | **Unsure women**<br>Diagnosed-7<br>Not Dx-106 | |
| Rodriguez-Seijas et al. (2023) | Diagnosed- 100<br>Not Dx-100 | Diagnosed-159<br>Not Dx-761 |
| Wanta et al. (2019 | Diagnosed-318<br>Not Dx- 9952 | Diagnosed- 48104<br>Not Dx- 53401295 |
| Zimmerman et al. (2022) | Diagnosed -25<br>Not Dx-44 | Diagnosed-403<br>Not Dx- 1740 |

*Figure 2. Forest Plot for binary data Meta-analysis based on Odd Ratios.*



| ID | LogOR | Lower | Upper | p-value |
|---|---|---|---|---|
| Carsten et al. (2024) | 1.18 | 1.02 | 1.33 | 0.00 |
| Kerridge et al. (2017)... | 0.60 | 0.05 | 1.14 | 0.03 |
| Kerridge et al. (2017)... | 0.99 | 0.30 | 1.67 | 0.00 |
| Kerridge et al.(2017)U... | 1.10 | 0.18 | 2.01 | 0.02 |
| Kerridge et al. (2017)... | 1.18 | 0.71 | 1.64 | 0.00 |
| Kerridge et al. (2017)... | 0.89 | 0.46 | 1.32 | 0.00 |
| Kerridge et al. (2017)... | 0.79 | 0.02 | 1.56 | 0.04 |
| Rodriguez-Seijas et al... | 1.57 | 1.24 | 1.89 | 0.00 |
| Wanta et al. (2019) | 3.57 | 3.46 | 3.68 | 0.00 |
| Zimmerman et al. (2022) | 0.90 | 0.39 | 1.40 | 0.00 |
| Overall | 1.30 | 0.74 | 1.87 | 0.00 |

Model: Random-effects model
Heterogeneity: Tau-squared = 0.75, H-squared = 32.61, I-squared = 0.97

*Figure 2* presents results from a random-effects meta-analysis comprised of five studies with ten comparative groups. These findings show that sexual and gender minority (SGM) participants were significantly more likely to receive a diagnosis of borderline personality disorder (BPD) than heteronormative (heterosexual and cisgender) individuals. The pooled log odds ratio was 1.30, 95% CI [0.74, 1.87], $p$ = .001, corresponding to an odds ratio of approximately 3.67. Between-study heterogeneity was substantial, Q(9) = 869.50, p < .001; $\tau^2$ = 0.75 and $I^2$ = 97.0%, suggesting considerable variability in measurement approaches and sample characteristics across the included studies. However, Wanta et al. (2019) study was identified as an outlier due to its disproportionately high event rate, which may be an indication of real world diagnostic practices as the data was taken from electronic health records.

As percentages were not uniformly reported across studies, three included studies, Cavale et al. (2024), Reuter et al. (2016) and Denning et al. (2022) comparing BPD symptom severity between sexual and gender minority (SGM) individuals and heterosexual/cisgender controls led to Hedges g effect size calculated from available summary data (means, t-values). This included separate effect sizes for both gay and bisexual subgroups compared to heterosexuals, utilising both measures, within Carvale et al. *See table 6.*

*Table 6. Effect sizes across comparative groups*

| Paper | Effect size |
|---|---|
| Cavale et al. (2024) | **MSI-BP** Hedges g = 0.34 (Gay vs. Het), g= 0.26 (Bi v het)<br>**BSL-23**, g=2.08 (Gay vs. Het), g= 1.04 (Bi v het), |
| Reuter et al. (2016) | Hedges g= 0.29 (SM vs Het) |
| Denning et al. (2022 | Hedges g= 0.96 (SGD v Het) |
| Pooled effect size from all comparative groups = **0.83**. | |

All effect sizes were positive, indicating consistently higher symptom scores among SGM groups. The pooled effect size was large (**0.83**) and statistically significant, with confidence intervals not crossing zero, suggesting a robust overall difference in symptom severity favouring disproportionate BPD-related outcomes among SGM populations. However, the need for estimations introduces a degree of inferential uncertainty to due to standard deviations being unavailable.

Rodriguez-Seijas et al. (2021) provided odds ratios for individual criterion, i.e. avoid abandonment, authors were unable to provide overall diagnostic rates when contacted. Therefore, they have been omitted from this question's meta-analysis. However, percentages and odds ratios were combined for each endor criterion to illustrate between-group disparities, see *Table 7.*

*Table 7. Criterion Disparities in Rodriguez-Seijas et al. (2021)*

| **Criterion Domain** | **# Items** | **Heterosexual (%)** | **SM (%)** | **Adjusted Heterosexual (%)** | **Adjusted SM (%)** | **OR (Unadjusted)** | **OR (Adjusted)** |
|---|---|---|---|---|---|---|---|
| **1. Efforts to avoid abandonment** | 2 | 6.14 | 12.41 | 2.60 | 4.14 | 2.17 | 1.62 |
| **2. Unstable relationships** | 1 | 19.17 | 26.05 | 11.31 | 12.92 | 1.49 | 1.16 |
| **3. Identity disturbance** | 4 | 7.90 | 12.54 | 4.94 | 7.76 | 1.67 | 1.62 |
| **4. Impulsivity** | 3 | 14.01 | 24.21 | 9.03 | 16.38 | 1.96 | 1.97 |
| **5. Suicidality/Self-injury** | 2 | 2.63 | 7.55 | 0.94 | 2.47 | 3.02 | 2.67 |
| **6. Affective instability** | 1 | 9.23 | 14.33 | 3.88 | 4.98 | 1.64 | 1.30 |
| **7. Emptiness** | 1 | 9.41 | 13.44 | 5.02 | 5.54 | 1.49 | 1.11 |
| **8. Intense anger** | 3 | 10.61 | 15.10 | 4.88 | 5.06 | 1.50 | 1.04 |
| **9. Paranoid ideation** | 1 | 12.12 | 21.40 | 6.98 | 11.14 | 1.97 | 1.67 |

*Table 7* illustrated a clear disparity in the percentages of sexual minorities that meet the diagnostic threshold for each item. Adjusted odds ratios for diagnostic criterion range from 1.04 (intense anger) to 2.67 (suicidality/ self-harm). This may be due to an increase in severity in BPD traits among minority sexualities but may also be indicative of issues with the AUDADIS-5 measure. This is explored further in the next section.

## Q2. How are BPD traits measured within these studies?

*Table 8. Measures Data extraction*

| **Measure used** | **Studies Using This Measure** | **Psychometric Properties** | **Measures Normative Sample** |
|---|---|---|---|
| AUDADIS-5 (Alcohol Use Disorder and Associated Disabilities Interview Schedule - DSM-5) | Carsten et al. (2024),<br>Kerridge et al. (2017)<br>Rodriguez-Seijas et al. (2021) | Cronbach's α = 0.86; Confirmatory Factor Analysis and logistic regression support construct validity | U.S. adults (N ≈ 35–36K); diverse demographics (Grant et al.2015) |
| MSI-BPD (McLean Screening Instrument for BPD) | Cavale et al. (2024) | Cronbach's α = 0.74; Spearman's ρ = 0.72 ($p < .0001$); evidence of internal consistency and criterion validity | Adults aged 18–65 from clinical and community settings; original validation included psychiatric outpatients and inpatients (Zanari et al. 2003) * |
| BSL-23 (Borderline Symptom List – 23) | Cavale et al. (2024) | Cronbach's α = 0.935–0.969; High construct validity (r = 0.958–0.963 vs. BSL-95) | German adults with BPD (n = 241), clinical controls (n = 176), and healthy controls (n = 356). (Kleindienst et al., 2020) * |
| BPFS-C (Borderline Personality Features Scale for Children) | Reuter et al. (2016) | Cronbach's α = 0.86; Regression analysis supports construct validity | 400 U.S. children (grades 4–6), 54% female. (Crick et al., 2005) |
| BPQ (Borderline Personality Questionnaire) | Denning et al. (2022) | Cronbach's α ≥ 0.92; KR-20 = 0.51–0.89 (subscales); Strong internal consistency and structural validity | U.S. undergraduate and community samples; original validation included 1,000+ adults from diverse backgrounds. (Poreh et al., 2006) |
| SIDP-IV (Structured Interview for DSM-IV Personality Disorders) | Rodriguez-Seijas et al. (2023)<br>Zimmerman et al. (2022) | Cohen's κ > 0.80; High inter-rater reliability | U.S. clinical and community samples; validated in psychiatric patients and general population. (Pfohl et al., 1997) |

| | | | |
|---|---|---|---|
| PID-5 BF (Personality Inventory for DSM-5 – Brief Form) | Rodriguez-Seijas et al. (2023) | Cronbach's α > 0.80 across domains | Representative U.S. adult sample (N = 2,065); also compared to community and clinical samples. (Krueger et al., 2012) |
| SCID (Structured Clinical Interview for DSM-IV) | Zimmerman et al. (2022) | K coefficients: 0.83–1.0; High inter-rater reliability | Community and clinical samples; SCID-I/NP designed for general population, SCID-I/P for psychiatric patients. (First et al., 2015) |
| DSM-5 Diagnosis, coded via EHR | Wanta et al. (2019) | Not reported | "Real world" representation. |

* Cavale et al. (2024) directly compared the MSI-BPD and BSL-23 among Indian gay, bisexual, and heterosexual men.

Across the included studies, BPD traits were assessed using a range of psychometrically established tools, including structured clinical interviews, self-report screeners, and dimensional trait measures.

Across the nine included studies, a range of diagnostic and screening tools were utilised to assess BPD traits, as detailed in *Table 8*. The most frequently used measure was the AUDADIS-5, appearing in three studies, followed by structured clinical interviews such as the SCID, SIDP-IV, and DSM-coded EHR data, each used in one to two studies. Self-report screening tools including the MSI-BPD, BSL-23, BPFS-C, and BPQ were utilised, though less frequently and typically in smaller, non-clinical samples.

Wanta et al. (2019) reports diagnostic rates as measured through DSM-5-based diagnostic codes via electronic health records. This glimpse into "real world" diagnostic rates utilising clinical judgement highlights a correlation to significant over representation in BPD diagnosis amongst SGM, However it is unclear whether any diagnostic measures where utilised.

All tools demonstrated high internal consistency within general population samples, with reported Cronbach's alpha values ranging from 0.74 to 0.97.

However, none of the measures in these studies were normed specifically on sexual or gender minority populations. Most were developed and validated on predominately heteronormative samples, limiting their population validity in SGM contexts. Measures such as the AUDADIS-5, SIDP-IV and SCID, while demonstrating excellent inter-rater reliability in general samples, may conflate normative expressions of minority stress with borderline symptomatology in SGM individuals, threatening content and face validity.

However, one study offered direct psychometric evaluation in a sexual minority sample, indicating a substantial gap in measurement equity. Cavale et al. (2024) directly compared the MSI-BPD and BSL-23 among Indian gay, bisexual, and heterosexual men. The findings suggest both tools performed consistently across sexual orientations, with positive correlations between the two measures with no significant associations with sexual orientation concealment (SOC) or demographic variables. This suggests face and construct validity for use in minority sexuality and gender identity groups, though the authors note the need for broader validation in larger, more diverse samples.

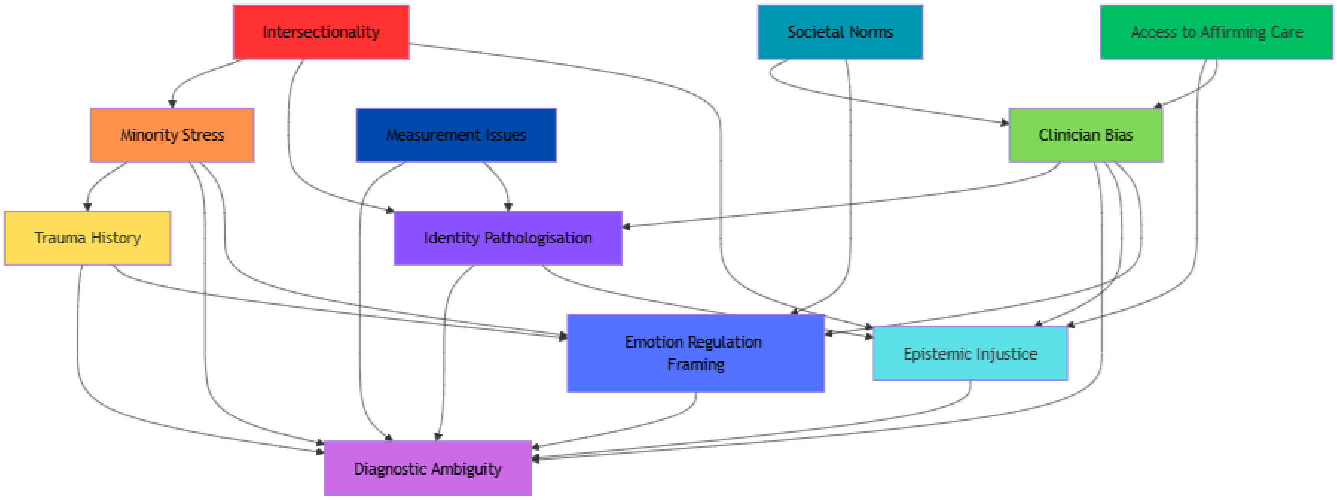
## Q3. What factors do researchers consider may influence the diagnoses of BPD amongst minority sexualities and gender identities?

*Table 9. Conceptual Matrix*

| Conceptual Factor. | Description. | No of studies. | Studies that feature it. |
|---|---|---|---|
| **Minority Stress** | Stress from experiences of stigma, discrimination and/or marginalisation which manifests as BPD criterion. | 9 | All included studies |
| **Trauma History** | Early experiences of abuse and/ or trauma as a confounding factor | 7 | Reuter et al. (2016), Rodriguez-Seijas et al. (2021), Rodriguez-Seijas et al. (2023), Zimmerman et al. (2022), Carsten et al. (2024), Cavale et al. (2024), Denning et al. (2022), Wanta et al. (2019) |
| **Diagnostic Ambiguity** | Overlap between identity development, minority stress and BPD traits. | 6 | Rodriguez-Seijas et al. (2023), Zimmerman et al. (2022), Carsten et al. (2024), Cavale et al. (2024), Denning et al. (2022), Wanta et al. (2019) |
| **Clinician Bias** | Clinician’s assumptions or stereotypes influence their perceptions of client’s distress/ symptomology. | 5 | Rodriguez-Seijas et al. (2021), Rodriguez-Seijas et al. (2023), Carsten et al. (2024), Cavale et al. (2024), Denning et al. (2022) |
| **Emotion Regulation Framing** | How emotional expression is interpreted through gendered or cultural | 5 | Rodriguez-Seijas et al. (2021), Rodriguez-Seijas et al. (2023), Carsten et al. (2024), Cavale |

| | | | |
|---|---|---|---|
| | lenses. | | et al. (2024), Denning et al. (2022 |
| **Identity Pathologisation** | Framing LGBTQ+ identities as unstable or symptomatic. | 5 | Rodriguez-Seijas et al. (2021), Rodriguez-Seijas et al. (2023), Carsten et al. (2024), Cavale et al. (2024), Denning et al. (2022) |
| **Societal Norms** | Cultural expectations influencing symptom interpretation. | 5 | Rodriguez-Seijas et al. (2021), Kerridge et al. (2017), Carsten et al. (2024), Cavale et al. (2024), Denning et al. (2022) |
| **Measurement Issues** | Concerns about diagnostic tools not being validated for LGBTQ+ populations. | 4 | Rodriguez-Seijas et al. (2021), Rodriguez-Seijas et al. (2023), Carsten et al. (2024), Denning et al. (2022) |
| **Intersectionality** | Overlapping identities (e.g., race, gender, sexuality) shaping experiences of adversity and oppression. | 4 | Rodriguez-Seijas (2021), Kerridge et al. (2017), Carsten (2024), Cavale (2024) |
| **Epistemic Injustice** | Dismissal of lived experience in clinical interpretation. | 3 | Rodriguez-Seijas et al. (2021), Carsten et al. (2024), Cavale et al. (2024) |
| **Access to Affirming Care** | Availability of culturally competent providers | 2 | Carsten (2024), Cavale (2024) |

*Figure 3. Semantic network. (Mermaid Live Editor).*



In line with Prior's (2020) guide, the conceptual framework was based on several identified mechanisms that may interact and impact the emergence of BPD specific traits. A content analysis of the introduction and discussion sections of each included paper revealed a strong consensus among researchers that concepts such as *minority stress*, *trauma history*, and *diagnostic ambiguity* may influence diagnostic outcomes for LGBTQ+ populations, however, the frequency and depth of these discussions varied. The findings were synthesised into a conceptual matrix, *Table 9*, that visually demonstrates the distribution of these factors across studies with *Figure 3* illustrating the interconnections of each concept within the semantic network.

*Minority stress* and *trauma history* emerged as the most consistently discussed influences, appearing in all or nearly all studies. Authors discussed the correlation between higher instances of trauma and minority stress amongst sexual and gender minorities acknowledging experiences of adversity and trauma-related symptomology as a potential confounding factor in the overrepresentation of BPD diagnoses among sexual and gender minorities.

*Clinician bias* and *measurement issues* were also prevalent, with several authors highlighting concerns about the appropriateness of diagnostic tools and the impact of a clinician's assumptions.

