

**Destigmatizing Women with Borderline Personality Disorder (BPD): An Attachment-  
Based and Trauma-Informed Approach**

By

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## Abstract

Borderline Personality Disorder (BPD) is highly stigmatized and disproportionately impacts women (American Psychiatric Association [APA], 2022; De-la-Morena-Perez et al., 2023). Though there is a large body of research that indicates a link between attachment insecurity, trauma history and the development of BPD traits, there is still debate over the exact interplay between these factors (Erkoreka et al., 2022; Formella & Ugwuanyi, 2024; Miano et al., 2021; Peng et al., 2021; Schulze et al., 2022). The research highlighted throughout indicated that counselling psychologists would benefit from a deeper understanding of these factors so they can incorporate this knowledge into everyday practice when working with clients who have BPD. Thus, this literature review explores the central question: Can understanding BPD in women from an attachment-based and trauma-informed lens help to destigmatize their experiences in the therapeutic setting? To answer this, this study synthesizes current literature and provides recommendations for future research and possible clinical/therapeutic applications. Relevant sources were selected from various databases, including ProQuest, PsychLit, EPSCO, PubMed and the Psychology and Behavioural Sciences Collection. The writer then conducted a thematic analysis of the literature to generate significant themes and evaluated this research through methodological analysis and ethical critiques. The most notable finding from this study is that individuals with BPD experience stigma on several levels, and that further research into understanding this disorder from an attachment-based and trauma-informed lens is warranted. It is recommended that mental health professionals, educational programs and researchers consider these lenses when studying BPD in an effort to reduce stigma for those with this disorder.

*Keywords:* borderline personality disorder, adult attachment styles, insecure attachment, disorganized attachment, trauma-informed therapy, destigmatization, gender bias, mental health

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## Chapter One: Introduction

Borderline Personality Disorder (BPD) is highly stigmatized and disproportionately impacts women (American Psychiatric Association [APA], 2022; De-la-Morena-Perez et al., 2023). The APA (2022) characterizes BPD by a pattern of instability in relationships caused by an intense fear of abandonment and is associated with an unstable sense of self, emotional dysregulation, and marked impulsivity. Individuals with this disorder also tend to experience high rates of suicidality, self-harming behaviours and psychiatric admissions (APA, 2022). The DSM-5-TR estimates the prevalence of BPD among women at 75%, though researchers theorize that this may be due to a diagnostic bias related to gender, which may further exacerbate the stigmatized nature of this disorder (De-la-Morena-Perez et al., 2023; Masland et al., 2022; Qian et al., 2022). De-la-Morena-Perez et al. (2023) noted that women tend to display more internalized clinical symptoms whereas men display more externalized symptoms, prompting researchers to speculate that manifestations of these traits and diagnostic interpretations may be influenced by the social construction of gender roles.

Women who receive a BPD diagnosis are likely to experience stigma in social settings, when accessing medical care and mental health resources. This can lead to an internalized sense of shame, decreased capacity to cope with daily life and manage interpersonal relationships, and may amplify their perceived experiences of negative emotions (De-la-Morena-Perez et al., 2023; Ring & Lawn, 2025). Research conducted by Koivisto et al. (2022) and Ring and Lawn (2025) further highlighted that individuals with BPD experience self-stigma and often feel powerless in interactions with mental health professionals (MHPs), which can heighten their distress and lead to reactions that may reinforce the stigmatizing views held by MHPs. Given this information, further research that focuses on the destigmatization of women with this disorder is not only warranted, but essential.

There is a growing body of literature that emphasizes that individuals who have been diagnosed with BPD exhibit attachment insecurity that is linked to past experiences of neglect, abuse, or inconsistent caregiving (De-la-Morena-Perez et al., 2023; Erkoreka et al., 2022; Formella & Ugwuanyi, 2024; Peng et al., 2021; Schulze et al., 2022). For example, Erkoreka et al. (2022) determined that attachment anxiety is a mediator of the relationship between childhood trauma and personality dysfunction in clients with BPD. Additionally, Schulze et al. (2022) found that various adverse childhood experiences (ACES) led to insecure attachment styles in participants with BPD features. Much of the research that focuses on attachment notes that women with BPD experience significant social isolation and a pattern of turbulent, unstable relationships (Di Bartolomeo et al., 2024; Howard et al., 2022; Jeong et al., 2022; Kroener et al., 2023; Miano et al., 2021; O'Leary et al., 2024; Schulze et al., 2022; Smith & South, 2020). Recent studies have also examined the link between attachment, trauma, and the internalized symptoms that impact women with BPD, such as identity disturbances, maladaptive emotional regulation, suicidality, self-injurious behaviours, and dissociative symptoms (De-la-Morena-Perez et al., 2023; Erkoreka et al., 2022; Fung et al., 2023; Jeong et al., 2022; Koivisto et al., 2022; Peng et al., 2021; Qian et al., 2022; Schulze et al., 2022). While this knowledge significantly contributes to the understanding of BPD, this paper seeks to synthesize the existing findings and to highlight gaps in the literature.

### **Research Problem**

As BPD is disproportionately diagnosed in women (De-la-Morena-Perez et al., 2023; Bozzatello et al., 2024), this will be the population that is focused on in this paper. As previously stated, there is significant research indicating that there is a link between attachment insecurity, trauma history and BPD traits (Erkoreka et al., 2022; Formella & Ugwuanyi, 2024; Miano et al., 2021; Peng et al., 2021; Schulze et al., 2022). However, these studies highlighted that there is still debate over the exact interplay between attachment styles and trauma and how this impacts

the development of BPD features. Furthermore, there is a lack of research that considers how counselling psychologists can incorporate this knowledge into everyday practice when working with clients who have a BPD diagnosis. Epidemiological studies estimate that the prevalence of BPD ranges between 0.7-5.8% in the general population, and the reality is that most graduate psychology students and new clinicians encounter clients with this diagnosis (Bozzatello et al., 2024; Mercand, 2015), so they must be adequately prepared to work with this population.

Furthermore, as BPD is highly stigmatized and clients with this diagnosis are incredibly vulnerable, so accessing adequate care that considers attachment and trauma histories is essential (Luyten et al., 2020). One study by Goodman et al. (2017) found that ~90% of their sample reported having engaged in self-harming behaviours and ~75% reported one or more previous suicide attempts. Another study that compared the mortality rate of individuals with BPD compared to those with other personality disorders found that at a 24-year-follow-up, 5.9% of the BPD clients and 1.4% of the comparison subjects died by suicide (Temes et al., 2019), while the literature generally estimates that up to 10% of BPD patients die by suicide (Luyten et al., 2020). Additionally, there is a high likelihood that clients with BPD have a history of childhood trauma and abuse, which only increases their vulnerability and need for care (De-la-Morena-Perez et al., 2023; Erkoreka et al., 2022; Luyten et al., 2020; Peng et al., 2021; Schulze et al., 2022). While the current research on this topic elucidates these themes and might highlight the stigmatizing nature of this disorder, there is no clear framework that might help to both mitigate risk for these clients and guide counselling psychologists who work with BPD in a therapeutic setting.

### **Research Question**

Given this information, the research question is: How can understanding BPD in women from an attachment-based and trauma-informed lens help to destigmatize their experiences in the therapeutic setting?

## **Justification of the Study**

Overall, the literature on this topic uses attachment theory and measures relating to trauma to understand the factors that contribute to BPD symptomology. However, there is a lack of integration between how these concepts can relate to treatment or can improve care for individuals with BPD. Despite the significant body of research that indicates that this is a highly stigmatized disorder that is influenced by a gender bias, there is little information on how clinicians can address and improve these issues both in building the therapeutic relationship and through treatment (Formella & Ugwuanyi, 2024; Miano et al., 2021). One possible explanation for this is that many attachment-based therapies, such as Emotion Focused Therapy (EFT), take a depathologizing stance and thus research in these areas will focus on concepts like 'disorganized attachment' rather than naming a clinical diagnosis (Johnson, 2019; Johnson & Campbell, 2022; Pos & Paolone, 2019). While this creates a gap in the literature, it also highlights how taking an attachment-based stance has the potential to depathologize individuals with BPD. Thus, the literature analysis in Chapter Three aims to gather information on this topic and to provide a clear theoretical framework that might help counselling psychologists so they can more effectively work with clients who have BPD in a therapeutic setting.

This paper also explores the possible gender bias related to BPD diagnoses as this knowledge will also benefit counselling psychologists' understanding of this disorder (De-la-Morena-Perez et al., 2023; Ring & Lawn, 2025). Another gap in the literature is the lack of information gathered on the experiences of transgender and non-binary individuals who have been diagnosed with BPD. Indeed, reviews on this topic indicated that most samples are predominantly female, heterosexual and overall lack ethnic and cultural diversity (Di Bartolomeo et al., 2024; Smith & South, 2020). Indeed, Qian et al. (2022) observed in their review that most of the studies conducted on BPD surveyed Western populations, as 55% were North American

samples and 33% were European. Thus, further research is required to fully understand the nuance of how various intersections of identity may impact potential BPD diagnosis, as well as the experiences of individuals with BPD.

### **Significance of the Study**

Research by Hartnell (2022) indicated that individuals with BPD desire therapists who can validate their emotional experiences, who are willing to get to know them as individuals, who can meet them where they are at in their healing journey, and who have a flexible approach to counselling. This study seeks to find evidence in present literature to support these expressed desires from the target population. As previously mentioned, BPD is a relatively common personality disorder and thus counselling therapists are likely to encounter clients with this diagnosis early in their careers (Bozzatello et al., 2024; Mercand, 2015). Chen and Hazler (2023) noted that novice counsellors often have elevated expectations about helping clients change quickly, which is generally unrealistic when working with this population. The researchers indicated that this can easily lead to burnout in young clinicians. If unaddressed, this can create a negative perception towards working with BPD, can reduce counsellor empathy, and can have a negative impact on therapeutic outcomes. Thus, this research is significant as it contributes to the understanding of BPD from a counselling perspective to improve the experience for both clinicians and clients. This research aims to offer a deeper, more holistic conceptualization of women with a BPD diagnosis based on the current literature to dispel negative stereotypes about the disorder and increasing counsellor awareness and empathy.

Moreover, traits associated with BPD, such as attachment insecurity, complex trauma, difficulties with emotional regulation, and difficulties with interpersonal relationships are common experiences that present in a variety of clients with different diagnoses. While these presenting problems can impact clients with different gender identities, it is notable that they can contribute

to experiences of stigmatization for female-identifying clients. Indeed, Ma and Else-Quest (2024) identified how concepts like 'emotionality' are linked to pervasive female-stereotypes that can contribute to the pathologization of women in therapeutic spaces. The writers further emphasized how these stereotypes, that impact women with and without BPD, decontextualize their mental health from adverse life experiences (e.g. gendered violence). Therefore, this research can offer insight into how counsellors can conceptualize a variety of presenting problems in female-identifying clients from a destigmatizing lens.

### **Theoretical Framework**

The primary theoretical framework that will guide this research is John Bowlby's attachment theory (1982), which suggested that an infant's connection with their caregiver influences their sense of security (Johnson, 2019; Lee & Hankin, 2009). Bowlby (1982) theorized that attachment behaviors evolved as a means of survival, and he suggested that infants and their caregivers are biologically wired for connection, and thus instinctually engage in proximity seeking behaviours. Lee and Hankin (2009) emphasized that various interactions with caregivers provide infants with information that allows them to organize their expectations of others and formulate an understanding of how the world operates. It is posited that this infant-caregiver relationship forms the basis of future relationship dynamics, and research supports that attachment styles influence adult relationships, which can either be secure or insecure (Bowlby, 1982; Lee & Hankin, 2009; Henschel et al., 2020). Notably, adult attachment is different from childhood attachment as the relationship is more reciprocal, is not as dependent on physical proximity, and it also includes dynamics related to caretaking and sexuality (Johnson, 2019). Henschel et al. (2020) indicated that securely attached adults are comfortable seeking connection and being alone, have confidence that they are valued, are resilient in the face of conflict, and are able to engage in emotional and physical intimacy. There are three types of insecure attachment styles in adults. The first is the anxious style, which is

characterized by insecurity concerning responses from others paired with an intense desire for intimacy and a strong fear of rejection. The avoidant style is defined by an insecurity concerning others' intentions, reduced expressions of affection and intimacy, and a rejection of assistance or a strong need for independence. Finally, the disorganized attachment style, as described by Johnson (2019) (which is sometimes referred to as the 'fearful-avoidant style') is characterized by a push-and-pull pattern, or a strong desire for intimacy and proximity to others paired with a fear of rejection and frequent reports of dissatisfaction in relationships. Johnson and Campbell (2022) noted that this attachment style is unique as it combines both anxious and avoidant traits in one person. This pattern is associated with a history of complex trauma, and the literature often links this attachment style to BPD symptomology (Miano et al., 2021; Peng et al., 2021; Smith & South, 2020). From an attachment lens, change is possible by having corrective emotional experiences in the therapeutic space, and by forming new, secure bonds (Johnson 2019; Johnson & Campbell, 2022).

To better understand the gendered experience associated with this disorder, this paper will also reference gender constructionism. This theory, proposed by Judith Butler (2004), purports that gender is socially constructed. She noted that historically, gender has been understood through a heteronormative and binary system that recognizes traditionally feminine and masculine models. Butler further suggested that social roles, attributes, values, behaviours and ideals are subjective and are learned through socialization. This notion is related to third wave and contemporary feminist theory that questions the notion of what it means to be a woman, and if it is something that someone inherently is or if gender is something that one must become or perform due to social expectations (Hekman, 2015). In the context of BPD, gender construction and feminist theory may influence the social expectations that women with this disorder face as well as their experiences of stigmatization (Bozzatello et al., 2024; De-la-Morena-Perez et al., 2023).

This research seeks to focus on women's experiences as the BPD diagnosis seems intrinsically linked to gendered experiences, and negative perceptions of BPD traits may be further exacerbated by female stereotypes (Bozzatello et al., 2024; Ma & Else-Quest, 2024).

Luyten et al. (2020) noted that clients with BPD tend to have a history of attachment trauma and complex trauma. It is impossible to address destigmatization without exploring the ethos of trauma-informed care. The trauma-informed theory of behaviour simply indicates that exposure to trauma leads to an elevated stress response, and that individuals try to address this response with the limited resources that they have available (Marks et al., 2021; van der Kolk, 2014). Marks and colleagues (2021) indicated that the goal of a trauma-informed approach is to recognize the symptoms and impacts of trauma and to avoid re-traumatizing clients by creating a safe and secure environment in the therapeutic setting. By taking an attachment and trauma-informed lens, this research seeks to better understand the experiences of women with BPD and to improve their experiences in therapy.

