University of Glasgow

Collins, Kirsty Margaret (2026) *Investigating pathways to care in young people (14-25) with Borderline Personality Disorder features.* PhD thesis.

https://theses.gla.ac.uk/86266/

Copyright and moral rights for this work are retained by the author

A copy can be downloaded for personal non-commercial research or study, without prior permission or charge

This work cannot be reproduced or quoted extensively from without first obtaining permission in writing from the author

The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the author

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given

Enlighten: Theses
https://theses.gla.ac.uk/
research-enlighten@glasgow.ac.uk

Investigating Pathways to Care in Young People (14-25) with Borderline Personality Disorder Features

Kirsty Margaret Collins (BSc Hons; MSc)

Student number: xxxxxxxx

(February 2026)

PhD

Submitted in fulfilment of the requirements for the degree of Doctor of Philosophy in

Mental Health and Wellbeing

(Alternative Format)

School of Health and Wellbeing

Medical Veterinary and Life Sciences

University of Glasgow

Abstract

An extensive literature review was conducted prior to embarking on empirical paper write-up. To carry out this literature review the following was implemented: First, the area of review was established with University supervisors, then relevant articles were searched by the first author using these databases: Web of Science; Google Scholar; Pub Med; CAS and University of Glasgow library database and the integrity of each paper was assessed and critically analysed, with findings laid out in the form of a literature review. The search terms and key words included: Borderline Personality Disorder or BPD AND history*, phenomenology*, aetiology*, adolescence/adolescents*, myths*, co-morbidity* trauma*, theories*, pathways*, prevalence*. The literature searched spanned 1938 - 2026. The decision to not undertake a systematic review was made owing to the broad nature of borderline personality disorder features (BPD; here on referred to as BPD or BPD features) research available with nascent research on pathways to care for young people with BPD features; this allowed for a deeper investigation into the wide literature available and for the gaps in research and service provisions for young people with complex needs characteristic of BPD, particularly the importance of lived experience in research and pathways to care in BPD, to be identified.

The literature review introduces the concept of BPD, the key theories, and characteristic of BPD, which are explored throughout the papers in this PhD thesis.

The thesis presents four papers, with the first describing the importance of lived experience of BPD in research (chapter 3) for developing a shared understanding of BPD, from both a researcher's perspective and from the point of view of those who are experts by experience. Throughout the thesis, there is emphasis on the importance of input from BPD experts by experience and emphasis

of experiential analysis. Experts by experience play a pivotal role in both this thesis and in research overall (Fischer et al., 2024). The powerful nature of the impact of lived experienced voices allows for a first-hand insight into journeys through varied systems such as criminal justice and health care systems, in turn, allowing for unique perspectives to drive change, influence co-design of research and tackle systemic challenges i.e. structural stigma in BPD (Collins et al., 2025). Mental health funding institutes such as NIHR and the Wellcome Trust (Banfield & Palmer, 2025) claim lived experience input to be imperative rather than desirable in research. More often services are relying on peers for support work from experts by experience. This thesis meets in a middle ground whereby the author is both a researcher and expert by experience. Arguably, this could drive bias through the thesis, but this is mitigated by the empirical studies using varied methodologies and the researcher's reflexivity throughout.

Chapter 4 uses data from 'The Pathways Study' (Gajwani et al., 2022) clinical case studies, exploring developmental pathways to care in conjunction with signs and symptoms from childhood through to age of participation in young adulthood (14-25). All participants had been through services but BPD, either threshold or subthreshold, was not identified. In this study, particular attention was paid to assessing developmental risk factors, particularly the role of neurodivergence in the emergence of BPD features. All four participants included in the case study analysis met criteria for neurodivergence traits but did not have a diagnosis at the time of the study. In addition, the lack of recognition of signs and symptoms of BPD features, by services during the course of the young person's involvement, highlighted the missed opportunities for care and a better understanding of the developmental evolution of BPD features in a young person's life. The findings in turn emphasised

the potential for missing early markers of risk and resilience, such as neurodivergence. It is then argued that a comprehensive and collaborative approach to assessing pathways to care would support the understanding of development of BPD features as well as an understanding of when, across the trajectory, BPD emerges in the context of neurodivergence. In addition, the case study helps understand the complex interplay between early adversity and neurodivergence in the context of BPD features.

Chapter 5, an Interpretative Phenomenological Analysis (IPA), attempts to lay the foundations for understanding participant experience of pathways to care in the context of The BRIDGE Project (Gajwani et al., 2024); their journeys through mental health care prior to and during their participation, and the barriers and facilitators they have experienced. Participants (n = 7) described barriers such as stigma, poor individualised care, and lack of continuity of care. The BRIDGE Project is a feasibility randomised controlled trial (fRCT) of brief, intensive assessment, and integrated formulation for young people (age 14-24) with features of borderline personality disorder (BPD). Participants were recruited from multiple community sectors including the National Health Service (NHS), community colleges and Universities and through social media advertising in Glasgow, Scotland. Twenty-five participants were randomised to either BRIDGE intervention or services-as-usual (SAU) and followed up at 12 (T1) and 24 weeks (T2). Those in the BRIDGE intervention arm were offered comprehensive assessments, up to 16 sessions on cognitive analytic therapy (CAT) and contextual intervention with services unique to the young person.

Although there were limitations to analysis of pathways to care, such as a small sample size, the value of lived experience explored empirically, in the form of IPA, echoes the benefits of incorporating experts by experience into research and

examining their experiences qualitatively (Fischer et al., 2024). The study highlighted the benefits of thorough, individualised assessment and care and directs future research to look at barriers to implementation of early BPD intervention. Importantly, the influence of historical missed identification for complex unmet needs and its impact on different aspects of the participants young lives is evident in the findings.

Further, in chapter 6, a clinical reflection is offered which explores the contentious issue of stigma associated with BPD and recommendations for informative collaboration between those with lived experience, including parents and carers, and health care professionals.

Contents

Abstract **2**

Contents 6

List of Papers 9

Contributions to papers 11

List of tables 12

List of figures 13

Appendices 14

Acknowledgements 15

Author's Declaration 16

Key terms with definitions 17

Abbreviations 20

Chapter 1: Literature review **22**

1. Understanding Borderline Personality Disorder 22

    1.1. What is 'Borderline Personality Disorder' (BPD)? 22
    1.2. Historical background 23
    1.3. Diagnostic controversies 24
    1.4. Categorical versus Dimensional Diagnosis of BPD 27
    1.5. BPD and overlapping clinical features: prevalence and implications 32

2. Developmental Pathways 36

    2.1. The Biosocial Theory (Linehan, 1993) & The Biosocial Development Model (Crowell et al., 2009). 36
    2.2. Emotional Cascade Model (Selby & Joiner, 2009) 39
    2.3. Mentalisation (Bateman & Fonagy, 2004) 41
    2.4. Neurodivergence and BPD developmental pathways 45
    2.5. Trauma and BPD developmental pathways 49
    2.6. Neurodivergence and trauma in BPD developmental pathways: Double jeopardy 53

3. Adolescence and BPD **55**

    3.1. Adolescent diagnosis versus adult diagnosis 55
    3.2. Early intervention for adolescents 58

3.3. Barriers in pathways to care 60
3.4. Stigma in BPD 63
4. Summary 65
5. Research aims 66
References 68

Chapter 2: Methodology **95**
1.1. Research challenges in exploring pathways to care in BPD 95
1.2. Researcher positionality 97
1.3. Research methodology 99
References 110

Chapter 3: Lived Experience of BPD **116**
Reflections on Chapter 3 123
References 126

Chapter 4: Pathways to care **128**
Abstract 128
1. Introduction 130
1.1. Adolescent BPD 131
1.2. Developmental pathways 133
2. Methods: 133
2.1. Procedure 133
2.2. Measures 134
2.3. Sampling 139
3. Analysis 140
4. Results 141
5. Discussion 151
References 157
Reflections on Chapter 4 167

Chapter 5: Journeys through care **170**
Abstract 171
1. Introduction 171
2. Methods: 175
2.1. Recruitment and Participants 175
2.2. Design 176
2.3. Data Analysis 177
2.4. Semi- Structured Interview 178
3. Results 178
4. Discussion 189
5. Conclusion 197
References 198

Reflections on Chapter 5 204

Chapter 6: Stigma **207**
1.1. Summary 207
1.2. Understanding Stigma First-Hand 207
1.3. Self-stigmatisation and structural stigma in BPD 208
1.4. Late diagnosis and perpetuation of stigma in BPD 210
1.5. BPD or typical teenage trajectory? 210
1.6. Age-related discrimination 211
1.7. Practical suggestions for including patients' experience in clinical practice 212
References 214
Reflections on Chapter 6 215

Discussion **218**
7.1. Overview 218
7.2. Findings 222
7.2.1. Chapter 3: Lived Experience 222
7.2.2. Chapter 4: Where is the Care? 226
7.2.3. Chapter 5: *"It was a horrible, just horrible, journey":* 232
7.2.4. Chapter 6: Stigma 239
7.3. PhD as part of a feasibility randomised controlled trial 240
7.4. Strengths and limitations 242
7.5 Clinical and research Implications 249

Conclusion **253**
References 256

Appendices **266**
Appendix 1: The BRIDGE Project Protocol (Gajwani et al, 2024) 266
Appendix 2: Ethical Approval for The BRIDGE Project 287
Appendix 3: Information sheet for The BRIDGE Project 291
Appendix 4: Consent form for The BRIDGE Project 297
Appendix 5: Interview Schedule 299

List of Papers

- Paper 1: Published (Journal of Psychiatric Practice) (Chapter 3)

McAllister, K. M. (2023) Through the valley of the shadow of death. Journey through major mental illness as experienced by a mental health PhD candidate. *Journal of Psychiatric Practice, 29(3)*, 235. https://doi.org/10.1097/PRA.0000000000000705

- Paper 2: Submitted to Early Intervention in Psychiatry (Chapter 4) (under review)

Collins, K.M., Maule, D., Nelson, R., Smith M., Gumley, A., Minnis, H., Gajwani, R. (2025). Where's the care? Pathways to care for early borderline personality disorder case study analysis.

- Paper 3: Accepted (subject to revisions) to PLOS one (Chapter 5)

Collins, K.M., Smith, H., McIntosh, E., Moran, P., Ougrin, Dennis, Chanen, A., Minnis, H., Gajwani, R., (2025) "It was a horrible, just horrible, journey": A qualitative examination of the journey through care and treatment of 14-24 years with borderline personality disorder features.

- Paper 4: Published (The British Journal of Psychiatrists: Advances) (Chapter 6)

Collins, K. M., Minnis, H., & Gajwani, R. (2025). Using clinician–patient collaboration to tackle structural stigma and age discrimination in borderline personality disorder. *BJPsych Advances*, 1-3. https://doi.org/10.1192/bja.2025.10140

- Appendix 1:

Gajwani, R., Sim, F., McAllister, K., Smith, H., McIntosh, E., Moran, P., Ougrin, D., Smith, M., Gumley, A. I., Chanen, A. M., & Minnis, H. (2024). The BRIDGE project: A feasibility randomised controlled trial of brief, intensive assessment, and integrated formulation for young people (age 14-24) with features of borderline

personality disorder(protocol). *Frontiers in Psychiatry*, 15,1389578. https://doi.org/10.3389/fpsyt.2024.1389578

Contributions to papers:

Paper 1: I was responsible for the conceptualisation of sharing my lived experience of BPD and my pathways to care and stigma experienced. I was responsible for writing the original draft and R. Gajwani and H. Minnis provided review and edits.

Paper 2: I was responsible for providing an up-to-date review of literature, data refinement and the final writing of the manuscript. All co-authors were involved in the design of the original study and feedback of the final manuscript.

Paper 3: I was responsible for conceptualisation of the research topic, aims and objectives in supervision and agreement with supervisors, R. Gajwani and H. Minnis. I also carried out all data analysis in the form of an IPA study and produced the results and discussion section. The co-authors contributed to the reviewing and editing of the final draft in particular, R. Gajwani and H. Minnis.

Paper 4: I was responsible for the topic chosen for critical review and clinical reflection along with my supervisors, H. Minnis, and R. Gajwani, who contributed to reviewing and editing of the manuscript. As the first author, I was responsible for writing the original and final drafts.

Appendix 1: I was responsible for contributing to BRIDGE protocol study co-design as Public and Patient Involvement (PPI) lead and reviewing the final manuscript.

List of tables

Chapter 2:

Table 1.1: Overall methodology summary 99

Chapter 4:

Table 1: Pathways to care interview 137

List of figures

Chapter 1:

Figure 1: Linehan Biosocial Theory (1993) 38
Figure 2: The Emotional Cascade Model (Selby & Joiner, 2009) 39
Figure 3. Mentalisation (Bateman & Fonagy, 2004) 43
Figure 4: Double jeopardy (Gajwani & Minnis, 2023) 54

Chapter 4

Figure 1: Pathways to care for case study 1 143
Figure 2: Pathways to care for case study 2 145
Figure 3: Pathways to care for case study 3 148
Figure 4: Pathways to care for case study 4 150

Appendices

Appendix 1: The BRIDGE Project Protocol

Appendix 2: Ethical approval for The Bridge Project

Appendix 3: Information sheet for The Bridge Project

Appendix 4: Interview schedule for chapter 5 study

Acknowledgments

First, I owe heartfelt thanks to the young people who contributed to this research. Their bravery in sharing their experiences has been deeply moving and inspirational.

To Dr Ruchika Gajwani and Professor Helen Minnis - Thank you for your expert guidance and unwavering support during my PhD. I am so grateful for the knowledge and inspiration you've provided.

I would also like to thank MQ Mental Health research for funding my PhD.

And to my 'PhD pals' especially Dr Naomi Wilson and Dr Gary Kainth. Thank you for your support and encouragement and for sharing the ups and downs of researcher life! I'm so glad our paths crossed on this challenging journey. And to Julie Donegan and Ruchika "we'll always have Australia". Thank you for a wonderful experience that allowed me to grow as a researcher and person.

Thank you also to Irene O'Neill who inspired me to keep organised and on top of things!

I'd also like to thank my parents, Ann and James McAllister and my brother Mark and his girlfriend, my good friend Emma, who have been so supportive in getting me through both this PhD and my difficult period of ill health. Thanks for listening to me babbling on about BPD and for letting me stay over when the journey between Glasgow and Dundee was too much to bear!

I entered this journey somewhat lost, seeking direction and a deeper understanding of my BPD experience. During this time, I was blessed to meet John, one of its greatest and most unexpected gifts. His presence brought purpose and clarity to my life—so much so that, in the words of Jane Eyre, "Reader, I married him" and I am deeply thankful for his unwavering support, patience, and belief in me.

Finally, to everyone who walked even a small part of this journey with me—thank you.

Author's Declaration

"I declare that, except where explicit reference is made to the contribution of others, that this dissertation is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution."

Printed Name: KIRSTY MARGARET COLLINS
Signature: *Kirsty Margaret Collins*

Key terms with definitions

Anti-Social Personality Disorder - Characterised by a pervasive pattern of disregard for and violation of the rights of others, beginning by age 15. To meet the criteria, individuals must exhibit at least three of the following characteristics: failure to conform to social norms, deceitfulness, impulsivity, irritability and aggressiveness, reckless disregard for safety, consistent irresponsibility, and lack of remorse (DSM -5, APA, 2013).

Attention deficit hyperactivity traits – Neurodevelopmental difference with strengths and challenges in social situations.

Autistic Spectrum Disorder - Neurodivergence traits displaying differences in social communication.

Borderline Personality Disorder - A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts (DSM-5, APA, 2013).

Cognitive Analytic Therapy – A programme of time-limited, brief therapy which looks at the interactions of how an individual thinks, feels and acts and often explores childhood

	experiences and relationships and their relational role to each other (Ryle, 1997).
Dialectic Behavioural Therapy –	A type of psychotherapy, developed by Marsha Linehan to help individuals manage emotional regulation difficulties, such as intense emotions, difficulties with relationships and distress.
Lived Experience -	"Lived experience refers to the first-hand accounts and impressions of living because of direct, personal participation or observation. It is a unique, subjective perspective that encompasses an individual's personal experiences, emotions, and responses." Healthy Young Minds, (2026)
Pathways Study –	
Gajwani et al., 2022)	A cross-sectional, feasibility study (2016-2018) exploring the clinical profiles of young people early in the course of severe mental illness, including their experiences of adverse childhood experiences (ACEs), emotional regulation difficulties, mapping pathways to care, borderline personality disorder features, psychosis, and neurodivergence.
The BRIDGE Project	

(Gajwani et al., 2024) - A Feasibility Randomised Controlled Trial of Brief, Intensive Assessment and Integrated Formulation for Young People (age 14-24) with features of borderline personality disorder (Protocol, Appendix 1).

Abbreviations

ACEs	Adverse Childhood Experiences
ADHD	Attention Deficit Hyperactivity Disorder
AMHS	Adult Mental Health Services
AMPD	Alternative Model of Personality Disorder
ASRS	Adult ADHD Self-Report Scale
ASSERT	Autism Symptoms Self-Report for Adolescents and Adults
BDM	Biosocial Development Model
BIS	Barrett Impulsivity Scale
BPD	Borderline Personality Disorder
BPFS-C	Borderline Personality Features Scale for Children
BSL	Borderline Symptoms List
CAMHS	Children and Adolescent Mental Health Services
CAT	Cognitive Analytic Therapy
CMHT	Community Mental Health Team
DBM	Biosocial Development Model
DBT	Dialectic Behavioural Therapy
DERS	Difficulties in Emotional Regulation Scale
DSM	Diagnostic Statistical Manual
d-RCT	Definitive Randomised Controlled Trial
GP	General Practitioner
f-RCT	Feasibility Randomised Controlled Trial
ICD-11	International Classification of Diseases-11
IPA	Interpretative Phenomenological Analysis

PD	Personality Disorder
SAU	Services-As-Usual
SCID -II	Structured Clinical Interview
SHI	Self-harm Inventory
UHR	Ultra-High-Risk

Chapter One:

Literature review

1. Understanding Borderline Personality Disorder

1.1. What is 'Borderline Personality Disorder' (BPD)*?*

Borderline Personality Disorder (BPD) was first labelled as a mental health condition in the Diagnostic and Statistical Manual of Mental Disorders-III (DSM III, 1980). However, a diagnosis of BPD was controversial, and its validity was questioned (Campbell et al., 2020). Phenomenologically, BPD was historically considered unclear, as first-person accounts of living with the disorder and subjective systematic research were limited (Chopra & Beatson, 1988). However, subsequent research has informed contemporary understandings of BPD (Sharp & Kim, 2015; Winsper, 2018). BPD was classified in the recent most Diagnostic Statistical Manual-5 (DSM-5, 2013, APA, 2013) as a complex psychiatric disorder with diverse symptoms that vary between individuals and with changes in severity over a lifetime (Santangelo et al., 2018). Characteristics of BPD include longstanding patterns of difficulties including affective dysregulation, cognitive or perceptual distortions, impulsive behaviour and intense but unstable relationships (Stone, 2024). The impact on individual psychosocial functioning can be adverse (Winsper et al., 2015). Related features often exhibited include suicide attempts, anger, feelings of emptiness, disassociation, and frantic efforts to avoid abandonment. At least five symptoms out of nine need to be present for a diagnosis of BPD with 256 potential symptom combinations of BPD creating significant heterogeneity (Leichsenring et al., 2024) (DSM-5, 2013; APA, 2013). Individuals with experience of BPD may overlap

with other psychiatric conditions such as bipolar disorder, with rapid cycles of mood, moving between states of depression to feelings of euphoria, in a short space of time, usually over the course of one day (Lieb at al., 2004). As the NICE guidelines (2009) highlight, BPD is frequently diagnosed along with other co-morbidities such as major depression, substance misuse and anxiety. It is argued that BPD is often underdiagnosed (Zimmerman et al., 2019) and many clinicians fail to recognise it or acknowledge that it is a common condition presented in various inpatient (Zanarini et al., 2017; Gregory et al., 2021) and outpatient (Ellison et al., 2018) clinical settings. When identified, the average length of time for individuals presenting with BPD symptoms and receiving a correct diagnosis can be upwards of ten years (Magnavita et al., 2010).

1.2. Historical background

The concept of a 'Borderline Personality' was first postulated by Adolph Stern (1938) who observed symptoms of some individuals to 'border' on other conditions – neurosis and psychosis. Very early theories such as those proposed by Knight (1953) sparked interest in the phenomenology of BPD. It was observed that individuals presenting with these borderline states demonstrated neurotic symptoms yet had typical execution in areas such as memory but struggled to maintain long term relationships or adapt readily to change (Knight, 1953; Bradley & Weston, 2005; Gonzalez, et al., 2006). Expanding on the borderline theory (Kernberg, 1975; Dell 'Amico & Picione, 2023), it was posited that BPD existed on a middle level continuum, ranging from neurotic to psychotic personality organisation, broadening the theory to Borderline Personality Organisation (BPO). Phenomenologically, BPO theory conceptualised that individuals did not have a direct loss of reality such as

that in psychosis but a distortion of it. Further, it was claimed that within a BPO framework, the regulation of emotions was maladaptive leading to emotional dysregulation (Kernberg, 1975). Additionally, it was argued that individuals with BPO had difficulty with mentalisation such as limited capacity to regulate mental states (Fonagy, 2009) and a "non-specific general ego weakness" (Bruhlmann, 1995), including impulsivity, increased anxiety, and emotional dysregulation. The following sections will explore and critically appraise BPD theories and evidence in more depth concluding that BPD is an inherently multifaceted mental health condition with complex aetiology such as the influences of nature vs nurture, and more specifically, the impact of adverse childhood experiences and neurodevelopmental vulnerabilities (Chapter 4).

1.3. Diagnostic controversies

This hesitancy and difficulty in diagnosing BPD has left dubiety in the research surrounding its prevalence in society. According to the most recent research (Chapman et al., 2024), BPD appears between 0.7% and 2.7% of the general population and in 22% of psychiatric patients in the United States with a further 11%-12% in outpatients. Similarly, National Institute for Health and Care Excellence (NICE, 2009) guidelines estimate that in the United Kingdom, around 0.7%- 2% of the general population and up to 20% of inpatients and between 10-30% of outpatients meet the criteria for a BPD diagnosis. The variation across these figures may reflect methodological inconsistencies in empirical research, including differences in sampling strategies, diagnostic instruments, and threshold criteria. Alternatively, it may indicate that diagnostic practices and clinical presentations vary across healthcare contexts and populations. Epidemiological research (Winograd et al.,

2008; Stone 2024; Shadid et al., 2025) on long term outcomes may present with further challenges such as high drop-out rates from longitudinal studies, fluctuating symptoms and ethical implications. As such, individuals may be hospitalised for other psychiatric reasons during longitudinal periods which may overlap with BPD signs and symptoms (Chapman et al., 2024). However, in contrast BPD can exacerbate other conditions which may contribute to hospitalisation (Leichsenring et al., 2023). Further, participant attrition over longitudinal periods may threaten internal validity, as decreasing sample sizes can reduce statistical power and introduce systematic bias (Shadid et al., 2025).

Evidence strongly supports the emergence of BPD onset in adolescence (Chanen & Kaess, 2012; Chanen, 2015) with a decrease in incidence and symptoms in adulthood (Winsper, 2021). However, Ouwens et al, (2025) argues that BPD is a lifetime illness which continues into older adulthood but with specific symptom changes as an individual ages. These symptom changes are characterised by a shift from emotional dysregulation, impulsivity, and suicidal ideation to poor relational functioning (Videler et al., 2019). However, the nature of these variances depends upon the context in which individuals find themselves; for example, therapeutic input will vary from person to person across the lifespan and this will play a role in symptom manifestation and severity. As Videler et al. (2019) points out, many longitudinal studies relating to BPD do not include participants over the age of 50, therefore understanding is limited and effectiveness of treatment is unknown.

Empirical research has found BPD to be one of the most common personality disorders. Yet only 1%of NIMH funding goes to BPD research, therefore perpetuating a lack of understanding of BPD. In a retrospective observational study, using the Millon Clinical Inventory Version – III (MCMI-III) to compare 450 adult psychiatry

outpatients (Ajinkya et al., 2021), it was identified that 46.63% of participants presented with borderline as the most common personality disorder type, 25.5% had borderline traits and 21.1% had BPD. As the MCM-III is a reliable, consistent, and robust self-report tool, these are compelling findings, and an indication of how often BPD patients are being missed in both the general population and in clinical settings, in turn, contributing to the variation in prevalence estimates. It should be highlighted that most studies examining prevalence of BPD have taken place in the West including the United States of America (Ten Have et al., 2016). A study in China (Zhu et al., 2017) looked at BPD prevalence within a forensic population however, to date, there is limited global research (Munson et al., 2022; Batool et al., 2024) which looks at differences and similarities in prevalence between multiple ethnicities and cultures. Similarly, a narrative review of studies conducted in India highlights that research on BPD is sparse and often exploratory, with limited large-scale epidemiological data (Choudhary, 2021). A cross-cultural study in the United States (De Genna & Feske, 2013) looking at the impact of race and socioeconomic status in BPD phenomenology found African American females presented with more severe symptoms. However, when compared to white females, they exhibited fewer suicidal behaviour. This disparity in phenomenology between race and culture is important in terms of improving diagnostic validity and refining appropriate treatments of BPD. Extensive empirical research needs to be conducted globally for a more nuanced picture of BPD prevalence and phenomenology in different populations because from evidence such as that outlined, BPD does not present in identical ways across cultures (Hedemann, 2023), societies and populations (Paris & Lis, 2012; Munson et al., 2022).

From the literature reviewed, BPD prevalence in both the general and clinical populations require further investigation in the global context. While there are many gaps and limitations relating to acknowledging features and diagnosis of BPD, including research method flaws and limited population diversity, the consensus is that BPD is a valid mental health condition which requires accurate diagnostic methods and appropriate patient care (Leichsenring et al., 2024). The following section considers the impact of diagnostic measures by comparing historical categorical methods with a more dimensional model of diagnosis.

1.4. Categorical versus Dimensional Diagnosis of BPD

Historically, it has been argued (Zanarini et al., 1989) that BPD must have firmly established and distinct characteristics to be a clinical diagnosis and distinguishable from other similarly phenomenological conditions such as bipolar disorders which can frequently lead to misdiagnosis. This is still seen in clinical practice. Previously, editions of the DSM, and the DSM 5 (2013) (APA, 2013), approached diagnosis of personality disorders from a categorical perspective meaning diagnosis is made directly from the criteria of the presence of at least five out of nine symptoms. However, there are associated weaknesses with this method and during the most recent revision of the DSM (DSM-5; APA, 2013), it was argued by the American Psychiatric Association' Personality and Personality Disorders Work Group (consisting of clinicians and researchers) that a more dimensional model of diagnosis was necessary given that personality traits appear on a continuum (Skodol, 2011). A dimensional approach to diagnosis of BPD means focusing more on the presence of traits which emphasises impairments in personality functioning (self and interpersonal) alongside pathological personality traits such as negative affectivity,

disinhibition, and antagonism. The dimensional approach looks for difficulties in functioning in the areas of sense of identity, self- direction, empathy, and intimacy. In a dimensional approach, these difficulties are rated in terms of severity (mild to extreme) rather than treated as simply present or absent. This allows clinicians to capture gradations of impairment and track change over time. Also, four of the personality traits need to be present for a diagnosis to be considered (Guilé et al., 2018). However, this perspective has been extensively criticised and was subsequently published in section three of DSM-5 (2013), as 'Emerging Measures and Models' therefore, very little weight was placed on its validity in use of diagnosis (Oldham, 2015). There is a lack of empirical evidence to support the concept of categorical symptoms and specific personality disorders (Clark et al., 2007; Trull et al., 2011; Anderson et al., 2014). Argument for a dimensional approach to the diagnosing of personality disorders is the potential for application to treatment and intervention (Hopwood, 2018). Categorical measures have been classed as 'reductionist', yet the dimensional model does not resolve all clinical difficulties such as diagnosis cut off points and the overlap with categorical measures (Alfonso et al., 2021) and points out that the DSM-5 attempted to incorporate the dimensional model almost as a conciliation.

It is important to note that the DSM is a diagnostic classification system designed to standardise mental health diagnoses and support clinical decision-making (Leising et al., 2009). The DSM 5 (2013) (APA, 2013) remains a widely used and valuable tool for the identification and diagnosis of Borderline Personality Disorder (BPD). However, while it provides operationalised criteria, it is primarily based on clinician-observed symptom clusters and consensus-based classification. As such, it may not fully incorporate first-person accounts or lived experiences of

individuals with BPD. This potential limitation could restrict understanding of the phenomenological heterogeneity of BPD, particularly how the disorder is subjectively experienced across diverse populations. This creates difficulties not only in diagnosis and treatment, but also within a research capacity (Cavelti et al., 2021). The contents of the DSM-5 (2013) (APA, 2013) inform screening tools to establish phenomenology and aid diagnosis; given its limitations as described, this can have implications for these tools and methods. A further area that can be overlooked when using strictly categorical tools is educed sensitivity to the symptom fluctuations, comorbid conditions and individual variations often seen in BPD (Leichsenring et al., 2024).

In recent years, the ICD-11, and the Alternative DSM-5 Model for Personality Disorders (AMPD), have made changes to how they approach the classification of personality disorders (PDs), implementing a dimensional attitude towards classification with particular emphasis on a "global level of severity" (known as criterion A) and "five trait qualifiers" (known as criterion B) (Bach & First, 2018; Zimmerman et al., 2019). Zimmerman et al. (2019) critiqued 237 studies finding that the measures used in this dimensional focused approach were, in the main, valid, and reliable. However, they argue that criterion A and B are greatly interrelated thus implying some conceptual challenges. However, Clark et al., (2024) argues that the AMPD is more consistent with the ICD-11 PDs model, thus offering a more comprehensive and unique portrayal of individuals with PD (Sharp et al., 2025), in turn supporting its use in clinical settings. However, research (Clark et al., 2024; Sharp et al., 2025) on AMPD is relatively new and for this thesis a categorical method was used. As outlined, the categorical model is not without limitations but there is still a strong argument for the clinical utility of AMPD and a categorical model.

Within the context of adolescence, Sharp (2020) points out that criterion A can explain for the onset of PD in adolescence while criterion B offers a helpful narrative account of the long-term trajectory of personality functioning.

As diagnosed within the DSM 5 (2013, APA, 2013) BPD is characterised by a combination of 256 presentations (Leichsenring et al., 2024); most individuals who meet criteria for BPD using the current DSM criteria are heterogenous in their symptom presentation. Although using the categorical model for diagnosis a straightforward method, it lacks the capacity to consider the nature and presentation of BPD unique to the individual and BPD collectively (Trull et al., 2011).

Further, the categorical criteria require individuals to meet at least 5 of the 9 criteria in the DSM 5 (2013, APA, 2013). Therefore, someone with four severe symptoms that have a profound impact on functioning may not meet DSM criteria and consequently may not receive appropriate treatment, despite potentially experiencing greater impairment in their daily life than someone with five milder features (Dhar et al., 2023). As outlined, symptom severity changes over a lifetime (Beheydt et al., 2019) so the capacity to measure the impact of this and administer timely, appropriate treatment may get missed. Heterogeneity and the manifestation of BPD can potentially be overshadowed through utilisation of the categorical model, representing a significant limitation. Dimensional models address this limitation by measuring severity across a continuum in the presence of traits and levels of functioning demonstrated by individuals. Hutsebaut and colleagues (2026) suggest that the alternative dimensional model of personality pathology may limit the heterogeneity issue, while still providing use insight for clinical practice, thus supporting the notion that it is more effective than the categorical model at gathering a more individualised understanding of personality pathology. Further, it

is argued (Skodol, 2012) that mental illnesses such as personality disorders span across continuums, therefore, placing them into individual categories does not take variation of the presentation of particular traits such as impulsivity (Fowler et al., 2021).

BPD has many co-morbidities such as depression and complex-PTSD (Simon et al., 2025), and the categorical model does little to differentiate BPD from these. This raises the question about the specificity of categorical model in identifying BPD, and consequently, has implications for bespoke intervention (Maffly-Kipp et al., 2024).

A particular area of contention is the stigma associated with the labels and language surrounding BPD (Collins et al., 2025). The categorical method actively places these labels upon individuals which may perpetuate this stigma and feelings of low self-worth associated with BPD (Brink, 2025).

So, why then has the categorical model been chosen over the dimensional model for this thesis? The categorical model does have some advantages in that it can be clinically useful, as it uses clear and accessible language; for example, there is little ambiguity when asking someone if they have a “fear of abandonment” in turn, making communication easier in both, clinical settings and in the general population (Monaghan & Bizumic, 2023). Some individuals may find it easier to relate to the terminology of the categorical model wording rather than having to describe their symptoms on a scale (Stanton et al., 2025). Also, the terminology is already in the clinical domain. Further, some participants in the current studies included in this thesis, would have had a BPD diagnosis using the categorical model therefore, it was directly applicable. Additionally, for the included studies, particularly paper 2 and The BRIDGE Project (Gajwani et al., 2024), the categorical method allowed

for transparent inclusion and exclusion criterion by drawing on established subthreshold criteria used in early intervention research for BPD (Chanen et al., 2009). Since the original pilot study (The Pathways Study, Gajwani et al., 2022) and the feasibility randomised controlled trial (Gajwani et al., 2024), the utility of the dimensional model has grown significantly (Hutsebaut et al., 2026) and it is imperative that this is considered in future research. Historically, BPD research has been based on the use of categorical models (Vanwoerden & Stepp 2022) which allowed for the author to compare findings with previous literature/evidence.

1.5 *BPD and overlapping clinical features: prevalence and implications*

It can be argued that due to the 'borderline' nature of the disorder it is difficult for clinicians to distinguish between PD as separate yet coexisting when compared with other co-morbidities. Anxiety, major depression, and Post Traumatic Stress Disorder (PTSD) have been shown to have the highest co-morbidity rates with BPD (Ajinkya et al., 2021). In a retrospective observational study (Ajinkya et al., 2021) the MCMI-III was administered to 450 adult patients; 46.63% of the participants presented with a borderline personality, 25.5% exhibited borderline traits and 21.1% had BPD. The prevalence of co-morbidities was as follows: 90.91% had anxiety, 85.23% presented with major depressive disorder and 46.59% exhibited PTSD (Ajinkya et al., 2021).

These co-morbidities are often treated as primary disorders and often BPD diagnoses avoided (Eaton et al., 2011). The key to differentiating BPD from other comorbidities is that symptoms of BPD are exacerbated and exhibited during times of extreme emotional distress (NICE, 2009) and are persistent. Perhaps, for future direction, individuals presenting with multiple conditions should be assessed for BPD

along with a comprehensive psychiatric assessment as standard good clinical practice to avoid underdiagnosis and allow for more bespoke treatment interventions to be administered thus, in turn, leading to better long-term outcomes (Choi-Kain & Gunderson, 2019). Evidence suggests that individuals with a BPD diagnosis also have high rates of severe mental illness, such as mood disorders, anxiety and bipolar disorder and experience similar symptoms to other conditions such as psychosis (Shah & Zanarini, 2018). Temes et al., (2024) estimate that 20% of those with bipolar also meet criteria for BPD and those with BPD experience this comorbidity with more intense symptoms and phenomenological differences when compared with individuals with a diagnosis of bipolar disorder on its own. Yet, there is limited exploration of treatment for this unique group. However, there are some clinicians who argue that BPD is an ultra-rapid cycling bipolar disorder (Parker, 2011).

In the context of the comorbidities of psychosis and BPD, it is estimated that 29-50% of individuals with BPD experience auditory hallucinations (Lo Buglio et al., 2024). However, studies (West et al., 2021; Pelizza et al., 2025) have shown distinct differences in interventions for BPD and high-risk psychosis. For instance, psychosis services attempt to negate a full psychotic episode (Lo Buglio et al., 2024), yet BPD interventions focus on tackling emerging PD (Chanen et al., 2022). Auditory hallucinations and full-episode psychosis are two distinct features of BPD and psychosis, but they do co-exist and appropriate intervention should be explored.

Although highly prevalent, the nature of the overlap between BPD and co-morbidities is not yet well understood, particularly due to limited research on developmental pathways to severe mental illness (Gajwani et al., 2022). The consequences of this lack of evidence can be highly problematic due to its

socioeconomic impacts and lack of timely treatment pathways, further casting doubt over aetiological theories and developmental pathways (Eaton et al., 2011).

Further, poor identification of conditions can result in inappropriate psychopharmacological treatment in the form of overuse of psychotropic drugs as a first line of treatment for BPD (Gunderson, 2011). Yet, as per current guidelines, there are no drugs recommended or approved for the treatment of BPD (Bridler et al., 2015). There is minimal evidence for the effectiveness of psychopharmacotherapy in the treatment and management of BPD (Stoffers & Lieb, 2015). There is very limited data on prescription drug use in BPD (Marin et al., 2018). However, in the USA and some parts of Europe, it has been identified that over 80% of BPD patients are treated with pharmacotherapy (Pascual et al., 2023). The European Drug Safety Project AMSP reported findings from a group of 2195 BPD patients from 2001 to 2011, where polypharmacy was common, with 70% participants prescribed antipsychotics either on their own or combined with antidepressants, 33% with anticonvulsants, 30% with benzodiazepines and 4% with lithium. It was found that many BPD patients were medicated even when not presenting with comorbidities (Kim & Lamb, 2024). Many of these drugs have sedative properties which can have a significant impact on an individual's day to day life as well as being at an increased risk of drug interactions, increased chances of addiction, becoming more vulnerable to self-harm through having access to potent medication and increased suicidal tendencies (Carballo et al., 2020) and the sedative properties can reduce the individual's ability to engage with any psychotherapy offered (Soler et al., 2022).

Often this misuse of psychopharmacology is due to a lack of understanding of BPD phenomenology. For example, treatment of co-existing symptoms of psychosis

and perceptual distortions and BPD are still poorly understood and under-researched (Slotema et al., 2012). Psychotic symptoms pertaining to BPD are not fully recognised in the DSM-5 (2013) (APA, 2013), therefore, not entirely informing a diagnosis or treatment plan when they co-exist. Further, they are often referred to as pseudo-hallucinations to differentiate them from the hallucinations experienced in psychotic disorders (D'Agnostino et al., 2019). Slotema et al. (2012) attempted to establish a more detailed understanding of the phenomenology of auditory hallucinations pertaining to psychosis in BPD through a study comparing borderline personality disorder experiences with those of schizophrenia patients and individuals with no diagnosis of a psychiatric disorder using the Psychotic Symptom Rating Scales (PSYRAT) (Drake et al., 2007). Slotema et al. (2012) found that auditory hallucinations in BPD patients tended to be severe and persistent experiences with a mean duration of 18 years, occurring daily and lasting for at least several minutes at any one time. Upon comparison with schizophrenic participants, in terms of phenomenology, no significant statistical differences were found. However, greater levels of distress and interruption of daily life was found in the BPD only patients. In addition, phenomenological differences were found between BPD patients compared with auditory hallucination non-patients; BPD patients scored higher for length, frequency and levels of distress caused by the auditory hallucinations. Although results were statistically significant, the sample size was very small and used only female participants limiting any comparative analysis across sub-groups. Further, co-occurring conditions were not considered, for example, the participant could potentially be amid developing a schizoaffective disorder which is yet to be diagnosed thus biasing the sample (Slotema et al., 2012).

In summary, while previous research has provided insightful findings into BPD nature and phenomenology, its primary focus has been on diagnosis and establishing prevalence in the clinical and general populations. However, as outlined, these have limitations given the methodology used i.e. longitudinal studies and the dimensional approach, in particular, offers advantages by addressing symptom fluctuations, identifying, and managing comorbidities and capturing the heterogeneity of BPD presentations (Shani & Stade, 2025). At the same time, while longitudinal studies may provide some insight into the long-term changes in PD functioning, they appear to lack input from those with lived experience, the impact on the long-term quality of life, and do not consider the co-morbidities and the remitting nature of BPD (Zanarini, 2003). Not only does this have an impact on long-term well-being trajectories but detract from a deeper understanding of BPD developmental pathways which in turn, could lead to earlier intervention and treatment when signs and symptoms of BPD become apparent (Chanen & Kaess, 2012). The following section will therefore explore these developmental pathways which may inform a deeper understanding of BPD, inform diagnostic tools refinement, and strengthen research methodologies in the future that are culturally appropriate.

2. Developmental Pathways

2.1. The Biosocial Theory (Linehan, 1993) & The Biosocial Development Model (Crowell et al., 2009).

BPD phenomenology can be divided into four main traits. These are: i) affective/emotional dysregulation, ii) impulsivity, iii) intense but unstable

relationships and iv) cognitive or perceptual distortions. These traits are not separate entities and are often interrelated and the phenomenological characteristics vary between individuals. Within these traits various behaviours are exhibited between individuals. These can include acts of self-harm, suicide, binge eating, intense anger, chronic feelings of emptiness, upsetting thoughts, rage/aggression, sorrow, and shame (NICE, 2009). Given the varying and unique nature between individuals who experience symptoms of BPD, a deeper understanding of developmental pathways could, in turn, inform BPD nature and phenomenology, resulting in earlier intervention and treatment unique to individual needs.

Within the context of affective/emotional dysregulation, BPD phenomenology and developmental pathways have been approached using a Biosocial Theory perspective (Linehan, 1993). It was posited that BPD is a result of wide-ranging emotional dysregulation influenced by a biological predisposition and environmental factors such as invalidating responses and difficulties in adopting adaptive coping strategies (Linehan, 1993). Further, within the theory, the author proposed that individuals with BPD experience three dimensions: intense emotional sensitivity, difficulty in regulating such emotions, for example, through maladaptive coping strategies, and a struggle to return to a stable emotional threshold.

As a core feature of BPD, hypersensitivity, and emotional dysregulation manifests in a negative bias towards emotional cues, a heightened reaction time and increased emotional reactions (Bortolla et al., 2019).

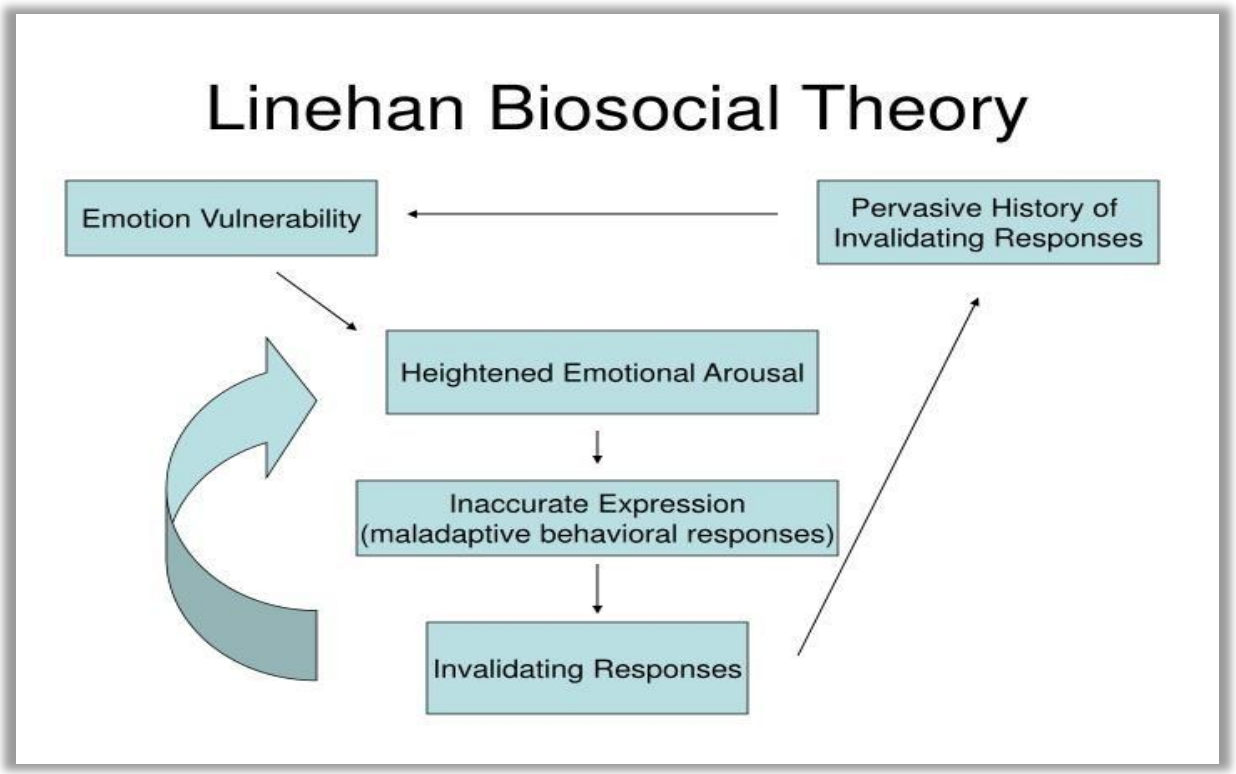


Figure 1: Linehan Biosocial Theory (1993)

In an earlier review (Carpenter & Trull, 2013), the Biosocial Theory (Linehan, 1993) was supported through identifying that emotional dysregulation did not necessarily have a beginning, middle and an end but is moreover a process by which these three states (emotional sensitivity, difficulties with regulation and struggles to return to stability) interact (Figure 1). It is a synergistic, cyclical reaction in which each of the three dimensions have negative effects on each other, thus, in turn, enhancing the associated psychological distress and dysfunction.

It is argued (Crowell et al., 2009) from a developmental pathway perspective, the impulsivity trait associated with BPD would appear to be closely correlated with Linehan's (1993) Biosocial Theory given the links between the emotional experience i.e. emotional vulnerability, of an individual and the invalidating behaviour

expressed. Further, that trait impulsivity can be result of psychological distress which has strong correlations with emotional dysregulation (Ebner-Priemer et al., 2008). This psychological distress associated with emotional dysregulation, is resultant in impulsivity and is often expressed in self-injurious behaviours both with the intent and non-intent of suicide. Yet, Crowell et al. (2009) argue that Linehan's early Biosocial Model (1993) neglects to explore this common trait of BPD that is impulsivity. Impulsivity can be correlated with phenomenon seen in BPD such as risk-taking behaviour including driving above the speed limit, walking on roof-tops, or taking illicit substances or medication at a higher dosage than prescribed. The Biosocial Theory was expanded on by Crowell et al. (2009) - The Biosocial Development Model (BDM) to incorporate the notion that evidence of early impulsivity increases the likelihood of emotional dysregulation, triggered by social risk factors such as adversity or mis-attuned care. Arguably (Crowell et al., 2009), this results in an adolescent developing poor coping methods, forming the basis for a subsequent diagnosis of BPD in adulthood. However, few studies on Linehan's (1993) Biosocial model have been carried out on young people, who may have met 'at-risk' criteria worthy of empirical testing. Further, Ebner-Priemer et al. (2008) previously pointed out that there are few empirical studies which explore the relational link between impulsivity and emotional dysregulation. Latterly, a relational link between trait impulsivity and family conflict was identified which partially supported the Biosocial model (Yin et al., 2025).

2.2. Emotional Cascade Model (Selby & Joiner, 2009)

Further, an important theory that must be considered in BPD development and phenomenology, particularly in the context of an affective dysregulation trait, is

Selby and Joiner's (2009) Emotional Cascade Model (Figure 2). Selby and Joiner (2009) argue that the emotional and behavioural dysregulation associated with BPD are resultant from emotional cascades with intense cycles of rumination and negative affect. Rumination by its very nature can heighten and perpetuate the three dimensions outlined in Linehan's Biosocial theory (1993). The rumination exacerbates emotional dysregulation in a positive feedback loop (Winsper, 2018). An example of this would be in distracting oneself with non-suicidal self-harm. Although non-suicidal self-harm is injurious to the individual, this theory argues that the dysfunctional behaviour reduces the negative emotion, in a sense, contributing to short-term self-soothing. However, the emotional cascade model (Selby & Joiner, 2009) neglects to explore why some individuals choose a maladaptive behaviour when others choose non-self-injurious activities such as exercise.

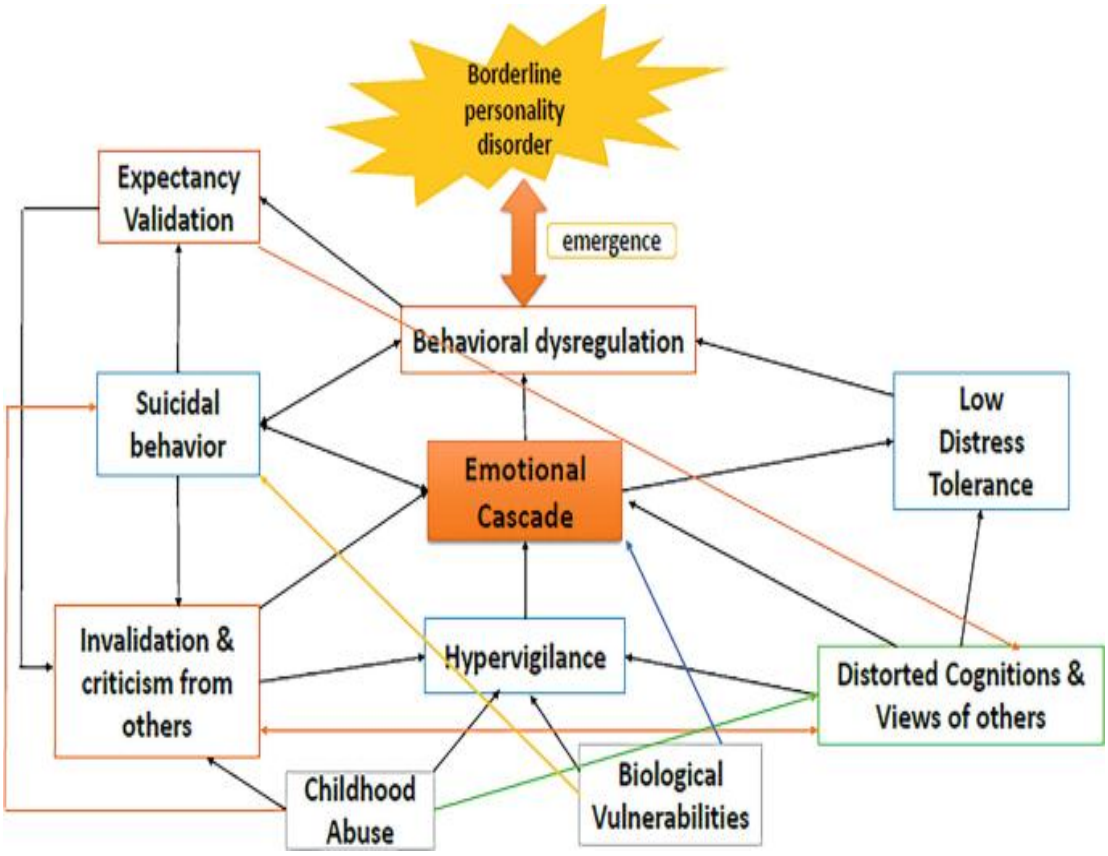


Figure 2. The Emotional Cascade Model (Selby & Joiner, 2009)

The Emotional Cascade model (Selby & Joiner, 2009) has mixed clinical implications. First, it should be noted that all of Selby's work (Selby et al., 2009; Selby et al., 2013,) is quantitative in nature and advanced our understanding of behavioural manifestations of an 'emotional cascade' but is limited in explaining the antecedent mechanisms. Given the individual and unique nature of rumination, it is bound to vary from person to person and causes different levels of distress. Therefore, research of a qualitative nature is necessary to better understand the types of emotions and their severity in relation to the Emotional Cascade Model, (2009) along with developing developmental models of rumination. Further, this model is limited in lack of longitudinal studies testing this model and is said to not effectively address childhood or adolescent experiences (Tuna & Bozo, 2014).

2.3. Mentalisation (Bateman & Fonagy, 2004)

A further developmental theory of BPD and its resultant phenomenology is the concept of mentalisation (Bateman & Fonagy, 2004). It is described as an individual's interaction with the world based on their perception of the mental states of self and others. For example, how one perceives other's beliefs, motives, and emotional states. Bateman and Fonagy (2004) add three further dimensions of mentalisation to the theory (Figure 3). First, related to implicit and explicit modes of functioning. Implicit mentalisation means the ability to understand another person's mental state unconsciously. Allen (2006) gives us the example of conversational turn-taking whereby there is no conscious reflection or dialogue exercised. Explicit mentalisation, on the other hand, involves conscious effort to interpret one's own, and others, emotional states. However, they argue that these are not two distinct

poles in the concept of mentalisation and it is possible to switch between both modes, and they can be utilised at the same time. For example, within psychotherapy where the therapist can be aware of the patient's state of mind yet also intuitively be influenced by the patient, for example, implicit mentalisation (Choi-Kain & Gunderson, 2008). The second dimension of mentalisation theory expanded upon 'the self' and 'the other', in terms of objects (Bateman & Fonagy, 2004). These mental states such as thoughts and feelings are described as interacting with each other in terms of a mentalisation framework i.e. focusing on the other to understand their mental state (Kain & Gunderson, 2008). The third dimension of mentalisation theory is that of cognitive and affective aspects, whereby mental states in self and others can be cognitively focused (Bateman & Fonagy, 2004; Choi-Kain et al., 2008). They argue that for mentalisation to be executed, robust mental states and cognitive capacities are required. It is argued that this is unstable in the BPD-experienced (Fonagy & Bateman, 2004).