Notably, *intersectionality*, *emotion regulation framing*, and *identity pathologisation* featured prominently in more recent studies, Rodriguez-Seijas (2021), Carsten (2024), Cavale (2024), indicating a growing awareness of how overlapping identities, heteronormative expectations and cultural norms may shape both symptom interpretation and diagnostic outcomes. Despite this awareness of inequality and marginalisation of minority groups, the authors less frequently acknowledged factors such *access to affirming care* and *epistemic injustice*, suggesting gaps in current research regarding systemic and structural contributors to diagnostic disparities.

## Researcher Reflexivity

Throughout this systematic review, my stance has been greatly informed by my understanding of minority stress, intersectionality, and critical identity theory. These frameworks allowed me to examine the in BPD, with a focus on the unique experiences of minority sexualities and gender identities. Integrating these perspectives allowed me to investigate how intersecting identities and minority stress influences the manifestation and understanding of identity disturbance within the evidence base. I was also aware of the impact societal norms and historical pathologies of homosexuality and gender may inadvertently impact both clinician's judgements and diagnostic biases. These approaches alongside reflective practice and consultation with my supervisor ensured a nuanced and objective analysis.

## Discussion

This review aimed to explore whether sexual and gender minority (SGM) individuals are disproportionately diagnosed with borderline personality disorder (BPD) compared to heteronormative populations, it sought to evaluate the measures used in these assessments and examine the factors researchers suggest may influence such diagnostic outcomes.

### Diagnostic disparity and symptom severity

Across nine studies of varying scale and design, SGM individuals were found to be diagnosed with BPD at significantly higher rates than control groups. Reported odds ratios ranged from small to extremely large, with Wanta et al. (2019) estimating a 36-fold increase based on EHR data. Whilst this may reflect the impact of real-world clinical judgement in diagnostic processes, a reliance on unstructured interviews was associated with significantly higher BPD rates compared to structured tools (Ford & Courtois, 2021) which may impact Wanta et al. (2019) findings as diagnostic processes were not reported. A random-effects model was utilised to reduce the disproportionate influence of its unusually high odds ratio derived from large-scale EHR data and situating it within the broader variability across different diagnostic methods and sample characteristics.

Meta-analytic synthesis of five studies supported this disparity, producing a pooled OR of approximately 3.67. Symptom severity was also consistently higher among SGM groups, with a large overall effect size (g = 0.83) across available comparisons. While this closely aligns with studies throughout the evidence base, some studies attempted to account for confounding factors, such as trauma or comorbidity, most did not control for these variables in detail. This limits the extent to which we can determine whether disparities are driven by true clinical need or shaped by external factors such as minority stress or diagnostic practices. Moreover, the small number of included studies and high between-study heterogeneity indicate caution is needed when generalising from these findings.

### Issues with assessment measures.

A range of measures were used to assess BPD traits, including structured clinical interviews, standardised questionnaires and self-report measures. Most demonstrated good internal reliability and construct validity in general populations. However, none were normed specifically on SGM samples, and only one study (Cavale et al., 2024) explicitly examined the performance of measures across different sexualities.

This presents a serious issue in terms of population validity. Measures developed for majority groups may not capture the nuances of identity exploration, cultural expression, or minority stress that influence SGM presentations. As a result, normative responses to adversity, such as identity questioning, emotional framing, or relationship instability, may be misconstrued as pathological. This correlates with concerns raised by Nyquist Potter (2013) and others that psychiatry has historically pathologised deviation from social norms.

The reliance on measures like the AUDADIS-5 and SIDP-IV, though reliable, may increase the risk of conflating lived experiences of marginalisation with traits such as emotional dysregulation or unstable identity. Even measures with strong psychometrics may fail to distinguish between trauma-related distress and true personality disorder features, especially in contexts where gender expression or sexual orientation is stigmatised.

### Diagnostic ambiguity, and clinician assumptions

While inter-rater reliability studies suggest moderate agreement (Zanarini et al., 2011), criticisms remain regarding the construct validity of BPD, especially its overlap with trauma responses (Ford & Courtois, 2021). LGBTQ+ individuals may exhibit emotional distress, and identity shifts due to societal pressures, which clinicians may misinterpret as pathological instability rather than adaptive coping (Hall et al., 2021; Porter, 2023). Clinicians may also misinterpret the adaptive behaviours of LGBTQ+ individuals, such as changing their appearance for safety reasons or an expression of their changing gender, as pathological identity disturbance. These disparities provide a strong rationale for the presence of a disorder and often result in higher rates of BPD diagnoses in LGBTQ+ populations compared to their heterosexual counterparts. Eubanks-Carter & Goldfried’s (2006) vignette-based study demonstrated the impact of clinician’s own perceptions and biases on diagnosis rates; 61% of men perceived as a “strong likelihood of being gay or bisexual” were more likely to be diagnosed compared to only 36% of men perceived as “likely heterosexual”. This is in keeping with wider findings found which showed there is a high risk of gender and cultural biases informing clinician's assessments and subsequent decision making about diagnosis (Nyquist Potter, 2013).

### Minority stress

A recurring theme across the studies was the impact of minority stress on diagnostic outcomes.  Minority stress is chronic psychological strain experienced by individuals from marginalised sexual orientations and gender identities, resulting from exposure to external stressors such as discrimination and rejection.  All included studies referred to this framework, highlighting how chronic exposure to discrimination, rejection, and systemic marginalisation can lead to internalised shame, dysregulated emotion, and difficulties with relationships traits that closely overlap with BPD criteria. Importantly, these responses may be adaptive or situational, particularly in contexts where identity concealment is necessary for safety or acceptance.

This aligns with Hall et al. (2021) and Porter (2023) findings that show significant oppression, minority stress and societal pressures, which can lead to stress responses such as shame that exacerbate identity disturbance. Stressors including repeated experiences of systemic discrimination as well as external and internalised homophobia or transphobia, can lead to maladaptive coping strategies or behaviours that resemble BPD symptoms. Whilst this intersection of sexual orientation or gender identity with BPD symptoms is complex. Several included papers also discussed this intersection of sexual orientation, or gender identity, with BPD symptoms and how LGBTQ+ individuals might present behaviours that align with BPD criteria due to the challenges of navigating their identities in a heteronormative society. This includes impulsivity, affective instability, and intense relationships, which can be responses to the challenges of coming out and societal rejection.

### Intersectionality and cultural norms

While minority stress and diagnostic ambiguity were well represented, only a few studies meaningfully considered intersectionality, the way multiple aspects of identity (e.g., race, class, gender) shape experience. This is a significant gap given evidence that individuals with multiple marginalised identities are at greater risk of misdiagnosis and negative outcomes (Barnett et al., 2019; Crenshaw, 1989, cited in Morgan et al., 2004). Most samples were drawn from white, Western populations, limiting generalisability to global and ethnically diverse contexts.

Fernando (2017) critiques Western psychiatric frameworks for failing to account for cultural context within diagnoses. The study cites research showing that Black individuals in crisis are disproportionately diagnosed with psychotic disorders, often due to clinician bias and cultural misunderstandings. The pathologisation of Black individuals' expressions of distress, suggest a broader pattern of cultural biases and need for greater awareness of how intersectional experiences of oppression and discrimination are shaped by the interconnectedness of multiple social identities, such as race, gender, class, and sexuality, which should not be contextualised in isolation from one another within psychiatric assessment. (Crenshaw, 1989, cited in Morgan et al., 2004; Barnett et al., 2019). This parallels this review's findings that a culmination of heteronormative societal norms, outdated psychiatry practices and minority stress factors directly influence the high prevalence of BPD diagnoses amongst minority sexualities and gender identities. It illustrates a need for increased cultural competency within the assessment process for psychiatric conditions, particularly when supporting a diverse population that encompasses minority groups.

## Strengths and Limitations

This systematic review was conducted following PRISMA 2020 guidelines and has notable strengths, including a comprehensive search strategy conducted across multiple databases and the use of an inclusive range of terms to ensure a broad evidence base. The involvement of EbE ensured the research focus is relevant and appropriate whilst also demonstrating sensitivity to LGBTQ+ experiences. The use of the QualSyst tool for quality appraisal as well as input from an external researcher ensures a systematic and transparent evaluation of included studies, with a PRISMA diagram enhancing transparency in study selection. The mix of quantitative and qualitative analysis provides a rich exploration into the topic and fully answers each research question.

However, there are limitations within this review. Firstly, many of the included studies lacked detailed reporting of outcomes such as the statistical data needed for a full meta-analysis. The lack of longitudinal data also limits understanding of causation or long-term implications. Additionally, the exclusion of non-English and grey literature may limit the global relevance of findings, while the focus on white, Anglosphere perspectives reduce applicability to global contexts. Despite these issues, the review highlights critical gaps and advocates for improved care and research in this area.

## Implications

The included studies highlight the importance of culturally competent care and the need for ongoing research to better understand the unique experiences of LGBTQ+ individuals with BPD. The impact of historical discrimination and minority stress highlight that there is a critical need for mental health professionals to provide affirmative and informed care to LGBTQ+ individuals. This includes understanding the unique stressors they face and differentiating between normative identity exploration and pathological identity disturbance. Further research should be undertaken to explore the validity of BPD measures for SGM populations and possible development of a more intersectional framework. Further training is needed to support clinicians to recognise their own biases to perpetuate stigma, avoid misdiagnosis and provide affirmative, person-centred care.

# References

Barnett, P., Mackay, E., Matthews, H., Gate, R., Greenwood, H., Ariyo, K., Bhui, K., Halvorsrud, K., Pilling, S., & Smith, S. (2019). Ethnic variations in compulsory detention under the Mental Health Act: A systematic review and meta-analysis of international data. *The Lancet Psychiatry, 6*(4), 305–317. https://doi.org/10.1016/S2215-0366(19)30027-6

Cano-Gonzalez, I., Charak, R., Ronzón-Tirado, R., & Cantu, J. I. (2025). The role of complex posttraumatic stress disorder in the associations between minority stressors and self-reported suicide likelihood in LGBTQ+ adults. *Traumatology, 31*(1), 45–55. https://doi.org/10.1037/trm0000488

Carsten E.E., Bornovalova M. & Rodriguez-Seijas C. (2024). An evaluation of measurement invariance of Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition borderline personality disorder criteria across heterosexual, lesbian, gay, and bisexual adults. Personality disorders, 15(6), 436-445. https://doi.org/10.1037/per0000696

Cavale J., Singh D.C. & Hemchand L. (2024). Comparison of two screening tools for borderline personality disorder (BSL-23 and MSI-BPD) among Indian gay, bisexual, and heterosexual men. Journal of Men's Health, 20(12), 92-105. https://doi.org/10.22514/jomh.2024.204

Centre for Reviews and Dissemination. (2009). *Systematic Reviews: CRD's guidance for undertaking reviews in health care*. University of York. ISBN 978-1-900640-47-3

Crick, N. R., Murray-Close, D., & Woods, K. (2005). Borderline personality features in childhood: A short-term longitudinal study. *Development and Psychopathology, 17*(4), 1051–1070. https://doi.org/10.1017/S0954579405050492

Denning, D. M., Newlands, R. T., Gonzales, A., & Benuto, L. T. (2022). Borderline Personality Disorder Symptoms in a Community Sample of Sexually and Gender Diverse Adults. *Journal of personality disorders*, *36*(6), 701–716. https://doi.org/10.1521/pedi.2022.36.6.701

Eubanks-Carter, C. and Goldfried, M.R. (2006), The impact of client sexual orientation and gender on clinical judgments and diagnosis of borderline personality disorder. J. Clin. Psychol., 62: 751-770. https://doi.org/10.1002/jclp.20265

Fernando, S. (2017). *Institutional racism in psychiatry and clinical psychology: Race matters in mental health*. Palgrave Macmillan

First, M. B., Williams, J. B. W., Karg, R. S., & Spitzer, R. L. (2015). *Structured Clinical Interview for DSM-5 Disorders, Clinician Version (SCID-5-CV)*. American Psychiatric Association Publishing.

Ford, J. D., & Courtois, C. A. (2021). Complex PTSD and borderline personality disorder. *Borderline Personality Disorder and Emotion Dysregulation, 8*(1), 16. https://doi.org/10.1186/s40479-021-00155-9

Grant, B. F., Chu, A., Sigman, R., Amsbary, M., Kali, J., Sugawara, Y., Tan, L., & Goldstein, R. (2015). *National Epidemiologic Survey on Alcohol and Related Conditions–III (NESARC-III): Source and accuracy* *statement*. National Institute on Alcohol Abuse and Alcoholism. https://www.niaaa.nih.gov/research/nesarc-iii

Hall, W. J., Dawes, H. C., & Plocek, N. (2021). *Sexual Orientation Identity Development Milestones Among Lesbian, Gay, Bisexual, and Queer People: A Systematic Review and Meta-Analysis*. Frontiers in Psychology, 12, 753954. https://doi.org/10.3389/fpsyg.2021.753954

Hatzenbuehler, M. L. (2009). How does sexual minority stigma "get under the skin"? A psychological mediation framework. *Psychological Bulletin, 135*(5), 707–730. https://doi.org/10.1037/a0016441

Hectors, A. (2023). *Homosexuality in the DSM: A Critique of Depathologisation and Heteronormativity*. New Zealand Sociology Special Issue: Theorising Mental Health, 38(1), 18-28.

Hurt, S. W., & Brown, R. (1984). Reliability of criteria for borderline personality disorder: a comparison of DSM-III and the Diagnostic Interview for Borderline Patients. *Am J Psychiatry*, *141*(9).

Kerridge, B. T., Pickering, R. P., Saha, T. D., Ruan, W. J., Chou, S. P., Zhang, H., Jung, J., & Hasin, D. S. (2017). Prevalence, sociodemographic correlates and DSM-5 substance use disorders and other psychiatric disorders among sexual minorities in the United States. *Drug and Alcohol Dependence, 170*, 82–92. https://doi.org/10.1016/j.drugalcdep.2016.10.038

Kleindienst, N., Jungkunz, M., Bohus, M., & Limberger, M. F. (2020). Psychometric evaluation of the Borderline Symptom List, short form (BSL-23) in a sample of patients with borderline personality disorder. *BMC Psychiatry, 20*, Article 411. https://doi.org/10.1186/s12888-020-02811-4

Kmet, L. M., Lee, R. C., & Cook, L. S. (2004). Standard quality assessment criteria for evaluating primary research papers from a variety of fields. Edmonton: Alberta Heritage Foundation for Medical Research (AHFMR). AHFMR - HTA Initiative #13

Krueger, R. F., Derringer, J., Markon, K. E., Watson, D., & Skodol, A. E. (2012). Initial construction of a maladaptive personality trait model and inventory for DSM-5. *Psychological Medicine, 42*(9), 1879–1890. https://doi.org/10.1017/S0033291711002674

Kusmaul, N., Wallace, B. H., Cheon, J. H., & Sundborg, S. (2022). Implementation of Trauma-Informed Care in Nursing Home Settings. *Journal of the American Medical Directors Association*, *23*(9), 1505-1506.

Lilienfeld, S. O., Wood, J. M., & Garb, H. N. (2000). The Scientific Status of Projective Techniques. *Psychological Science in the Public Interest*, *1*(2), 27-66. https://doi.org/10.1111/1529-1006.002

Hernandez Mozo E., Siegel J.A., Jones I.J., Rivera D.B. & Blashill A.J. (2025). The association between minority stressors, intraminority stressors, and borderline personality disorder symptomatology among sexual minority men. Personality disorders, 16(2), 193-197. https://doi.org/10.1037/per0000705

Marchi M, Travascio A, Uberti D, et al. Post-traumatic stress disorder among LGBTQ people: a systematic review and meta-analysis. *Epidemiology and Psychiatric Sciences*. 2023;32:e44. doi:10.1017/S2045796023000586

Morgan, C., Mallet, R., Hutchinson, G., & Leff, J. (2004). Negative pathways to psychiatric care and ethnicity: The bridge between social science and psychiatry. *Social Science & Medicine, 58*(4), 739–752. https://doi.org/10.1016/S0277-9536(03)00233-8

Nyquist Potter, Nancy. (2013) *Mapping the Edges and the In-between: A critical analysis of Borderline Personality Disorder*, International Perspectives in Philosophy & Psychiatry (Oxford, 2009; online edn, Oxford Academic, 1 Feb. 2013), https://doi.org/10.1093/med/9780198530213.001.0001, accessed 5 Dec. 2024.

New, A. S., & Triebwasser, J. (2018). A history of borderline personality disorder. In B. Stanley & A. S. New (Eds.), *Borderline personality disorder* (pp. 1–16). Oxford University Press. https://doi.org/10.1093/med/9780199997510.001.0001

Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. (2020) The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *PLOS Medicine* [Online]. 2021 [cited 2022 Feb 22];18(3):e1003583 [15p.]. Available from: https://doi.org/10.1371/journal.pmed.1003583

Pfohl, B., Blum, N., & Zimmerman, M. (1997). *Structured Interview for DSM-IV Personality: SIDP-IV*. American Psychiatric Press.