### **Definition of Key Terms**

**Complex Trauma:** "Complex trauma is typically interpersonal and generally involves situations in which the person who is traumatized cannot escape from the traumatic experiences because he or she is constrained physically, socially, or psychologically (Herman, 1992). Because of this, people who have experienced complex trauma often have additional disturbances in their ability to self-regulate—beyond those seen in PTSD—that are not related to complex trauma. These include difficulties in emotional regulation, difficulties in one's capacity for relationships, problems with attention or consciousness (e.g., dissociative experiences), a disturbed belief system, and/or somatic complaints or disorganization (Briere & Scott, 2012; Cloitre et al., 2011; van der Kolk, McFarlane, & Van der Hart, 1996)" (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014, pp. xvi-xvii).

**Disorganized Attachment:** An insecure attachment style “most often found in people who have experienced complex trauma at the hands of attachment figures, is called *fearful-avoidant... or disorganized*. Since others are experienced as both a source of fear and of solace, the fearful-avoidant person tends to flip between the hyper arousal typical of the responses of more anxious individuals and the dismissing responses of avoidants” (Johnson & Campbell, 2022, pp. 27).

**Emotional Dysregulation:** “A core feature and contributor to BPD, emotion dysregulation (ED), consists of deficits in the ability to regulate emotions in a manner that allows the individual to pursue important goals or behave effectively in various contexts...According to the DSM-V, five of nine criteria are required for the diagnosis; these criteria largely capture difficulties in relationships, impulsive and self-damaging behavior, identity and mood disturbance, and affective instability. Similarly, in the ICD-10, BPD symptoms fall within the category ‘emotionally unstable personality disorder’ and include disturbances in emotions, cognition, relationships, and behavior. ED or instability are central features of BPD within both diagnostic systems.” (Chapman, 2019, pp. 1143-144).

**Pathologization:** “‘Pathologization’ can be defined as the psycho-medical, legal, and cultural practice of identifying a feature, an individual, or a population as intrinsically disordered...In the last 10 years, there have been movements in favour of the right of depathologization, based on the right to health and to non-discrimination.” (Castro-Peraza et al., 2019, pp. 2). In other words, depathologization rejects the notion that certain conditions or behaviours are inherently disordered.

**Stigmatization:** There are different types of stigmas referred to throughout this paper. “Stigma in mental health settings is described as a set of negative and unrealistic beliefs about those with mental illness...Internalized stigma refers to how people with mental illness see themselves as mentally unwell and, therefore, of lesser value” (Vieira et al., 2023, pp. S1032).

Internalized stigma, in some works, is also referred to as *self-stigma*. “Social stigma is structural in society and can create barriers for persons with a mental or behavioral disorder” (Ahmedani, 2011, pp. 4). Structural stigma is defined as “the societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and wellbeing of the stigmatized” (Hatzenbuehler, 2016, pp. 742).

### **Positionality and Reflexivity**

The paper by Holmes (2020) indicated that it is essential for a researcher to identify their own positionality to highlight and interrogate potential biases. Holmes noted that positionality is influenced by an individual’s values, beliefs, political views, gender, sexuality, geographical and social location, culture, ethnicity, social class, etc. I am a Canadian, cisgendered, queer woman with European ancestry. I recognize that I am a settler who grew up in a country deeply impacted by colonialism and the oppression of Indigenous peoples. I consider myself to be an intersectional feminist and I completed an undergraduate degree in Women and Gender Studies prior to starting a Master of Counselling program. I was raised in a lower-middle class family, and from the age of seven I experienced stigmatization due to a mental health diagnosis.

As a graduate student who is currently completing a counselling internship, I have several female-identifying clients who have been previously diagnosed with BPD. My grounding theory is EFT, which uses attachment theory to conceptualize cases and purports a depathologizing stance (Johnson, 2019; Johnson & Campbell, 2022). This heavily influences my own bias towards how to assess and treat clients. I also have a family member who has been diagnosed with BPD, which colours my perception of how this disorder presents in individuals, and I must be mindful not to use this as my only basis for interpreting BPD traits. Furthermore, in my work with my own therapist who practices from an emotionally focused lens, we have begun to process my own disorganized attachment style, which is the attachment style that is most common in those diagnosed with BPD.

As a new therapist I have felt some hesitancy in regard to working with clients with a BPD diagnosis. However, I have found that the depathologizing stance of EFT has helped me to approach these clients from a person-first stance and has challenged me to interrogate my own biases and assumptions associated with this disorder. Since EFT seeks to address attachment wounds and to increase emotional awareness and regulation, I believe aspects of this attachment-based treatment are a good fit for clients with BPD, and that this has the potential to help to destigmatize the clients' experiences in therapy. However, I do not want to be too idealistic in my approach as I recognize that BPD is a complex and multifaceted disorder, and that this population is high-risk due to high rates of suicidality, self-harm and comorbidity with other disorders (Luyten et al., 2020). Furthermore, there is limited research indicating the effectiveness of attachment-based interventions for treating BPD. Thus, rather than focusing on treatment recommendations, this paper seeks to understand the BPD diagnosis through an attachment and trauma-informed lens. My passion for social advocacy, while important, may also create a potential bias while conducting this research. I recognize that to minimize subjectivity it is important to follow evidence-based recommendations when conducting thematic-analysis and to engage in reflective practices to avoid misinterpreting or skewing existing data (Holmes, 2020; Vaismoradi et al. 2016).

Holmes (2020) emphasized another important dimension of research is the on-going practice of reflexivity, in which a researcher must identify, construct, critique and articulate their own positionality. Reflexive practice is a means for the researcher to examine how their own changing beliefs may have influenced the design, execution and subsequent interpretation of the research data, and this process helps to identify and interrogate potential biases. As previously mentioned, my own biases include an interest in EFT and depathologizing interventions, an interest in social justice, a background in women and gender studies, current clients who have a BPD diagnosis, and personal experiences with BPD symptomology. While

this list demonstrates a level of self-awareness, I am prepared to address my ever-changing positionality to the best of my abilities throughout the research process to maintain as much objectivity as possible. My objectivity will further be strengthened by ensuring that my observations are supported by empirical evidence found in the literature.

### **Overview**

Chapter One provided context surrounding symptomology, attachment and trauma histories, and the stigmatization faced by women with a BPD diagnosis. It further explored the rationale for this research, the theoretical lenses used throughout, definitions of key terminology, and an analysis on the writer's positionality and reflexivity. Chapter Two will examine the methods of completing this capstone research and will examine the methodological strengths and limitations of the studies reviewed in this project. Chapter Three will provide a synthesis as well as a critical and thematic analysis of the existing literature on this topic and findings followed by an ethical discussion. Chapter Four will focus on practical applications to the field of counselling as well as cultural considerations, and Chapter Five will provide conclusions derived from thematic findings and methodological critiques and recommendations for therapeutic interventions as well as future research.

## **Chapter Two: Methods**

This chapter delineates the methodological procedures used in this work and demonstrates how appropriate research articles were selected for review through inclusion and exclusion criteria. It further outlines the data analysis procedure, the methodological strengths and limitations and the core articles that are critiqued in this chapter and throughout Chapter Three. The intention of this chapter is to present the methodology in order to enhance transparency, provide context for this research and to support the results and recommendations that will be enumerated in the coming chapters.

### **Literature Search Process**

The methods for this research included several steps. First, the writer searched for literature on the following databases: ProQuest, PsychLit, EPSCO, PubMed and the Psychology and Behavioural Sciences Collection. These databases were accessed through the City University of Seattle Library and through Google Scholar. The research was primarily filtered to only show results from the past five years and to only show full texts that are peer reviewed. This was to ensure that the most up-to-date research is being reviewed. The only exception to this is when the writer sought seminal work related to the theoretical frameworks, work that provided clear definitions, or cases where background information or context for the research was required.

The keywords that were included in the search are: borderline personality disorder, BPD, attachment, insecure attachment, adult attachment, disorganized attachment, stigma\*, destigma\*, personality disorders, women, adult women, gender, gender construction\*, attachment intervention\*, treatment, trauma, trauma-informed, counselling, counselling psychology, new clinician\*, and student therapist\*. The writer used Boolean operators to narrow or widen search results as needed. For example, the writer used AND to tell the database that all listed research terms must be present, OR to connect similar concepts and to broaden

results, NOT to exclude keywords, quotation marks to search for exact phrases, and \* at the end of a word to widen the search to include many possible endings to that word (i.e. the search for “stigma\*” would include all of the following keywords: stigma, stigmatize, stigmas, stigmatization, etc.) (MIT Libraries, n.d.).

After collecting and reviewing current research, the writer conducted a thematic analysis of the current literature. In a thematic analysis, the researcher’s aim is to uncover hidden complexities within the present data and to provide a nuanced interpretation of this data (Vaismoradi & Snelgrove, 2019). Vaismoradi et al. (2016) and Vaismoradi and Snelgrove (2019) provided information on how thematic analysis is used in qualitative research. The researchers highlighted the phases of theme development, tips on coding and data organization, different types of codes, and further information on relating themes to established knowledge. They further suggested using the ‘ladder of abstraction process’ step-by-step as a tool to facilitate theme development, and to reduce possible researcher subjectivity. This process refers to the notion that language moves from concrete details to abstract concepts. This strategy for coding allows researchers to move from concrete concepts found in the research into broad, abstract themes.

### **Inclusion and Exclusion Criteria**

The sources included in this study had to meet certain criteria. All sources presented are peer-reviewed academic journal articles that were published within the last five years. The presented articles focused on adult women with BPD, and all had either predominantly or entirely female-identifying samples, and the work explored this disorder from either an attachment or trauma-informed lens. Both primary and secondary sources were used; the secondary sources are a systematic review by Di Bartolomeo et al. (2024) and a meta-analysis by Smith and South (2020). These secondary sources were incorporated as they captured a broad overview of the topic, and they highlighted the prevalence of attachment research in

relation to BPD. Furthermore, given the complexity of this topic and the many important factors related to BPD and attachment, these secondary sources provided more evidence and support when needed (e.g. by including the meta-analysis by Smith and South the writer is able to capture a wide variety of research specifically on romantic attachment styles in adults with BPD rather than examining one study with a limited sample size). Articles with populations that included were not predominantly adult samples (i.e. participants over the age of 18) and with samples that were not predominantly female-identifying were excluded to help to narrow-down the research. This decision was made with the intention of focusing on a specific population that is predominantly diagnosed with BPD and impacted by the associated stigma. Additionally, the *DSM-5-TR* notes that BPD is considered to be an adult-onset disorder as symptoms that present in adolescence related to BPD may change over time (APA, 2022), and thus this research excluded articles with adolescent samples.

### **Data Analysis**

This research was conducted using inductive thematic analysis, which is a qualitative research method that involves coding research data and organizing it into appropriate themes (Creswell & Creswell, 2018; Vaismoradi et al, 2016). The themes used in the literature review in Chapter Three were selected by thoroughly scanning the articles and noting keywords related to the research question. These keywords were then organized into themes and synthesized to produce a coherent overview of the literature related to the selected topic. To determine the quality of the research, the section in this chapter on methodological strengths and limitations as well as the ethical critiques in Chapter Three refer to the primary research articles that are listed in Appendix A. To represent a more diverse dataset, the selected articles include both quantitative and qualitative studies, as well as both primary and secondary sources. The in-depth analysis of selected articles is done to increase transparency and to elucidate possible

biases or gaps that may be present in this research and in the recommendations included later in this work.

### **Methodological Strengths and Limitations**

The studies listed in Appendix A were analyzed for methodological strengths and limitations. Of these selected articles, eight used quantitative methods and three used qualitative methods, while nine are primary sources and two are secondary sources. The intention of this analysis is for the writer to determine the quality of research that was surveyed for this study, as well as to examine the potential limitations and how these may impact the thematic findings and recommendations included in subsequent chapters.

#### ***Quantitative Studies***

**Strengths.** The quantitative studies reviewed all took a postpositivist worldview. According to Creswell and Creswell (2018) this approach creates hypotheses by carefully measuring variables to assess both causes and outcomes. The application of the scientific method in these studies allowed the researchers to support, refute, and refine theories regarding the link between BPD and other factors (i.e. attachment theory and trauma). Given the many possible factors that may influence both the diagnosis and presentation of BPD, the postpositivist paradigm is an appropriate choice at this point in time.

All of the quantitative studies examined in this research used a cross-sectional design (Erkoreka et al., 2022; Formella & Ugwuanyi, 2024; Fung et al., 2023; Hashworth et al., 2021; Miano et al., 2021; Peng et al., 2021; Schulze et al., 2022), except for the study by Di Bartolomeo et al. (2023), which was a systematic review. The studies that used a cross-sectional design were able to efficiently collect data at a single point in time, which provided an overview of the associations between variables (e.g. trauma and BPD features). Since researchers are still determining the link between different variables and BPD, the cross-sectional design is appropriate and is able to help with hypothesis generation that will inform

future research. By using a systematic review, Di Bartolomeo et al. (2023) were able to provide a comprehensive summarization and evaluation of multiple studies that allowed them to draw conclusions regarding the relationship between BPD and social connectedness. By utilizing this type of design, the researchers were also able to highlight gaps in the literature, such as a lack of longitudinal studies on this topic.

The researchers in these studies ensured that the data collection and analyses that were conducted maintained a high standard of objectivity. Each study used validated tools and employed rigorous and appropriate statistical methods. For example, some studies used Pearson's correlation coefficient to determine the relationship between two variables (Erkoreka et al., 2022; Fung et al., 2023; Hashworth et al., 2021), while others used more advanced methods such as network analysis (Di Bartolomeo et al., 2023; Schulze et al., 2022), correlational analyses (Formella & Ugwuanyi, 2024), Cohen's d (Hashworth et al., 2021; Peng et al., 2021), pathway analysis (Peng et al., 2021), and other objective analysis methods as needed. Overall, a strength across the literature is the diverse and rigorous statistical methods used. Notably, the study conducted by Miano et al. (2021) was quasi-experimental that recruited both couples who were either in an experimental group or a control group. This study ensured objectivity by utilizing three independent observers who rated the couples' behaviours based on predefined criteria observed in video recordings. The observers were blind to the research questions and the participant group assignments to increase objectivity. Another aspect of research that enhances objectivity is appropriate data collection, such as the use of online data collection, which eliminates the researchers' interactions with the participants. Online data collection was implemented by both Hashworth et al. (2021) and Schulze et al. (2022).

