

Destigmatizing Borderline Personality Disorder: A Call to Action for Psychological Science

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Abstract

Despite recognition that borderline personality disorder (BPD) is one of the most stigmatized psychological disorders, destigmatization efforts have thus far focused on the views and actions of clinicians and the general public, neglecting the critical role that psychological science plays in perpetuating or mitigating stigma. This article was catalyzed by recent concerns about how research and editorial processes propagate stigma and thereby fail people with BPD and the scientists who study BPD. We provide a brief overview of the BPD diagnosis and its history. We then review how BPD has been stigmatized in psychological science, the gendered nature of BPD stigma, and the consequences of this stigmatization. Finally, we offer specific recommendations for researchers, reviewers, and editors who wish to use science to advance our understanding of BPD without perpetuating pejorative views of the disorder. These recommendations constitute a call to action to use psychological science in the service of the public good.

Keywords

borderline personality disorder, stigma, psychological science

Borderline personality disorder (BPD) has long been stigmatized in academic work, clinical practice, and the broader mental-health discourse. Although most efforts to assess and address this stigmatization have focused on mental-health clinicians, researchers commonly perpetuate stigma in the scientific literature. A recent example highlights the need for efforts to improve education and research practices with regard to BPD. In March 2020, *Personality and Individual Differences* published an article online titled “Testing the Hot-Crazy Matrix: Borderline Personality Traits in Attractive Women and Wealthy Low Attractive Men Are Relatively Favoured by the Opposite Sex” (Blanchard et al., 2021). In brief, this work used an Internet-derived “theory” called the “hot-crazy matrix” that postulates first that all women are “at least a 4 crazy” on a 10-point scale

and that, as a woman’s “hotness” increases, so does her “crazy.” A woman must be attractive but not *too* attractive. At the “right” attraction level, a man can tolerate some level of apparent crazy in a woman. To assess how crazy interacts with hotness to influence men’s dating preferences, Blanchard et al. (2021) substituted “BPD traits” for “crazy.” A critique of this article is available elsewhere (Olino et al., 2020), but this work is not alone in its use of pejorative, sexist language to describe people with BPD.

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Negative biases and connotations of BPD unfortunately remain a consistent theme across decades of clinical lore, written work, empirical research, and public sentiment. As a group of concerned scientists who study BPD and related processes, we encourage ourselves and the field to advance beyond pejorative, stigmatizing understandings of BPD. In this article, we provide a brief overview of BPD and the history of the diagnosis, discuss how BPD has been stigmatized with a focus on peer-reviewed psychological research and other academic texts, describe the gendered nature of this stigma, and explicate its consequences. Finally, we outline recommendations for addressing stigma in research and publication processes.

Borderline Personality Disorder: History, Negative Attitudes, and Stigma

Given its prevalence in the general population (1%–2%; Lenzenweger et al., 2007) and in clinical settings (as high as 22.6%; Korzekwa et al., 2008), most people are likely to know someone with BPD, and most clinicians will treat many people with BPD. Likewise, many researchers will include people with BPD in their studies, whether or not the diagnosis is actually assessed or recognized. The disorder manifests as a pervasive pattern of instability in behavior, mood, identity, and relationships (American Psychiatric Association [APA], 2022). People with BPD use mental-health care more frequently than people with other mental illnesses (Paris & Zweig-Frank, 2001), make an average of 3.4 lifetime suicide attempts (Soloff et al., 1994), and die by suicide at high rates (10%; Black et al., 2004; Oldham, 2006; Paris & Zweig-Frank, 2001). The disorder is associated with significant distress and impairment yet has a hopeful course (Choi-Kain et al., 2020) and effective treatment options (Choi-Kain et al., 2017).

The diagnosis of BPD has been heavily stigmatized, meaning that it has come to serve as a marker of socially undesirable traits or behaviors. For BPD and other mental illnesses, this stigmatization occurs at several levels, including self-stigma (internalized stigma related to one's mental-health difficulties), public stigma (stereotypes and consequent discriminatory behaviors endorsed by society at large), and structural stigma (how institutional policies intentionally or unintentionally lead to adverse consequences for people with mental illness; see Corrigan & Bink, 2016). We touch on each of these levels of stigma in reviewing the history of BPD's stigmatization.