Poreh, A. M., Rawlings, D., Claridge, G., Freeman, J. L., Faulkner, H., & Shelton, C. (2006). The BPQ: A scale for the assessment of borderline personality based on DSM-IV criteria. *Journal of Personality Disorders, 20*(3), 247–260. https://doi.org/10.1521/pedi.2006.20.3.247

Porter, C., Palmier-Claus, J., Branitsky, A., Mansell, W., Warwick, H., & Varese, F. (2019). Childhood adversity and borderline personality disorder: A meta-analysis. Acta Psychiatrica Scandinavica, 141(1), 6–20. https://doi.org/10.1111/acps.13118

Porter, H. (2023). It’s not my sense of self that’s unstable, it’s the world’s sense of me: the harms of the construct of ‘personality disorders’ towards transgender communities. *Journal of Psychosocial Studies,* 16(2), 135-148. Retrieved Dec 18, 2024, from https://doi.org/10.1332/147867321X16862

Prior, Lindsay (2020). *Content Analysis.* In *The Oxford Handbook of Qualitative Research* (2nd ed.), Oxford University Press.

Reuter, T. R., Sharp, C., Kalpakci, A. H., Choi, H. J., & Temple, J. R. (2016). Sexual Orientation and Borderline Personality Disorder Features in a Community Sample of Adolescents. *Journal of personality disorders*, *30*(5), 694–707. https://doi.org/10.1521/pedi_2015_29_224

Rodriguez-Seijas C, Morgan TA, Zimmerman M. (2021) A Population-Based Examination of Criterion-Level Disparities in the Diagnosis of Borderline Personality Disorder Among Sexual Minority Adults. Assessment. 2021 Jun;28(4):1097-1109. doi: 10.1177/1073191121991922. Epub 2021 Feb 15. PMID: 33583188.

Rodriguez-Seijas, C., Morgan, T. A., & Zimmerman, M. (2023). Transgender and gender diverse patients are diagnosed with borderline personality disorder more frequently than cisgender patients regardless of personality pathology. *Transgender Health*. DOI: 10.1089/trgh.2023.0062

Schmideberg, M. (1959). The borderline patient. *American handbook of psychiatry*.

Shamseer L, Moher D, Clarke M, Ghersi D, Liberati A, Petticrew M, Shekelle P, Stewart LA, the PRISMA-P Group. Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols (PRISMA-P) 2015: elaboration and explanation. BMJ 2015.349:g7647. doi: 10.1136/bmj.g7647

Shubert A., Griffin N., Mashburn A., Dorsey S. & Rodriguez-Seijas C. (2025). Stigma, Situational Triggers, and Symptoms: How Providers Justify Borderline Personality Disorder Among Sexual and Gender Minority Individuals. Personality and mental health, 19(2), e70012. https://doi.org/10.1002/pmh.70012

Testa, R. J., Habarth, J., Peta, J., Balsam, K., & Bockting, W. (2015). Development of the Gender Minority Stress and Resilience Measure. *Psychology of Sexual Orientation and Gender Diversity, 2*(1), 65–77. https://doi.org/10.1037/sgd0000081

Wanta, J. W., Niforatos, J. D., Durbak, E., Viguera, A., & Altinay, M. (2019). Mental Health Diagnoses Among Transgender Patients in the Clinical Setting: An All-Payer Electronic Health Record Study. *Transgender health*, *4*(1), 313–315. https://doi.org/10.1089/trgh.2019.0029

Wilson, D. B. (2023). *Practical meta-analysis effect size calculator* (Version 2023.11.27). Campbell Collaboration. https://www.campbellcollaboration.org/calculator/ [accessed 10/7/2025]

Zanarini, M. C., Vujanovic, A. A., Parachini, E. A., Boulanger, J. L., Frankenburg, F. R., & Hennen, J. (2003). A screening measure for BPD: The McLean Screening Instrument for Borderline Personality Disorder (MSI-BPD). *Journal of Personality Disorders, 17*(6), 568–573. https://doi.org/10.1521/pedi.17.6.568.25355

Zimmerman, M., Benjamin, I., & Seijas-Rodriguez, C. (2022). Psychiatric Diagnoses Among Transgender and Gender Diverse Patients Compared to Cisgender Patients. *The Journal of clinical psychiatry*, *83*(6), 21m14062. https://doi.org/10.4088/JCP.21m14062

# Chapter 2: Major Research Project

## A Qualitative Study Exploring Clinicians' Perceptions of the Diagnosis of Borderline Personality Disorder within Older People.

Prepared in accordance with the author requirements for British Journal of Clinical Psychology: Author Guidelines

# Plain Language Summary

## Background

Borderline Personality Disorder (BPD) is a mental health condition that affects people's emotions, relationships, and behaviours. It is often diagnosed in younger adults but is less known in older people. (Masland et al. 2022). This may be due to not really understanding BPD or it being missed in early life because the public weren't as aware. Many of the symptoms appear different in older people. There are stereotypes that may impact clinicians' views of BPD. (Beatson et al. 2016). There are mixed views as to whether the diagnosis is useful for guiding treatment in this age group.

## Aim

This study aimed to explore clinicians' views and how they decide to diagnose and treat BPD in older people.

## Methods

16 psychiatrists and psychologists, who work with older people in mental health services, were interviewed. They were asked 8 questions to share their views and experiences of diagnosing and treating BPD. They described challenges and barriers that they face. The interviews were then written out and common words were then grouped together into themes.

## Main Findings

The study found that many clinicians feel unsure about using the BPD diagnosis for older people. They said that BPD symptoms can look different in older people compared to younger groups. For example, older people may show their distress by having physical illnesses or depending more on others, rather than impulsive or risky behaviours often seen in younger people. Life events such as loss, retirement, or physical health decline can also lead to struggles with emotions in later life.

Therapies that are helpful for BPD are often not given to older people, so staff rely on a person-centred approach. This means they focus on understanding each person's life and how things such as their past trauma or unhealthy relationship may impact their distress instead of the diagnosis. The study also found issues like bad views of the BPD label, both among healthcare teams and in society. Some clinicians' worry that the diagnosis might not benefit the patient and could even lead to negative views from staff. The findings indicate that a BPD diagnosis may not properly guide treatment for older people, as it fails to capture their unique needs. Instead, clinicians often focus on reducing their symptoms and providing person centred care.

### Conclusions

These findings show it’s important to understand how mental health conditions change with age and make sure that older people receive the care they need. The study found that creating clear guidance and making it easier for older people to access therapies will help improve care. It also showed a need for better training for healthcare staff and more resources for older people’s mental health services. By fixing these gaps, services can provide more caring and helpful support for older people struggling with strong emotions.

# Abstract

## Objectives

This study explores clinicians' perceptions and decision-making processes in diagnosing and treating Borderline Personality Disorder (BPD) in older people. It aimed to understand age-related biases, systemic barriers, and the influence of contextual factors on diagnostic practices and care planning.

## Methods

Sixteen qualified mental health clinicians (8 psychiatrists and 8 clinical psychologists) from Older People's inpatient and community settings within NHS Greater Glasgow and Clyde participated in semi-structured interviews. The data was analysed using reflexive thematic analysis to identify key themes related to clinicians' experiences and perceptions.

## Results

The data revealed five key themes regarding clinicians' perceptions of diagnosing and treating BPD in older people: 1. Re-Emergence and Recognition; 2. Manifestations and Meaning; 3. Diagnostic Discomfort and Dissonance; 4. Systemic Constraints and Care Logics; 5. Function vs. Futility of Diagnosis.

## Conclusions

The findings question the utility of a BPD diagnosis for older people, as systemic factors, resource constraints and age-related biases undermine its role in driving treatment. Clinicians often favour formulation-driven care to address unique needs such as trauma, interpersonal difficulties, and somatic complaints. These findings call for age-sensitive diagnostic frameworks, expanded evidence-based pathways, and multidisciplinary training to promote equitable and effective care for this underserved population.

# Introduction

## Epidemiology and phenomenology

Whilst the prevalence of Borderline Personality Disorder (BPD) within the general population is estimated to be around 1.8%, the prevalence in outpatient mental health clinics is much higher (10% to 12%), growing to 20% to 22% among inpatients (Tyrer, 2022) The variation in prevalence rates correlates with the clinician's use of standardised diagnostic methods or informal unstructured approaches (Ellison et al. 2018). Demographics such as age and gender are positively correlated with a BPD diagnosis, with younger people and women being most likely to attract a BPD diagnosis compared to older people or men. This could be sampling bias, as younger people and women are more likely to display their dysregulated emotions in behaviours such as self-injury, resulting in higher referral rates to services (Masland et al. 2022).

Stigma surrounding BPD, is due to misinformation, a lack of knowledge of the condition and the development of symptoms (Ring & Lawn, 2019; Chartonas et al.2017). This creates, and perpetuates, the narrative that sufferers are "attention seeking" and "difficult to treat" rather than promoting an empathetic look at maladaptive coping styles and low distress tolerance that may have arisen in difficult circumstance, which often results in the emotional intensity, interpersonal difficulties and complex needs of this client group. Often these negative prejudices are more commonly shared by mental health professionals than the public (Knaak et al. 2015). This stereotypical view of BPD and presentation variations may explain why the prevalence rates of BPD amongst older people appear much lower than the general population. Molinari et al. (1994) suggested that 7% of older people in an inpatient setting met the diagnosis compared to 22% of adolescents. This figure is lower within the community with an estimated 1 per 200 older people meeting the criteria for BPD. Beatson et al.'s (2016) systematic review concluded that factors such as a missed diagnosis earlier in life, a lack of understanding of symptomology in older people and the perception that BPD only affects younger adults may account for the lower prevalence rates.

Both the ICD-11 (WHO, 2022) and the DSM-5-TR (APA, 2022) have adopted a dimensional model of personality disorder, with distress rated in severity across four criteria chronic feelings of emptiness, impulsivity, affective instability and reactivity, and patterns of unstable or intense interpersonal relationships. The ICD-11 includes qualifier criterion for Borderline Pattern. However, the age of a client at presentation to services, the variation in perceived functioning because of different lifestyle factors and a high occurrence of comorbidities such as physical health conditions, depression or cognitive decline, may result in diagnostic overshadowing (Beatson et al. 2016; Cruitt & Oltmanns, 2018). Diagnostic criterion, such as the DSM-5-TR and ICD-11, are designed for presentations in working age individuals which results in older people being misdiagnosed or overlooked because of a lack of recognition of the variations in symptomology in later life. These factors could account for the discrepancies in diagnosis and access to treatment of BPD for older people.

### Lifespan and BPD

Across the lifespan BPD does not present the same. Externalised features of personality disorders such as self-injury, impulsivity and aggression may fade in later life, suicide ideation can increase with attempts becoming less frequent but more lethal. Self-harm behaviours manifest differently in older people with BPD, e.g. use of medication non-adherence as a form of self-harm rather than self-mutilation (Cruitt & Oltmanns, 2018: Matter & Khan, 2017). Older people are more likely to display depressive, anxious and somatic symptoms resulting in higher physical impairment compared to younger groups. (Khasho, 2019, Frias et al. 2017). Ng, Bourke & Grenyer's (2016) systematic review found that as many as 85% of adults diagnosed with BPD no longer meet the criteria after ten years. This may contribute to the belief that older people are less likely to present with BPD in later life. Whilst research into BPD suggests that a remission of symptoms is common with the development of effective coping strategies and supportive interpersonal relationships, Videlar et al. (2019) found a correlation between life events and the emergence of previously well managed therefore, undetected personality difficulties. Significant life events may include the death of a supportive loved one who previously mitigated the person's difficulties, and/or transitional periods in later life such as retirement. Employment may be a protective factor that offers a sense of purpose, routine and identity to individuals living with BPD, therefore, transitional periods such as retirement may exacerbate difficulties such as emotional dysregulation (Mattar & Khan, 2017).

The impact of confounding factors such as age, gender, individual temperament and support systems, means BPD is often poorly recognised by clinicians despite having an insidious impact on daily functioning and link to suicidality. This may be because symptoms such as dysregulation, relational difficulties and chronic emptiness, being present across several conditions such as complex PTSD (C-PTSD). These symptoms manifest in varied behaviours depending on external factors therefore, there is a need for clinicians to recognise age-related symptom variations and consider contextual differences in the perceived functioning of older people (Beatson et al, 2016).

## Diagnosing BPD

Despite the prevalence of personality disorders being very high within mental health services, there can often be a reluctance to diagnose (Nakash & Nagar, 2018). This could be because a limited amount of information uncovered during assessment that directly related to the diagnostic criteria. This may be because clinicians opted to take a narrative approach, rather than utilising tools such as The Structure Clinical Interview for DSM-5 (SCID-5) interview guidance to ask explicit questions to assess diagnostic criterion. This is beneficial in allowing clients to discuss their motivation for support and gaining a naturalistic account of their difficulties. However, the underuse of diagnostic tools could lead to symptomatology being overlooked and key diagnostic information missed. These findings are particularly relevant when considering the implication for missed diagnoses for older people as engagement with mental health services are lower than for general adults (GA). Missed symptomology indicative of personality difficulties are more likely identified in service users utilising primary care, criminal justice systems, disability or social services, Tyrer et al. (2022).

Hillman et al. (1997) found that clinicians were less willing to give a diagnosis for personality disorders in older people, with 29% of respondents stating that patient age is an important variable in the omission of a PD diagnosis. Only 14 % of clinicians were able to provide the correct BPD diagnosis within older people samples which the authors attributed to ageism and a lack of identifying criterion in older people contexts. The contentious nature of the BPD diagnosis may lead to a reluctance to diagnose.

Trevillion et al. (2022) found benefits of a diagnosis when it informs an effective care plan. Participants, 20% of which were older people living with BPD, attributed a diagnosis as helping them to be understood, validated their experiences and provided them with the knowledge to self-manage their symptoms. Access to specialist services is, generally, based on diagnosis, therefore, flaws within the diagnosis process can lead to inadvertent discrimination to service access for older people.

A structured clinical care approach developed by Russell (2018) provides benchmarks in what a service can do to support someone with personality dysfunction, emphasising the importance of understanding their complex needs and managing associated risks. A multidisciplinary approach is integral to providing effective treatment, it requires a structured, supportive environment where safety, containment, and therapeutic exploration are prioritised. Upskilling staff, to recognise and consistently manage these conditions, help foster a shared understanding, empathetic response and avoids exacerbating the client's symptoms and are key to compassionate needs-led care.

An accurate diagnosis, formulation and treatment planning early in the client's journey within mental health services maximises the chance of recovery through ensuring access to appropriate, multi-disciplinary care from knowledgeable clinicians. The impact of a missed diagnosis earlier in life leaves older people vulnerable to being denied the validation, knowledge and specialist care needed to cope with the distressing symptoms commonly found in BPD (Choi Kain et al. 2016).

### Aim of current study

Evidence suggests factors including demographic variations in symptomology, clinician biases, discrepancies in clinician's use of diagnostic tools and the reliability of these tools across a diverse sample contribute to the difficulty in diagnosing BPD in older people. There is a need to engage with clinicians to better understand how these possible age-related biases, perceptions and contextual factors impact the diagnostic process in their clinical practice.

This study aimed to explore clinicians' perceptions and uncover factors that may impact the diagnosis and treatment of BPD within Older People.

# Methods

## Ethics

Ethical approval was obtained in June 2024 (College of Medical Veterinary and Life Sciences Ethics Committee, Reference: 200230349; NHS Greater Glasgow and Clyde R&D Reference: UGN24MH171; Appendices 6, p.100-102).

## Ontological and Epistemological Stance

This research is grounded in a critical realist ontology. This acknowledges that while a reality exists independently of human perception, our understanding of psychological phenomena, such as personality disorder is shaped by social, cultural, and historical contexts. The study adopts an interpretivist epistemology, recognising that knowledge is co-constructed between researcher and participant. This lens led to line-by-line context-sensitive coding, which allowed for a nuanced understanding of clinician experiences and meaning-making processes in the assessment and diagnosis of BPD in older people.

## Experts by Experience (EbE)

Consultations were undertaken with EbE, participants of a UK wide BPD support group, throughout this project. Firstly, to gain perspectives on the proposal and coproduce the interview guide. Lastly, to discuss the themes that occurred, provide guidance for the discussion section and give input to how this research could inform future practices.

## Recruitment

The following eligibility criteria was applied to ensure a purposeful sample was obtained.

Table 1. Eligibility criteria

| Inclusion Criteria | Exclusion Criteria |
|---|---|
| • Qualified Clinical Psychologist or Psychiatrist (minimum specialty training levels)<br>• Currently working clinically within either inpatient or community mental health services. | • Unqualified clinicians<br>• Not currently working within mental health services or in NHSGGC. |

| | |
|---|---|
| - Employed by NHS Greater Glasgow and Clyde (NHSGGC). | |

The research team disseminated information via team meetings and professional leads in psychology and psychiatry. Prospective participants then expressed an interest in participating directly to the researcher and further information and consent was provided.

## Procedure

The interviews took place, on Microsoft teams, from July to September 2024, with a duration of 23- 49 minutes (mean= 37) and were recorded for later transcription. Only the primary researcher and participant were present and field notes were not taken.
Verbal consent was obtained on commencing the interview. Participants were asked eight open ended questions, followed by prompts to expand upon or clarify information e.g. “how do you, in general, go about assessing someone who you think might attract a diagnosis of personality disorder?” Prompts: “Are there any diagnostic tools or processes you use during the assessment?” A link to the interview schedule is in *Appendix 7*.

On completion of the interviews, recordings were transcribed verbatim and pseudo-anonymised prior to thematic analysis. No interviews were repeated and due to time constraints, participants did not review their transcript.