There was a wide range of sample sizes in the studies with cross-sectional designs, with the smallest being a sample of 60 outpatients (Erkoreka et al., 2022) who were all recruited from the same hospital and the largest being an international sample of 1692 participants (Schulze et

al., 2022) who were recruited online (i.e. via international mental health platforms, social media and through a University). The studies with smaller and less diverse samples (Erkoreka et al., 2022; Formella & Ugwuanyi, 2024; Hashworth et al., 2021; Miano et al., 2021) have limited generalizability of findings. However, these smaller sample sizes still ranged from N=60 to N=120, demonstrating that the sample sizes are still substantial and thus a strength across the body of research examined. White (2023) noted that there are disagreements across academic literature regarding what a minimum sample size should be for studies that implement quantitative research, but he suggested that groups that are made up of rarer diagnoses who might be more difficult to contact can justify smaller sample sizes, which is applicable to working with individuals diagnosed with BPD, as this is a specific and vulnerable demographic. All the studies with cross-sectional designs examined were made up of entirely adult samples, and in the systematic review by Di Bartolomeo et al. (2023) most of the studies sampled (i.e. more than 50%) only included participants aged 18+ due to the concerns regarding the validity of BPD diagnosis in youth. There is also a notable gender bias across these studies, with all studies having a sample that is primarily female-identifying. Only Miano et al. (2021) sought out an entirely female sample and examined how this may possibly limit the generalizability of results. The gender bias across the research will be examined in-depth in Chapter 3.

**Limitations.** Notably, none of the studies reviewed included an analysis of the researchers' potential biases and how those might impact the findings. While it is not regular practice to interrogate personal biases in quantitative research, this would enhance transparency and would minimize the potential of selection bias and researcher bias.

White (2023) highlighted how most researchers lack transparency around how their sample size is selected, which is the case across the research examined in this work. Another limitation is that most of the studies reviewed did not address possible selection bias when discussing sampling, despite the fact that several recruited participants with a specific

psychiatric diagnosis (BPD) from either in-patient or out-patient settings (Erkoreka et al., 2022; Formella & Ugwuanyi, 2024; Peng et al., 2021). The only study that mentioned selection bias was Fung et al. (2023), which stated that they used diverse recruitment methods, such as posters at local medical clinics and online advertising to reduce potential bias. All other studies either solely used in-person recruitment (to ensure that the participants selected were diagnosed with BPD) or online recruitment (to reduce sampling bias). Given the fact that this research focuses on a very specific population, it is understandable that most studies ran into this issue.

The studies that relied on various self-reporting measures (Di Bartolomeo et al., 2024; Erkoreka et al., 2022; Fung et al., 2023; Hashworth et al., 2021; Miano et al., 2021; Schulze et al., 2022) are of course subject to potential biases (i.e. recall bias, bias in memory, social desirability bias, insight limitations or overestimations of associations between constructs or possible incorrect identification of BPD features), but only Erkoreka et al. (2022) took the time to address this in-depth. Several studies (Erkoreka et al., 2022; Formella & Ugwuanyi, 2024; Fung et al., 2023) used purposive sampling to ensure that the participants met the diagnostic criteria for BPD, while all other studies relied on self-reporting methods and validated tools that measured BPD features. This limits the accuracy of these studies as some participants may have BPD traits but might not fully meet the diagnostic criteria for the disorder.

### ***Qualitative Studies***

**Strengths.** Both the studies by Koivisto et al. (2022) and Smith and South (2020) align with the postpositivist worldview (Creswell & Creswell, 2018). However, the qualitative study by De-la-Morena-Perez et al. (2023) employs the paradigm of constructivism as the researchers highlighted that the individuals that they interviewed have subjective experiences in regard to their BPD diagnoses. The open-ended interview questions used in this study allowed the researchers to examine the participants' views on what it's like to be a woman with BPD and

enabled them to consider broader social constructs that might influence the participants' experiences (i.e. gender constructionism and possible gender biases) (Creswell & Creswell, 2018; De-la-Morena-Perez et al., 2023). Of the three studies, the designs used included a hermeneutic phenomenological design (De-la-Morena-Perez et al., 2023), content analysis (Koivisto et al., 2022), and a meta-analysis that only examined studies with qualitative designs (Smith & South, 2020). The advantage of using hermeneutic phenomenology is that it offered an in-depth understanding of the lived experiences of a specific population, and in this instance, it gave voice to a marginalized and highly stigmatized group of individuals (De-la-Morena-Perez et al., 2023). This methodology also provided insight into this population's experiences and, which can contribute to the development of new theories in the future. The content analysis by Koivisto and colleagues used an unobtrusive method that provided insight into the complexity of human thought and communication. The unique design of this study provided insight into how participants viewed themselves by analyzing content that included self-invalidation (SI) in individuals with BPD. The operationalization of SI allowed researchers to make inferences regarding complex topics such as self-perception, self-stigmatization, self-esteem attachment and communication styles in this population, which are difficult concepts to measure.

Notably, both Koivisto et al. (2022) and De-la-Morena-Perez et al. (2023) used multiple coders (thus helping to establish inter-coder reliability) and presented direct quotes to support each theme. These enhance the reliability of this study as well as the accuracy of reporting as the direct quotes allow the reader to interpret coder accuracy. These researchers further engaged in transparent methodological choices by including a clear research aim, a detailed data collection process (e.g., Koivisto and others video recorded 80 hours of group therapy sessions and De-la-Morena-Perez and others audio recorded semi-structured interviews and then both had these made into verbatim transcripts), and an explicit analytic approaches (i.e. inductive qualitative content analysis and systematic coding respectively to develop relevant

themes). Notably, the reliability of both these studies was enhanced as they were carried out in clinical settings and were done by experienced researchers. The meta-analysis by Smith and South (2020) was also transparent about its methodology. For example, the researchers clearly outlined their database search strategy (i.e. only using PsycINFO and PubMed and including research terms used), provided a clear explanation of the selection process of articles, clear coding protocols (i.e. specificity regarding the variables that were extracted), the use of the meta-analytic model (to account for both within-study sampling errors and between study heterogeneity) and the use of moderator analyses between studies. Overall, the three studies reviewed have a clear and transparent presentation of their methodologies.

A strength of the qualitative studies reviewed is that they have clear inclusion and exclusion criteria. Both De-la-Morena-Perez et al. (2023) and Koivisto et al. (2022) selected participants who have a clinical BPD diagnosis, while Smith and South (2020) included articles with participants who either had a BPD diagnosis based on the DSM-5-TR criteria or who had dimensional scores through self-reporting measures. The other inclusion criteria from the article by Koivisto and others is that patients must be over the age of 18, and they must have consented to participation in group therapy and recording, while De-la-Morena-Perez and others required participants to be women over the age of 18 who were under treatment at José Germain University Hospital (HUJG) for more than a year. Koivisto and colleagues excluded anyone who had severe cognitive impairments, active psychosis or a current substance dependence, while De-la-Morena-Perez and others excluded participants who had difficulty understanding Spanish (the language in which the study was conducted) as well as women who presented with clinical symptoms at the time of the research. Since Smith and South (2020) conducted a meta-analysis, the inclusion and exclusion criteria were different. The inclusion criteria for this study was: studies in which BPD was assessed in relation to romantic attachment (using attachment anxiety and avoidance dimensions), studies that had a sample

size of at least  $N = 10$ , studies published from 1980 onward, and studies in which attachment was assessed using validated instruments (e.g. ECR, ECR-R, RAAS, AAS, AAQ, etc...). The researchers excluded non-empirical papers, studies that did not assess for both BPD and attachment and specifically for romantic attachment, did not report usable effect sizes, did not properly assess for BPD, replication samples from previous studies, studies that were not in English, and studies that were not available in university catalogs.

**Limitations.** As previously mentioned, Smith and South (2020) used the meta-analysis framework, which synthesized findings from multiple qualitative studies and helped to examine trends and gaps in the literature. While meta-analyses can provide important information by analyzing current research, there are several disadvantages to this type of study. In their research on the effectiveness of meta-analyses, Corker (2022) noted that this framework can be subject to issues like publication bias, selection bias, the inclusion of low-quality studies and the heterogeneity of studies (e.g., examining studies with different methodological approaches makes it difficult to combine and interpret results). Additionally, since Smith and South (2020) are broadly summarizing many articles there is a strong likelihood that certain details, such as the interrogation of researcher biases in individual studies, might be overlooked. This can easily lead to a misinterpretation of the data, which must be considered when interpreting the conclusions in this research. Overall, the writer determined that there was a lack of current and relevant qualitative research on the present research topic, and thus the inclusion of the meta-analysis was necessary. The lack of research was limited by the selected databases that the writer used, and this might have been improved by widening research parameters or by including other databases in the initial research.

Another limitation across the qualitative research is the sampling techniques used. Both De-la-Morena-Perez et al. (2023) and Koivisto et al. (2022) used convenience sampling methods and required clinical referrals when recruiting participants. While this sampling method

might be easy and less costly, it is important to recognize that it can lead to significant bias and limit the studies' generalizability as well as their external validity (Andrade, 2020). Smith and South (2020) included articles with a variety of sampling and recruitment methods, and according to Corker (2022) this may limit the generalizability of findings and might make it difficult to compare studies in research. De-la-Morena-Perez and others used a data saturation principle, while Koivisto and others' sample size was limited by budgeting constraints. Both studies had eight participants who were all or mostly female identifying. Meanwhile, the research by Smith and South only included studies with at least 10 participants, though they are unclear of the range of the sample sizes in the 26 articles reviewed. This is in-line with the average requirement for sample sizes across qualitative research, as saturation is typically achieved in samples between 5 to 24 participants (Hennink & Kaiser, 2022). Of course, given the relatively small sample sizes in these studies, there is limited generalizability of these findings, but this is consistent across all qualitative research.

Notably, of the three studies included in this section, only the work by Koivisto et al. (2022) acknowledged possible researcher biases and asserted that the researchers involved in the study used reflexivity as a tool. Koivisto and colleagues acknowledged that the researchers had a pre-understanding of the relevance of SI to the psychopathology of BPD. However, the writers noted that given the high number of instances of SI across the recordings examined, they decided to continue with their research. Koivisto and colleagues could have limited potential bias by conducting a new study with researchers who were blind to the objective of their study. However, the inclusion of reflexivity within this paper enhances transparency, which is something that is missing from the other two qualitative studies included in this analysis.

Overall, the qualitative research utilized in this study uses sound methodological approaches and provides a wide range of in-depth data reflecting the experience of women with

BPD. These studies could be improved by being more explicit regarding researcher positionality and reflexivity to interrogate potential research biases in the studies.

### Chapter Three: Literature Review

This chapter examines the salient concepts present in the literature on BPD and uses thematic analysis as a means to synthesize the findings across current research. The four main themes that were identified include: 1) gender, sex and BPD, 2) experiences of stigma, 3) insecure attachment, and 4) the relationship between BPD and trauma. An overview of the prevalent themes as well as the identified subthemes that are explored in this chapter is summarized in Table 1. The final portion of this chapter examines ethical considerations pertaining to the core research articles mentioned throughout.

**Table 1**

*Summary of Themes*

<b>Theme</b>	<b>Topic</b>
Theme 1	Gender, Sex and BPD
Subtheme 1a	<i>Prevalence and Symptomology Based on Sex</i>
Subtheme 1b	<i>Gender Bias and Impact</i>
Theme 2	Experiences of Stigma
Subtheme 2a	<i>Internalized Stigma</i>
Subtheme 2b	<i>Stigmatizing Views held by MHPs and Researchers</i>
Theme 3	Insecure Attachment
Subtheme 3a	<i>The Relationship Between Insecure Attachment and BPD</i>
Subtheme 3b	<i>Social Impairment and Adult Relationships</i>
Theme 4	The Relationship Between BPD and Trauma
Subtheme 4a	<i>Trauma History and Childhood Trauma</i>
Subtheme 4b	<i>Trauma, Adult Attachment and Internalized Symptoms</i>

## Literature Findings

### Theme 1: Gender, Sex and BPD

#### ***Subtheme 1a: Prevalence and Symptomology Based on Sex***

The *DSM-5* estimated that the prevalence of BPD among women is 75% (American Psychiatric Association [APA], 2013) as clinical samples demonstrated a 3:1 female-to-male ratio. However, the updated *DSM-5-TR* highlights that while BPD is more common among women than men in clinical samples, there is no difference in prevalence among community samples (APA, 2022). The *DSM-5-TR* further noted that this discrepancy may be attributed to the higher degree of help-seeking behaviour amongst women, but more research is required to better understand this discrepancy. It has been found that clinical manifestations of psychopathology tend to be more severe among women, and that they are more likely to display “internalizing symptoms” than their male counterparts (APA, 2022; Bozzatello et al., 2024; De-la-Morena-Perez et al., 2023). Internalizing symptoms are more “self-focused” and include affect instability, self-harm, isolation, identity disturbance and dissociation (De-La-Morena-Perez et al., 2023; Qian et al., 2022). Contrastingly, Qian et al. (2022) noted that males are more likely to display “externalizing symptoms” associated with this disorder, such as aggression, impulsivity and novelty seeking.

The reviews conducted by Bozzatello et al. (2024) and Qian et al. (2022) both noted that males with BPD are more likely to have a comorbid substance abuse disorder than females. Qian and colleagues further indicated that mixed-sex studies also found males with BPD tended to have higher rates of cluster A personality disorders (i.e. paranoid, schizoid and schizotypal disorders) and cluster B personality disorders (i.e. antisocial, histrionic and narcissistic disorders). By contrast, both reviews found substantial evidence that females with BPD tend to have comorbid eating disorders and anxiety disorders, and some evidence suggested that women have higher rates of mood disorders. Qian and colleagues also analyzed several studies

indicating that women with BPD more often met the criteria for a PTSD diagnosis than their male counterparts.