Fonagy (1991) argued that mentalisation develops in childhood and any adverse event causing interruptions in typical development can have significant implications later in life, such as the development of BPD. In terms of disordered mentalisation, Bateman and Fonagy (2006) strongly support Bowlby's (1969) attachment theory and its implications in the development of BPD. Bowlby (1969) posited that poor attachment can develop when one's parenting styles neglect to meet the emotional needs of the child during infancy. It is argued that disordered attachment styles may contribute significantly to BPD dysregulation, particularly within relational functioning (Fonagy & Bateman, 2006). Insecure attachment styles disturb mentalisation, resulting in an inhibited sense of self and perception of others. Given BPD is often characterised by unstable self-image and emotional

dysregulation in social settings, this concept could have significant implications in the aetiology of BPD, it's phenomenology and its treatment (Choi-Kain & Gunderson, 2008).



Figure 3. Mentalization (Bateman & Fonagy, 2004)

As outlined above, a maladaptive trait associated with BPD is intense but presents as unstable relationships. Many individuals with BPD have significant difficulties with trust and have an intense fear of rejection and abandonment. This fear of abandonment is tied to the intense but unstable relationships trait. Aetiologically, Bowlby's attachment theory comes in to play here as argued by Bateman and Fonagy (2008). Gunderson (2001) describes the fear of abandonment as a fear of being alone. This intense fear is then phenomenologically exhibited in behaviours such as threatening suicide, anger outbursts and other behaviours associated with the impulsivity trait, if it is perceived that an individual is

threatening to leave. This intense fear of abandonment can leave those who experience it very vulnerable and open to negative interaction, such as manipulation, especially in a sexual context (Willis & Nelson Gray, 2017). Frantic efforts to avoid abandonment can trigger the dysregulated impulsive behaviours associated with BPD and lead to individuals engaging in sexual acts that they may not necessarily want to, in a bid to prevent someone from leaving them (Bouchard et al., 2009). A systematic review (Palihawadana et al., 2019) of the fear of abandonment in BPD was conducted; Bateman and Fonagy's (2006) mentalisation theory is reflected strongly when attempting to understand the fear of abandonment whereby this difficulty with mentalisation increases sensitivity to perceived or real rejection.

Bateman & Fonagy (2004) developed a mentalisation-based treatment programme for those with experience of BPD symptoms. Mentalisation theory (MBT), aims to enhance an individual's ability to expand on thinking patterns when experiencing emotional distress in turn, challenging the impulsivity trait which can result in the self-harm associated behaviours. Although the evidence base strongly supports the efficacy of MBT (Bateman and Fonagy, 2008; Bateman and Fonagy, 2009; Bales et al., 2015; Smits et al., 2019) in the treatment of BPD, there are still some implications which must be taken into the consideration, especially considering some of the phenomenology of BPD, such as intense but unstable relationships and genetic predispositions which may be assist us in understanding who may be vulnerable to poor developmental outcomes.

These earlier theories of aetiology/developmental pathways such as Linehan's Biosocial Theory (1993) can be useful in understanding areas such as emotional dysregulation. Theories of developmental pathways can be highly useful

in contributing to a better understanding of the nature of BPD and its development. However, the theories outlined are not without limitations and do not consider why some people are more predisposed to developing BPD. Also, protective factors have not been considered in models such as The Biosocial Theory (Linehan, 1993) and not been measured developmentally in child/adolescent populations, which is counterintuitive in trying to establish developmental pathways. Acknowledgement of fluctuations in BPD signs and symptoms are limited in these developmental models outlined. However, each of these models have the potential to be integrated so advantages of each can be beneficial to our understanding of BPD aetiology and developmental pathways. Further, there are a limited number of robust psychometric tools developed for the consideration of BPD in childhood (Crick et al., 2005).

The following sections discuss the roles of developmental risk factors, specifically trauma and neurodivergence and their influence on developmental pathways of BPD. Whilst the terms trauma and adverse childhood experiences (ACEs) are used interchangeably in this thesis, it is beyond the scope of this research to consider the differences - the evidence on complex nature of ACEs has been systematically reviewed elsewhere by experts in the field (Lacey & Minnis, 2020) along with the impact of this on research design and practice.

2.4. Neurodivergence and BPD developmental pathways

Neurodivergence of different types (neurodiversity), such as Autism and Attention Deficit/Hyperactivity Disorder (ADHD), have an onset and are often, though not always, diagnosed in childhood, continuing into adulthood (Langevin, et al., 2025).

They can be described as neurological characteristics which display differences in social communication and ways of interpreting ones' environment (McLennan et al., 2025).

Diagnosis of autism has increased significantly recently, namely due to adaptations of diagnostic assessment (Hansen et al., 2015). Within the context of BPD, there is increasing acknowledgement of Autism being a comorbidity (Iliffe-Lewis & Bacon, 2026). However, it has also been noted that many individuals consider themselves to have been misdiagnosed with BPD prior to their autism diagnosis (Tamilson et al., 2025). Tamilson et al. (2025) acknowledged that receiving a diagnosis of Autism was life changing for participants in an IPA study, who had previously been misdiagnosed with BPD. For The 10 individuals who took part in this IPA study, this life changing experience, however, was in part, due to the removal of the stigma associated with BPD and the diagnostic overshadowing. They claimed that they did not resonate with a BPD diagnosis; however, this appears questionable given their responses of relief when the perceived stigma associated with BPD was removed.

PDs and neurodivergence such as autism and ADHD, have been identified as having many overlapping symptoms and clinical features (Weiner et al, 2019). It should be noted that co-occurrence rates vary in the literature. It is important to be clear that BPD is not considered to be a neurodiversity. BPD is estimated to co-exist with autism in approximately 4% of individuals considered autistic (Dudas & Cheney, 2025). Furthermore, 60% of individuals diagnosed with BPD met criteria for an ADHD diagnosis in childhood (O'Malley, 2016). ADHD, in particular, shares features with BPD, such as impulsivity and emotional dysregulation (Ditrich et al., 2021), with co-occurrence rates reported to be approximately 38% (van Dijk et al., 2021). It has

been identified that self-regulation may be at the root of similarities in symptoms of PD and neurodiversity (Martin et al., 2026). BPD is often not diagnosed until late adolescence or adulthood in many cases (Sharp & Fonagy, 2016), whereas ADHD for example, is commonly recognised earlier (Langevin et al., 2025). It now being recognised that neurodivergence may increase the risk of various psychiatric outcomes, including BPD (Gajwani et al., 2022).

Although, BPD, and neurodivergence such as ADHD and Autism are distinct and separate clinical conditions, there is significant overlap through common features as outlined above. In the presence of these features, there is the potential to consider both BPD and neurodiversity. However, it is imperative that appropriate tools and measures are used when assessing individuals for either or both features. Although there is an argument for the misdiagnosis of BPD in those also presenting as neurodiverse, it is also possible that the two co-exist (Zenner, 2019). If neurodiverse features are present early in childhood and overlap or contribute to the development of BPD features, then it would be pertinent to assess for both which may in turn help reduce the emergence of BPD or misdiagnosis of either.

There are significant social consequences of the late recognition and intervention in BPD including employment, relationships, and education (Dudas & Cheney, 2025). Therefore, it is imperative that the links between neurodiversity and BPD are further investigated to identify earlier points in which neurodiversity and BPD could be recognised in turn, providing opportunities for early intervention to impede the development of BPD or at least limit it severity. This is considered in more detail in chapter 4 "*Where is the Care? Investigating pathways-to-care in young people with borderline personality disorder features: Clinical case studies*".

Individuals with autism and BPD are more likely to access mental health services and in particular, inpatient treatment with an increased likelihood of experiencing suicidal and self-harm thoughts and behaviours (Woods et al., 2025). In a qualitative study (Woods et al., 2025) looking at the experiences of inpatients with BPD and autism, a common theme was "I don't think anyone's every asked me about the two before". This is an important theme as it identifies there is a paucity in the understanding of the potential for someone to have both BPD and neurodivergence. Stigma also played out in this study which is elaborated on below and in Chapter 6 of this thesis. These findings show just how underrepresented in treatment and research vulnerable individuals with both diagnoses are and how it is imperative to be explored further to influence care. Woods et al. (2025) is an informative study as it included a diverse population and considered those with both diagnoses. However, what is missing from this study is a focus on the routes and pathways that led these individuals to receive a diagnosis of both autism and BPD given a connection between the two had not previously been apparent in individual's care. Their pathways to care are not clear from this study nor is there any evidence of collaboration between services i.e. social work and community mental health teams.

Research in developmental pathways to care in BPD is lacking and there is missed opportunities for early intervention and BPD emergence in the presence of neurodiversity. Further, more joined up working is needed between services who meet with populations early in their journeys of neurodiversity with (and without) mental health services, especially PD services to consider the possibility of the later emergence of BPD in the presence of neurodiversity. It is apparent that there is more training required for clinicians to firstly, establish the possibility of BPD and

neurodivergences co-occurring to avert diagnostic overshadowing and in refining treatment in a way that is personalised to the individual needs. Comprehensive assessment is imperative in a joined-up journey through services to ensure individuals are not missed or experience misdiagnosis (Gajwani et al., 2022; Gajwani et al., 2024).

2.5. Trauma and BPD developmental pathways

Childhood trauma is a multifaceted and complex issue (Aydin, 2024); it includes both physical (including sexual) and psychological abuse and/or neglect of young people under 18 years old by a caregiver, parent or adult who has a caring responsibility or been witness to familial intimate partner violence particularly towards the maternal figure (Bozzatello et al., 2019).

The consequences of ACEs, if left unidentified and untreated, can forge the path for difficulties in adolescence and adulthood such as emotional dysregulation (Chapman, 2019), distorted self-image (Cristofanellie et al., 2024), impact on the developing brain in turn affecting neurobiology (Bohus et al., 2004; Ruocco & Carcone, 2016) and maladaptive coping strategies such as self-harm or substance use (Chapman, 2019).

Childhood trauma and adverse childhood experiences (ACEs) are widely considered to play a significant role in the developmental pathways of Borderline Personality Disorder (BPD) (Estric et al., 2022). However, the aetiology of BPD remains multifactorial, with researchers advancing differing, though often complementary, perspectives. Neurobiological research highlights the role of structural and functional brain differences, particularly in regions associated with emotion regulation and impulse control (Silbersweig et al., 2007; Donegan et al.,

2003). Genetic studies further suggest a heritable component to borderline traits (Torgersen et al., 2008), while developmental and attachment-based models emphasise the influence of early caregiving relationships and environmental context (Sharp & Fonagy, 2015). Collectively, these perspectives support a biopsychosocial understanding of BPD development. Yet there is significant potential that a combination of all these constructs plays a major role in BPD developmental pathways (Cattane et al., 2017;Leichsenring et al., 2024). For example, it has been identified that 61.5% of adolescents with a BPD diagnosis had experienced emotional neglect (Xiao et al., 2023).

The debate over whether and how trauma plays a significant role in the developmental pathway of BPD has transpired over many years and continues to cause debate amongst researchers and clinicians. The pathways to the development of BPD in relation to trauma were explored through a review of the empirical evidence and a model offered by Zanarini and Frankenburg (1997); they argue that for BPD to develop three elements must be present, first, a traumatic childhood, second, a vulnerable temperament and third, a triggering event or sense of events. Trauma, researchers argue that there is no single specific or universal traumatic experience that accounts for the development of BPD. Rather, individuals who develop BPD appear to follow diverse and highly individualised developmental pathways, supporting the view that there is no singular traumatic antecedent common to all cases. Nevertheless, when comparing PDs more broadly, individuals with BPD have been found to report significantly higher rates of childhood maltreatment (Wu et al., 2022). Furthermore, female gender and experiences of childhood sexual abuse have been identified as predictors of increased self-harm and suicide risk within BPD populations. In addition, a multiple regression analysis

examining age of onset as the dependent variable found that earlier emergence of BPD symptoms was most strongly associated with traumatic experiences such as emotional neglect, chaotic family environments, and bullying (Bozzatello et al., 2020), suggesting that specific forms of adversity may influence both severity and timing of symptom development. As Bozzatello et al., (2020) points out the participant numbers were small in this sample, thus limiting statistical significance and making replication difficult. Additionally, a retrospective design was used which could influence recall bias thus impacting upon the reliability of the study. Further, in a cohort of college students, it was found that those who had experienced sexual abuse were more likely to have BPD (Wu et al., 2022). Yet an earlier meta-analysis (Fossati et al., 1999) found there to be a weak link between the two. Ball et al. (2009) applied the Hill's criteria (i.e. causal as opposed to correlational associations) to the literature, looking at causal relationships between the two variables - childhood trauma and the development of BPD. Although a link was established, Ball et al. (2009) argue that several aetiological factors must be taken into consideration.

Evidently, trauma can, for some, have a significant impact on the development of BPD, but it is argued that trauma can be more complex than the sometimes reductionist view in clinical practice and not necessarily applicable to every individual with experience of BPD symptoms (Winsper, 2018). For instance, many studies (; Schulze, 2022; Skauget al., 2022; Yuan et al., 2023) do not find commonalities between the types of ACEs contributing to BPD. Alternatively, some have argued that individuals with PD are experiencing a form of post-traumatic response (van der Kolk et al., 2005), but this is contentious.

It should also be highlighted that many studies on the impact of trauma and the development of BPD use participants over the age of 18 with the inclusion of

few adolescents; this would seem counterintuitive to understanding the relationship between the development of BPD and ACEs. In a study of younger participants (Venta et al., 2012), this was examined from an adolescent perspective (n=147). Trauma symptoms, trauma history and BPD development were explored, finding that those with BPD were more likely to have experienced sexual trauma than non-BPD experienced adolescents, later supported by Wu et al. (2022).

Community cohort and twin studies have identified that although dysregulated coping strategies can be seen in children who go on to have BPD, they do not fully manifest into BPD which can be measured and diagnosed until after the age of 12 (Bohus et al., 2021). Twin studies are very powerful study designs as the impact of nature vs. nurture can be looked at in depth (Wilson et al., 2021). An Environmental Risk (E-Risk) Longitudinal Twin Study (Wertz et al., 2020), examining 2232 British twins, found that those children who exhibited borderline symptoms at age 12, were more likely to be at risk for poorer outcomes during the transition into adulthood, being three times more likely to exhibit suicidal and self-injurious behaviours. Given there were children with increased BPD symptoms at the age of 12, aetiological links such as the influence of genetics was proffered in this study, yet the researchers point out that the identical twin without the increased BPD symptoms were also at risk for poorer outcomes. This then brings in the argument for the influence of genetic and environmental interactions in BPD development (Bornovalova et al.,2017; Cattane et al., 2017). Given all this evidence, it would seem appropriate to investigate and treat BPD early in adolescence (Chanen, 2015) from a lifespan approach (Winsper et al., 2021). Within the context of neurodiversity, we can see that trauma might initiate a chain reaction which could in turn, lead to the development of BPD signs and symptoms.

2.6. Neurodivergence and trauma in BPD developmental pathways: Double jeopardy

Two key risk factors in the development of severe mental illness, including BPD are neurodivergence and trauma (Dinkler et al., 2017; Gajwani et al., 2021; Gajwani & Minnis, 2023). Many individuals who go on to display BPD features have experienced ACEs and trauma as outlined above. BPD in the presence of neurodivergence is an area that requires much more in-depth research. Research on the presence of both trauma/ACEs and neurodiversity in the emergence of BPD features has been sparce. Gajwani et al. (2021) pointed out that children who had experienced ACEs including abuse and neglect, and had neurodevelopmental conditions were two times more likely to develop features of severe mental illness in adolescences. Gajwani & Minnis (2023) have proposed the double jeopardy model (figure 4) which highlights the role of ACEs and neurodiversity and the impact of both on longer term outcomes across the lifespan, including increased risk of health outcomes in childhood and adolescence.

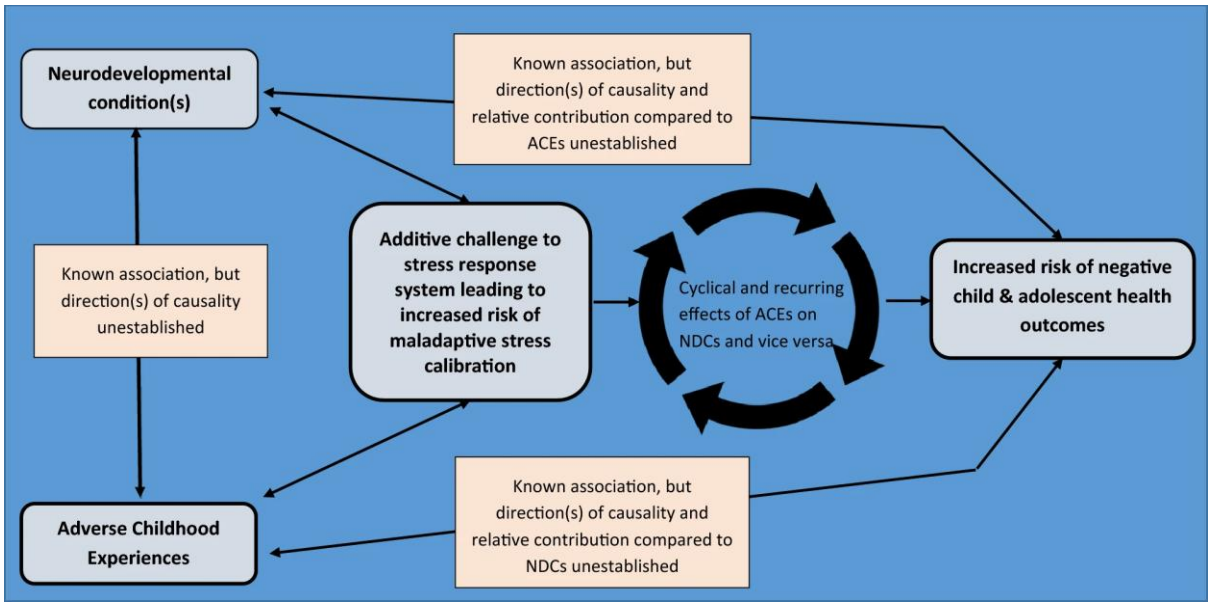


Figure 4: Double jeopardy: a developmental model delineating the role of adverse child experiences (ACEs) and neurodevelopmental disorders (Neurodiversity) for child health (Gajwani & Minnis, 2023).

Within the context of BPD developmental pathways, the double jeopardy model could be very useful for highlighting the potential for the impact of both ACEs/trauma and neurodiversity in the emergence of BPD features. Gajwani et al. (2022) found that young people who were early in the course of developing severe mental illness who had experienced ACEs, also exhibited high rates of neurodiversity traits. In participants at clinical high risk (threshold and subthreshold) of SMI, emotional dysregulation was a strong marker for future clinical severity levels, mediating the association between developmental risk factors of ACEs and neurodivergence and borderline personality symptom severity. While bearing in mind emotional dysregulation is a key feature of BPD, future research would benefit from longitudinal studies which take neurodiversity and ACES into consideration.

This section examined models and current research in developmental pathways in BPD including the impact of neurodiversity and trauma on BPD development. While most of the studies agreed that there is significant emotional dysregulation preceding BPD developmental pathways, issues such as the impact of trauma and neurodivergence have shed new light on the intricacies and unique impact they can have on developmental pathways (Gajwani & Minnis, 2023). Further, there appears to be a lack of consensus between the models and theories of developmental pathways although there is no reason why more than one model cannot be applied to aid our understanding. Whilst the findings of many studies are valid and reliable, it should be highlighted that very few studies on developmental pathways to BPD have taken place with children and adolescents thus missing crucial data on impact and the development of BPD. It would seem pertinent then to focus

on BPD and the issues affecting adolescents when it comes to gaining a better understanding of developmental pathways. The following section explores the nature of BPD in adolescence and the barriers that young people with features of BPD are faced with.

3. Adolescence and BPD

3.1 Adolescent diagnosis versus adult diagnosis

In the DSM-5 (2013) (APA, 2013), the diagnosis of BPD in adolescence is considered using the same criteria as applied to over 18s. From the categorical diagnostic perspective, this includes a pattern of pervasive symptoms and the presence of at least five of the nine BPD associated symptoms, for at least one year. The diagnostic manual also stipulates that there must also be a significant impact on the individuals functioning in association with the symptoms. When assessed for BPD, the most frequently used tools for diagnosis of BPD in adolescence are the DSM-5 Structured Clinical interview, the SCID-II (DSM-5, 2013; APA, 2013) and the ICD-10 International Personality Disorder examination (WHO, 2016) (Chanen, et al., 2008). Fonagy et al. (2015) argue that these measures require work to accommodate the normal developmental ebb and flow of adolescent years.

Identifying and naming the phenomenology associated with BPD (Hutsebaut et al., 2023), adolescents can play a significant role in giving a correct diagnosis and avoid any confusion with a non-BPD crisis's that can be attributed to normal developmental experience, and to differentiate between the many co-morbidities that can accompany BPD. An awareness of pervasive and maladaptive traits associated with BPD can help play a role in early diagnosis and deciding on the most

appropriate intervention. Fonagy et al. (2015) have argued that fundamentally, adults and adolescents present with similar BPD traits and symptoms that would meet criteria for a diagnosis of BPD. For example, unstable sense of self, fear of abandonment and trait impulsivity are prominent features of BPD in both adults and adolescents. However, the authors have argued that there are some phenomenological differences between them; BPD experienced adolescents often present with more acute experiences of persistent self-harm, suicidal tendencies, impulsivity, and self-directed harmful behaviours. Adults appear to have more intense BPD symptoms in areas such as intense but unstable relationships and an unstable sense of self (Lawrence et al., 2015). Earlier studies found that symptoms and traits including sense of self, emotional dysregulation and anger were most likely to be seen in adolescents with BPD (Videler, et al., 2019). Sharp and Fonagy (2015) point out that this correlates closely with the phenomenology and predictive power of adults with BPD. Speranza, Pham-Scottez & Revah-Levy (2012) point out that affective instability featured prominently in adolescent outpatients, yet identity disturbance featured more markedly in adolescent inpatients (Becker, McGlashan & Grilo, 2006). Chanen and McCutcheon (2013) argue that BPD is in fact a single construct which spans across life, first emerging and peaking at puberty with its intensity reducing over adulthood. They argue that this is due to individuals maturing and becoming more socialised.

BPD is known to change predominance of symptoms from adolescence to adulthood (Videler, et al., 2019) in the sense that characteristics such as affective dysregulation, suicidality, and maladaptive coping strategies, like self-harm, are no longer the prevailing characteristics once an individual with BPD has reached adulthood. Further, it is argued that there are periods of remission and relapse of

diagnosis (Zanarini et al., 2010). Given the phenomenological differences between adolescents and adults (and across the lifespan), adaptations to the DSM – 5 (APA, 2013) are necessary for it to adequately measure and assess the impact of presenting symptoms in adolescents against its criteria. Further, it would be useful to have input from parents and caregivers to fully inform a clinician's understanding of the young person's experience of BPD and encourage combined working (Marriner et al., 2025).

Alternatively, the dimensional approach is much more appropriate for informing a diagnosis in adolescents, given its compatibility with the varying nature of BPD (Guilé et al, 2018). It is more qualitative in nature, allowing for greater discussion and input from those experiencing symptoms. Further, the alternative model for PD and the ICD-11 have removed the factor of age being a restriction for diagnosis of PD (Kaess & Cavelti, 2025). Kaess & Cavelti, (2025) refer to the AMPD as a "hybrid model" which can assess severity (criterion A) and functioning levels, and maladaptive expressions (criterion B) of personality traits. Sharp et al. (2025) identified that the AMPD model shows greater reliability and stronger clinical utility over categorical models and are fit to be used in the DSM -5 (APA, 2013) but argues that the "hybrid model" adds a level of complexity that is unnecessary. Natoli et al. (2025) further exploration of how dimensional models can improve clinical practice is needed.

As Sharp and Fonagy (2015) argue, early assessment and identification of adolescents presenting with BPD features is imperative to prevent long term harm, reduce suffering and economic consequences. An effective evidence-based approach must be used to achieve this. Therefore, much more research is required to further

explore the limitations and strengths of diagnostic models to pave the way for early identification and intervention in BPD.

There are not only diagnostic barriers but areas such as limitations in early interventions and the problem of stigma which will be explored in the following sections.

3.2. Early intervention for adolescents

Chanen et al. (2017, 2020) and others (Christea et al., 2017; Oud et al., 2018; Beck et al., 2020; Jorgenson et al., 2021) provide significant evidence base derived from randomised controlled trials that support the efficacy of specialised psychotherapies for BPD in adults and more recently in young people. However, they are not without their challenges and limitations. Chanen et al. (2020) highlight that while there are BPD interventions for adolescents globally, they tend to be specialised and complex leaving little opportunity for replication across different health systems. According to Gratz and Gunderson (2006), Dialectical behavioural therapy (DBT) and Mentalisation-Based treatment (MBT) are effective in treating both BPD and self-harm in adolescents (Hajek Gross et al., 2024). However, these are often intense and lengthy therapies requiring significant commitment from an individual (and practitioner) which could be perceived as a barrier to treatment. Trautman et al. (1993) found that up to 77% of adolescents presenting with self-harm tended not to engage for long periods without patient treatment and identified that four to six follow-up sessions were the average for engagement. As a result, it is argued that brief, early and effective interventions are needed especially when it comes to symptoms like self-harm (Kraupl-Taylor, 2008). Further, the evidence base (Kliem et al., 2010) shows that in adults effect sizes are small and unstable at follow-up

and do not match the scale of the problem. In addition, in the context of adolescence, interventions such as DBT and MBT have been developed for adults without due consideration of prevention, which is important in adolescence.

Cognitive Analytic Therapy (CAT) is a programme of time-limited, brief therapy which looks at the interactions of how an individual thinks, feels and acts and often explores childhood experiences and relationships and their relational role to each other (Ryle, 1997). CAT has significant theoretical advantages for early intervention due to the nature of its approach of encompassing the co-morbidities common to individuals with BPD. In a pilot study by Taylor et al. (2021) it was found that those who engaged in at least one session of a brief therapy showed a reduction in psychological distress. Chanen et al. (2008) found that participants in an RCT comparing CAT versus SAU showed participants improved more rapidly when compared to a 'Good Clinical Care' group. However, there are limitations such as sample size in the original RCT, and more complex clinical trials are needed to further examine the clinical and cost effectiveness of treatments for earlier intervention and treatment of BPD in adolescents. Since then, systematic review on the clinical effectiveness of psychotherapies in comparison to treatment as usual has been inconclusive (Jørgensen et al., 2021). High attrition rates and methodological issues weaken the reliability of the findings, emphasizing a gap in evidence and a pressing need for better-designed studies.

3.3 Barriers in pathways to care

Pathways to care for BPD remain unclear and disjointed (Flynn et al., 2019). The National Institute for Mental Health for England (NIMH, 2003) issues policy implementation guidelines stating PDs were no longer a diagnosis of exclusion. BPD

patients frequently present at emergency departments in crisis (Broadbear et al, 2020) following self-harm and suicide attempts. Repeated self-harm rates in BPD are as high as 90% (Bailey & Lewis, 2015). Admission to hospital in these acute crisis situations lack therapeutic value (Gunderson & Links, 2015). It is therefore important to ask why individuals must reach crisis point before receiving any help, which is generally given by the wrong service. Research on early intervention and service provision in BPD is relatively new (Chanen et al., 2007), however, what is evident is that BPD patients frequently fall through the cracks of health and social care. Negative clinician attitudes, poor competency when assessing, lack of joined up working and stigma can all contribute to being turned away from appropriate and timely intervention for BPD (Lamb et al., 2018; Flynn et al., 2019; French et al., 2019). Therefore, pathways to care in BPD must be explored in more depth to better understand individual journeys which, in turn, could influence effective service provision and early intervention in BPD.

Individuals with BPD signs and symptoms are reported to be four times more likely to initially present to their GP (Riihimäki et al., 2016). In a qualitative study exploring pathways to care for males with BPD (Broadbear et al., 2025), significant barriers to diagnosis and treatment were identified. A recurrent theme was that adverse childhood experiences (ACEs) were frequently overlooked at earlier stages of contact with services. Participants described early manifestations of anger, sadness, and anxiety, which were not recognised by healthcare providers as potential indicators of ACEs or co-morbid conditions such as neurodevelopmental differences. Consequently, none of the participants received mental health support at these early points of presentation.

Another theme highlighted in a study by Broadbear et al. (2025) was that initial help-seeking via a GP commonly resulted in misdiagnoses of depression or anxiety, leading to prescriptions of medication that were perceived as ineffective in addressing difficulties in interpersonal and intrapersonal functioning. The final stage in the pathway to care involved receiving a BPD diagnosis, with a mean age of diagnosis of 36 years. Considering the literature advocating for early identification and intervention in BPD, this suggests a markedly protracted pathway to appropriate care, accompanied by significant psychological distress across the lifespan.

However, studies such as Broadbear et al. (2025) relied on male participants who self-selected for inclusion, meaning that formal diagnostic verification was not always present and findings may also reflect potential gender bias in access to, or receipt of, a professional diagnosis.

Clearly, there are significant barriers to care in BPD, especially for adolescents; it is argued that young people fail to recognise their own signs and symptoms of BPD and seek out appropriate care (Wall et al., 2021). However, this could be misinterpreted as blaming the young person for not being aware of their needs. It should be highlighted that BPD is one of the most underfunded mental health conditions meaning trained professionals in BPD may not be accessible (Wall et al., 2021). Therefore, the onus may be left on a young person to seek appropriate care, but autonomy can be lacking which leaves individuals vulnerable and met with the many barriers outlined.

Studies such as ‘Managing the Link and Strengthening Transition from Child to Adult Mental Healthcare’ (MILESTONE Project, Singh et al., 2017) identified that poor transition from CAMHS to Adult Mental Health Services (AMHS) can impose significant barriers to continuity of care and continuous treatment in turn impacting

upon a young person's mental health and well-being in the longer term; this was significant for adolescents with PD and neurodivergence (Islam et al., 2016). It is argued that managed transitions from CAMHS to AMHS can lead to significant improvements in the mental health of young people moving through services; further, managed transitions can be cost effective (Singh et al., 2023). The MILESTONE Project (2017) identified that improved collaboration between young people, their caregivers, and clinicians, had a significant and speedier improvement on mental health in the 15 months which followed the trial.

Similarly, a UK wide analysis (Peytrignet & Grimm, 2022) identified significant inequalities in accessing services, issues associated with the ambulance service during a mental health crisis, retention during the transition from child to adult services and drug prescription patterns among young people. These findings are for mental health issues in general; what is not apparent is the figures, barriers to treatment and individual experiences of mental health services when presenting with signs and symptoms of BPD early in its course.

Given the high risk of injurious behaviours in young people with BPD, a greater social and financial pressure is put on healthcare services owing to medication use and emergency admissions (Zanarini et al., 2004), therefore, it would be useful for healthcare settings to identify what the barriers are in accessing early intervention and treatment. Effective, timely and collaborative outpatient care is imperative to individual positive clinical care journeys in BPD. In turn, healthcare settings can then be supported in their treatment and management of BPD presenting patients.

A significant factor that has become apparent in accessing care and early intervention for those with BPD features is that of stigma, especially in the context of age. The following section will report on the issue and identify ways in which

significant harm is caused by stigma to those seeking help for BPD signs and symptoms.

3.4. Stigma in BPD

Link and Phelan (2001) argued that the concept of stigma is made up of four parts; first, through the identification of individual differences; second, these differences are considered negative by society; third, those who are considered different are then stigmatised; and finally, significant loss in areas such as opportunity is experienced by the stigmatised group. Grambal et al., (2016) identified that individuals with a diagnosis of BPD self-stigmatised to a much higher extent compared with patients with anxiety disorder. However, arguably this stigma is seen not only from the patient's and the general population's perspective but within clinicians themselves: language from clinicians such as "managing this difficult and often disruptive patient group" (Ryle, 2007, pg329) is derogatory and unhelpful in promoting good quality, non-biased patient care in clinical settings.

Some clinicians and the general population, argue that BPD can be misdiagnosed in adolescence as symptoms can be emulated in normal developmental processes (Sharp, 2017), thus perpetuating the assumption of incorrectly labelling a young person with a very serious and complex illness, potentially leading to stigma and discrimination (Stiles et al., 2023). However, DSM-5 (2013) criteria clearly stipulate the symptoms must be pervasive, lasting for at least one year and have a significant impact on the functioning of an adolescent. Often, this criterion is ignored or poorly understood, and behaviours seen as being on a normal teenage developmental trajectory are used as a defence for not giving a BPD diagnosis

(Chanen, 2015). This only perpetuates the problem of stigma and discrimination, as not giving the correct diagnosis or simply brushing off symptoms as 'normal teen angst' can be very damaging, have long term consequences and forms a barrier between the young person and the highly evidenced need of access to early treatment and intervention (Ring & Lawn, 2025). Catthoor et al. (2015) explored differences in stigma between adults and adolescents with PDs, finding adolescents experienced significantly more stigma than adults, and adolescents with BPD experienced an even greater level of stigma.

Poor clinician attitudes (Lindell-Innes et al., 2023) equate to the patient avoiding diagnosis and BPD appropriate treatments which, if administered in a timely manner, could potentially save lives, and improve long-term outcomes for many young people. Although there have been some improvements in clinician attitudes (Day et al., 2018), stigma and discrimination still play major roles in BPD diagnosis, or lack thereof, perpetuating the cycle of negativity and hesitancy surrounding it (Fonagy et al., 2015). There is significant scope here for patients and clinicians (Collins et al., 2025), along with the general population, to work towards tackling and reducing the negative connotations associated with BPD, thus in turn, supporting individuals to seek appropriate care and receive bespoke treatment plans.

Evidently, much more research is required into the nature and phenomenology of stigma and discrimination in young people with a diagnosis of BPD and those early in the course of the disorder who may be reluctant to seek help. Qualitative research could better inform mental health professionals allowing for a better therapeutic relationship to be formed. Further, identifying and highlighting positive symptoms associated with BPD can help tackle stigma and discrimination.

It is also imperative that the young person's voice and opinion is heard when it comes to the contentious issue of giving a BPD diagnosis.

4. Summary

Evidently, significant gaps remain in both the evidence base and clinical practice relating to BPD, warranting further exploration. The literature outlined above demonstrates a relative absence of lived experience perspectives in shaping theoretical and developmental understandings of BPD. Although such contributions may not always be empirical in nature, incorporating lived experience could meaningfully inform how the 256 possible symptom combinations manifest across individuals, thereby providing a foundation for future empirical investigation. Moreover, the voices of those most severely affected by BPD are notably underrepresented within the literature. This thesis seeks to address that gap by foregrounding lived experience as central to informing intervention development, with the ultimate aim of reducing unnecessary and prolonged suffering across the lifespan.

A further gap in the literature concerns the need for a clearer understanding of co-morbidities in early development, particularly whether the presence of adverse childhood experiences (ACEs) and neurodevelopmental differences in childhood may indicate an increased risk of later BPD. Clarifying these associations could support earlier identification, targeted intervention, and more appropriate care pathways. The current lack of such understanding highlights how many young people may be overlooked by services throughout their mental health trajectories.

The phenomenology of early onset BPD is lacking with young people being screened with the same measurements used in adult diagnosis; It is evident from

the phenomenology highlighted that the nature and severity of BPD differ over the lifespan. This leads to incorrect or missed diagnosis resulting in no intervention, untimely treatments, the use of incorrect or over prescription of psychotropic medications or missed opportunities for care. Further, it contributes significantly to stigma, especially structural stigma. The limited understanding of how these factors collectively shape pathways to mental health care in BPD represents a significant barrier to improving outcomes. Without greater clarity regarding their contribution, opportunities for timely and effective intervention may be missed, ultimately affecting individuals' experiences of care and long-term recovery.

5. **Research aims:**

In this thesis, the following research aims are endeavoured to be investigated:

Research aims 1: Highlight the necessity of incorporating experts by experience of BPD into research and treatment.

Research aims 2: Explore 'pathways to care' for early borderline personality disorder taking early developmental risk factors of neurodivergence and trauma into consideration.

Research aims 3: Investigate, qualitatively, the journey through mental health care of young people experiencing signs and symptoms of BPD in the context of the BRIDGE project, fRCT.

Research aims 4: Explore the nature of stigma in BPD and highlight the benefits of patient – clinician collaboration.

References

Aggression, impulsivity, and psychopathic traits in combined antisocial personality disorder and substance use disorder (2013). *The Journal of Neuropsychiatry and Clinical Neurosciences, 25*(3), 229–232.

Ajinkya, S. A., Sharma, P. S., & Ramakrishnan, A. (2021). Proportion of psychiatry outpatients with borderline personality and associated clinical syndromes using the millon clinical multiaxial inventory-III: A retrospective study. *Journal of Clinical &Amp; Diagnostic Research,* (1)

Alareqe, N. A., Roslan, S., Nordin, M. S., Ahmad, N. A., & Taresh, S. M. (2021). Psychometric properties of the millon clinical multiaxial inventory-III in an arabic clinical sample compared with american, italian, and dutch cultures. *Frontiers in Psychology, 12*

Alcorn, J. L., III, Gowin, J. L., Green, C. E., Swann, A. C., Moeller, F. G., & Lane, S. D. (2013). Aggression, Impulsivity, and Psychopathic Traits in Combined Antisocial Personality Disorder and Substance Use Disorder. The Journal of Neuropsychiatry and Clinical Neurosciences, 25(3), 229–232. https://doi.org/10.1176/appi.neuropsych.12030060 (Original work published July 1, 2013)

Allen, J. G. (2006). *Mentalizing in practice. handbook of mentalizationbased treatment*

Anderson, J., Snider, S., Sellbom, M., Krueger, R., & Hopwood, C. (2014). A comparison of the DSM-5 section II and section III personality disorder structures. *Psychiatry Research, 216*(3), 363–372.

Axis II comorbidity in borderline personality disorder is influenced by sex, age, and clinical severity (2011). *Comprehensive Psychiatry, 52*(6), 725–730.

Aydn, E. F., & Koca Laçin, T. (2024). The association between borderline personality disorder, childhood trauma, neuroticism, and self-rated or clinician-rated functional impairment in euthymic bipolar disorder-1 patients. *Frontiers in Psychiatry, 15* doi:10.3389/fpsyt.2024.1444583

Bales, D. L., Timman, R., Andrea, H., Busschbach, J. J., Verheul, R., & Kamphuis, J. H. (2015). Effectiveness of day hospital mentalizationbased treatment for patients with severe borderline personality disorder: A matched control study. *Clinical Psychology &Amp; Psychotherapy, 22*(5), 409–417.

Ball, J. S., & Links, P. S. (2009). Borderline personality disorder and childhood trauma: Evidence for a causal relationship. *Current Psychiatry Reports, 11*(1), 63–68.

Banzhaf, A., Ritter, K., Merkl, A., Schulte-Herbrüggen, O., Lammers, C., & Roepke, S. (2012). Gender differences in a clinical sample of patients with borderline personality disorder. *Journal of Personality Disorders, 26*(3) doi:10.1521/pedi.2012.26.3.368

Barrachina, J., Pascual, J. C., Ferrer, M., Soler, J., Rufat, M. J., & Andión, O. (2012). *Untitled*

Bateman, A. W., & Fonagy, P. (2003). The development of an attachment-based treatment program for borderline personality disorder. *Bulletin of the Menninger Clinic, 67*(3), 187–211.

Bateman, A. W., & Fonagy, P. (2004). Mentalization-based treatment of BPD. *Journal of Personality Disorders, 18*(1), 36–51.

Bateman, A., & Fonagy, P. (2008a). 8-year follow-up of patients treated for borderline personality disorder: Mentalization-based treatment versus treatment as usual. *American Journal of Psychiatry, 165*(5), 631–638.

Bateman, A., & Fonagy, P. (2009). Randomized controlled trial of outpatient mentalization-based treatment versus structured clinical management for borderline personality disorder. *American Journal of Psychiatry, 166*(12), 1355–1364.

Beck, E., Bo, S., Jørgensen, M. S., Gondan, M., Poulsen, S., Storebø, O. J., . . . Pedersen, J. (2020). Mentalization-based treatment in groups for adolescents with borderline personality disorder: A randomized controlled trial. *Journal of Child Psychology and Psychiatry, 61*(5), 594–604.

Becker, D. F., Mcglashan, T. H., & Grilo, C. M. (2006). Exploratory factor analysis of borderline personality disorder criteria in hospitalized adolescents. *Comprehensive Psychiatry, 47*(2), 99–105. doi:10.1016/j.comppsych.2005.07.003

Bellino, S., Bosia, M., Montemagni, C., Rocca, P., & Bozzatello, P. (2021). In Stoffers-Winterling M., Sharp J., Krause-Utz C., Schmahl A., Lieb C. and K(Eds.), *Psychosis and personality disorders* Springer. doi:10.1007/978-3-031-09058-5_6bohus

Bohus, M., Schmahl, C., & Lieb, K. (2004). New developments in the neurobiology of borderline personality disorder. *Current Psychiatry Reports, 6*(1), 43–50.

Bonnington, O., & Rose, D. (2014). Exploring stigmatisation among people diagnosed with either bipolar disorder or borderline personality disorder: A critical realist analysis. *Social Science &Amp; Medicine, 123*, 7–17.

Borderline personality disorder recognition and management national institute for clinical excellence(2009). NICE guidelines.

Bornovalova, M. A., Verhulst, B., Webber, T., Mcgue, M., Iacono, W. G., & Hicks, B. M. (2018). Genetic and environmental influences on the codevelopment among borderline personality disorder traits, major depression symptoms, and substance use disorder symptoms from adolescence to young adulthood. *Development and Psychopathology, 30*(1), 49–65.

Bortolan, A. (2020). Narratively shaped emotions: The case of borderline personality disorder. *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine, 45*(2), 212–230.

Bortolla, R., Cavicchioli, M., Galli, M., Verschure, P. F., & Maffei, C. (2019). *A comprehensive evaluation of emotional responsiveness in borderline personality disorder: A support for hypersensitivity hypothesis. borderline personality disorder and emotion dysregulation*

Bouchard, S., Sabourin, S., Lussier, Y., & Villeneuve, E. (2009). Relationship quality and stability in couples when one partner suffers from borderline personality disorder. *Journal of Marital and Family Therapy, 35*(4), 446–455.

Bowlby, J. (1969). *Attachment and loss*. New York: Basic Books.

Bozzatello, P., Rocca, P., & Bellino, S. (2020). Trauma and psychopathology associated with early onset BPD: An empirical contribution. *Journal of Psychiatric Research, 131*, 54–59. doi:10.1016/j.jpsychires.2020.08.038

Bradley, R., & Westen, D. (2005). The psychodynamics of borderline personality disorder: A view from developmental psychopathology. *Development and Psychopathology, 17*(4), 927–957.

Brand, G., Wise, S., & Walpole, K. (2021). A disordered personality? it's time to reframe borderline personality disorder. *Journal of Psychiatric and Mental Health Nursing, 28*(3), 469–475.

Bridler, R., Häberle, A., Müller, S. T., Cattapan, K., Grohmann, R., Toto, S., . . . W. (2015). Psychopharmacological treatment of 2195 in-patients with borderline personality disorder: A comparison with other psychiatric disorders. *European Neuropsychopharmacology, 25*(6), 763–772.

Broadbear, J. H., Bhagwandas, M. G., Crowley, S., Cheney, L., & Rao, S. (2025). Exploring the pathways to diagnosis for men with borderline personality disorder: A qualitative study. *International Journal of Mental Health Nursing, 34*(1)

Broadbear, J. H., Dwyer, J., Bugeja, L., & Rao, S. (2020). Coroners' investigations of suicide in australia: The hidden toll of borderline personality disorder. *Journal of Psychiatric Research, 129*, 241–249.

Brühlmann, T. (1994). The borderline patient. diagnosis, psychodynamics and physician-patient relation.*Praxis, 84*(23)

Busch, A. J., Balsis, S., Morey, L. C., & Oltmanns, T. F. (2016). Gender differences in borderline personality disorder features in an epidemiological sample of adults age 55-64: Self versus informant report. *Journal of Personality Disorders, 30*(3), 419–432.

Buss, A. H., & Perry, M. (1992). The aggression questionnaire. *Journal of Personality and Social Psychology, 63*(3)

Campbell, K., Clarke, K., Massey, D., & Lakeman, R. (2020). Borderline personality disorder: To diagnose or not to diagnose? that is the question. *International Journal of Mental Health Nursing, 29*(5), 972–981. doi:10.1111/inm.12737

Caparrós, B. C., Hoz, E. V., Carballo, J. J., Llorente, C., Kehrmann, L., Flamarique, I., . . . C. (2013). Millon clinical multiaxial inventory III (MCMI-III) and communication styles in a sample of university students. *European Child &Amp; Adolescent Psychiatry, 16*(6), 759–776.

Carlson, E. A., Egeland, B., & Sroufe, L. A. (2009). A prospective investigation of the development of borderline personality symptoms. *Development and Psychopathology, 21*(4), 1311–1334.

Carpenter, R. W., & Trull, T. J. (2013). Components of emotion dysregulation in borderline personality disorder: A review. *Current Psychiatry Reports, 15*, 1–8.

Cattane, N., Rossi, R., Lanfredi, M., & Cattaneo, A. (2017). Borderline personality disorder and childhood trauma: Exploring the affected biological systems and mechanisms. *BMC Psychiatry, 17*(1)

Catthoor, K., Feenstra, D. J., Hutsebaut, J., Schrijvers, D., & Sabbe, B. (2015). *Adolescents with personality disorders suffer from severe psychiatric stigma: Evidence from a sample of 131 patients. adolescent health, medicine and therapeutics*

Cavelti, M., Thompson, K., Betts, J., Fowler, C., Luebbers, S., Cotton, S. M., & Chanen, A. M. (2021). Borderline personality disorder diagnosis and symptoms in outpatient youth as risk factors for criminal offenses and interpersonal violence. *Journal of Personality Disorders, 35*, 23–37.

Chanen, A. M., McCutcheon, L. K., Jovev, M., Jackson, H. J., & McGorry, P. D. (2007). Prevention and early intervention for borderline personality disorder. *Medical Journal of Australia, 187*(S7), S18–S21.

Chanen, A. M., Jackson, H. J., McCutcheon, L. K., Jovev, M., Dudgeon, P., Yuen, H. P., ... & McGorry, P. D. (2009). Early intervention for adolescents with borderline personality disorder: quasi-experimental comparison with treatment as usual. *Australian & New Zealand Journal of Psychiatry*, *43*(5), 397-408.

Chanen, A. M., & Mccutcheon, L. (2013). Prevention and early intervention for borderline personality disorder: Current status and recent evidence. *The British Journal of Psychiatry, 202*, 24–29.

Chanen, A. M. (2015). Borderline personality disorder in young people: Are we there yet? *Journal of Clinical Psychology, 71*(8), 778–791.

Chanen, A., Sharp, C., Hoffman, P., & For Prevention, G. A. (2017). Prevention and early intervention for borderline personality disorder: A novel public health priority. *World Psychiatry, 16*(2)

Chanen, A. M., Nicol, K., Betts, J. K., & Thompson, K. N. (2020). Diagnosis and treatment of borderline personality disorder in young people. Current Psychiatry Reports, 22, 1–8.

Chapman, A. L. (2019). Borderline personality disorder and emotion dysregulation. *Development and Psychopathology, 31*(3), 1143–1156.

Chapman, J., Jamil, R. T., Fleisher, C., & Torrico, T. J. (2024). *StatPearls* StatPearls Publishing.

Choi-Kain, L. W., & Gunderson, J. G. (2008). Mentalization: Ontogeny, assessment, and application in the treatment of borderline personality disorder. *American Journal of Psychiatry, 165*(9), 1127–1135.

Choi-Kain, L. W., & Gunderson. (2019). *Applications of good psychiatric management for borderline personality disorder: A practical guide* American Psychiatric Pub.

Chopra, H. D., & Beatson, J. A. (1988). Some aspects of the phenomenology of borderline personality disorder. *Indian Journal of Psychiatry, 30*(3), 221–226.

Choudhary, S. (2021). Borderline personality disorder: A review of indian studies. *Journal of Psychology & Clinical Psychiatry, 12*(2), 58–62.

Chun, S., Harris, A., Carrion, M., Rojas, E., Stark, S., Lejuez, C., . . . M A. (2017). A psychometric investigation of gender differences and common processes across borderline and antisocial personality disorders.*Journal of Abnormal Psychology, 126*(1)

Clark, L. A. (2007). Assessment and diagnosis of personality disorder: Perennial issues and an emerging reconceptualization. *Annu. Rev. Psychol, 58*(1), 227–257.

Collins, K. M., Minnis, H., & Gajwani, R. (2025). Using clinician–patient collaboration to tackle structural stigma and age discrimination in borderline personality disorder. *BJPsych Advances,* , 1–3.

Colombetti, G. (2009). What language does to feelings. *Journal of Consciousness Studies, 16*(9), 4–26.

Crick, N. R., & Grotpeter, J. K. (1995). Relational aggression, gender, and socialpsychological adjustment.*Child Development, 66*(3), 710–722.

Cristea, I. A., Gentili, C., Cotet, C. D., Palomba, D., Barbui, C., & Cuijpers, P. (2017). Efficacy of psychotherapies for borderline personality disorder: A systematic review and meta-analysis. *Jama Psychiatry, 74*(4), 319–328.

Cristofanelli, S., Testa, S., Centonze, E., Baccini, G., Toniolo, F., Vavalle, V., & Ferro, L. (2024). Exploring emotion dysregulation in adolescence and its association with social immaturity, selfrepresentation, and thought process problems. *Frontiers in Psychology, 15*

Crowell, S. E., Beauchaine, T. P., & Linehan, M. M. (2009). *A biosocial developmental model of borderline personality*: *Elaborating and extending linehan's theory*

Dagostino, A., Monti, M. R., & Starcevic, V. (2019). Psychotic symptoms in borderline personality disorder: An update. *Current Opinion in Psychiatry, 32*(1), 22–26.

Day, N. J., Hunt, A., Cortisjones, L., & Grenyer, B. F. (2018). Clinician attitudes towards borderline personality disorder: A 15year comparison. *Personality and Mental Health, 12*(4), 309–320.

De Genna, N. M., & Feske, U. (2013). Phenomenology of borderline personality disorder: The role of race and socioeconomic status. *The Journal of Nervous and Mental Disease, 201*(12), 1027–1034.

Dehlbom, P., Wetterborg, D., Lundqvist, D., Maurex, L., Dal, H., Dalman, C., & Kosidou, K. (2022). Gender differences in the treatment of patients with borderline personality disorder. *Personality Disorders, 13*(3), 277–287. doi:10.1037/per0000507

Dell Amico, S., & De Luca Picione, R. (2023). The borderline personality organization in otto F. kernberg's psychodynamic perspective. *European Journal of Psychotherapy &Amp; Counselling, 25*(4), 432–447. doi:10.1080/13642537.2023.2277427

Dhar, A., Hay, P., & Meade, T. (2023). Social and occupational functioning in individuals with BPD: A systematic review. *Journal of Personality Disorders, 37*(6), 691–723.

Diagnostic label borderline personality disorder (2025).

Diagnostic and statistical manual of mental disorders: DSM III (1980). American Psychiatric Association.

Ditrich, I., Philipsen, A., & Matthies, S. (2021). Borderline personality disorder (BPD) and attention deficit hyperactivity disorder (ADHD) revisited-a review-update on common grounds and subtle distinctions. *Borderline Personality Disorder and Emotion Dysregulation, 8*(1)

Donegan, N. H., Sanislow, C. A., Blumberg, H. P., Fulbright, R. K., Lacadie, C., Skudlarski, P., ... & Wexler, B. E. (2003). Amygdala hyperreactivity in borderline personality disorder: implications for emotional dysregulation. *Biological psychiatry*, *54*(11), 1284-1293.

Drake, R., Haddock, G., Tarrier, N., Bentall, R., & Lewis, S. (2007). The psychotic symptom rating scales (PSYRATS): Their usefulness and properties in first episode psychosis. *Schizophrenia Research, 89*(1-3), 119–122.

Eaton, N. R., Krueger, R. F., & Keyes, K. M. (2011). Borderline personality disorder co-morbidity: Relationship to the internalizing-externalizing structure of common mental disorders. *Psychol Med, 41*, 1041–1050.