Stigma toward BPD is especially longstanding and pervasive across clinical and research contexts (Juurlink et al., 2019; McKenzie et al., 2021; Nehls, 1998; Servais & Saunders, 2007). This is likely due in part to the

history of the diagnostic label. The term “border line” was originally intended to be descriptive—connoting the disorder's existence at the edge, or border, of psychosis and neurosis (Knight, 1953; Stern, 1938). The diagnosis quickly evolved to mark patients deemed “untreatable” (Knight, 1953) and was wielded as a pejorative marker or literal stigma, primarily against women who were considered “difficult” (Stern, 1938; Stone, 1977) or “problematic” (see Gunderson, 2001).¹ Its inclusion in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) catalyzed research efforts and the development of clinical interventions. However, BPD remains understudied compared with other psychological disorders (Zimmerman & Gazarian, 2014). Moreover, the diagnostic criteria for BPD have not changed in the more than 30 years since the *DSM-III-R* (APA, 1987) despite significant research and treatment advances and substantive changes to many other DSM diagnoses. This reflects that evolving knowledge about BPD has not been well integrated in the nomenclature.

BPD is highly stigmatized among mental-health professionals, perhaps more so than other disorders (e.g., Bodner et al., 2011; Deans & Meocevic, 2006; Dickens et al., 2016; Juurlink et al., 2019; McKenzie et al., 2021; Nehls, 1998; Servais & Saunders, 2007). However, one study found that negative attitudes have improved over the past 15 years (Day et al., 2018). Clinicians across disciplines commonly express less sympathy, empathy, and optimism about, and more hostility toward, patients with BPD than those with other disorders (Brody & Farber, 1996; Deans & Meocevic, 2006; Dickens et al., 2016; Fraser & Gallop, 1993; Holmqvist, 2000; Lam et al., 2016; Markham & Trower, 2003; McKenzie et al., 2021; Servais & Saunders, 2007). Common descriptors of people with BPD include “manipulative,” “difficult,” “attention seeking,” “undesirable,” and “dangerous” (Deans & Meocevic, 2006; Gallop & Wynn, 1987; Nehls, 1998; Servais & Saunders, 2007; Stone et al., 1987; Woollaston & Hixenbaugh, 2008). These attitudes likely foster discrimination and contribute to poor treatment outcomes (see Aviram et al., 2006; Rüsche et al., 2008). For example, clinicians self-report that they are less likely to engage in helpful behaviors when working with people with BPD compared with other disorders (Forsyth, 2007) and that they are more likely to use “overly custodial interventions” that deprive patients of their autonomy (e.g., lengthy hospitalizations, frequent use of mental-health legislation) for people with BPD (Krawitz & Batcheler, 2006). Moreover, they are more likely to avoid treating patients with BPD entirely (Black et al., 2011; Markham, 2003; Servais & Saunders, 2007; Westwood & Baker, 2010). People with BPD commonly report experiences of discrimination or feeling that they are not being respected or taken seriously by clinicians (Juurlink

et al., 2019; Lawn & McMahon, 2015). Some research has identified that clinician attitudes about BPD can be modified with training (e.g., Keuroghlian et al., 2016; Masland et al., 2018; Shanks et al., 2011), but to our knowledge no work has addressed the modification of these attitudes in other spheres, including research and editorial processes.

Negative attitudes about BPD are also pervasive outside of clinical contexts (e.g., among police; Martin & Thomas, 2015; in employment settings; Juurlink et al., 2019; in the press; Bowen, 2019). As clinicians, we caution our patients to be careful about how they search for information online or in print resources labeled as “self-help” because such resources commonly include stigmatizing and/or equivocal content. Likewise, negative and/or inaccurate depictions in film and television (e.g., *Fatal Attraction*) result from and advance a public narrative of BPD as nefarious, manipulative, and dangerous, which harms people with BPD in their interactions with others. Despite recent public acknowledgments by well-known figures of their experiences with BPD (e.g., Carey, 2011; Carollo, 2011; Todd, 2021), much education is still needed to rectify misunderstandings about the disorder. Indeed, one study found that participants were more likely to label vignettes describing BPD symptoms with depression or anxiety than BPD, showing little community understanding of this disorder (Furnham et al., 2015).