## Participants

A purposive sample was recruited. All sixteen participants were qualified clinical psychologists (n=8) or psychiatrists (n=8) with experience ranging from 5 to 35 years in NHS. They comprised of a range of bands and experience levels, from resident Psychiatrists to professional leads. All specialised in older people’s mental health and reported clinical experience with clients who may attract a BPD diagnosis. However, many stated they had limited formal training in personality disorders. The majority were white (75%) and female (69%).

### Justification of Sample Size

Braun and Clarke (2022) suggested a dataset size of 10-20 participants is sufficient for a medium thematic analysis project. The researchers aimed to recruit adequate representation of both disciplines and data saturation had been reached with recurring themes being discussed in later interviews.

## Analysis

A six-phase thematic analysis (Braun & Clarke, 2022) was conducted by hand to extract descriptive or interpretive codes line-by-line, often using in vivo codes. The coding process was inductive to allow data-driven codes to emerge from participants' narratives, unconstrained by existing frameworks. This approach aligns well with exploratory qualitative research, particularly when the goal is to understand subjective experiences (e.g. clinicians' perceptions).

Similar codes and recurrent patterns were then collated and clustered into emerging themes that capture shared meaning, these were then refined and checked for coherence. The researcher then systematically explored commonalities and overlapping emergent subthemes using a bottom-up approach in grouping subthemes together to form core themes. Core themes were then named to reflect their essence and relevance to the research aim, *appendix 8.* A sample of the data was independently reviewed by a second researcher to check reliability of themes and their relationships. The themes were then agreed between the research team.

### Researcher Reflexivity

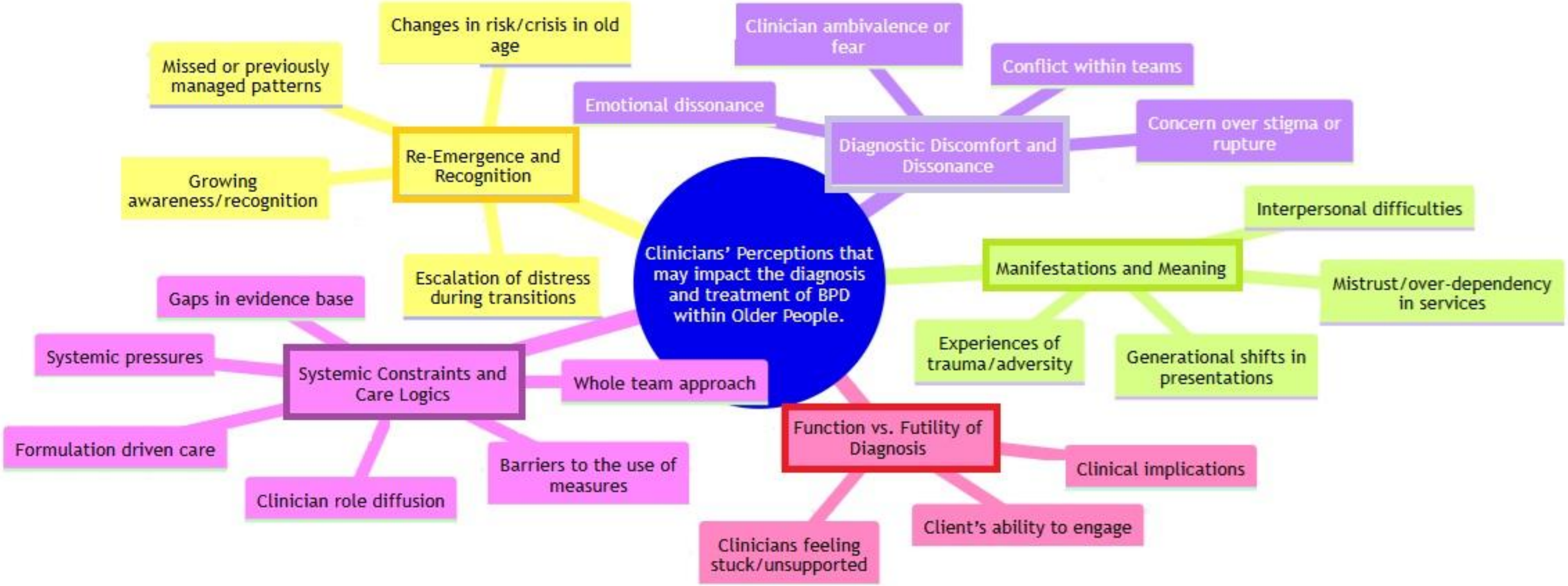
As a trainee Clinical Psychologist with lived experience of BPD, I recognise that my personal experiences may influence my interpretation of participants' perspectives. While my background allows me to empathise with clients, I have experienced first-hand the challenges of working with complex care needs in pressured mental health services. This lived experience was not disclosed to any participants, to prevent any influences. I recognise there was the potential for bias in the data collection and analysis. To address this, I regularly wrote reflective logs, met my research supervisor monthly to discuss the process and reflect on any responses I had. I remained conscious of my biases and strived to approach the data objectively using a bottom-up analysis. The transcripts, initial coding and overall analysis were shared, reviewed, independently screened and discussed within the research team.  I am committed to ensuring that my personal views do not overshadow the participants' voices but rather enhance my understanding of their experiences.

## Results

The reflexive thematic analysis revealed five interconnected themes reflecting how clinicians perceive, navigate, and emotionally experience the process of diagnosing and treating BPD in older people. These themes not only illuminate how BPD manifests in this population, but also how clinicians engage with the diagnosis amid uncertainty, system limitations, and emotional conflict. Each theme contributes to a deeper understanding of the contextual, relational, systemic and professional factors that shape diagnostic decisions and care planning.

The researcher had anticipated that emerging themes may be individual to certain disciplines, whilst others may be identified across all participants. However, homogeneity was noted amongst the emerging themes with a slight variation in stances or perspectives.

Figure 1: Thematic mind map (Mermaid live editor)



## 1. Re-Emergence and Recognition

The data illuminated how personality-related difficulties become more apparent in later life with participants noting several factors they have come across whilst assessing clients first presenting to their service with difficulties that may indicate BPD.

### *Re-emergence of previously managed patterns*

Many participants highlighted that there is often a longstanding pattern of relational and emotional difficulties, these may have been managed by protective factors such as a spouse or stabilising life roles, for example, parenting or employment. As such, there may have been little interaction with mental health services in the client's past. Clinicians recognised that these difficulties often re-emerge in later life because of age-related events that occurred. Examples that emerged from the data included distress arising from isolation, lack of purpose, retirement or an increased dependency on loved ones, such as adult children, due to failing health or the death of a spouse. The impact of transitions was a recurring subtheme emerging from the data, illustrating that first presentations to mental health services are often triggered by life events such as bereavement, retirement, or declining health which are seen to destabilise previously effective coping mechanisms, leading to a marked escalation in distress or crisis presentations.

*"…periods of stability in their lives but are at an age were either through bereavements, or breakdown in relationships over time. People moving or the person moving themselves that they're suddenly more isolated. Adrift from other relationships or supports… maybe the symptoms that they've struggled with at various times in their lives kind of come to the surface a bit more."*- Andrew. Clinical Psychologist

### *Escalation of distress*

The impact of aging itself was discussed in the context of frailty and physical health deteriorations which change the dynamics of relationships as older people's expressions of distress increase. Participants reflected that this shift from "traits" to more distinct clinical features of a "disorder" often occurs as the older person's independence reduces, and caregivers struggle to manage. Clinicians may perceive BPD as contextually latent.

*"As people get older and frailer, those protective relationships may fall apart… then you start to see the disorder rather than the traits."* -Kate, Psychiatrist

The diagnosis becomes legible only when social scaffolding erodes. This "unmasking" effect reveals not just missed opportunities for earlier intervention, but clinicians' reliance on perceived functionality and relational stability as key markers of BPD. The emphasis on frailty and relational dependency reframes BPD from an impulsivity-dominant pathology (as often conceptualised in younger adults) to one embedded in attachment disruption and existential vulnerability. This illustrates how clinicians negotiate diagnostic thresholds not only on symptom severity, but on contextual deterioration in functioning within their clinical reasoning which may often leads to missed diagnosis in seemingly "high functioning" clients.

### *Changes in risk*

Almost all participants noted an increase in the number of clients presenting in services with clinical traits of BPD and expressed a concern at the increasing level of crises within this presentation. Participants provided examples of clients who had serious suicide attempts which resulted in their first presentation to mental health services in later life. Several participants reflected on how older people often have the means to end their life in the form of strong medication which highlights the dynamic need to manage risk in clients with suicidal ideation or self-harm behaviours. Many clinicians echoed a concern at the elevated risk of suicide or accidental death because of using overdose as means of self-harm.

*"We've had, you know, thinking about the SEARS [serious incident reports] that I have looked at, there's maybe one or two like that that you think actually was the intent to die or was this, you know, just another kind of overdose that they're wanting to reach out. So yeah, you're always concerned about self-harm behaviours and, and you know isolation getting older...Just ageing and pain, you know, access to opiates being more…. there's your means."*- Grace, Psychiatrist

The availability of means (e.g. prescribed medication) combined with a deterioration in social supports was seen to increase both intent and lethality in self-harm behaviours. Some clinicians emphasised that this increased risk required closer management, especially where coping resources had diminished, and distress had escalated quietly over time. However, this concern was not universally held. One participant believed suicide attempts in older people were more likely to be help-seeking than fatal, suggesting that crisis presentations might reflect communicating overwhelming emotional needs rather than end-of-life intent.

*"I don't think really a 65-year-old person is going to [complete suicide], and it's also different… So, I think it's kind of the different ways in seeking care or seeking attention and I use that term kind of neutrally."* -Lucas, Psychiatrist

### *Growing awareness*

Overall, the data suggests that the clinicians have an increased awareness and recognition of personality related traits within older people. All participants discussed specific examples of clients they saw in their practice that may attract the diagnosis and were able to share their perceptions of why their difficulties were well managed enough to not need mental health services until later life. The data suggests that whilst the persistent nature of personality disorder were likely always present in these clients, they were perceived as being managed well enough to prevent a referral to services until the emergence of behaviours that adversely affect caregivers and/or primary services which increase the likelihood of a referral for mental health support.

*"So things have changed. So I think the patients were there, but… their needs weren't always recognised, and they weren't always directed to psychology, whereas I think they're more likely to be on that pathway now."*- Christine, Clinical Psychologist

## 2. Manifestations and Meaning

This theme illustrates clinicians' perception of how BPD traits are shaped and expressed in older people, revealing diagnostic complexity across the lifespan. Participants described a generational reframing of symptoms that they interpreted not simply as age-related variation, but as expressions influenced by cultural norms, trauma histories, and long-term coping styles.

### *Generational shifts*

Clinicians consistently described deviations in how BPD presents in older people compared to GA. This included descriptions of less overt dysregulation, more somatic complaints, and entrenched relational difficulties. Importantly, the participants seemed to conceptualise these behaviours not simply as “differences” but as generational expressions of distress which are shaped by cultural norms, trauma exposure, and shifting interpersonal dynamics over time.

*Isla, a Clinical Psychologist said “In general adult, you see emotional dysregulation through volatile behaviour. In older adults, it's more somatic and dependent traits.”* which reflects a reconfiguration of perceived BPD symptomology, where older adults may externalise emotional pain through physical symptoms or service over-reliance. These reframing challenges the diagnostic tools normed on younger cohorts and reveals clinicians’ use of contextual heuristics to identify pathology in older populations.

Almost all participants discussed differences in how the age groups may present in crisis, with GA described as not engaging well in a planned intervention but presenting out of hours or at A&E in crisis, often because of risk taking or self-harm behaviours. Whereas older people attend appointments and seem to engage in the intervention at a surface level without implementing any strategies. Clinician’s felt this resulted in reassurance seeking and somatic manifestations of their distress which are commonly misinterpreted as a physical health concern.

The data revealed exasperation at the belief that clients with BPD “burn out” in old age. Participants named more likely factors such as the client’s distress being managed by psychological interventions or (more likely) social supports and a lack of stressors, their distress then escalates when their circumstances change.

*"In general adult population, they talk about people sort of burning themselves out with personality disorder, so the distress, I suppose, lessens over time as a result of, you'd like to think their input and support that they do get from mental health services, even though, the patient themselves might feel it hasn't been that helpful. So, I suppose the older adult population or the slow burners, if you like, they have, they have not burned themselves out. It's continued at a sort of low level."-Neil, Psychiatrist*

### *Experiences of trauma*

A common perception that emerged from the data was that trauma is a formative antecedent for presentations that align with BPD traits. Participants noted that generational factors and cohort beliefs shape these presentations. Older clients were described as less likely to discuss trauma openly, with distress expressed through a mistrust of services or over-dependence on clinical staff. However, analytical tension emerged around whether clinicians viewed trauma as co-occurring, explanatory, or synonymous with BPD, with some participants describing PTSD or C-PTSD as a common co-morbidity whilst others displayed a stronger stance that suggest clinicians often wrestled with differentiating trauma-related symptoms from BPD specific pathology, often noting conceptual overlap with C-PTSD pathology. This raises questions about diagnostic validity and formulation practice that were explored in subsequent themes.

*"Trauma and EUPD go hand in hand most of the time, whether it's real or perceived."*
— Kate, Psychiatrist

### *Interpersonal difficulties*

Clinicians provided examples of behaviours that often reflected early relational trauma, which continued to impact interpersonal functioning. Many commented on the difficulties in obtaining collateral information from family members due to estrangement or fragmented relationships whilst others highlighted how common a lifelong pattern of relationship difficulties is within their client's lives. An emergent subtheme that was deducted from the data was that interpersonal difficulties could adversely impact the team's views of that client. Descriptions suggested that they often play out in sessions with clinicians, which can complicate treatment and add to the clinician's concerns over potential ruptures in the therapeutic alliance. However, many participants understood these interpersonal styles as an adaptive response to early experiences of trauma and demonstrated compassion when explaining that these experiences lead to a mistrust of services and *"testing"* of clinicians to ensure they can be trusted.

*"In my clinical experiences, there are usually more than one discipline involved… then again through not any fault of their own, people may, may recreate dynamics that are, re-enacting, I suppose, early relational traumas."- Julia, Clinical Psychologist*

As illustrated by Julia, interpersonal mistrust and behaviours were often understood as adaptive responses to early adversity, though their recurrence within clinical relationships often strained teams and heightened concerns around therapeutic rupture.

## 3. Diagnostic Discomfort and Dissonance

These complex, often ambiguous, presentations raise important questions about which factors clinicians consider when giving a diagnosis. There were varied perspectives on diagnosis, including the tensions between formulation and labelling, emotional dissonance as well as the role of professional training and context in shaping these decisions.

### *Clinician's ambivalence*

Participants expressed internal conflict between recognising personality-related distress and applying a formal diagnosis. Inductive coding highlighted that their ambivalence was not simply procedural; it was affective, relational, and epistemological. The data suggested the majority of clinician's held a negative perception of the diagnostic label; BPD was frequently positioned as a label fraught with assumptions, stigma, and emotional consequences. Emotions such as helplessness, frustration and avoidance were elicited from the data with many participants having expressed a sense of "how helpful is this for my client?"

*"Is it helpful anyway as an older person to be given that diagnosis? Is it helpful at any point like how helpful is that as a label? It's not. It's just, it just sounds strange, the label in itself…. it just doesn't, doesn't inspire much hope and definitely doesn't inspire much hope in the team when that label is attached to someone."*- -Beth, Clinical Psychologist

*"It doesn't inspire hope"* highlights the sense that the BPD diagnosis may become a site of moral and professional tension within the individual clinician, client and wider team. The data suggests diagnosis may often be viewed as a tool clinicians reluctantly give, conscious of its potential to rupture therapeutic relationships or reinforce pejorative beliefs.

### *Dissonance.*

The emotional dissonance evident in such reflections suggested that clinicians experience diagnosis not simply as a clinical decision, but as an affectively and ethically charged act. This diagnostic hesitancy mirrors the social representations described by Moscovici (1984), wherein concepts like BPD become symbolically loaded through cultural discourse, shaping clinical attitudes and emotional responses.

*"I think because when I trained and for most of my working life, the thoughts were that it's a diagnosis that would not be well received. But I give dementia diagnosis and they're not well received either. And I think because…One of my fears, I think, is that I might alienate the patient and not be able to help them, that they might withdraw from me with that diagnosis, and then I lose that opportunity to try and support them."*- Helena, Clinical Psychologist

### *Conflict with teams.*

Participants described internal team conflict regarding the appropriateness of assigning a BPD diagnosis, underscoring how stigma permeates not only service-level practices but also interdisciplinary dynamics. Several clinicians highlighted the negative perceptions of BPD within their own disciplines and wider teams, expressing concern that the label itself carries prejudicial weight and providing examples of feeling the need to “advocate” for clients in teams where BPD was suggested due to relational difficulties between the client and frontline staff.

*“I feel like sometimes my non-psychology colleagues can be quite quick to jump to that, they've got a personality disorder, you know when it is seen as it is kind of very much this negative thing. It's like a, you know, like an insult almost.”*- Beth, Clinical Psychologist

These connotations appeared to influence diagnostic hesitation, particularly where clinicians were concerned about the impact of assigning a stigmatised identity to an older client.