Ebner-Priemer, U. W., Kuo, J., Schlotz, W., Kleindienst, N., Rosenthal, M. Z., Detterer, L., . . . M. (2008). Distress and affective dysregulation in patients with borderline personality disorder: A psychophysiological ambulatory monitoring study. *The Journal of Nervous and Mental Disease, 196*(4), 314–320.

Edwards, E. R., Epshteyn, G., Diehl, C. K., Ruiz, D., Coolidge, B., Weiss, N. H., & Stein, L. (2024). Prison or treatment? gender, racial, and ethnic inequities in mental health care utilization and criminal justice history among incarcerated persons with borderline and antisocial personality disorders. *Law and Human Behavior, 48*(2), 104–116. doi:10.1037/lhb0000557

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.

Estric, C., Calati, R., & Lopez-Castroman, J. (2022). Adverse childhood experiences and neurocognition in borderline personality disorder: A call-to-action perspective review. *Harvard Review of Psychiatry, 30*(4), 248–260.

Flynn, S., Raphael, J., Graney, J., Nyathi, T., Williams, A., Kapur, N., . . . Shaw, J. (2019a). The personality disorder patient pathway: Service user and clinical perspectives. *Personality and Mental Health, 13*(3), 134–143.

Flynn, S., Raphael, J., Graney, J., Nyathi, T., Williams, A., Kapur, N., . . . Shaw, J. (2019b). The personality disorder patient pathway: Service user and clinical perspectives. *Personality and Mental Health, 13*(3), 134–143.

Fonagy, P. (1991). Thinking about thinking: Some clinical and theoretical considerations in the treatment of a borderline patient. *International Journal of Psychoanalysis, 72*(4), 639–656.

Fonagy, P., & Bateman, A. W. (2006). Mechanisms of change in mentalizationbased treatment of BPD. *Journal of Clinical Psychology, 62*(4), 411–430.

Fonagy, P., & Campbell, C. (2015). Bad blood revisited: Attachment and psychoanalysis. *British Journal of Psychotherapy, 31*(2), 229–250.

Fossati, A., Madeddu, F., & Maffei, C. (1999). Borderline personality disorder and childhood sexual abuse: A meta-analytic study. *Journal of Personality Disorders, 13*(3), 268–280.

Fowler, J. C., Carlson, M., Orme, W. H., Allen, J. G., Oldham, J. M., Madan, A., & Frueh, B. C. (2021). Diagnostic accuracy of DSM-5 borderline personality disorder criteria: Toward an optimized criteria set. *Journal of Affective Disorders, 279*, 203–207. doi:10.1016/j.jad.2020.09.138

Frankfurt, D. (2012). In Leichsenring T. H. S., Steinert J. F. H.(Eds.), *Handbook of borderline personality disorder* Springer.

French, L., Moran, P., Wiles, N., Kessler, D., & Turner, K. M. (2019). GPs' views and experiences of managing patients with personality disorder: A qualitative interview study. *BMJ Open, 9*(2), e026616.

Gajwani, R., & Minnis, H. (2023). Double jeopardy: Implications of neurodevelopmental conditions and adverse childhood experiences for child health. *European Child &Amp; Adolescent Psychiatry, 32*(1), 1–4.

Gajwani, R., Sim, F., Mcallister, K., Smith, H., Mcintosh, E., Moran, P., . . . H. (2024). The BRIDGE project: A feasibility randomised controlled trial of brief, intensive assessment and

integrated formulation for young people (age 14-24) with features of borderline personality disorder (protocol). *Frontiers in Psychiatry, 15*

Gajwani, R., & Minnis, H. (2023). Double jeopardy: Implications of neurodevelopmental conditions and adverse childhood experiences for child health. *European Child & Adolescent Psychiatry, 32*(1), 1–4.

Glaser, J. P., Van Os, J., Thewissen, V., & Myingermeys, I. (2010). Psychotic reactivity in borderline personality disorder. *Acta Psychiatrica Scandinavica, 121*(2), 125–134.

Golomb, M., Fava, M., Abraham, M., & Rosen-Baum, J. F. (1995). Gender differences in personality disorders.*American Journal of Psychiatry, 152*, 579–582.

Goodman, M., & New, A. (2000). Impulsive aggression in borderline personality disorder. *Current Psychiatry Reports, 2*(1), 56–61.

Graaf, R. (2016). Prevalence rates of borderline personality disorder symptoms: A study based on the Netherlands mental health survey and incidence study 2. *BMC Psychiatry, 16*, 1–10.

Grambal, A., Prasko, J., Kamaradova, D., Latalova, K., Holubova, M., Marackova, M., . . . M. (2016). Self-stigma in borderline personality disorder-cross-sectional comparison with schizophrenia spectrum disorder, major depressive disorder, and anxiety disorders. *Neuropsychiatric Disease and Treatment,* , 2439–2448.

Grant, B. F., Chou, S. P., Goldstein, R. B., Huang, B., Stinson, F. S., Saha, T. D., . . . W J. (2008). Prevalence, correlates, disability, and comorbidity of DSM-IV borderline personality disorder: Results from the wave 2 national epidemiologic survey on alcohol and related conditions. *Journal of Clinical Psychiatry, 69*(4)

Gratz, K. L., & Gunderson, J. G. (2006). Preliminary data on an acceptance-based emotion regulation group intervention for deliberate self-harm among women with borderline personality disorder. *Behavior Therapy, 37*(1), 25–35.

Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the difficulties in emotion regulation scale. *Journal of Psychopathology and Behavioral Assessment, 26*, 41–54.

Gregory, R., Sperry, S. D., Williamson, D., Kuch-Cecconi, R., & Spink, G. L. (2021). High prevalence of borderline personality disorder among psychiatric inpatients admitted for suicidality. *Journal of Personality Disorders, 35*(5), 776–787.

Guilé, J. M., Boissel, L., Alaux-Cantin, S., & De La Rivière, S. G. (2018). *Borderline personality disorder in adolescents: Prevalence, diagnosis, and treatment strategies. adolescent health, medicine and therapeutics*

Gunderson, J. G. (2007). Disturbed relationships as a phenotype for borderline personality disorder. *American Journal of Psychiatry, 164*(11), 1637–1640.

Gunderson, J. G., & Links, M. D. (2015). *Handbook of good psychiatric management for borderline personality disorder*

Hansen, S. N., Schendel, D. E., & Parner, E. T. (2015). Explaining the increase in the prevalence of autism spectrum disorders: The proportion attributable to changes in reporting practices. *JAMA Pediatrics, 169*(1), 56–62.

Hajek Gross, C., Oehlke, S., Prillinger, K., Goreis, A., Plener, P. L., & Kothgassner, O. D. (2024). Efficacy of mentalization-based therapy in treating self-harm: A systematic review and meta-analysis. *Suicide and Life-Threatening Behavior, 54*(2), 317–337.

Hedemann, T. L., Asif, M., Aslam, H., Maqsood, A., Bukhsh, A., Kiran, T., . . . Lane, S. (2023). Clinicians', patients' and carers' perspectives on borderline personality disorder in pakistan: A mixed methods study protocol. *Plos One, 18*(6), e0286459.

Hennen, J., & Silk, K. R. (2004). Mental health service utilization by borderline personality disorder patients and axis II comparison subjects followed prospectively for 6 years. *J Clin Psychiatry, 65*(1), 28–36.

Herpertz, S. C., Nagy, K., Ueltzhöffer, K., Schmitt, R., Mancke, F., Schmahl, C., & Bertsch, K. (2017). Brain mechanisms underlying reactive aggression in borderline personality disorder-sex matters. *Biological Psychiatry, 82*(4), 257–266.

Hutsebaut J, Weekers LC, De Saeger H. A Brief Report on the Implementation of the Alternative Model for Personality Disorders in Clinical Practice. J Psychiatr Pract. 2026 Jan 1;32(1):35-39. doi: 10.1097/PRA.0000000000000901. PMID: 41591427.

Hutsebaut, J., Clarke, S. L., & Chanen, A. M. (2023). The diagnosis that should speak its name: Why it is ethically right to diagnose and treat personality disorder during adolescence. *Frontiers in Psychiatry, 14*, 1130417.

Hutsebaut, J., Sharp, C., & Kramer, U. (2026). Dimensional constructs of personality disorders: Implications for psychotherapy integration. *Journal of Psychotherapy Integration*, *36*(1), 1.

Iliffe-Lewis, R., & Bacon, A. M. (2026). The true me': Unravelling the dual narrative of borderline personality disorder and autistic spectrum disorder. *British Journal of Clinical Psychology, 65*(2), 689–707. doi:10.1111/bjc.70042

International classification of diseases 10th revision (2016). World Health Organization.

Islam, Z., Ford, T., Kramer, T., Paul, M., Parsons, H., Harley, K., . . . Singh, S. P. (2016). Mind how you cross the gap! outcomes for young people who failed to make the transition from child to adult services: The TRACK study. *BJPsych Bulletin, 40*(3), 142–148.

Jo, R., Broadbear, J. H., Hope, J., & Rao, S. (2023). Late manifestation of borderline personality disorder: Characterization of an underrecognized phenomenon. *Personality and Mental Health, 17*(2), 165–175.

Johnson, D. M., Shea, M. T., Yen, S., Battle, C. L., Zlotnick, C., Sanislow, C. A., . . . M C. (2003). Gender differences in borderline personality disorder: Findings from the collaborative longitudinal personality disorders study. *Comprehensive Psychiatry, 44*(4), 284–292.

Johnson, J. G., Cohen, P., Smailes, E. M., Skodol, A. E., Brown, J., & Oldham, J. M. (2001). Childhood verbal abuse and risk for personality disorders during adolescence and early adulthood. *Comprehensive Psychiatry, 42*(1), 16–23. doi:10.1053/comp.2001.19755

Jørgensen, M. S., Storebø, O. J., Stoffers-Winterling, J. M., Faltinsen, E., Todorovac, A., & Simonsen, E. (2021a). Psychological therapies for adolescents with borderline personality disorder (BPD) or BPD features—A systematic review of randomized clinical trials with meta-analysis and trial sequential analysis. *PloS One, 16*(1), e0245331.

Kaess, M., & Cavelti, M. (2025a). Research review: What we have learned about early detection and intervention of borderline personality disorder. *Journal of Child Psychology and Psychiatry, 66*(12), 1829–1848.

Kernberg, O. F. (1975). Borderline conditions and pathological narcissism. *J. Aronson,*

Kimura, D. (1992). Sex differences in the brain. *Scientific American, 267*(3), 118–125.

Kliem, S., Kröger, C., & Kosfelder, J. (2010). Dialectical behavior therapy for borderline personality disorder: A meta-analysis using mixed-effects modeling. *Journal of Consulting and Clinical Psychology, 78*(6), 936.

Knight, R. P. (1952). *Joint session of the american psychoanalytic association and the section on psychoanalysis of the american psychiatric association* International Universities Press, Inc.

Koenigsberg, H. W., Harvey, P. D., Mitropoulou, V., New, A. S., Goodman, M., Silverman, J., . . . L J. (2001). Are the interpersonal and identity disturbances in the borderline personality disorder criteria linked to the traits of affective instability and impulsivity. *Journal of Personality Disorders, 15*(4), 358–370.

Korzekwa, M. I., Dell, P. F., Links, P. S., Thabane, L., & Webb, S. P. (2008). Estimating the prevalence of borderline personality disorder in psychiatric outpatients using a two-phase procedure. *Comprehensive Psychiatry, 49*(4), 380–386.

Kraupl-Taylor, D. O., Ng, A. V., & Low, J. (2008). Therapeutic assessment based on cognitive-analytic therapy for young people presenting with self-harm: Pilot study. *Psychiatric Bulletin, 32*(11), 423–426.

Lacey, R. E., & Minnis, H. (2020). Practitioner review: Twenty years of research with adverse childhood experience scores–advantages, disadvantages and applications to practice. *Journal of Child Psychology and Psychiatry, 61*(2), 116–130.

Langevin, R., Abou Chabake, S., & Beaudette, S. (2025). Intergenerational cycles of maltreatment: An updated scoping review of psychosocial risk and protective factors. *Trauma, Violence, &Amp; Abuse,*

Látalová, K., & Praško, J. (2010). Aggression in borderline personality disorder. *Psychiatric Quarterly, 81*, 239–251.

Lawrence, K. A., Allen, J. S., & Chanen, A. M. (2011). A study of maladaptive schemas and borderline personality disorder in young people. *Cognitive Therapy and Research, 35*, 30–39.

Leichsenring, F., Fonagy, P., Heim, N., Kernberg, O. F., Leweke, F., Luyten, P., . . . C. (2024). Borderline personality disorder: A comprehensive review of diagnosis and clinical presentation, etiology, treatment, and current controversies. *World Psychiatry, 23*(1), 4–25.

Leising, D., Rogers, K., & Ostner, J. (2009). The undisordered personality: Normative assumptions underlying personality disorder diagnoses. *Review of General Psychology, 13*(3), 230–241.

Lieb, K., Zanarini, M. C., Schmahl, C., Linehan, M. M., & Bohus, M. (2004). Borderline personality disorder. *The Lancet (British Edition), 364*(9432), 16770–16776. doi:10.1016/s0140-673604

Lindell-Innes, R., Phillips-Hughes, A. L., Bartsch, D., Galletly, C., & Ludbrook, C. (2023). Attitudes of psychiatry trainees towards patients with borderline personality disorder: Does the stigma begin during training?*Personality and Mental Health, 17*(4), 387–395.

Linehan, M. M., & Kehrer, C. A. (1993). *Borderline personality disorder. clinical handbook of psychological disorders*

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*(1), 363–385.

Loranger, A. W., & Sartorius, N. (1994). *International personality disorder examination screening questionnaire (IPDE-SQ)* World Health Organization.

Maffly-Kipp, J., & Morey, L. C. (2024). Comparing the DSM-5 categorical model of personality disorders and the alternative model of personality disorders regarding clinician judgments of risk and outcome. *Personality Disorders: Theory, Research, and Treatment, 15*(5)

Magnavita, J. J., Levy, K. N., Critchfield, K. L., & Lebow, J. L. (2010). Ethical considerations in treatment of personality dysfunction: Using evidence, principles, and clinical judgment. *Professional Psychology, Research and Practice, 41*(1), 64–74. doi:10.1037/a0017733

Mancke, F., Herpertz, S. C., & Bertsch, K. (2015). Aggression in borderline personality disorder: A multidimensional model. *Personality Disorders: Theory, Research, and Treatment, 6*(3)

Marriner, L., Larkin, M., Urquhart Law, G., & Kaur Bhogal, S. (2025). 'I'm ruined': Young people's and their mothers' experiences of living with, and receiving a diagnosis of, borderline personality disorder: An interpretative phenomenological analysis. *Psychology and Psychotherapy: Theory, Research and Practice, 98*(2), 361–372.

Mattingley, S., Youssef, G. J., Graeme, L., Sloan, E., Manning, V., & Hall, K. (2024). Negative urgency, distress tolerance, and symptoms of substance use, eating, and borderline

personality disorders in treatmentseeking young people. *Journal of Clinical Psychology, 80*(2), 261–278. doi:10.1002/jclp.23579

Monaghan, C., & Bizumic, B. (2023). Dimensional models of personality disorders: Challenges and opportunities. *Frontiers in Psychiatry, 14*

Monte, F. L., & Englebert, J. (2018). Borderline personality disorder and lived time.*39;Évolution Psychiatrique, 83*(4), 37.

Natoli, A. P., Murdock, J. G., Merguie, J. L., & Hopwood, C. J. (2025). Dimensional models of personality and a multidimensional framework for treating personality pathology. *BJPsych Advances, 31*(3), 137–146.

Neale, B. (2021). *The craft of qualitative longitudinal research: The craft of researching lives through time*

New, A. S., Hazlett, E. A., Newmark, R. E., Zhang, J., Triebwasser, J., Meyerson, D., . . . M S. (2009). Laboratory induced aggression: A positron emission tomography study of aggressive individuals with borderline personality disorder. *Biological Psychiatry, 66*(12), 1107–1114.

Newhill, C. E., Eack, S. M., & Mulvey, E. P. (2012). A growth curve analysis of emotion dysregulation as a mediator for violence in individuals with and without borderline personality disorder. *Journal of Personality Disorders, 26*(3), 452–467.

Newton-Howes, G., Clark, L. A., & Chanen, A. (2015). Personality disorder across the life course. *The Lancet, 385*(9969), 727–734.

O'malley, G. K., Mchugh, L., Mac Giollabhui, N., & Bramham, J. (2016). Characterizing adult attention-deficit/hyperactivity-disorder and comorbid borderline personality disorder: ADHD symptoms, psychopathology, cognitive functioning and psychosocial factors. *European Psychiatry, 31*, 29–36.

Oldham, J. M. (2015). *The alternative DSM-5 model for personality disorders*

Oud, M., Arntz, A., Hermens, M. L., Verhoef, R., & Kendall, T. (2018). Specialized psychotherapies for adults with borderline personality disorder: A systematic review and meta-analysis. *Australian & New Zealand Journal of Psychiatry, 52*(10), 949–961.

Palihawadana, V., Broadbear, J. H., & Rao, S. (2019). Reviewing the clinical significance of 'fear of abandonment 'in borderline personality disorder. *Australasian Psychiatry, 27*(1), 60–63.

Patton, J. H., Stanford, M. S., & Barratt, E. S. (1995). Factor structure of the barratt impulsiveness scale.*Journal of Clinical Psychology, 51*, 768–774.

Peytrignet, S., & Grimm, F. (2022). Children and young people's mental health in england, scotland and wales-case studies using linked data from the networked data lab. *International Journal of Population Data Science, 7*(3)

Qian, X., Townsend, M. L., Tan, W. J., & Grenyer, B. F. S. (2022). Sex differences in borderline personality disorder: A scoping review. *PloS One, 17*(12) doi:10.1371/journal.pone.0279015

Rihmer, Z., & Benazzi, F. (2010). *Impact on suicidality of the borderline personality traits impulsivity and affective instability*

Riihimäki, K., Sintonen, H., Vuorilehto, M., Jylhä, P., Saarni, S., & Isometsä, E. (2016). Healthrelated quality of life of primary care patients with depressive disorders. *European Psychiatry, 37*, 28–34.

Ring, D., & Lawn, S. (2025). 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, 34*(1), 57–77.

Ruocco, A. C., & Carcone, D. (2016). A neurobiological model of borderline personality disorder: Systematic and integrative review. *Harvard Review of Psychiatry, 24*(5), 311–329.

Ryle, A. (1997). The structure and development of borderline personality disorder: A proposed model. *Br J Psychiatry,* (170), 82–87.

Salavati, M., & Selby, E. A. (2025). *Theories of borderline personality disorder: Concepts and empirical base* Springer.

Sansone, R. A., & Sansone, L. A. (2011). Gender patterns in borderline personality disorder. *Innovations in Clinical Neuroscience, 8*(5)

Sansone, R. A., Wiederman, M. W., & Sansone, L. A. (1998). The self-harm inventory (SHI): Development of a scale for identifying self-destructive behaviors and borderline personality disorder. *J Clin Psychol, 54*, 973–983. doi:10.1002/sici1097-467919981154:7

Santangelo, P. S., Koenig, J., Kockler, T. D., Eid, M., Holtmann, J., Koudelahamila, S., . . . Ebnerpriemer, U. W. (2018). Affective instability across the lifespan in borderline personality disorder -a crosssectional ediary study. *Acta Psychiatrica Scandinavica, 138*(5), 409–419. doi:10.1111/acps.12950

Schulze, A., Cloos, L., Zdravkovic, M., Lis, S., & Krause-Utz, A. (2022). *On the interplay of borderline personality features, childhood trauma severity, attachment types, and social support. borderline personality disorder and emotion dysregulation*

Scott, L. N., Stepp, S. D., & Pilkonis, P. A. (2014). Prospective associations between features of borderline personality disorder, emotion dysregulation, and aggression. *Personality Disorders: Theory, Research, and Treatment, 5*(3)

Selby, E. A., Franklin, J., Carsonwong, A., & Rizvi, S. L. (2013). Emotional cascades and self injury: Investigating instability of rumination and negative emotion. *Journal of Clinical Psychology, 69*(12), 1213–1227.

Selby, E. A., & Joiner, T. E. (2009). Cascades of emotion: The emergence of borderline personality disorder from emotional and behavioral dysregulation. *Review of General Psychology, 13*(3), 219–229.

Shah, R., & Zanarini, M. C. (2018). *Comorbidity of borderline personality disorder: Current status and future directions. the psychiatric clinics of north america* doi:10.1016/j.psc.2018.07.009

Sharp, C. (2016). Current trends in BPD research as indicative of a broader sea-change in psychiatric nosology. *Personality Disorders, 7*(4), 334–343. doi:10.1037/per0000199

Sharp, C. (2017). Bridging the gap: The assessment and treatment of adolescent personality disorder in routine clinical care. *Archives of Disease in Childhood, 102*(1), 103–108. doi:10.1136/archdischild-2015-310072

Sharp, C., & Kim, S. (2015). Recent advances in the developmental aspects of borderline personality disorder. *Current Psychiatry Reports, 17*(4), 556–556.

Sharp, C., Clark, L. A., Balzen, K. M., Widiger, T., Stepp, S., Zimmerman, M., & Krueger, R. F. (2025). The validity, reliability and clinical utility of the alternative DSM-5 model for personality disorders (AMPD) according to DSM-5 revision criteria. *World Psychiatry, 24*(3), 319–340.

Shen, C. C., Hu, L. Y., Tsai, S. J., Yang, A. C., Chen, P. M., & Hu, Y. H. (2018). Risk stratification for the early diagnosis of borderline personality disorder using psychiatric comorbidities. *Early Intervention in Psychiatry, 12*(4), 605–612.

Silbersweig, D., Clarkin, J. F., Goldstein, M., Kernberg, O. F., Tuescher, O., Levy, K. N., & . (2012). *Untitled*

Simon, J. J., Spiegler, K., Coulibaly, K., Stopyra, M. A., Friederich, H. C., Gruber, O., & Nikendei, C. (2025). Beyond diagnosis: Symptom patterns across complex PTSD and borderline personality disorder. *Frontiers in Psychiatry, 16*

Singh, S. P., Tuomainen, H., Bouliotis, G., Canaway, A., De Girolamo, G., Dieleman, G. C., & . (2023). Effect of managed transition on mental health outcomes for young people at the child-adult mental health service boundary: A randomised clinical trial. *Psychological Medicine, 53*(6), 2193–2204.

Singh, S. P., Tuomainen, H., De Girolamo, G., Maras, A., Santosh, P., Mcnicholas, F., . . . L. (2017). Protocol for a cohort study of adolescent mental health service users with a nested cluster randomised controlled trial to assess the clinical and cost-effectiveness of managed

transition in improving transitions from child to adult mental health services (the MILESTONE study). *BMJ Open, 7*(10)

Skaug, E., Czajkowski, N. O., Waaktaar, T., & Torgersen, S. (2022). Childhood trauma and borderline personality disorder traits: A discordant twin study. *Journal of Psychopathology and Clinical Science, 131*(4)

Skodol, A. E. (2012). Personality disorders in DSM-5. *Annual Review of Clinical Psychology, 8*(1), 317–344.

Slotema, C. W., Daalman, K., Blom, J. D., Diederen, K. M., Hoek, H. W., & Sommer, I. E. C. (2012a). Auditory verbal hallucinations in patients with borderline personality disorder are similar to those in schizophrenia.*Psychological Medicine, 42*(9), 1873–1878.

Smits, M. L., Luyten, P., Feenstra, D. J., Bales, D. L., Kamphuis, J. H., Dekker, J. J., . . . J J. (2022). Trauma and outcomes of mentalization-based therapy for individuals with borderline personality disorder. *American Journal of Psychotherapy, 75*(1), 12–20.

Soler, J., Casellas-Pujol, E., Pascual, J. C., Schmidt, C., Domínguez-Clavé, E., Cebolla, A., . . . M. (2022). Advancing the treatment of long-lasting borderline personality disorder: A feasibility and acceptability study of an expanded DBT-based skills intervention. *Borderline Personality Disorder and Emotion Dysregulation, 9*(1)

Soloff, P. H., Meltzer, C. C., Becker, C., Greer, P. J., Kelly, T. M., & Constantine, D. (2003). Impulsivity and prefrontal hypometabolism in borderline personality disorder. *Psychiatry Research: Neuroimaging, 123*(3), 153–163.

Soloff, P., White, R., & Diwadkar, V. A. (2014). Impulsivity, aggression and brain structure in high and low lethality suicide attempters with borderline personality disorder. *Psychiatry Research: Neuroimaging, 222*(3), 131–139.

Speranza, M., Pham-Scottez, A., Revah-Levy, A., Barbe, R. P., Perez-Diaz, F., Birmaher, B., & Corcos, M. (2012). Factor structure of borderline personality disorder symptomatology in

adolescents. *Canadian Journal of Psychiatry, 57*(4), 230–237. doi:10.1177/070674371205700406

Stanton, K., Gillikin, L., Willis, L., Woods-Gonzalez, R., Myntti, W., Paige, C., . . . N N. (2025). Understanding broader community perspectives on the scientific accuracy and stigma of personality trait labels. *Personality Disorders: Theory, Research, and Treatment, 16*(1)

Stern, A. (1938). Psychoanalytic investigation of and therapy in the border line group of neuroses. *Psychoanal. Quart, 7*(4), 467–489.

Stern, E. (2010). Failure of frontolimbic inhibitory function in the context of negative emotion in borderline personality disorder. *Focus, 8*(2), 250–260.

Stiles, C., Batchelor, R., Gumley, A., & Gajwani, R. (2023). Experiences of stigma and discrimination in borderline personality disorder: A systematic review and qualitative meta-synthesis. *Journal of Personality Disorders, 37*(2), 177–194.

Stoffers, J. M., & Lieb, K. (2015). Pharmacotherapy for borderline personality disorder-current evidence and recent trends. *Current Psychiatry Reports, 17*(1)

Stone, B. M. (2024). *The pathogenesis of borderline personality disorder: Evolution of evidence and treatment implications for two prominent models* SAGE Publications. doi:10.1177/00332941221127618

Swartz, M., Blazer, D., George, L., & Winfield, I. (1990). Estimating the prevalence of borderline personality disorder in the community. *Journal of Personality Disorders, 4*(3), 257–272.

Tadi, A., Wagner, S., Hoch, J., Bakaya, Ö, Von Cube, R., Skaletz, C., . . . N. (2009). Gender differences in axis I and axis II comorbidity in patients with borderline personality disorder. *Psychopathology, 42*(4), 257–263.

Tamilson, B., Eccles, J. A., & Shaw, S. C. (2025). The experiences of autistic adults who were previously diagnosed with borderline or emotionally unstable personality disorder: A phenomenological study. *Autism, 29*(2), 504–517.

Taylor, P. J., Adeyemi, I., Marlow, K., Cottam, S., Airnes, Z., Hartley, S., . . . S. (2024). *The relational approach to treating self-harm (RELATE): Study protocol for a feasibility randomised controlled trial study of cognitive analytic therapy for adults who self-harm versus treatment at usual. pilot and feasibility studies*

ten Have, M., Verheul, R., Kaasenbrood, A., van Dorsselaer, S., Tuithof, M., Kleinjan, M., & de Graaf, R. (2016). Prevalence rates of borderline personality disorder symptoms: A study based on the netherlands mental health survey and incidence study-2. *BMC Psychiatry, 16*(1), 249-249. https://doi.org/10.1186/s12888-016-0939-x

Terzi, L., Martino, F., Berardi, D., Bortolotti, B., Sasdelli, A., & Menchetti, M. (2017). Aggressive behavior and self-harm in borderline personality disorder: The role of impulsivity and emotion dysregulation in a sample of outpatients. *Psychiatry Research, 249*, 321–326.

Tomko, R. L., Trull, T. J., Wood, P. K., & Sher, K. J. (2014). Characteristics of borderline personality disorder in a community sample: Comorbidity, treatment utilization, and general functioning. *Journal of Personality Disorders, 28*(5) doi:10.1521/pedi_2012_26_093

Torgersen, S., & Waaktaar, T. (2019). The oslo university adolescent and young adult twin project: Recruitment and attrition. *Twin Research and Human Genetics, 22*(6), 641–646.

Trautman, P. D., Stewart, N., & Morishima, A. (1993). Are adolescent suicide attempters noncompliant with outpatient care. *Journal of the American Academy of Child &Amp; Adolescent Psychiatry, 32*(1), 89–94.

Trull, T. J., Distel, M. A., & Carpenter, R. W. (2011). DSM-5 borderline personality disorder: At the border between a dimensional and a categorical view. *Current Psychiatry Reports, 13*, 43–49.

Tuna, E., & Bozo, Ö. (2014). Exploring the link between emotional and behavioral dysregulation: A test of the emotional cascade model. *The Journal of General Psychology, 141*(1), 1–17.

Van Der Kolk, Bessel, A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma: Complex trauma and a few thoughts about the need for more rigorous research on treatment efficacy, effectiveness, and safety.*Journal of Traumatic Stress, 18*(5), 389–399.

Vanwoerden, S., & Stepp, S. D. (2022). The diagnostic and statistical manual of mental disorders, alternative model conceptualization of borderline personality disorder: A review of the evidence. *Personality Disorders: Theory, Research, and Treatment, 13*(4)

Venta, A., Sharp, C., & Hart, J. (2012). The relation between anxiety disorder and experiential avoidance in inpatient adolescents. *Psychological Assessment, 24*(1)

Videler, A. C., Hutsebaut, J., Schulkens, J. E. M., Sobczak, S., & Van Alphen, S. P. J. (2019). A life span perspective on borderline personality disorder. *Current Psychiatry Reports, 21*(7), 51–58. doi:10.1007/s11920-019-1040-1

Vives, G., Diaz-Marsa, S., Fuentenebro, M., Lopez-Ibor, F., Aliño, J. J., & Carrasco, J. L. (2006). Historical review of the borderline personality disorder concept. *Actas Españolas De Psiquiatría, 34*(5)

Wall, K., Kerr, S., & Sharp, C. (2021). Barriers to care for adolescents with borderline personality disorder. *Current Opinion in Psychology, 37*, 54–60.

Wearne, D., Curtis, G. J., Genetti, A., Samuel, M., & Sebastian, J. (2017). Where pseudohallucinations meet dissociation: A cluster analysis. *Australasian Psychiatry, 25*(4), 364–368.

Weiner, L., Perroud, N., & Weibel, S. (2019). Attention deficit hyperactivity disorder and borderline personality disorder in adults: A review of their links and risks. *Neuropsychiatric Disease and Treatment,* , 3115–3129.

Wertz, J., Caspi, A., Ambler, A., Arseneault, L., Belsky, D. W., Danese, A., . . . T E. (2020). Borderline symptoms at age 12 signal risk for poor outcomes during the transition to adulthood:

Findings from a genetically sensitive longitudinal cohort study. *Journal of the American Academy of Child &Amp; Adolescent Psychiatry, 59*(10), 1165–1177.

Wexler, B. E. (2003). Amygdala hyperreactivity in borderline personality disorder: Implications for emotional dysregulation. *Biological Psychiatry, 54*(11), 1284–1293.

Widiger, T. A., & Weissman, M. M. (1991). Epidemiology of borderline personality disorder. *Psychiatric Services, 42*(10), 1015–1021.

Winsper, C. (2018). The aetiology of borderline personality disorder (BPD): Contemporary theories and putative mechanisms. *Current Opinion in Psychology, 21*, 105–110. doi:10.1016/j.copsyc.2017.10.005

Winsper, C. (2021). *Borderline personality disorder: Course and outcomes across the lifespan. current opinion in psychology*

Wright, A. G. (2019). Integrating structure and dynamics in personality assessment: First steps toward the development and validation of a personality dynamics diary. *Psychological Assessment, 31*(4), 516–531. doi:10.1037/pas0000625

Wu, Y., Zheng, Y., Wang, J., & Zhang, T. (2022). Specific type of childhood trauma and borderline personality disorder in chinese patients. *Frontiers in Psychiatry, 13*

Xiao, Q., Yi, X., Fu, Y., Jiang, F., Zhang, Z., Huang, Q., . . . B T. (2023). Altered brain activity and childhood trauma in chinese adolescents with borderline personality disorder. *Journal of Affective Disorders, 323*, 435–443.

Yuan, Y., Lee, H., Eack, S. M., & Newhill, C. E. (2023). A systematic review of the association between early childhood trauma and borderline personality disorder. *Journal of Personality Disorders, 37*(1), 16–35.

Zanarini, M. C. (1997). *Role of sexual abuse in the etiology of borderline personality disorder* American Psychiatric Pub.

Zanarini, M. C., & Frankenburg, F. R. (1997). Pathways to the development of borderline personality disorder.*Journal of Personality Disorders, 11*(1), 93–104.

Zanarini, M. C., Frankenburg, F. R., Chauncey, D. L., & Gunderson, J. G. (1987). The diagnostic interview for personality disorders: Interrater and test-retest reliability. *Comprehensive Psychiatry, 28*(6), 467–480.

Zanarini, M. C., Frankenburg, F. R., Reich, D. B., Marino, M. F., Haynes, M. C., & Gunderson, J. G. (1999). Violence in the lives of adult borderline patients. *The Journal of Nervous and Mental Disease, 187*(2), 65–71.

Zanarini, M. C., Frankenburg, F. R., Vujanovic, A., & Hilsenroth, M. J. (2003). The McLean screening instrument for borderline personality disorder: A preliminary report. *Journal of Personality Disorders, 17*(3), 266–273.

Zanarini, M. C., Gunderson, J. G., & Frankenburg, F. R. (1989). Axis I phenomenology of borderline personality disorder. *Comprehensive Psychiatry, 30*(2), 149–156.

Zanarini, M. C., Temes, C. M., Magni, L. R., Fitzmaurice, G. M., Aguirre, B. A., & Goodman, M. (2017). Prevalence rates of borderline symptoms reported by adolescent inpatients with BPD, psychiatrically healthy adolescents and adult inpatients with BPD. *Personality and Mental Health, 11*(3), 150–156.

Zener, D. (2019). Journey to diagnosis for women with autism. *Advances in autism*, *5*(1), 2-13.

Zhu, X. M., Zhou, J. S., Chen, C., Peng, W. L., Li, W., Ungvari, G. S., . . . Y T. (2017). Prevalence of borderline personality disorder and its risk factors in female prison inmates in china. *Psychiatry Research, 250*, 200–203.

Zimmermann, J., Woods, W. C., Ritter, S., Happel, M., Masuhr, O., Jaeger, U., . . . Wright, A. G. (2019). Integrating structure and dynamics in personality assessment: First steps toward the development and validation of a personality dynamics diary. *Psychological Assessment, 31*(4), 516.

Chapter 2: Methodology

This chapter outlines the methodological framework upon which chapters 3, 4 and 5, are grounded. Research design, data gathering and analytical methods alongside ethics, strengths, and limitations of the methods used are considered. The individual methodology for all studies is outlined in detail in each chapter (except chapter 6 which is a critical review).

1.1 Research challenges in exploring pathways to care in BPD

The nature and phenomenology of borderline personality disorder (BPD) is highly complex, with a possible combination of 256 presentations (DSM-5, 2013; APA, 2013), with comorbidities. Therefore, it is unlikely that two individuals would have the same experience of BPD. The overall aim of this PhD is to investigate how BPD presents developmentally (chapter 4), the impact of missed opportunities from a lived experience perspective (chapter 3), and the consequences of these missed opportunities for those with BPD features in these journeys/pathways to care in the context of mental health services provision or lack thereof (chapter 5). This PhD was part of a feasibility randomised controlled trial (fRCT) 'The BRIDGE Project' (Gajwani et al., 2024) which, along with chapter 3 (researcher's own lived experience), formed the basis for the thesis research aims.

Although there is growing evidence over the last two decades that highlight the importance of early intervention in BPD (Chanen & McCutcheon, 2013; Sharp & Fonagy, 2015; Chanen et al., 2017; Hutsebaut et al., 2023) and barriers and facilitators to care (Wall, Kerr & Sharp, 2021), there are fewer papers which explore

pathways to care in the context of BPD (Flynn et al, 2019). This calls into debate why developmentally considered pathways to care in BPD is not being given due attention, in contrast to other psychiatric conditions, such as psychosis (Fitzpatrick et al., 2024). Further, there is little information surrounding the best ways to conduct pathways to care research across overlapping psychiatric conditions, their identification and subsequent intervention. For example, Flynn et al. (2019) used focus groups with clinicians who had experience of working with PDs, followed by thematic analysis (TA) to investigate group recurring themes. In addition, Flynn et al. (2019) used online surveys with service users with PDs to describe their experiences of mental health services and make recommendation for improvement. However, using online surveys meant that there could be no follow-up questions that would clarify, or expand upon, service user views, unlike the methodology of chapter 5, which used semi-structured interviews followed by IPA allowing for a more in-depth responses, thus reinforcing group experiential themes across the interviews. However, similar conclusions between Flynn et al. (2019) and those in chapter 5 were reached in terms of barriers and facilitators in pathways to care from service users. Arguably then, a qualitative approach would prove to be more nuanced and fruitful approach when assessing pathways to care in BPD and the barriers and facilitators encountered.

Qualitative and quantitative methods have very different approaches to data gathering and analysis. Quantitative data offers the potential to be statistically analysed thus finding significant relationships and patterns across whole groups. However, qualitative data often offers smaller, enriched detail of individual experiences of a particular phenomenon. An in-depth understanding of unique experiences can be obtained. However, qualitative data has the potential to be

interpreted differently by multiple researchers. It is argued (Alghamdi et al., 2023) that there is scope for quantitative methodology and qualitative methodology to complement one another.

Although this PhD thesis recognises the value of both quantitative and qualitative methods, importantly, lived experience and public and patient involvement is also considered to be necessary to inform and complement empirical research. This has been found to be highly beneficial in mental health research and has tended to be ignored in the past as an important part of research (Jennings et al., 2018). However, this is not to say it is a straightforward process, or it can always be carried out effectively: ethical and practical implications must be considered (Vinnicombe., et al 2023).

1.2 Researcher positionality

It was decided at the beginning of the PhD that given the author's own BPD journey and pathway through the mental health system in Scotland during adolescence and early adulthood, lived experience would play a central role in this thesis and in the development of research aims. This was discussed at length with supervisors, carefully considering the appropriateness of sharing the author's personal journey within this thesis and the potential risk of re-traumatisation. To abate these issues, regular supervision was held which allowed the author to debrief and explore any issues that may have come up. During time of writing (chapter 3), the author was undergoing psychotherapy and was able to explore any issues arising with her therapist. The author had control over the content of the paper and was able to decide how in-depth it went. No one other than the author could be identified from the paper. The journey of the author's lived experience provided

the basis for exploring and comparing other young people's journeys 20 years after her own. It proved a very useful exercise but, unfortunately, highlighted very similar journeys two decades later. The lived experience paper (McAllister, 2023) (chapter 3) was published in the Journal of Psychiatric Practice in the USA and was well-received. Subsequently, the author was invited to speak at the International Society for the Study of Personality Disorders (ISSPD, Nov 2023). Overall, this lived experience input provided a strong basis for the arguments and themes found throughout the papers and strongly supports the need for co-production and the involvement in research of experts by experience/service users. Potential bias was mitigated through said supervision and the author's own reflexive practice.

1.3 Research methodology

Table 1.1. *Overall methodology summary*

Research aim	*Method*	*Data source*
1. Highlight the necessity of incorporating experts by experience of BPD into research and treatment.	Lived experience input	• Author's lived experience paper (published).
2. Explore 'pathways to care' for early borderline personality disorder taking neurodevelopmental conditions into consideration	Qualitative	• Clinical Case Studies taken from 'Pathways study' (under review)
3. Investigate, qualitatively, the journey through mental health care of young people experiencing signs and symptoms of BPD.	Qualitative	• Semi-structured interviews followed by IPA (accepted with revisions)
4. Critically review stigma in BPD and make recommendations for collaboration between patients and clinicians	Critical review	• Clinical reflection (published)

Chapter 3/paper 1: Lived experience

Aims:

Highlight the necessity of incorporating experts by experience of BPD into research and treatment.

Design:

Lived Experience narrative from researcher of this thesis. Case reports often provide an initial exploration of a phenomenon and can be valuable in advancing the field by offering new clinical insights. However, they typically present findings from the clinician's perspective, positioning the participant primarily as the subject of observation rather than exploring the person's subjective experience in depth (Alpi & Evans, 2019). As such, incorporating a lived experience narrative represents an important next step, as it centres the individual's voice and meaning making, moving beyond description of symptoms or outcomes to a more holistic understanding of the phenomenon.

Strengths and limitations:

Incorporating lived experience in research is necessary to obtain a better understanding of the needs of the target population (Bray & Collier, 2015) especially with young people whose views and voices often go unheard. This can be due to the population being potentially vulnerable, legalities, and limitations in researchers' ability to conduct lived experience research (Bradbury-Jones & Taylor, 2024). There are several strengths associated with lived experience, both for the lived experience researcher and study design and participants. For example, in group lived experience research, individual participants can benefit from hearing the experiences of others

with similar conditions and situations offering a safe space for discussion and peer support (Werner-Seidler & Shaw, 2019). Further strengths of lived experience input into research are that researchers can co-produce, thus giving more depth of understanding of the issues affecting the target population and informing research aims and designs which may be more pertinent.

Using lived experience as part of research can have its limitations: Hildalgo-Padilla et al. (2025) highlight the potential for power imbalances between academic researchers and the expert by experience, noting that involvement can risk becoming "tokenistic" if not meaningfully integrated into the research process. To mitigate this, they recommend including a peer researcher as part of the research team to help ensure authentic collaboration and shared decision-making. This approach was adopted in this thesis.

As well as the potential for bias, there is the impact of the subjectivity of the expert by experience's interpretation of the phenomenology (Wiltsche, 2025). Furthermore, it is difficult to generalise a singular, holistic lived experience to a wider group of individuals participating in research or to broader research questions. One person's lived experience remains precisely that—one person's account, situated within their own context, history, and meaning-making processes and should not be assumed to represent the experiences of others. Also, generalising an individual's experience could disempower them as they may feel they are being grouped and not being heard as an individual with a unique story.

Although drawing on lived experience for contributing to research can be cathartic for the lived experience researcher and informative for the wider research community, there are significant ethical implications such as the potential for re-traumatisation, particularly in the context of limited support for the lived

experience researcher and study participants if boundaries are not maintained (Gatwiri et al., 2025). This may however still be the case where academic researchers deviate from good research practise. However, this was mitigated in chapter 3 through regular academic supervision, and the author/PhD student was in therapy at the time to maintain balance between the two experiences.

Chapter 4/Paper 2: Pathways to care

Aims:

Explore 'pathways to care' for early borderline personality disorder taking neurodevelopmental conditions into consideration.

Design:

For chapter 4, clinical case studies were selected from 'The Pathways Study', a feasibility study (Gajwani et al., 2022) (conducted between 2016 and 2018. The cross-sectional feasibility study investigated participants (aged 14-25) accessing specialist mental health services for developmental pathways (i.e. symptoms and care pathways).

Participants from 'The Pathways Study' were recruited from NHS Greater Glasgow and Clyde's Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health services (AMHS). Written informed consent was obtained in this study, therefore using the clinical case studies for further analysis (chapter 4). Participants (N=48) in the Pathways Project were presenting with early psychosis or early borderline personality disorder. The primary outcome measures used to establish symptom chronology were: 'Comprehensive Assessment of At-Risk Mental State (CAARMS) (Yung et al., 2022) and the Structured Clinical Interview for DSM-IV: Personality Disorders (BPD Section) (SCID II) (First et al., 1997). The secondary outcome measures included Mini-SCID (Raffoul & Lyles, 1993), Adverse Childhood Experiences Questionnaire (ACE) (Felitti et al., 1998), Borderline Personality Questionnaire (BPQ) (Poreh et al., 2006), The Autism Symptom Self-ReporT for adolescents and adults (ASSERT) (Posserud et al., 2013), Adult ADHD Self-report

scale (ASRS-v 1.1) (Diagre et al., 2009), and Autism Spectrum Screening Questionnaire (ASSQ) (Mittila et al., 2009). In addition, measure on 'pathways to care' was developed for the study (Table 1, chapter 4), drawing on similar assessments conducted in psychosis (Singh et al., 2005). A strength of 'The Pathways Study' was that the greatest recruitment came from specialist children's services thus highlighting that whilst clinicians were recognising longstanding unmet need, however, recognition, assessments and intervention of BPD and early psychosis in young people continued to be missed.

Analysis:

Pathways-to-care data, along with clinician rated psychiatric symptoms, including BPD and psychosis, assessments of neurodiversity (ADHD, Autism) and Adverse Childhood Experiences (ACES) were used to create a descriptive analysis to map journeys through services.

Strengths and limitations:

The study in chapter 4 was designed with case study methodology which was considered valid and reliable as the journeys through care and missed opportunities for appropriate intervention could be highlighted and examined in more depth thus expanding on the overview that lived experience offers (chapter 3). Case studies offer a holistic view (Yin, 2009), of the individual's unique journey and pathways to care, or lack thereof. This allowed for several cases to be examined for untreated BPD symptoms amongst four participants presenting with complex risk histories (that of ACEs and Neurodiversity) thus providing an opportunity to determine any similar patterns across pathways to care. In addition, unique contexts (social, educational,

and environmental service providers where information was available) were taken into consideration, thus identifying both positive and negative events on the journeys to care (Yin, 2009).

Although it was considered relevant for chapter 4, case study methodology is not without its limitations. These include a small sample; therefore, it is difficult to apply findings to larger groups and further, it can be a time-consuming process and be difficult to replicate given each case study is unique to the individual. However, case study methodology was still considered the most relevant methodology owing to the deep exploration and data that it offers.

Chapter 5/Paper 3: IPA study “It was a horrible, horrible journey”

Aims: Investigate, qualitatively, the journey through mental health care of young people experiencing signs and symptoms of BPD.

Design:

Participants from the BRIDGE feasibility randomised controlled trial (fRCT) (Gajwani et al., 2024) (appendix 1) participated in the study on journeys through mental health services for those with features of BPD (chapter 5). The BRIDGE Project is a feasibility randomised controlled trial (fRCT) of brief, intensive assessment, and integrated formulation for young people (age 14-24) with features of borderline personality disorder (BPD). Participants in the wider BRIDGE fRCT were recruited from multiple sources including the NHS, colleges, and universities and through social media advertising in Scotland. Twenty-five participants were randomised to either BRIDGE intervention or services as usual (SAU) and followed up at 12 and 24 weeks. Those in the BRIDGE arm were offered up to 16 sessions of cognitive analytic therapy. Of those, seven participants were recruited to examine participant experiences of care journeys, both historical and during the course of their participation in the BRIDGE project. Participants were recruited based on their completion status of The BRIDGE Project (Gajwani et al., 2024) at that particular time and were contacted by telephone interviews were conducted six months post-randomisation, after the completion of second follow-up assessments. Ethical approval (Appendix 2) and Informed consent (Appendix 3) was sought as part of the

BRIDGE project. A consent form (Appendix 4) was completed by the participant and the researcher.

Data collection:

The semi-structured interview (Appendix 5) was recorded (with permission) and began with "Can you tell me about your experiences with services before you took part in The BRIDGE Project?" Based on participants answers, further questions followed.

Analysis:

IPA was chosen over thematic analysis (TA) for chapter 5 given its many advantages in this context and research question investigating experiential process of care journeys. IPA allowed for lived experience of BPD patients to be scrutinised more closely, with much more focus on the individual and their unique needs (Smith et al., 2022). In turn, as it's a two-step process, whereby the individual gives an account of their interpretation of their experience, the researcher then interprets the participant's interpretation, (double hermeneutics) allowing the researcher to gain a deeper understanding of how individuals themselves perceive their experiences. Although TA has its advantages (Braun et al., 2022), it does not explore the narratives in as detailed depth and is theoretically limited, as the data is mostly descriptive.

Strengths and limitations:

In the context of chapter 5, IPA was deemed the most appropriate methodology owing to the limited qualitative data available and the opportunity afforded to

examine the individual experience. However, IPA also has some limitations including the use of small sample sizes; within one area of Scotland in this study. IPA methodology is a very time consuming and rigorous process, demanding a lot of effort on the part of the researcher. Also, as outlined, the researcher had a vested interest in the topic from both a personal and academic perspective, which has the potential to introduce bias into the interpretation. This was mitigated through the process of triangulation with supervisors and reflexivity on the part of the researcher, as outlined in the section above.

Undertaking a PhD as part of a larger trial had many advantages as the fRCT captured the complexity of BPD and the impact of early intervention, and the nature and phenomenology of BPD in adolescents. This allowed for paper 3 to draw on the data and develop further research questions such as pathways to care, and barriers and facilitators of BPD care, in multiple services. Further, a wider range of participants could be reached in the fRCT giving broad perspectives of BPD symptoms.

Chapter 6/Paper 4:

Collins, K. M., Minnis, H., & Gajwani, R. (2025). Using clinician–patient collaboration to tackle structural stigma and age discrimination in borderline personality disorder. *BJPsych Advances*, 1-3.

Aims:

Critically review stigma in BPD and make recommendations for collaboration between patients and clinicians

Design:

Clinical reflection usually centres on the practitioner's experiential learning from clinical practice (Schön, 1983). It is typically narrative and reflexive, emphasising professional insight, ethical considerations, and practice development rather than systematic evaluation of the literature. In this paper, we consider the impact on stigma on BPD through clinical reflection through lived experience and clinician collaboration.

Strengths and limitations:

There are many strengths and advantages of carrying out a clinical-lived experience collaboration reflection on structural stigma in BPD; Clinicians may benefit from this as it offers the opportunity for reflective practice and gives them a wider view of the topic itself as they may not be aware that it is an issue in the first instance (Wakeling et al., 2019). Learning can then be garnered from the reflection and shared cascading across multi-disciplinary teams. Further, it offered the author of this thesis the chance to understand why issues such as structural stigma evolve and reflect on their own professional and personal experience of the issue. As this clinical reflection offers ideas for collaboration between patients and clinicians, continued professional development can be derived from professional reflection and learning (Collins et al, 2025).

Similarly, as with lived experience writing, bias can become apparent in this clinical reflection. Reflection is not subject to empirical testing and may therefore be perceived as judgmental rather than fostering a supportive and psychologically safe space for reflection (Bowers et al., 2025). It may create feelings of unease in clinicians instead of offering a chance to better understand a certain phenomenon

(Merkebu et al., 2025). Chapter 6 is very specific to BPD and therefore not generalisable across other mental health conditions, although stigma impacts psychiatric service access across the lifespan.

References

Alghamdi, N. A., Dunn, K., Cairns, D., & Melville, C. (2023). Utilising quantitative methods to study the intersectionality of multiple social disadvantages in women with common mental disorders: A systematic review. *International Journal for Equity in Health, 22*(1), 264–14. doi:10.1186/s12939-023-02061-8

Alpi, K. M., & Evans, J. J. (2019). Distinguishing case study as a research method from case reports as a publication type. *Journal of the Medical Library Association: JMLA, 107*(1), 1.

American psychiatric association. (2013). diagnostic and statistical manual of mental disorders (5th ed.).

Bowers, M., Terry, D., & Irwin, P. (2025). The impact of reflective practice on nursing students: A scoping review. *Nurse Education in Practice,* , 104468.

Bradbury-Jones, C., & Taylor, J. (2015). Engaging with children as co-researchers: Challenges, counter-challenges and solutions. *International Journal of Social Research Methodology, 18*(2), 161–173.

Braun, V., & Clarke, V. (2022). Conceptual and design thinking for thematic analysis. *Qualitative Psychology, 9*(1), 3.

Bray, L., & Collier, S. (2016). Research essentials. *Nursing Children and Young People, 28*(4), 12.

Chanen, A. M., & McCutcheon, L. (2013). Prevention and early intervention for borderline personality disorder: Current status and recent evidence. *The British Journal of Psychiatry, 202*(s54), s24–s29.

Chanen, A., Sharp, C., Hoffman, P., & for Prevention, G. A. (2017). Prevention and early intervention for borderline personality disorder: A novel public health priority. *World Psychiatry, 16*(2), 215.

Collins, K. M., Minnis, H., & Gajwani, R. (2025). The need for increased collaboration between clinicians and those with experience of borderline personality disorder to tackle structural stigma and age discrimination. *BJPsych Advances,*

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245–258.

First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. (1995). The structured clinical interview for DSM-III-R personality disorders (SCID-II). part I: Description. *Journal of Personality Disorders, 9*(2), 83–91.

Fitzpatrick, S., Goss, S., Di Bartolomeo, A., Varma, S., Tissera, T., & Earle, E. (2024). Follow the money: Is borderline personality disorder research underfunded in canada? *Canadian Psychology/Psychologie Canadienne, 65*(1), 46.