This section focuses on a narrative review by Bozzatello et al. (2024) and a scoping review by Qian et al. (2022), which offer a large range of data. Qian and colleagues excluded any articles with samples that included transgender individuals, while Bozzatello and colleagues seemed to focus on keywords pertaining to the gender binary (e.g. “male gender” and “female gender”). Furthermore, much of the research on sex differences in BPD did not focus on why these differences might exist. The theoretical orientation of gender constructionism (Butler, 2004) or a feminist or queer theory lens may be beneficial for researchers in the future to better understand the relationship between BPD symptomology, gender and biological sex.

Additionally, the over-representation of women in clinical samples is often attributed to high levels of help-seeking behaviour (APA, 2022), which might also be explained by attachment theory and an examination of how insecure attachment presents differently across different gender identities (Johnson, 2019). For example, research by Ciocca et al. (2020) found that masculinity was linked to higher rates of avoidant attachment styles while femininity was associated with higher rates of the anxious style. Given the fact that Johnson (2019) noted that anxious attachment is associated with excessive needs for reassurance and validation, a deeper look into how attachment styles might influence BPD symptomology presentation across genders would be beneficial. Further research is required to better conceptualize the potential biological and social factors that might contribute to BPD presentation and subsequent help-seeking behaviours.

### ***Subtheme 1b: Gender Bias and Impact***

Much of the literature on BPD suggests that the higher rates of diagnoses in women is related to diagnostic biases related to gender (De-la-Morena-Perez et al., 2023; Ring & Lawn, 2025). However, Masland and colleagues (2022) noted that while epidemiological research

(which often uses samples that are limited to the gender binary) shows a higher prevalence of BPD in women than men, community samples show roughly equal rates of BPD across all gender identities, which is supported by the updated section on gender and BPD found in the *DSM-5-TR* (APA, 2022).

An impact of potential gender bias is the trend of pathologizing traits that are traditionally considered to be “feminine,” particularly with diagnoses like BPD (De-la-Morena-Perez et al., 2023). From a critical feminist perspective, Ma and Else-Quest (2024) noted that BPD descriptors (e.g. emotionality) are linked to female stereotypes that pathologize women. Indeed, De-la-Morena-Perez et al. (2023) research found themes across interviews related to the stereotypes of female frailty and care-seeking, which the researchers related to the gender bias and experiences of stigma. Conversely, a key finding in the review conducted by Bozzatello et al. (2024) is that traits such as anger and impulsivity tended to be viewed as more “pathological” in women with BPD, despite being more common in men with this disorder. This suggests that gender bias not only influences the diagnostic process but also the way that symptomatology is interpreted. These findings demonstrate how when women with BPD act in a way that aligns with gendered stereotypes that can be pathologizing, but when they act in ways that go against gendered norms this can also be considered deviant or pathological. This can be explained by Butler’s (2004) theory on gender constructionism and contemporary feminist theory (Hekman, 2015), as the social constructions of what it means to be ‘feminine’ and ‘masculine’ seem to have an impact on how BPD manifests, is diagnosed and is interpreted. This theory suggests that in order to destigmatize BPD, we must also deconstruct our social understandings of gendered behaviours.

Various dimensions of BPD may be causing the possible gender bias. For example, the perceived link between gendered violence and BPD traits may impact clinician’s perceptions (Ma & Else-Quest, 2024). Of the eight cisgendered women who were interviewed by De-La-

Morena-Perez et al. (2023), several identified that they had been victims of sexual violence and many of their perpetrators were close relations. The research by Schulze et al. (2022) investigated the impact of different adverse childhood experiences (ACES) on BPD features. While the researchers noted that previous studies had found a link between past sexual abuse and BPD traits, their research found no significant association between these factors. Indeed, in their review of existing literature, Ring and Lawn (2025) found that the higher risk for sexual abuse among women is sometimes attributed amongst researchers to a greater prevalence of BPD. These studies indicate that there needs to be more research on the link between gender-based violence and BPD, as it could indicate certain complexities surrounding the gender bias associated with this disorder.

Another theme related to gender is that of motherhood. De-la-Morena-Perez et al. (2023) identified that participants who were mothers found it difficult to balance caregiving duties while seeking treatment. Indeed, one interviewee reported being discharged not because she was well, but because her doctor reported that she needed to take care of her children. Furthermore, participants identified feeling unable to exercise the role of “mother,” which caused guilt and suffering. In their review, Ring and Lawn (2025) indicated that the fear of being judged by services deterred parents from seeking help for their disorder. These findings suggest that there is some tension between the role of “mother” and the way that clients and society at large perceive BPD. While there needs to be more research into this topic, it does bring up how focus on the gender binary can impact the experiences of women with BPD.

This section continues to utilize the narrative review by Bozzatello et al. (2024) and the qualitative study by De-la-Morena-Perez et al. (2023), which was described in the previous subtheme. The systematic review, conducted by Di Bartolomeo et al. (2024) included articles from reputable databases (PsycInfo, PsycArticles and PubMed), and of the 1,962 articles reviewed, 62 met eligibility criteria. This study utilized a cross-sectional research design.

Given that the populations that were sampled across all research were predominantly made up of cisgendered, female-identifying clients, it can be concluded that the sampling in the available literature is relatively homogeneous (De-la-Morena-Perez et al., 2023; Erkoreka et al., 2022; Hashworth et al., 2021; Koivisto et al., 2022; Miano et al., 2021; Schulze et al., 2022). Indeed, the studies referenced all had samples that are all >70% female. The study by Peng et al. (2021) had a clinical sample that was still mostly female, with 56.22%. The reviews that were surveyed (Bozzatello et al., 2024; Di Bartolomeo et al., 2024; Smith & South, 2020) included more varied samples across studies, though all indicated that most participants were still female. This highlights a possible gender bias in sampling and research that cannot be ignored that may influence the perceptions of researchers and the subsequent themes in the literature. The homogeneity of the samples limits the generalizability of the data.

Overall, there needs to be more research into the possibility of gender bias and how it relates to BPD. In their survey of the literature, Ring and Lawn (2025) noted that this issue could exist at several levels. For example, women tend to seek health care services at a higher rate compared to men so there may be differences in community vs. clinical samples. They further suggested there may be a bias related to the diagnostic construct of BPD itself or a bias in the diagnostic and assessment procedures, which may lead to higher rates of diagnosis in cisgendered women. The depth of the qualitative interviews conducted by De-la-Morena-Perez et al. (2023) helps to highlight real-world issues of women with BPD. On the other hand, the reviews published by Bozzatello et al. (2024) and Qian et al. (2022) were able to survey high volumes of research and provide overviews of the literature on this topic. However, there needs to be more research that surveys gender and sex differences in BPD, and that considers BPD outside of the gender binary context.

## **Theme 2: Experiences of Stigma**

### ***Subtheme 2a: Internalized Stigma***

Notably, those who have been diagnosed with BPD can experience internalized stigma related to their disorder. Koivisto et al. (2022) highlighted how crucial it is for an individual to be able to trust their own perceptions to maintain psychological well-being. These researchers reviewed 80 hours of videotaped group-therapy and found that there were a total of 534 self-invalidating (SI) expressions found across all reviewed data. Examples of this included verbal expressions of SI, and descriptions of self-erasing and compliant behaviour in interpersonal relationships. However, it is notable that the researchers could only record overt, verbal expressions of SI, so this study lacks insight into more subtle expressions as well as SI thoughts. Both Koivisto and colleagues and De-la-Morena-Perez et al. (2023) noted that participants in their studies experienced guilt, shame, anger and resentment in regard to their diagnosis. One theme in the De-la-Morena-Perez and others study was that some participants felt as though they could not fit in with others who had differing psychiatric diagnoses in mental health institutions, nor could they fit in with others in the real world. The literature reviewed by Ring and Lawn (2025) found that patients with BPD held overall positive views towards receiving a BPD diagnosis as it helped them to better understand their condition and to identify their symptoms as a disease rather than negative aspects of the self. Both the studies conducted by Koivisto and others and De-la-Morena-Perez and others emphasized how women with BPD felt as though certain traits, such as emotionality or self-harm, made them a “burden” to others. Participants expressed either seeing their own reactions in moments of crisis as being “abnormal,” or they conveyed uncertainty about their own perceptions and their ability to comprehend normalcy. Across all three studies, it was found that participants were aware of negative stereotypes and prejudices associated with BPD, particularly the stigmatizing views of

mental health professionals (MHPs). All studies noted the impact that this had on participants' help-seeking behaviors and on their views of the self.

***Subtheme 2b: Stigmatizing Views held by the MHPs and Researchers***

A prominent theme across the literature suggests that MHPs tend to hold stigmatizing views towards clients with BPD (Barr et al., 2020; De-la-Morena-Perez et al., 2023; Hartnell, 2022; Klein et al., 2022; Ring & Lawn, 2025). One possible explanation for this is the high rate of suicidality and a set of complex needs among this population, which leads them to seek frequent support from emergency and mental health services (Klein et al., 2022; Ring & Lawn, 2025). Ring and Lawn's (2025) review on the topic found that overall, MHPs perceive BPD clients to be untreatable and demanding of services. Indeed, this review found that consumers with BPD tended to access mental health services at a much higher rate than other consumers. Research by Sulzer (2015) reported discourse among MHPs around wanting to minimize responsibility for BPD patients, and in some cases, an admission of outright denying treatment to these patients. This study further found that MHPs perceived BPD patients as 'manipulative,' and suggested that this is due to the de-medicalization of the diagnosis. In other words, Sulzer proposed that there is a widespread perception that BPD is a moral issue or a personal defect rather than a legitimate disorder. This is supported by Ring and Lawn, who purported that many MHPs question whether BPD is a "real" mental illness, view the disorder as complex and untreatable, perceive patients with BPD as manipulative and controlling, and perceive BPD patients as being less deserving of sympathy. As previously stated, this pattern of stigmatization is supported from the client perspective as well. From an attachment perspective, the tension between clients and MHPs may be explained by the 'push-and-pull nature' of the disorganized attachment style (Johnson, 2019) that is so common among BPD patients. If clinicians are taught to view BPD from an attachment lens, this may increase clinician empathy and may help to reduce stigmatizing views towards certain BPD behaviours (Formella & Ugwuanyi, 2024).

Overall, patients with BPD report that when accessing mental health care they experience: stigma and prejudice from MHPs, a lack of communication and empathy during the diagnostic process, difficulty accessing competent care from MHPs who specialize in this disorder, a general lack of accessible care and quality services (Barr et al., 2020; De-la-Morena-Perez et al., 2023; Ring & Lawn, 2025). Klein et al. (2022) indicated that the limited capacity of mental health systems that are already strained combined with the complex needs of those with BPD have led to structural stigma around this disorder. Generally, researchers noted that there is a lack of specialized education around BPD for MHPs, despite MHPs identifying that they would like to learn more about this disorder (Klein et al., 2022; Ring & Lawn, 2025). The literature also identifies a significant gap in research that focuses on person-centered and compassionate approaches towards treating BPD (Barr et al, 2020; Klein et al., 2022). While qualitative studies on the topic (Barr et al. 2020; De-la-Morena-Perez et al.2023; Hartnell, 2022) are able to capture in-depth data about this topic, the reviews (Klein et al., 2022; Ring & Lawn, 2025) indicated that these findings are fairly generalizable and that this issue is widespread. Importantly, these issues may contribute to the re-traumatization of clients if not adequately addressed, and thus the trauma-informed approach should be central to any efforts to ameliorate these issues (Marks et al., 2021).

It is notable that there are similar instances of stigma found in social sciences research on BPD. Language used by researchers often perpetuates stigmatizing views and focuses on individual deficits rather than considering broader social contexts that may contribute to the development of personality disorders (Klein et al., 2022; Masland et al., 2023; Rodriguez-Seijas et al., 2023). Masland et al. (2023) highlighted that when researchers create codes, for example, that imply that clients with BPD are “manipulative,” they are contributing to gendered and stigmatizing stereotypes that influence views of MHPs and the general population. Again, Butler’s (2004) idea of gender constructionism may help researchers to better understand how

language can be impacted by the social constructions of gender, which increase stigmatization. Implications of biased language in research will be further discussed in the ethical considerations section of this chapter.

### **Subtheme 3: Insecure Attachment**

#### ***Subtheme 3a: The Relationship Between Insecure Attachment and BPD***

There is a significant amount of research indicating that there is a relationship between insecure attachment styles and BPD traits. From a clinical perspective, Formella and Ugwuanyi (2024) found that when MHPs incorporated attachment theory into their assessment and clinical practices it improved their views on the prognosis and enhanced overall understanding of personality disorders. As for the types of insecure attachment associated with BPD, Erkoreka and colleagues (2022) suggested that attachment anxiety was a mediator in the relationships between childhood trauma and personality dysfunction in BPD. In particular, this research found that physical neglect (i.e. the failure of a caretaker to provide their child with basic needs) was related to the anxious attachment style. Conversely, other recent research highlighted that patients with BPD display a mix of both anxious and avoidant attachment styles, otherwise known as disorganized attachment (or fearful-avoidant) (Hashworth et al., 2021; Miano et al., 2021; Peng et al., 2021; Smith & South, 2020). Researchers suggest that the combination of both anxious and avoidant attachment styles may, in part, explain the complex nature of BPD. Smith and South (2020) explained this attachment style as a rapid shift between the desire for closeness and extreme distance, which causes significant social impairment and emotional dysregulation, both of which are marked features of BPD (Hashworth et al., 2021; Miano et al., 2021). Peng et al. (2021) further noted that the interplay between childhood trauma and disorganized attachment is linked to the reduced capacity for mentalization found among BPD patients.

While attachment theory is used across research to conceptualize this disorder, it is important to note that attachment insecurity is not the sole predictor of BPD. The interplay between attachment insecurity, trauma and maladaptive emotional regulation (ER) is complex, and the researchers above noted that there may be other factors that contribute to the development of BPD features (Erkoreka et al., 2022; Peng et al., 2021). Furthermore, researchers cannot establish causal ordering between trauma, attachment, and the personality features associated with BPD (Erkoreka et al., 2022). While the literature on this topic indicates the importance of considering attachment trauma when conceptualizing BPD, it also highlights that there is a lack of research into the effectiveness of attachment-based interventions for this disorder (Erkoreka et al., 2022; Formella & Ugwuanyi, 2024; Miano et al., 2021).