### *Concerns over stigma*

These findings illustrate how age-related biases, professional perceptions, and contextual factors often shape clinicians’ use of diagnostic frameworks. Clinicians expressed ambivalence about diagnosing BPD in older people, revealing tensions between professional responsibility, therapeutic alliance, and systemic stigma. The data suggests the diagnosis is emotionally and ethically burdensome not only due to its negative connotations but because it was perceived to offer limited therapeutic value.

*“They don't want to be labelled… they don't want to have the label, so for them there is a stigma they don't want to carry it. So I think this would have an impact on their day-to-day lives. Maybe increase the level of depression which is or take them into a path of addiction, alcohol drugs or something like that.”*- Maria, Psychiatrist

Participants were concerned that assigning a formal label could compromise relational trust, reinforce systemic bias and maladaptive coping, this leads to diagnostic avoidance or preference for terms like “traits.” Team-level disagreements further complicated decision-making, underscoring the influence of stigma both within and across disciplines contributing to moral dissonance amongst clinicians.

## 4. Systemic Constraints and Care Logics.

This theme captured the *structural and service-level* factors shaping how BPD is treated in older people's mental health services. It included descriptions and interpretive illustrations of perceived barriers to assessment, differing expectations between disciplines, team dynamics, and treatment delivery. The data provided insight into how clinicians navigate structural constraints, role boundaries, and service limitations when devising care plans for clients.

### *Whole team approach*

There was broad consensus on the importance of multidisciplinary teams (MDTs) in supporting clients that may attract a BPD diagnosis. Clinicians described a philosophy of shared responsibility, where different professionals play distinct roles in recognising, managing, and containing distress. The emphasis on relational engagement across the MDT underscored a commitment to holistic care and relational safety.

*"It's about building up a relationship with them and trust with, not just the psychiatrist, but the whole MDT. Having CPNS involved, who can check in on them and recognise increases in stress or relapses… or increase in suicidal ideation or help with self-harming behaviour… psychological therapies, DBT and such like. OTs can be involved with enhancing our sort of repertoire of activities and social contacts that they would have."- Neil, Psychiatrist*

### *Clinician role diffusion*

This commitment to collaborative care was complicated by contrasting perceptions of professional remit. Many clinical psychologists felt it was not their role to diagnose and was within the remit of a psychiatrist. Whereas several psychiatrists felt clinical psychologists are the best discipline to assess and care for patients that may attract a diagnosis of BPD, noting the value of a formulation driven approach over the use of diagnostic criterion or standardised measures.

*“That's a question that's more for our psychiatric colleagues, 'cause. I would very rarely diagnose somebody… I suppose it's not, my main role to diagnose people, but more to develop an understanding and the formulation.”- Julia, Clinical Psychologist*

*“I might sort of do a very sort of small maybe 5P formulation or maybe a small sort of longitudinal formulation of like the Becks kind and just kind of take it to the psychologists or discuss it in the team… if you really want to treat EUPD, that's a domain of psychologists and not psychiatrists.”- Lucas, Psychiatrist*

Whilst there are benefits to a person-centred approach, this ambiguity may generate gaps in accountability and unhelpful expectations that lead to role diffusion, with role delegation frequently shaped by perceived professional legitimacy rather than training or confidence in assessment. The resulting fluidity could mean diagnostic decisions are vulnerable to dilution, misalignment, or strategic avoidance which adversely impacts cohesive care.

### *Barriers to the use of measures.*

Many clinicians viewed structured diagnostic tools as reductive or inadequate in capturing complex presentations, while others framed their avoidance as protective a way of preserving therapeutic optimism and client dignity.

*“Often people don't fall into nice categories. They're often, you know, bits of this bits of that. So, you know, in the past, I've said that people have got traits. And sometimes I feel more comfortable about saying people have got traits rather than a particular diagnosis.”* -Grace, Psychiatrist

This rejection of diagnostic labels in favour of “traits” reflected both pragmatic and epistemological considerations, clinicians instead advocated for trauma-informed, transdiagnostic approaches. Symptoms were often reframed as adaptive responses to unresolved trauma rather than intrinsic features of BPD. This perspective introduced nuance and placed additional burden on clinicians to translate experience into care without diagnostic clarity.

### *Gaps in evidence base.*

A recurring narrative among psychiatrists was the view that inpatient care for BPD, particularly in older people, can lead to worsening outcomes through behavioural escalation and institutional dependency. Ewan expressed the opinion that *"…inadvertently there has been worse outcomes for some people, in particular for the older generations."* These beliefs functioned as a form of risk logic, informing clinical thresholds for admission and further discouraging diagnostic certainty

### *Systemic pressures.*

Clinicians' narratives made visible the emotional burden of working in under-resourced systems. Psychological interventions such as Dialectical Behaviour Therapy (DBT) and Mentalisation-Based Therapy (MBT) were described as the preferred treatment modalities for BPD. However, they were acknowledged as largely inaccessible for older people in community settings. The lack of tailored pathways and evidence-based therapies was described as a major barrier to timely and effective care. This absence of therapeutic continuity significantly influenced clinicians' willingness to diagnose.

*"[After diagnosis] there's nowhere to go. We've got to do it. We've got to try and do our best to work with people without any additional services or specialist support… So it stops with us and we are basically sharing bad news a lot of the time, and the idea that a patient is presenting with depressive symptoms for personality disorder feels like, for some clinicians, it's again a door shut."-Kate, Psychiatrist*

The data revealed how diagnostic practices are shaped by a mix of pragmatic care logics, ethical concerns around offering a stigmatised diagnosis in a resource-scarce environment. Participants described how diagnostic hesitancy is often not simply a reflection of diagnostic difficulty but emerges from age-related service gaps and ambivalent clinical mandates. These intersecting dynamics have contributed to a culture in which BPD in later life is often marginalised, with its treatment approaches shaped more by circumstantial feasibility than clinical coherence.

### 5. Function vs. Futility of Diagnosis.

This theme explores clinicians' perceptions on the *practical consequences* of a BPD diagnosis. While participants acknowledged its purpose was to in inform care pathways and allow access to specialist resources, many questioned its actual benefit for clients themselves. Clinicians reflected on the emotional strain of working within structurally limited systems and described therapeutic impasses, often compounded by service user disengagement or high levels of distress. The diagnosis was seen by some as clinically useful, but by others as potentially stigmatising or ethically problematic, particularly in the absence of appropriate interventions.

#### *Clinical implications*

Although some participants described the diagnosis as a functional tool that helps to orient treatment direction or communicate client needs across disciplines/ services, few believed it substantially benefited older clients. Instead, the diagnosis was often described as loaded, fixed, and potentially disempowering, particularly when therapeutic pathways were absent.

*"The, the name in itself is a negative label. It's like to do with like your personality. So people like, well, I can't change my personality, whereas with them we're saying that, you know, you can't be treated from having borderline personality disorder."- Olivia, Clinical Psychologist*

This sentiment echoed a wider scepticism about whether a diagnostic label is useful in scaffolding recovery. Many participants questioned whether the function of the diagnosis was for the client or for the wider system. The perception that it is merely utilised as a recordable category rather than a catalyst for therapeutic engagement was communicated through the data. Several commented that diagnosis may serve future clinicians, but its value to the current therapeutic relationship was often ambiguous or even harmful.

*"I think it's more for the skills for the staff to manage the situation and you know that would be more important than the patients themselves knowing the diagnosis."-Pearl, Psychiatrist*

### *Clinicians feeling unsupported*

A common pattern across the data, was the emotional toll of navigating systemic inadequacies while supporting clients with complex needs. Several clinicians expressed frustration at being unable to offer meaningful interventions following diagnosis, attributing this to systemic pressures within the NHS such as underfunding, staffing shortages, and service design that may not fully meet the need for older people.

*"I really think that is one of the main problems that we've come up against is just lack of funding. So, training we might be able to get training, but are we going to get more nurses? Are we going to get more psychologists… for the more complex kind of presentations, that's just going to get harder and harder. And these are not often the people who are going to have the money to throw at private care, and neither should they have to."- Beth, Clinical Psychologist*

This sense of powerlessness fostered what might be termed a therapeutic impasse where clinicians felt emotionally fatigued, ethically conflicted, and unsupported. The absence of a clear care pathway following diagnosis meant clinicians often carried the burden of both delivering the label and absorbing the weight of its implications, without sufficient systemic scaffolding.

### *Client's ability to engage.*

Participants reflected on the complexities of client engagement. While person-centred approaches were strongly endorsed, several clinicians emphasised that high levels of emotional distress, trauma histories, and limited insight could interfere with clients' ability to receive or make use of a diagnosis. Rather than increasing clarity, the diagnosis sometimes disrupted the therapeutic relationship or created rupture:

*"It lands in a context that's not ready for it, or where the person's not able to hear it, and then it just kind of sits there… sometimes it closes down rather than opens up the work."*- Helena, Clinical Psychologist

These accounts illuminate how diagnostic decision-making is influenced not only by clinical presentation, but by a perceived alignment (or misalignment) between the diagnosis and a client’s reflective capacity. Some clinicians appeared to use this as a rationale for avoiding formal diagnosis altogether, preferring to work with symptoms or relational strategies that felt more attuned and less pathologising.

This theme reflects how diagnostic practice is situated within and are shaped by wider systemic and socio-relational contexts. Clinicians’ reflections reveal the weight of navigating a diagnosis they perceive as both clinically complex and politically charged, particularly when applied to a demographic historically excluded from specialist services. The data underscore the need to engage with clinicians not only as diagnosticians, but as actors negotiating structural bias, therapeutic ethics, and age-related stigma.

## Discussion

The data revealed five key themes regarding clinicians’ perceptions of diagnosing and treating BPD in older people: 1. Re-Emergence and Recognition; 2. Manifestations and Meaning; 3. Diagnostic Discomfort and Dissonance; 4. Systemic Constraints and Care Logics; 5. Function vs. Futility of Diagnosis.

Participants discussed several common features that precipitate the first presentation of PD in mental health services. This includes an escalation of difficulties that often coincided with major life transitions, such as bereavement or retirement, which destabilised previously effective coping mechanisms. Clinicians described how losses in social roles and relationships may exacerbate emotional dysregulation, leading to crisis presentations. The transition to retirement may contribute to a loss of identity, routine, and coping structures, thereby increasing emotional distress and suicidal ideation (Mattar & Khan, 2017). Participants reported a high correlation of trauma histories, C-PTSD and BPD traits. They discussed how these factors impact the client’s engagement and interpersonal style with services. This learned use of maladaptive strategies adopted by clients to get their needs met may explain some of the negative misconceptions, as without a shared understanding of these behaviours function, it may be misinterpreted as “manipulative” (Ring & Lawn, 2019).

Participants' explored generational differences in how distress is expressed which further influenced clinicians' identification of generational and age-related shifts in symptom expression. A somatic expression of distress was particularly salient in older adults, who often presented with physical complaints as proxies for emotional dysregulation, a pattern less commonly observed in GA populations and consistent with ageing literature (Cruitt & Oltmanns, 2018). This reflects the findings of Beatson et al. (2016), who noted diagnostic overshadowing of comorbidities such as trauma, depression or cognitive decline. Several participants challenged the misconception that BPD symptoms "burn out" in later life. It was observed that OP with BPD present with fewer instances of overt emotional dysregulation and impulsivity, instead exhibiting traits like somatic complaints and dependency which some participants described as "slow burners". This mirrors findings within lifespan studies (Matter &Khan,2017, Frias et al. 2017, Cruitt & Oltmanns, 2018) that state despite lower instances of violent self-injury, older people are higher risk as their persistent low mood and internalised distress over a long period of time can escalate quickly and manifest in significant crises. This is contextualised through lifespan developmental theories such as Erikson's Psychosocial Development Theory (1950), which theorises that later life is characterised by challenges of integrity versus despair, which may exacerbate underlying personality traits, leading to heightened distress. Costa & McCrae's (2019) Five-Factor Model posits that personality traits like neuroticism, often associated with BPD, tend to decrease with age as individuals develop greater emotional stability and coping strategies. However, physical frailty, reduced social networks and potential cognitive decline in later life may exacerbate dependency behaviours, as older people struggle to adapt to declining resources and increased isolation. This correlates to the clinical descriptions from almost all the participants and showcases the importance of viewing BPD symptomology within the broader framework of ageing and personality development.

## Implications for clinical practice

The results show that there are many systemic barriers to providing effective, evidence-based care to older people living with symptoms that would indicate a BPD diagnosis. There is a clear disparity in the perceived benefits of the diagnosis and the stark reality. The hope is that a diagnosis will provide clients with a compassionate understanding of their distress, supporting staff to manage a shared understanding of the client's needs and access to evidence-based treatments. Whilst the reality is often that the diagnostic label is attached to prejudices and unhelpful biases that may adversely impact the quality of their care. (Ring & Lawn, 2019). Many clinicians admitted they do not want to share the diagnosis with their client and are mindful of the impact it may have on the team. Whilst the diagnosis may be met with compassionate understanding, it is often not the case. This concern that mental health professionals often hold prejudices about BPD is sadly well documented within the evidence, (Nakash & Nagar, 2018, Chartonas et al. 2017 and Ring & Lawn 2019) and compounded by age-related stereotypes means many clinicians are reluctant to diagnose. (Hillman et al. 1997)**.** Social Representations Theory (Moscovici, 1984) may explain this phenomenon, as clinicians' views are shaped by dominant cultural narratives that associate BPD with younger adults, leading to diagnostic hesitancy. By recognising how such representations shape practice, services may reduce epistemic injustice and better support reflective, person-centred care

Within our findings and the wider research stress the importance of a multidisciplinary approach to ensure a full assessment that identifies and addresses complex needs. Despite the potential benefits, participants noted significant barriers to effective multidisciplinary collaboration in services. These include resource constraints, such as insufficient staffing, and the limited availability of training specific to OP with BPD. Differences in professional perspectives and roles can lead to inconsistent approaches to care, with some disciplines prioritising symptom management over relational or trauma-focused interventions (Nakash & Nagar, 2018). An interesting discrepancy in role distinctions was uncovered throughout the analysis with each discipline attributing the lead role of care to the other discipline. There was a strong belief amongst many clinical psychologists that diagnosis should fall to psychiatry and within psychiatry that care planning should be psychology led. Addressing these discrepancies requires organisational commitment to fostering communication between disciplines, providing specialised training, and allocating resources to develop cohesive care pathways tailored to older people.

There are significant gaps in provision with referrals to specialist services not being accepted due to their age and OPCMHT clinicians lacking the training or confidence in providing interventions for “personality disorders”. The data shows limited access to evidence-based therapies, such as DBT, MBT and Schema therapy within older adult mental health services. It has been recognised that there is the need for formulation driven approaches, incorporating specialist therapies like DBT and MBT to be provided over an extended period within the community (Russell, 2018). Unfortunately, lack of training, time pressures and financial constraints mean this is rarely available within OP services. (Masland et al. 2023; Beatson et al. 2016). Ageism often results in OP being deprioritised for such interventions, with assumptions that they may not benefit from therapies designed for younger individuals. (Bangash, 2020; Khasho et al. 2019). Logistical challenges, including mobility issues, cognitive decline and physical difficulties, further limit accessibility of intensive therapy sessions (Cruitt & Oltmanns, 2018). It is worth considering that, even when these interventions are available, the empirical basis for their use with older people is questionable. The supporting studies for evidence-based interventions for PD focus on a narrow view of BPD within GA population and rarely include older people.

In addition to barriers in accessing appropriate pathways, there are several practical and systemic issues in implementing treatment. The data echoes Nakash & Nagar's (2018) findings that inadequate diagnostic tools and training impede effective care, underscoring the need for systemic improvements. This leads to a clear preference for formulation-driven approaches focused on symptom reduction rather than formal BPD interventions, emphasising the need for compassionate, person-centred approaches tailored to older peoples’ unique presentations and vulnerabilities. In contrast to Trevillion et al.’s (2022) belief that diagnosis leads to more effective care planning, the findings illustrate that to overcome systemic barriers, clinicians often utilise a more transdiagnostic approach to tackle individual symptoms and key areas of distress, often around emotional dysregulation and interpersonal difficulties. These approaches are often more beneficial without the need for a formal diagnosis. It brings up a key consideration, how helpful is a BPD diagnosis in practice?

### Future directions for research

The findings reflect a need for further research into PD in older people. There are significant gaps in diagnostic frameworks and service provision, raising questions about whether the diagnosis is fit for purpose in this context. The development of age-sensitive frameworks and expanded research on effective interventions that address generational and developmental differences are urgently needed. Future studies with a diverse sample of service users would be helpful in shaping an innovative approach that better meets the needs of this population while promoting inclusive and compassionate care.

Future research is needed to enhance the awareness of the impact of intersectional factors on the presentation of mental health conditions. By shifting focus toward a more holistic, formulation-driven approaches and advocating for improved evidence-based pathways, mental health services can better address the socio-cultural components of psychological distress

### Limitations

There was a lack of diversity in the sample, as most participants were white and female. Inclusion was restricted to a single health board, which may limit generalisability of the findings. Additionally, interviews were conducted online, which may have inhibited rapport or emotional expression. There was potential for recruitment bias, as participants were drawn from services with a specific interest in personality disorder, which may not represent the broader clinician perceptions. Social desirability bias could have influenced responses, as participants may be motivated to present their practice in a favourable light. Additionally, aspects of the interview content, such as the framing of questions, may have shaped the narratives provided and introduced subtle interviewer bias. There was also a potential for confirmation bias given the researcher’s lived experience with BPD, despite steps taken to mitigate this, *see reflexivity.* Another consideration is the researcher’s choice to not disclosure her lived experience to participants, had this been shared it may have increased the likelihood of socially desirable responses. The researcher had suspected there may have been more disclosure of stigma or negative beliefs when not disclosing, however, this seemed unfounded.