Flynn, S., Raphael, J., Graney, J., Nyathi, T., Williams, A., Kapur, N., . . . Shaw, J. (2019). The personality disorder patient pathway: Service user and clinical perspectives. *Personality and Mental Health, 13*(3), 134–143.

Gajwani, R., Sim, F., McAllister, K., Smith, H., McIntosh, E., Moran, P., . . . Chanen, A. M. (2024). The BRIDGE project: A feasibility randomised controlled trial of brief, intensive assessment and integrated formulation for young people (age 14-24) with features of borderline personality disorder (protocol). *Frontiers in Psychiatry, 15*, 1389578.

Gajwani, R., Wilson, N., Nelson, R., Gumley, A., Smith, M., & Minnis, H. (2022). Recruiting and exploring vulnerabilities among young people at risk, or in the early stages of serious mental illness (borderline personality disorder and first episode psychosis). *Frontiers in Psychiatry, 13*, 943509.

Gatwiri, K., McPherson, L., Canosa, A., Day, K., & Kim, S. (2025). Reflections of 'Doing'Research that involves trauma: A methodological guide and framework for researchers. *International Journal of Qualitative Methods, 24*, 16094069251350310.

Hidalgo-Padilla, L., Ramirez-Meneses, D., Ariza-Salazar, K., Lucchetti, S. C., Olivar, N., Stanislaus Sureshkumar, D., . . . Uribe-Restrepo, J. M. (2025). Incorporating the voice of young people in mental health research: Reflections from three lived experience advisory panels in latin america. *Research Involvement and Engagement, 11*(1), 34.

Hutsebaut, J., Clarke, S. L., & Chanen, A. M. (2023). The diagnosis that should speak its name: Why it is ethically right to diagnose and treat personality disorder during adolescence. *Frontiers in Psychiatry, 14*, 1130417.

Jennings, H., Slade, M., Bates, P., Munday, E., & Toney, R. (2018). Best practice framework for patient and public involvement (PPI) in collaborative data analysis of qualitative mental health research: Methodology development and refinement. *BMC Psychiatry, 18*(1), 213–11. doi:10.1186/s12888-018-1794-8

Kopp, S., & Gillberg, C. (2011). The autism spectrum screening questionnaire (ASSQ)-revised extended version (ASSQ-REV): An instrument for better capturing the autism phenotype in girls? A preliminary study involving 191 clinical cases and community controls. *Research in Developmental Disabilities, 32*(6), 2875–2888.

McAllister, K. (2023). Through the valley of the shadow of death. journey through major mental illness as experienced by a mental health PhD candidate. doi:10.1097/PRA.0000000000000705

Merkebu, J., Soh, M., Loncharich, M., Hawks, M. K., Costello, J. A., Shapiro, M., . . . Zheng, B. (2025). Emotions and clinical reasoning in medical education and clinical practice: A scoping review. *Academic Medicine,* , 10.1097.

Poreh, A. M., Rawlings, D., Claridge, G., Freeman, J. L., Faulkner, C., & 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.

Posserud, M., Breivik, K., Gillberg, C., & Lundervold, A. J. (2013). ASSERT–the autism symptom SElf-ReporT for adolescents and adults: Bifactor analysis and validation in a large adolescent population. *Research in Developmental Disabilities, 34*(12), 4495–4503.

Raffoul, P. R., & Lyles, E. (1993). (Mini-SCID): Structured clinical interview for DSM-III—R. *Computers in Human Services,*

Schön, D. A. (2017). *The reflective practitioner: How professionals think in action* Routledge.

Sharp, C., & Fonagy, P. (2015). Practitioner review: Borderline personality disorder in adolescence - recent conceptualization, intervention, and implications for clinical practice. *Journal of Child Psychology and Psychiatry, 56*(12), 1266–1288. doi:10.1111/jcpp.12449

Singh, S. P., Cooper, J. E., Fisher, H. L., Tarrant, C. J., Lloyd, T., Banjo, J., . . . Jones, P. (2005). Determining the chronology and components of psychosis onset: The nottingham onset schedule (NOS). *Schizophrenia Research, 80*(1), 117–130.

Smith, J. A., & Nizza, I. E. (2022). *Essentials of interpretative phenomenological analysis.* American Psychological Association.

Vinnicombe, S., Bianchim, M. S., & Noyes, J. (2023). A review of reviews exploring patient and public involvement in population health research and development of tools containing best practice guidance. *BMC Public Health, 23*(1), 1271–14. doi:10.1186/s12889-023-15937-9

Wakeling, J., Holmes, S., Boyd, A., Tredinnick-Rowe, J., Cameron, N., Marshall, M., . . . Archer, J. (2019). Reflective practice for patient benefit: An analysis of doctors' appraisal portfolios in scotland. *Journal of Continuing Education in the Health Professions, 39*(1), 13–20.

Wall, K., Kerr, S., & Sharp, C. (2021). Barriers to care for adolescents with borderline personality disorder. *Current Opinion in Psychology, 37*, 54–60. doi:10.1016/j.copsyc.2020.07.028

Werner-Seidler, A., & Shaw, F. (2019a). The social and emotional impact of involving individuals with mental illness in the research process. *Qualitative Health Research, 29*(11), 1634–1640.

Werner-Seidler, A., & Shaw, F. (2019b). The social and emotional impact of involving individuals with mental illness in the research process. *Qualitative Health Research, 29*(11), 1634–1640.

Wiltsche, H. (2025a). The challenge from expert experience. on the role of qualitative methods in phenomenology of science. *European Journal for Philosophy of Science, 15*(4), 1–32.

Wiltsche, H. (2025b). The challenge from expert experience. on the role of qualitative methods in phenomenology of science. *European Journal for Philosophy of Science, 15*(4), 1–32.

Yin, R. K. (2009). *Case study research: Design and methods* sage.

Yung, A., Phillips, L., McGorry, P., Ward, J., Donovan, K., & Thompson, K. (2002). Comprehensive assessment of at-risk mental states (CAARMS). *Unpublished Manuscript, PACE Clinic, Department of Psychiatry, University of Melbourne,*

Chapter 3:

Lived Experience of BPD

McAllister, K. M. (2023). Through the valley of the shadow of death. Journey through major mental illness as experienced by a mental health PhD candidate. *Journal of Psychiatric Practice, 29(3)*, 235. https://doi.org/10.1097/PRA.0000000000000705

Chapter 3 is a lived experience narrative by the PhD candidate of this thesis. The aim of this paper was to reflect on her journey with BPD exploring phenomenology, misdiagnosis and co-morbidities and the identification of missed opportunities by the health care system. Further, the piece was written to highlight how imperative collaborating with those with lived experience, of any condition, is necessary to future research and successful health trajectory outcomes.

*Trigger warning – paper mentions depression, anxiety, borderline personality disorder, self-harm and suicide ideation.

By the time you read this paper, I'll be alive…You see, I was dead for 16 years.

My childhood began traumatically with severe asthma attacks leading to an untold number of hospital admissions, collapsed lungs, I.V. drips, separation from my Mum at times and a lot of sympathy for my small broken body. I recently met my primary school dinner lady on the bus who asked, over 30 years later, "were you the wee girl who was always sick?" At the time, it became the norm but the frustration of having to come in from being 'out to play' or listening to my sister and our friends from the street out playing whilst I was stuck in bed with a chest infection on my nebuliser still makes me sad to this day. However, once I started primary school, except for my frequent outpatient clinic appointments things improved and miraculously the asthma settled. So, I got better, and this instilled in me the notion that it's possible to recover.

Primary school was pleasant enough with a few best friends, nice days out and a fair bit of praying and trips to Mass. At the time, we dreaded going to chapel as sitting quietly or miming hymns and not being able to talk to your pals for a half hour was an inconvenience as it ate into playtime. Little did I know, church would later save my life. I plodded on to secondary school, passed exams, pleased everyone at parent's nights and never really gave the future much thought other than career choices. I certainly never expected what was to come. In sixth year of high school the cliché of "The darkness" descended and so ensued the loneliest journey into adulthood which became the valley of the shadow of death [1] and my life with

mental illness. My lifelong friend decided to leave school mid-way through sixth year, and I became quite isolated and alone. So, I cut myself off from the rest of my cohort and spent most lunchtimes in the school library, doing homework and reading some of the classics. It didn't bother me too much, being alone, it meant I could hide under my cloud and read which I love to do (another thing which saved my life). Eventually school finished and so began my university career- Year one of Theology studies (Surprised? Me too!). There were some lovely people on the course, a few girls my age and some others training to be Ministers. Not a thing was wrong, but the sense of loss of the security of school was massive, I missed my teachers and the routine. Here I was with free reign to do whatever I pleased, and it terrified me. The darkness became overwhelming with people beginning to notice my low demeanour. I was not enjoying the course and felt like it was the end of the world. I had spent the year before studying frenziedly to get good grades and preparing to begin my career and the rest of my life. And here I was unable to eat and sleep because my 18-year-old mind felt like a disaster had occurred and life as I knew it was over. Cue the first sign of my fear of endings and abandonment and a life with Borderline Personality and Major Depressive Disorders. And so, it really began…

I woke up in the middle of the night having a heart attack. Okay, to be more accurate, it was my first experience of a panic attack but to be fair, with chest pain, breathlessness, sweating, dizziness, and a feeling like you're about to die, they're easy to get mixed up! The next morning, I lay in bed and realised I had absolutely no reason to get up. Eventually a trip to the GP ensued and my first experience with anti-depressants began…but more on that later! And, so, this experience repeated itself day and night for many years to come. The dread, the despondency, the fear

and having no motivation to wash, dress, eat a healthy diet or see anyone at all dragged on. On the days I bothered to get dressed, it would take me half an hour just getting the strength to put on my socks- no exaggeration. In the later years, I recall walking about with ripped shoes, my crazy untamed red hair that hadn't been cut in a long time and an old jacket, usually going to my GP surgery begging for help or trailing round a pharmacy searching for alternative health products that I'd been convinced would save me from this hell. Self-harm in the form of cutting my arms and legs was my go-to method of punishment but also to feel the rush of "that thing" that you feel after it that I couldn't possibly describe. I also wanted the world to see my pain, yet I kept my cuts and scars well hidden. I had permanent thoughts of suicide. My will to live had completely evaporated and thoughts of how I could end my life became an everyday occurrence. My brother was just a baby at this time and I used to think, "If I do it now, he'll not remember me and it won't cause him any pain."

After first year, I quit the course and over the years and tried various routes and paths, even working briefly as a student midwife in Malawi but absolutely nothing filled the gaping hole in my soul. I had no sense of who I was or what I wanted. I now realise how very ill I was and that I should have been getting treatment for my poor mental health and resting at home. But society's expectations – "you've got qualifications, you've got everything going for you, you're too young to be depressed" and my own lack of understanding and self-compassion meant I struggled on. There were several breaking points like standing on the other side of a bridge over the M8 one New Year's Eve, saved by some kindly Policemen who brought me home, distraught; or the numerous overdoses which were met with remarks from

some hospital staff who were busy treating “genuinely ill patients”. All I ever wanted throughout this time was to ‘return to normal’ and not have to take anti-depressants. After all, my life-threatening asthma disappeared so why couldn’t this depression? However, that was not to be the case.

Throughout this long period of time, one thing remained: my faith in God. Although, not unwavering, I must confess. I prayed for years to be ‘cured’. My idea of being cured meant no medication, no treatment required and a return to the person I was before my mental health deteriorated. I consistently went to the church, almost daily, for all those years. Sometimes it was impossible to pray, I felt nothing at all. And, for a long time, there was no answer from God. Nothing. There were no big miracles or transfiguration moments just terrible dark nights of loneliness and feeling like God had abandoned me. I was to find out later that I could not have been more wrong. There was always a quiet voice telling me to hang on. That voice never left me, ever. I’m a firm believer in the saying that “The Lord works in mysterious ways”; One day I was about to cross the road when a car came through the lights just missing me. I realised I didn’t get a fright or even react; I wished it had hit me. Coincidentally, or not, I had a GP appointment that afternoon. When I reached her office, I knew I’d come to the end of the road. I told her I did not want to be here anymore, and I was days away from ending my life. For the first time, I wasn’t in and out of the surgery in under two minutes. The doctor asked me what I meant and what my plans were. There was no “try different antidepressants and come back in two weeks”. I was finally taken seriously and referred to secondary mental health services to see a psychiatrist. It had been at least 10 years since my first diagnosis of depression. I had finally met a light in the darkness. Although, I

cannot say it was plain sailing and there were many challenges, long waits, hoops to jump through and people to convince that I was in fact 'sick enough' to qualify for treatment. And so began the journey to help and recovery, answered prayers and, a few years later, meeting the individual who saved my life.

Finally, the appointment came around to see the psychiatrist. I was told he didn't want to hear my story of how I ended up suicidal and needing psychiatric input. Instead, I was asked "have you ever taken any illicit drugs and if so, did they help? I'm trying to work out what would be the best medication for you?". So, that was a hugely disappointing first appointment experience with a psychiatrist. There followed approximately a year and a half of pointless mood diaries, a never-ending cycle of SSRIs and being asked "are you self-harming because you are bored?" I finally told him I'd had enough; SSRIs weren't working and "I do not self-harm because I'm bored". The atmosphere changed in the room, and this marked the beginning of the end of the battle. He decided to give me a mood stabiliser to throw into the mix for luck. Handing me the BNF he asked me to choose one of the two options available and explained the side effects. He also decided I should have regular appointments with a Community Psychiatric Nurse (CPN). So off I went, cynically, to give the new pills a try, not expecting much from the CPN who I thought would give me a couple of sessions and discharge me. But this really was when my prayers were answered, and my life started to turn around.

I was sitting in the waiting room with my low expectations where here in enters God's healing love. It's all a blur now but I can honestly say that this woman saved my life. Week after week for three years she listened to every word I had to say,

believed me, laughed with me, sat with me through all the tears, helped me find the strength to challenge my thoughts, to build a life back up, to get dressed most days and most importantly to want to live again. I couldn't believe that there were people who genuinely wanted to help those like me. She helped me piece back together the fragments of my life and showed me my worth. To help someone go from not being able to put their socks on to graduating with a merit MSc in Psychology was truly the work of someone special. The mood stabilisers also had a great impact on my well-being, and, with the help of my nurse and my mix of medication, I was truly on the road to recovery. I realised that God had answered my prayers but not in the way I had been expecting. They were answered in a much greater way, not through a miracle touch for a quick healing but through the road less travelled, meeting some fascinating characters and some foes along the way. If I had had the quick "back to normal" healing I was looking for I would never have played on the shores of Lake Malawi with the happiest, most loving children I've ever met, I would never have searched for answers in books I'd never have thought of reading before, nor would I have had the relationship with God that I have now. I will never be "back to normal", this is normal now and you know something? That's ok, I'll take it. I will probably always take my medication, I know that I'll use the crisis CPNs from time to time and maybe I'll struggle with my socks again, but I now know that, eventually, all shall be well.

[1] Poetic analogies for severe depression might also be found in other religious texts.

1.2 Reflections on chapter 3

Upon writing and reflecting upon the lived experience described in chapter 3, the following points appear significant in the context of BPD research and in highlighting the gaps outlined in the research aims of this paper:

Mental health research is now beginning to embrace co-production with experts by experience (Mayer & McKenzie, 2017) patient and public engagement (INVOLVE), along with scientific and other stakeholders in the provision of service development and evaluation (Norton, 2025). However, the governance and bureaucratic challenges to meaningful engagement and involvement of experts by experience in science continues to be blighted by stigma (Minnis, 2021).

Lived Experience brings a real-world, insightful perspective from BPD experienced individuals, allowing for the unique journey to be heard and incorporated into future research plans. It can be cathartic in nature, allowing the individual to debrief from their experiences, be heard, and perhaps allow for those who cannot take part in research due to ethical dilemmas and limitations (such as participation when acutely unwell) to have their views considered. The process of co-production with lived experience offers empowerment (Friesen et al, 2022).

- In the context of BPD, paper 1 highlights the unique needs of the individual being met through effective collaboration with health care providers. As we can see, the patient in this paper benefited greatly from a good therapeutic relationship in the form of psychotherapy and combined psychopharmacology.

- Psychopharmacology on its own was not sufficient in meeting the needs of the author and only when the nature and phenomenology of the author's BPD was explored, was effective care established.

- This lived experience paper highlights the unique impact of some of the features of BPD i.e. early childhood trauma and self-isolation, which warrant deep and further exploration in collaboration with health care providers and contributes to the understanding of the nature and phenomenology of BPD.

- It is also apparent from this lived experience paper the impact of late diagnosis and treatment, and the devastating, unnecessary, consequences such as suicidal ideation.

All these considerations highlight the need for a shift towards holistic assessment, incorporating a lifespan approach, respect for the patient narrative, based on the foundation of a sound therapeutic relationship. This is explored in chapter 4.

Incorporating 'Lived Experience' into research approaches can inform researchers and clinicians in understanding the unique nature and phenomenology of BPD in individuals. The developmental pathways to BPD are an area of recent research investigation (Chanen & Kaess, 2012; Sharp, 2020; Gajwani et al., 2022), along with the historical pathways to care (Sharp & Oldham, 2023) and missed opportunities (Beatson et al., 2016) that contribute to worsening of symptoms (iatrogenic harm) within BPD (Coyle et al., 2018). The developmental underpinnings, particularly in

relation to early risk factors such as adverse childhood experiences, neurodevelopmental conditions and their association with BPD symptoms were explored in our pilot study (Gajwani et al., 2022). This is explored further in chapter 4.

References

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.

Chanen, A. M., & Kaess, M. (2012). Developmental pathways to borderline personality disorder. *Current Psychiatry Reports, 14*(1), 45–53.

Coyle, T. N., Shaver, J. A., & Linehan, M. M. (2018). On the potential for iatrogenic effects of psychiatric crisis services: The example of dialectical behavior therapy for adult women with borderline personality disorder. *Journal of Consulting and Clinical Psychology, 86*(2), 116.

Friesen, L., Gaine, G., Klaver, E., Burback, L., & Agyapong, V. (2022). Key stakeholders' experiences and expectations of the care system for individuals affected by borderline personality disorder: An interpretative phenomenological analysis towards co-production of care. *Plos One, 17*(9), e0274197.

Gajwani, R., Wilson, N., Nelson, R., Gumley, A., Smith, M., & Minnis, H. (2022). Recruiting and exploring vulnerabilities among young people at risk, or in the early stages of serious mental illness (borderline personality disorder and first episode psychosis). *Frontiers in Psychiatry, 13*, 943509.

Mayer, C., & McKenzie, K. (2017). '… It shows that there's no limits': The psychological impact of co-production for experts by experience working in youth mental health. *Health & Social Care in the Community, 25*(3), 1181–1189.

Minnis, H. (2021). Stigma in practice. *The Lancet Psychiatry, 8*(6), 466–468.

Norton, M. J. (2025). Co-production and mental health service provision: A scoping review. *Irish Journal of Psychological Medicine,* 1–14.

Sharp, C. (2020). Adolescent personality pathology and the alternative model for personality disorders: Self-development as nexus. *Psychopathology, 53*(3-4), 198–204.

Sharp, C., & Oldham, J. (2023). Nature and assessment of personality pathology and diagnosis. *American Journal of Psychotherapy, 76*(1), 3–8.

Chapter 4: Pathways to care

Where is the Care? Investigating pathways-to-care in young people with borderline personality disorder features: Clinical case studies

Kirsty Collins[1], Darcy Maule[2], Rebecca Nelson[3], Michael Smith[1,3], Andrew Gumley[1,3], Helen Minnis[1,3], Ruchika Gajwani[1,3*]

1. School of Health and Wellbeing, University of Glasgow, Glasgow, UK
2. Wolfson Medical School Building, University Avenue, Glasgow, G12 8QQ, Scotland, UK
3. NHS Greater Glasgow and Clyde, Glasgow, UK

* Correspondence Author:

Dr Ruchika Gajwani, Mental Health and Wellbeing, School of Health and Wellbeing, University of Glasgow, 90 Byres Road, Glasgow, UK. Email: Ruchika.Gajwani@glasgow.ac.uk

Abstract:

Introduction: Borderline Personality Disorder (BPD) symptoms often emerge in adolescence resulting in significant adaptive challenges and poorer long-term outcomes. However, individuals with BPD features have unmet care needs and often access services at crisis point rather than early in the course of BPD. Recognition of developmental precursors of BPD has been increasing.

The aims of this study were to explore developmental pathways to BPD care, developmental symptom trajectories, service involvement and missed opportunities for care in the context of adverse childhood experiences (ACES) and neurodivergence.

Methods: Four detailed clinical case studies outlining care journeys were purposively selected from participants (aged 15-25) from a cross-sectional 'Pathways' feasibility study (n=48). Pathways-to-care data, along with clinician rated assessments of neurodiversity (ADHD, Autism) and Adverse Childhood Experiences (ACEs) were used to create a descriptive analysis to map journeys through services.

Results: Participants had untreated BPD at the time of study participation. Neurodiversity (ADHD and/or Autism) was recognised but no participants had a formal diagnosis of neurodiversity or BPD at the time of study participation. This was evident particularly in the context of ACES.

Conclusion: Multiple missed opportunities and long-term iatrogenic harm can be avoided through a collaborative approach to assessing pathways-to-care, along with developmentally sensitive comprehensive assessments, including BPD features. It is important to point out that the presence of neurodiversity does not mean BPD features will develop.

Keywords: Pathways-to-care, Borderline Personality Disorder, Young People, Neurodivergence

No conflicts of interest

Introduction

Suicidality is a prominent feature of Borderline Personality Disorder (BPD), frequently leading individuals to access support during crisis (Broadbear et al., 2020). Untreated BPD is linked to long term adverse outcomes, including high rates of psychiatric care and social service use (ten Have et al., 2016), with co-morbid mental health difficulties such as depression and substance misuse (Carlson et al., 2009; Coid et al., 2009; Williams et al., 2021) high suicide rates (Thomson et al., 2019), psychosocial morbidity and functional impairment (Carlson et al., 2009; ten Have et al., 2016; Thomson et al., 2019) Without timely intervention, sub-threshold BPD symptoms are similarly associated with psychiatric comorbidity and long-term functional disability (Ten Have et al., 2016). Subsequently, individuals with longstanding unmet needs characteristic of BPD typically access support through long-term outpatient care or in crisis settings adding to the stigmatisation of BPD (Collins et al., 2025) and iatrogenic harm (Fernandez, 2024).

1.1 Adolescent BPD

BPD symptoms typically emerge in early adolescence, peak in mid to late adolescence or young adulthood, and then tend to attenuate during adulthood (Lenzenweger, 1999; Zanarini et al., 2003; Zanarini et al., 2006; Cohen et al., 2008). The consequences of this onset in adolescence are adverse and enduring, resulting in ‘adaptive failure’ (Wall et al., 2021) in education, employment, interpersonal relationships, and poorer long-term trajectories in terms of functioning

psychosocially (Sharp & Wall, 2021; Brandrett & Gajwani, 2024). In a study of sub-threshold BPD in outpatient youth, depressive disorders, substance abuse and impulse control disorders were highly prevalent, although they were more likely to be referred for mental health treatment due to suicidality or disruptive behaviour (Thompson et al., 2019). The levels of psychosocial morbidity were comparable to adults with sub-threshold BPD (Winograd et al., 2008; ten-Have et al., 2016).

Despite DSM-5 including criteria for identifying BPD below age eighteen (when symptoms persist for at least one year) (DSM-5, 2013; APA, 2013) and the National Institute for Health and Clinical Excellence guidelines in the UK (NICE, 2009) supporting early assessment and timely treatment of BPD in youth, identifying BPD symptoms in young people remains contentious. This is due to stigma, fear of discrimination and concerns regarding stability of diagnosis as a personality pathology, thought to be transient during adolescence (Griffiths, 2011; Laurenssen, 2013). As a result, BPD in young people is not recognised, often mis-diagnosed, in turn preventing referral to appropriate treatments (Chanen et al., 2020). This has long term negative serious health and social care implications for untreated BPD symptoms (Carlson et al., 2009; Fok et al., 2012; Ha et al., 2014; Moran et al., 2016) including premature mortality in comparison to their peers. The lack of identification and treatment means young people with enduring patterns of difficulties in functioning characteristic of BPD, and subsequently adults with BPD, experience exclusion (Chanen et al., 2020) and complex service utilisation (Grambal et al., 2017) leading to adverse treatment outcomes (Coyle et al., 2018).

1.2. Developmental pathways:

BPD aetiology is not fully understood and remains an area of examination (Sharp & Kim, 2015) with neurobiological and experimental data variable (Leichsenring et al., 2024). With the inclusion of the Alternative Model of Personality Disorder (AMPD) in DSM- 5, the scope for a developmentally sensitive paradigm to investigate the nature and phenomenology of BPD has recently unfolded (Iacino, 2020). Arguably, the complex interaction between genetic and environmental risk factors and developmental processes are an area of research investigation (Wilson et al., 2021).

There is growing recognition of the developmental antecedents of BPD (Chanen & Kaess, 2012). Adverse childhood experiences (ACEs) and trauma have been well-established as significant contributors to the aetiology of BPD (Stepp et al., 2016; Benczcowski, 2022). More recently, attention has turned to the potential role of neurodivergence, including Attention-Deficit/Hyperactivity Disorder (ADHD), Autism Spectrum Disorder (ASD), and conduct disorder, in the emergence of BPD features (Ditirich et al., 2021; May et al., 2021). For example, the phenotypic overlap between BPD and ADHD has been increasingly studied, as both disorders share behavioural and emotional characteristics (Philipsen et al., 2006; Matthies et al., 2014). Studies have reported that approximately 38% of individuals with BPD also meet criteria for ADHD, and up to 60% of those with BPD meet criteria for ADHD in childhood (van Dijk et al., 2014; O'Malley et al., 2016). Additionally, research has highlighted commonalities in symptom profiles and severity between ADHD and BPD, including high levels of self-harm and suicidal ideation (Stepp et al., 2016; Akca et al., 2020; Koupis et al., 2022).

However, under-researched is the interaction between ACEs and neurodivergence in the development of severe mental illness (Gajwani & Minnis, 2023). For instance, in a co-twin control analysis, we showed that children exposed

to maltreatment and trauma exhibited higher rates of neurodivergence including ASD and ADHD, than those without such exposure (Dinkler et al., 2017; Gajwani et al., 2022). This association was explained by shared genetic variance. We have also shown in a longitudinal twin data study that children with maltreatment exposure and neurodivergence were at twice the risk of developing juvenile mania in adolescence (Gajwani et al., 2021).

The aims of this study were to explore through case study methodology on developmental pathways to care in BPD (symptoms and service-involvement) and missed opportunities for mental health intervention in the context of trauma, ACEs and neurodivergence.

2. Methods

The research project was part of a feasibility study, 'The Pathways Study' (Gajwani et al., 2022), conducted between 2016 and 2018. The cross-sectional feasibility study investigated participants (aged 15-25) accessing specialist mental health services for developmental pathways (i.e. symptoms and care pathways).

Ethical approval for the study was gained from an NHS ethics committee, United Kingdom (Ethics Ref.:16/WS/0133). All study participants gave written informed consent and could withdraw from the study at any point without treatment being affected.

2.1 Procedure

Participants were recruited from mental health services across a region in Scotland. Clinicians were requested to gain and record verbal consent from the participants. Potential participants were given a minimum of twenty-four hours before the research team contacted them to arrange an appointment to seek informed consent. Participants were informed that they could withdraw from the study at any point and that this would not affect the care or treatment that they receive. Participants providing informed consent were given the opportunity to ask any further questions about the study and begin the comprehensive assessments over two sessions.

2.2 Measures

1. Borderline Personality Disorder

    I. Structural Clinical Interview for DSM-IV-II (SCID-II BPD section)

SCID-II BPD section is a semi-structured interview guide to assess for BPD. It was carried out by a research assistant under supervision of a clinician. SCID-II reliability was found to be 'excellent' in an inter-rater reliability study (Lobbestael et al., 2011). In a further validity and reliability study (van Alebeek et al., 2015) the SCID-II was found to have a Cronbach alpha score of 0.85 thus demonstrating good reliability in assessing young people with BPD signs and symptoms. Further, it was found to have adequate levels of sensitivity and specificity. SCID-II, although now updated in DSM-5 (APA, 2013), can be easily replicated for future studies (Piedmont et al., 2003).

    II. Borderline personality questionnaire (BPQ)

BPQ is a scale for the assessment of borderline personality symptoms based on DSM-IV criteria (Poreh et al., 2006). The BPQ consists of 80 items that categorise into 9 sub-scales: Impulsivity; affective instability; abandonment; relationships; self-image; suicide/self-mutilation; emptiness; intense anger; and quasi-psychotic states. A total sum score of ≥56 indicates the participant likely meets DSM-IV criteria for BPD (≥3 on 5 or more items of SCID-II BPD). Upon measurement of validity and reliability (Poreh et al., 2006) it was found to be a useful tool for screening borderline personality disorder features in the general and clinical populations. In a Turkish study (Ceylan et al., 2017) exploring factorial validity, it was found through Cronbach's alpha coefficients, BPQ was found to range between 0.46 to 0.81 thus concluding the BPQ to be a robust and reliable measurement in the assessment of borderline systems. Further, in a comparison study (Chanen et al., 2008), the BPQ was identified as being a highly reliable tool, but caution was advised around using it in place of a formal diagnosis.

2. Neurodivergence:

The self-report scales were assessed alongside the interview. It should be highlighted that these are both screening tools, rather than diagnostic tools.

I. Autism Symptom Self-Report for Adolescents and Adults (ASSERT)

ASSERT is a brief self-report screen for autism symptoms in adolescents and adults (Posserud et al., 2013). Response options are ''not true'' (score 0) – ''somewhat true'' (score 1) – ''certainly true" (score 2), leading to a score range of 0–16 points. The suggested cut off score for ASD is greater or equal to 8, but it should be highlighted that this is a screening tool, rather than a diagnostic tool.

To measure reliability and validity of the ASSERT in adolescents a bifactor analysis was performed (Posserud et al., 2013) finding it had good screening properties with a diagnostic odds ratio (DOR) of 15.8.

II. Adult ADHD Self-Report Scale (ASRS)

ASRS-v.1.1 is a brief self-report screen for autism symptoms in adolescents and adults (Kessler, 2003). Response options are ‘‘not true’’ (score 0) – ‘‘somewhat true’’ (score 1) – ‘‘certainly true’’ (score 2), leading to a score range of 0–16 points. The suggested cut off score for ASD is greater or equal to 8, but it should be highlighted that this is a screening tool, rather than a diagnostic tool.

When used to measure adult ADHD with addiction and co-morbidities including BPD (Diagre et al., 2009), the ASRS-V1.1 factor structure is indicated by factors pertaining to inattention and hyperactivity/impulsivity accounting for 67.7% variance. Further, with a 4 cut-off, 87.5% sensitivity and 68.6% specificity concluding that it is a useful screening tool and has acceptable validity.

3. Adverse childhood Experiences (ACEs) questionnaire

ACEs Questionnaire (Felitti et al., 1998) is a 10-item self-report measure developed to identify childhood experiences of abuse or neglect, and family dysfunction such as domestic abuse, and substance misuse. Higher scores predict greater incidences of mental and physical ill-health in later life, with a maximum score of 10 (Felitti et al., 1998).

Validity and reliability of the ACE-10 was explored with adolescent participants in the child welfare system (Olah et al., 2023); findings showed

acceptable internal consistency (a=0.701) and item total correlations (rpb=0.25 - 0.65, p<0.001). However, it was shown that the item 'parental separation/divorce' had a weak correlation with the total ACE score and remaining questionnaire items (Olah et al., 2023). Overall, it was concluded that the ACE-10 is a viable screening tool. However, McLennan et al., (2020) advise caution around ACE measures given a simplistic scoring approach and an absence of psychometric assessment.

4. Pathways to care

The pathways-to-care interview (Table 1) asked participants to describe their mental health over the course of their lifetime from early childhood to present day and their interaction with healthcare services. Participants were asked to self-report key life events such as parental separation, trauma, transitions through education and significant relationships with others. They were asked to identify significant changes in their mental health or emotional state throughout their lifetime. The Pathways interview schedule was adapted from previous research in psychosis (Singh et al., 2006).

Table 1

Infancy (0-5 years) • Any birth complications? • Any medical conditions? • Any medication? Childhood (5-12 years) • Key Events	• When did you first start to feel unwell or that something was different? • When did you first feel that you needed help? • Who realised the initial change in behaviour – you or someone else?

Teenage (13-19 years) • Key Events Young adult (19-35) • Key Events	• What did they notice? When? • How many times did you try before receiving treatment? (What happened in the prior attempts?) • What was it that made you seek help – what were the initial symptoms? • What was done? • What advice was given? • How helpful was the advice? • Were there any delays in help seeking, if so, what were they? • Did you have any barriers to care? Financial Difficulty reaching treatment centres Shyness/embarrassment as discussing illness Suggested not to take treatment Family's lack of awareness Difficulty getting appointment Lack of insight Difficulty accessing care Not knowing where to go • Who has been involved in identifying, treating or helping with your symptoms? Teachers

	Psychologists GP Psychiatrist Family friends Social workers Emergency room Faith healers/religious figures Police Counselling service Peers • What did they do? • Were there any referrals made, to whom? How long did they take? • What was the outcome? Were you treated, what was the treatment, how long for? • Were there any delays to your assessment or treatment?

Sampling

The intrinsic, collective case study method (Stake, 1995) was used to select four participants from the feasibility study early in the course of BPD to provide a descriptive analysis of the pathways-to-care in relation to their presenting symptoms. The intrinsic method selects cases based on their uniqueness (Stake, 1995). They are considered suitable for examining those within this BPD group with complex needs characterised in this study through early risk factors. Four

participants from the full sample (n=48) were purposively selected based on meeting criteria for neurodivergence (both, ASD, and ADHD) and ACEs exposure. Participants were originally recruited from Community Mental Health Teams across Glasgow, clinical psychology services, Children and Adolescent mental health services (CAMHS) and personality disorder teams (AMHS).

The purposive sampling inclusion criteria were (i) meeting at least 2 out of 9 of the SCID criteria for BPD for a period of two years, (ii) self-reported 4 or more ACEs and (iii) positive screen on either, or both, of the ASSERT or ASRS measures. The exclusion criteria were non-English speakers.

Purposive sample selection was influenced by provision of complete interview data and available transcriptions.

Analysis

Case studies can be used to describe events or phenomena in the everyday contexts in which they occur from the perspective of those involved (Yin, 2009). For an in-depth analysis of the complexity of the pathways-to-care process, a case study analysis was deemed most appropriate. A descriptive analysis methodology was chosen to understand how services and support are received and experienced over time by young people with BPD, and the effect of neurodiversity and ACEs on this.

The case study method allows for a holistic picture of each participant's pathways to care presented in the results section in their individual pathway figure. The figures conceptualise the data from the Pathways interview, SCID-II interview, neurodiversity and ACEs questionnaires into a chronological timeline of each participant's interaction with services, BPD symptoms and key life events. The

participants were referred to the study for "query BPD" or "BPD" and their presenting symptoms were assessed retrospectively.

The use of multiple sources of data (data triangulation) is recommended in a case study to increase the internal validity of a study (Yin, 2009). A descriptive analysis complements each figure. The duration of BPD symptoms from sub-threshold criteria, assessed retrospectively by the principal investigator, was calculated in years. All patient data were anonymised, and names used in the case studies are pseudonyms.

Results

Findings from the feasibility study have been published (Gajwani et al., 2022); In Summary, mean age for the full sample was 15-20 years; Seventy nine percent of participants were female, with 21 % male; 64% of the early BPD group reported parental psychopathology and 48% had ≥4 ACEs. Only 28% of participants had a previous neurodivergent diagnosis in the early BPD group, however, 71% screened positive for ADHD and 53% screened positive for ASD. Forty-two percent screened positive for both ADHD and ASD. Forty-eight percent of the early BPD group had a previous psychiatric admission; 74% of participants had attempted suicide in their lifetime.

Case study 1: Hannah

Hannah's adverse childhood events included physical and sexual abuse. She has a family history of depression, anxiety, and dissociative seizures. She had received a BPD diagnosis aged 21 years and was receiving treatment for anxiety,

depression, and auditory hallucinations. Hannah was referred to the Pathways study by the Personality Disorder (PD) team for BPD and was 24 years at time of research participation. Her pathway is illustrated in Figure 1.

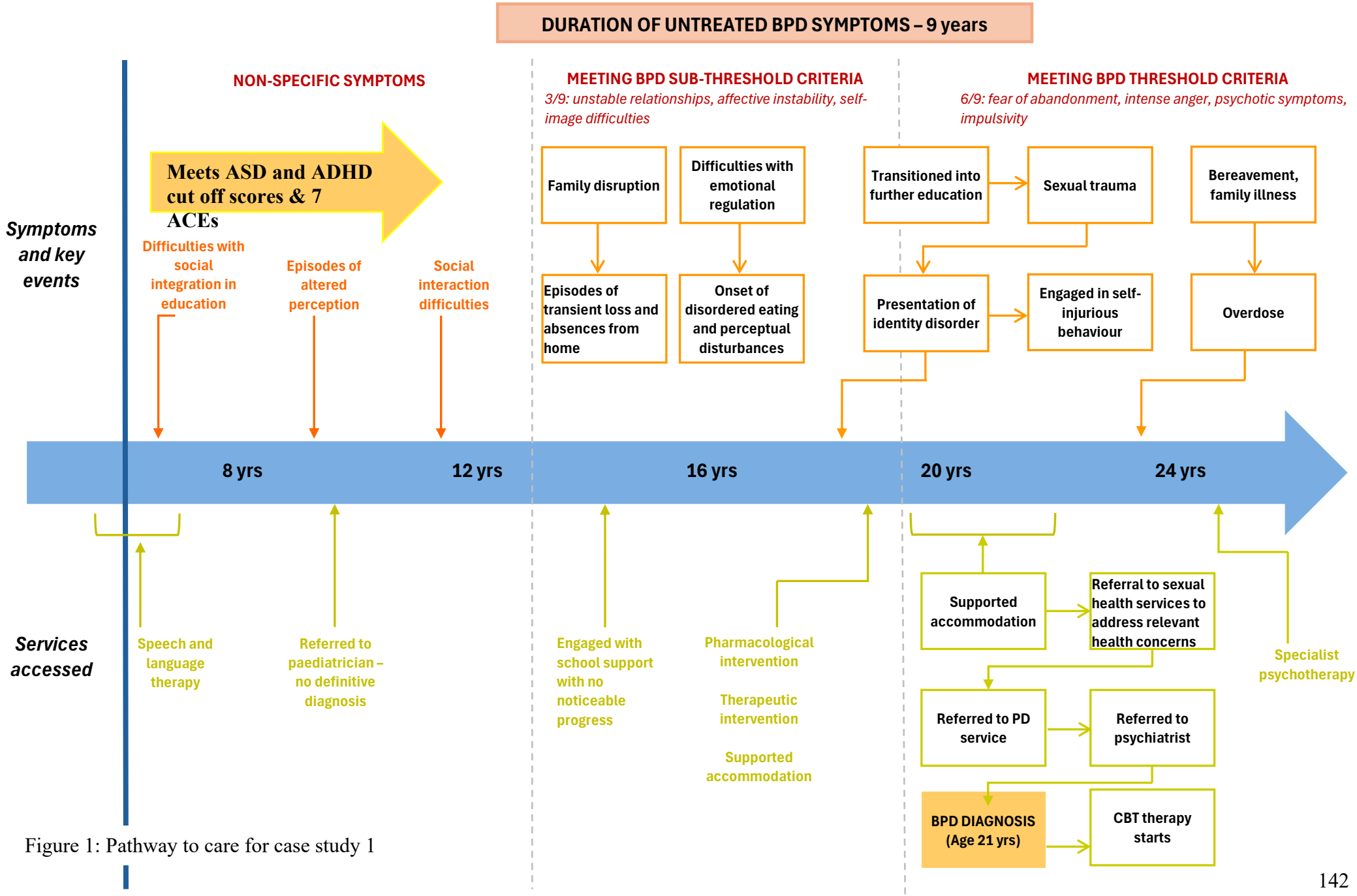


Figure 1: Pathway to care for case study 1

Retrospective assessment of BPD criteria by the SCID-II interview found she met sub-threshold criteria for BPD at age 12 years. Hannah received a diagnosis of BPD at 21 years by the PD team. At the time of research, Hannah met 6out of 9 of the SCID-II criteria and had a BPQ score of 45 (<56). Hannah had BPD symptoms for 9 years before she received treatment and started cognitive behavioural therapy (CBT). She met criteria for ADHD and Autism however she had no previous neurodiversity diagnosis.

Hannah was previously referred to a range of services and mental health charities which led to her receiving a BPD diagnosis. It was a serious assault incident and development of a dissociative identity disorder that resulted in her having increased support from services and she was, as a result, referred to a personality disorder (PD) service.

Once seen in the PD service, Hannah felt she was "understood" by a clinician for the first time. She felt once she got mental health support for her BPD, she could understand herself better and be more confident. She has reported having "changed for the good" over the last year after receiving mentalisation based therapy (MBT) aged 24.

Case 2: Anna

Anna was referred to the study with emerging psychosis and was 18 years at the time of study participation. Anna was diagnosed with psychotic depression aged 18 and was accessing general adult psychiatry service and seeing a CPN at the time of the research participation. Anna's adverse childhood events included emotional and physical abuse and neglect. Anna had a family history of psychiatric comorbidity. Her pathway is illustrated in Figure 2.

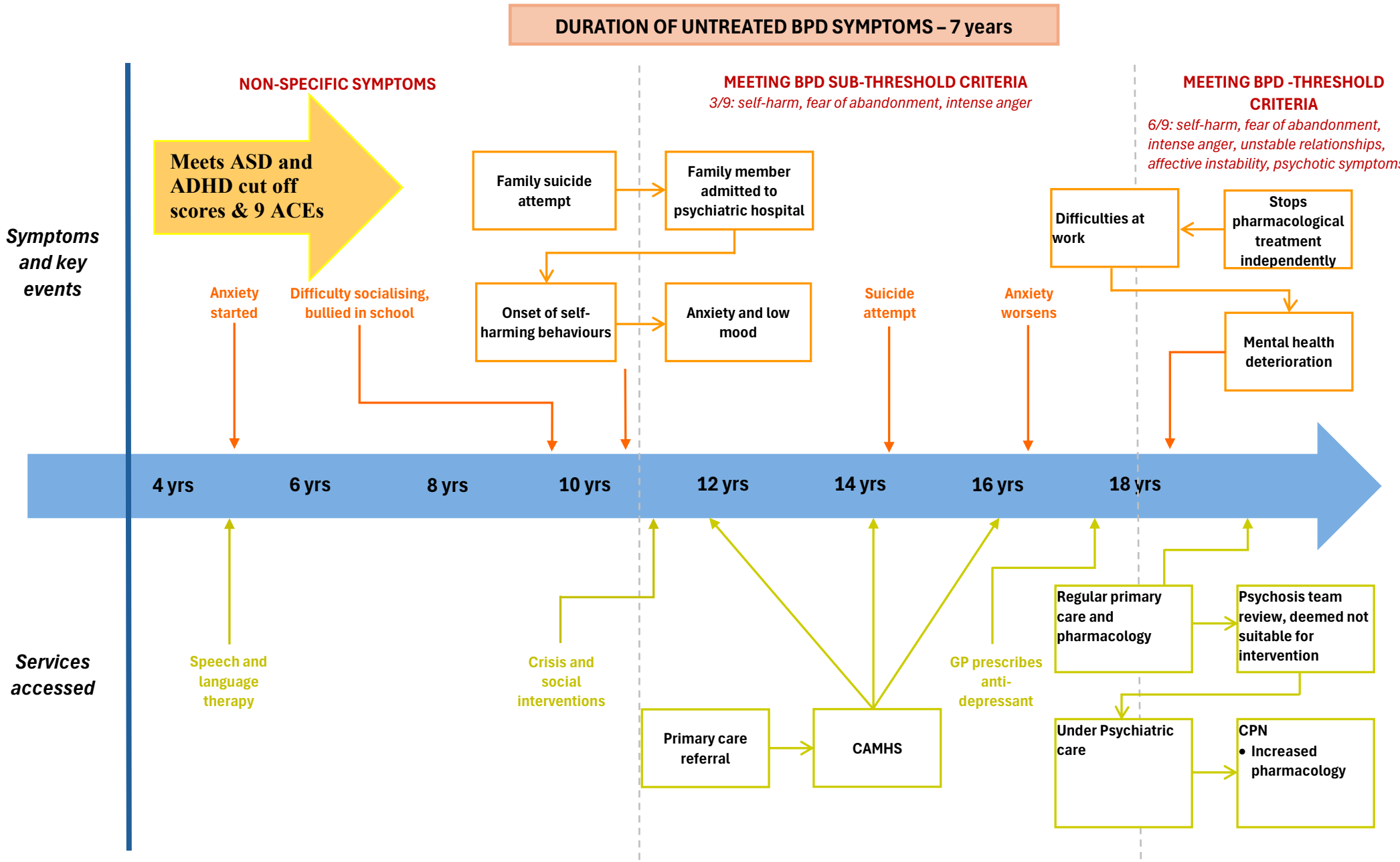


Figure 2: Pathway to care for case study 2

Anna had no previous diagnosis of BPD despite meeting the threshold criteria for 6 out of 9 of SCID-II criteria at the time of research participation. Her BPQ total score was 61, over the clinical cut-off score of 56. Her previous referrals did not lead to her being diagnosed, or having her symptoms treated for BPD despite having BPD symptoms for 7 years. Anna also met the criteria for ADHD and ASD but had no neurodivergent diagnosis.

Three key events in Anna's pathway (her mother's hospital admission, Anna's suicide attempt and Anna's crisis at her job) were serious events leading to her being referred to services. Anna described her sessions with Child and Adolescent Mental Health Service (CAMHS) (where she was given pamphlets with coping mechanisms) as being less useful than her 'crisis counselling', where she felt her confidence grew with her therapist. Anna had never received any psychotherapy treatment.

Case 3: Liam

Liam was referred to this study by CAMHS for emerging psychosis at age 15. He was accessing CAMHS for depression, anxiety and hallucinations and seeing a psychiatrist. Liam entered foster care at age 3. Liam had a family history of depression and schizophrenia. His pathway is illustrated in Figure 3.

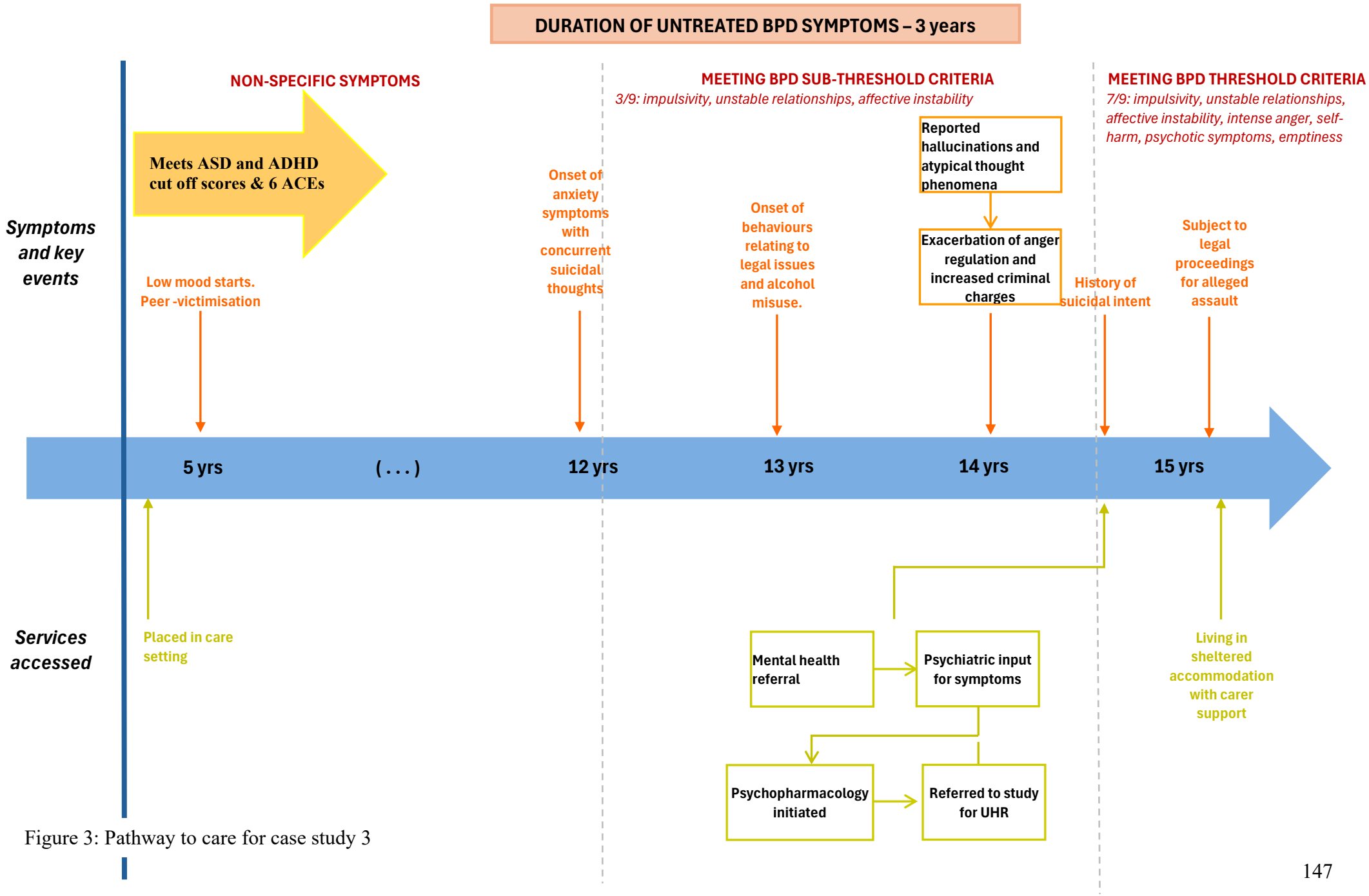


Figure 3: Pathway to care for case study 3

Whilst accessing CAMHS, Liam had no psychological intervention for, or diagnosis of, BPD. He met 7 out of 9 of the SCID-II criteria at age 15. His total BPQ score was 60 (>56). His BPD symptoms had been untreated for 3 years.

Liam's suicide attempt at age 14 resulted in a referral to CAMHS after years of depression and anxiety and months of psychotic symptoms.

Liam met the self-reported cut-off scores for both ADHD and ASD and did not have a neurodivergent diagnosis. He described ongoing anger control issues and had previously been charged with assault.

Case 4: James

James was referred to the study by the Community Mental Health Team (CMHT) for "query BPD" and was aged 25 years at the time of research participation. He was prescribed medication for depression and anxiety. James was on anti-psychotic medication and receiving support from a Community Psychiatric Nurse (CPN). James' adverse childhood experiences included emotional abuse, household substance abuse, parental mental illness (including a family history of bipolar disorder), and domestic violence. His pathway is illustrated in Figure 4. This is illustrated by the example of the iceberg as James was assessed but not treated for ADHD at a young age but evidently, there are clearly missed opportunities for early intervention.