### ***Subtheme 3b: Social Impairment and Adult Relationships***

The data across available research suggested that individuals with BPD tend to experience volatile and turbulent relationships (Di Bartolomeo et al., 2024; Howard et al., 2022; Jeong et al., 2022; Kroener et al., 2023; Miano et al., 2021; O'Leary et al., 2024; Schulze et al., 2022; Smith & South, 2020). The research emphasized that insecure attachment styles are positively correlated with relationship-related problems. Di Bartolomeo et al. (2024) and Jeong et al. (2022) both noted that participants with BPD reported lower relationship quality, satisfaction and happiness in various types of adult relationships. These writers also found that their samples reported high rates of loneliness, social exclusion and isolation compared to participants in control groups. Additionally, researchers who studied the quality of romantic relationships in participants with BPD reported higher rates of conflict, distress, dissolution and overall relationship dissatisfaction (Di Bartolomeo et al., 2024; O'Leary et al., 2024; Smith & South, 2020). There is somewhat limited research into experiences of partners of individuals with BPD, but O'Leary et al. (2024) and Jeong and colleagues both indicated that partners report high rates of relationship distress, increased conflict and feeling burdened with caretaking

responsibilities. Interestingly, both sources stated that partners feel as though they must tiptoe around their significant other due to their mental illness. Other common partner complaints found across the literature cited in this section include maladaptive communication styles, relationship instability, strained relationships with shared children, and difficulty coping with their partner's impulsivity, particularly in regard to financial or social decisions. One particular study by Miano et al. (2021) measured the attachment styles, support seeking behaviours, and dyadic emotional regulation between unmarried, heterosexual couples. In every couple selected, the female-identifying member had a BPD diagnosis, and their results were compared to a healthy control group of couples with a similar demographic. The researchers found that the women diagnosed with BPD engaged in more support seeking behaviours and tended to engage in more negative behaviours to elicit support. Overall, the women with BPD tended to display more fluctuations between creating closeness and distance when engaging in a personally threatening condition, and they reported an increase in negative emotions after engaging in relationship-threatening conversations with their partner compared to the healthy control. The results of this study are supported by the reviews conducted by Di Bartolomeo and others and Smith and South (2020), which emphasized similar patterns across the literature. Smith and South attributed the pattern of fluctuating between closeness and distance in romantic relationships and an indication of disorganized attachment, as addressed in the previous section.

Overall, the experiences described above that relate to social impairment in adult relationships seem to be linked to the dimension of attachment insecurity that is prevalent in BPD clients. One feature related to this phenomenon is rejection sensitivity (RS), a cognitive-affective process in which individuals tend to expect and easily perceive intentional rejection, which can lead to strong emotional reactions (Di Bartolomeo et al., 2024; Jeong et al., 2022; O'Leary et al., 2024). Much of the literature indicated that it is common for a person with BPD to

attach to others and to have their emotional regulation and often their self-worth dependent on another person. Jeong et al. (2022) in particular, described how people with BPD tend to have a “favourite person” whom they are often heavily emotionally attached to and dependent upon. However, it is common for the person with BPD to oscillate between idealizing this person when they feel a strong connection and devaluating the relationship when this person fails to fulfill their expectations. This research is further supported by Hashworth et al. (2021), who found that participants with BPD were more likely to report low personal agency and disorganized attachment styles compared to the controls. This interpersonal pattern is related to RS, which is a part of the *push-and-pull* dynamic that is so common amongst adults with disorganized attachment.

Both O’Leary et al. (2024) and Miano et al. (2021) suggested that shared externalization of the disorder and increased awareness for both partners regarding how BPD influences attachment may improve relationship quality. The researchers indicated that therapy was also helpful for improving relationship quality and communication. Furthermore, Miano and others and Hashworth et al. (2021) shared that treatment should focus on reducing an over-reliance on dyadic emotional regulation, seek to strengthen positive support-seeking behaviours, bolster personal agency, and bring awareness to the possibly conflicting signals that women with BPD may send to their partners when seeking support. However, the literature on this topic does not seem to have sufficient evidence for these recommendations, thus further research is required to determine the effectiveness of these proposed intervention strategies. Notably, one longitudinal study conducted by Howard et al. (2022) found that a decrease in relationship quality between assessments was associated with higher BPD features, which highlights the importance of increasing the quality of relationships among those with this disorder.

Once again, samples surveyed in these studies that focused on relationships seem to be made up of mostly heterosexual couples in which the female-identifying participant had a BPD

diagnosis, and these studies also noted that the majority of participants identified as Caucasian (Jeong et al., 2022; Miano et al., 2021; O'Leary et al., 2024). The reviews by Di Bartolomeo et al. (2024) and Smith and South (2020) also only selected peer-reviewed publications in English, which limits the diversity of the findings. This lack of diversity highlights a large gap in the literature. The sample sizes varied significantly depending on the study across all surveyed research, particularly in the review conducted by Di Bartolomeo and others, which surveyed 62 articles which had sample sizes that ranged from 22 to 4,800 participants. Sample compositions were also varied across all research, which helps to bolster the generalizability of these findings. Another limitation across these articles is the inconsistency in what was measured and the tools used. For example, Smith and South noted that some studies use the Experiences in Close Relationships (ECR) questionnaire, which does have excellent internal consistency, test-retest reliability and higher information measurement indices compared to other measures. However, other studies noted that there was an over-reliance on self-reporting measures, some of which had limited reliability. It is notable that this measure only looks at attachment anxiety and avoidance, and thus researchers assessing for disorganized attachment styles must interpret the results to determine that a client is high in both these dimensions. Furthermore, some of the literature surveyed measured dimensions of attachment insecurity based on interview questions or other, less reliable tools. Similarly, Di Bartolomeo and colleagues noted a lack of consistency across research as some studies assessed for perceived social connectedness, while others measured objective social connectedness (i.e. marital status). Additionally, when researchers attempt to measure dimensions such as support-seeking behaviours in relationships there are other factors, such as prior experiences of support giving quality of the partner, that may influence the results of the current research. Finally, there was a lack of longitudinal studies across the body of research, except for the study by Howard et al. (2022). This study importantly highlighted that BPD features did not remain stable across time, which is contrary to

most other research which assumes that these traits are more stable. This indicates the importance of more longitudinal studies for this population to better understand the dynamic between fluctuating relationship quality and BPD symptomology.

#### **Theme 4: The Relationship Between BPD and Trauma**

##### ***Subtheme 4a: Trauma History and Childhood Trauma***

As previous sections indicated, an insecure attachment style alone is not a predictor of BPD features. Indeed, the research suggests that childhood trauma and trauma history play a significant part in the development of BPD (De-la-Morena-Perez et al., 2023; Erkoreka et al., 2022; Fung et al., 2023; Peng et al., 2021; Schulze et al., 2022). Peng et al.'s (2021) research found that there was a direct effect of childhood trauma on BPD features, and that there were three mediating pathways through which childhood trauma might increase the severity of BPD features. They discovered that the most likely chained mediation pathway was from childhood trauma through insecure attachment, then through maladaptive ER to BPD features. Despite this finding, the researchers noted that this study still cannot determine a causal relationship between the factors, which is supported by other research on this topic (Erkoreka et al., 2022; Schulze et al., 2022). Overall, the research surveyed in this section emphasizes that BPD symptomology is likely caused by a complex interplay between the factors enumerated in the study by Peng and others.

It is important to note that there are different types of trauma, which may have an impact on an individual's likelihood to develop BPD features. Schulze et al. (2022) measured these different types of trauma by administering the Adverse Childhood Experiences (ACEs) short-form questionnaire, while Erkoreka et al. (2022) used the Childhood Trauma Questionnaire-Short Form (CTQ). While the study by Schulze and others found that a history of emotional abuse had the most impact on attachment insecurity and all other features of BPD except for affective instability, Erkoreka and colleagues instead suggested that this type of abuse impacted

dissocial symptoms (i.e. a lack of empathy, exploitativeness and an egocentric attitude). Interestingly, the latter study found novel evidence that linked physical neglect to be linked to dimensions of anxious attachment and emotional dysregulation. This is in line with attachment theory (Bowlby, 1982; Johnson, 2019), which suggested that neglect from a caregiver is inherently traumatic and has lasting effects on internal and relational patterns. In the qualitative interviews conducted by De-la-Morena-Perez et al. (2023) participants reported having traumatic childhoods and teenagehoods. This data highlighted patterns of physical violence and instability as well as several instances of rape and ongoing sexual abuse, mostly with the perpetrators being family members. Interestingly, the research by Fung et al. (2023) used a self-report measure, the Brief Betrayal Trauma Survey (BBTS), in their research and they discovered that participants with BPD had high rates of both childhood and adulthood trauma. This indicates that individuals with this disorder continue to be at high risk for retraumatization throughout adulthood, which further shows the importance of finding adequate treatment options for this population. This is supported by trauma-informed theory (Marks et al., 2021), which aims to understand trauma history as a means of reducing trauma in the present. It is further supported by attachment theory (Bowlby, 1982; Johnson, 2019), which seeks to create corrective emotional experiences in the therapeutic setting so a client can experience safety and security, which will help to reduce retraumatization. Fung and colleagues recommended that MHPs take a trauma-informed approach when working with BPD clients, given the high rate of trauma found in this population. While most of the research on BPD tends to make this link, very few researchers seem to mention trauma-informed care in their recommendations.

While the relationship between trauma and BPD is complex, the research clearly indicated that there is a strong association between the two. As demonstrated in this analysis, there are several different measures used to assess trauma. This lack of consistency between the measures used highlights that this is an incredibly difficult dimension to assess, even though

they have all been found to be generally valid and reliable tools. One difficulty of measuring a concept like trauma is that it can be incredibly subjective, which is why a qualitative study was also included in this section. Interestingly, compared to other themes analyzed in this paper, there is more cultural diversity in the work highlighted in this section. Of the studies surveyed, two were conducted in China, two in Spain and one in the Netherlands (De-la-Morena-Perez et al., 2023; Erkoreka et al., 2022; Fung et al., 2023; Peng et al., 2021; Schulze et al., 2022). While several of these studies still took place in European countries, none of the studies were conducted in English. The cultural diversity represented in this section helps to highlight that topics like trauma, while lacking consistent measures, appear cross-culturally and are thus more generalizable. However, further consistency in the tools used and in tools that are appropriate to use across different cultures will only enhance these findings in future research.

#### ***Subtheme 4b: Trauma, Adult Attachment and Internalized Symptoms***

Several studies noted that the complex interplay between insecure attachment in adults and trauma is likely what causes internalized symptoms for BPD patients. The internalized BPD symptoms that will be examined are: identity disturbances, struggles with self-image and self-concept, experiences of maladaptive ER, suicidality and self-injurious behaviours, and dissociative symptoms (De-la-Morena-Perez et al., 2023; Erkoreka et al., 2022; Fung et al., 2023; Jeong et al., 2022; Koivisto et al., 2022; Peng et al., 2021; Qian et al., 2022; Schulze et al., 2022).

Identity disturbances and difficulty with self-image or self-concept can manifest in a variety of ways. Individuals with BPD tend to have a negative self-image, maladaptive identity formation, rapid changes in identity and a fragmented sense of self, which leads to difficulties in goal setting and maintaining relationships (Schulze et al., 2022). On one hand, identity disturbances can be related to attachment insecurity as individuals with BPD may look to others to gain a sense of identity (Jeong et al., 2022). This struggle may be linked to a deficient sense

of normalcy and high levels of self-doubt (Koivisto et al., 2021), which could be caused by a variety of factors. When studying the relationship between ACEs and BPD, Erkoreka et al. (2022) found that identity disturbance was a central node in their research and was strongly linked to affective instability, emotional abuse and attachment anxiety. Similarly, emotional dysregulation, or affective instability, is another central feature of BPD. As it was previously mentioned, RS and perceived abandonment are factors across the literature that have been found to trigger emotional dysregulation in BPD patients (Di Bartolomeo et al., 2024; Jeong et al., 2022; O'Leary et al., 2024). As Peng et al. (2021) noted, attachment anxiety and specific types of childhood trauma seem to be related to significant emotional dysregulation in this population. While it may not be clear in the literature, a lack of secure identity may be linked to the pattern of emotional dysregulation. This is because without a secure sense of self to anchor them, the person with BPD cannot self-regulate (Jeong et al., 2022). However, there needs to be further research into this topic to support this claim.

The research also indicated high rates of self-harming behaviours among individuals with BPD (De-la-Morena-Perez et al., 2023; Fung et al., 2023; Qian et al., 2022; Schulze et al., 2022). As previously mentioned, Qian et al. (2022) highlighted how self-injurious behaviour was more common in women with BPD than in their male counterparts, though this is true in the general population and is not specific to BPD samples (De-la-Morena-Perez et al., 2023). One possible explanation across the literature is that it may serve as a coping mechanism that is related to gender expression, but this still requires more robust research. Again, a gender-constructionist perspective and critical feminist perspective (Butler, 2004; Hekman, 2015) may serve as a possible explanation for this discrepancy. Schulze et al. (2022) looked at how impulsive self-harm relates to other features of BPD and found that it is indirectly associated with insecure attachment through an unstable self-image and difficulties in relationships. De-la-Morena-Perez et al. (2023) emphasized how self-harm is used as a means to cope with crisis

and a means to regain control when individuals with BPD experience intense, negative emotions. Another factor to consider is dissociation, which is a strong predictor of self-harm and suicidality in research done in clinical settings (Fung et al., 2023). Indeed, De-la-Morena-Perez et al. (2023) and Fung et al. (2023) drew parallels between early experiences of trauma, dissociative experiences and self-harm (e.g. depersonalization, intrusive symptoms). They suggested that trauma-related dissociation and self-harm be maladaptive coping skills that were developed because of childhood trauma, and that these skills help during moments of crisis and extreme emotional turmoil. It is clear that the relationship between trauma and internalized symptoms of BPD is complex, but given its prevalence in the literature, it is imperative that clinicians consider how trauma-history may contribute to the development of BPD symptomology.

As gleaned from above, BPD is a complex disorder that is likely caused by a variety of interpersonal and environmental factors. Clients with this disorder face stigmatization and require specialized care. Overall, the literature on this topic identified that attachment-related issues and trauma are prevalent and a key part of assessment, but further research on how to incorporate this knowledge into assessment and conceptualization is required. There is also a lack of understanding regarding how counselling psychologists can effectively work with BPD clients, despite the likelihood that they will encounter clients with this diagnosis early in their careers.