## Conclusion

Clinicians' perceptions of the BPD diagnosis are multifaceted. Many experience moral and emotional dissonance when deploying the label. This ambivalence could be because opposing views simultaneously recognise the potential benefits of diagnosis in guiding care, such as fostering understanding and facilitating access to resources, alongside the negative aspects and lack of function of the diagnosis within services. The findings highlight factors such as systemic barriers, stigma, age-related biases, and lack of tailored evidence-based interventions, often undermine the function of a diagnosis. This study highlights the need to re-evaluate the role of a BPD diagnosis in driving treatment. Data revealed that many clinicians opt for a formulation-driven approach rather than relying on structured interventions tied to the BPD diagnosis. This reflects the limited availability of specialist pathways for older people as the evidence-base focusing predominantly on younger populations. Transdiagnostic approaches allow clinicians to address their client's distress whilst meeting the unique needs of OP, such as navigating the cognitive decline associated with aging, somatic complaints, and interpersonal challenges within the context of their trauma histories, without being constrained by diagnostic labels. Systemic changes, including upskilling clinicians and fostering multidisciplinary collaboration, are essential to ensure equitable access to care.

# References

Bangash, A. (2020). Personality disorders in later life: epidemiology, presentation and management. *BJPsych Advances,* 26(4), 208-218

Beatson, J., Broadbear, J. H., Sivakumaran, H., George, K., Kotler, E., Moss, F., & Rao, S. (2016). Missed diagnosis: The emerging crisis of borderline personality disorder in older people. *Australian & New Zealand Journal of Psychiatry*, *50*(12), 1139-1145.

Braun, V., Clarke, V. (2022) *Thematic Analysis: A Practical Guide.* SAGE.

BPD Criteria in DSM & ICD- Borderline Personality Disorder - *DSM -5 and ICD -11 Diagnostic Criteria* (psychscenehub.com)

Chartonas D, Kyratsous M, Dracass S, Lee T, Bhui K. (2017) Personality disorder: still the patients psychiatrists dislike? BJPsych Bull. 2017 Feb;41(1):12-17. doi: 10.1192/pb.bp.115.052456. PMID: 28184311; PMCID: PMC5288087.

Choi-Kain, L. W., Albert, E. B., & Gunderson, J. G. (2016). Evidence-based treatments for borderline personality disorder: Implementation, integration, and stepped care. *Harvard Review of Psychiatry*, *24*(5), 342-356.

Costa Jr, P. T., McCrae, R. R., & Löckenhoff, C. E. (2019). Personality across the life span. *Annual review of Psychology*, *70, 423-448.*

Cruitt PJ, Oltmanns TF. (2018) Age-related outcomes associated with personality pathology in later life. *Curr Opin Psychol. Jun;21:89-93*. doi: 10.1016/j.copsyc.2017.09.013. Epub 2017 Oct 6. PMID: 29073530; PMCID: PMC6058683.

Ellison, W. D., Rosenstein, L. K., Morgan, T. A., & Zimmerman, M. (2018). Community and clinical epidemiology of borderline personality disorder. *Psychiatric Clinics*, *41*(4), 561-573.

Frías, Á., Palma, C., Solves, L., Martínez, B., & Salvador, A. (2017). Differential symptomatology and functioning in borderline personality disorder across age groups. *Psychiatry Research*, *258*, 44-50. DOI: 10.1016/j.psychres.2017.09.081

Hillman, J. L., Stricker, G., & Zweig, R. A. (1997). Clinical psychologists' judgments of older adult patients with character pathology: Implications for practice. *Professional Psychology: Research and Practice*, *28*(2), 179–183. https://doi-org.ezproxy.lib.gla.ac.uk/10.1037/0735-7028.28.2.179

Knaak, S., Szeto, A. C. H., Fitch, K., Modgill, G., & Patten, S. (2015). Stigma towards borderline personality disorder: Effectiveness and generalizability of an anti-stigma program for healthcare providers using a pre-post randomized design. *Borderline Personality Disorder and Emotion Dysregulation*, 2(1), 9. https://doi.org/10.1186/s40479-015-0030-0

Khasho, D. A., Van Alphen, S. P. J., Heijnen-Kohl, S. M. J., Ouwens, M. A., Arntz, A., & Videler, A. C. (2019). The effectiveness of individual schema therapy in older adults with borderline personality disorder: Protocol of a multiple-baseline study. *Contemporary clinical trials communications*, *14*, 100330

Masland, S. R., Victor, S. E., Peters, J. R., Fitzpatrick, S., Dixon-Gordon, K. L., Bettis, A. H., ... & Rizvi, S. L. (2023). Destigmatizing Borderline Personality Disorder: A Call to Action for Psychological Science. *Perspectives on Psychological Science*, *18*(2), 445-460.

Mattar, S., & Khan, F. (2017). Personality disorders in older adults: diagnosis and management. *Progress in Neurology and Psychiatry*, *21*(2), 22-27.

Mermaid Live Editor. (n.d.) Mermaid Live Editor v11.4.0. Available at: https://mermaid.live [Accessed: 30/12/2024]

Moscovici, S. (1984). The phenomenon of social representations. *In R. M. Farr & S. Moscovici (Eds.), Social representations* (pp. 3-69). Cambridge University Press

Nakash, O., & Nagar, M. (2018). Assessment of diagnostic information and quality of working alliance with clients diagnosed with personality disorders during the mental health intake. *Journal of Mental Health*, *27*(4), 314-321.

National Institute for Health and Care Excellence. (2021). *Borderline personality disorder: Recognition and management.* National Institute for Health and Care Excellence. https://www.nice.org.uk/guidance/cg78

Ng, F. Y., Bourke, M. E., & Grenyer, B. F. (2016). Recovery from borderline personality disorder: a systematic review of the perspectives of consumers, clinicians, family and carers. *PloS one*, *11*(8), e0160515.

Trevillion, K., Stuart, R., Ocloo, J., Broeckelmann, E., Jeffreys, S & Oram, S. (2022). Service user perspectives of community mental health services for people with complex emotional needs: a co-produced qualitative interview study. *BMC Psychiatry*, *22*(1), 1-18.

Tyrer, P., Mulder, R., Crawford, M. J., Newton-Howes, G., Simonsen, E., Ndetei, D., & Fossati, A. (2022). Personality disorder: A global perspective. *World Psychiatry, 21*(2), 245–246. https://doi.org/10.1002/wps.20976

Ring, D., & Lawn, S. (2019). Stigma perpetuation at the interface of mental health care: a review to compare patient and clinician perspectives of stigma and borderline personality disorder. *Journal of Mental Health*, 1-21.seen thst

Russell, C. (2018). *Inpatient care of individuals with personality disorders*. Forensic Network.

# Appendices

## Appendix 1: PRISMA checklist

### PRISMA 2020 Checklist

| Section and Topic | Item # | Checklist item | Location where item is reported |
|---|---|---|---|
| **TITLE** | | | |
| Title | 1 | Identify the report as a systematic review. | Abstract and methods |
| **ABSTRACT** | | | |
| Abstract | 2 | See the PRISMA 2020 for Abstracts checklist. | Abstract |
| **INTRODUCTION** | | | |
| Rationale | 3 | Describe the rationale for the review in the context of existing knowledge. | Introduction |
| Objectives | 4 | Provide an explicit statement of the objective(s) or question(s) the review addresses. | Introduction |
| **METHODS** | | | |
| Eligibility criteria | 5 | Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses. | Methods |
| Information sources | 6 | Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted. | Methods |
| Search strategy | 7 | Present the full search strategies for all databases, registers and websites, including any filters and limits used. | Appendix 2 |
| Selection process | 8 | Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process. | Methods |
| Data collection process | 9 | Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process. | Methods |
| Data items | 10a | List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect. | Methods |

| Section and Topic | Item # | Checklist item | Location where item is reported |
|---|---|---|---|
|  | 10b | List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information. | Table 3 |
| Study risk of bias assessment | 11 | Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process. | Methods, tables 1, 2 |
| Effect measures | 12 | Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results. | Table 4, results |
| Synthesis methods | 13a | Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)). | Methods, Figure 1, table 1 |
|  | 13b | Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions. | Methods |
|  | 13c | Describe any methods used to tabulate or visually display results of individual studies and syntheses. | Tables, 1,2,3, 3, 4,5,6,7.9, Figure 2 and 3 |
|  | 13d | Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used. | Methods-Data analysis, appendix 4 |
|  | 13e | Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression). | Results, Meta-analysis, figure 2, table 2, limitations |
|  | 13f | Describe any sensitivity analyses conducted to assess robustness of the synthesized results. | Methods-Data analysis, |
| Reporting bias assessment | 14 | Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases). | Results, tables 2 and 3 |

| Section and Topic | Item # | Checklist item | Location where item is reported |
|---|---|---|---|
| Certainty assessment | 15 | Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome. | N/A |
| **RESULTS** | | | |
| Study selection | 16a | Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram. | Methods Figure 1, results |
| | 16b | Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded. | Table 1, Figure 2, methods-screening |
| Study characteristics | 17 | Cite each included study and present its characteristics. | Table 4 |
| Risk of bias in studies | 18 | Present assessments of risk of bias for each included study. | Table 2 and 3 |
| Results of individual studies | 19 | For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots. | Table 4 |
| Results of syntheses | 20a | For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies. | Table 2 and 4 |
| | 20b | Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect. | Results, figure 2, tables 5 and 6 |
| | 20c | Present results of all investigations of possible causes of heterogeneity among study results. | Results, figure 2, discussion |
| | 20d | Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results. | Results, tables 4-9, discussion and limitations |

| Section and Topic | Item # | Checklist item | Location where item is reported |
|---|---|---|---|
| Reporting biases | 21 | Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed. | Table 2 &3, results, limitations |
| Certainty of evidence | 22 | Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed. | Table 4,Results Figure 2, discussion |
| **DISCUSSION** | | | |
| Discussion | 23a | Provide a general interpretation of the results in the context of other evidence. | discussion |
| | 23b | Discuss any limitations of the evidence included in the review. | Strengths& limitations |
| | 23c | Discuss any limitations of the review processes used. | Strengths& limitations |
| | 23d | Discuss implications of the results for practice, policy, and future research. | Implications |
| **OTHER INFORMATION** | | | |
| Registration and protocol | 24a | Provide registration information for the review, including register name and registration number, or state that the review was not registered. | Methods-registration |
| | 24b | Indicate where the review protocol can be accessed, or state that a protocol was not prepared. | Methods-registration-and appendix 3 |
| | 24c | Describe and explain any amendments to information provided at registration or in the protocol. | Abstract& Funding and Conflicts of Interest |
| Support | 25 | Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review. | Funding and Conflicts of Interest |

| Section and Topic | Item # | Checklist item | Location where item is reported |
|---|---|---|---|
| Competing interests | 26 | Declare any competing interests of review authors. | Funding and Conflicts of Interest |
| Availability of data, code and other materials | 27 | Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review. | Appendix 3 and 9 |

## Appendix 2: Full search strategies

| Database | Limiters | Search Strategy | Date search ran | Initial results |
|---|---|---|---|---|
| **OVID Embase** | Presentation/ diagnosis<br>Human population<br>English only<br>Peer reviewed<br>Remove Duplicates | 1.<br>borderline state/<br>2.<br>(borderline state or borderline or BPD or EUPD or (personalit* adj3 state*) or "Axis II" or "Cluster B" or flamboyant or "F60.3" or "F60.30" or "F60.31").mp.<br>3.<br>((unstab* or instab* or poor or disturb* or fail* or weak or dysregulat* or self* or impuls* or interperson* or identit* or relationship* or emotion* or affect) adj3 (personality or character or PD)).mp.<br>4.<br>or/1-3<br>5.<br>exp transgender/<br>6.<br>exp gender identity/<br>7.<br>exp sexual orientation/ | 5th July 2025 | 3,668 |

| | | | | |
|---|---|---|---|---|
| | | 8.<br>gender identity/<br>9.<br>(LGBT* or GLBT* or LGB or LGBQ* or LGBS* or M2F or GLB or GLBQ* or GLBs* or heteroflexible* or GBMSM* or msm or TGNC* or YTW or Gay or gays or lesbi* or bisexual* or transgender* or bicurious* or transpeople* or asexual* or "women loving women" or "women who have sex with women" or transvestite or cross sex* or crosssex* or crossgender* or F2M or transperson* or transsexual* or homosexual* or intersex* or queer*).mp.<br>10.<br>(trans adj2 (people or individual or individuals or person or persons or sexual* or man or men or male or female or youth* or woman or women or population*)).mp.<br>11.<br>((gender or gender* or sex or sexual) adj2 (change or dysphoria or reversal or identit* or reassign or transform* or transition* or minority* or sexual* or binary)).mp.<br>12.<br>or/5-11<br>13.<br>4 and 12 | | |
| **OVID Medline** | | 1.<br>borderline state/ | 5th July 2025 | 2,027 |

| | | | | |
|---|---|---|---|---|
| | | 2.<br>(borderline state or borderline or BPD or EUPD or (personalit* adj3 state*) or "Axis II" or "Cluster B" or flamboyant or "F60.3" or "F60.30" or "F60.31").mp.<br><br>3.<br>((unstab* or instab* or poor or disturb* or fail* or weak or dysregulat* or self* or impuls* or interperson* or identit* or relationship* or emotion* or affect) adj3 (personality or character or PD)).mp.<br><br>4.<br>or/1-3<br><br>5.<br>exp transgender/<br><br>6.<br>exp gender identity/<br><br>7.<br>exp sexual orientation/<br><br>8.<br>gender identity/<br><br>9.<br>(LGBT* or GLBT* or LGB or LGBQ* or LGBS* or M2F or GLB or GLBQ* or GLBs* or heteroflexible* or GBMSM* or msm or TGNC* or YTW | | |

| | | | | |
|---|---|---|---|---|
| | | or Gay or gays or lesbi* or bisexual* or transgender* or bicurious* or transpeople* or asexual* or "women loving women" or "women who have sex with women" or transvestite or cross sex* or crosssex* or crossgender* or F2M or transperson* or transsexual* or homosexual* or intersex* or queer*).mp.<br>10.<br>(trans adj2 (people or individual or individuals or person or persons or sexual* or man or men or male or female or youth* or woman or women or population*)).mp.<br>11.<br>((gender or gender* or sex or sexual) adj2 (change or dysphoria or reversal or identit* or reassign or transform* or transition* or minority* or sexual* or binary)).mp.<br>12.<br>or/5-11<br>13.<br>4 and 12 | | |
| **EBSCOhost: PsycINFO** | | 1. **MH "Borderline Personality Disorder"**<br>2. **TX (borderline state OR borderline OR BPD OR EUPD OR (personalit* N3 state*) OR "Axis II" OR "Cluster B" OR flamboyant OR "F60.3" OR "F60.30" OR "F60.31")**<br>3. **TX ((unstab* OR instab* OR poor OR disturb* OR dysregulat* OR self* OR impuls* OR interperson* OR identit* OR relationship* OR emotion* OR affect) N3 (personality OR character OR PD))** | 5th July 2025 | 2,183 |

| | | | | |
|---|---|---|---|---|
| | | 4. **S1 OR S2 OR S3**<br>5. **MH "Transgender Persons"**<br>6. **MH "Gender Identity"**<br>7. **MH "Sexual Orientation"**<br>8. **MH "Gender Identity"**<br>9. **TX (LGBT* OR GLBT* OR LGB OR LGBQ* OR LGBS* OR M2F OR GLB OR GLBQ* OR GLBs* OR heteroflexible* OR GBMSM* OR msm OR TGNC* OR YTW OR Gay OR gays OR lesbi* OR bisexual* OR transgender* OR bicurious* OR transpeople* OR asexual* OR "women loving women" OR "women who have sex with women" OR transvestite OR cross sex* OR crosssex* OR crossgender* OR F2M OR transperson* OR transsexual* OR homosexual* OR intersex* OR queer*)**<br>10. **TX (trans N2 (people OR individual OR individuals OR person OR persons OR sexual* OR man OR men OR male OR female OR youth* OR woman OR women OR population*))**<br>11. **TX ((gender OR gender* OR sex OR sexual) N2 (change OR dysphoria OR reversal OR identit* OR reassign OR transform* OR transition* OR minority* OR sexual* OR binary))**<br>12. **S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11**<br>13. **S4 AND S12** | | |

## Appendix 3: Systematic Review Open Science Framework link

All relevant appendices relevant to chapter 1’s systematic review, i.e. completed screening checklists, full critical appraisals, conceptual framework, meta-analysis dataset, syntax and output are available to view at:

OSF Disparities in the assessment and diagnosis of Borderline Personality Disorder (BPD) among minority sexualities and gender identities: A systematic review.

## Appendix 4: Description of concept analysis process

Drawing from Lindsay Prior's (2020) interpretation of content analysis as a method for tracing conceptual presence and relational meaning across texts, I carried out a conceptual analysis of the introduction, discussion and limitation sections of the included papers that explored BPD diagnoses in minority sexualities and gender identities.