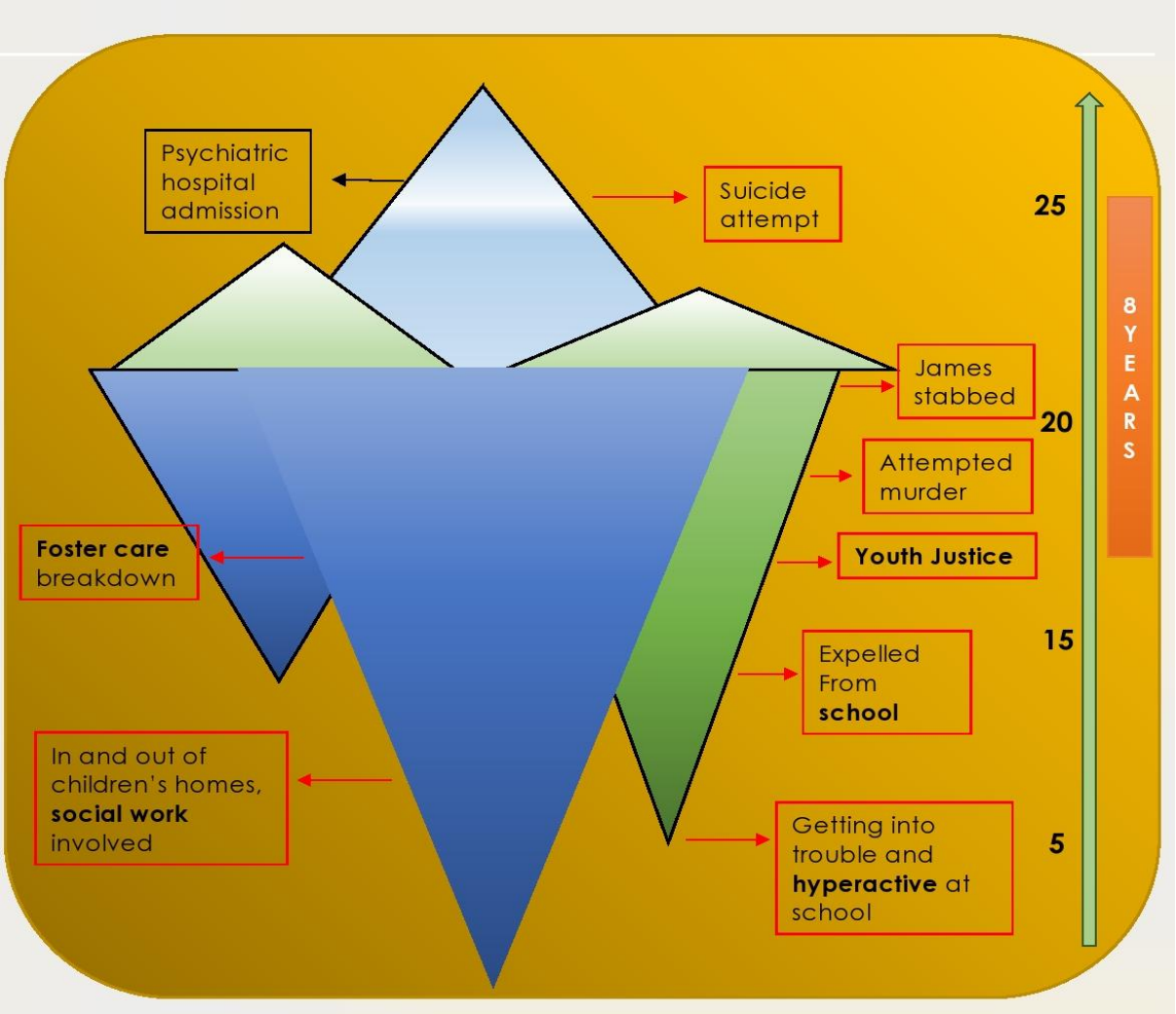


Figure 4: Pathway to care for case study 4.

James met 5 out of 9 of the SCID-II criteria for BPD but did not have a diagnosis. His total BPQ score was 48 (<56). He met the self-report cut off score for ADHD but had no neurodiversity diagnosis, despite having had an assessment at primary school. James was in children's homes, involved with social workers and in and out of custody interacting with services throughout his childhood and adolescence. After a suicide attempt at age 23, he was admitted to a psychiatric hospital. James had not received any form of psychological intervention. Retrospective assessment of BPD

criteria by the SCID-II interview suggested his BPD symptoms had been unidentified for 8 years.

Discussion

The Pathways project (Gajwani et al., 2022) aimed to investigate developmental trajectories and pathways to care for young people (15-25 years) accessing specialist mental health service in one region of UK between 2016 and 2018. Participants presenting with trauma related disorders in child or adult psychiatry may benefit from an understanding of their neurodivergence which may have contributed to their presenting difficulties (Harm et al., 2013). All four participants included in the case study analysis met criteria for BPD and the duration of untreated BPD symptoms when assessed by a clinician for the study, retrospectively, ranged from 3 to 9 years. Despite the repeated interaction with services and referrals to mental health teams, the four participants in this study described a long duration of undiagnosed and untreated symptoms of BPD. All four participants met criteria for neurodivergence (Autism and/or ADHD) but did not have a diagnosis at the time of study participation. In the Pathways study 79% met criteria for ADHD and/or ASD (Gajwani et al., 2022). All four participants reported difficulties very early on in school, such as socialising, difficulties fitting in or hyperactivity; this was missed or poorly identified by services in the context of adversity in their home lives.

Emotional dysregulation (DSM-5, APA, 2013) is a core feature of BPD with it also being a prominent symptom of ADHD (Moukhtarian et al., 2021). It has been identified (Weiner et al., 2019) that emotional dysregulation is similar in both conditions with high levels of instability and intensity of negative emotions with a

slower return to baseline. There is symptomatic overlap between BPD and ADHD but if a child meets criteria for ADHD, it is imperative that they be treated for it. Results of these case studies highlight the likelihood of BPD being a lifespan developmental condition (Tackett et al., 2009) when associated with significant risk factors such as ACEs for those with BPD and ADHD. Evidently, BPD needs to be explored in more depth long before it emerges as a process of potential missed opportunities for timely assessment of neurodivergence and potential trauma exposure. This study and that of Dinkler et al., (2017) identifies young people with childhood trauma have been shown to be at higher risk of neurodiversity's. Early precursors of BPD need to be identified but the question is how this can be achieved (Lenzenweger & Cicchetti, 2005).

We argue that a comprehensive approach to assessing pathways to care (symptom presentation and appropriate service input) would contribute to the understanding of the development of BPD and an understanding of when, across the lifespan, neurodivergence emerged. This may help clinicians use opportunities for early intervention with a developmental framework. However, as can be seen from the case studies, all individual journeys are unique and complex with different experiences and timings (Cicchetti & Rogosch, 1996); whilst services may take a 'developmental history', the case studies suggest that this should be supplemented with comprehensive assessments to understanding of diverse needs and embracing complexity.

There is now evidence to support that children who experienced maltreatment are more likely to have a high neurodiversity load (Dinkler et al., 2017) and was explained by shared genetic liability, increasing both the risk of being maltreated and of having more co-occurring neurodiversity (Dinkler et al.,

2017). We have also shown that the presence of neurodivergence and maltreatment doubles the risk of 'adult-type' symptoms for severe mental illness, in the form of juvenile mania (Gajwani et al., 2021).

ADHD is a frequent co-morbidity of BPD (Philipsen et al., 2008; Calveti et al., 2019; Weiner et al., 2019) and the group with comorbid BPD and ADHD has greater rates of mental state and personality pathology, impulsivity, and psychosocial impairment than those without BPD (Calveti et al., 2019). ADHD and BPD share difficulties in emotional regulation as a central feature (Calveti et al., 2019). It may be that treatment of co-morbid ADHD may improve outcomes for treatment of BPD pathology.

BPD across mental health services

These case studies have demonstrated how BPD was not confined to 'Personality Disorder services', as referrals were received from generic CAMHS and Adult MH services. Young people with BPD symptoms (subthreshold and full threshold) present to various psychiatric, social, and forensic services (Gajwani, et al., 2022). From the case study analysis, our findings support that young people are accessing care in a state of crisis such as suicide attempts, under extreme stress or repeated criminal offences (Broadbear et al., 2020).

Furthermore, all four cases also had a complex history of psychotic symptoms such as hallucinations, paranoia, and intrusive thoughts, and two cases were referred to in the study as being at 'ultra-high risk (UHR) for psychosis. BPD and UHR psychosis display clinical overlap such as impaired functioning, increased risk of suicide and high psychiatric admission rates (West et al., 2021). Co-ordination and communication across services of potential BPD patients could be key in

implementing intervention strategies. This could help individuals access the help they need before presenting in this late, high-risk state and prevent the high use of mental-health resources BPD patients are associated with (Lieb et al., 2004).

Strengths and limitations

The strength of this study is its investigation of a group of young people with high levels of unmet needs in the form of undiagnosed neurodivergence, borderline psychopathology and comorbid difficulties such as Post-Traumatic Stress Disorder (PTSD). This group has a high rate of self-harm, suicidal history, and psychiatric admission. This study set out to explore how these individuals were accessing services and their pathway to begin discussions of an early intervention programme. Furthermore, the investigation of these pathways can act to empower the participants of the study as it values their lived experiences.

A limitation of this study is its retrospective assessment of ACEs and BPD symptoms which was reliant on participants, and informants, reported history of when they have met criteria for sub-threshold BPD, a group correlated with psychosocial morbidity still (Thompson et al., 2019). It was not feasible to follow up positive screens for neurodivergence in participants not previously diagnosed, with diagnostic assessments. It may be that participants self-attribute neurodivergence traits however all assessments were conducted by clinically supervised researchers.

The intrinsic, purposive sampling technique used in this study was to identify how these individuals who are at highest risk of poor outcomes and complex needs are accessing services. These findings may not be generalisable to everyone presenting with BPD, however the purpose of case study research is to “make theoretical, rather than empirical, generalisations” (Yin, 2009).

However, due to the nature of case studies, participant selection can have methodological implications. Within the context of selecting participants for a case study (Yin, 2009) review it is important to recognise that the aim is not necessarily to obtain quantifiable data, but rather to provide high-quality, in-depth information that captures the research study/question. Consequently, whilst case studies can provide rich and detailed insights, their findings may have limited generalisability beyond specific case examined(Driskco, 2025).

As with any small studies, the individuals chosen from The Pathways Study (Gajwani et al., 2022) may not be representative of the larger clinical population of young people with BPD features, thus considering variability when considering in BPS presentations (MacKinnon, 2026).

An additional limitation of a case study methodology is confidentiality; as there is so much descriptive information, there is the potential for participants to be identified especially if there are unique features in their history (Itzik & Walsh et al., 2023). Therefore, Pseudonyms were chosen in an attempt to mitigate this as well as making specific data points (for example, life events) more generic and less identifiable of the participants and their histories.

The potential methodological implications for the quality of data in this particular study could influence the conclusions drawn. For example, case studies maybe based predominantly on individuals with negative experiences of service pathways and earlier missed opportunities, meaning the overall experiences of all participants may not be adequately represented. This may therefore exclude important perspectives that could contribute to the overall conclusions, such as whether opportunities for care are frequently and commonly missed across all services.

The study inclusion criteria was 2/9 threshold (DSM 5, 2013; APA, 2013) for the original Pathways study (Gajwani et al., 2022), this is particularly low and may not be representative of those with severe and enduring BPD features. Young people with subthreshold criteria may have different service interactions to those with full threshold criteria or those further along the BPD continuum. Whilst potentially missing the wider experiences of the main study, these four case studies used allowed for in-depth, holistic data within the clinical context which in turn, improved the richness and integrity of the data.

Early intervention in young people with BPD is shown to improve long-term outcomes (Chanen et al., 2009). These cases highlight areas for possible interventions. There should be increased awareness and education of BPD diagnosis in adolescents throughout a range of services. There is potential for standardised clinical assessment of neurodiversity in the presence of trauma and vice versa.

Further research on care journeys with a lifespan, non-linear approach may be beneficial to understand experiences of those marginalized or excluded from services. This is particularly poignant in the context of BPD, due to systemic bias, which is further aggravated in context of complexity, where there is missed recognition of neurodivergence in the context of 'trauma' and multi-morbidity. Epidemiological data linkage, along with clinical trials and qualitative case study are urgently needed in BPD research, so we do not continue to exclude some of the most vulnerable children and families from worsening health inequalities.

References

Akça, Ö F., Wall, K., & Sharp, C. (2020). Borderline personality disorder and attention deficit/hyperactivity disorder in adolescence: Overlap and differences in a clinical setting. *Borderline Personality Disorder and Emotion Dysregulation, 7*(1), 7.

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.)

Benczkowski, T. (2022). *The Relationship between Adverse Childhood Experiences and Borderline Personality Disorder among Inpatient Adolescents,*

Bozzatello, P., Bellino, S., Bosia, M., & Rocca, P. (2019). Early detection and outcome in borderline personality disorder. *Frontiers in Psychiatry, 10*, 710.

Brandrett, B., & Gajwani, R. (2024). The impact of psychological interventions on functioning in the context of borderline personality disorder features for adolescents and young adults; a systematic review and meta-analysis.

Broadbear, J. H., Dwyer, J., Bugeja, L., & Rao, S. (2020). Coroners' investigations of suicide in Australia: The hidden toll of borderline personality disorder. *Journal of Psychiatric Research, 129*, 241–249.

Calvetti, P. Ü, de Vargas, F., & Gauer, G. (2019). Neurosciences and emotional self-regulation applied to mental health contexts. *Cognitive behavioral therapy-theories and applications* IntechOpen.

Carlson, E. A., Egeland, B., & Sroufe, L. A. (2009). A prospective investigation of the development of borderline personality symptoms. *Development and Psychopathology, 21*(4), 1311–1334.

Ceylan, V., Kose, S., Akin, E., & Turkcapar, M. H. (2017). Normative data and factorial structure of the Turkish version of the borderline personality questionnaire (Turkish BPQ). *Psychiatry and Clinical Psychopharmacology, 27*(2), 143–151.

Chanen, A. M., Jovev, M., Djaja, D., McDougall, E., Yuen, H. P., Rawlings, D., & Jackson, H. J. (2008). Screening for borderline personality disorder in outpatient youth. *Journal of Personality Disorders, 22*(4), 353–364.

Chanen, A. M., & Kaess, M. (2012). Developmental pathways to borderline personality disorder. *Current Psychiatry Reports, 14*(1), 45–53.

Chanen, A. M., Mccutcheon, L. K., Germano, D., Nistico, H., Jackson, H. J., & Mcgorry, P. D. (2009). The HYPE clinic: An early intervention service for borderline personality disorder. *Journal of Psychiatric Practice®, 15*(3), 163–172.

Chanen, A. M., Nicol, K., Betts, J. K., & Thompson, K. N. (2020). Diagnosis and treatment of borderline personality disorder in young people. *Current Psychiatry Reports, 22*(5), 25.

Cicchetti, D., & Rogosch, F. A. (1996). Equifinality and multifinality in developmental psychopathology. *Development and Psychopathology, 8*(4), 597–600.

Cohen, P., Chen, H., Gordon, K., Johnson, J., Brook, J., & Kasen, S. (2008). Socioeconomic background and the developmental course of schizotypal and borderline personality disorder symptoms. *Development and Psychopathology, 20*(2), 633–650.

Cohen, P., Crawford, T. N., Johnson, J. G., & Kasen, S. (2005). The children in the community study of developmental course of personality disorder. *Journal of Personality Disorders, 19*(5), 466–486.

Coid, J., Yang, M., Bebbington, P., Moran, P., Brugha, T., Jenkins, R., . . . Ullrich, S. (2009). Borderline personality disorder: Health service use and social functioning among a national household population. *Psychological Medicine, 39*(10), 1721–1731.

Collins, K. M., Minnis, H., & Gajwani, R. (2025). Using clinician–patient collaboration to tackle structural stigma and age discrimination in borderline personality disorder. *BJPsych Advances,* , 1–3. doi:10.1192/bja.2025.10140

Coyle, T. N., Shaver, J. A., & Linehan, M. M. (2018). On the potential for iatrogenic effects of psychiatric crisis services: The example of dialectical behavior therapy for adult women with borderline personality disorder. *Journal of Consulting and Clinical Psychology, 86*(2), 116.

Daigre, C., Ramos-Quiroga, J. A., Valero, S., Bosch, R., Roncero, C., Gonzalvo, B., . . . Casas, M. (2009). Adult ADHD self-report scale (ASRS-v1. 1) symptom checklist in patients with substance use disorders. *Actas Españolas De Psiquiatría, 37*(6), 299–305.

Dinkler, L., Lundström, S., Gajwani, R., Lichtenstein, P., Gillberg, C., & Minnis, H. (2017). Maltreatment-associated neurodevelopmental disorders: A co-twin control analysis. *Journal of Child Psychology and Psychiatry, 58*(6), 691–701.

Ditrich, I., Philipsen, A., & Matthies, S. (2021). Borderline personality disorder (BPD) and attention deficit hyperactivity disorder (ADHD) revisited–a review-update on common grounds and subtle distinctions. *Borderline Personality Disorder and Emotion Dysregulation, 8*(1), 22.

Drisko, J. W. (2025). Transferability and generalization in qualitative research. *Research on social work practice*, *35*(1), 102-110.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245–258.

Fernandez, S. A. (2024). An overview of borderline personality disorder: Etiology, stigma, and treatment approaches.

Fok, M. L., Hayes, R. D., Chang, C., Stewart, R., Callard, F. J., & Moran, P. (2012). Life expectancy at birth and all-cause mortality among people with personality disorder. *Journal of Psychosomatic Research, 73*(2), 104–107.

Gajwani, R., Dinkler, L., Lundström, S., Lichtenstein, P., Gillberg, C., & Minnis, H. (2021). Mania symptoms in a Swedish longitudinal population study: The roles of childhood trauma and neurodevelopmental disorders. *Journal of Affective Disorders, 280*, 450–456. doi:10.1016/j.jad.2020.10.076

Gajwani, R., & Minnis, H. (2023). Double jeopardy: Implications of neurodevelopmental conditions and adverse childhood experiences for child health. *European Child & Adolescent Psychiatry, 32*(1), 1–4.

Gajwani, R., Wilson, N., Nelson, R., Gumley, A., Smith, M., & Minnis, H. (2022a). Recruiting and exploring vulnerabilities among young people at risk, or in the early stages of serious mental illness (borderline personality disorder and first episode psychosis). *Frontiers in Psychiatry, 13*, 943509.

Grambal, A., Prasko, J., Ociskova, M., Slepecky, M., Kotianova, A., Sedlackova, Z., . . . Kamaradova, D. (2017). Borderline personality disorder and unmet needs. *Neuroendocrinol Lett, 38*(4), 275–289.

Griffiths, M. (2011). Validity, utility and acceptability of borderline personality disorder diagnosis in childhood and adolescence: Survey of psychiatrists. *The Psychiatrist, 35*(1), 19–22.

Ha, C., Balderas, J. C., Zanarini, M. C., Oldham, J., & Sharp, C. (2014). Psychiatric comorbidity in hospitalized adolescents with borderline personality disorder. *J Clin Psychiatry, 75*(5), e457–e464.

Harm, M., Hope, M., & Household, A. (2013). American psychiatric association, 2013, diagnostic and statistical manual of mental disorders, 5th edn, Washington, dc: American psychiatric association Anderson, j, Sapey, b, Spandler, h (eds.), 2012, distress or disability? Lancaster: Centre for disability research. *Arya, 347*, 64.

Iacino, K. A. (2020). *Borderline Personality Disorder in the DSM-5 Alternative Model for Personality Disorders: A Critical Review,*

Itzik, L., & Walsh, S. D. (2023). Giving them a choice: Qualitative research participants chosen pseudonyms as a reflection of self-identity. Journal of Cross-Cultural Psychology, 54(6-7), 705-721.

Kendall, T., Pilling, S., Tyrer, P., Duggan, C., Burbeck, R., Meader, N., & Taylor, C. (2009a). Borderline and antisocial personality disorders: Summary of NICE guidance. *BMJ, 338*

Kendall, T., Pilling, S., Tyrer, P., Duggan, C., Burbeck, R., Meader, N., & Taylor, C. (2009b). Borderline and antisocial personality disorders: Summary of NICE guidance. *BMJ, 338*

Kessler, R. C., Adler, L., Ames, M., Demler, O., Faraone, S., Hiripi, E., . . . Spencer, T. (2005). The world health organization adult ADHD self-report scale (ASRS): A short screening scale for use in the general population. *Psychological Medicine, 35*(2), 245–256.

Kouppis, E., Gerdin, B., Björkenstam, C., Björkenstam, E., & Ekselius, L. (2022). Effect of comorbid ADHD on mortality in women with borderline personality disorder. *Borderline Personality Disorder and Emotion Dysregulation, 9*(1), 25.

Laurenssen, E. M., Smits, M. L., Bales, D. L., Feenstra, D. J., Eeren, H. V., Noom, M. J., . . . Dekker, J. J. (2014). Day hospital mentalization-based treatment versus intensive outpatient mentalization-based treatment for patients with severe borderline personality disorder: Protocol of a multicentre randomized clinical trial. *BMC Psychiatry, 14*(1), 301.

Leichsenring, F., Fonagy, P., Heim, N., Kernberg, O. F., Leweke, F., Luyten, P., . . . Steinert, C. (2024). Borderline personality disorder: A comprehensive review of diagnosis and clinical presentation, etiology, treatment, and current controversies. *World Psychiatry, 23*(1), 4–25.

Lenzenweger, M. F. (1999). Stability and change in personality disorder features: The longitudinal study of personality disorders. *Archives of General Psychiatry, 56*(11), 1009–1015.

Lenzenweger, M. F., & Cicchetti, D. (2005). Toward a developmental psychopathology approach to borderline personality disorder. *Development and Psychopathology, 17*(4), 893–898.

Lieb, K., Zanarini, M. C., Schmahl, C., Linehan, M. M., & Bohus, M. (2004). Borderline personality disorder. *The Lancet, 364*(9432), 453–461.

Lobbestael, J., Leurgans, M., & Arntz, A. (2011). Inter-rater reliability of the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID I) and Axis II Disorders (SCID II). *Clinical psychology & psychotherapy*, *18*(1), 75–79. https://doi.org/10.1002/cpp.693

MacKinnon, E. (2026). Bridging lived experience and neurodiversity: an interpretative phenomenological analysis of engagement amongst young people with borderline personality disorder features and a systematic review of comorbid borderline personality disorder features and attention deficit hyperactivity disorder.

Matthies, S. D., & Philipsen, A. (2014). Common ground in attention deficit hyperactivity disorder (ADHD) and borderline personality disorder (BPD)–review of recent findings. *Borderline Personality Disorder and Emotion Dysregulation, 1*(1), 1–13.

May, T., Pilkington, P. D., Younan, R., & Williams, K. (2021a). Overlap of autism spectrum disorder and borderline personality disorder: A systematic review and meta-analysis. *Autism Research, 14*(12), 2688–2710.

McLennan, J. D., MacMillan, H. L., & Afifi, T. O. (2020). Questioning the use of adverse childhood experiences (ACEs) questionnaires. *Child Abuse & Neglect, 101*, 104331.

Moran, P., Romaniuk, H., Coffey, C., Chanen, A., Degenhardt, L., Borschmann, R., & Patton, G. C. (2016). The influence of personality disorder on the future mental health and social adjustment of young adults: A population-based, longitudinal cohort study. *The Lancet Psychiatry, 3*(7), 636–645.

Moukhtarian, T. R., Reinhard, I., Moran, P., Ryckaert, C., Skirrow, C., Ebner-Priemer, U., & Asherson, P. (2021). Comparable emotional dynamics in women with ADHD and borderline personality disorder. *Borderline Personality Disorder and Emotion Dysregulation, 8*(1), 6.

O'malley, G. K., McHugh, L., Mac Giollabhui, N., & Bramham, J. (2016). Characterizing adult attention-deficit/hyperactivity-disorder and comorbid borderline personality disorder: ADHD symptoms, psychopathology, cognitive functioning and psychosocial factors. *European Psychiatry, 31*, 29–36.

Oláh, B., Fekete, Z., Kuritárné Szabó, I., & Kovács-Tóth, B. (2023). Validity and reliability of the 10-item adverse childhood experiences questionnaire (ACE-10) among adolescents in the child welfare system. *Frontiers in Public Health, 11*, 1258798.

Philipsen, A., Limberger, M. F., Lieb, K., Feige, B., Kleindienst, N., Ebner-Priemer, U., . . . Bohus, M. (2008). Attention-deficit hyperactivity disorder as a potentially aggravating factor in borderline personality disorder. *The British Journal of Psychiatry, 192*(2), 118–123.

Piedmont, R. L., Sherman, M. F., Sherman, N. C., & Williams, J. E. (2003). A first look at the structured clinical interview for DSM-IV personality disorders screening questionnaire: More than just a screener? *Measurement and Evaluation in Counseling and Development, 36*(3), 150–160.

Popovic, A., & Huecker, M. R. (2023). Study bias. In *Statpearls [internet]*. StatPearls Publishing.

Poreh, A. M., Rawlings, D., Claridge, G., Freeman, J. L., Faulkner, C., & 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.

Posserud, M., Breivik, K., Gillberg, C., & Lundervold, A. J. (2013). ASSERT–the autism symptom SElf-ReporT for adolescents and adults: Bifactor analysis and validation in a large adolescent population. *Research in Developmental Disabilities, 34*(12), 4495–4503.

Sharp, C., & Kim, S. (2015). Recent advances in the developmental aspects of borderline personality disorder. *Current Psychiatry Reports, 17*(4), 21.

Sharp, C., & Wall, K. (2021). DSM-5 level of personality functioning: Refocusing personality disorder on what it means to be human. *Annual Review of Clinical Psychology, 17*(1), 313–337.

Singh, S. P., & Grange, T. (2006). Measuring pathways to care in first-episode psychosis: A systematic review. *Schizophrenia Research, 81*(1), 75–82.

Stake, R. (1995). Case study research. *Cham: Springer,*

Stepp, S. D., Scott, L. N., Jones, N. P., Whalen, D. J., & Hipwell, A. E. (2016). Negative emotional reactivity as a marker of vulnerability in the development of borderline personality disorder symptoms. *Development and Psychopathology, 28*(1), 213–224.

Tackett, J. L., Balsis, S., Oltmanns, T. F., & Krueger, R. F. (2009). A unifying perspective on personality pathology across the life span: Developmental considerations for the fifth edition of the diagnostic and statistical manual of mental disorders. *Development and Psychopathology, 21*(3), 687–713.

ten Have, M., Verheul, R., Kaasenbrood, A., van Dorsselaer, S., Tuithof, M., Kleinjan, M., & de Graaf, R. (2016). Prevalence rates of borderline personality disorder symptoms: A study based on the Netherlands mental health survey and incidence study-2. *BMC Psychiatry, 16*(1), 249.

Thomas, C., Mulnick, S., Krucien, N., & Marsh, K. (2022). How do study design features and participant characteristics influence willingness to participate in clinical trials? Results from a choice experiment. *BMC Medical Research Methodology*, *22*(1), 323.

Thompson, K. N., Jackson, H., Cavelti, M., Betts, J., McCutcheon, L., Jovev, M., & Chanen, A. M. (2019). The clinical significance of subthreshold borderline personality disorder features in outpatient youth. *Journal of Personality Disorders, 33*(1), 71–81.

Van Alebeek, A., van der Heijden, P. T., Hessels, C., Thong, M. S., & Van Aken, M. (2015). Comparison of three questionnaires to screen for borderline personality disorder in adolescents and young adults. *European Journal of Psychological Assessment,*

Van Dijk, F., Schellekens, A., van den Broek, P., Kan, C., Verkes, R., & Buitelaar, J. (2014). Do cognitive measures of response inhibition differentiate between attention deficit/hyperactivity disorder and borderline personality disorder? *Psychiatry Research, 215*(3), 733–739.

Wall, K., Kerr, S., & Sharp, C. (2021). Barriers to care for adolescents with borderline personality disorder. *Current Opinion in Psychology, 37*, 54–60.

Weiner, L., Perroud, N., & Weibel, S. (2019). Attention deficit hyperactivity disorder and borderline personality disorder in adults: A review of their links and risks. *Neuropsychiatric Disease and Treatment,* , 3115–3129.

West, M. L., Guest, R. M., & Carmel, A. (2021). Comorbid early psychosis and borderline personality disorder: Conceptualizing clinical overlap, etiology, and treatment. *Personality and Mental Health, 15*(3), 208–222.

Williams, R., Farquharson, L., Rhodes, E., Dang, M., Butler, J., Quirk, A., . . . Crawford, M. J. (2021). Impact of substance use disorder on quality of inpatient mental health services for people with anxiety and depression. *Journal of Dual Diagnosis, 17*(1), 80–93.

Wilson, N., Robb, E., Gajwani, R., & Minnis, H. (2021). Nature and nurture? A review of the literature on childhood maltreatment and genetic factors in the pathogenesis of borderline personality disorder. *Journal of Psychiatric Research, 137*, 131–146. doi:10.1016/j.jpsychires.2020.12.025

Winograd, G., Cohen, P., & Chen, H. (2008). Adolescent borderline symptoms in the community: Prognosis for functioning over 20 years. *Journal of Child Psychology and Psychiatry, 49*(9), 933–941.

Yin, R. K. (2009). *Case study research: Design and methods* sage.

Zanarini, M. C. (2003). Zanarini rating scale for borderline personality disorder (ZAN-BPD): A continuous measure of DSM-IV borderline psychopathology. *Journal of Personality Disorders, 17*(3), 233–242.

Zanarini, M. C., Frankenburg, F. R., Hennen, J., Reich, D. B., & Silk, K. R. (2006). Prediction of the 10- year course of borderline personality disorder. *The American journal of psychiatry, 163(5),* 827–832. https://doi.org/10.1176/ajp.2006.163.5.827

Reflections on chapter 4

- These clinical case studies highlight how pathways to care in BPD, for those who are neurodivergent, are complex and unique to everyone. It is evident that there are many missed opportunities for mental health intervention over the course of a lifetime and often individuals present to services in crisis with historical trauma, adverse childhood experiences and neurodivergence (Chanen & Kaess, 2012). There is limited data examining what came before the signs and symptoms manifested (Geiger et al., 2010). All participants had a history of psychotic symptoms, BPD features and neurodivergence but, with a lack of collaboration across services, no intervention was implemented.

- Vulnerable young people are consistently being missed (Gajwani et al., 2022) and let down through lack of communication, education and awareness across multi-sector services – i.e. CAHMS, social work and youth criminal justice systems. The pathways to care appear to be broken and disjointed. This clinical case studies paper further reinforces the arguments that care and collaboration between services, young people and their carers is lacking. Opportunities for early intervention and identification of important conditions that increase the risk of BPD emerging, such as neurodivergence, are being missed leading to untold consequences such as misdiagnosis, inappropriate use of psychopharmacology and unnecessary suffering (Baltzersen, 2021).

- A unique feature of these clinical case studies is that all participants met criteria for BPD and neurodivergence. Few studies on developmental pathways

explore this connection. Neurodivergence is more often diagnosed in childhood therefore, further research is needed to establish identification tools which may bring early features of BPD to the forefront. The identification of neurodivergence could open doors in terms of exploring the potential of the emergence of BPD. In turn, allowing for early intervention thus limiting the impact of BPD symptoms. Pathways to care could then be joined up thus reducing the impact BPD has when early intervention is missed. Although, as outlined in the study the presence of neurodivergence does not categorically mean BPD will emerge in future.

- This raises the question of what are these barriers to care? While the clinical case studies are compelling and allowed for a lifetime trajectory view, the voices, feelings and experiences of the young people are missing. There is a lack of evidence which directly considers the voice of the young person on this journey, and which sheds light on the processes, along the journey to eventual BPD diagnosis, that can lead to recovery or, conversely, to iatrogenic harm. There is the potential for service users to share how the care they receive makes them feel i.e. receiving a diagnosis or the power dynamic between service user and clinician (Osborne, 2025). Intervention services would benefit significantly from hearing the experiences of young people's journeys to, and of, care. The following chapter (5), paper 3, takes an interpretative phenomenological analysis (IPA) perspective of young people's attempts to access appropriate mental health care when experiencing signs and symptoms of BPD.

References

Baltzersen, Å. (2021). Moving forward: Closing the gap between research and practice for young people with BPD. *Current Opinion in Psychology, 37*, 77–81. doi:10.1016/j.copsyc.2020.08.008

Didier, O., & Terradas, M. M. (2025). Attachment representations and emerging borderline personality features in school-aged children under youth protective care, consulting psychologists or child psychiatrists, and from the general population. *Children and Youth Services Review, 176*, 108391. doi:10.1016/j.childyouth.2025.108391

Gajwani, R., Wilson, N., Nelson, R., Gumley, A., Smith, M., & Minnis, H. (2022). Recruiting and exploring vulnerabilities among young people at risk, or in the early stages of serious mental illness (borderline personality disorder and first episode psychosis). *Frontiers in Psychiatry, 13*, 943509. doi:10.3389/fpsyt.2022.943509

Kaess, M., & Cavelti, M. (2025). Research review: What we have learned about early detection and intervention of borderline personality disorder. *Journal of Child Psychology and Psychiatry, 66*(12), 1829–1848.

Osborne, J. (2025). *Discursive Constructions of Emotionally Unstable Personality Disorder and Borderline Personality Disorder: A Critical Exploration of how Diagnosis is Constructed by Service Users and Clinicians,*

Chapter 5: Journeys through care

"It was a horrible, just horrible, journey": An interpretative phenomenological analysis of care journeys of young people with borderline personality disorder features.

Kirsty Collins[1], Helen Smith[3], Emma McIntosh[1], Paul Moran[4], Dennis Ougrin[5], Andrew Chanen[6,7], Helen Minnis[1,2], Ruchika Gajwani[1,2*]

[1] School of Health and Wellbeing, University of Glasgow, Glasgow, UK

[2] NHS Greater Glasgow and Clyde, Glasgow, UK

[3] NHS Ayrshire and Arran, Scotland, UK

[4] Department of Population Health Sciences, University of Bristol, Bristol, UK

[5] Youth Resilience Unit, Queen Mary University of London, London, UK

[6] Orygen, Melbourne, Australia

[7] Centre for Youth Mental Health, The University of Melbourne, Melbourne, Australia

* Correspondence:

Dr Ruchika Gajwani: Ruchika.Gajwani@glasgow.ac.uk

Kirsty Collins: Kirsty.collins2@research.gla.ac.uk

Keywords: Borderline Personality Disorder (BPD), BPD features, Young People, Pathways to care, Interpretative Phenomenological Analysis, Feasibility RCT (fRCT)

ABSTRACT

Borderline Personality Disorder (BPD) is becoming increasingly acknowledged as a valid diagnosis in adolescents. It is characterised by pervasive features such as impulsivity and unstable relationships. BPD features are commonly missed in adolescents and young people by healthcare providers, leading to adverse social and psychiatric complications, and iatrogenic harm. Many have reached crisis point when BPD is considered. Evidence of young people's journeys through care with BPD symptoms is lacking. A qualitative study was carried out to better understand pathways through care, identifying barriers and facilitators of effective care. This study is conducted in the context of a feasibility RCT – The BRIDGE Project. Three Group Experiential Themes (GETs) were identified: not being heard or validated, journey of finding/understanding the self, and the impact of positive perceptions and treatment during The BRIDGE Project. Stigma and the lack of dialogue about their longstanding unmet needs, was also identified as a barrier. BPD literacy in clinicians and the general population could enhance effective, earlier care and reduce individuals reaching crisis point.

1. Introduction

Borderline Personality Disorder (BPD) is a complex and pervasive mental health condition which manifests in persistent patterns of instability in functioning (DSM-5, APA, 2013). BPD has been recognised amongst clinicians as a diagnosable and treatable condition in adolescence (Chanen, 2015; Skabeikyte & Barkauskiene, 2021; Jørgensen et al., 2024). However, this has only become apparent in the last two decades. Often, BPD is not diagnosed and treated until the age of eighteen

(Laurenssen et al., 2013), despite research showing that symptoms can present much earlier in adolescence (Newton-Howes et al., 2015; Chanen et al., 2020). Whilst there is a growing recognition amongst some health professionals for the identification and treatment of BPD in adolescence (Foubister & Simpson, 2023), this remains contentious (Hartley et al., 2022).

Patients experience stigma and discrimination from clinicians and the general population (Stiles et al., 2023), as often BPD patients are deemed as 'manipulative' or 'difficult to treat' (Navarre, 2025). This further increases feelings of rejection and abandonment associated with BPD, thus perpetuating, and worsening of symptoms experienced (Aviramet al., 2006; Wall et al., 2021). Further, it is argued that stigma is more commonly associated with BPD than with any other mental illness (Amestoy et al., 2024).

Further, self-stigma resultant from attitudes of clinicians and the general population would appear to be common (Ociskova et al., 2023). This indicates that knowledge of BPD is lacking in society and in healthcare settings, which is filtering down to patients. Self-stigma leads to the individual having a negative perception of themselves due to being labelled and then potentially being told they are 'untreatable', thus having very serious consequences i.e. social isolation (Livingston & Boyd, 2012). As Widuch (2021) points out the linguistics surrounding the label of BPD can have terrible effects on wellbeing and a shift around this label may be required in order to tackle the perpetuation of stigma.

The hesitance to diagnose or at least acknowledge signs and symptoms of BPD by clinicians is possibly well meant: There is evidence (Motala & Price, 2024; Ring & Lawn 2025; Warrender, 2025) to suggest that receiving a diagnosis of BPD can be very damaging for some. Qualitative studies such as Molata & Price (2024) found a

diagnosis of BPD to be negative experience and themes such ‘public understanding and online stigma’, ‘attitudes and behaviours of healthcare professionals’ and ‘responses’ from the general population were identified as damaging. Some participants felt like it was a “death sentence” and wondered if they were an “awful person”. Arguably, this perhaps well-meaning avoidance of acknowledgement of BPD, further contributes to and perpetuates the associated stigma and the discrimination that comes with it. At the core of these negative feelings around being diagnosed with BPD, Ring and Lawn, (2025) identified that poor mental health literacy around BPD by patients and clinicians contribute to this idea of a BPD diagnosis being perceived as negative and education could help tackle this feeling of helplessness when it comes to receiving a diagnosis.

Yet avoiding and ignoring the presence of BPD features could be very detrimental to the individual in that untreated symptoms lead to unnecessary suffering over a lifetime. There is compelling epidemiological evidence for BPD features (i.e. those meeting subthreshold and clinical threshold) predicting adverse negative health and social outcomes, such as increased risk of mortality (Fok et al., 2014), psychiatric complications (Winsper et al., 2021), multiple contact with crisis services (Wall et al, 2021), worsening outcomes due to missed opportunities for early intervention (Winsper, 2021). At the point of crisis, several opportunities for treatment of BPD features have been missed by services, with previous suicide attempts perpetuating future attempts to manage long-unmet needs and suffering (Greenfield et al., 2008). It is common for young people with BPD features to experience significant barriers to treatment in turn leading to exclusion from services and creating an unhelpful reciprocal relationship with services (Cavelti et al., 2024).

Given the high risk of injurious behaviours in young people with BPD features, it is important to identify what barriers exist in relation to such young people accessing early intervention and treatment alongside stigma. A systematic review (Wall et al., 2021) highlighting barriers to care for adolescents with BPD identified that an individual may not have the ability to recognise their symptoms as BPD or feel the need to seek care or engage in treatment, leaving the onus on mental health professionals and the general population to be educated and aware of BPD signs and symptoms. However, accessibility and availability of services presents many challenges to young people, those caring for them and healthcare services (Lohman et al., 2016) For instance, BPD in adolescence may be less widely recognised by members of the general population (Furnham et al., 2012) and health care professionals (Morgan and Zimmerman, 2015) owing to symptoms being likened to a typical teenage trajectory (Sharp, 2017). Further, treatment avoidance is a common occurrence in those with a BPD diagnosis due to previous poor experiences with health care providers (Strike et al., 2006). A UK wide analysis (Peytrignet and Grimm, 2022) identified significant inequalities in accessing services, issues associated with the ambulance service during a mental health crisis, retention during the transition from child to adult services and prescription drug patterns among young people. These findings are for mental health issues in general; what is not apparent in the figures is the unrelenting barriers to treatment, along with the understanding of lived experiences of young people when presenting to mental health services with BPD features. These barriers and missed opportunities by professionals have a significant impact on pathways to care and can seriously hinder a young person's journey through mental health services and their recovery (Tusiani-Eng et al., 2018).

Given the significant consequences of these barriers to, and missed opportunities for care, it is imperative to identify and explore individual experiences of journeys through mental health care through a qualitative perspective to establish a richer picture. This would help to form better pathways to care and identify barriers for BPD-experienced individuals and healthcare practitioners. The aims of this study are: (1): To qualitatively explore the experiences of care journeys and service contact of young people with BPD features. (2): To identify barriers and facilitators of care in the context of The BRIDGE Project (Gajwani et al, 2024).

METHODS

2.1. Recruitment and Participants:

'The BRIDGE Project' (ClinicalTrial.gov Identifier: NCT05023447: RECRUITMENT PERIOD 01/09/2021 – 30/09/2024) is a feasibility randomised controlled trial of brief, intensive assessment, and integrated formulation for young people (age 14-24) with features of borderline personality disorder. Participants of The BRIDGE Project (Gajwani et al., 2024) were randomised to services as usual (SAU) or BRIDGE Intervention. The intervention group were offered comprehensive assessments, up to 16 sessions of cognitive analytic therapy (CAT) and contextual intervention in conjunction with the young person and the multi-agency teams that they had contact with. Participants for the present study were recruited over a 3-month period from 'The BRIDGE Project'. On completion of the BRIDGE Project, the participants were subsequently approached via telephone to ask if they would like to take part in the current study. A total of seven participants were recruited with three who had been randomised to 'Services as Usual' (SAU) and four randomised to 'BRIDGE

Intervention'. Of the participants three were female, one transgender, one non-binary and two males. All participants were recruited in Glasgow, Scotland. Pseudonyms are in place to maintain confidentiality.

2.2 Design

Interpretative Phenomenological Analysis (IPA) was used to interpret and analyse the emergent data (Smith, Flowers, and Larkin, 2021). IPA explores the lived experience of individuals in a particular area of research and allows the researcher to understand and interpret how participants make sense of their experience. In this research, the purpose was to gain first-hand reflections into seeking help for BPD signs and symptoms to identify barriers and limitations to care, highlighting the journey a young person must take to get help for such signs and symptoms. IPA uses semi-structured interviews and open-ended questions allowing participants to describe their experiences, affording the researcher the opportunity to carry out exploratory investigation and establish themes and sub-themes and gain a richer understanding of the experiences of the participants. The interview guide was co-developed following an extensive literature review, which explored the nature and phenomenology of BPD in young people and the barriers to diagnosis and treatment. Participants were not involved in the design of this study but were part of a wider youth advisory group which was involved in the design and execution of 'The BRIDGE Project' (Gajwani et al., 2024).

The researcher conducting the study was a female PhD student with a BPD diagnosis, although this was unknown to the participants. They had been trained in IPA at undergraduate level. As the participants knew the researcher from 'The BRIDGE Project' (Gajwani et al., 2024), a good rapport had already been established.

All 7 participants took part in the study with no dropout rate. The interviews took place either in person at the university or on MS teams, as per the participants preference.

Data Analysis

Qualitative Interpretative Phenomenological Analysis (IPA) was utilised to explore the experiences of young people aged 14-24 who are experiencing signs and symptoms of borderline personality disorder, to learn about their experiences of seeking help and their journey to treatment for these signs and symptoms in a Scottish health board. The study also looked at the impact of BRIDGE intervention versus SAU in participant making meaning of their care journeys, prior to and during participation in 'The BRIDGE Project.' (Gajwani et al., 2024). The current study was granted ethical clearance from the UK Research and Ethics Committee.

IPA was chosen over thematic analysis (TA) due to one of the authors having a diagnosis of BPD. The rationale behind this was that IPA allowed for the author's perspective to be part of the interpretation (although bias was mitigated). IPA works from the basis of 'double hermeneutics', meaning the researcher's goal is to understand and make sense of the participants understanding of their experience (Smith, 2017). It allowed for the researcher to both understand a shared experience but to hear it from a different perspective thus allowing for reflexivity.

After verbatim transcription, the data was analysed using the IPA method outlined by Smith, Flowers, and Larkin (2021). Data analysis was carried out by the PhD researcher. The first step taken was reading and re-reading each case; second, exploratory noting was carried out, third, constructing experiential statements, fourth, searching for connections across experiential statements, fifth, continuing

the individual analysis of other cases, and steps six and seven working with personal experiential themes to develop group experiential themes across cases.

Semi-structured Interview (Appendix 4)

After informed consent was obtained, with permission, recording started and the interview began with “Can you tell me about your experiences with services before you took part in The BRIDGE Project?” follow-up questions were guided by the participant's responses. Topics such as continuity of care and stigma became apparent and guided the follow-up questions. Further structured questions in the interview were aimed at a process evaluation for The BRIDGE Project and answers were not used for this investigation.

RESULTS

Three group experiential themes (GETs) emerged in relation to feelings of hopelessness as experiences of their care journey and contacts with services: These included ‘Not being heard or validated’, ‘journey of finding/understanding the self, ‘the impact of positive perceptions and treatment during The BRIDGE Project.’.

1. Not being heard or validated

1.1 Not acknowledged as having individual and unique needs from service providers

Prior to participating in The BRIDGE Project, all participants experienced challenging journeys through services, and this resulted in the recurring theme of feelings of hopelessness and reduced engagement with services. With previous therapeutic input lacking in their care, participants spoke of a ‘one-size fits all’ approach and experiencing no autonomy in their care.

*"So, I go to the GP, I was referred to CAMHS, when I was 13, I think. And erm that was the first time I'd seen like an NHS professional from mental health. Erm, and it was just like a kind of 6 weeks kinda counselling sort of thing. I didn't find it very helpful at all, I didn't feel heard or listened to at all, you know, it was just kind of a get you in the door, tick the box and get you back out the door again. Erm, I actually didn't go for my last session, erm, with that, I think it was a nurse practitioner or something I was seeing. I didn't go to that last session. I just couldn't find any benefit in going…" (*Melissa)

Melissa expresses a feeling of almost being processed. The mental health provider is trained in a particular therapy and does not diverge from this. They have not made it clear to Melissa what their role is and the purpose of the therapy. There is no bespoke care tailored to her needs.

The thing that didn't work for me with CAMHS was that I wasn't trying to like address like the group of an issue, it was just trying to cope with it. So, it was more instead of like, me…it was very like blanket statements to try and, like, make me calm down, but I don't think, like it wasn't working for me because I couldn't calm down when I was really like pent-up just by like going on a walk or something…" (James)

"Um, I felt like, I didn't really get on with them I think, it was a bit more like generalised advice I got rather than like personalised to me. So, it'd be like "Well, if you're feeling angry snap a rubber band on your arm" which

didn't really help me. Um, and I felt like no matter how many times I went, how many times, I like did different therapies it was always the same kinda advice "Oh you're feeling that way because you're stressed about exams and stuff, and it just didn't feel relevant to me as a person… Just like really the advice they'd give ye. Like "oh if you're feeling anxious go a walk" and I wasn't really delving into why I felt anxious and like fixing it from there. It was more kinda bulleted list of advice they'd give ye." (Judith)

"I had some bad experiences with therapy before I went to my current one. It tended to be a come and see us and get discharged as soon as we can discharge you kinda thing." (Alex)

"Erm, they weren't really sure what to do with me. There was a lot of like safety planning and, you know, just making sure, you know, something they do with everybody, it wasn't really personalised care." (Melissa)

The extracts above illustrate a strong feeling of futility in the interaction between the participants and their experiences of specialist services. Their signs and symptoms appear to be dismissed and attributed to teenage normative development trajectories rather than explored and supported as individuals experiencing severe distress and mental ill health. Further, through the accounts of young people, it was clear that investigation into the unique needs of the young person were not explored.

1.2 Negative impact due to lack of continuity of care

Participants clearly perceived therapeutic relationships to lack continuity of care. What was consistently emerging in participants interviews was that a safe and consistent space was not created in their experience of health care professionals, to allow for a therapeutic relationship to develop.

> *"Um, so I never really seen anyone for more than like maybe a month, I think. The only time I really did see someone for longer than that was like a dietician from CAMHS because I had an eating disorder, so, um but, they didn't really…they would say "alright well try this then we'll let you go kinda thing." And I felt like I wasn't given it my all because I went through it so many times that I'd just gave up on the whole process. I'd seen like countless like nurses and school counsellors and CBT therapists and um… I wasn't really supported between CAMHS and adult CAMHS. Um, I was just kinda, I moved, and they just put me in adult CAMHS But again, I just didn't really find it helpful at all."* (Judith)

> *"Erm, the psychiatrist I wasn't the biggest fan of. Erm, just because there was a lot of times, I feel like she was very harsh, and we shouldn't need to be very harsh. Erm, like, there was like one time of the top of my head I remember always talking with her, I had an appointment with her, and she was always asking me like "what is it you think you're dealing with?" Like, I basically just like kinda went on a rant about how, erm how I'd looked into diagnoses and stuff like that, and I think it was either like BPD or like depression or something. At least depression at the slightest. Erm and she*

said to me "I think you really need to hear this, but you're not depressed. You don't have depression, that's not what's going on here, so I think you really just need to hear that". And I don't know if she meant it another way but to me that just kinda been like "you're not depressed, don't say that" like that's, like, maybe a bit like saying that your issues aren't that bad." (Daniel)

"Em, you would just really speak to them, and they wouldn't offer advice. I did find that helpful at the time. Like just speaking through some of my issues. Um bit it didn't last very long. I think you were only allowed like 7 or 8 sessions." (Judith)

Judith's experiences demonstrated what was being described by other participants, that there was some therapeutic value in just talking to someone, but the length of appointments or sessions failed to achieve any kind of lasting therapeutic outcome, as they did not allow for any sort of deeper meaning into the participant's thoughts and feelings, nor did it offer long term support. The circularity of "questioning" did not allow for therapeutic alliance, with participants experiencing advice (both directed and undirected) as not shared mutually but done-to.

1.3 The effect of positive continuity of care and longer-term treatment

However, those participants who were randomised to 'The BRIDGE Project' (Gajwani et al., 2024) and received up to 16 sessions of Cognitive Analytic Therapy, focusing on BPD signs and symptoms, had a much more positive experience and were able to establish a good therapeutic relationship in a safe space, which had a greater impact on their overall wellbeing. As described by Isla, many participants spoke of being

asked questions that they had never been asked before, that there was a process of 'naming' the difficult feelings, and the process of understanding why they had learned to experience life as they had, which was at times overwhelming. Although the process was felt as overwhelming at times, it was seen as beneficial:

> *"I always, uh, it's one of the things, it's one of the reasons why BRIDGE helped me so much and why, um, even those meetings that were overwhelming were sweet because I always felt safe. Yeah. I was cared for compared to like, the care that I'd received before the dismissal [from other services]. Like, it was always so centred to me that it felt like the whole team was working for me".* (Isla)

> *"Talking about it with someone that was like nice and also like understood it a bit and also like wasn't sort of immediately like judging me for it, I think, kind of helped me. So, once I had that environment that I could talk about it and then I could learn more about it like by myself, I think, that made me like more comfortable with it in general.* (James)

> *"I mean it was quite, it was different from all the other experiences that I've had. And the other experiences I've had have either been really short; erm, I was seeing CAMHS for bit. It was maybe a six to eight weeks thing as well. And there was therapy and that was like 6 sessions. So that was about a month and a half. And then when I was seeing my psychologist when I was like 16, 17, that was just like prolonged care. It didn't really have a point. And, it also didn't really have an end. But then, with the BRIDGE project*

there was a target that we were reaching for like the 16 sessions or whatever it was. And then, I knew it was going to come to an end. It was long enough that we'd develop a really good relationship." (Melissa)

Isla, James, and Melissa all made strong comparisons between what had been different in their experience of participating in the study and indicating that a good therapeutic relationship is imperative to the success of the therapy but the only way this can be developed is through continuity of carer, the opportunity to make sense of their own difficult experiences without feeling judged, and a significant length of time in therapy. All participants seemed surprised to be offered up to 16 sessions with the same therapist. This was not experienced in other services.

2. Journey of finding/understanding self

2.1 Naming the unnameable

From the participants' accounts, it was clear that assigning someone with the label of having 'BPD' was avoided or at least approached cautiously by healthcare professionals. Although the BRIDGE Project (Gajwani et al., 2024) was not offering a diagnosis of BPD, all the participants were seeking support for their experiences of unmanageable distress, and although some participants had already received a diagnosis of BPD, their experience was not understanding "it" (i.e. the label and their own experiences of 'it"). However, participants spoke of their journey from receiving a diagnosis to self-acceptance as being tumultuous. Many found the concept of 'naming it' and attributing their symptoms to BPD a relief, and that it

offered a sense of understanding, but before reaching this stage, a voyage through self-blame and self-stigma was travelled.

> *"Erm, I get my diagnosis and I'm so, it sounds wrong, but I am really chuffed that this has a name. Cause I know there's this thing, erm, where doctors, and I understand it, to an extent."* (Isla)

> *"Erm, it was at that point that someone had brought up BPD. Er, it had never been mentioned before. Nothing about personality disorders had been brought up before. It was all just hormones and growing up and family problems and friendships problems and stuff and it was kinda like that could be an actual reason for anything. The doctor at the time wasn't too keen on it cause I was 17, erm but the more that I looked into it and the more that my psychiatrist discussed it with me, the more that I thought that that probably did fit for me, and it did affect me personally".* (Melissa)

> *"I don't really know how I dealt with it because it was just sort of like, it felt quite, like even though I had it before I got diagnosed, but actually having that label it was just like really weird and quite scary kinda."* (James)

In contrast, James felt quite scared on receiving a diagnosis.

> *"I need a name to it, like what I'm going through… And, just the whole time I was at CAMHS I really pushed really hard because I wanted a name to it. It*

was just, very, at least for me it's like really hard knowing what I'm dealing with knowing that I don't have a name to it." (Daniel)

Participants had very personal relationships with their diagnosis, however, the common theme of 'naming it' as source of reassurance could be identified through each interview. Whilst some participants experienced the label as confusing and "scary", others felt the opportunity to understand their experiences with someone, then helped in making connections with the label.