### **Ethical Considerations**

It is imperative to consider the ethical implications when conducting and analyzing research, and thus the articles (see Table 1) included in this research have been examined for ethical adherence and possible ethical concerns. The two documents that will be referenced are the fourth edition of the *Canadian Code of Ethics for Psychologists* by the Canadian Psychological Association (CPA, 2017) and the *Tri-Council Policy Statement: Ethical Conduct*

*for Research Involving Humans* by the Canadian Institutes of Health Research [CIHR], Natural Sciences and Engineering Research Council of Canada [NSERC], & Social Sciences and Humanities Research Council of Canada [SSHRC] (CIHR, NSERC, & SSHRC, 2018). The main themes that appear across the core articles include informed consent and withdrawal, privacy and confidentiality, deception, conflicts of interest, and fairness and equity.

### **Informed Consent and Withdrawal**

In accordance with *Principle I: Respect for the Dignity of Persons and People* (CPA, 2017) and the Tri-Council Policy Statement's section on the consent process (CIHR, NSERC & SSHRC, 2018), researchers must gather informed consent from their prospective research participants. This must include the purpose of the study, possible risks and benefits, an assurance that participants are under no obligation to participate and can withdraw at any time (e.g. consent must be uncoerced), information regarding incentives, and the identity and contact information of appropriate individuals outside of the research team whom can be contacted regarding possible ethical issues. Of the core articles used, most included explicit descriptions that informed consent was obtained (De-la-Morena Perez et al., 2023; Erkoreka et al., 2022; Fung et al., 2023; Hashworth et al., 2021; Koivisto et al., 2022; Miano et al., 2021; Schulze et al., 2022), but only De-la-Morena-Perez and others (2023) specifically detailed the participants' right to withdraw. While it might be assumed that this was a part of the informed consent document signed, the researchers could have improved their ethical responsibility by clearly stating this to indicate that their participants provided consent that was fully informed and uncoerced. Only Hashworth et al. (2021) mentioned that only participants who were legally adults (aged 18+) were included in the study in the context of the informed consent process. However, all other studies did mention that only adults were included in the sampling process, but this was not elaborated on in the context of consent. Only three studies clearly stated that participants were provided with detailed information about the study prior to signing the informed

consent documentation (De-la-Morena-Perez et al., 2023; Erkoreka et al., 2022; Koivisto et al., 2022). However, it must be noted that the majority of the core articles did explicitly state that institutional review board (IRB) approval was granted prior to conducting the research (De-la-Morena-Perez et al., 2023; Erkoreka et al., 2022; Fung et al., 2023; Hashworth et al., 2021; Koivisto et al., 2022; Miano et al., 2021; Schulze et al., 2022), which indicates that participants were likely fully informed about the study's purpose. The exceptions to this were two reviews (Di Bartolomeo et al., 2024; Smith & South, 2020) and two research articles (Formella & Ugwuanyi, 2024; Peng et al., 2021), which did not mention ethical considerations at all, including the process of informed consent and withdrawal and IRB approval. This raises concerns from an ethical perspective, particularly in the context of this analysis as it has been established that participants with BPD already experience a high amount of stigma within research and mental health care. As this is an incredibly vulnerable population, writers should prioritize strict adherence to ethical standards and practices.

### **Privacy and Confidentiality**

It is imperative that participants' privacy and confidentiality are protected, as outlined in *Principle I: Respect of the Dignity of Persons and People* (CPA, 2017) and the *Tri-Council Policy Statement* (CIHR, NSERC & SSHRC, 2018). After analyzing the core research, only the article by De-la-Morena-Perez et al. (2023) indicated that the topic of confidentiality was addressed with their participants. The researchers further stated that confidentiality was ensured throughout the coding process, and that accessibility to the original manuscripts was only granted to the principal investigator. Since this was the only qualitative study included this is unsurprising as this type of research poses a greater risk of unintentionally disclosing identifying information given the nature of the data collection, as detailed in the Tri-Council's information regarding ethical qualitative research (CIHR, NSERC & SSHRC, 2018). In the context of BPD research, this also aligns with the notion of maximizing benefit and minimizing

harm, as addressed in *Principle II: Responsible Caring* (CPA, 2017), as the publication of identifying information may increase the risk of stigmatization and harm to these individuals based on their identities. Notably, Fung et al. (2023) stated in their research that no identifiable information or media would be published (including no details, images or videos relating to an individual person). Meanwhile, Schulze et al. (2022) stated that consent for publication from participants was “not applicable,” but did not elaborate further. While privacy and confidentiality is an essential part of the ethical duty of psychologists and researchers, it was not focused on in these studies, and when it was mentioned, it lacked detail (CPA, 2017; CIHR, NSERC & SSHRC, 2018). Again, given the lack of trust that many individuals with BPD have towards researchers and MHPs, this lack of ethical consideration is incredibly concerning.

### **Deception**

The use of ethical deception in research is touched upon in *Principle III: Integrity in Relationships* (CPA, 2017) and the consent process section of the Tri-Counsel’s Policy Statement (CIHR, NSERC & SSHRC, 2018). These documents highlight that deception can be used in research when there is minimal risk of harm, there is no other alternative available, and when there is a clear debriefing plan built into the study (CPA, 2017; CIHR, NSERC & SSHRC, 2018). This was not addressed in any of the research as deception was not used in any of the present studies. Thus, there are no ethical concerns of note.

### **Conflicts of Interest**

The notion of conflicts of interest is addressed in *Principle III: Integrity in Relationships* (CPA, 2017) and in the Tri-Council Policy Statement’s section on conflicts of interest (CIHR, NSERC & SSHRC, 2018). Several studies clearly declared that the researchers did not have a known competing/conflict of interest (Fung et al., 2023; Koivisto et al., 2022; Miano et al., 2021; Peng et al., 2021; Schulze et al., 2022). Several of the studies included could have improved their ethical competence by addressing this in detail. For example, the research by Koivisto et

al. (2022) included transcriptions of group therapy conducted with a group of participants who had a BPD diagnosis. It would have been beneficial if the researchers provided more depth into the transcribing and coding process. Additionally, this article implies that those conducting the group therapy are not affiliated with the researchers, but again, this could have been stated more clearly to improve transparency. Furthermore, several researchers indicated that participants were recruited from outpatient settings at psychiatric hospitals (De-la-Morena-Perez et al., 2023; Erkoreka et al., 2022; Miano et al., 2021; Peng et al., 2021), but this recruiting process was not addressed in detail in any of the listed studies. These studies could have improved their ethical considerations if the researchers clearly stated that they had no affiliation with the programming at these outpatient settings.

### **Fairness and Equity**

The notion of equity and fairness is addressed in *Principle I: Respect for the Dignity of Persons and People* (CPA, 2017) and the Tri-Council Policy Statement on fairness and equity in research participation (CIHR, NSERC & SSHRC, 2018). Notably, the policy statement indicates that individuals whose circumstances may make them vulnerable in the context of research should not be inappropriately included or automatically excluded on the basis of their circumstances. As previously mentioned, participants with BPD are incredibly vulnerable given the high rates of suicidality and hospitalizations in this population (De-la-Morena-Perez et al., 2023; Erkoreka et al., 2022; Peng et al., 2021; Schulze et al., 2022). However, this topic was not addressed in any of the research articles included in this analysis. The sampling across most studies was fairly homogenous and made-up of mostly female-identifying participants. While it is an ethical responsibility for researchers to include women in their studies as they have historically been excluded from most research (CIHR, NSERC & SSHRC, 2018), in the context of BPD this may contribute to gender bias. Further consideration could also have been given to the language used within research to avoid female-stereotypes and stigmatizing descriptions of

BPD clients (Masland et al., 2023). Again, the inclusion of these considerations would have enhanced the equity and fairness of these studies. It would also be beneficial for these researchers to address the potential resources and care provided to the participants in their studies. This would once again help to maximize benefit and minimize harm, as addressed in *Principle II: Responsible Caring* (CPA, 2017), which is essential when working with a vulnerable population.

### **Ethical Considerations When Treating BPD**

There are several ethical issues that arise when working with a client who has a BPD diagnosis in a counselling setting. Firstly, *Principle II: Responsible Caring* (CPA, 2017, II.6-8) highlights that a psychologist must be competent in the areas that they practice and must seek adequate supervision or refer their client to another appropriate professional if the client's issues are beyond their scope. Chen and Hazler (2023) highlighted that while it is imperative that clients with BPD have competent care, it is also common that novice counsellors experience general feelings of incompetence and that they are at a unique stage in their career where they are acquiring new knowledge and skills. The researchers further noted that intense feelings of incompetence in novice counsellors may lead to burnout and may be damaging for both the clinician and the BPD client. Chen and Hazler suggested that this can be mitigated by the counsellor having a supervisor who is highly knowledgeable in BPD. However, the researchers indicated that there are systemic issues at play, and that counselling programs should consider whether or not they are adequately preparing novice counsellors to work with complex personality disorders.

Another aspect captured in *Principle II: Responsible Caring* is the notion of maximizing benefit and minimizing harm (CPA, 2017). When treating a client with BPD, it is imperative that a counselling psychologist consider how their treatment plan may impact the client's wellbeing. Given the high rates of self-harming behaviours and suicidality in clients with BPD (APA, 2022)

a psychologist should be constantly assessing for risk when working with this population. Chen and Hazler (2023) emphasized the importance of novice counsellors balancing care and empathy with firm boundaries as clients with BPD tend to find ways to break relational boundaries to get closer to counsellors (e.g. not respecting professional boundaries when in crisis, engaging in suicidal gestures in front of a counsellor, etc.). The constant assessment of risk versus harm is an essential part of providing ethical care for this vulnerable population.

If a client is at imminent risk of harm to themselves or others, this indicates that a psychologist will need to break confidentiality to ensure client safety, as outlined by *Principle I: Respect for the Dignity of Persons and People* (CPA, 2017). This further demonstrates why it is important that a counsellor have adequate supervision, as clients with a high risk of suicidality may quickly become in need of urgent care and it is important that psychologists ask appropriate questions to determine the level of risk. Lundahl et al. (2024) noted that because of their frequent suicidal behaviour and crises, BPD patients in Western countries are often admitted to in-patient settings, both voluntarily and compulsorily. Lundahl and others highlighted that there is conflicting research that suggests that in some cases clients with BPD may be decision-incompetent during a crisis, while in other cases they appear to be mostly-decision-competent. They indicated the importance of BPD clients being assessed for decision-competence prior to admitting them involuntarily to an in-patient setting. This prioritizes client autonomy, which is essential in ethical care as the rights of the individual are most important in the hierarchical organization of the *Canadian Code of Ethics for Psychologists*.

Another consideration related to autonomy is the notion that compulsory care is needed when dealing with suicidality. Lundahl et al. (2024) noted that while this is a common belief, controlled studies actually suggest that compulsory hospitalization does not help in suicide-prevention for BPD clients. It has been found in many instances to have negative effects and to increase suicide attempts in this population. Other research outlined by Lundahl and colleagues

stated that in many cases, compulsory care is not in BPD patients' best interest, but rather in the interest of protecting clinicians against anxiety or criticism. This also brings up the issue of objectivity or bias, as outlined in *Principle III: Integrity in Relationships* (CPA, 2017), as clinicians may assume that because a client who has BPD is expressing distress or suicidal ideation that they warrant compulsory care. This is a significant issue, as it may limit clients' autonomy and increase stigmatizing experiences, as was outlined earlier in this chapter. Additionally, counselling psychologists must be aware that clients with BPD have likely had negative experiences with MHPs that have been stigmatizing or have taken away their sense of autonomy. This should be considered when addressing these topics and assessing risks to avoid retraumatization. Again, bias towards BPD clients can be mitigated by self-reflection, further training, appropriate assessment and supervision or consultation.

## **Chapter Four: Application to Clinical Practice**

This study examines the experiences of women with BPD from an attachment-based and trauma-informed lens to better understand client symptomatology as well as their experiences of stigma in the therapeutic setting. The findings explored in this research are likely to impact women with BPD, clinicians' understandings of this population and the BPD diagnosis, as well as possible assessments and treatment approaches that can be utilized in the counselling setting. This chapter examines the clinical and therapeutic applications of this research as well as its contributions to scientific knowledge and the well-being of society. It further explores cultural and diversity considerations related to this topic.

### **Clinical and Therapeutic Applications**

This research offers several important contributions to the field of counselling psychology. Firstly, it aims to deepen clinicians' understanding of BPD, a disorder that they often encounter early in their careers but are not adequately prepared to work with (Bozzatello et al., 2024; Chen & Hazler, 2023; Mercand, 2015). Prior to working with clients with BPD, novice counsellors should be aware that one of the biggest challenges they may face when working with this population is maintaining an effective counselling relationship with the client (Chen & Hazler, 2023). To address this, Chen and Hazler (2023) suggested that therapists learn to balance a close or secure relationship with their client while still maintaining clear professional boundaries. For this reason, it is imperative that counsellors understand BPD from an attachment lens. The research in Chapter Three on the attachment styles of individuals with BPD indicated that these clients tend to have an insecure attachment style and often exhibit both anxious and avoidant tendencies (Erkoreka et al., 2022; Formella & Ugwuanyi, 2024; Hashworth et al., 2021; Miano et al., 2021; Peng et al., 2021; Smith & South, 2020). From an attachment perspective, Johnson & Campbell (2022) highlighted how important it is for the therapist to be a safe and secure base for their clients, particularly when working with

attachment trauma. However, given the BPD client's tendency to flip between anxious and avoidant styles, it is important that the clinician has an in-depth knowledge of how this might present in-session so they can assist their clients in a compassionate and informed way. Since a client with attachment trauma grew up in an environment that did not feel safe and lacked healthy boundaries, the balance between both is essential in gaining the trust of a client and providing appropriate treatment (Johnson, 2019; Johnson & Campbell, 2022). Clinicians who possess this understanding can work to form strong therapeutic relationships, which are especially important when working with this population. Literature suggests that clients with BPD have high dropout rates when receiving treatment but are more likely to stay if early in the therapeutic process they perceive that the therapist is highly responsive (Culina et al., 2023; Steuwe et al., 2023). However, Hartnell (2022) noted that clients with BPD also want counsellors who set clear boundaries as this increases their sense of safety, and helps them feel informed (e.g., preparing in advance for termination). Overall, understanding BPD from an attachment-lens can empower clinicians to form stronger connections with this population while still meeting the clients' specific needs.