Rather than treating the literature as a series of isolated findings, the process centred on identifying conceptual consistency and uncovering recurring concepts that shaped the various factors that lead to a BPD diagnosis were understood across the evidence-base.

- **Corpus Familiarisation**
  The first stage involved reading each study with attention to how BPD symptomology was framed in relation to minority sexualities and gender identities. I noted recurrent ideas like minority stress, trauma impact, and clinician bias as they emerged organically across papers. This step reflected Prior's notion of documents as cultural artefacts, signalling broader institutional assumptions.

- **Inductive Concept Identification**
  Rather than applying pre-defined categories, I extracted concepts that surfaced frequently and with interpretive weight. For instance, the notion of diagnostic ambiguity i.e. where identity development blurred with symptom expression, was flagged across multiple studies. I colour coded annotations on each paper (see coding key and sample below) and utilised a coding framework to track the presence, nuance, and position of each construct.

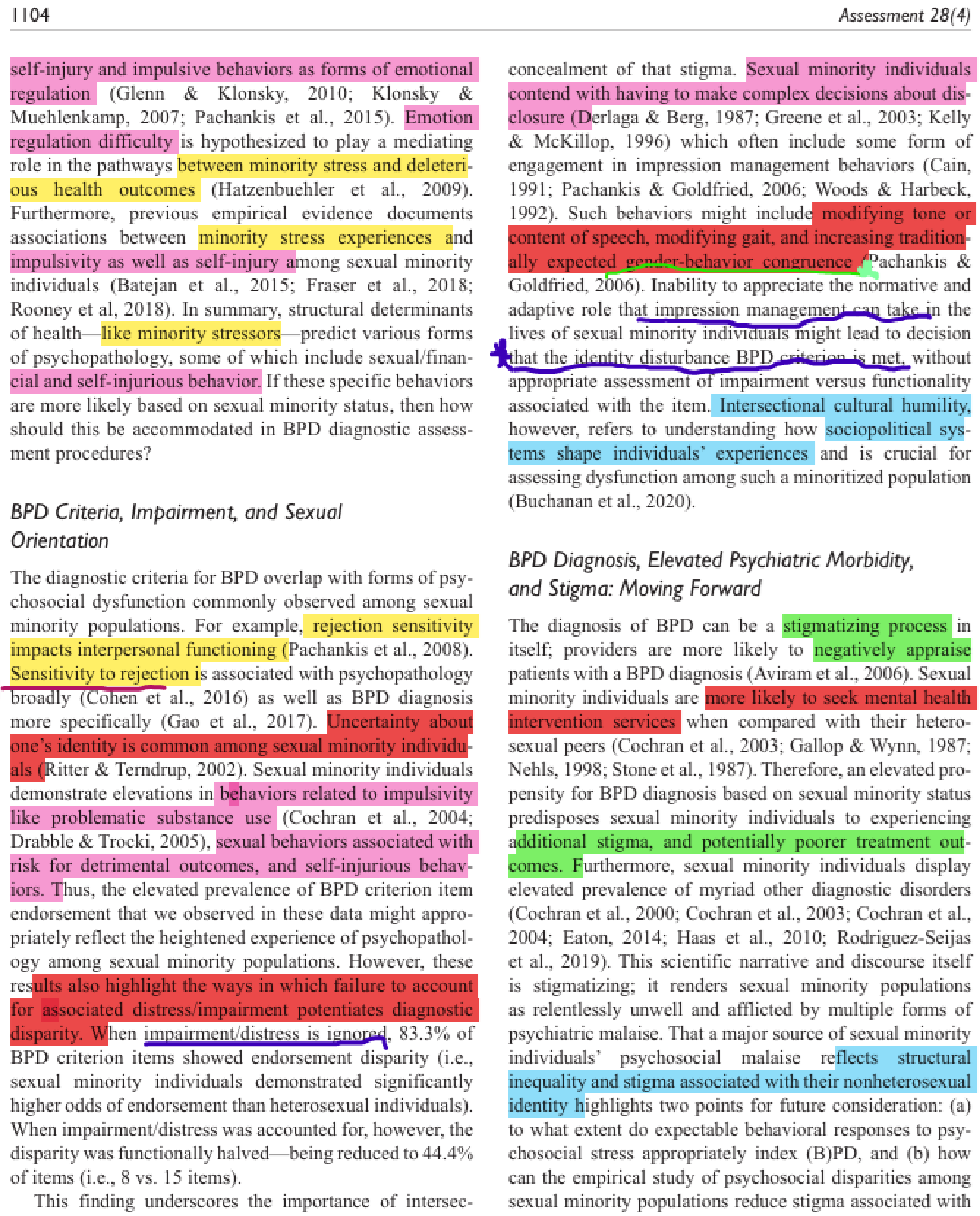
- **Matrix Development**
  These recurring constructs were then organised into a conceptual matrix, outlining how and where they appeared across the corpus. Concepts were clustered where overlapping themes were evident (e.g. clinician bias often intersected with emotion regulation framing or epistemic injustice) and I created a sematic map to depict these relationships. Definitions were refined to ensure clarity while retaining analytic depth.

- **Theoretical Integration**
  Drawing on minority stress theory, intersectionality, and epistemic injustice, the matrix was interpreted critically, not just documenting concept frequency, but considering how clinical discourses positioned SGM identities in relation to pathology. This aligned with Prior's emphasis on the social function of documents and the role of texts in reproducing meaning.

Overall, the process allowed for a structured and theoretically informed synthesis of diagnostic tensions by highlighting how intersecting identities, expression of distress, and clinical interpretation coalesce in the framing of BPD among LGBTQ+ populations.

**Coding key**

- Minority Stress
- Clinician Bias
- Intersectionality
- Measurement Issues
- Trauma History
- Identity Pathologisation
- Diagnostic Ambiguity
- Societal Norms



self-injury and impulsive behaviors as forms of emotional regulation (Glenn & Klonsky, 2010; Klonsky & Muehlenkamp, 2007; Pachankis et al., 2015). Emotion regulation difficulty is hypothesized to play a mediating role in the pathways between minority stress and deleterious health outcomes (Hatzenbuehler et al., 2009). Furthermore, previous empirical evidence documents associations between minority stress experiences and impulsivity as well as self-injury among sexual minority individuals (Batejan et al., 2015; Fraser et al., 2018; Rooney et al, 2018). In summary, structural determinants of health—like minority stressors—predict various forms of psychopathology, some of which include sexual/financial and self-injurious behavior. If these specific behaviors are more likely based on sexual minority status, then how should this be accommodated in BPD diagnostic assessment procedures?

### *BPD Criteria, Impairment, and Sexual Orientation*

The diagnostic criteria for BPD overlap with forms of psychosocial dysfunction commonly observed among sexual minority populations. For example, rejection sensitivity impacts interpersonal functioning (Pachankis et al., 2008). Sensitivity to rejection is associated with psychopathology broadly (Cohen et al., 2016) as well as BPD diagnosis more specifically (Gao et al., 2017). Uncertainty about one's identity is common among sexual minority individuals (Ritter & Terndrup, 2002). Sexual minority individuals demonstrate elevations in behaviors related to impulsivity like problematic substance use (Cochran et al., 2004; Drabble & Trocki, 2005), sexual behaviors associated with risk for detrimental outcomes, and self-injurious behaviors. Thus, the elevated prevalence of BPD criterion item endorsement that we observed in these data might appropriately reflect the heightened experience of psychopathology among sexual minority populations. However, these results also highlight the ways in which failure to account for associated distress/impairment potentiates diagnostic disparity. When impairment/distress is ignored, 83.3% of BPD criterion items showed endorsement disparity (i.e., sexual minority individuals demonstrated significantly higher odds of endorsement than heterosexual individuals). When impairment/distress was accounted for, however, the disparity was functionally halved—being reduced to 44.4% of items (i.e., 8 vs. 15 items).

This finding underscores the importance of intersec-

concealment of that stigma. Sexual minority individuals contend with having to make complex decisions about disclosure (Derlaga & Berg, 1987; Greene et al., 2003; Kelly & McKillop, 1996) which often include some form of engagement in impression management behaviors (Cain, 1991; Pachankis & Goldfried, 2006; Woods & Harbeck, 1992). Such behaviors might include modifying tone or content of speech, modifying gait, and increasing traditionally expected gender-behavior congruence (Pachankis & Goldfried, 2006). Inability to appreciate the normative and adaptive role that impression management can take in the lives of sexual minority individuals might lead to decision that the identity disturbance BPD criterion is met, without appropriate assessment of impairment versus functionality associated with the item. Intersectional cultural humility, however, refers to understanding how sociopolitical systems shape individuals' experiences and is crucial for assessing dysfunction among such a minoritized population (Buchanan et al., 2020).

### *BPD Diagnosis, Elevated Psychiatric Morbidity, and Stigma: Moving Forward*

The diagnosis of BPD can be a stigmatizing process in itself; providers are more likely to negatively appraise patients with a BPD diagnosis (Aviram et al., 2006). Sexual minority individuals are more likely to seek mental health intervention services when compared with their heterosexual peers (Cochran et al., 2003; Gallop & Wynn, 1987; Nehls, 1998; Stone et al., 1987). Therefore, an elevated propensity for BPD diagnosis based on sexual minority status predisposes sexual minority individuals to experiencing additional stigma, and potentially poorer treatment outcomes. Furthermore, sexual minority individuals display elevated prevalence of myriad other diagnostic disorders (Cochran et al., 2000; Cochran et al., 2003; Cochran et al., 2004; Eaton, 2014; Haas et al., 2010; Rodriguez-Seijas et al., 2019). This scientific narrative and discourse itself is stigmatizing; it renders sexual minority populations as relentlessly unwell and afflicted by multiple forms of psychiatric malaise. That a major source of sexual minority individuals' psychosocial malaise reflects structural inequality and stigma associated with their nonheterosexual identity highlights two points for future consideration: (a) to what extent do expectable behavioral responses to psychosocial stress appropriately index (B)PD, and (b) how can the empirical study of psychosocial disparities among sexual minority populations reduce stigma associated with

## Appendix 5: COREQ Checklist

# Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

| **No. Item** | **Guide questions/description** | **Reported on Page #** |
|---|---|---|
| **Domain 1: Research team and reflexivity** | | |
| *Personal Characteristics* | | |
| 1. Interviewer/facilitator | Which author/s conducted the interview or focus group? | 56 |
| 2. Credentials | What were the researcher's credentials? E.g. PhD, MD | 57 |
| 3. Occupation | What was their occupation at the time of the study? | 57 |
| 4. Gender | Was the researcher male or female? | 57 |
| 5. Experience and training | What experience or training did the researcher have? | 57 |
| *Relationship with participants* | | |
| 6. Relationship established | Was a relationship established prior to study commencement? | **56/57** |
| 7. Participant knowledge of the interviewer | What did the participants know about the researcher? e.g. personal goals, reasons for doing the research | 56 |
| 8. Interviewer characteristics | What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic | 57 |

| | | |
|---|---|---|
| **Domain 2: study design** | | |
| *Theoretical framework* | | |
| 9. Methodological orientation and Theory | What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis | 56 |
| *Participant selection* | | |
| 10. Sampling | How were participants selected? e.g. purposive, convenience, consecutive, snowball | 56 |
| 11. Method of approach | How were participants approached? e.g. face-to-face, telephone, mail, email | 56 |
| 12. Sample size | How many participants were in the study? | 56 |
| 13. Non-participation | How many people refused to participate or dropped out? Reasons? | N/A |
| *Setting* | | |
| 14. Setting of data collection | Where was the data collected? e.g. home, clinic, workplace | 56 |
| 15. Presence of non-participants | Was anyone else present besides the participants and researchers? | 56 |
| 16. Description of sample | What are the important characteristics of the sample? e.g. demographic data, date | 56 |
| *Data collection* | | |
| 17. Interview guide | Were questions, prompts, guides provided by the authors? Was it pilot tested? | 56, Link to full schedule in Appendix 7 |
| 18. Repeat interviews | Were repeat interviews carried out? If yes, how many? | 56 |
| 19. Audio/visual recording | Did the research use audio or visual recording to collect the data? | 56 |
| 20. Field notes | Were field notes made during and/or after the interview or focus group? | 56 |
| 21. Duration | What was the duration of the interviews or focus group? | 56 |
| 22. Data saturation | Was data saturation discussed? | 57 |
| 23. Transcripts returned | Were transcripts returned to participants for comment and/or correction? | 56 |
| **Domain 3: analysis and** | | |

| **findings** | | |
|---|---|---|
| *Data analysis* | | |
| 24. Number of data coders | How many data coders coded the data? | 57 |
| 25. Description of the coding tree | Did authors provide a description of the coding tree? | 57 |
| 26. Derivation of themes | Were themes identified in advance or derived from the data? | 57 |
| 27. Software | What software, if applicable, was used to manage the data? | n/a |
| 28. Participant checking | Did participants provide feedback on the findings? | 56 |
| *Reporting* | | |
| 29. Quotations presented | Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number | Pseudonyms used. |
| 30. Data and findings consistent | Was there consistency between the data presented and the findings? | 59-72 |
| 31. Clarity of major themes | Were major themes clearly presented in the findings? | 59-72 |
| 32. Clarity of minor themes | Is there a description of diverse cases or discussion of minor themes? | 59-72 |

## Appendix 6: Ethical approval confirmations

**MVLS College Ethics Committee**

*Qualitative Study Exploring Clinician's Perceptions of the Diagnosis of Borderline Personality Disorder within Older People.* *200230349*

The College Ethics Committee has reviewed your application and has agreed that there is no objection on ethical grounds to the proposed study.

We are happy therefore to approve the project, subject to the following conditions

- NHS GG&C R&I approvals in place
- No concerns from Data Protection Office
- Project end date as stipulated in original application.
- The data should be held securely for a period of ten years after the completion of the research project, or for longer if specified by the research funder or sponsor, in accordance with the University's Code of Good Practice in Research: (http://www.gla.ac.uk/media/media_227599_en.pdf)
- The research should be carried out only on the sites, and/or groups or datasets as defined in the application.
- Any proposed changes in the protocol should be submitted for reassessment, except when it is necessary to change the protocol to eliminate hazard to the subjects or where the change involves only the administrative aspects of the project. The Ethics Committee should be informed of any such changes.
- For projects requiring the use of an online questionnaire, the University has an Online Surveys account for research. To request access, see the University's application procedure at https://www.gla.ac.uk/research/strategy/ourpolicies/useofonlinesurveystoolforresearch/.
- You should submit a short end of study report within 3 months of completion.

Yours sincerely,

Dr Terry Quinn

**Terry Quinn**
FWSO, FESO, MD, FRCP, BSc (hons), MBChB (hons)

College of Medicine, Veterinary & Life Sciences

School of Cardiovascular and Metabolic Health

New Lister Building, Glasgow Royal Infirmary

Glasgow G31 2ER

terry.quinn@glasgow.gla.ac.uk
Tel – 0141 201 8519

The University of Glasgow, charity number SC004401

NHS
Greater Glasgow
and Clyde

**Research & Innovation**
**Dykebar Hospital, Ward 11**
**Grahamston Road**
**Paisley, PA2 7DE**
**Scotland, UK**

19/06/2024

Danielle Campbell
NHSGGC
Gartnavel Royal Hospital
Glasgow

## NHS GG&C Board Approval

Dear Ms Campbell

| | |
|---|---|
| **Study Title:** | A Qualitative Study Exploring Clinicians Perceptions of the Diagnosis of Borderline Personality Disorder within Older People |
| **Principal Investigator:** | Danielle Campbell |
| **GG&C HB site** | Older People & Adult MH Services across NHS Greater Glasgow & Clyde |
| **Sponsor** | University of Glasgow |
| **R&I reference:** | UGN24MH171 |
| **REC reference:** | N/A - NHS REC not req'd (staff-only study) |
| **Protocol no: (including version and date)** | V1.3 – 27.11.2023 |

I am pleased to confirm that Greater Glasgow & Clyde Health Board is now able to grant **Approval** for the above study.

**Conditions of Approval**

1. **For Clinical Trials** as defined by the Medicines for Human Use Clinical Trial Regulations, 2004
    a. During the life span of the study GGHB requires the following information relating to this site
        i. Notification of any potential serious breaches.
        ii. Notification of any regulatory inspections.

It is your responsibility to ensure that all staff involved in the study at this site have the appropriate GCP training according to the GGHB GCP policy (www.nhsggc.org.uk/content/default.asp?page=s1411), evidence of such training to be filed in the site file. Researchers must follow NHS GG&C local policies, including incident reporting.