2.2 Lonely journey and the impact on relationship with self and others

Most participants expressed feelings of loneliness or chose to actively self-isolate due to lack of social and familial support. The lack of belonging was felt by most participants as adding to self-blame and shame, as illustrated below:

"I think, you can feel quite alone because you don't, like everyone thinks you're a bit mad". (James)

"I didn't have a lot of support from my family. They didn't really understand where I was coming from. I come from quite a big family; I've got six siblings and a single mum and it's quite difficult for them to understand why I was behaving the way I was or why I felt the way I was. So, erm, there was just kinda a lot of bickering and like blaming and stuff like that so I kinda kept to myself." (Melissa)

2.3: Self-stigma and that of the general population

Most participants welcomed a dialogue around a BPD diagnosis; however, this was not immediate, and it was evident that education around BPD was lacking or actively avoided within health care professionals and in the general population.

> *"I went home and kind of looked it up and it felt a bit like jarring, kind of because it was like, I think, a lot of like the rep about it, or at least what I was reading about it was quite intense and quite sort of going on a bit, how like hard it is to, like, how bad it can be or like, all that stuff or like it was all quite negative, like I just felt kind of like, oh, sh*t, like this is not good. Um, or like when I looked it up, like a lot of it was about like support for like living with someone that has it, instead of support for someone that actually has it, which was quite jarring as well, I guess, sort of like it gave the impression that, like people, they were going to need to have support to actually deal with me, because I was going to be like mental forever"* (James).

> *"That's kind of like where I got pi***d off reading about it, um, especially in like forms and stuff like that, like there were a lot of people just sort of complaining about like our partners and stuff like that, and I was like, 'oh no'. Um, but eventually, I don't read books, and my dad got a book about it, and I read that, and it was kind of helpful and I understood it a bit more but, I think, my main sort of thing was I really don't want, like, to be like this. It was good because some stuff made sense…I'd still sort of been carrying like this thing underneath me that I didn't want to talk about it because it felt like something wrong. Like, it just felt like this weird, like,*

like as I was saying, I feel like it's quite stigmatising, and not wanting to tell people about it, just wanted to like to pretend it wasn't going on." (James)

We can see from James' experience that his internalised self-stigma stemmed significantly from the information on BPD that is widely available to the general population. It felt like a weight, a burden to have this illness, and there was a sense of shame associated with having a BPD diagnosis. James repeatedly uses the word "jarring" when referring to his diagnosis, giving a sense of shock that he could be associated with an illness that significantly stigmatises the sufferers.

3. The impact of positive perceptions and treatment during The BRIDGE Project (Gajwani et al., 2024)

However, on coming to The BRIDGE Project, (Gajwani et al., 2024) all participants, including those who were randomised to 'services as usual' (SAU) highlighted the positive impact of naming the unnameable, on being asked questions with curiosity and openness, and how they were not to blame for their feelings and behaviours:

"*I think, I don't get mad at myself for being upset any more, I also don't like, I think it's, it's given me like, it's like a bit of stress, I think I'd call it, between something happening and the feeling I've got, like, maybe, like a couple of seconds now where like when something happens I've got that like opportunity in my head to sort of control how I respond to it*" (James)

> *"I mean I think any help in a sense is worthwhile. Erm, cause for at least there was a point that I took something back from it. Erm, so I think overall, there was helpful points within it even if I wasn't doing the actual therapy part of it. Erm, there was still, even just like doing the questionnaires and just like discussing things I think there was at least something I'd take back from it. So, I think that's still helpful for me anyways."* (Daniel)

> "*Erm, I was fine with it [SAU] because I knew that I was getting help from CAMHS as well so it was good to speak over things cause then I could sort of feedback what I'd written down and stuff from The BRIDGE Project*." (Leah)

It is evident that participants benefited from being treated as individuals with unique needs, that the label was part of the story telling and the process of shared meaning making was central to the entire project, which perhaps influenced alliance even before participants were allocated to intervention. Having someone ask the difficult questions, naming the difficult feelings, and having a voice in the process was described by the young people as helpful in coming to terms with their diagnosis of "it".

4. DISCUSSION

The aims of this study were to identify recurring themes in barriers to care and highlight missed opportunities for care. In the context of the feasibility RCT, the BRIDGE project (Gajwani et al., 2024) the study explored experiences of care journeys and service contact of young people with BPD features. Also, the study explored the process of what works for whom, where and when to understand the

interactions between services and young people who have longstanding unmet needs that are characteristic of BPD features. An IPA qualitative analysis was conducted. Three Group Experiential Themes (GETs) emerged in relation to their experiences of their care journey and contacts with services: These included 'Not being heard or validated', 'Journey of finding/understanding self' and 'The impact of positive perceptions and treatment during The BRIDGE Project' (Gajwani et al., 2024).

The journey through multiple care systems for the participants was overall, perceived to be negative. The young person's experiences identified a challenging journey with many barriers to effective care of signs and symptoms and/or diagnosis of BPD. A common recurring theme was that participants felt that they were not being treated as individuals and their unique needs were not being identified and considered by several health care providers, leaving them feeling futile, dismissed, and helpless. Although 83% of psychiatrists in Scotland (Foubister & Simpson, 2023) agreed that BPD was a valid diagnosis, it is evident that it is not being reflected in practice, and many opportunities for care and treatment are being missed. As there is a possible combination of 256 presentations of BPD (DSM-5, APA, 2013), this resistance in acknowledging BPD may reflect practitioners' low confidence levels in the field (Popadopoullos, et al., 2021, Sterna and Moskalewicz, 2023). Along with misassumptions around BPD particularly in young people then leads to avoidance of assessing and intervening earlier on (Sharp, et al., 2017). This then begs the question of what is at the root of this resistance? Given structural stigma (Lam et al., 2016; Lam et al., 2016) and that of the general population that was apparent in this study, it suggests that there are educational, and training needs necessary in mental health services around BPD knowledge and treatment. It is, therefore, imperative to conduct studies from the perspectives of mental health professionals to allow for

reflection to identify training needs (Ng et al., 2016; Day et al., 2018; Hedemann et al., 2023). Collaboration with service users would also be highly beneficial (Acres et al., 2019; Miller et al., 2024). The current situation is leading to service users disengaging with their treatment and being left with feelings of hopelessness due to being passed from pillar to post in terms of accessing services, and their needs being missed or dismissed. All of these creating services feeling overwhelmed and burnt out (Linehan et al., 2000) and young people feeling dismissed, as described by participants in this study.

Compounding this, was the lack of continuity of care throughout their journey which often meant good therapeutic relationships were lacking, impacting disengagement with services, thus adding to drop out from treatment rates (Camabis 2012; Lau et al., 2024). Participants described very short treatment programmes and a revolving door of practitioners throughout their care as very unhelpful. The findings reinforce existing evidence of the difficulty of achieving a smooth transition from Child to Adult services for young people that present with experiences akin to personality disorders (Singh et al., 2023). This poor continuity of care, management of passage and lack of collaboration (Viksveen et al., 2022) can have serious consequences for individuals seeking care at a crucial time in their development. Feeling dismissed and isolated by services and family members alike, left participants with feeling that no one wanted to be part of their journey. Crucially, several participants spoke of “never being asked these questions before”, thus adding to missed opportunities for appropriate and effective care. This also equates to practitioners missing out on learning experiences which would enable them to better understand BPD and the unique needs of the individual (Toews et al., 2024)

which would be useful for continued professional development and could influence and improve the practices of their colleagues.

A recurring theme that emerged in participant's narratives were related to their own journey of finding/understanding the self, particularly in naming BPD as a diagnosis. As outlined, not acknowledging the signs and symptoms of BPD can have a negative impact on treatment, relationships with others and self-identity (Biskin & Paris, 2012; Sterna & Moskalewicz, 2023). Participants identified a sense of relief when they could put a name to what they had been experiencing for a long time as distressing and confusing. However, recognising experiences that were akin BPD was mostly described as a sense of relief, but that was not immediate, due to stigma and discrimination around the label, structural and internalised by the participants. Once more, this highlights the influence of stigma and shame associated with BPD and the need for education, treatment, and understanding of the condition at an early stage (Allison et al., 2022). The need for early identification and treatment of the signs and symptoms of BPD is imperative to a successful and less harmful journey through mental healthcare (Bozzatello, et al., 2019).

The third theme highlights the importance and significance of breaking down barriers to care and improving young people's experience of accessing services. In taking part in 'The BRIDGE Project' (Gajwani et al., 2024), participants expressed that they were given the time and space to explore their individual needs, and this increased their engagement with The BRIDGE Project (Gajwani et al., 2024). Participants also described space for therapeutic relationships to be established, and simply having one's needs heard allowed for positive outcomes, including for those who were randomised to SAU.

Interestingly, those who had been randomised to services as usual, which for some could be no services at all, found that having a safe space and time with the researchers on The BRIDGE Project and, this current study, to answer questions that they had never been asked before, that this was very helpful in their recovery journeys.

Limitations and strengths

The study was not without its limitations. There are several methodological considerations for this study; first the use of IPA when analysing participant data for the study. With the aim of double hermeneutics of IPA, that is the researcher understanding the participant's understanding of their experience, participant group sizes tend to be small and homogenous (Larkin, Shaw & Flowers, 2019; Smith et al., 2021) i.e. this particular study used 7 participants, all from a feasibility RCT examining a brief intervention for BPD features. While IPA provides an in -depth and richer interpretation of individual and group experiences, it does limit how much of the findings can be applied to a heterogenous group of young people with BPD features. Often, participants are selected because they have experienced the phenomenon being explored (Creswell & Poth, 2023).

The individuals in this study had previously been participants in 'The BRIDGE Project' (Gajwani et al. 2024). Recruitment for this study was mainly self-referral through social media and advertising in health care and education settings. This may infer that there was self-selection bias, however, there was clear inclusion and exclusion criteria, and each participant had been screened with robust and reliable measures such as the SCID-II by trained researchers. This could be seen as a positive for recruitment of this study (chapter 5) because participants were already agreeable to sharing their experiences and had been through a vigorous screening

process prior to taking part. Further, they were already familiar with the researcher who had worked on 'The BRIDGE Project' (Gajwani et al., 2024). As they had taken part in The BRIDGE Project (Gajwani et al., 2024), there is the potential for the participants to already be primed, in a sense, to talk and use the language that the researchers used during The BRIDGE Project (Gajwani et al., 2024) which may influence the way they answer questions in the semi-structured interview. It may not necessarily reflect their experience but how they heard it presented to them in the questions asked in the fRCT, thus having an impact on the conclusions made by the researcher. However, IPA steps (Smith et al., 2009) were followed by the researcher for the validity and robustness of the study enquiry. Further, evidence of the participants ability to articulate their experiences was clear and evidence throughout the study. All participants in the sub-study (i.e. qualitative interview about their participation) showed a willingness to offer reflection and express experiences of their journeys through the mental health system. As supported by Cudjoe (2022), researcher gave the participants in a semi- structured way thus offering the space for them to talk openly and take the interview in the direction that they felt comfortable and appropriate. The semi-structured format provided participants with flexibility to direct the discussion towards experiences they consider as important; however, the interviewers choice of questions and prompts may nevertheless have shaped the accounts produced. These methodological considerations do not negate the findings, but they do require the findings to be interpretated cautiously. In particular, the findings should be understood as an interpretation of the experiences of a small, self-selected group of participants who had previously engaged in the BRIDGE Project (Gajwani et al., 2024) rather than as representative of the experiences of people with BPD more broadly. Previous

participation in the BRIDGE Project (Gajwani et al., 2024) may have influenced how participants conceptualised and described their experiences. Furthermore, because IPA involves an interpretative process in which the researcher makes sense of the participants' accounts, the themes and conclusions cannot be considered entirely independent of the researcher's position and analytic decisions. The findings, therefore, provide an in-depth account of particular experiences rather than definitive evidence about the experiences of people with BPD generally.

Further, the study looked entirely at young people's experiences of care journeys; it did not take into consideration the views and experiences of carers and parents, nor were the opinions of the recurring themes explored with health care workers who may have been able to shed light on why certain processes in the services and experiences were negative. With the view that this would be useful, the BRIDGE project is also conducting process evaluation of the context to get a wider perspective of family members and service providers. In addition to this, the demographics were restricted to a city in Scotland which may not be a fair reflection of all services in UK or globally, for those presenting with BPD signs and symptoms; however, other existing studies have shown light on similar themes when conducted globally (Broadbear, et al., 2025; Webb, et al., 2023). It may also be those participants from marginalised background, who did not have access to the study participation were unable to have their experiences shared. however, this is the first community-based study (i.e. including young people who may not be known to any service) that recruited from a wide range of referral sources, including self-referrals. As statement of researcher positioning, it is also important to note that the first author has a BPD diagnosis and negative experiences in their journey through mental health care (McAllister, 2023) may have influenced the

interpretation of findings. Although this was explored with supervisors and the researcher had a strong awareness of this potential and carried out the research through a careful process of IPA.

However, using qualitative narratives to examine the unique needs and barriers to care for the participants allowed for a rich and insightful understanding of the journeys experienced and gave a voice to the numbers of the quantitative data already available. It also afforded the opportunity for the participants to debrief following their experience through mental health care. As mentioned in the interviews, participants, unexpectedly, found being able to talk to someone whether it was the researcher or the therapist on The BRIDGE Project (Gajwani et al., 2024) was highly useful in terms of being heard and sharing their experiences, thoughts, and feelings, therefore, the study may have been cathartic for some.

Future research directions

The results are, therefore, highly significant in the understanding of barriers to care and why young people with signs and symptoms of BPD are having negative experiences with mental health care and are being missed by services. It also highlights patient's perceptions of good relational assessment and care as efficacious in the treatment of BPD. The participants' qualitative data indicates that future research would do well to focus on areas such as the barriers to implementation of early intervention for young people presenting with BPD features, including the role of dis/continuity of care on an appropriate timescale and adequate developmentally sensitive periods for BPD assessments and interventions to be effective. Further, research is needed in supporting transition of care from child to adult services, looking at the needs of patients, carers, and health care professionals.

Conclusion

The qualitative data analysis of this study reinforced the existing evidence of barriers and negative journeys through mental health care, highlighting missed opportunities for care, whilst offering a new insight into missed opportunities and experiences of young people who may be ‘hidden’ or excluded by services. The positive impact of taking part in a clinical trial of early intervention, ‘The BRIDGE Project’ was identified with participants' needs of being heard and validated being met regardless of whether they were part of SAU or the therapy group. A safe space with individualised care was identified as being one of the most important facilitators of care. A high level of stigma and discrimination in BPD is apparent, significantly increasing barriers to treatment through preventing early intervention, and contribution to the development of poor therapeutic relationships and delayed or missed treatment (Iliakis et al., 2019). Education and collaboration for tackling these barriers is imperative to improve individual and systemic therapeutic journeys through mental health services.

References

Cambanis, E. V. (2012). Treating borderline personality disorder as a trainee psychologist: Issues of resistance, inexperience, and countertransference. *Journal of Child and Adolescent Mental Health, 24*(1), 99–109. doi:10.2989/17280583.2011.639075

Chanen, A. M. (2015). Borderline personality disorder in young people: Are we there yet. *Journal of Clinical Psychology, 71*(8), 778–791. doi:10.1002/jclp.22205

Chanen, A. M., Nicol, K., Betts, J. K., & Thompson, K. N. (2020). Diagnosis and treatment of borderline personality disorder in young people. *Current Psychiatry Reports, 22*(5), 25–25. doi:10.1007/s11920-020-01144-5Creswell, J. W., & Poth, C. N. (2023). *Qualitative inquiry and research design: Choosing among five approaches* (Fifth ed.). SAGE Publications, Inc. (US).

Cudjoe, E. (2022). Using diaries with interpretative phenomenological analysis: Guidelines from a study of children whose parents have mental illness. *International Journal of Qualitative Methods*, *21*, 16094069221084435.

Day, N. J. S., Hunt, A., Cortisjones, L., & Grenyer, B. F. (2018). Clinician attitudes towards borderline personality disorder: A 15year comparison. *Personality and Mental Health, 12*(4), 309–320. doi:10.1002/pmh.1429

Fok, M. L. Y., Stewart, R., Hayes, R. D., & Moran, P. (2014). Predictors of natural and unnatural mortality among patients with personality disorder: Evidence from a large UK case register. *PloS One, 9*(7)

Foubister, L., & Simpson, S. (2023). CAMHS clinician attitudes to borderline personality disorder in adolescence across Scotland. *The Journal of Nervous and Mental Disease, 211*(9), 664–669. doi:10.1097/nmd.0000000000001684

Furnham, A., & Dadabhoy, H. (2012). Beliefs about causes, behavioural manifestations and treatment of borderline personality disorder in a community sample. *Psychiatry Research, 197*(3), 307–313. doi:10.1016/j.psychres.2011.12.024

Gajwani, R., Sim, F., McAllister, K., Smith, H., Mcintosh, E., Moran, P., . . . Minnis, H. (2024). The BRIDGE project: A feasibility randomised controlled trial of brief, intensive assessment, and integrated formulation for young people (age 14-24) with features of borderline personality disorder (protocol). *Frontiers in Psychiatry, 15* doi:10.3389/fpsyt.2024.1389578

Greenfield, B., Henry, M., Lis, E., Slatkoff, J., Guilé, J. M., Dougherty, G., . . . F. (2015). Correlates, stability and predictors of borderline personality disorder among previously suicidal youth. *European Child &Amp; Adolescent Psychiatry, 24*, 397–406.

Hartley, S., Baker, C., Birtwhistle, M., Burgess, J. L., Chatburn, E., Cobbaert, L., . . . Timoclea, R. (2022). Commentary: Bringing together lived experience, clinical and research expertise -a commentary on the May 2022 debate (should CAMH professionals be diagnosing personality disorder in adolescence? *Child and Adolescent Mental Health, 27*(3), 246–249. doi:10.1111/camh.12586

Hedemann, T. L., Asif, M., Aslam, H., Maqsood, A., Bukhsh, A., Kiran, T., . . . Husain, M. O. (2023). Clinicians', patients' and carers' perspectives on borderline personality disorder in Pakistan: A mixed methods study protocol. *PloS One, 18*(6), 286459. doi:10.1371/journal.pone.0286459

Holloway, I., & Todres, L. (2003). The status of method: Flexibility, consistency and coherence. *Qualitative Research, 3*(3), 345–357.

Iliakis, E. A., Sonley, A. K. I., Ilagan, G. S., & Choi-Kain, L. W. (2019). *Treatment of borderline personality disorder: Is supply adequate to meet public health needs? psychiatric services* doi:10.1176/appi.ps.201900073

Jørgensen, M. S., Møller, L., Bo, S., Kongerslev, M., Hastrup, L. H., Chanen, A., . . . Simonsen, E. (2024). The course of borderline personality disorder from adolescence to early adulthood: A 5-year follow-up study. *Comprehensive Psychiatry, 132*, 152478–152478. doi:10.1016/j.comppsych.2024.152478

Lam, D. C. K., Poplavskaya, E. V., Salkovskis, P. M., Hogg, L. I., & Panting, H. (2016). An experimental investigation of the impact of personality disorder diagnosis on clinicians: Can we see past the borderline? *Behavioural and Cognitive Psychotherapy, 44*(3), 361–373. doi:10.1017/s1352465815000351

Lam, D. C. K., Salkovskis, P. M., & Hogg, L. I. (2016). 'Judging a book by its cover': An experimental study of the negative impact of a diagnosis of borderline personality disorder on clinicians' judgements of uncomplicated panic disorder. *British Journal of Clinical Psychology, 55*(3), 253–268. doi:10.1111/bjc.12093

Larkin, M., Shaw, R., & Flowers, P. (2019). Multiperspectival designs and processes in interpretative phenomenological analysis research. *Qualitative Research in Psychology, 16*(2), 182-198. https://doi.org/10.1080/14780887.2018.1540655

Lau, P., Amestoy, M. E., Roth, M., & Monson, C. (2024). Patient related factors associated with patient retention and noncompletion in psychosocial treatment of borderline personality disorder: A systematic review. *Personality and Mental Health, 18*(4), 300–322. doi:10.1002/pmh.1627

Laurenssen, E. M. P., Hutsebaut, J., Feenstra, D. J., Van Busschbach, J. J., & Luyten, P. (2013). Diagnosis of personality disorders in adolescents: A study among psychologists. *Child and Adolescent Psychiatry and Mental Health, 7*, 1–4.

Linehan, M. M., Cochran, B. N., Mar, C. M., Levensky, E. R., & Comtois, K. A. (2000). Therapeutic burnout among borderline personality disordered clients and their therapists: Development

and evaluation of two adaptations of the Maslach burnout inventory. *Cognitive and Behavioral Practice, 7*(3), 329–337.

Lohman, M. C., Whiteman, K. L., Yeomans, F. E., Cherico, S. A., & Christ, W. R. (2017). Qualitative analysis of resources and barriers related to treatment of borderline personality disorder in the United States. *Psychiatric Services, 68*(2), 167–172.

McAllister, K. M. (2023). Through the valley of the shadow of death. journey through major mental illness as experienced by a mental health PhD candidate. *Journal of Psychiatric Practice, 29*(3) doi:10.1097/pra.0000000000000705

Miller, J., Nguyen, E., Lam, A. Y. H., Brann, P., Innes, S., Buntine, P., . . . Hope, J. (2024). Experiences of consumers, carers and clinicians during borderline personality disorder presentations to the emergency department-an integrative review. *Journal of Psychiatric and Mental Health Nursing, 31*(4), 572–582. doi:10.1111/jpm.13009

Navarre, K. M. (2025). You sure she's not making this up?": A qualitative investigation of stigma toward adults with borderline personality disorder in physical healthcare settings. *Personality and Mental Health, 19*(1) doi:10.1002/pmh.1646

Newton-Howes, G., Mulder, R., & Tyrer, P. (2015). Diagnostic neglect: The potential impact of losing a separate axis for personality disorder. *British Journal of Psychiatry, 206*(5), 355–356. doi:10.1192/bjp.bp.114.155259

Ng, F. Y. Y., Bourke, M. E., & Grenyer, B. F. S. (2016). Recovery from borderline personality disorder: A systematic review of the perspectives of consumers, clinicians, family and carers. *PloS One, 11*(8), 160515. doi:10.1371/journal.pone.0160515

Papadopoullos, R., Fisher, P., Leddy, A., Maxwell, S., & Hodgekins, J. (2022). Diagnosis and dilemma: Clinician experiences of the use of 'borderline personality disorder' diagnosis in children and adolescents. *Personality and Mental Health, 16*(4), 300–308. doi:10.1002/pmh.1541

Peytrignet, S., & Grimm, F. (2022). Children and young people's mental health in england, Scotland and Wales -case studies using linked data from the networked data lab. *International Journal of Population Data Science, 7*(3) doi:10.23889/ijpds.v7i3.1866

Robinson, C., & Williams, H. (2024). Interpretative Phenomenological Analysis: Learnings from Employing IPA as a Qualitative Methodology in Educational Research. The Qualitative Report, 29(4), 939+. http://dx.doi.org.ezproxy1.lib.gla.ac.uk/10.46743/2160-3715/2024.6487

Sharp, C., & Trull, T. J. (2017). *Emotion dysregulation in adolescents with borderline personality disorder. emotion regulation and psychopathology in children and adolescents*

Singh, C. K., & Dudi, J. (2023). Review on the effects of borderline personality disorder on human life. *Indian Journal of Health and Wellbeing, 14*(2), 265–270.

Skabeikyte, G., & Barkauskiene, R. (2021). A systematic review of the factors associated with the course of borderline personality disorder symptoms in adolescence. *Borderline Personality Disorder and Emotion Dysregulation, 8*(1), 12–12. doi:10.1186/s40479-021-00151-zsmith

Smith, J. A., Larkin, M., & Flowers, P. (2021). Interpretative phenomenological analysis: Theory, method and research.

Smith, J. A., Flowers, P., & Larkin, M. (2022). *Interpretative phenomenological analysis: Theory, method and research* (2nd Core new ed.). SAGE Publications Ltd.

Sterna, A., & Moskalewicz, M. (2023). As if there are two of us": The battle of borderline personality disorder diagnosis in lived time. *Psychopathology, 56*(4), 239–250. doi:10.1159/000527028

Stiles, C., Batchelor, R., Gumley, A., & Gajwani, R. (2023). Experiences of stigma and discrimination in borderline personality disorder: A systematic review and qualitative metasynthesis. *Journal of Personality Disorders, 37*(2), 177–194.

Strike, C., Rhodes, A. E., Bergmans, Y., & Links, P. (2006). Fragmented pathways to care: The experiences of suicidal men. *Crisis, 27*(1), 31–38.

Toews, A. J., Letourneau, N., Pohl, C., & Ruse, K. (2024). Effective strategies and interventions for engaging at-risk youth: A rapid systematic review of the literature. *Discover Psychology, 4*(1), 34–54. doi:10.1007/s44202-024-00147-0

Tusiani-Eng, P., & Yeomans, F. (2018). Borderline personality disorder: Barriers to borderline personality disorder treatment and opportunities for advocacy. *The Psychiatric Clinics of North America, 41*(4) doi:10.1016/j.psc.2018.07.006

Untitled *Psychiatry,* , 1–12.

Viksveen, P., Bjønness, S. E., Cardenas, N. E., Game, J. R., Berg, S. H., Salamonsen, A., . . . Aase, K. (2022). User involvement in adolescents' mental healthcare: A systematic review. *European Child &Amp; Adolescent Psychiatry, 31*(11), 1765–1788. doi:10.1007/s00787-021-01818-2

Wall, K., Kerr, S., & Sharp, C. (2021). *Barriers to care for adolescents with borderline personality disorder. current opinion in psychology*doi:10.1016/j.copsyc.2020.07.028

Webb, B., Looi, J. C., Allison, S., Nance, M., Dhillon, R., & Bastiampillai, T. (2023). A proposed clinical pathway for the patients with borderline personality disorder presenting to emergency departments. *Australasian Psychiatry, 31*(4), 458–462.

Winsper, C. (2021). *Borderline personality disorder: Course and outcomes across the lifespan. current opinion in psychology*

Zimmerman, M. (2015). Borderline personality disorder: A disorder in search of advocacy. *The Journal of Nervous and Mental Disease, 203*(1), 8–12.

Reflections on chapter 5

- Young people with features of borderline personality disorder have complex journeys when accessing mental health care. We can see that individuals have unique journeys yet share similarities in barriers to care. For example, as there are 256 possible BPD presentations, the young people in this study experienced a lack of personalisation of individual care needs. The therapeutic relationship was lacking; misdiagnosis and inappropriate psychopharmacology were common and unnecessarily protracted pathways to care were endured.

- The qualitative methodology was highly effective in drawing out the barriers and facilitators to helpful pathways to care for those with BPD features. It drew out the voices of those experts by experience allowing for in-depth analysis complimenting the quantitative data (Hermens et al., 2011) already available whilst paving the way for future research to draw upon the findings.

- Although BPD is considered a valid diagnosis by 83% of psychiatrists in Scotland (Foubister & Simpson, 2023), it is clear from the study that opportunities for effective and timely care are being missed. This was owing to lack of training and education in BPD for health professionals and the presence of stigma surrounding BPD. There is a significant lack of collaboration between health care providers, patients and carers and other stakeholders which limits opportunities for increased understanding, the breaking down of structural stigma, and a better care journey experience for those with BPD features.

- Considering these findings, and that of the previous chapters, it was felt that further exploration of stigma in BPD was necessary to highlight the issue and explore ways of tackling both self-stigma in young people and structural stigma through patient-clinician collaboration. Chapter 6 offers a clinical reflection of stigma in BPD.

References

Foubister, L., & Simpson, S. (2023). CAMHS clinician attitudes to borderline personality disorder in adolescence across Scotland. *The Journal of Nervous and Mental Disease, 211*(9), 664–669. doi:10.1097/NMD.0000000000001684

Hermens, M. L. M., van Splunteren, P. T., van den Bosch, A., & Verheul, R. (2011). Barriers to implementing the clinical guideline on borderline personality disorder in the Netherlands. *Psychiatric Services (Washington, D.C.), 62*(11), 1381–1383. doi:10.1176/ps.62.11.pss6211_1381

Chapter 6
Stigma

- Published (The British Journal of Psychiatry: Advances)

Collins, K. M., Minnis, H., & Gajwani, R. (2025). Using clinician–patient collaboration to tackle structural stigma and age discrimination in borderline personality disorder. *BJPsych Advances*, 1-3. https://doi.org/10.1192/bja.2025.10140

Kirsty Margaret Collins, Helen Minnis & Ruchika Gajwani

1.1 SUMMARY

In this clinical reflection, we report on stigma and ageism and their impact on those experiencing signs and symptoms of borderline personality disorder (BPD). We highlight the need for increased collaboration between those with lived experience of the disorder and healthcare providers. This is an important issue in BPD as the impact of structural stigma is significantly affecting the quality of life and short- and long-term trajectories of those with BPD, especially during adolescence.

KEYWORDS

Personality disorders; stigma and discrimination; child and adolescent psychiatry; collaboration; structural stigma.

1.2. Understanding stigma first-hand

'With experience of receiving a borderline personality disorder (BPD) diagnosis at age 32, I am familiar with the impact of late diagnosis and experiences of stigma and discrimination. During a long journey to my referral being accepted by services, none of the many general

practitioners, psychiatrists, and mental health nurses I encountered even considered BPD. Only when my long- term psychiatrist left and I was able to fully discuss my feelings, behaviours and emotions with a locum psychiatrist was a BPD diagnosis agreed, following my suggestion. Yet stigma continued: I read books on BPD that finished with a warning about avoiding individuals with BPD. Treatment began and, fortunately, this opened doors in the form of dialectical behaviour therapy (DBT), psychotherapy and changes in my psychopharmacology, resulting in my journey to recovery (McAllister, 2023).

It is clear from my experiences as both a mental health researcher and an individual with BPD that it was meaningful collaboration with a healthcare provider that led to my diagnosis. Although I had years of unnecessary suffering, I consider myself fortunate to have benefitted from my diagnosis. For many individuals this is not the case: many, especially young people, are met with the same barriers, stigma, and discrimination that I experienced in the early days of my journey to diagnosis. This is a result of lack of education in both the general population and health professionals and of poor collaboration between mental health services and patients.'

(Kirsty Collins, an expert by experience researcher)

Stigma has four parts (Link 2001): first, individual differences are identified and labelled; second, these differences are considered negative by society; third, labelled individuals or groups are considered different; finally, these individuals or groups experience significant status loss (in areas such as opportunity) and discrimination.

Self-stigmatisation and structural stigma in BPD

Significant stigma is associated with borderline personality disorder (BPD). In the

general population, the negative perceptions associated with those with a diagnosis of BPD often manifest in labels such as 'attention-seeking', manipulative' and 'untreatable': these labels lead to self-stigmatisation, social exclusion and deterioration of symptoms and they form barriers to appropriate care and treatment.

Stigma and discrimination can also come from 'structural stigma', i.e. policy and practices that disadvantage specific groups in the population. This can occur in areas such as healthcare, employment, education, and culture. Therefore, implementation of practices and delivery of services can reinforce stigma and discrimination, with structural stigma woven into the fabric of care in health systems. This is particularly evident in BPD compared with other mental illnesses. A qualitative study (van Schie 2024) explored the language used around BPD both within and outside of healthcare settings and the impact that it had on patients and their carers. All participants disclosed experience of stigmatising language, including 'psycho' and 'can't be helped'. Further, behaviours that invalidate the individual's needs, such as being ignored or given generic advice of how to manage their signs and symptoms of BPD, were identified. Appropriate assessment and treatment, if administered contemporaneously, could potentially save lives and improve long-term outcomes.

Some argue that BPD as a diagnostic construct is invalid and unnecessary, and that the associated pejorative connotations potentially cause further harm and negatively affect the development of appropriate treatment. Others argue that BPD should be named and treated as early as possible. Yet, clinicians are often less likely to engage in an encouraging manner with those with a BPD diagnosis,

which can result in imposing lengthy hospital stays or, conversely, avoiding treating those with BPD altogether.

Late diagnosis and perpetuation of stigma in BPD

Stigma and discrimination play major roles in early diagnosis of BPD, or lack thereof, perpetuating the cycle of negativity. A systematic review and qualitative meta-synthesis (Stiles, 2023) found resistance on the part of clinicians, such as withholding information, to be a key theme.

National Institute for Health and Care Excellence (NICE) guidelines highlight that BPD is often not diagnosed nor treated until the age of 18 (NICE, 2009), but research has identified that symptoms can present much earlier (Newton-Howes 2015; Chanen 2020). BPD is common in young people, with an estimated prevalence of 1–3% in the community, 11–22% in psychiatric out-patients and 33–49% in in-patients (Chanen 2017). Yet, clinicians are hesitant to diagnose BPD in adolescents. Given the strong associations between early developmental and childhood attachment styles, adverse childhood experiences (ACEs), potential genetic influences, psychosocial factors and familial impact outlined in BPD theories, it would seem pertinent to intervene early. However, only in the past two decades has the potential of a diagnosis in adolescents been recognised.

BPD or typical teenage trajectory?

Clinicians and the general population argue that BPD can be misdiagnosed in adolescence, as symptoms can emulate expected developmental processes such as mood changes due to organic hormonal fluctuations, thus incorrectly labelling a

young person with a complex illness. DSM-5 criteria stipulate those symptoms be pervasive, have lasted for at least 1 year and have a significant impact on functioning (American Psychiatric Association 2013). Often, these criteria are ignored. Misconceptions regarding BPD and a gap in knowledge add to the possibility that interactions with healthcare systems will cause harm to some of the most vulnerable. This perpetuates the problem; giving an incorrect diagnosis or brushing off chronic symptoms as 'normal teen angst' can be very damaging and forms a barrier between the young person and service providers. Individualised assessment and treatment of BPD are imperative to achieve good clinical outcomes, and therefore tackling stigma and discrimination is essential.

Age-related discrimination

Adolescents experience significantly more stigma than adults when it comes to mental illness; further, adolescents with BPD experience an even higher level of stigma. A qualitative study (Tedesco 2024) of individuals with BPD focusing specifically on illness onset and experience of diagnosis and treatment highlighted that the mean age at diagnosis was 30.2 years, yet 85% of participants felt that a diagnosis in adolescence would have been beneficial; only 27% felt well supported when receiving the diagnosis, indicating that a diagnosis did not necessarily open many doors in terms of appropriate treatment. Another qualitative study explored how clinicians perceive and use the BPD diagnosis in child and adolescent mental health services (CAMHS) in England (Papadopoullos, 2022). The overall reflections of the 13 participating clinicians revealed unease in terms of working with BPD patients and giving a diagnosis.

Practical suggestions for including patients' experience in clinical practice

Evidently, much more research is required into the nature and phenomenology of stigma and discrimination in BPD. There is scope here for all to work towards tackling and reducing the associated negative connotations, thus supporting individuals to seek care and receive bespoke treatment plans.

Qualitative research, particularly focusing on people with lived experience of BPD, could better inform, educate and influence training for mental health professionals, allowing for a better therapeutic relationship to be formed. Collaboration between experts by experience and clinicians is imperative in all areas, including research design, to achieve a better understanding of the impact of structural stigma on opportunities for those with BPD and where use of language can be reviewed. Conversations, active listening and more engagement with patients would allow researchers and clinicians to build meaningful, therapeutic relationships and enhance their knowledge and understanding of BPD and how it manifests in unique ways. Further, collaboration with third sector organisations might create a bridge to connect in non-confrontational ways, since a neutral party can encourage sensitivity and anti-stigma behaviours.

DSM-5 (American Psychiatric Association, 2013) and ICD-11 (World Health Organization, 2019)introduced improvements to their diagnostic frameworks that allow for the person behind the diagnosis to be considered rather than a label more closely related to disease, thus appearing more empathetic and in turn attempting to reduce stigma.

It is clear that collaboration is needed in tackling structural stigma and improving chances and outcomes. Such collaboration could reduce the suffering of many young people with BPD from an earlier stage in their diagnosis.

References

ICD-11: International classification of diseases 11th revision (2019). WHO.

McAllister, K. (2023). Through the valley of the shadow of death. journey through major mental illness as experienced by a mental health PhD candidate. doi:10.1097/PRA.0000000000000705

Newton-Howes, G., Clark, L. A., & Chanen, A. (2015). Personality disorder across the life course. *The Lancet, 385*(9969), 727–734.

Papadopoullos, R., Fisher, P., & Leddy, A. (2022). Diagnosis and dilemma: Clinician experiences of the use of 'borderline personality disorder' diagnosis in children and adolescents. *Personality and Mental Health, 16*, 300–308.

Stiles, C., Batchelor, R., & Gumley, A. (2023). Experiences of stigma and discrimination in borderline personality disorder: A systematic review and qualitative meta-synthesis. *Journal of Personality Disorders, 37*, 177–194.

Tedesco, V., Day, N., & Lucas, S. (2024). Diagnosing borderline personality disorder: Reports and recommendations from people with lived experience. *Personality and Mental Health, 18*, 107–121.

Van Schie, C., Matthews, E. L., & Marceau, E. M. (2024). Affective and neural mechanisms of how identity dysfunction in borderline personality disorder may interfere with building positive relationships. *Personality Disorders: Theory, Research, and Treatment, 16*, 122–136.

Reflections on chapter 6

- A clinical reflection on stigma and ageism was long overdue owing to the lack of early intervention (Kaess & Cavelti, 2025) in BPD in adolescents. Throughout this PhD both self-stigma and potential structural stigma in the context of BPD features prominently. This indicates that a deeper exploration was necessary. Conclusions from the reflection found that all forms of stigma in relation to age and that of clinicians and the general population is having a significant impact on the short and long-term trajectories of those with BPD features, particularly in adolescence.

- The evidence in this clinical reflection supported the previous papers in this thesis; The reported studies and lived experience paper (chapters 3, 4 and 5) highlight areas such as pejorative language, limited access to appropriate and timely care, and clinicians' passive attitudes (Navarre, 2025; Ring & Lawn, 2025) towards individuals with BPD features are still highly prevalent challenges in BPD in adolescence.

- This reflection highlights the profound lack of collaboration between patients and clinicians and the lack of attempts to challenge this stigma associated with BPD, thus perpetuating stigma and the ill effects it has on treatment and recovery.

- Using a clinical reflection to explore this was useful for several reasons: first, it afforded the opportunity to explore the literature already available and to identify pre-existing patterns, further, the clinical reflection allowed for comparison between current day issues with BPD stigma with those of the past allowing for judgement of any change or improvement. Second, a wide range of literature and data was available thus no empirical study was required. Third, it affords the opportunity to set the basis for future research aims, for example, identifying the issues around stigma i.e. language, rather than stigma as an overall concept.

- Finally, this is a highly pertinent piece to include in this thesis given the strong theme of stigma throughout and lends weight to the findings of the literature review and chapters 3, 4 and 5. The reflections in this paper identify a strong undercurrent to the reasons pathways to care in BPD are complex and challenging and pave the way for a breakthrough in tackling this.

Now follows a discussion on this thesis which will combine the aims of this thesis with the findings and reflections of the papers and reach conclusions over the complexity of pathways to care in adolescence.

References

Kaess, M., & Cavelti, M. (2025). Research review: What we have learned about early detection and intervention of borderline personality disorder. *Journal of Child Psychology and Psychiatry, 66*(12), 1829–1848. doi:10.1111/jcpp.70011

Navarre, K. M. (2025). “You sure she's not making this up?”: A qualitative investigation of stigma toward adults with borderline personality disorder in physical healthcare settings. *Personality and Mental Health, 19*(1), e1646–n/a. doi:10.1002/pmh.1646

Ring, D., & Lawn, S. (2025). 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 (Abingdon, England), 34*(1), 57–77. doi:10.1080/09638237.2019.1581

Chapter 7

Discussion

7.1. Overview

The aim of this thesis was to explore developmental pathways, and barriers and facilitators to early intervention in Borderline Personality Disorder (BPD), with particular focus on adolescence, as well as a preliminary exploration of an assessment/intervention approach that took these aspects into consideration. The work was conducted through consideration of research questions, which led to decisions about design and appropriate methodologies. The specific aims were explored in 2 empirical papers (chapters 4 & 5), a critical review (chapter 6) and a lived experience opinion peer-reviewed article (chapter 3); first, to highlight the importance of co-design informed through lived experience of BPD into research and treatment; second, to explore pathways for early borderline personality disorder taking neurodivergence into consideration using case studies; third, using IPA to investigate the journeys through mental health care of young people experiencing signs and symptoms of BPD in order to highlight barriers and facilitators to care, with a fourth paper offering a clinical reflection of stigma in BPD which was a strong, controversial topic throughout this thesis.

In Chapter 3, the aim of the paper was to consider the researcher's own lived experience of their journey through the mental health system in Scotland to recovery and functioning with a diagnosis of BPD, with the view of contributing to The BRIDGE Project (Gajwani, et al., 2024) fRCT. The major findings highlight how a collaborative relationship between those with BPD and health care providers is imperative to a successful therapeutic journey; individuals with BPD features should be actively partnered and collaborated with and have meaningful contributions in

their treatment plans. Further, good therapeutic relationships need to be established for treatment and support be beneficial.

Chapter 3 reinforced the need for lived experience collaboration in the design of the fRCT; in the main, areas including ethics and practicalities were considered and measures such as that of the individuals' functioning were explored. Measuring participant functioning in the fRCT helped to establish whether the intervention had an impact on their wellbeing rather than only the feasibility of the study. Ethics could be explored more closely given the vulnerability of the participants; the lived experience paper (chapter 3) highlighted how burdensome the process of seeking help for BPD can be; this could be accounted for in the fRCT as ethical implications were more deeply explored, in turn, informing the potential for a full RCT. For example, safeguarding measures were put in place, and all researchers were fully informed of how to manage situations if the participant became distressed but also how to minimise them becoming distressed in the first instance. This was achieved by identifying, with the lived experience author/researcher, what areas and measures had the potential for triggering anything distressing.

In Chapter 4, we examined four case studies of young people with both BPD features and neurodivergence, purposively selected from a larger study (Pathways Study, Gajwani et al., 2022) which outlined pathways to care in mental health services in young people aged 15-25. Findings from the case studies suggest the importance of early intervention as numerous opportunities for care during childhood and early adolescence were missed by staff across different service sectors, such as GPs, social workers, school pastoral care, and other healthcare professionals. The case studies in chapter 4 highlighted that adolescents and young

adults were either presenting to services in a state of crisis or too late, which could be avoided if opportunities for early intervention were not consistently missed across services. For example, in the case of James, early identification of ADHD and, later, early identification of BPD i.e. increasing distress and risk to self and very early presentation to services, could have been monitored regularly with interventions appropriate for the age and situation. In turn, this could have significantly reduced the chances of the later stage of an attempted murder, a suicide attempt and a psychiatric admission significantly improving overall functioning and reduction in symptoms such as self-harm (Boone et al., 2025; Broadbear et al., 2025).

The case studies were selected from forty-eight young people who participated in the 'Pathways study' (Gajwani et al., 2022), based on presenting with both neurodivergence and exposure to ACEs. Findings from the data on the pathways study (Gajwani et al., 2022) showed only 28% of participants had a previous neurodivergent diagnosis in the early BPD group, however, 71% screened positive for ADHD and 53% screened positive for Autism. Forty-two percent screened positive for both ADHD and Autism. Forty-eight percent of the early BPD group had a previous psychiatric admission; and 74% of participants had attempted suicide in their lifetime. It would be beneficial to explore the connection between neurodivergence and BPD in more depth in future research including examining the presence of neurodivergent traits and their links to the development of BPD features.

This is further reinforced in the findings of our IPA study, presented in chapter 5, with numerous recurring themes identifying significant barriers to care, from early childhood to the time of participation in the studies as adolescents and young adults (age 15-25). The young people's journeys in turn highlight the impact

of missed opportunities for care and early intervention and of unnecessary pain and suffering over the course of a lifetime. Further, there are significant societal costs such as the impact on families and carers and the economic impact of visits to crisis services and A&E when the individual is so overwhelmed and in distress owing to lack of early intervention (Kaess & Cavelti, 2025).

Across the two empirical papers (Chapters 4 & 5), the theme of stigma was important, which tended to shape BPD care journeys. The role of stigma in BPD has been examined and written about through various lenses, for example, clinician's perspectives (McLaughlin., et al 2025; Sheppard et al., 2025). In this thesis, the role of stigma was reviewed through a novel collaboration between patients and clinicians (chapter 6). Evidence suggests professionals are more likely to label co-morbidities such as depression and anxiety rather than exploring BPD as a morbidity (Beatson et al., 2016). In the IPA study, (chapter 5), stigma emerged as a prominent theme, both from the perspective of the young person's self-stigma and their perception of the existence of structural stigma. The role and impact of stigma should be considered when examining care journeys and when attempting to understand developmental pathways of BPD. Collectively, these studies called for the role of stigma to be further explored (chapter 6). The following sections explore each of the research findings in more depth and elaborate more fully on the issue of stigma.

7.2 Findings

7.2.1 Chapter 3: Lived Experience:

McAllister, K. M. (2023) Through the valley of the shadow of death. Journey through major mental illness as experienced by a mental health PhD candidate. *Journal of Psychiatric Practice, 29(3),* 235. https://doi.org/10.1097/PRA.0000000000000705

Lived experience can be defined as a first-hand account of a phenomenon such as mental ill health or a traumatic event, which is subjective and includes details of emotions and reactions (Healthy Young Minds, 2026). It affords the opportunity for a deeper, broader perspective of a phenomenon to enhance researcher, clinician and the general population's understanding of a phenomenon which may be difficult to measure in other ways. With a meaningful partnership, it may allow for a healthy contrast/dialogue between two parties such as health care providers views compared with service user experience. Further, sharing lived experience in collaboration with others such as researchers or peer groups, may serve as an informal debriefing for the participant. Often, the most unwell are excluded from research due to ethical implications. Lived experience then, offers the excluded individuals the opportunity to have their points, views and experiences heard and incorporated in the research and policy, including their recollections of what worked and did not work for the person when they were most unwell.

The author of this thesis provided a lived experience account of their BPD journey through mental health services over 32 years. Several key points became apparent and were reinforced throughout the studies in chapters 4 and 5. These

included the researcher's own journey through adolescent onset, being dismissed by services, feelings of isolation, misdiagnosis, and experiencing unnecessary pharmacology input. This highlighted that although this was one individual experience, patterns did emerge when triangulated with findings from the other studies (chapters 4 & 5) and highlight that BPD journeys through services has not changed significantly over the years when compared to that of researcher's own experience described in the lived experience paper in chapter 3. A few positive themes were established such as the power of continuity of care which in this case, facilitated recovery. Further, the benefits of being given the opportunity to be asked questions that they had never been asked before could be seen across chapters 3, 4 & 5. It could be argued that this came from the improved continuity of care and the chance to establish supportive and safe relationships with professionals. It was often the case in chapter 3, 4 and 5 that the revolving door of services and professionals meant one had to continually repeat the story of one's journey which has negative effects on the individual. From the author's own lived experience perspective – and that of those in the IPA study - this is very wearing and really adds to the care journey feeling futile.

Arguably (Grant, 2014), the 'authentic voice' of lived experience comes with challenges; first, that "meta-physics of presence", meaning the interconnectedness of being and reality, is not always reliable. Subjectivity plays a role in accounts of lived experience and of that, researchers should be mindful (Casey, 2023). Further, it is the author of this thesis opinion that the reader's sense of self and subjectivity will influence the interpretation of the lived experience piece. However, the key findings from this lived experience paper were seen throughout chapters 4 and 5,

therefore, although it was subjective and a unique experience, there is a fundamental undercurrent of barriers to care and missed opportunities to intervene early in BPD. Therefore, lived experience input, although with its limitations, can play a major role in research and policy as it provides fundamental guidance for the key areas that need further exploration, thus directing future research. Further lived experience can be exceptionally useful for peer support (Bradstreet, 2006). There is limited research on this topic, but a naturalistic study which looked at the feasibility and efficacy of implementing a peer-support worker as a co-leader in a psychoeducation group for BPD patients was carried out (Blay et al., 2025). Findings highlighted that most patients found this presence 'useful' and 'relevant' and completion rates of the group therapy were high. Hope and validation were the main themes identified in the context of the presence of the peer-support worker. Grenyer et al., (2024) also argues that peer support in the form of co-therapists in BPD treatment may improve engagement with treatment, challenge stigma and give those with experience of BPD a feeling of hopefulness of recovery.

In terms of future directions for the co-production of research with lived experience there are many avenues to be explored. Given Grant's (2013) argument, areas such as methodology and the design of lived experience partnership working could enhance research further. Conveying lived experience does not necessarily have to be through word; stories can be communicated through art (Lane, 2005), storyboards (Page & Thomas, 2011), or even digital measures (Lambert, 2013). Additionally, co-production can fuel the efficacy of self-report measures which in turn contributes to quantifiable data (Boness et al., 2025). A further important future direction in terms of incorporating lived experience into research would be

for ethical implications to be more closely examined to minimise risks such as re-traumatisation. Ethical regulations should be explored further to give a good basis for managing such risks without eliminating marginalised groups from research (Shaw et al., 2020). Finally, funding for lived experience research is lacking, meaning the benefits and advantages are being missed on a large scale (Greenwood et al., 2016). Lived experience is invaluable to researchers and clinicians and empowering to those whose stories must be heard.

Both the lived experience paper (chapter 3), and the case studies (chapter 4), have allowed a clear mapping of the author's and participants' journeys through care and gave more accurate timescales for when and where care, and other issues were missed. This mapping could be highly beneficial for health care providers for both caring for a patient and understanding their own learning needs in terms of identifying opportunities for care (Bravo et al., 2015). Although the case studies were able to lay out times and places, fundamentally the voices behind the experiences, alongside the impact of experiences on individuals, were missing. Combined with a lived experience perspective a broad understanding of care, needs and unique experience can be obtained, in turn contributing to quality care and significantly less suffering. Lived experience research therefore has scope for offering keys insights for future research and treatment.

The lived experience paper (chapter 3) continually added to the development of 'The BRIDGE Project' (Gajwani et al., 2024) (appendix 1) throughout, encouraging researchers to question how the trial was being delivered, and whether it was feasible and ethical to continue, were participants experiencing any difficulties with taking part (i.e. re-traumatisation) and could participants be retained. Further, the

journey of the author of chapter 3 informed the basis for chapters 4 & 5 through gaining a deeper understanding of the challenges faced by those with BPD features and help-seeking across a lifetime. As discussed, themes reoccurred across all papers.

7. 2.2. Chapter 4:

Where is the Care? Investigating pathways-to-care in young people with borderline personality disorder features: Clinical case studies

The aims of this study were to explore developmental pathways to BPD care, developmental symptom trajectories, service involvement and missed opportunities for care in the context of adverse childhood experiences and neurodivergence. Four case studies were selected from 'The Pathways study' (Gajwani et al., 2022) (Appendix 2). The 'Pathways Study' (Gajwani et al., 2022) mapped out young people's (ages 15-25) journeys through services who presented with neurodiversity, emerging BPD features and some with ultra-high risk (UHR) of psychosis. Developmental pathways of BPD are highly complex for each individual and there is no one particular route that leads to the manifestation of BPD. The influence of nature versus nurture (Wilson et al., 2021) must be reflected upon when considered in the context of equifinality (i.e. where multiple starting points can result in a single outcome) (Leichsenring et al., 2024). Biological (nature) factors such as brain development, genetics, and neurodivergence all contribute. In terms of nurture, factors to consider include the impact of early childhood attachment (Bowlby, 1969)

and the presence of ACEs (Ciringione et al., 2025), which can all lead to significant emotional dysregulation. This nature/nurture interplay is evidenced in twin studies where two children born to the same parents and environment can display different outcomes in terms of mental well-being (Skaug et al., 2022). As chapter 4 identifies, each pathway to BPD manifestation is unique with individuals having diverse ACEs, healthcare support, social care input or lack thereof. However, not everyone who experiences ACEs and psychological traumas goes on to develop BPD (Estric et al., 2022). As Dinkler et al., (2017) point out, children who experience ACEs/maltreatment are much more likely to have neurodivergent traits which are not a result of trauma. Thus, the presence of neurodivergence is likely to be more important in BPD aetiology than first thought.

This scientific and clinical stance is complicated by overlapping features of BPD with neurodivergence, particularly in the context of ADHD where impulsivity and emotional dysregulation are commonly exhibited (Instanes, 2020). In the context of overlapping symptoms of ADHD and BPD, we can see where Linehan's Biosocial Theory (1993) of BPD comes into play when exploring developmental pathways. The presence of emotional dysregulation and impulsivity in ADHD may be an important early risk factor for BPD, i.e. treating ADHD might be an important strategy for preventing BPD (MacDonald et al., 2023; O'Grady & Hinshaw 2023). In addition, ADHD might signify early risk of features of BPD especially in the presence of misaligned care, which might increase or consolidate the negative relational aspects of BPD (Kastin, 2023). This would support the notion of biological vulnerabilities as being important to consider in BPD. However, at this stage, we cannot be sure because of the limited data on the subject - but there is growing interest and data

(Weiner et al., 2019; Ditrich et al., 2021). The present work (chapter 4) contributes to this increase in data and knowledge. Developmental trajectories should be further explored in terms of neurodivergence and BPD: it should be made clear that BPD and ADHD are distinct conditions but risk factors for BPD development in the presence of neurodivergence should be considered. Commonalities could signal the need for developmentally appropriate prevention and early intervention.