Secondly, this research provides a framework that can help to reduce stigmatizing views held by mental health professionals (MHPs) towards clients with BPD. Chen & Hazler (2023) cautioned that if novice therapists are not adequately prepared to work with individuals with BPD this could lead to burnout, which can strengthen negative perceptions towards individuals with this disorder. Working with a personality disorder can be intimidating, but the attachment-based and trauma-informed approach offers a clear framework and encourages therapists to get to know each individual and their unique history. This can help to enhance empathy and to encourage clinicians to have a more holistic view of their clients that extends beyond a diagnosis (Barr et al., 2020; Hartnell, 2022; Klein et al., 2022; Ring & Lawn, 2025). While diagnoses provide information and can be helpful in obtaining appropriate care, it is important

that counsellors are aware of the potential stigma that a BPD diagnosis holds and how this might influence their own perceptions as well as clients' self-perception (Ring & Lawn, 2025). If therapists are aware of the emotional patterns and possible trauma-history that clients with BPD might have, they can seek appropriate supervision and education when working with these clients to avoid clinical burnout (Chen & Hazler, 2023). Additionally, this approach is client-centered and can help to avoid retraumatization (Marks et al., 2021), which is essential when working with a vulnerable population that has likely experienced significant stigma within medical systems (Barr et al., 2020; Klein et al., 2022; Ring & Lawn, 2025). This practice may also help to reduce the self-stigma that clients with BPD experience (De-la-Morena-Perez et al., 2023; Koivisto et al., 2022; Ring & Lawn, 2025). Additionally, the knowledge in this review regarding BPD and gender bias provides more information for clinicians to consider when interrogating their own biases around this disorder, which will be discussed further throughout this chapter (De-la-Morena-Perez et al., 2023; Ma & Else-Quest, 2024). Overall, the attachment and trauma-informed framework empowers counsellors by enhancing their understanding of BPD, highlighting potential biases that they might have about the disorder, and allowing them to address these biases through a depathologizing lens.

Finally, this research elucidates possible assessment and treatment options for individuals with BPD. Formella and Ugwuanyi (2024) determined that when clinicians incorporated attachment theory into their assessment it improved their views on prognosis and enhanced their understanding of personality disorders. Furthermore, the research explored in this work suggests possible features of BPD that may be important to target in treatment, such as enhancing client awareness of attachment styles, identification of internal and relational patterns, emotional literacy and regulation skills and tools to improve interpersonal communication. This will be expanded on further in the discussion on Treatment Recommendations in Chapter Five.

### **Contributions to Scientific Knowledge**

This work offers important insight into how trauma, and more specifically attachment-trauma, impacts psychopathology and the development of BPD traits (De-la-Morena-Perez et al., 2023; Erkoreka et al., 2022; Fung et al., 2023; Peng et al., 2021; Schulze et al., 2022). Since the link between adult attachment styles, an individual's history of trauma and BPD features remains a gap in the literature, the overview of current research contributes to the furthering of scientific understanding in regard to cognitive development and BPD. The research synthesized in Chapter Three demonstrates the complex relationship between attachment and trauma and how these lead to features such as: maladaptive emotional regulation (ER), identity disturbances, struggles with self-concept and self-image, difficulty in relationships, suicidality, self-injurious behaviours, and dissociative symptoms (De-la-Morena-Perez et al., 2023; Erkoreka et al., 2022; Fung et al., 2023; Howard et al., 2022; Jeong et al., 2022; Koivisto et al., 2022; Peng et al., 2021; Qian et al., 2022; Schulze et al., 2022). While further research is still required to fully understand the link between adult attachment styles, an individual's history of trauma and BPD features, the literature reviewed suggests that individuals with BPD tend to have experienced trauma at the hand of attachment figures and during key developmental years (De-la-Morena-Perez et al., 2023; Erkoreka et al., 2022; Peng et al., 2021). This provides important information on how attachment trauma might impact cognitive development (i.e., individual's ability to engage in mentalization, which can influence therapeutic treatments).

### **Contributions to the Well-Being of Society**

Mental health systems are already strained and clients with BPD access these resources at a higher frequency than the general population (Klein et al., 2022). This results in health systems that are over-capacity, limited care options, long waits, and significant costs for publicly funded institutions as well as financial burdens for those with BPD as well as their families (Klein et al., 2022; Ring & Lawn, 2025). The high demand for care from patients with

BPD paired with the systemic issue of healthcare facilities with limited resources perpetuates the narrative that individuals with BPD who are frequently seeking care are “manipulative,” “needy” and “untreatable” (Ma & Else-Quest, 2024; Ring & Lawn, 2025). The current system is unsustainable on every level and negatively impacts individuals with BPD, their families, their communities and society at large. This review intends to examine BPD from a destigmatizing lens so that individuals working in the counselling profession can provide better care and assessment to individuals with this disorder. By addressing some of the root causes of BPD symptomology (i.e. insecure attachment styles and a history of trauma) the hope is that counsellors can address some of the deeper issues with their clients, which in turn will contribute to them gaining better coping mechanisms and thus putting less strain on emergency mental health services.

Furthermore, the notion of gender bias in relation to BPD is important to discuss in the context of societal well-being. The overrepresentation of cisgendered women and underrepresentation of men as well as sexual and gender minority (SGM) individuals in clinical research perpetuates negative stereotypes about women and ignores the diverse experiences of those with this disorder (APA, 2022; De-la-Morena-Perez et al., 2023; Masland et al., 2022; Qian et al., 2022; Ring & Lawn, 2025). As discussed in Chapter Three, descriptors for BPD (i.e., “emotionality”) are associated with traditionally feminine stereotypes (Ma & Else-Quest, 2024). The idea that BPD is more prevalent in women contributes to the narrative that women are “overly emotional,” and perpetuates the history of pathologization that has oppressed women for centuries. This also completely ignores the fact that gender bias may be impacting BPD symptomology on a diagnostic level and that the very description of the disorder may be influenced by sexist stereotypes (Ma & Else-Quest, 2024; Ring & Lawn, 2025). Aside from contributing to outdated and oppressive views on women’s mental health, there is a lack of research that focuses on men and SGM individuals with this disorder. This may lead to under-

diagnosis for certain individuals, which negatively impacts their ability to receive adequate care. Given the high rates of suicidality in this population, this can have fatal consequences that will be explored further in the following section (APA, 2022; Ma & Else-Quest, 2024). Working towards destigmatizing the experiences of vulnerable individuals improves the health of society overall, and thus it is important that counsellors are aware of their own potential biases as well as the potential diagnostic biases that other MHPs might hold.

### **Cultural and Diversity Considerations**

It is crucial to consider gender bias when interpreting research on BPD. Dehlbom et al. (2022) noted that only 11% of the participants in the studies they surveyed on BPD were men. The lack of information on how BPD presents in men could lead to misdiagnoses in this population. Additionally, if men are diagnosed with BPD they may experience significant stigmatization as the disorder is often considered to be a “women’s disorder” (Dehlbom et al., 2022; Ma & Else-Quest, 2024; Masland et al., 2023; Qian et al., 2022). The social stigmatization related to BPD also contributes to other concerning statistics, such as men’s lack of help-seeking behaviours when in crisis as well as the high fatality rate associated with suicide attempts made by men (Watson et al., 2022). There is also significant debate regarding the inclusion of SGM individuals in BPD research. From the literature reviewed in Chapter Three, SGM individuals were not represented in most of the samples. On one hand, Rodriguez-Seijas et al. (2023) found that people with BPD were more likely to identify as a SGM than those without BPD, which may be explained by Meyer’s Minority Stress Theory. Rodriguez-Seijas and colleagues argued that SGM individuals should be excluded from BPD diagnoses as the manifestation of BPD symptoms in this population can be attributed to minority stress and other environmental factors, and that this diagnosis will further stigmatize these individuals. However, Ma and Else-Quest (2024) critiqued this suggestion, and stated that excluding SGM individuals from research and attributing their symptoms to external factors implies that BPD in the rest of

the population is an “individual deficit.” Indeed, this suggestion does the opposite of eradicating stigma and fails to note the social, biological, environmental and systemic factors that contribute to the development and diagnosis of BPD. Furthermore, excluding SGM individuals from research helps to perpetuate the gender binary and heterosexist ideology and ignores the needs of an entire group of individuals (Masland et al., 2023; Ma & Else-Quest, 2024). This debate demonstrates the need for further research around BPD from a destigmatizing lens, as it is clear that the association between BPD and psychopathology creates hesitancy to research and diagnose this disorder in marginalized populations.

The taboo of associating BPD with marginalized individuals is further exemplified in the conversation surrounding BPD and cultural/ethnic diversity. Indeed, most research on BPD is conducted almost exclusively on White women (Masland et al., 2023; Ma & Else-Quest, 2024) despite research across different cultural/ethnic groups showing a comparable rate of diagnosis (Becker et al., 2023). This brings up the question as to why ethnically diverse individuals are underrepresented in BPD literature? This phenomenon was observed in research on the prevalence of BPD in Indigenous populations in Australia (Thompson, 2022; Ma & Else-Quest, 2024). Thompson (2022) noted that despite presenting with BPD symptoms, research on this population tended to instead refer to “complex trauma,” possibly as an effort to destigmatize a population that already experiences significant marginalization. Thompson posited that this may indicate a cross-cultural bias in regard to the identification and diagnosis of BPD. The literature on this topic indeed seems to indicate that because of the stigmatization of this disorder, there is a hesitancy to research and label individuals that are already marginalized with this diagnosis. However, this contributes to the erasure of these populations in the literature, and ironically further perpetuates the narrative of stigmatization. Of course, it is important for researchers to consider cultural differences when studying any disorder as this may influence the presentation and interpretation of symptoms. While much of the research surveyed in Chapter Three was

conducted by researchers from different countries (e.g., China, the Netherlands, Spain, the United Kingdom, the United States, etc...) none addressed possible cultural differences. Jani et al. (2016) noted that the concept of BPD was first discussed in Europe, but despite this it is often considered to be an “American disease” as the diagnostic criteria allegedly reflected cultural values from the United States in the 1960s-1980s. Jani and others indicated that while BPD is now internationally recognized, its criteria is often criticized as being broad, non-specific and lacking consideration for cultural and environmental influences.

Overall, contemporary literature on BPD lacks cultural and diversity considerations. Most samples are homogenous, and researchers fail to acknowledge possible gender and cultural biases associated with this disorder. While some researchers may be intentionally excluding individuals who already experience significant marginalization from their samples, this limits the generalizability of findings and contributes to the stigmatization surrounding BPD. Chapter Five includes recommendations for future research in an effort to help to reduce these gaps in literature.

## Chapter Five: Conclusions and Recommendations

This research aimed to answer the question: Can understanding BPD in women from an attachment-based and trauma-informed lens help to destigmatize their experiences in the therapeutic setting? This chapter synthesizes the findings explored throughout this work by providing conclusions and recommendations for future research. The intention in presenting this current literature on BPD from an attachment-based and trauma-informed lens is to enhance the readers' understanding of this topic and to hopefully provide some suggestions that would be helpful for their clinical work or future research.

### Conclusions From the Literature Analysis

Based on the review and analysis of the current literature on BPD it was found that:

1. There appears to be a gender bias that impacts diagnosis and the perception and manifestation of BPD symptomatology (APA, 2022; Bozzatello et al., 2024; De-la-Morena-Perez et al., 2023; Dehlbom et al., 2023; Ma & Else-Quest, 2024; Masland et al., 2022; Ring & Lawn, 2025). Overall, cisgender women tend to display more “internalizing symptoms” (APA, 2022; Bozzatello et al., 2024; De-la-Morena-Perez et al., 2023), while their male counterparts tend to display more “externalizing symptoms” (Qian et al., 2022).
2. There is an overrepresentation of cisgender women in clinical samples but community samples tend to have more equal division between genders (APA, 2022; Ring & Lawn, 2025), which once again suggests a possible gender bias that exists at a systemic level. Overall, sexual and gender minority (SGM) individuals seem to be excluded from the current literature on BPD, which uses language that primarily focuses on the gender binary (Bozzatello et al., 2024; Ma & Else-Quest, 2024; Qian et al., 2022; Rodriguez-Seijas, 2023).

3. Clients with BPD experience stigma on several levels. This can look like: internalized stigma, social stigma, stigma in mental health settings, stigma in research and structural stigma (Barr et al., 2020; De-la-Morena-Perez et al., 2023; Hartnell, 2022; Klein et al., 2022; Koivisto et al., 2022; Masland et al., 2023; Ring & Lawn, 2025; Sulzer, 2015).
4. Individuals with BPD are incredibly vulnerable as they typically have a complex trauma history and experience various types of stigma, high rates of suicidality, high rates of self-injurious behaviours, identity disturbances, and significant isolation that impacts social relationships (De-la-Morena-Perez et al., 2023; Erkoreka et al., 2022; Fung et al., 2023; Jeong et al., 2022; Koivisto et al., 2022; Luyten et al., 2020; Peng et al., 2021; Qian et al., 2022; Schulze et al., 2022).
5. BPD is associated with an insecure attachment style in adults. Clients with BPD tend to display both anxious and avoidant traits, or a disorganized attachment style (Erkoreka et al., 2022; Hashworth et al., 2021; Miano et al., 2021; Peng et al., 2021; Smith & South, 2020).
6. The current literature suggests that adults with BPD tend to have volatile and turbulent relationships (Di Bartolomeo et al., 2024; Howard et al., 2022; Jeong et al., 2022; Kroener et al., 2023; Miano et al., 2021; O'Leary et al., 2024; Schulze et al., 2022; Smith & South, 2020). This leads to isolation, loneliness, social exclusion, high rates of conflict, dissolution and overall relationship dissatisfaction (Di Bartolomeo et al., 2024; Jeong et al., 2022; O'Leary et al., 2024; Smith & South, 2020). This can be associated with traits such as maladaptive emotional regulation (ER), maladaptive communication styles, rejection sensitivity (RS), impulsivity, and a general push-and-pull dynamic that is common amongst individuals with a disorganized attachment style (Di Bartolomeo et al., 2022; Hasworth et al., 2021; Jeong et al., 2022; Miano et al., 2021; O'Leary et al., 2024; Smith & South, 2020).