Often the discourse on BPD’s stigmatization stops here, with the message that clinicians and the general public endorse and perpetuate misguided negative attitudes about people with the disorder. Yet these discussions ignore how researchers and scientific literature create and further entrench these negative attitudes. Mental-health professionals must reckon with how they may cause harm to the very people they seek to help, but so too must researchers across subdisciplines, starting with clinical science and psychiatry, by critically examining how our methods and language contribute to stigmatizing discourse.

Stigma in the Research Literature

Beyond the specific research article that catalyzed the current article, pejorative terms and attitudes around BPD permeate academic work. One particularly common example in academia is the ascription of negative intentions to people with BPD. For example, peer-reviewed articles frequently ascribe manipulative intent to people with BPD (e.g., Allen & Whitson, 2004; Bailey & Shriver, 1999; Goodman et al., 2009; Harvey & Watters, 1998; Kush, 1995; Láng, 2015; Lansky & Rudnick, 1987; McEnany & Tescher, 1985; McGlashan, 1983; Rowe, 1984; Schweitzer, 2015). Measuring manipulation, or the

act of “deliberately influencing or controlling the behavior of others to one’s own advantage by using charm, persuasion, seduction, deceit, guilt induction, or coercion” (Hamilton et al., 1986, p. 191), requires determining the individual’s intent and goals, yet these constructs are rarely explicitly measured in BPD research.

The frequent use of the term “manipulation” in reference to people with BPD and their symptoms is puzzling given the findings of empirical work. Although several studies have shown that health-care providers perceive people with BPD to be manipulative (Deans & Meocevic, 2006; Stroud & Parsons, 2013; Woollaston & Hixenbaugh, 2008), evidence suggesting that people with BPD actually intend to manipulate others is lacking. Studies have presented mixed evidence with respect to specific manipulative behaviors, namely sexual coercion (Centifanti et al., 2016; Khan et al., 2017), with some suggesting that people with BPD are *less* likely to “use charm, grace or sex appeal to achieve something” (Mandal & Kocur, 2013). Recent work supports the idea that the fear of abandonment may contribute to harmful sexual *compliance* among women rather than manipulation (M. Willis & Nelson-Gray, 2017). Another study labeled specific types of interpersonal behaviors often expressed by people with BPD (e.g., begging, threatening to end relationships) manipulative but did not evaluate the intention motivating those behaviors (Mandal & Kocur, 2013).

Given that sensitivity to perceived rejection and interpersonal conflict is a hallmark of BPD (Foxhall et al., 2019), behaviors perceived as manipulative may reflect direct consequences of dysregulated emotions and efforts to alleviate distress rather than intentional manipulation. All people engage in behaviors that could be called “manipulative” to meet their needs in their social environments, including alleviating distress. These behaviors are typically those that have been previously reinforced by virtue of being effective. Notably, for many people with BPD, engaging in extreme behavior patterns may have been the only effective means to have their needs met in the invalidating, chaotic, or neglectful environments common in their early lives (Fossati et al., 1999; Laporte et al., 2011). Moreover, it is possible that the labile presentation of BPD symptoms leads people to assume that the variability in their presence over time is due to an intentional shift over which individuals with BPD have personal control (Markham & Trower, 2003). However, researchers interested in BPD are aware that this instability has a variety of known causes outside of one’s control (e.g., emotion dysregulation, hormonal changes; Peters & Eisenlohr-Moul, 2019).