Findings in chapter 4 were that, in the presence of BPD features, neurodivergence (Autism and/or ADHD) and ACES, as well as opportunities for care and early intervention for BPD, were missed by many services. From James's case study we can see that he was not "query BPD" until age 25, and this is remarkable given his significant contact with services over his lifetime from a young age and the fact that he had clear BPD symptoms for several years before his diagnosis. Additionally, James had been diagnosed with depression and anxiety and was receiving medication for this without recognition of BPD. During participation in the Pathways study (Gajwani et al., 2022) it was identified that James met five out of nine criteria for BPD but with no intervention or diagnosis. Similar patterns can be seen across all participants in chapter 4.

This study supports the notion that many young people are only granted access to mental health care and appropriate interventions at very late stages in their journey where iatrogenic harm is established (Zuccala et al., 2025). This is causing significant harm and unnecessary suffering highlighting that early intervention is non-existent for so many young people. For example, James presented to services at a very young age only to later end up in the criminal justice system; this signifies iatrogenic harm in the sense that his needs were either missed

or not taken seriously enough to warrant help in the first instance. Similarly with Anna, she presented to services with ultra-high risk of psychosis; to reach this crisis point indicates missed opportunities for appropriate care thus iatrogenic harm.

Those with the power to influence policies relating to children and adolescent mental health care would benefit from a thorough understanding of the needs of young people i.e. early intervention and appropriate, bespoke treatment. Case studies could be used to inform this. A better understanding of the journeys of young people from studies such as those of chapter 4 could influence policy and create easier and more accessible pathways to mental health care. No one should be left to reach crisis point before being granted access to services and this should be at the centre of government plans.

In terms of future directions for clinicians and other service workers, education regarding BPD features both alone and in the presence of neurodiversity should be at the forefront of assessment and diagnosis. An awareness of co-morbidities and commonalities are imperative to successful pathways of care in BPD. Collaboration and networking of all services and parties involved is imperative for joined up working so that no young person falls under the radar and is missed and left to reach crisis point.

Although case studies are informative and useful in the context of exploring where the care is in pathways of BPD they do come with limitations. Given that only 4 participants were used for this study, it can be difficult to generalise the findings (Simon & Goes, 2013). Case studies are highly useful for exploring unique journeys and pathways and obtaining a holistic view but in terms of data output it is a small picture. In addition, a further limitation of case studies is that they are quite

descriptive (Baxter & Jack, 2008), therefore, they show stage by stage unfolding rather than causation i.e. the challenge of whether nature or nurture impacted more upon the journey could not be fully established here. Although chapter 4 argued that co-morbidities should be more closely examined in terms of early presentation of BPD, it would still be quite difficult to establish whether a feature was BPD or that of another comorbidity. The cases in paper 2 highlighted criminality and sexual health issues during participants journeys: it could be argued that these are negative features of BPD thus worsening current opinions about BPD, in turn perpetuating stigma from the general population and increased self-stigma thus supporting findings such as Klein et al., (2022) and Ociskova et al., (2023). Lastly, case studies are very difficult to replicate or be used in larger scale studies given the uniqueness of each journey.

However, there are many strengths of case study design, in systematically mapping pathways to care in BPD. They can be seen to depict intricate details of lived experience such as poor engagement with services (Crawford et al., 2009; Muzari et al., 2022) and highlight real life narratives (Greenhalgh, 2025) how one aspect of care such as being missed by the community mental health can lead to engagement with criminal justice services as shown in chapter 4. A further positive aspect of clinical case studies is models such as the biosocial model (Linehan, 1993) can be applied to real-life and allow for a better understanding of the developmental pathways. In turn, contributing to deeper insight and paves the way understanding BPD aetiology and how intervening earlier in these pathways can make a significant difference to the impact of BPD over a lifetime trajectory.

An important point by Haynes and Loblay (2024) is that case study methodology can be without the backing of theory and implies the that the care journey is linear and one directional. This can cause important contact with services to be missed in case study mapping such as re-referral or signposting to a service.

7.2.3 Chapter 5:

"It was a horrible, just horrible, journey": A qualitative examination of the journey through care and treatment of young people with borderline personality disorder features.

The aim of chapter 5 was to better understand pathways through care, identifying barriers and facilitators of effective care. This study was conducted in the context of a feasibility RCT – The BRIDGE Project (Gajwani et al., 2024) (Appendix 1). The BRIDGE Project is a feasibility randomised controlled trial (fRCT) of brief, intensive assessment and integrated formulation for young people (age 14-24) with features of borderline personality disorder (BPD). Participants were recruited from multiple sources including the NHS, colleges and universities and through social media advertising in Scotland. Twenty-five participants were randomised to either BRIDGE intervention (n=13) or services as usual (SAU) (n=12) and followed up at 12 and 24 weeks. Those in the BRIDGE arm were offered up to 16 sessions on cognitive analytic therapy. Of these 25 participants, 7 volunteered to take part in the IPA study in chapter 5.

Eighty-three percent of psychiatrists in Scotland who participated in a clinician survey reported BPD to be a valid diagnosis in adolescence (Foubister & Simpson, 2023). From the study in chapter 5, it was clear this view was not reaching the frontline of the treatment of BPD features in young people. The three group experiential themes (GETs) in this IPA study (chapter 5) identified were: 1) 'not being heard or validated', 2) 'journey of finding the self' and 3) 'the impact of the positive perceptions and treatment during 'The BRIDGE Project'' (Gajwani et al., 2024)'. The concept of stigma was also apparent throughout the findings of this

paper. That young people were not being heard or validated when it came to discussing their symptoms and care with health professionals impacted upon the journey of understanding the self in terms of being labelled and comprehending their diagnosis or features of BPD and receiving the appropriate treatment. As well as these themes, sub themes were identified including the missed opportunities for care and the impact of stigma, which came across in all three papers. Overall, the young people in this study had negative experiences of pathways to care. Particularly, experiences with specialist Children's services were poor as illustrated in Melissa's statement:

"So, I go to the GP, I was referred to CAMHS, when I was 13, I think. And erm that was the first time I'd seen like an NHS professional from mental health. Erm, and it was just like a kind of 6 weeks kinda counselling sort of thing. I didn't find it very helpful at all, I didn't feel heard or listened to at all, you know, it was just kind of a get you in the door, tick the box and get you back out the door again."

Individual needs were not acknowledged by clinicians and there was no continuity of care.

Theme 2 illustrated naming BPD had mixed outcomes as some participants felt that they could relate to this diagnosis and helped them understand themselves more fully *"Erm, I get my diagnosis and I'm so, it sounds wrong, but I am really chuffed that this has a name. Cause I know there's this thing, erm, where doctors, and I understand it, to an extent." (Isla)*, yet some found it "scary" and "jarring".

The perspective of stigma came from self-stigma, and the participants views of the general population's understanding of BPD.

Finally, theme 3 found that when compared with participants who were in the 'services as usual' (SAU) group, those who were in the intervention group receiving BRIDGE intervention (i.e. comprehensive assessments, up to 16 sessions of cognitive analytic therapy (CAT) and unique multi-agency support where possible) found it very effective due to continuity of care - the idea of a beginning, a middle and an end of therapy and being listened to and carrying out mapping in collaboration with the therapist, thus supporting the benefits of lived experience as discussed in chapter 3. Interestingly, those in 'SAU' found that, although they did not receive any therapy, having the opportunity to talk freely and openly about how they were feeling to researchers when the measures were being implemented in the study had a positive impact.

The findings of the IPA study (chapter 5) are compelling; Wall et al., (2021) argues that individuals with BPD features may not have the knowledge and understanding to recognise them. Wall et al., (2021) claim that individuals must recognise their healthcare needs and want help and often this is not the case due to poor mental health literacy. Apparently, patients may not see their symptoms as "problematic", which is yet more stigmatising language from researchers. However, the findings in chapter 5 challenge this as the participants felt that the generic help which they were given initially was not the right fit for them signifying they had a deeper understanding of their needs. The young people made clear that they had never been asked these types of questions before i.e. questions related to BPD features in 'The BRIDGE Project' (Gajwani et al., 2024) and gave articulate answers.

Lack of recognition or assessments was often described as a barrier to not receiving appropriate services, as illustrated. This signifies where the lack of training for clinicians in BPD may limit appropriate care as patients are not getting enough time with healthcare providers for timely recognition and intervention for patterns of longstanding clinical features. This then highlights the lack of collaboration and a therapeutic relationship for a positive recovery journey to be made, also illustrated in the researcher own lived experience (McAllister, 2023).

For participants in the BRIDGE project (Gajwani et al., 2024), their journey to care often started with their GP, which is common practice in the BPD journey (Riihimakim et al., 2016). However, what appeared not to be common practice was a consideration of the participant experiencing BPD in primary or secondary care. Almost all participants were diagnosed with other co-morbidities, such as depression. Although it is argued that conditions such depression is one of the most common co-morbidities with BPD (Ajinkya et al., 2021), it is often only when an individual is in crisis that a potential BPD diagnosis is considered. This was reflected throughout the interviews in chapter 5. Often, this results in ineffectual treatment of difficulties with functioning (inter and intrapersonal) with psychopharmacology, again a common theme throughout this study, thus reinforcing previous studies (Ripoll, 2013). This highlights a training need for all, from primary care to specialist CAMHS services for better identification. Often, lack of specialist treatments, such as DBT are cited as a challenge for poor identification. However, there is now good evidence to support generalist treatments for BPD, which is explored further in Chapter 5, in the main findings of the BRIDGE study, comparing SAU and specialist BPD treatment.

It is difficult to say if the educational need is that of an understanding of the nature and phenomenology of BPD or if it stems from the impact of stigma which is apparent through this thesis owing to the lack of data from studies with frontline workers, particularly GPs (Lawn & McMahon, 2015). Given engagement with services can be poor (Lau et al., 2024) for BPD patients, it is imperative that appropriate assessment and care is available on the frontline, starting with GPs all the way to emergency staff. Given that they are usually the first point of contact when someone's mental health journey begins, (Wlodarczyk et al., 2018) identified the main barriers to GPs providing care to BPD patients; first, there is limited knowledge around diagnosing BPD; Second, the co-morbidities and complexity of BPD; third, difficulties maintaining a good relationship with the patient and fourth, identifying support systems. The interviews in the IPA study (chapter 5) identifies that, GP and other specialist services lend weight to these barriers. There is a massive gap here in research and practice in terms of first-line care of patients approaching services with BPD features; It is imperative that similar qualitative studies with health care practitioners are carried out to further establish specific training and educational needs and to tackle prejudices towards BPD experienced. In turn, these findings could better inform policy and break down the structural stigma as described in chapter 6 to challenge the problem of unmet needs of those with BPD features.

These journeys through care highlight similarities to the lived experience account (chapter 3) where there are significant missed opportunities for care and early intervention. Most of the participants in the IPA study (chapter 5) sought help in early adolescence but were met with many barriers. These barriers in turn, meant that young people were only being helped when they reached crisis point, similarly

to the lived experience paper, and their developmental pathways to BPD care were significantly protracted causing unnecessary harm and suffering. The IPA study (chapter 5) reinforces the findings of case studies (chapter 4) in this respect but also highlights how studies such as Chanen (2015; 2020) are still supported 5 -10 years later, and not in a good way. This shows how slowly the progression of acknowledgement and treatment of BPD features is going. It would seem there is very little being done to break down the barriers of poor care for those with BPD signs and symptoms. This IPA study (chapter 5) supports Winsper et al. (2021) and offers a deeper insight from the perspective of young people as to where future research should focus. This includes areas like early intervention, individual treatment plans and continuity of care. Much of the focus of current research is about the need for early intervention (Chanen et al., 2017); but if this is achieved, it would be helpful to establish what the unique needs are for both patients and healthcare providers to offer effective early intervention. The key features such as a fixed number of sessions, the therapist being knowledgeable in BPD and collaboration such as mapping should be key focuses for future direction. Further, it is argued (Boone et al., 2025) generalist models are needed to improve BPD outcomes in adolescents. For example, good psychiatric management approaches for young people have been evidenced (Links & Ross 2025) to show promise for positive outcomes in in BPD especially where early intervention is seen.

It is evident that chapter 5 complements the small landscape of existing knowledge (Tusiana-Eng & Yeomans, 2018; Pigot et al., 2019; Wall et al., 2021) in terms of barriers and facilitators of care in BPD. Although it supports this pre-existing knowledge it unfortunately shows very little improvement in pathways to

care for young people. It is still being described as “a horrible journey” in 2025 and given paper one is a historical piece from the author from late adolescence in early 2000s (chapter 3), it is very disheartening for there to be very little improvement in the individual journeys of BPD care in almost 25 years. Given the pain and suffering, the economic costs, the impact on carers and unemployment associated with BPD, it should be a public health priority (Chanen et al., 2017). Knowledge around BPD and early intervention is increasing but little is being done to actively challenge the barriers to it.

The study in chapter 5 then founds the basis for future research as it hears the voices of the young people behind these barriers and pinpoints important places to begin breaking them down. Studies such as chapter 5 would be simple to replicate across cultures and populations and adapted to be used with clinicians to establish barriers and education needs. However, the following limitation should be taken into consideration and research adapted to challenges them; first and foremost, as it has been made clear, the author of this thesis and paper 1 has a BPD and complex – trauma diagnosis. Therefore, there was significant scope for bias throughout the study. However, it is evident from the themes drawn out from the IPA study that there are consistencies across the board in terms of early intervention and pathways to care. The author also has a strong background in psychology research at undergraduate and master’s level and has an acute awareness of the potential for this bias. This bias was negated by frequent supervision with PhD supervisors and fellow researchers on ‘The BRIDGE Project’ (Gajwani et al., 2024) and author reflexivity. However, it did contribute some positives to the study such as a deeper critical awareness as the author was personally invested. Although the participants

were not aware of this, the interviews showed an extra level of compassion and understanding from the researcher, thus making it easier for the participant to be as open and honest in turn making the data more robust and reliable. Further, the 7 steps of IPA (Smith, Larkin & Flowers, 2021) were carried out offering reflexivity. Given that the paper was IPA, any researcher's perspective would play a role in shaping the narrative outcomes and the same reflexivity was applied by this researcher. Other limitations and strengths of the study are discussed in chapter 5.

7.2.4.

Chapter 6: Stigma

Collins, K. M., Minnis, H., & Gajwani, R. (2025). Using clinician–patient collaboration to tackle structural stigma and age discrimination in borderline personality disorder. *BJPsych Advances*, 1-3. https://doi.org/10.1192/bja.2025.10140

The aims of chapter 6 were to explore the nature of stigma in BPD and highlight the benefits of patient – clinician collaboration.

A clinical reflection is a highly useful tool for researchers and clinicians alike when attempting to improve and learn in areas that may require deeper insight to highlight and challenge problems, in this case structural stigma. Although clinicians can reflect professionally in a structured format, a clinical reflection from an independent perspective can prove highly useful. In this clinical reflection, an in-depth enquiry into stigma in BPD care was deemed necessary given that the topic was apparent in each paper in this thesis. Ageism tended to be a particular problem given early intervention was a contentious issue, for instance, late diagnosis even though BPD in adolescence is recognised thus perpetuating stigma. Further, it was

found that self-stigma was an issue for BPD patients given the attitudes they were met with in society such as pejorative language. This reinforced the findings of the problem of stigma in each of the papers in this thesis. Using a clinical reflection contributed greatly to the understanding of stigma in BPD owing to the robust nature of the clinical reflection and how it contributed to the overall aims of the thesis. It put stigma in context in BPD thus highlighting that it is a pertinent issue in BPD from research, clinical and ethical perspectives with implications in these areas.

7.3. PhD as part of a feasibility randomised controlled trial (The BRIDGE Project, (Gajwani et al., 2024)

As a randomised controlled trial is the gold standard of research (Webber & Prouse, 2018), undertaking this PhD as part of a feasibility randomised controlled trial (fRCT) 'The Bridge Project' (Gajwani et al., 2024) and 'Pathways Study' (Gajwani et al., 2022) had many advantages. Given the author's vested interest in the progress of BPD early intervention, pathways to care and treatment there was consistent drive and enthusiasm throughout the project. The author is an early career researcher therefore the fRCT afforded the opportunity for training in all aspects of setting up a trial including design and methodology and writing up of findings. As outlined the mixed methodology used offered the opportunity for the fRCT to consider how these might be used in a larger trial. Although the data gathered did not contribute to the fRCT, it did provide insightful, nuanced, and innovative findings which pave the way for future research on a larger scale, including a planned definitive RCT.

There are several methodological considerations relating to chapter 5, which evolved from its participants being recruited as part Their accounts may therefore have been influenced by their previous experiences of the BRIDGE intervention, research assessments or engagement with researchers. Consequently, the findings should be interpreted as reflecting the experiences of this particular group of participants rather than necessarily representing the experiences of all young people with BPD features who engage with mental health services. of a fRCT. Their accounts may therefore have been influenced by their previous experiences of the BRIDGE intervention, research assessments or engagement with researchers. Consequently, the findings should be interpreted as reflecting the experiences of this particular group of participants rather than necessarily representing the experiences of all young people with BPD features who engage with mental health services.

Potentially, the smaller participant number may not have allowed for a broader experience of young people with BPD features, both subthreshold and full threshold, for example, those in more marginalised communities that may not have had access to BRIDGE research participation. However, inviting participants from the fRCT afforded the opportunity of in-depth understanding of young people who were otherwise missed by specialist services, through the use of IPA i.e. those who had been screened for BPD features and the impact it had had on their functioning and who had journeyed through the mental health system. The participants were already screened and considered a relevant group for the IPA study. As pointed out in chapter 5, there is the potential that the individuals could have, in a sense, been primed or shaped for the IPA study through their prior involvement in the fRCT. Further, as the initial study was a feasibility trial, the goal was not necessarily set

to establish whether the intervention was effective but to identify if the study was viable and had potential for a definitive study. Therefore, the IPA study (chapter 5) should also be considered in the same context, as ultimately participants were recruited as part of a feasibility study.

As the participants in chapter 5 came from the feasibility study, they were already screened and considered to meet threshold for BPD. However, this then leaves a gap in the study as many young people who were considered subthreshold (less than 2 threshold symptoms on the DSM V) in The BRIDGE Project (Gajwani et al., 2024) were not included in either study, thus meaning a considerable number of lived experience accounts of young people going through the mental healthcare system were not captured in this study. Potentially broadening the thresholds for inclusion criteria could be revisited for any definitive trial of The BRIDGE Project (Gajwani et al., 2024), by using a dimensional model of Personality Disorder functioning.

7.4. Strengths and Limitations

The overarching aim of this thesis was to investigate pathways to care in young people (14-25) with borderline personality disorder features. To achieve this, three papers explored the impact of co-production by expert by experience in research (chapter 3); took neurodiversity and ACEs into consideration when reflecting on emerging BPD (chapter 4); and examined barriers and facilitators to effective mental health care for young people with BPD features (chapter 5). During the process of the studies, a strong undercurrent of stigma became apparent, and a clinical

reflection was deemed necessary to explore the impact of stigma and ageism on BPD intervention and to identify how patients and clinicians can collaborate effectively to tackle these challenges (Collins et al., 2025).

The findings from chapter 3 strongly supported the need for the input of lived experience in research and recovery (Ng et al., 2019) owing to the strengths it provides i.e. informing researchers of the grassroot issues affecting those with BPD features, so they are focusing on pertinent areas and questions. In this thesis, the input of lived experience informed the individual research aims for each chapter which allowed for very specific questions to be asked in the research as issues such as timelines of care, discrimination and stigma were apparent from chapter 3. Further, including experts by lived experience in research allows for the most vulnerable to have their voice heard in a safe environment as they can disclose as little or as much as they feel comfortable with thus supporting ethical research practice (Fusar-Poli et al, 2024).

However, incorporating lived experience in the thesis (chapter 3) was not without limitations: these included the potential for the researcher to unconsciously bias the research questions given that their experience seemed to reflect the findings of the overall studies, particularly that of chapter 5. Although, semi-structured, follow-up questions of the IPA study could have been influenced by their own experience. But, given 7 participants, in the main, reported similar journeys, it may be fair to say that it is highly unlikely the themes were influenced by bias on the researcher's part. A further limitation in the context of chapter 3 was the potential to retraumatise the participant/researcher. As outlined in other chapters,

the was significant controls for these eventualities and the researcher was very reflexive.

As a lived experience researcher and author of this thesis, the researcher's position was complex yet pivotal in directing the studies and in analysing findings and reaching the conclusions outlined. There is little evidence to help understand the identity of this role (Gupta et al., 2023) but there is significant movement in the field of mental health which attempts to integrate healthcare professionals and researchers to share their own experiences of health (Richards et al., 2016). My position afforded the opportunity to direct the studies in appropriate directions due to having a more nuanced understanding of the concepts and aspects of the research. As a lived experience researcher, it is challenging to demonstrate that these findings could only have been produced by a researcher with lived experience. Rather, the literature suggests several ways in which lived experience may contribute to research, and I critically consider how these possibilities may have operated within this thesis. Although this could not be measured empirically, being in the position to understand first-hand the experiences of the participants may have, unintentionally and/or unconsciously, enabled them to feel more comfortable disclosing their experiences (Horgan et al., 2021). This could be due to there being no perceived power imbalance (Rocelli et al., 2024). Disclosure of my lived experience may have reduced perceived distance between researcher, and participant, and may, in some instances, have facilitated rapport and openness. However, this cannot be assumed to have occurred for all participants or the interaction with other researchers were somehow less authentic. This is important when using IPA, as detailed accounts of participants experiences are vital (Smith,

2017). In turn, as a lived experience researcher, I was able to reflect and understand in-depth what really matters to those who have experience of BPD and journeys through mental health care in Scotland. Many research papers conclude with "more research is needed". As a lived experience researcher, I was able to use the process of double hermeneutics within IPA, to crucially identify themes that were relevant to the study, whilst holding the position of a lived experience researcher. My lived experience may have contributed to my sensitivity to particular nuances within participants' accounts, particularly in relation to experiences of BPD and mental health care. However, it is not possible to determine whether these interpretations would have been identified differently by a researcher without lived experience. Upon further reflection, it may have been empowering for the myself as the researcher and for the participant to disclose my BPD diagnosis, in a contextually appropriate way. This may have influenced recruitment to the study for the reasons outlined. Only a small number of studies (Flanagan et al., 2007: Flanagan et al., 2010) look at the first-hand perspective in the suffering of mental illness and the impact of being in treatment. More often, the studies themselves look at treatment effectualness. However, as Kverme et al., (2019) argue there are more important aspects to recovery that goes further than empirical data. This includes meaningful understanding of one's recovery journey (Lavik et al., 2018).

This is not to say that researchers without BPD lived experience would have obtained different results. But having a lived experience researcher can help challenge assumptions about BPD (Gillard et al., 2015) through co-creation with the wider research team. It is possible for lived experience researchers to produce non-biased findings through thorough reflexivity and supervision. Although the added

value of lived experience cannot be isolated empirically within the present research, a growing literature suggests that lived experience involvement can contribute distinctive perspectives to mental health research (West et al., 2022; Bradley et al., 2024). However, this evidence does not establish that the findings of the present thesis could only have been reached by a researcher without BPD lived experience.

Although lived experience does not have the same rigour as empirical studies, it would seem by taking the above into consideration, overall, the methodology of using lived experience by the researcher was very effective in supporting the research aims and the development of further research questions throughout the thesis.

Chapter 4 aims explore an area with limited research, using case study methodology, that is neurodiversity and the emergence of BPD features. The findings of the study supported current research and contributed further to the area by identifying that across a typical young person's trajectory there are many missed opportunities for care and significant iatrogenic harm which could be improved through joined up services i.e. social work communicating with psychiatry input. Further, comprehensive assessment of BPD emergence independently and in the presence of neurodiversity should be considered, therefore the methodology was very effective. Case study analysis uses multiple sources which can provide a holistic analysis.

Further, the case study methodology (Yin, 2009) used in chapter 4 allowed for an in depth look at not just the impact and input, or lack thereof, of mental health services but other services such as education and social work and highlighted where joined up working is imperative to prevent missed opportunities for care

which in turn would lead to the alleviation of suffering over long term trajectories. It also allowed for other findings such as the potential for BPD features to emerge in the presence of neurodiversity and trauma.

However, case study methodology (Yin, 2009) also has limitations which were apparent in this study. For instance, although patterns were seen across the case studies, there is no quantifiable data which would make findings statistically significant or generalisable (Yin, 2013) and can be seen to be lacking scientific rigour. In turn, it is argued (Yin, 2013) that the case studies can become descriptive or anecdotal and subject to researcher bias. However, given the overall findings in chapter 4, that is all participants had BPD and neurodiverse features, the methodology is valid and robust, in this case.

Chapter 5 explored the journeys of young people with BPD features through mental health services in a location in Scotland, using interpretative phenomenological analysis (Smith et al., 2021). This method was effective as group experiential themes emerged which elaborated on current research on the barriers and facilitators to mental health care and the journeys of young people accessing services. These methods afforded young people with BPD features the opportunity to be heard from a grassroots level, thus supporting lived experience input, and missed opportunities and barriers to care could be empirically recorded simultaneously. A further strength which should be considered is demographics (MacLeod, 2019). All participants came from different backgrounds and were of different genders, cultures and have varying co-morbidities yet these three themes along with stigma emerged.

The three methods used i.e. lived experience, clinical case studies and qualitative interviews offered fruitful and robust findings which complemented each other and helped to deliver a broader picture of the developmental pathways of BPD and to care. Each study fed into the next augmenting the scope of the research thus providing reliable qualitative data and paving the way for future research. Additionally, recruitment for chapter 5 came from young people who had taken part in 'The Bridge Project', (Gajwani et al., 2024) this meant that any previous measures such as SCID-II BPQ had already been undertaken and the participants had been screened to meet the requirements of 'The BRIDGE Project (Gajwani et al., 2024) in chapter 5. These measures were robust and reliable tools. Similarly, as the participant data from the clinical studies (chapter 4) came from 'The Pathways Project' the same standards were met. The theme of stigma in BPD emerged from all three papers which formed the basis for the long overdue clinical reflection which offered suggestions for effective collaboration between clinicians and patients in a bid to tackle stigma.

In chapter 6, a clinical reflection provided an informative view of stigma in BPD. The reflection was deemed necessary after a pattern emerged across all three previous papers where stigma was noticed to be a contentious issue. There were numerous strengths in conducting a clinical reflection in this thesis on the issue of stigma as the finding could be more closely explored and looked at from the positions of practitioners, researchers and patients. Then author was able to see where problems stemmed such as the use of pejorative language in clinicians and the general population resulted in self-stigma, Further, ageism became apparent. This suggested that stigma plays a central role in the diagnosis and early intervention of

BPD. It also allowed the authors to be reflexive on their own positionality of stigma in BPD, and they could reflect on how this may have influenced their research throughout the thesis.

However, clinical reflections do have limitations in the sense that stigma in BPD is an emotive subject, and this could drive the author's conclusions and recommendations. Further, it only captured a small part of the potential solution of increased patient and clinician collaboration. Other ideas and problems in BPD could not be captured owing to the niche nature of the reflection.

7.5 Clinical and research Implications

Given that the aims of this thesis were achieved, and findings contribute further to the existing bodies of knowledge in each of the areas, it is important to consider how this affects clinical practice and identify ways in which the new findings can be effectively integrated into research practices.

Chapter 3: Lived experience in research clinical implications:

An interesting point that this thesis makes is that researchers and those who experience mental health conditions/lived experience are not always separate bodies (Taylor, 2025). That is, the researcher can also be someone with lived experience and therefore be both expert by experience and a mental health researcher. Although they may complement each other, clinically they are still considered different entities. This may have both positive and negative implications in clinical practice; for example, the grassroots questions can be driven by the researcher having a sound understanding of the real-life experience and emotions associated with the research topic but there is also the potential for researcher bias

which would need to be accounted for by reflexivity and supervision. However, the researcher with lived experience could contribute to tackling the stigma associated with mental health, in this case BPD. The idea of 'the wounded healer' (Daneault, 2008) may not be lost in the concept of a lived experience researcher.

Incorporating researchers with lived experience into research is not as simple as it may seem; Rajvinder (2025) argues that in BPD, emotions intensify and change at pace. With a BPD diagnosis herself, she points out that she perceives her 'sense of self' as "limited" while her healthcare professionals consider it to be "stable". Therefore, not only are the lines blurred in terms of the context and findings of the research but also one's own well-being can be jeopardised and lead to destabilisation of understanding of the self. Clinicians and researchers should be mindful of this ontological complication and the ethical implications accompanying it. In terms of more general clinical implications of incorporating lived experience into research is that treatment can be more focused on unique needs such as contributing to individual pathways to care.

Chapter 4 identified serious gaps in the collaborative working of services resulting in iatrogenic harm and multiple missed opportunities for early intervention, particularly in the presence of neurodiversity, psychosis and emerging BPD. As seen in chapter 4, participants screening for BPD all had neurodiversity. Given this and the limited previous research, (Gajwani et al., 2022) it is crucial to assess neurodevelopmental profiles and BPD simultaneously. Therefore, it is imperative that those in this field understand and use the clinical tools and measurements available in practice. Training and awareness must be given to clinicians of a) the possibility of neurodiversity and potential emergence of BPD, particularly for those

at high risk and b) the ability to identify and manage this should it become apparent. Incorporating such measurements, leading to appropriate interventions, could have an impact on suicide risk and emotional dysregulation (Links et al., 2025). However, many tools and clinical assessments are not yet developed in the context of BPD and neurodiversity, and much further work is necessary.

Further clinical implications of the findings of chapter 4 indicate that stepped care models may be useful in this context (Pickard et al., 2021). Offering unique, personalised care and adjusting through continuous monitoring would be highly appropriate (NICE, 2009) given the labile nature of BPD and overlapping symptoms with neurodiversity. Owing to the nature of stepped care i.e. "least restrictive" and "self-correcting" (Pickard et al, 2021), there are numerous benefits to the individual such as less time in treatment and ease of access, this in turn may also tackle the issue of stigma associated with accessing mental health treatment.

Within the context of research, it is imperative that more research is carried out that would encourage collaborative working, inform the development of effective tools and diagnostic measurements, and take co-morbidities in assessment into consideration.

Chapter 5 IPA: The clinical implications of chapter 5, which highlighted young people's journeys through multiple services and identified barriers and facilitators to care are vast. The first theme in which it was identified that the young people had not felt heard or validated in when accessing mental health services indicates the need for stronger therapeutic relationships but also collaborative care between services. Collaborative care models have been set up in countries such as Norway which integrated mental health practitioners in a GP practice who were then able

to seek advice and assessment from this team (Rugkåsa et al., 2020). This was found to be highly effective as the co-location made accessibility easier. Further, the collaboration was patient centred and having mental health specialists on-site made early assessment possible with the right type of treatment and with the correct specialist. However, funding was a barrier, which would be a universal problem therefore, more financial consideration would be needed before implementation locally. Integrated services may improve patient engagement with treatment and tackle stigma in the sense that going to your GP surgery may not seem as daunting as attending a specialist mental health clinic. In turn, better collaboration between services and with patients may in turn boost practitioners' confidence especially on the frontline i.e. GPs in identifying and referring individuals to the correct service in a timely fashion. Further, joined-up practice could reduce iatrogenic harm whereby individuals are seen by one service and one practitioner, or at least practitioners who communicate making care patients centred. Chapter 5 has brought these issues to the forefront of BPD journeys and if they are considered and researched further could make journeys through mental health care easier, timelier and more effective.

Research into barriers and facilitators of care and mental health journeys requires a much more qualitative approach, perhaps even combined with mapping such as that of chapter 4. The input of clinicians and the general population would be especially helpful in know where training and mental health literacy is at, especially in BPD. In turn, this may help to tackle the problem of stigma.

Chapter 6 Stigma: There are many clinical areas which may benefit from the reflections in chapter 6. In the first instance, the findings have highlighted training needs for clinicians in areas such as the use of positive language when referring to and talking with BPD patients and the general population. In addition, educational needs are necessary for clinicians to feel confident in identifying, intervening early and referring to the correct services when met with a patient with potential BPD features.

Further, the topic of stigma in BPD offers an excellent opportunity for professional/clinical reflection and this can be taken to and discussed at supervision. This opens the dialogue for more positive attitudes and practices when met with someone with BPD features which can filter down to other colleagues and offer peer support for clinicians.

For future clinical reflections, perhaps carers, clinicians and the general population could be reflected up and included in research in a similar way to identify areas of challenge within stigma such as staff burnout, compassion fatigue and a general understanding of BPD.

Conclusion

Borderline personality disorder remains an under researched, contentious topic, particularly in adolescence. This thesis explores the journeys of those with BPD features through mental health care, taking lived experience, neurodiverse conditions, trauma and barriers and facilitators to effective, timely care into consideration. Stigma, especially structural, played a significant role in these

studies and the author felt it essential to explore this in more depth forming the basis for collaborative approaches between clinicians and patients.

In the main, findings are compelling. Across all papers, the need for co-production in research with experts by experience is apparent. Further, joined up working between services is imperative to timely intervention to prevent missed opportunities for care. In addition, barriers and facilitators to care were identified which highlighted the importance of early intervention,
continuity of carer, and tackling stigma, both structural and within the self.

These main findings across all chapters highlight the complexity of BPD and the needs of those with features, in particular, adolescents who would benefit significantly from early intervention and appropriate care. The findings also opened new areas for research such as the presence of both neurodiversity and trauma and their impact on long term outcomes in adolescence, in this case, the emergence of BPD. The potential for iatrogenic harm was also apparent throughout these studies. These findings were unpacked using qualitative approaches, that is case studies and IPA analysis. As a result, it would seem qualitative analysis, and the incorporation of lived experience, was pertinent to the research aims and to the study of pathways to care in BPD.

All the findings in this thesis open further avenues for future research and much more consideration to each area is due. As chapter 4 outlines, there is a lack of evidence which directly looks at the voices of young people. Listening to young people (and retrospective journeys i.e. the author's lived experience) and involving them in the co-production of research would pave the foundations for important questions to be asked and answered. Not only would service users benefit but

clinicians would also be able to use findings to reflect on their own practice and integrate the voices of young people into care protocols. Clinician's voices should also be heard to identify what is contributing to these barriers and missed opportunities. In turn, this may validate their feelings, challenge areas such as structural stigma and offer relief in areas such as compassion fatigue. Therefore, we conclude that pathways to care in BPD is area where much more research, time and consideration is required, and this thesis lays the foundations for brighter futures and clearer pathways for young people with BPD features.

References

Ajinkya, S. A., Sharma, P. S., & Ramakrishnan, A. (2021). Proportion of psychiatry outpatients with borderline personality and associated clinical syndromes using the millon clinical multiaxial inventory-III: A retrospective study. *Journal of Clinical & Diagnostic Research, 15*(1)

Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The Qualitative Report, 13*(4), 544–559.

Blay, M., Uludag-Martin, A., Lagadec, S., Zenou, M., & Benmakhlouf, I. (2025). Peer-support and group psychoeducation for patients with borderline personality disorder: A feasibility study. *L'Encéphale,*

Boness, C. L., Hebden, H. M., Lardier, D. T., Spurgeon, L., Timmons, A., Simms, L. J., . . . Witkiewitz, K. (2025). Engaging people with lived experience of psychological disorders: Current research and future directions for community-engaged measure development in psychological science. *Clinical Psychological Science, 13*(4), 720–739. doi:10.1177/21677026241304339

Boone, K., Choi-Kain, L., & Sharp, C. (2025). The relevance of generalist approaches to early intervention for personality disorder. *American Journal of Psychotherapy, 78*(1), 16–23.

Bowlby, J. (1969). *Attachment and loss: Attachment*. London: Hogarth Press. Retrieved from https://go.exlibris.link/PrK3Fr6X

Bradstreet, S. (2006). Harnessing the 'lived experience': Formalising peer support approaches to promote recovery. doi:10.1108/13619322200600019

Bravo, P., Edwards, A., Barr, P. J., Scholl, I., Elwyn, G., McAllister, M., . . . Cochrane Healthcare Quality Research Group, Cardiff University. (2015). Conceptualising patient empowerment: A mixed methods study. *BMC Health Services Research, 15*(1), 252. doi:10.1186/s12913-015-0907-z

Broadbear, J. H., Bhagwandas, M. G., Crowley, S., Cheney, L., & Rao, S. (2025). Exploring the pathways to diagnosis for men with borderline personality disorder: A qualitative study. *International Journal of Mental Health Nursing, 34*(1), e13413.

Casey, P. J. (2023). Lived experience: Defined and critiqued. *Critical Horizons : Journal of Social & Critical Theory, 24*(3), 282–297. doi:10.1080/14409917.2023.2241058

Chanen, A. M. (2015). Borderline personality disorder in young people: Are we there yet? *Journal of Clinical Psychology, 71*(8), 778–791.

Chanen, A. M., Nicol, K., Betts, J. K., & Thompson, K. N. (2020). Diagnosis and treatment of borderline personality disorder in young people. *Current Psychiatry Reports, 22*(5), 25.

Chanen, A., Sharp, C., Hoffman, P., & for Prevention, G. A. (2017). Prevention and early intervention for borderline personality disorder: A novel public health priority. *World Psychiatry, 16*(2), 215.

Ciringione, L., Perinelli, E., Mancini, F., & Prunetti, E. (2025). Beyond the scars: An analysis of adverse childhood experiences and the interconnections between emotion dysregulation, dissociation, and trauma in patients with borderline personality disorder. *Brain Sciences, 15*(8), 889. doi:10.3390/brainsci15080889

Collins, K. M., Minnis, H., & Gajwani, R. (2025). Using clinician–patient collaboration to tackle structural stigma and age discrimination in borderline personality disorder. *BJPsych Advances,* , 1–3.

Daneault, S. (2008). The wounded healer: Can this idea be of use to family physicians? *Canadian Family Physician, 54*(9), 1218–1219.

Ditrich, I., Philipsen, A., & Matthies, S. (2021). Borderline personality disorder (BPD) and attention deficit hyperactivity disorder (ADHD) revisited–a review-update on common grounds and subtle distinctions. *Borderline Personality Disorder and Emotion Dysregulation, 8*(1), 22.

Estric, C., Calati, R., & Lopez-Castroman, J. (2022). Adverse childhood experiences and neurocognition in borderline personality disorder: A call-to-action perspective review. *Harvard Review of Psychiatry, 30*(4), 248–260.

Flanagan, E. H., Davidson, L., & Strauss, J. S. (2007). Issues for DSM-V: Incorporating patients' subjective experiences. *American Journal of Psychiatry*, *164*(3), 391-392.

Flanagan, E. H., Davidson, L., & Strauss, J. S. (2010). The need for patient-subjective data in the DSM and the ICD. *Psychiatry*, *73*(4), 297-307.

Foubister, L., & Simpson, S. (2023). CAMHS clinician attitudes to borderline personality disorder in adolescence across scotland. *The Journal of Nervous and Mental Disease, 211*(9), 664–669.

Fusar-Poli, P., Estradé, A., Esposito, C. M., Rosfort, R., Basadonne, I., Mancini, M., . . . Allen, L. (2024). The lived experience of mental disorders in adolescents: A bottom-up review co-designed, co-conducted and co-written by experts by experience and academics.*World Psychiatry, 23*(2), 191–208.

Gajwani, R., Sim, F., McAllister, K., Smith, H., McIntosh, E., Moran, P., . . . Minnis, H. (2024). The BRIDGE project: A feasibility randomised controlled trial of brief, intensive assessment and integrated formulation for young people (age 14-24) with features of borderline personality disorder (protocol). *Frontiers in Psychiatry, 15*, 1389578. doi:10.3389/fpsyt.2024.1389578

Gajwani, R., Wilson, N., Nelson, R., Gumley, A., Smith, M., & Minnis, H. (2022a). Recruiting and exploring vulnerabilities among young people at risk, or in the early stages of serious mental illness (borderline personality disorder and first episode psychosis). *Frontiers in Psychiatry, 13*, 943509.

Gajwani, R., Wilson, N., Nelson, R., Gumley, A., Smith, M., & Minnis, H. (2022b). Recruiting and exploring vulnerabilities among young people at risk, or in the early stages of serious mental illness (borderline personality disorder and first episode psychosis). *Frontiers in Psychiatry, 13*, 943509. doi:10.3389/fpsyt.2022.943509

Gillard, S., Turner, K., & Neffgen, M. (2015). Understanding recovery in the context of lived experience of personality disorders: a collaborative, qualitative research study. *BMC psychiatry*, *15*(1), 183.

Grant, A. (2014). Troubling 'lived experience': A post-structural critique of mental health nursing qualitative research assumptions.*Journal of Psychiatric and Mental Health Nursing, 21*(6), 544–549. doi:10.1111/jpm.12113

Greenhalgh, T. (2025). Case studies: A guide for researchers, educators, and implementers. *BMJ Medicine, 4*(1), e001623.

Greenwood, M., Fakih, B., Steff, M., Bechange, S., & Mwifadhi, M. (2017). Hear my voice: A community-based participatory study gathering the lived experiences of people with disabilities and older people in tanzania.

Grenyer, B. F., Lucas, S., Barr, K. R., Finch, A., Denmeade, G., & Day, N. J. (2025). A randomized controlled trial of a peer and clinician led group program for borderline personality disorder. *Psychotherapy Research,* , 1–12.

Gupta, V., Eames, C., Golding, L., Greenhill, B., Qi, R., Allan, S., ... & Fisher, P. (2023). Understanding the identity of lived experience researchers and providers: a conceptual framework and systematic narrative review. *Research Involvement and Engagement*, *9*(1), 26.

Haynes, A., & Loblay, V. (2024). Rethinking barriers and enablers in qualitative health research: Limitations, alternatives, and enhancements. *Qualitative Health Research, 34*(14), 1371–1383.

Horgan, A., O Donovan, M., Manning, F., Doody, R., Savage, E., Dorrity, C., ... & Happell, B. (2021). 'Meet Me Where I Am': Mental health service users' perspectives on the desirable qualities of a mental health nurse. *International Journal of Mental Health Nursing*, *30*(1), 136-147.

Jazayeri, D., Banfield, M., Tapp, C., Tjung, C., Stettaford, T., Stewart, V., ... & Palmer, V. J. (2025). Capacity-building strategy for next-generation mental health research: embedding a national network infrastructure to grow mental health researcher capabilities and mental health lived-experience research leaders. *BMJ mental health*, *28*(1), e301554.

Kaess, M., & Cavelti, M. (2025). Research review: What we have learned about early detection and intervention of borderline personality disorder. *Journal of Child Psychology and Psychiatry, 66*(12), 1829–1848. doi:10.1111/jcpp.70011

Kastin, J. (2023). *Relations among attention deficit hyperactivity disorder features in childhood and adolescence, resilience, and borderline personality disorder features in adulthood* Pace University.

Klein, P., Fairweather, A. K., & Lawn, S. (2022). Structural stigma and its impact on healthcare for borderline personality disorder: A scoping review. *International Journal of Mental Health Systems, 16*(1), 48.

Kverme, B., Natvik, E., Veseth, M., & Moltu, C. (2019). Moving toward connectedness–a qualitative study of recovery processes for people with borderline personality disorder. *Frontiers in psychology*, *10*, 430.

Lambert, J. (2013). *Digital storytelling: Capturing lives, creating community* (Fourth ed.). London; New York: Routledge. doi:10.4324/9780203102329 Retrieved from https://go.exlibris.link/qrkvTR4v

Landry, D. (2017). Survivor research in Canada:'Talking'recovery, resisting psychiatry, and reclaiming madness. *Disability & Society*, *32*(9), 1437-1457.

Lane, M. R. (2005). Spirit body Healing—A hermeneutic, phenomenological study examining the lived experience of art and healing.*Cancer Nursing, 28*(4), 285–291. doi:10.1097/00002820-200507000-00008

Lau, P., Amestoy, M. E., Roth, M., & Monson, C. (2024). Patient-related factors associated with patient retention and non-completion in psychosocial treatment of borderline personality disorder: A systematic review. *Personality and Mental Health, 18*(4), 300–322.

Lavik, K. O., Veseth, M., Frøysa, H., Binder, P. E., & Moltu, C. (2018). What are "good outcomes" for adolescents in public mental health settings?. *International Journal of Mental Health Systems*, *12*(1), 3.

Lawn, S., & McMahon, J. (2015). Experiences of care by A ustralians with a diagnosis of borderline personality disorder. *Journal of Psychiatric and Mental Health Nursing, 22*(7), 510–521.

Leichsenring, F., Fonagy, P., Heim, N., Kernberg, O. F., Leweke, F., Luyten, P., . . . Steinert, C. (2024). Borderline personality disorder: A comprehensive review of diagnosis and clinical presentation, etiology, treatment, and current controversies. *World Psychiatry, 23*(1), 4–25. doi:10.1002/wps.21156

Links, P. S., Aslam, H., & O'Donnell, M. (2025). Personality disorders and clinical disorders: The challenge of comorbid autism spectrum disorder (ASD), eating disorders (EDs),

posttraumatic stress disorder (PTSD), or somatic symptom disorder (SSD). *Current Psychiatry Reports, 27*(1), 1–9.

Links, P. S., & Ross, J. (2025). Good psychiatric management of borderline personality disorder: Foundations and future challenges.*American Journal of Psychotherapy, 78*(1), 4–10.

MacDonald, L., & Sadek, J. (2023). Management strategies for borderline personality disorder and bipolar disorder comorbidities in adults with ADHD: A narrative review. *Brain Sciences, 13*(11), 1517.

McAllister, K. (2023). Through the valley of the shadow of death. journey through major mental illness as experienced by a mental health PhD candidate. doi:10.1097/PRA.0000000000000705

Muzari, T., Shava, G. N., & Shonhiwa, S. (2022). Qualitative research paradigm, a key research design for educational researchers, processes and procedures: A theoretical overview. *Indiana Journal of Humanities and Social Sciences, 3*(1), 14–20.

Ng, F. Y., Townsend, M. L., Miller, C. E., Jewell, M., & Grenyer, B. F. (2019). The lived experience of recovery in borderline personality disorder: A qualitative study. *Borderline Personality Disorder and Emotion Dysregulation, 6*(1), 10.

O'Grady, S. M., & Hinshaw, S. P. (2023). Developmental predictors of young adult borderline personality disorder: A prospective, longitudinal study of females with and without childhood ADHD. *BMC Psychiatry, 23*(1), 106.

Ociskova, M., Prasco, J., Vanek, J., Nesnidal, V., Sollar, T., & Slepecky, M. (2023a). Stigma and Self-Stigma in borderline personality disorder: A narrative review. *Neuroendocrinology Letters, 44*(4), 206–215.

Page, R. E., & Thomas, B. (2011). *New narratives: Stories and storytelling in the digital age*. Lincoln: University of Nebraska Press. doi:10.2307/j.ctt1df4h49 Retrieved from https://go.exlibris.link/SX6GTkvt

Phipps, M., Barnes, T., & Morrison, J. (2023). Lived experience of peer-clinician collaboration in a mental health service. *International Journal of Mental Health Nursing, 32*(2), 615–619. doi:10.1111/inm.13101

Pickard, J. A., Finch, A., Huxley, E., Townsend, M. L., Deuchar, S., Lewis, K. L., . . . Grenyer, B. F. S. (2021). Assessing the efficacy of a stepped-care group treatment programme for borderline personality disorder: Study protocol for a pragmatic trial. *Current Controlled Trials in Cardiovascular Medicine, 22*(1), 383–9. doi:10.1186/s13063-021-05327-0

Pigot, M., Miller, C. E., Brockman, R., & Grenyer, B. F. (2019). Barriers and facilitators to the implementation of a stepped care intervention for personality disorder in mental health services. *Personality and Mental Health, 13*(4), 230–238.

Richards, J., Holttum, S., & Springham, N. (2016). How do “mental health professionals” who are also or have been “mental health service users” construct their identities?. *Sage Open*, *6*(1), 2158244015621348.

Riihimäki, K., Sintonen, H., Vuorilehto, M., Jylhä, P., Saarni, S., & Isometsä, E. (2016). Health-related quality of life of primary care patients with depressive disorders. *European Psychiatry, 37*, 28–34.

Ripoll, L. H. (2013). Psychopharmacologic treatment of borderline personality disorder. *Dialogues in Clinical Neuroscience, 15*(2), 213–224.

Smith, J. A. (2017). Interpretative phenomenological analysis: Getting at lived experience. *The journal of positive psychology*, *12*(3), 303-304.

Speers, J., and J. Lathlean. 2015. “Service User Involvement in Giving Mental Health Students Feedback on Placement: A Participatory Action Research Study.” Nurse Education Today 35, no. 9: 84–89.

Tusiani-Eng, P., & Yeomans, F. (2018). Borderline personality disorder: Barriers to borderline personality disorder treatment and opportunities for advocacy. *Psychiatric Clinics, 41*(4), 695–709.

Wall, K., Kerr, S., & Sharp, C. (2021). Barriers to care for adolescents with borderline personality disorder. *Current Opinion in Psychology, 37*, 54–60.

Warr, D., Mann, R., & Tacticos, T. (2011). Using peer-interviewing methods to explore place-based disadvantage: dissolving the distance between suits and civilians. *International Journal of Social Research Methodology*, *14*(5), 337-352.

Weiner, L., Perroud, N., & Weibel, S. (2019). Attention deficit hyperactivity disorder and borderline personality disorder in adults: A review of their links and risks. *Neuropsychiatric Disease and Treatment,* , 3115–3129.

West, J., Birt, L., Wilson, D., Mathie, E., & Poland, F. (2022). A case study of co-production within a mental health Recovery College dementia course: Perspectives of a person with dementia, their family supporter and mental health staff. *Frontiers in Rehabilitation Sciences*, *3*, 920496.

Wilson, N., Robb, E., Gajwani, R., & Minnis, H. (2021). Nature and nurture? A review of the literature on childhood maltreatment and genetic factors in the pathogenesis of borderline personality disorder. *Journal of Psychiatric Research, 137*, 131–146. doi:10.1016/j.jpsychires.2020.12.025

Wlodarczyk, J., Lawn, S., Powell, K., Crawford, G. B., McMahon, J., Burke, J., . . . Litt, J. (2018). Exploring general practitioners' views and experiences of providing care to people with borderline personality disorder in primary care: A qualitative study in australia. *International Journal of Environmental Research and Public Health, 15*(12), 2763.

Yin, R. K. (2009). *Case study research: Design and methods* sage.

Yin, R. K. (2013). Validity and generalization in future case study evaluations. *Evaluation, 19*(3), 321–332.

Zuccala, M., Webb, S., & Yong, C. (2025). When hospital harms more than helps: Iatrogenic processes in adolescent inpatient settings. *Clinical Child Psychology and Psychiatry, 30*(3), 670–682. doi:10.1177/13591045251332134

Appendices

Appendix 1

Gajwani, R., Sim, F., McAllister, K., Smith, H., McIntosh, E., Moran, P., Ougrin, D., Smith, M., Gumley, A. I., Chanen, A. M., & Minnis, H. (2024). The BRIDGE project: A feasibility randomised controlled trial of brief, intensive assessment, and integrated formulation for young people (age 14-24) with features of borderline personality disorder (protocol). *Frontiers in Psychiatry, 15*, 1389578. https://doi.org/10.3389/fpsyt.2024.1389578

The BRIDGE project: A feasibility randomised controlled trial of brief, intensive assessment and integrated formulation for young people (age 14-24) with features of borderline personality disorder (Protocol)

Ruchika Gajwani[1,2*], Fiona Sim[1], Kirsty McAllister[1], Helen Smith[3], Emma McIntosh[1], Paul Moran[4],
Dennis Ougrin[5], Michael Smith[1,2], Andrew Gumley[1,2], Andrew Chanen[6,7], Helen Minnis[1,2]

School of Health and Wellbeing, University of Glasgow, Glasgow, UK

NHS Greater Glasgow and Clyde, Glasgow, UK

NHS Ayrshire and Arran, Scotland, UK

Department of Population Health Sciences, University of Bristol, Bristol, UK

Youth Resilience Unit, Queen Mary University of London, London, UK

Orygen, Melbourne, Australia

Centre for Youth Mental Health, The University of Melbourne, Melbourne, Australia

Correspondence:

Ruchika Gajwani

Ruchika.Gajwani@Glasgow.ac.uk

Keywords: Borderline Personality Disorder (BPD), BPD features, Early Intervention, Young People,
Feasibility RCT (fRCT), Community Intervention, Cognitive Analytic Therapy (CAT)

Introduction

Borderline personality disorder (BPD) is a severe mental disorder that is characterised by a pervasive pattern of instability of interpersonal relationships, self-image, and mood as well as marked impulsivity. BPD has its peak incidence and prevalence from puberty through to

emerging adulthood. The adverse personal, social and economic consequences of BPD during this developmental period have been summarised in many publications . In brief, BPD among young people uniquely predicts severe and harmful current problems, increases the complexity of clinical presentation and treatment delivery and acts as a gateway to diverse and serious problems later in life that includes a mortality rate 10 times that of general population and an almost two-decade reduction in life expectancy (2, 3). Moreover, those who care for and about these young people also experience severe difficulties.