2. **For all studies** the following information is required during their lifespan.
    a. First study participant should be recruited within 30 days of approval date.
    b. Recruitment Numbers on a monthly basis
    c. Any change to local research team staff should be notified to R&I team
    d. Any amendments – Substantial or Non Substantial

## Appendix 7: MRP Open Science Framework link

The approved proposal (https://osf.io/qyfmd ),

participant information sheet (https://osf.io/yhkaq ),

consent form (https://osf.io/mgtxd ),

recruitment process (https://osf.io/cme4g ),

thematic analysis plan (https://osf.io/g7hq5 ) and

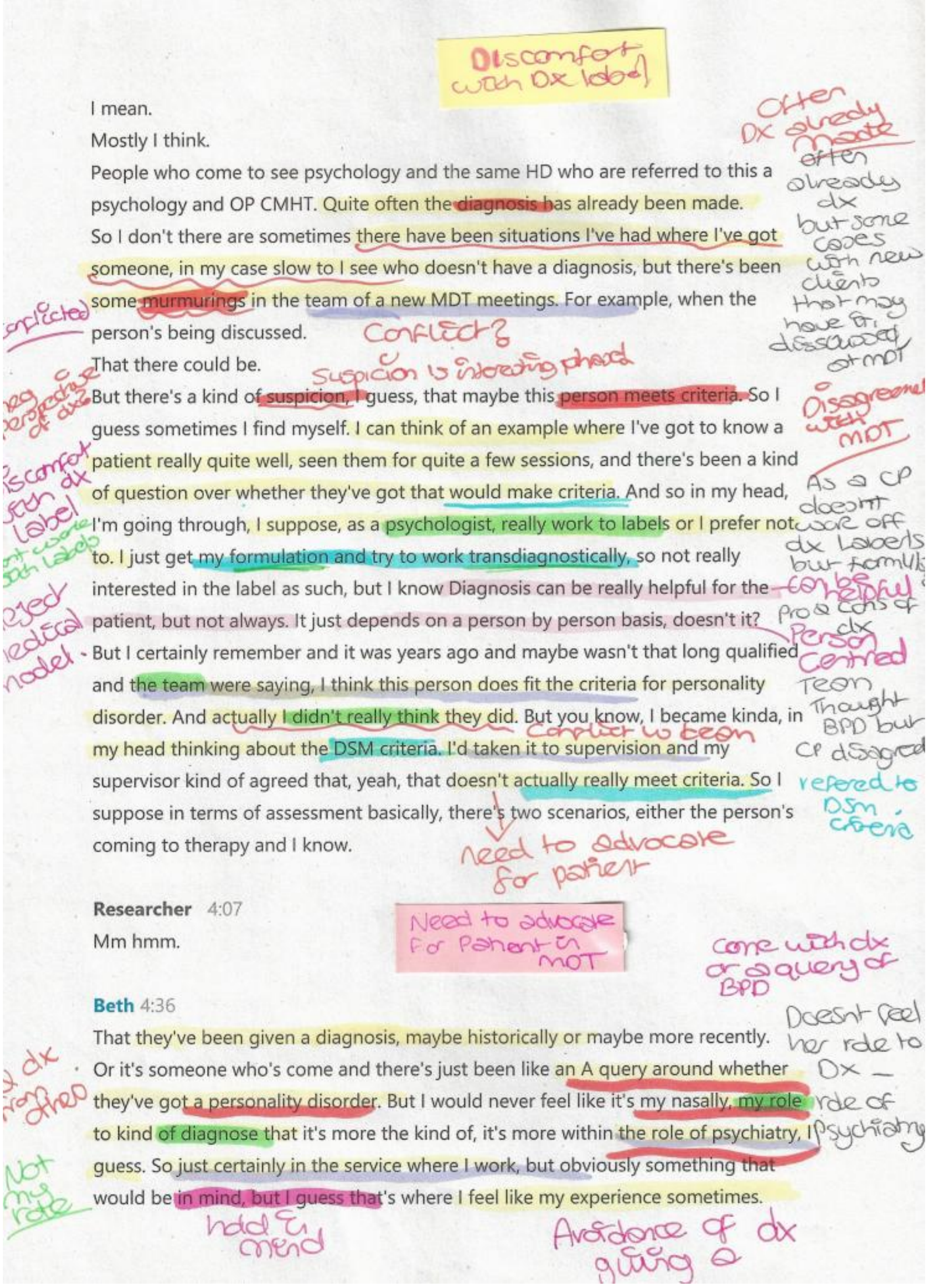
interview schedule (https://osf.io/3kjaq ) are all available to view at;

OSF | A Qualitative Study Exploring Clinicians' Perceptions of the Diagnosis of Borderline Personality Disorder within Older People.

## Appendix 8: Description of the thematic analysis process

Following Braun and Clarke’s (2022) reflexive framework, I used a bottom-up, inductive process to analyse the data. I began by familiarising myself with the transcripts which entailed highlighting phrases, words, and sentences that felt significant during initial readings. I wrote early impressions directly onto the pages in pen, using the margins for informal annotation to let ideas emerge naturally.

After familiarisation, I returned to the data and identified descriptive and inductive codes from the content. These were highlighted in different colours or underlined to differentiate ideas and analytic directions. The codes were noted by hand on the transcripts to stay close to the data and retain a tactile understanding of participants’ language.



I mean.
Mostly I think.
People who come to see psychology and the same HD who are referred to this a psychology and OP CMHT. Quite often the diagnosis has already been made.
So I don't there are sometimes there have been situations I've had where I've got someone, in my case slow to I see who doesn't have a diagnosis, but there's been some murmurings in the team of a new MDT meetings. For example, when the person's being discussed.
That there could be.
But there's a kind of suspicion, I guess, that maybe this person meets criteria. So I guess sometimes I find myself. I can think of an example where I've got to know a patient really quite well, seen them for quite a few sessions, and there's been a kind of question over whether they've got that would make criteria. And so in my head, I'm going through, I suppose, as a psychologist, really work to labels or I prefer not to. I just get my formulation and try to work transdiagnostically, so not really interested in the label as such, but I know Diagnosis can be really helpful for the patient, but not always. It just depends on a person by person basis, doesn't it?
But I certainly remember and it was years ago and maybe wasn't that long qualified and the team were saying, I think this person does fit the criteria for personality disorder. And actually I didn't really think they did. But you know, I became kinda, in my head thinking about the DSM criteria. I'd taken it to supervision and my supervisor kind of agreed that, yeah, that doesn't actually really meet criteria. So I suppose in terms of assessment basically, there's two scenarios, either the person's coming to therapy and I know.

**Researcher** 4:07
Mm hmm.

**Beth** 4:36
That they've been given a diagnosis, maybe historically or maybe more recently.
Or it's someone who's come and there's just been like an A query around whether they've got a personality disorder. But I would never feel like it's my nasally, my role to kind of diagnose that it's more the kind of, it's more within the role of psychiatry, I guess. So just certainly in the service where I work, but obviously something that would be in mind, but I guess that's where I feel like my experience sometimes.

To help visualise and group emerging concepts, I used post-it notes to capture key inductive codes, particularly those that appeared across transcripts. These notes allowed me to cluster ideas and spot initial patterns while reflecting on tensions and possible contradictions.

This process was iterative with the codes and patterns evolving as I revisited the data and refined my interpretations. I then took note of all the emerging codes on a word document and adding  to it with each transcript. I then went through the codes and grouped them into emergent themes, of which 21 distinct subthemes emerged. I defined each subtheme within a table which I  used to group into core themes. I then met with my supervisor who had independently coded a sample of  the transcripts and we compared our findings. From this, the core themes were then clearly defined and it was agreed that Clinical implications of diagnosis, Clinicians' feeling "stuck," "helpless," or unsupported, Client's ability to engage had enough thematic seperation from Systemic Constraints and Care Logics and a fifth theme; Function vs. Futility of Diagnosis was developed, see table 10 below. The themes were shared with two experts by experience that had been involved in the initial research stages who provided some feedback on their perceptions and hopes for future research/ clinical implications.

**Table 10. Definitions of themes and subthemes (working draft)**

| Theme | Subthemes | Description |
|---|---|---|
| **Re-Emergence and Recognition**<br>This theme explores how previously overlooked or well-managed patterns of emotional and interpersonal difficulty surface later in life. These difficulties often re-emerge around key transitions and prompt new engagement with services, leading to increased clinician recognition of personality-related traits in older people. | Missed or previously managed patterns throughout life | Clinicians reflect on historical patterns of difficulties that were not identified as BPD, were masked by a protective factor (i.e. spouse) or other life roles (e.g. parenting, employment). |
| | Escalation of distress during transitions | Distress increases due to aging, bereavement, or life changes. These transitions destabilise coping strategies and trigger re-referral or risk escalation. |
| | Changes in risk/crisis in old age | Focuses on how clients' level of risk and crises often evolve with aging, leading to a first engagement with mental health services or increased need to manage risk. |
| | Growing awareness/ recognition | Clinicians reported increase in personality related presentations which indicate an increase in awareness and recognition of traits. |
| **Manifestations and Meaning:**<br>This theme examines how BPD traits are perceived in older people, and how historical trauma, generational factors, and service engagement shape the expression and interpretation of these behaviours. | Interpersonal difficulties | Explores challenges individuals face in social interactions, mistrust, boundary testing, relational volatility, or emotional dependence. |
| | Generational shifts in presentations | Addresses how patterns of mental health or behavioural issues may change across generations, reflecting evolving cultural norms and the impact of aging. |
| | Experiences of trauma/adversity | Focuses on how past trauma or adversity impacts current behaviours and mental health presentations. |
| | Mistrust/over-dependency in services | Looks at how clients may develop mistrust or become overly dependent to services, complicating treatment. |
| **Diagnostic Discomfort and dissonance**<br>This theme reflects clinicians' inner and interpersonal conflict around using the BPD diagnosis in older people. It includes concerns about stigma, relational rupture, and emotional impact. | Clinician ambivalence or fear about giving the diagnosis | Hesitation to apply the label due to stigma, age-related norms, or relational consequences. |
| | Concern that diagnosis will lead to rupture or stigma | Worry that the diagnosis could harm therapeutic alliance, impact locus of control or reinforce societal stigma. |
| | Emotional Dissonance | Emotional burden (guilt, frustration, avoidance) and inner turmoil of the clinician (will this help my client?). |

| | | |
|---|---|---|
| | Conflict within teams about the diagnosis. | Differing views among disciplines about whether BPD is appropriate or helpful in this population. |
| **Systemic Constraints and Care Logics**<br>This theme captures the structural and service-level factors shaping how BPD is treated in older adult mental health services. It includes barriers to assessment, differing expectations between disciplines, multidisciplinary dynamics, and treatment delivery. | Whole team approach | Emphasises the importance of involving multiple professionals in the development of a holistic care plan. |
| | Clinician role diffusion | Clinicians often described rigid ideas of the limits of their role and there was differing expectations around which professional should take the lead in diagnosing or managing BPD in older people. |
| | Gaps in evidence base | Highlights the need for more empirical evidence and guidance to improve the quality of assessment and diagnostic process for older people. |
| | Barriers to the use of measures | Refers to the use and challenges of utilising measures within practice (diagnostic criteria, psychometrics and problem specific tools) |
| | Formulation driven care | Recognition of formulation driven treatment that target specific symptoms or BPD specific traits related to the client’s presenting difficulties. |
| | Systemic pressures | Considers confounding factors such as quality of support systems, staff turnover, compassion fatigue etc. that may influence the person’s care |
| **Function vs. Futility of Diagnosis**<br>This theme explores clinicians’ reflections on the *practical consequences* of using a BPD diagnosis. It focuses on whether the label enables care or adds barriers — and whether clients benefit from knowing the diagnosis. | Clinical implications of diagnosis | Included discussion of accessing diagnosis specific specialist resources as well as concerns about the impact of diagnosis such as a fear of client rupture. |
| | Clinicians’ feeling “stuck,” “helpless,” or unsupported. | Describes clinician’s experiences of emotional fatigue, lack of systemic support, or therapeutic impasses. |
| | Client’s ability to engage | Refers to the client’s level of insight and participation in their own treatment process, including engagement with clinicians and therapies. |

## Appendix 9: Data availability statement

The author confirms that data supporting the findings of the systematic review is openly available at:

OSF Disparities in the assessment and diagnosis of Borderline Personality Disorder (BPD) among minority sexualities and gender identities: A systematic review.

The supplementary material for the empirical study is openly available at:

OSF | A Qualitative Study Exploring Clinicians' Perceptions of the Diagnosis of Borderline Personality Disorder within Older People.

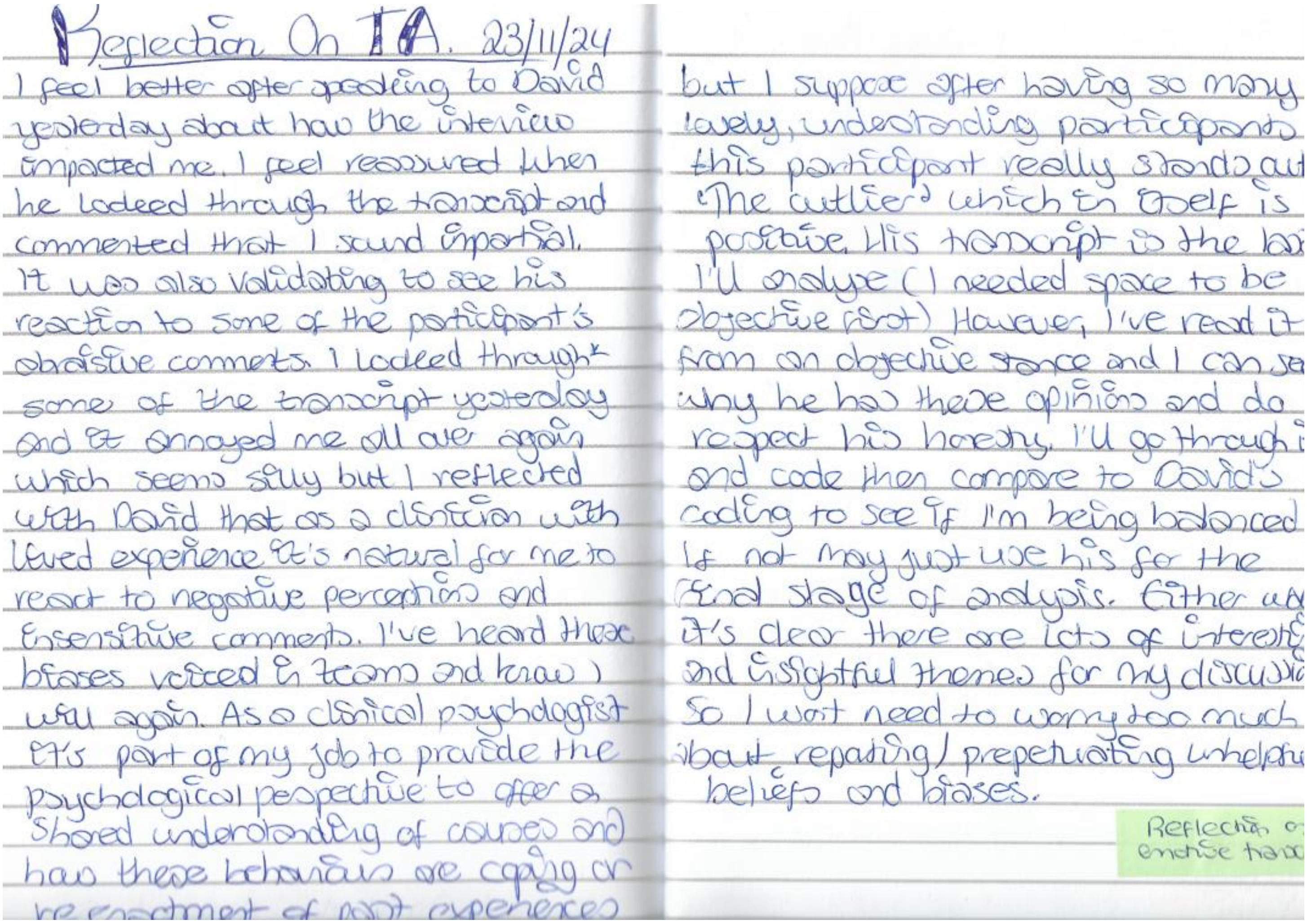
Written and verbal consents were obtained from participants; however, this did not include permission for their data to be shared for public access. Therefore, supporting data, such as scanned transcripts, are not publicly available due to concerns that despite the data being pseud-anonymised, there may still be information that could compromise the privacy of research participants. Additional requests may be made to the corresponding author, DC, for access to supporting data.

All data was securely stored on the researcher's University of Glasgow OneDrive server and in adherence to University and NHS GGC policy will be available for ten years.

## Appendix 10: Sample of reflective log

As discussed in the reflexivity statement, the primary research kept a handwritten reflective diary throughout the research process to reflect on interviews and throughout the analysis process. This was helpful to manage any emotions that some of the content may have brought up for her.

Below is a sample of the researcher's reflection following the analysis of an emotive interview.



Reflection On TA. 23/11/24

I feel better after speaking to David yesterday about how the interview impacted me. I feel reassured when he looked through the transcript and commented that I sound impartial. It was also validating to see his reaction to some of the participant's abrasive comments. I looked through* some of the transcript yesterday and it annoyed me all over again which seems silly but I reflected with David that as a clinician with lived experience it's natural for me to react to negative perceptions and insensitive comments. I've heard these biases voiced in teams and know I will again. As a clinical psychologist it's part of my job to provide the psychological perspective to offer a shared understanding of causes and how these behaviours are coping or re enactment of past experiences but I suppose after having so many lovely, understanding participants this participant really stands out "The outlier" which in itself is positive. His transcript is the las I'll analyse (I needed space to be objective first) However, I've read it from an objective stance and I can se why he has these opinions and do respect his honesty. I'll go through i and code then compare to David's coding to see if I'm being balanced if not may just use his for the final stage of analysis. Either wa it's clear there are lots of interesti and insightful themes for my discussi So I won't need to worry too much about repeating/prepetuating unhelpfu beliefs and biases.

Reflection o
emotive tran