In addition, people with BPD are frequently identified as “attention-seeking” in academic texts (e.g., Bandelow et al., 2010; Butler et al., 2002; Fossati et al., 2016;

Gunderson, 1996). For example, Bandelow and colleagues (2010) suggested that people with BPD often wear attention-seeking, “provocative” clothing or seek attention by choosing artistic careers. We are not aware of any empirical literature that suggests BPD is associated with particular types of clothing or particular intentions regarding clothing choices. Further, despite routine descriptions of people with BPD as attention-seeking, minimal research has tested this construct in relation to the disorder. One study suggested that people with BPD are elevated in attention-seeking because they exhibited greater endorsement of the belief that “people will pay attention only if I act in extreme ways” than those with other personality disorders (Butler et al., 2002). However, holding the belief that acting in extreme ways will get attention does not assess the tendency to engage in attention-seeking behavior explicitly or the motivation for such behavior. Furthermore, such a belief may be accurate in the abusive, invalidating, or neglectful environments from which people with BPD so commonly originate (e.g., Fossati et al., 1999; Golier et al., 2003; Laporte et al., 2011; Linehan, 1993).

BPD symptoms themselves, especially self-injury, suicide attempts, and frantic efforts to avoid abandonment, are often pejoratively reduced to attention-seeking. Although nonsuicidal self-injury (NSSI) is prevalent for people in the general community (approximately 5.5% of adults and up to 17.2% of adolescents; Swannell et al., 2014), it is extremely common (90%–95%) in BPD (see Reichl & Kaess, 2021). Clinical science suggests that motives for this behavior are very rarely to manipulate and more likely include expressing anger, relieving tension or unpleasant feelings, punishing oneself, generating normal feelings, and distracting oneself (Brown et al., 2002; Hooley & Franklin, 2018; Kleindienst et al., 2008; Taylor et al., 2018). Even when a person with BPD reportedly seeks attention with unhealthy strategies, it is important to consider that people with BPD experience significant distress and emotion dysregulation (Gratz et al., 2015). These behaviors may therefore reflect reinforcing feedback loops (i.e., positive and negative reinforcement), attempts to meet one’s needs, or attempts to regulate emotions in the absence of other strategies (see Hooley & Franklin, 2018). Thus, pejoratively reducing BPD symptoms to attention-seeking overlooks more likely reasons for the behavior, which are well studied and thoughtfully considered in the functional assessment of behaviors in other psychological conditions (e.g., substance use; Bresin & Mekawi, 2019). Attributing manipulative or attention-seeking intent to BPD symptoms, particularly NSSI, may also have differential impacts for women, as well as sexual- and gender-minority individuals, given that it is a more common behavior for these

populations than for men, heterosexuals, and/or cisgender people (Bresin & Schoenleber, 2015; Liu et al., 2019).

Taken together, little to no evidence exists to support commonly used pejorative assumptions regarding the intentions of people with BPD despite their propagation throughout academic texts. Unfortunately, the belief that people with BPD are manipulative or attention-seeking has also reached proposals for diagnostic nosology: The *DSM-5* Alternative Model of Personality Disorders (AMPD; APA, 2013) treats “manipulativeness,” “attention seeking,” and “deceitfulness” as lower-order antagonism traits that may characterize BPD and other personality pathology. More broadly, many of the trait labels in the AMPD are pejorative *prima facie* and, if not paired with careful explanation, have the potential to further embed stigma into future nosology. This would likely have negative cascading consequences for people with BPD.

The enduring misapplication of these terms to BPD has also intersected with a broader culture that questions the credibility of distress, particularly when it pertains to women and sexual-assault survivors. For example, Engle and O’Donohue (2012) argued, without supporting data, that people with BPD are likely to make false allegations of sexual assault partly as a result of manipulateness and attention-seeking. Another study (Bailey & Shriver, 1999) examined “alternative explanations” for why childhood sexual abuse is commonly reported by people with BPD, noting that “BPD patients are frequently manipulative, and thus may be more likely than other patients to fabricate a history of sexual abuse in order to gain sympathy or escape responsibility” (p. 47). This study is more than 20 years old, and it is rare to find rhetoric that so explicitly questions the credibility of sexual-assault survivors’ experiences in more recent academic work. However, in our collective clinical experience, we have found that these harmful ideas continue to thrive. Moreover, older texts may have enduring effects in propagating harmful societal and legal rhetoric that sexual-assault survivors with BPD still feel today. The myth that sexual-assault allegations are often false is commonly endorsed (McGee et al., 2011), and police are especially likely to question the credibility of people reporting sexual assault when they have a mental illness (O’Neal, 2019). Pejorative, victim-blaming ideology within academia may contribute to a harmful health-care context for people with BPD in which their traumatic experiences are automatically disbelieved and their intentions maligned. This ideology exacerbates mental-health difficulties and reinforces the invalidating early experiences that often contribute to BPD (e.g., Crowell et al., 2009; Linehan, 1993).