7. Insecure adult attachment alone is not a predictor of BPD (Peng et al., 2021). Childhood trauma and a history of trauma play a significant role in the development of BPD symptomatology (De-la-Morena-Perez et al., 2023; Erkoreka et al., 2022; Fung et al., 2023; Peng et al., 2021; Schulze et al., 2022).
8. Individuals with BPD tend to have a history of trauma but notably the types of trauma that were experienced by adults with this disorder varied greatly across the literature. Research indicated that adults with BPD reported having traumatic experiences throughout both childhood and adulthood. Furthermore, different types of trauma (e.g. attachment trauma, experiences of abuse or neglect, etc.) were found to have an impact on various features associated with BPD (De-la-Morena-Perez et al., 2023; Erkoreka et al., 2022; Fung et al., 2023; Schulze et al., 2022).
9. The complex interplay between an individual's trauma history and their adult attachment style is linked to the internalized symptoms related to BPD. These symptoms include: identity disturbances, struggles with self-image and self-concept, experiences of maladaptive ER, suicidality and self-injurious behaviours, and dissociative symptoms (De-la-Morena-Perez et al., 2023; Erkoreka et al., 2022; Fung et al., 2023; Jeong et al., 2022; Koivisto et al., 2022; Peng et al., 2021; Qian et al., 2022; Schulze et al., 2022).
10. BPD is a complex disorder, and yet clinicians are not adequately prepared to work with this population. The lack of training and understanding around this disorder further perpetuates stigma in mental health fields (Chen & Hazler, 2023; Ring & Lawn, 2025).

### **Conclusions From Methodological Analysis**

A methodological analysis of several key articles in the literature concluded that:

1. All quantitative studies took a postpositivist worldview, and most used a cross-sectional design (Erkoreka et al., 2022; Formella & Ugwuanyi, 2024; Fung et al., 2023; Hashworth

et al., 2021; Miano et al., 2021; Peng et al., 2021; Schulze et al., 2022) except for the study by Di Bartolomeo and others (2023), which was a systematic review.

2. A strength across the quantitative studies is that the data collection and analyses maintained a high level of objectivity by using empirically validated tools and research designs (Di Bartolomeo et al., 2023; Erkoreka et al., 2022; Formella & Ugwuanyi, 2024; Fung et al., 2023; Hashworth et al., 2021; Miano et al., 2021; Peng et al., 2021; Schulze et al., 2022).
3. There was a wide range of sample sizes across all quantitative studies (Di Bartolomeo et al., 2023; Erkoreka et al., 2022; Formella & Ugwuanyi, 2024; Fung et al., 2023; Hashworth et al., 2021; Miano et al., 2021; Peng et al., 2021; Schulze et al., 2022), with the smallest samples still being a sufficient size considering that the research is examining a very specific population with a specific diagnosis, according to White (2023).
4. Notably, the quantitative studies lacked an analysis of potential researcher bias, transparency in how sample size was selected, as well as recruitment methods and possible selection biases (Di Bartolomeo et al., 2023; Erkoreka et al., 2022; Formella & Ugwuanyi, 2024; Fung et al., 2023; Hashworth et al., 2021; Miano et al., 2021; Peng et al., 2021; Schulze et al., 2022).
5. Only three of the quantitative studies reviewed (Erkoreka et al., 2022; Formella & Ugwuanyi, 2024; Fung et al., 2023) used purposive sampling to ensure that clients met the diagnostic criteria for a BPD diagnosis before participating. The remaining studies relied on self-reporting measures to determine whether or not participants had BPD or exhibited BPD traits (Di Bartolomeo et al., 2024; Hashworth et al., 2021; Miano et al., 2021; Schulze et al., 2022). This limits the generalizability and validity of this research as participants may be subject to self-reporting bias and may be either over or under-

reporting BPD symptomatology. Ultimately, this limitation was not adequately addressed by researchers.

6. The qualitative studies were transparent about their methodological choices and enhanced the reliability of their studies by employing various strategies. Examples of this include outlining how they used multiple coders, studies were conducted by experienced researchers, and designs had clear coding protocols (De-la-Morena-Perez et al., 2023; Koivisto et al., 2022; Smith & South, 2020).
7. Another strength in the qualitative studies that were reviewed is that they had clear inclusion and exclusion criteria for their sampling, which ensured that the populations were well-defined and increased the validity of the results (De-la-Morena-Perez et al., 2023; Koivisto et al., 2022; Smith & South, 2020).
8. A limitation of the qualitative studies reviewed is that they did not discuss their sampling techniques or recruitment of participants in-depth. Both De-la-Morena-Perez et al. (2023) and Koivisto et al. (2022) used convenience sampling, while Smith and South (2020) conducted a meta-analysis and failed to discuss the various sampling methods or possible biases in the literature that they reviewed. This limits the generalizability of findings across the qualitative literature.
9. Overall, a limitation of the qualitative studies is that they lacked discussions pertaining to possible researcher biases and transparency regarding researcher background and positionality (De-la-Morena-Perez et al., 2023; Koivisto et al., 2022; Smith & South, 2020).

### **Recommendations at the Clinical/Therapeutic Level**

The following recommendations can enhance clinicians' ability to work effectively with clients who have a BPD diagnosis in a therapeutic setting:

1. It would be beneficial if clinicians, particularly new clinicians, seek further education about BPD as it is likely they will encounter clients with this diagnosis in their practice (Bozzatello et al., 2024; Merced, 2015).
2. Taking an attachment-based and trauma-informed lens can provide therapists with a more in-depth understanding of BPD (De-la-Morena-Perez et al., 2023; Erkoreka et al., 2022; Fung et al., 2023; Jeong et al., 2022; Koivisto et al., 2022; Luyten et al., 2020; Peng et al., 2021; Qian et al., 2022; Schulze et al., 2022). These lenses also offer a less stigmatizing view of this disorder. Since clients who have BPD are incredibly vulnerable and experience stigma and social isolation, it is important to consider how trauma might be impacting individuals so the therapist can try to avoid re-traumatization. This is the basis of trauma-informed care (Marks et al., 2021).
3. Clinicians should be aware of their own positionality and biases and how this might impact their work with clients who have BPD or BPD traits. Examples of this might include a potential gender bias, diagnostic bias, bias regarding diagnoses in marginalized populations, stigmatizing views or labels associated with BPD, and imposter syndrome regarding their own competence when working with BPD (Holmes, 2020; Ma & Else-Quest, 2024; Masland et al., 2023; Ring & Lawn, 2025). These biases may be internalized, so engaging in reflective practice is essential when examining potential biases (Holmes, 2020).
4. Clinicians should seek to find a balance between creating a secure attachment and strong therapeutic relationship while maintaining professional boundaries (Chen & Hazler, 2023; Hartnell, 2022; Johnson & Campbell, 2022).
5. Clinicians should consider empirically validated research and therapeutic interventions when treating clients with a BPD diagnosis (Formella & Ugwuanyi, 2024; Hashworth et al., 2021; Miano et al., 2021). They should consider how these interventions might help

to target adult attachment styles as well as a client's history of trauma in a way that empowers the client and avoids re-traumatization (Marks, 2021).

6. New clinicians should consider their scope of practice when working with clients who have a BPD diagnosis and should seek appropriate supervision or should provide referrals to more intensive care when needed (Chen & Hazler, 2023). This should be balanced with the consideration of the client's attachment style and potential history of trauma or history of stigmatization in mental health settings (Barr et al., 2020; Ring & Lawn, 2025).
7. To avoid retraumatization of a vulnerable population, clinicians should prioritize client autonomy when considering outside referrals or the termination of care for individuals with BPD (Marks et al., 2021; Lundahl et al., 2024; Ring & Lawn, 2025).

### **Recommendations for Future Research**

To further research around BPD from a destigmatizing stance, the writer recommends the following:

1. Researchers should consider the concept of gender bias when designing their studies. This could be done by considering how gender bias might influence the population examined, sampling and recruitment, inclusion and exclusion criteria, as well as influences on coding and the interpretation of data (Klein et al., 2022; Masland et al., 2023; Rodriguez-Seijas et al., 2023). Masland et al. (2023) noted that words like 'emotional' or 'manipulative' used in coding can influence stigmatizing views as well as perpetuate a gender bias in research. The writer would like to recommend that researchers consider how to incorporate more cisgender men and SGM individuals in BPD research.
2. Researchers should further consider how BPD impacts marginalized populations and those with intersectional identities (Ma & Else-Quest, 2024; Rodriguez-Seijas et al.,

2023). To maximize benefit and minimize harm to these populations researchers should consider taking a trauma-informed approach (Mark et al., 2021). Further research incorporating Minority Stress Theory may be helpful in understanding the manifestation of BPD traits in individuals from marginalized populations (Meyer, 2003).

3. There needs to be further research regarding how experiences of trauma, insecure attachment styles, and other factors influence the development of BPD symptomatology in adults. While current research establishes that there is a correlation between these factors, more research on this topic would enhance understanding of this disorder (De-la-Morena-Perez et al., 2023; Erkoreka et al., 2022; Fung et al., 2023; Peng et al., 2021; Schulze et al., 2022).
4. Researchers should focus on how to address adult attachment patterns and a history of complex trauma when treating clients with BPD in a therapeutic setting. While the current research strongly suggests that there is a link between insecure attachment styles and trauma history in adults with BPD symptomatology (De-la-Morena-Perez et al., 2023; Erkoreka et al., 2022; Fung et al., 2023; Peng et al., 2021; Schulze et al., 2022), the research fails to consider what therapeutic treatments best address these concerns for clients (Formella & Ugwuanyi, 2024). Further research into the efficacy of current BPD treatments in addressing these concerns would be beneficial.
5. Since social isolation is so common for individuals with BPD, it would be helpful to have more research that investigates how to support individuals with BPD and their loved ones in navigating this disorder (Di Bartolomeo et al., 2024; Howard et al., 2022; Jeong et al., 2022; Kroener et al., 2023; Miano et al., 2021; O'Leary et al., 2024; Schulze et al., 2022; Smith & South, 2020). While some existing research helps to address this, it would be helpful if more research examined this through the lens of adult attachment theory as it would provide a concrete framework.

6. It would be beneficial if there was more research regarding the therapeutic relationship in the context of treating a client with BPD. Given the importance of the therapeutic relationship when treating a client with attachment trauma (Johnson & Campbell, 2022), it is essential to consider how clinicians can best support clients with this disorder while still maintaining professional boundaries and working within their scope of practice (Chen & Hazler, 2023; Hartnell, 2022).
7. Researchers should consider how BPD assessment and treatment approaches could be more trauma-informed and client-centered in the future (Ma-Else-Quest, 2024; Marks et al., 2021). This will help to address the systemic stigmatization of individuals with BPD that impacts their care and overall well-being.

### **Reflections**

This research study aimed to review the current literature through an attachment and trauma-informed lens to better understand how BPD in women is understood and treated in a therapeutic context. The research question that the writer sought to address was: Can understanding BPD in women from an attachment-based and trauma-informed lens help to destigmatize their experiences in the therapeutic setting? The literature provided valuable insight into the experiences of women with BPD, as well as the experiences of MHPs and researchers who work with this disorder. The writer is appreciative that there is a current focus in the literature on better understanding the factors that might cause the onset of BPD, as well as the desire to interrogate potential biases that might be impacting individuals with this disorder, from diagnosis to treatment. The writer believes that this understanding will continue to improve the experiences of individuals with BPD, as well as the perception of this disorder held by MHPs, researchers, and the general public.

The literature reviewed in this work highlighted the need for further investigation into BPD with the intention of reducing stigma. Many skilled professionals have already started to

investigate this disorder in the context of adult attachment and trauma-informed practices, and the findings give further insight into how to better treat a population that requires specialized care. The research compiled in this paper offers a hopeful glimpse into a future in which individuals with BPD are able to access care from competent and compassionate professionals that is free from stigma and addresses the root of their needs, rather than putting them into a box that labels them as defective or pathological.

As a new practitioner in the field of counselling psychology, this research process taught me to approach client-care from a more holistic perspective, regardless of their previous diagnoses or their presenting problems. I have begun to reflect on my own biases in regards to personality disorders, and specifically towards BPD traits and I realized that I had many internalized assumptions prior to starting this research. By learning more about the factors that contribute to BPD I discovered that an individual's unique history, from the way they connected with caregivers as children to their chosen gender identity, impacts the development of psychopathology. I was surprised to learn how in turn this can influence individuals on so many levels, including the quality of their intimate relationships in adulthood, the way that MHPs and society at large perceive them, and the way that they view themselves. Going forward in my career, I intend to prioritize meeting my clients as humans first and to create a secure and non-judgemental environment in therapy. I am thankful to have learned more about BPD, and I believe that it will continue to serve me as I work in the field as an attachment therapist who prioritizes trauma-informed care.

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## Appendix A

### *Reference list of Studies Critiqued for their Methodology and Ethics*

<b>Author</b>	<b>Year</b>	<b>Title</b>	<b>Journal</b>	<b>Type/Method</b>
De-la-Morena Perez et al.	2023	Experiences of women diagnosed with borderline personality disorder: Perception of motherhood, social, health, and construction of gender	<i>Perspectives in Psychiatric Care</i>	Qualitative
Erkoreka et al.	2022	Attachment anxiety as mediator of the relationship between childhood trauma and personality dysfunction in borderline personality disorder	<i>Clinical Psychology and Psychotherapy</i>	Quantitative
Di Bartolomeo et al.	2024	Borderline personality disorder and social connectedness: A systematic review	<i>Personality Disorders</i>	Quantitative
Formella & Ugwuanyi	2024	The role of attachment theory in understanding and treating personality disorders: A clinical psychology perspective	<i>Journal of Humanities and Social Policy</i>	Quantitative
Fung et al.	2023	Borderline personality disorder features and their relationship with trauma and dissociation in a sample of community health service users	<i>Borderline Personality Disorder and Emotion Dysregulation</i>	Quantitative
Hashworth et al.	2021	Personal agency in borderline personality disorder: The impact of adult attachment style	<i>Frontiers in Psychology</i>	Quantitative
Koivisto et al.	2022	Self-invalidation in borderline personality disorder: A content analysis of patients' verbalizations	<i>Psychotherapy Research</i>	Qualitative
Miano et al.	2021	Dyadic emotion regulation in women with borderline personality disorder	<i>Cognitive Therapy and Research</i>	Quantitative
Peng et al.	2021	Insecure attachment and maladaptive emotion regulation mediating the relationship between childhood trauma and	<i>Depression and Anxiety</i>	Quantitative

		borderline personality features		
Schulze et al.	2022	On the interplay of borderline personality features, childhood trauma severity, attachment types, and social support	<i>Borderline Personality Disorder and Emotion Dysregulation</i>	Quantitative
Smith & South	2020	Romantic attachment style and borderline personality pathology: A meta-analysis	<i>Clinical Psychology Review</i>	Qualitative