Despite these compelling facts, along with good evidence that early intervention can improve these short- and long-term outcomes (4), in the UK, BPD has become a controversial diagnosis when applied to young people (5). This is largely because the condition is associated with a high degree of public, self, structural and institutional stigma. This has commonly led to clinical cultures in which the diagnosis is avoided or delayed, or substitute diagnoses are used, in the belief that this is in the best interests of young people. In turn, this leads to delays in effective treatment, risks the use of inappropriate and/or harmful treatments leading to poor outcomes and risks further stigmatising people living with the disorder (6).

Young people with the persistent and complex needs that are characteristic of BPD – i.e. those with the poorest functioning and most complex psychiatric presentations - often find themselves falling out of contact with services by age eighteen (7). Barriers to diagnosis and treatment of BPD in young people include the myths that a BPD diagnosis implies permanent disability, will lead to clinical and self-experiential discrimination (8), and to widening social, health and occupational disadvantage. Despite randomised controlled trial (RCT) evidence for the effectiveness of specialised psychosocial treatments for BPD in young people (4), the effect sizes for these treatments are modest and not uniformly sustained at follow-up. Furthermore, these specialised treatments are often complex, costly and unlikely to be scalable at a population level. Scalable approaches to mitigate against the short- and long-term adverse outcomes for young people living with BPD, for the benefit of the whole population, is a public health priority (9).

Young people with early BPD benefit from good clinical care and targeted intervention (10), however their needs are often under-recognised. NICE guidelines for BPD recommend (11) that people with BPD should not be excluded from any social and health care services but, in practice,

BPD sufferers experience of discrimination and disengagement from specialist services which perpetuates social and health inequalities (12, 13).

In this paper, we will outline the protocol of a feasibility randomised controlled trial (f-RCT) of a novel therapeutic intervention of brief, intensive assessment and integrated formulation (BRIDGE intervention). The intervention delivers on three core elements: a) shared formulation of comprehensive psychiatric, health, functioning assessments, b) up to sixteen sessions of Cognitive Analytic Therapy, c) contextual work with the young person and multi-agency teams involved with the participant. With this in mind, this trial aims to establish the feasibility of engaging and retaining of young people with features of borderline personality disorder in the community for participation in the f-RCT. We also aim to map the complex and varied needs of this group of young people with BPD features, who may otherwise be missed from services because they don't "fit" a traditional service model/diagnosis, and to examine the acceptability of the trial processes.

Our approach to understanding the complex social/service delivery for this group is informed by syndemics, the term given to the co-occurrence of multiple, inter-related health problems at the individual- and population-level, developing and being sustained by harmful/unhelpful social contexts. This approach (14) is our key methodology for examining and optimising interdisciplinary working. Syndemics is embedded within the research methodology, the multi-agency intervention approach, our international network of collaborators, and the central role of young people at all stages of study design, delivery, and dissemination.

Consultation with individuals with lived experience of borderline personality disorder has been a cornerstone of the development and ongoing refinement of this clinical trial. A Youth Advisory Group
(YAG) comprising individuals from the Transdisciplinary Research for the Improvement of Youth Mental Public Health network (TRIUMPH
http://triumph.sphsu.gla.ac.uk/) was established at the funding application stage of the trial and has offered consultation throughout the trial. Co-investigators with lived experience of BPD have provided insight and guidance to the acceptability of procedures (i.e. design and planned recruitment) on an ongoing basis.

Methods

Trial objectives

To assess the feasibility of conducting a randomised controlled trial (f-RCT) of BRIDGE, a brief intervention programme for young people (age 14-24) with BPD features (sub- or full-threshold), in a community sample of Glasgow, Scotland.

Research Questions

Are recruitment and retention rates adequate to suggest a future full-scale RCT would be possible (quantitative)?
What are the characteristics (in terms of mental health and service use) of the young people referred to the study (whether or not eventually randomised).
How acceptable are the trial processes and interventions to the participants (qualitative and Patient and Public involvement; PPI)?
Is it feasible to collect clinical and health economic outcome data for a future definitive randomised controlled trial (d-RCT) (missingness and data quality)?
Does the trial need adapting for participants in different settings (qualitative and PPI)?
Do trial processes need adapting in order to successfully recruit participants from different referral routes (quantitative and qualitative)?

Trial design/settings

We plan to conduct a single-blind, parallel groups f-RCT following the Medical Research Council Complex Interventions Framework(15) over a period of 36 months. We will randomise young people with features of BPD to BRIDGE (and service as usual (SAU)) or SAU (alone) and explore aspects of feasibility using qualitative and quantitative methods.

The study is set in the city of Glasgow, Scotland's largest and most ethnically diverse city with an estimated population of 635,130, of which almost 12% represent an ethnic minority. Adolescents and young people represent approximately 12% of the Glasgow population; over half live in areas in the two most deprived deciles within Scotland, whilst only 4% Glaswegian

children live in areas in the least deprived decile within Scotland (https://www.gov.scot/collections/scottish-index-ofmultiple-deprivation-2020/).

Inclusion criteria:

3 or more of the 9 DSM-5 BPD criteria assessed using the SCID-PD.

Age 14-24 (inclusive).

Exclusion criteria:

Currently receiving evidence-based psychosocial treatment for BPD, with a minimum of six sessions attended prior to any disengagement/drop-out.

Has received any previous evidence-based psychosocial treatment for BPD.

Receiving specialist intensive psychiatric treatment at the time of study entry, for severe mental health disorder (such as DSM-V psychosis or severe anorexia nervosa).

Insufficient fluency in English to complete the study protocol.

Living out-with Glasgow City health board.

Participant recruitment

Recruitment is taking place over 24-months, from October 2021 to September 2023. As per recommended Medical Research Council guidelines for f-RCTs (16), a formal sample size calculation is not appropriate. Our pilot work suggests that we will achieve a sample size of forty adolescents and young people (age 14-24), with subthreshold or full-threshold BPD features, recruited from the community and randomized to each of the two arms of the trial. This sample will allow us to estimate the sample size for a phase III trial and the human resources required to achieve recruitment and retention.

We will also explore the feasibility of different routes of referral to the trial. Participants might or might not be involved with a mental health service provider to meet criteria for trial. However, there will be an expectation that all participants will be registered with a GP. Where a participant has no fixed abode, a GP will be identified within the homelessness GP team. Participants will be recruited through ethically approved channels that might include:

Self-referral through advertisements in public places (i.e., transport, libraries, social media)

Referral from professional within the NHS GG&C (specialist children's services, Adult mental health services, GP, A&E)

Referral from professional within social work, forensic services, youth support services

Referral from third sector organisations

Professionals within each of the above services will be made aware of the study through presentations with the trial team. They will then be regularly asked if any patients on their caseload/service users meet inclusion criteria for the study and can be approached for participation. With potential participants, verbal consent will be sought and noted before referring for further participation with the clinical trial.

The screening will include a two phased approach:

Phase 1 (screening): Participants (accessed through a range of settings in Glasgow) will selfcomplete the brief (15- item) SCID-II PQ-BPD questionnaire. Potential participants will be either referred by a professional in a range of settings in Glasgow or can self-refer: everyone will complete either an online (www.bridgeproject.co.uk) or paper screening assessment. Those meeting the cut off for the SCID-II PQ BPD (>11 out of 15) will be invited to Phase 2. SCID-II PQ-BPD has good psychometric properties and is used as a screening tool for BPD in outpatient youth (17).

Phase 2 (diagnostic screening): All potential participants will be invited for an interview conducted using the Structured Clinical Interview for DSM-V Axis II Personality Disorders (SCID-5-PD) BPD module. This will be carried out by a clinician or clinically trained researcher. Those young people who meet 3 or more SCID-5-BPD criteria (subthreshold or full-threshold) will be eligible for randomisation to the BRIDGE study.

Intervention

Brief, intensive assessment and integrated formulation (BRIDGE) intervention development has been guided by the emerging evidence base for community based comprehensive assessment and brief intervention with young people with longstanding unmet needs characteristic of BPD features.

BRIDGE will be delivered over 3-6 months and has three foci:

Comprehensive assessment, taking up to two sessions, including BPD symptoms, copresenting difficulties, neurodevelopmental profile, life events history and psychosocial functional impact.
Up to 16 sessions of Cognitive Analytic Therapy (CAT)(18).
Develop a shared formulation with the young person, using CAT principles (Reformulation, Recognition and Revision) and their comprehensive assessment, and, where clinically applicable, their family and service-providers. Developing a shared formulation with the young person and multi-agency group would be unique to the participant, using contextual CAT.

Treatment fidelity

A fidelity evaluation framework will be optimised to the specific needs of this complex intervention (19) with the focus on a) participant responsiveness as engagement and retention is the primary focus of the trial b) complex intervention adherence (Frequency, duration and nature of engagement) c) quality of delivery (protocol adherence, monitoring assessments and treatment delivery) d) identifying barriers and facilitators (recruitment, engagement, retention) e) outcome measurement of change and sustainability. Trial therapists will have two-weekly supervision with a senior CAT practitioner and supervisor, accredited by the Association of Cognitive Analytic Therapists (ACAT), with extensive experience of working with young people with BPD.

Comparison (SAU)

For participants randomised to SAU, a routine letter acknowledging their participation will be shared with their service provider(s), including the GP. SAU, which is likely to range from social services, mental-health services, forensic services, to no intervention, will be documented for each participant. The intervention will be described in detail through the qualitative process evaluation.
There will be no formal measure of treatment fidelity for SAU.

Procedure

Our three-month pre-trial set-up phase will establish a detailed system for managing referrals, randomization, and networking with likely referral sources, including any self-referrals detailed in
Table 1. All potential participants will receive a 'Participant Information Leaflet' and a 'Trial Consent Form' prior to Screening 1. The trial research team will then invite young people meeting criteria at screening 1 for an assessment (Phase 2) to determine eligibility for

subthreshold or full-threshold BPD features. The assessment will be conducted by a clinically trained researcher, prior to study randomisation.

Young people (age 14-24) or parents (for those aged 14-16 who are judged by a healthcare professional, i.e. GP, as incapable of providing written, informed consent) with child assent will complete the Participant Information sheet (online or paper format) and consent form. Capacity to consent will be confirmed and documented by a healthcare professional at diagnostic screening 2, prior to randomisation.

Randomisation

Randomisation will be managed by the Trial Team at the University of Glasgow. Participants will be randomised (1:1) to either BRIDGE (+SAU) or SAU. A statistician from the Robertson Centre for Biostatistics at the University of Glasgow will generate a randomisation table. Research outcome assessors will be blind to treatment allocation. The randomisation list, containing the unique study
ID and participant name, will be stored on a password protected file within the Trial Team's private
Microsoft Teams channel (following sponsor representative GDPR guidelines, at the university of Glasgow secure server). Access will be restricted only to those members of the research team who will remain unblinded throughout the study. A log of access will be maintained. Participants will be randomised by a member of the administrative team independent of the trial, using the randomisation procedure provided by the study statistician.

All participants consenting to participate will be invited to complete assessments, postrandomisation, at baseline, 12- and 24- weeks post-randomisation. A minimum data set of care pathways will be described at baseline. Follow-up of all participants will occur for the purpose of future modelling of health economics impacts in relation to quality of life and functional outcomes.

Case-study methodology will be used to understand individual contexts, involving embedded qualitative evaluation with about 10- 15 young people (five to seven from BRIDGE intervention and five to seven from SAU's) and, where possible, their parents and relevant service providers. Topics will include acceptability of the three elements of BRIDGE, perceived mechanisms of

change and exploration of requirements for data collection for a future d-RCT, including for future health economic evaluation.

Measures

The only quantitative outcome measures in the f-RCT are recruitment (i.e. proportion of young people referred as eligible who are consented and randomised) and retention (i.e. proportion of those randomised who complete follow-up assessments at six months post randomisation).

We have examined the literature and best practice guidelines to select likely outcome measures for use in a future definitive RCT (d-RCT) (e.g., the International Committee for Harmonization of Outcome Measures for Personality Disorder (20)) The f-RCT will investigate the acceptability and appropriateness of these measures for a future d-RCT which include, at screening 1/prerandomisation: The Structured Clinical Interview for DSM-V Axis II for Personality disorders (SCID-II PQ-BPD)(21) consists of 15 questions which explore the presence of BPD symptoms using 'Yes' or 'No' answers. SCID-II PQ-BPD has been found to show moderate to excellent accuracy AUC = 0.86, SE=0.02, P> 0.0001(22).

Should an individual score a minimum of 11 of the 15 questions they are invited to the Structured Clinical Interview for DSM-V Axis II Personality Disorders (SCID-5-PD) BPD module (23). This is a semi-structured interviewed which explores these 15 questions in depth measuring on a scale of ?-3 to what extent an individual's symptoms impact on their functioning. (? = inadequate information, 1= absent or false, 2 = subthreshold, 3 = threshold or true. A pervasive pattern of instability in relationships, self-image, mood, impulsivity, anger and the occurrence of dissociation are explored. Although the DSM-5 (24) used the criteria that five of these categories are met, for the purposes of BRIDGE, the present of three meets inclusion for criteria as identifying early signs and symptoms is the objective.

In this second screening further measures are carried out. KIDSCREEN 10 (23) is a health questionnaire for children and young people, exploring how they have perceived their health to be in the previous week. The KIDSCREEN 10 (23) is a standardised assessment tool for health and its impact on quality of life, demonstrating good internal consistency (Cronbach's alpha =.82), and good test-retest reliability (r=.73; ICC=.72) (25).

Participants will complete the following measures pre-randomisation: Pathways to care and demographic questionnaire, Mini International Neuropsychiatric Interview (MINI) 7.0.2 (18yrs+) and the Mini International Neuropsychiatric Interview (MINI-KID) 7.0.2 (under 18yrs) (26); The M.I.N.I-
International Neuropsychiatric Interview (Mini) 7.0.2 (18yrs+) and Mini International Neuropsychiatric Interview (MINI-KID) 7.0.2 (under 18 years)) is a diagnostic, structured tool for assessing common psychiatric disorders. Studies (27) have shown that the MINI has psychometric reliability and validity, and can be delivered with short training input and in a brief period of time. Adverse Childhood Experiences Scale (ACES) (28) asks 10 questions regarding traumatic experiences that occurred before the age of 18. Autism Symptoms adolescents (ASSERT) (29) is a self-report tool with 8-questions pertaining to poor social understanding, rigidity and repetitive behaviours and interests. Adult ADHD Self-Report Scale (ASRS) (30) is an 18-question screening tool used by BRIDGE to screen for attention deficit disorder symptoms such as feelings, conduct and level of impairment in the previous 6 months. It has 2 subscales; 1) Inattention and 2)
Hyperactivity. It has been found to be a reliable and valid scale, showing high internal consistency (Cronbach's alpha 0.88) and rater-administration (Cronbach's alpha 0.89)(31).

At baseline, 12- and 24- week follow-up, assessments include: Borderline symptoms list (BSL-23)
(32) This 23-item list explores the impact of BPD symptoms in the course of the previous week.. The questions explored include concentration, emotions, vulnerability and overall daily functioning. A BSL supplement is also used in BRIDGE which assesses behaviours over the course of the previous week. The BSL-23 has excellent psychometric properties, high internal consistency (Cronbach = 0.97) and test-retest reliability (0.82) (33). Sheehan's Disability Scale (SDS)(34) is a self-reporting tool which assess the impact of symptoms on functional impairment. There are three scales, 1) Work*/school, 2) Social life, 3) Family and home responsibilities. Days lost and days unproductive due to symptoms are also rated. Barratt Impulsiveness Scale (BIS-Brief) (35)
(Revised) is consists of 30 questions which consider 1) Attentional Facet, 2) Motor Facet, 3) Planning Facet. The Cronbach alphas range from 0.73 to 0.83 indicating good reliability. Difficulties in Emotional Regulation Scale-SF (DERS-SF) (36) consists of 18 questions and measures how an individual relates to their emotions such as understanding, awareness and

acceptance. In terms of validity and reliability the DERS-SF had a Cronbach-Alpha range of 0.90-0.98 and 81-96% shared variance. Patient Health Questionnaire-9 (PHQ – 9) (37) is a self-report tool of 9-questions which monitors the severity of depression. It measures areas such as sleep, low mood and appetite. Quality of Life Questionnaire (EQ-5D 5L) (38) is a short self-report tool which asks participants to measure their health on that day on a scale of 5 levels - "no problems, I slight problems, moderate problems, severe problems and unable to carry out activity" .

Quality of Life will be assessed with ICECAP-A (39), with a Cronbach's Alpha of 0.86. Suicidal Ideation Scale (SIS) (40) is a 10-question 1-5 scale (1 being "never or none of the time and 5 being "always or a great many times") which can detect early suicidal ideation amongst adolescent and young people in the general population. It was found to have excellent internal consistency and test-retest reliability.

The feasibility and acceptability of this battery will be explicitly assessed as one of the trial's key feasibility parameters: qualitatively, we will examine the acceptability and appropriateness of these outcome measures in terms of whether or not participants think we are asking the right questions and whether the measures are acceptable or too burdensome. Prior to final decisions about use of measures in a future d-RCT, the measurement battery will also be discussed in the expert Scientific Advisory Group and Youth Advisory Group.

All the measures will be incorporated into a user-friendly questionnaire "book" and participants will have the option of completing on paper, in a telephone interview, or a mixture – a technique that has worked well in previous studies. These measures will be conducted by trained researcher assessors, blind to group status, at 12- and 24-weeks post-randomization.

Statistical Analysis

Statistical analyses will be conducted by a statistician/researchers who are blinded to treatment allocation. Recruitment, retention rates and the BRIDGE sessions attended will be calculated with 95% confidence intervals (CI). A simple descriptive analysis of recruitment/retention relative to eligible/approached population will be conducted. While underpowered, between-group change in each measure after adjustment for baseline will be estimated using analysis of covariance (ANCOVA). The emphasis will not be on reporting of significance but variance in outcome measures between groups by reporting mean differences based on change from baseline with 95% CI and effect sizes reported. The standard deviation of the assessments for the putative outcome

measures at baseline and follow-up will be estimated, shaping the future d-RCT. Statistical analysis plan and data sharing agreement will be agreed by the Scientific Advisory Group in consultation with the NHS Scotland's Mental Health Network PPI group.

Process evaluation

Interpretative Phenomenological Analysis will be used to explore participant's experience of engagement and retention with the BRIDGE project. Process evaluation of the contexts and experiences of the young person presenting to the BRIDGE project will enable us to develop a framework for context-mechanism-outcome configurations (CMOCs) (41) that will be unique to the young person's experiences and the multi-agency engagement (or the lack of) around them (42). This would involve qualitative interviews with ten to fifteen young people and, where possible, their parents and relevant service providers. Topics will include acceptability of the three elements of BRIDGE intervention, perceived mechanisms of change and exploration of requirements for data collection for a future d-RCT, including for future health economic evaluation.

Health economics

For the economic analysis, data will be collected on cost of delivering the intervention, in addition to participant's use of health, personal, and social services and broader educational and societal resources in the six months before study baseline data collection. Adolescent and young adult's quality of life will also be measured within trial using the ICECAP-A (39). Measurement of quality of life is an important input for the economic component of this study and will enable assessment of any short-term change in quality of life for young people between baseline and 6 months, and also between the trial arms. The clinical and service use characteristics of young people referred to the study will be used to build a health economic logic model for potential lifetime impacts of BRIDGE.

Discussion

Young people with BPD benefit from evidence-based psychosocial interventions. However they are infrequently identified or are excluded from services. NICE guidelines for BPD recommend that people with BPD should not be excluded from any social and health care services. Yet, in practice, discrimination and disengagement from specialist services perpetuates pre-existing

social and health inequalities. We aim to identify the feasibility of recruiting and engaging adolescents and young people with features of BPD to both, research and to the intervention. This feasibility trial, which will recruit from both health services and the community will contribute towards the building evidence base on the complex needs of young people with BPD features who might otherwise be missed from services because they don't "fit" a traditional service model/diagnosis. This description will be useful to commissioners and policy-makers.

The study has been developed through careful pilot work (43) and collaborations with local service providers, national and international experts in BPD research, academics leading complex clinical trials, youth advisory team, experts by experience and commissioners who are motivated to reduce health inequalities and have a specific focus on mental health resilience for the most vulnerable young people in Scotland. The endeavour to support the feasibility trial in Scotland shows commitment to the mission of early intervention and prevention - not just in principle but through multi-agency collaboration with the endeavour to improve services for some of the most vulnerable children and young people. This feasibility trial includes ongoing consultation with young people with lived experience, and a dissemination plan to bring together commissioners and family members. The outcomes of this feasibility trial will guide a Phase lll clinical trial/definitive RCT.

By conducting a community-based clinical trial with young people, and not limiting the intervention to specialist mental health services, we aim to identify 'hidden' young people. This might include, for example, those avoiding contact with services due to previous trauma or neurodevelopmental conditions (for example, ADHD) or complex family needs. We also aim to assess pathways to care and missed opportunities for participation in treatment, and to examine for the possibility of early identification of young people with BPD features in the community, and the possibility of early intervention through joined-up, multi-agency work (schools, youth workers, counsellors, GP's).

Transparency and data sharing are now widely encouraged for intervention clinical trials, although their application is suboptimal. To promote open science in clinical trials, the fRCT will engage in cross-disciplinary agreement between the Data Monitoring Committee (DMEC) and the Trial Steering Committee (TSC), in consultation with the service user researcher group in

NHS Scotland's Mental Health Network, for a data sharing protocol for a d-RCT. Our syndemics approach is our key methodology for ensuring excellent interdisciplinary working. Syndemics is embedded within the research methodology, the multi-agency intervention approach, our international network of collaborators, and the central role of young people at all stages of study design, delivery and dissemination.

Currently, BPD is viewed erroneously by many clinicians as intractable, with 'trauma' as its sole aetiology. Moreover, where specialist services do exist, treatment is usually delayed and/or limited to a select few. Our own pilot study ('Pathways study', Gajwani et al, 2022, Darcy et al., submitted), and work from other groups, has shown that, despite the high risk of morbidity and mortality, young people with BPD features are less likely to be assessed and/or treated and often fall into the service gap between child and adolescent and adult mental health services. The development of workable, multi-agency services proposed in the trial would be a major advance in optimising care pathways, regardless of trial outcome. Societal and professional attitudes to people living with personality disorders, and to service provision for this vulnerable group, have an important effect upon how services are delivered.

Limitations

There are systematic, structural barriers to undertaking clinical research with young people living with BPD features. We can therefore never know if we are reaching the entire eligible population. Participants in the trial will not be receiving a diagnosis of BPD. Without a diagnosis, it can be hard for young people to access services, yet, with a diagnosis there is a risk of labelling, stigma and discrimination. We are limited to measure the contribution of structural and individual experiences of stigma and discrimination on engagement and retention within the study. This might mean that eligible participants are excluded by gatekeepers who do not regard them as eligible. We also do not have the resources to actively engage with potentially eligible participants who do not have English as a first language. Although a tool is being developed for the purposes of a treatment fidelity within the f-RCT, there is limited measurement of treatment fidelity for BRIDGE intervention and SAU. No measurement of the content of SAU and no measure of 'contamination'. The scope of the study limits mapping and modelling of multi-agency service provisions for this group of young people and examining the extent of its contribution to the delivery/completion of the intervention.

Conflict of Interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Author Contributions

RG was awarded the fellowship for the clinical trial, leading the conceptualisation, design, protocol development and trial delivery; FS, KM have contributed to study protocol, data management and planned process evaluation; HM, AG and AC are mentors and collaborators, involved in overall trial design, conceptualisation and planned trial delivery; PM, DO, HS, MS have contributed to study design, assessments and clinical & scientific protocol development; EM is leading the health economics study design.

Acknowledgments

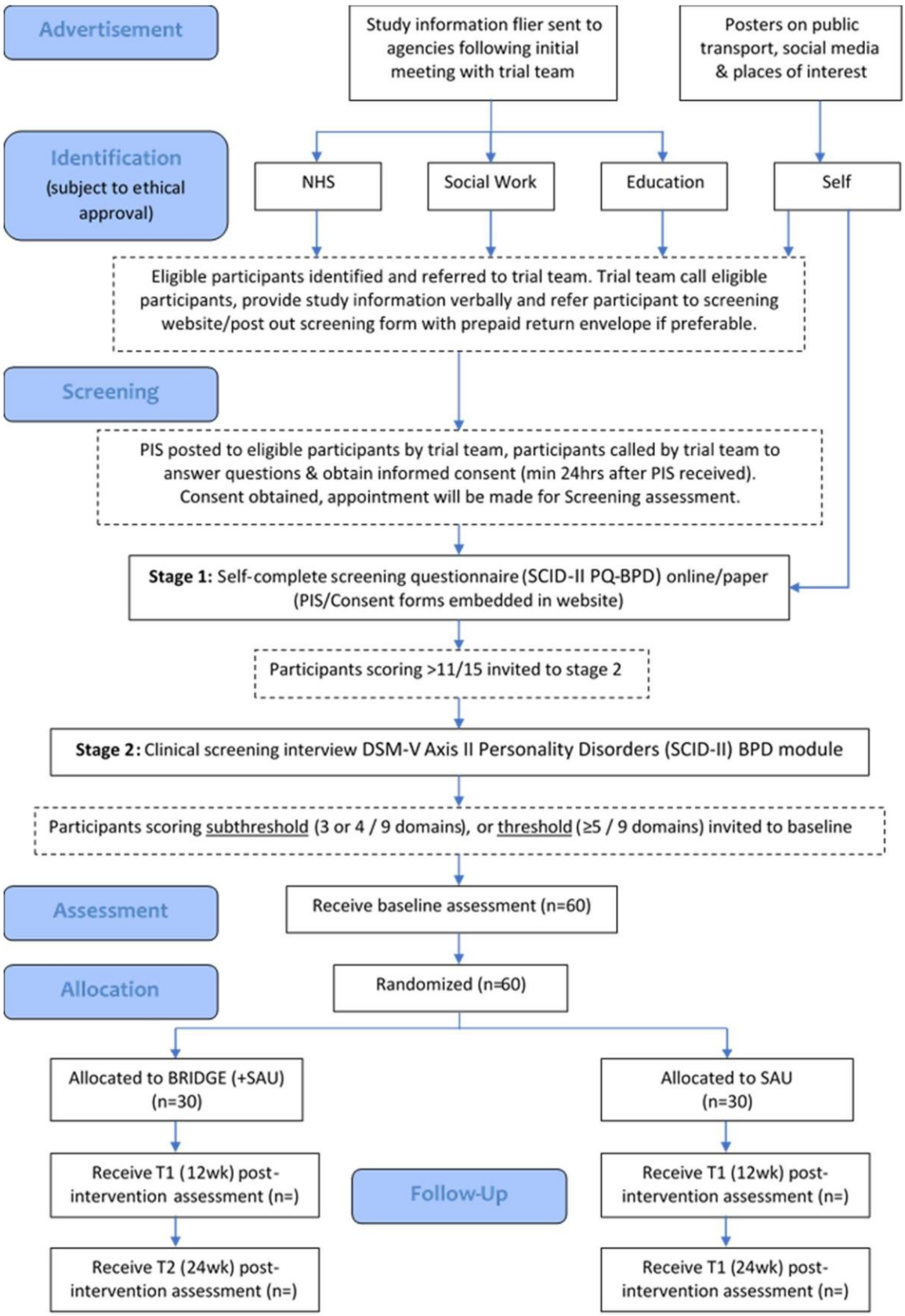
The clinical trial is funded by MQ as a clinical fellowship: Transforming Mental Health 2016 | Registered charity in England/Wales: 1139916 & Scotland: SCO46075 | Company number: 7406055. MQ have received funding for the project from two funders, the Rosetrees Trust (Registered with the Charity Commissions, No. 1197546) and a private family donation. The trial comes under the Research Governance sponsorship arrangements of NHS Greater Glasgow and Clyde with a shared ethics agreement with the University of Glasgow.

Trial Registration

The f-RCT has been registered with the ClinicalTrial.gov Identifier: NCT05023447; The BRIDGE Project: A Feasibility Randomised Controlled Trial of Brief, Intensive Assessment and Integrated Formulation for Young People (Age 14-24) Early in the Course of Borderline Personality Disorder

446

447 Table 1. Participant flow diagram


Advertisement
Study information flier sent to agencies following initial meeting with trial team
Posters on public transport, social media & places of interest
Identification (subject to ethical approval)
NHS
Social Work
Education
Self
Eligible participants identified and referred to trial team. Trial team call eligible participants, provide study information verbally and refer participant to screening website/post out screening form with prepaid return envelope if preferable.
Screening
PIS posted to eligible participants by trial team, participants called by trial team to answer questions & obtain informed consent (min 24hrs after PIS received). Consent obtained, appointment will be made for Screening assessment.
Stage 1: Self-complete screening questionnaire (SCID-II PQ-BPD) online/paper (PIS/Consent forms embedded in website)
Participants scoring >11/15 invited to stage 2
Stage 2: Clinical screening interview DSM-V Axis II Personality Disorders (SCID-II) BPD module
Participants scoring subthreshold (3 or 4 / 9 domains), or threshold (≥5 / 9 domains) invited to baseline
Assessment
Receive baseline assessment (n=60)
Allocation
Randomized (n=60)
Allocated to BRIDGE (+SAU) (n=30)
Allocated to SAU (n=30)
Receive T1 (12wk) post-intervention assessment (n=)
Follow-Up
Receive T1 (12wk) post-intervention assessment (n=)
Receive T2 (24wk) post-intervention assessment (n=)
Receive T1 (24wk) post-intervention assessment (n=)

427

References:

Chanen AM, Sharp C, Nicol K, Kaess MJF. Early intervention for personality disorder. 2022;20(4):402-8.

Fok ML-Y, Hayes RD, Chang C-K, Stewart R, Callard FJ, Moran PJJopr. Life expectancy at birth and all-cause mortality among people with personality disorder. 2012;73(2):104-7.

Moran P, Romaniuk H, Coffey C, Chanen A, Degenhardt L, Borschmann R, et al. The influence of personality disorder on the future mental health and social adjustment of young adults: a population-based, longitudinal cohort study. 2016;3(7):636-45.

Chanen AM, Nicol K, Betts JK, Thompson KN. Diagnosis and Treatment of Borderline Personality Disorder in Young People. Current Psychiatry Reports. 2020;22(5):25-.

Hartley S, Baker C, Birtwhistle M, Burgess JL, Chatburn E, Cobbaert L, et al. Commentary: Bringing together lived experience, clinical and research expertise–a commentary on the May 2022 debate (should CAMH professionals be diagnosing personality disorder in adolescence?). 2022;27(3):246-9.

Biskin RS. The lifetime course of borderline personality disorder. The Canadian Journal of Psychiatry. 2015;60(7):303-8.

Singh SP, Paul M, Ford T, Kramer T, Weaver T. Transitions of care from child and adolescent mental health services to adult mental health services (TRACK study): a study of protocols in Greater London. BMC Health Services Research. 2008;8(1):135.

Sharp C. Bridging the gap: the assessment and treatment of adolescent personality disorder in routine clinical care. Archives of Disease in Childhood. 2017;102(1):103-8.

Holmes EA, O'Connor RC, Perry VH, Tracey I, Wessely S, Arseneault L, et al. Multidisciplinary research priorities for the COVID-19 pandemic: a call for action for mental health science. The Lancet Psychiatry. 2020.

Choi-Kain LW, Albert EB, Gunderson JG. Evidence-based treatments for borderline personality disorder: implementation, integration, and stepped care. Harvard Review of Psychiatry. 2016;24(5):342-56.

Health NCCfM, editor Borderline personality disorder: treatment and management2009: British Psychological Society.

Moran P, Romaniuk H, Coffey C, Chanen A, Degenhardt L, Borschmann R, et al. The influence of personality disorder on the future mental health and social adjustment of young adults: a population-based, longitudinal cohort study. The Lancet Psychiatry. 2016;3(7):636-45.

Hastrup LH, Kongerslev MT, Simonsen E. Low vocational outcome among people diagnosed with borderline personality disorder during first admission to mental health services in Denmark: a nationwide 9-year register-based study. Journal of personality disorders. 2019;33(3):326-40.

Singer M, Bulled N, Ostrach B, Mendenhall E. Syndemics and the biosocial conception of health. The Lancet. 2017;389(10072):941-50.

Craig P, Dieppe P, Macintyre S, Michie S, Nazareth I, Petticrew M. Developing and evaluating complex interventions: the new Medical Research Council guidance. Bmj. 2008;337.

Craig P, Dieppe P, Macintyre S, Michie S, Nazareth I, Petticrew M. Developing and evaluating complex interventions: the new Medical Research Council guidance. 2013.

Chanen AM, Jovev M, Djaja D, McDougall E, Yuen HP, Rawlings D, et al. Screening for borderline personality disorder in outpatient youth. 2008;22(4):353-64.

Ryle AJJopD. The contribution of cognitive analytic therapy to the treatment of borderline personality disorder. 2004;18(1):3-35.

Carroll C, Patterson M, Wood S, Booth A, Rick J, Balain SJIs. A conceptual framework for implementation fidelity. 2007;2:1-9.

Prevolnik Rupel V, Jagger B, Fialho LS, Chadderton L-M, Gintner T, Arntz A, et al. Standard set of patient-reported outcomes for personality disorder. 2021;30:3485-500.

Williams JB, First M. Diagnostic and statistical manual of mental disorders. Encyclopedia of social work2013.

Fowler JC, Madan A, Allen JG, Patriquin M, Sharp C, Oldham JM, et al. Clinical utility of the DSM-5 alternative model for borderline personality disorder: Differential diagnostic accuracy of the BFI, SCID-II-PQ, and PID-5. Comprehensive psychiatry. 2018;80:97-103.

First M, Williams J, Karg R, Spitzer RJA, VA: American Psychiatric Association. Structured Clinical Interview for DSM-5® Disorders—Clinical Trials Version (SCID-5-CT). 2015;1.

American Psychiatric Association D, Association AP. Diagnostic and statistical manual of mental disorders: DSM-5: American psychiatric association Washington, DC; 2013.

Ravens-Sieberer U, Gosch A, Erhart M, von Rueden U, Nickel J. Kidscreen Group Europe. The Kidscreen Questionnaires: Quality of Life Questionnaires for Children and Adolescents. 2006.

Sheehan DV, Lecrubier Y, Sheehan KH, Amorim P, Janavs J, Weiller E, et al. The MiniInternational Neuropsychiatric Interview (MINI): the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. Journal of clinical psychiatry. 1998;59(20):22-33.

Pinninti NR, Madison H, Musser E, Rissmiller D. MINI International Neuropsychiatric Schedule: clinical utility and patient acceptance. European psychiatry. 2003;18(7):361-4.

Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. American journal of preventive medicine. 1998;14(4):245-58.

Posserud M-B, Breivik K, Gillberg C, Lundervold AJ. ASSERT–the autism symptom SElfReporT for adolescents and adults: bifactor analysis and validation in a large adolescent population. Research in Developmental Disabilities. 2013;34(12):4495-503.

Kessler RC, Adler L, Ames M, Demler O, Faraone S, Hiripi E, et al. The World Health Organization Adult ADHD Self-Report Scale (ASRS): a short screening scale for use in the general population. Psychological medicine. 2005;35(2):245-56.

Adler LA, Spencer T, Faraone SV, Kessler RC, Howes MJ, Biederman J, et al. Validity of pilot Adult ADHD Self-Report Scale (ASRS) to rate adult ADHD symptoms. Annals of Clinical Psychiatry. 2006;18(3):145-8.

Bohus M, Kleindienst N, Limberger MF, Stieglitz R-D, Domsalla M, Chapman AL, et al. The short version of the Borderline Symptom List (BSL-23): development and initial data on psychometric properties. Psychopathology. 2009;42(1):32-9.

Bohus M, Schmahl C, Fydrich T, Steil R, Müller-Engelmann M, Herzog J, et al. A research programme to evaluate DBT-PTSD, a modular treatment approach for Complex PTSD after childhood abuse. Borderline personality disorder and emotion dysregulation. 2019;6(1):1-16.

Leon AC, Olfson M, Portera L, Farber L, Sheehan DV. Assessing psychiatric impairment in primary care with the Sheehan Disability Scale. The international journal of psychiatry in medicine. 1997;27(2):93-105.

Barratt E, Patton J. Barratt impulsiveness scale-11. Handbook of psychiatric measures. 1995;10.

Kaufman EA, Xia M, Fosco G, Yaptangco M, Skidmore CR, Crowell SE. The Difficulties in Emotion Regulation Scale Short Form (DERS-SF): Validation and replication in adolescent and adult samples. Journal of Psychopathology and Behavioral Assessment. 2016;38:443-55.

Kroenke K, Spitzer RL. The PHQ-9: a new depression diagnostic and severity measure. Slack Incorporated Thorofare, NJ; 2002. p. 509-15.

Balestroni G, Bertolotti G. EuroQol-5D (EQ-5D): an instrument for measuring quality of life. Monaldi Archives for Chest Disease. 2012;78(3).

Al-Janabi H, N Flynn T, Coast JJQolr. Development of a self-report measure of capability wellbeing for adults: the ICECAP-A. 2012;21:167-76.

Beck AT, Kovacs M, Weissman A. Assessment of suicidal intention: the Scale for Suicide Ideation. Journal of consulting and clinical psychology. 1979;47(2):343.

Pawson R, Tilley N. Realistic evaluation: sage; 1997.

Moore GF, Audrey S, Barker M, Bond L, Bonell C, Hardeman W, et al. Process evaluation of complex interventions: Medical Research Council guidance. 2015;350.

Gajwani R, Wilson N, Nelson R, Gumley A, Smith M, Minnis HJFiP. Recruiting and exploring vulnerabilities among young people at risk, or in the early stages of serious mental illness (borderline personality disorder and first episode psychosis). 2022;13:943509.

APPENDIX 2 -Ethical Approval for The BRIDGE Project

Health Research Authority

North West - Haydock Research Ethics Committee

2 Redman Place
Stratford
London
E20 1JQ

17 April 2024

Ms Alison Hamilton NHSGG&C
NHSGG&C - Research & Innovation Ward 11
Dykebar hospital
Paisley PA2
7DE

Dear Ms Hamilton

Study title:	**The BRIDGE project: A feasibility randomised controlled trial of brief, intensive assessment and integrated formulation for young people (age 14-24) early in the course of borderline personality disorder.**
REC reference:	**21/NW/0209**
Amendment number:	**SA 09**
Amendment date:	**20 February 2024**
IRAS project ID:	**299825**

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Completed Amendment Tool [SA09 Locked amendment tool BRIDGE]	n/a	14 March 2024
Covering letter on headed paper [REC Cover Letter SA09 21.02.24]	1	21 February 2024
Participant consent form [BRIDGE Family and Friends Consent Form Version 3 06.02.24]	3	06 February 2024
Participant information sheet (PIS) [BRIDGE Friends and Family	3	06 February 2024

Information Sheet Version 3 06.02.24]		
Research protocol or project proposal [BRIDGE Protocol Version 6 06.02.24]	6	06 February 2024
Research protocol or project proposal [BRIDGE Protocol V6.0 06.02.24 tracked]	6	06 February 2024

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

Amendments related to COVID-19

We will update your research summary for the above study on the research summaries section of our website. During this public health emergency, it is vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you have not already done so, please register your study on a public registry as soon as possible and provide the HRA with the registration detail, which will be posted alongside other information relating to your project.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and- improving-research/learning/

Yours sincerely

Chair

E-mail: haydock.rec@hra.nhs.uk

Enclosures:	*List of names and professions of members who took part in the review*
Copy to:	*Dr Ruchika Gajwani, University of Glasgow*

North West - Haydock Research Ethics Committee Attendance at

Sub-Committee of the REC meeting on 16 April 2024

Committee Members:

Name	*Profession*	*Present*	*Notes*
Professor Paul Eldridge	Retired Consultant Neurosurgeon	Yes	
Mrs Sue Fitzpatrick	Director	Yes	

Also in attendance:

Name	*Position (or reason for attending)*
Mr Joe Wakeham	Approvals Administrator

Appendix 3

The BRIDGE Project Information Sheet

Invitation to take part

We would like to invite you to take part in The BRIDGE Project. This is a research study about support for young people with symptoms of Borderline Personality Disorder (BPD).
The project is inviting sixty young people aged between 14 and 24 who are experiencing symptoms of BPD to take part in this research. Before you decide if you would like to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish. Ask us if there is anything that is not clear or if you would like more information. Please note, we will not be giving a diagnosis of BPD during your participation in the study.

What is the research about?

The project is looking to find the best option for supporting young people with BPD symptoms. We are particularly interested in exploring the effectiveness of the BRIDGE intervention which includes, initial assessments of your needs, up to 16 sessions of Cognitive Analytic Therapy and working with any team around you, as compared with the normal service which would be received by someone with symptoms of BPD, this is known as 'Service as Usual'.

Why have I been asked to take part?

You have been asked to take part because you are aged between 16-24 years and are experiencing symptoms of BPD.

Do I have to take part?

No, you do not have to take part in the research, and it will not affect any medical service or treatment that you are receiving. You are free to withdraw from the study at any time. You can also refuse to answer any questions that you do not feel comfortable with.

What will I be asked to do?

You will be asked to sign a consent form and undertake a 15-item questionnaire related to BPD on the website. This will involve answering some questions about 1) your BPD symptoms, 2) difficulties you are currently experiencing, 3) how you are presently functioning. Depending on your responses to this questionnaire, you meet the criteria for the second stage of the screening process.

At the second stage of the screening process, all potentially eligible participants will be invited for a short (less than 30 minutes) interview by a clinician.

If you are found to be suitable to take part in the study, you will be offered the BRIDGE intervention which involves brief assessments, up to 16 sessions of Cognitive Analytic Therapy and you will continue to work with any team around you or continue with 'Service as Usual' alone. This is randomly assigned, much like the throwing of a dice. You will then have follow-up assessments at 12 and 24 weeks after the Cognitive Analytic Therapy or continued interventions have ended.

What is Cognitive Analytic Therapy

Cognitive Analytic Therapy (CAT) is a time-limited psychological therapy first developed in the UK by Anthony Ryle. The goal of CAT is to help you explore the ways you think, feel and act and reflect upon the impact of early life experiences on your relationships and present behaviours. It works as a combination of various therapies and is tailored to an individual's needs and goals.

What is Service as usual

Service as usual means that you will continue to receive the care and support from anyone you may be seeing (for example, counsellor, support worker, GP) at the time of participation.

Who will know I am taking part in the study?

Only certain members of the research team will have access to your information order, for example, to phone you or visit you to complete questionnaires. We would like to tell your GP you are taking part, but only with your permission. It is a requirement that your records in this study are made available if requested by monitors from the Sponsor. The Regulatory Authorities, whose roles it is to check this research is properly conducted and the interests of those taking part in this study are protected, may also need to look at your records.

Will my information be protected?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. All information which is collected about you during the research, including identifiable data, will be kept strictly confidential and will be held securely for 10 years after the study has ended in accordance with the latest Data Protection legislation.

The NHS Greater Glasgow & Clyde is the sponsor and data controller for this study and is responsible for looking after your information and using it properly. You can find more about this at GG&C website for Data Protection: https://www.nhsggc.org.uk/media/259281/nhsggc_gdpr_data_protection_notice-v4.pdf

The local research team, including researchers from the University of Glasgow, will have access to your information. They will use your name and contact details to contact you about the study, to make sure that relevant information about the study is recorded, and to oversee the quality of the study.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate.

Other researchers may wish to access data from this study in the future. However, it will not be possible to identify participants from this data because it will not include names, addresses or dates of birth. The sponsor will ensure that other researchers comply with legal, data protection and ethical guidelines and have ethics approval for their research.

What are the benefits of taking part?

The main benefit of your participation in the study is to help us understand how effective certain types of treatment are in terms of dealing with difficulties with your thoughts and feelings, and other life factors that may contribute to your mental wellbeing. You will also know that you will be helping to find better ways for other young people to get the best kind of help in the future. If you decide not to take part, you will still receive the support you would normally receive from the NHS.

Is there a downside to taking part?

We do not expect that taking part will cause you any problems.

If you do become distressed, we will stop the session immediately. As a participant we want to ensure that the research project does not negatively impact on your well-being and therefore if there is any concern the research team will ask for your consent to discuss these concerns with your direct care team. We would also encourage you to discuss any thoughts and feelings arising during the study with your care team.

If you share information that makes the research team concerned for your safety or the safety of other people, we may be required to tell others involved in your care (e.g. your keyworker or Psychiatrist). If we identify that you may benefit from any additional support relating to symptoms other than those explored during the BRIDGE intervention, we will feed this back to your general practitioner or team involved with you (for example CAMHS). We will always notify you beforehand if we are going to do this and explain why.

If at any point during the research process there is a question about your capacity to continue with the research, we would terminate the assessment/session immediately and consult with your direct care team. We will of course discuss this with you fully before talking with anyone. If this occasion were to arise and your capacity is restored, we would require confirmation with your direct care team before continuing with any assessment.

What will happen at the end of the study?

During your time in the study, if randomised to the BRIDGE intervention, your care will be provided by psychologists working within the NHS. At the end of the study, your care will be transferred to your GP or team around you, as your needs require.

What will happen to the results of the study?

The results will be published in a health science journal and the research team will make sure that the general public know about our results. Your name will not be used in any report.

Can I speak to someone who is not involved in the study?

Yes, for independent advice about this study please contact… [TBC]

Who is organising and funding the research?

The University of Glasgow is the organiser of the research as well as the
Chief Investigator Dr Ruchika Gajwani (contact details are provided at the end of this information sheet).

MQ Mental Health Research is providing the funding for this research.

What if I have any further questions about the study?

If you would like to talk about the study further or have any questions about your participation, please contact Dr Ruchika Gajwani (Chief investigator) or Dr Fiona Sim (trial manager). Their contact details are listed at the end of this information sheet.

What if something goes wrong?

If you have a concern about any aspect of this study, you should ask to speak with the researcher who will do their best to answer your questions.

If you remain unhappy and wish to complain formally you can do this through the normal NHS complaints procedure by contacting the Complaints Department by email at: complaints@ggc.scot.nhs.uk, by phone on 0141 210 4500, or in writing:

Complaints Department
North East Sector Offices,
Stobhill Hospital300 Balgrayhill Road
Glasgow
G21 3UR

If taking part in this study harms you, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have ground for legal action but you may have to pay your legal costs. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanism is available to you.

If you have private medical insurance, you may wish to check with your company before agreeing to take part in the study to ensure participation will not affect your insurance cover.

Who has reviewed the study?

The study was reviewed and approved by the NHS Research Ethics Committee.

Thank you for taking the time to read this information sheet.

Dr Ruchika Gajwani
University of Glasgow
General Practice and Primary Care
House 1, Room 311 (Academic CAMHS)
1 Horselethill Road
Glasgow
G12 9LX Tel: 0141 201 9239
E-mail: Ruchika.Gajwani@glasgow.ac.uk

Dr Fiona Sim
University of Glasgow
General Practice and Primary Care
House 1, Room 311 (Academic CAMHS)
1 Horselethill Road
Glasgow
G12 9LX Tel: 0141 201 9239
E-mail:Fiona.Sim@glasgow.ac.uk

Appendix 4: BRIDGE Project Consent form







Please read the following statements and **initial** in the box:

I confirm that I have read and understood the information sheet (Version 2, 06/05/2021) and have had the chance to ask questions about the project and my participation.	
I voluntarily agree to participate in the study.	
I understand that I do not have to take part in the research and I am free to withdraw at any time without giving any reason, and without my medical or legal rights being affected.	
The procedures regarding confidentiality have been clearly explained (e.g. use of names, pseudonyms, anonymisation of data, etc.) to me.	
I agree for my GP to be informed about my participation in the study.	
I am willing for relevant information to be shared with my clinical team in the form of a brief report.	
I would like to receive a brief report of my participation in the research study.	
Interviews may be recorded and transcribed. Following transcription the original recording will be destroyed and all personal data removed from the transcription. I agree to my interviews being recorded and transcribed for this study. Any quotes taken from transcriptions will be anonymised.	
I would like to receive a copy of the research findings.	
I agree that an informant (someone who knows me well) can be contacted to ask further questions about my mental health.	
I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from NHS Greater Glasgow and Clyde (study sponsor) or regulatory authorities, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	
I consent to members of the research team obtaining routinely collected health data including from my medical notes	

I confirm that I can be contacted in the future by a member of the BRIDGE Project Team to discuss possible participation in further research arising from this study. I understand that this will not commit me in any way to taking part in further research.	
I give permission for my data to be anonymously shared with researchers on an NHS GGC sponsored linked project.	

If you have any further questions about the study please contact:
Dr Ruchika Gajwani: 0141 201 9239

I consent to take part in The BRIDGE Project:

Name (Printed): ……. Name (Signed): …….

Date: Date:

Researcher's Signature: …….

Researcher's Name (Printed): …….. Date:

Appendix 5: Interview Schedule

Title: Exploring the experiences of participants of The BRIDGE Project

Introduction

Thank you for meeting me today. **(After providing information sheet and obtaining consent)**

- I will be recording the interview, is this okay? (Show participant device or ask for permission if conducted over Teams). It is just so I have something to help me remember more accurately what we talk about today. It also means I don't have to make lots of notes whilst we are chatting. I won't be playing the recordings back to anyone else, only I will hear them.
- What we talk about today will remain confidential- I won't be sharing any details with other members of your family or friends. However, if you do mention, or I witness something that makes me feel really worried about your safety, or the safety of someone else, I will have to share this with an appropriate person in your care team so they can try and support you. In the unlikely event that I need to take this action I will tell you first.
- If there is anything you don't want to talk about just say so. We can stop whenever you like. If you want to take a break or stop the interview; please just let me know and we can finish the session.
- You will not be named in anything I write about this research.

(Data from Pathways timeline will be summarised to gather a background on participant and to allow for the details to be used as probes).

Interview Schedule:

1) What was your experience of services before you took part in BRIDGE?

Possible prompts: (1) ***Did you have any support during your time with BRIDGE i.e., friends, family, other services?*** (2) What/who were they? (3) What was helpful/unhelpful about them? (4) How do you feel about them?

2) What was your initial experience of The BRIDGE Project?

Possible prompts: (1) Why did you decide to take part? (2) How did you feel undertaking the online questionnaire? (3) How did you feel about the face- to face assessments? (4) Were the questionnaires too lengthy/too short? (5) Were the questions relevant to your experiences? (6) Did we miss any important questions?

3) How did you feel about BRIDGE overall?

Possible prompts: (1) 24 weeks…too much/too little? -How long would you like it to be? (2) What do you think was done well/not well? (3*)* what would you like to change in anyway?? (4) Location/transport (5) Not giving you a diagnosis.

4) ***How did you feel about being part of the group receiving therapy/ not receiving therapy? What was this experience like for you?***

Possible Prompts: (1) Can you reflect on what this meant to you? (2) What prompted you to continue to take part in BRIDGE knowing that you would not be receiving therapy? (3) How did you make sense of your experience? Talking to Claire?

5) ***Has taking part in BRIDGE changed your life in anyway? Influenced relationships, also with self?***

Possible prompts: (1) How did you feel about life before you took part in BRIDGE? (2) Do you do things differently now? (3) How did you make sense of your experience? (4) What are your hopes and expectations for the future?

6) ***What are your hopes and expectations for the future?***

Post Interview – debrief

• Are you feeling okay about what we have talked about?
•Outline what happens next: 1) Now I am going to go away and type up what I have recorded today.

We would like to thank you for your participation in the BRIDGE project, for giving us your time and sharing your experiences so we can understand how we can engage with young people better.

N.B. If the participant becomes upset, the researcher will use the following approaches depending on participant's wishes and circumstances:

1) If the participant is happy for researcher to do so, she will stay with the participant until they are feeling better and either leave or restart session depending on participant's wishes.

2) Later that day researcher would make a follow up phone call to check how participant is. Do a safe and well check, along with a risk assessment as outline in the standard operating procedures with the trial protocol.

3) If researcher feels there is reason to be concerned for the immediate physical or mental health of a participant, researcher will inform the participant of her intention to take appropriate action, e.g. call the client's responsible clinician and care coordinator to get advice, and discuss the client with supervisor.