The Gendered Nature of BPD Stigma

The stigmatization of BPD has disproportionately affected women with the label, even before it was a formal diagnosis (Stone, 1977). Negative attitudes about BPD live at the intersection of sexist attitudes toward women more broadly and negative attitudes toward emotionality and mental illness (see Becker, 1997). Messages from media, public discourse, and clinical and academic settings suggest a woman's physical attractiveness, sexuality, and mental illness are intertwined. For example, in a memoir published by a physician about his marriage to a woman with BPD, the book description states that "he can't understand how such a beautiful, sexy young woman would want to kill herself" (Walker, 2008). Here, the implication is that sexy and attractive women have no reason to want to kill themselves. Despite the glaring misconceptions and harmful depictions of BPD outlined even in just the book's description, it received positive reviews. These sexualized ideas about BPD do harm in clinical settings. Although anecdotal, the current authors recall clinical supervisors during their training describing a physical profile of "borderlines" as thin and attractive. This rhetoric serves to stigmatize women with BPD and make it difficult for women to seek and receive validating and effective mental-health support. Even more concerning is the fact that these deeply sexist and stigmatizing ideas have been perpetuated in scientific research, as demonstrated in the article that spurred this critical commentary (Blanchard et al., 2021) and its depiction of "hot, crazy" women.

Gendered and sexualized ideas about BPD are also likely to harm men. Epidemiological research (which is notably limited by the use of a gender binary) suggests that prevalence rates of BPD in men and women are roughly equal in the community (e.g., Lenzenweger et al., 2007; Torgersen et al., 2001). Studies in clinical populations, albeit somewhat dated, have similarly suggested a lack of prevalence differences by gender (Carter et al., 1999; Golomb et al., 1995; Sansone & Sansone, 2011) or that personality disorders in general may be more common in men (Grilo, 2002; Grilo et al., 1996, 2002; Jackson et al., 1991). However, the disorder is disproportionately diagnosed in women (APA, 2022), and women with a BPD diagnosis are more likely to receive psychiatric and/or psychological treatment (Dehlbom et al., 2022). This may be due to sampling bias (Skodol & Bender, 2003) and a number of clinician and assessment biases (Crosby & Sprock, 2004). Men with BPD often present with more antisocial and narcissistic traits, whereas women present with more depressive, anxious, and somatic symptoms (Silberschmidt et al., 2015). These differences may evoke differential

diagnostic responses from clinicians. Feminized views of BPD may also discourage men with BPD from seeking help.

Differences between general prevalence and diagnostic rates may also be due in part to a glaring problem with our science: Most BPD studies have used almost exclusively White female samples, which perpetuates the myth that BPD is a "women's disorder" and neglects potential differences across the gender spectrum. Most BPD-treatment clinical trials have been conducted exclusively with women with BPD or are populated mostly by women (see Cristea et al., 2017). Few studies to our knowledge have examined whether BPD treatment outcomes vary by gender, and it is unclear whether BPD treatments work as well or the same for individuals who are not cisgender women. There is also a lack of representation of sexuality in BPD research. Although people with BPD are more likely to identify as LGBTQ than those without BPD (Reich & Zanarini, 2008), most research examining relationship processes in people with BPD and their intimate partners has been conducted in exclusively heterosexual samples in which the women have BPD (e.g., Bouchard et al., 2009; de Montigny-Malenfant et al., 2013; Miano et al., 2017). Consequently, considerably less is known regarding how BPD processes may influence the relationships of people identifying as LGBTQ and/or male.

Words such as "manipulative" and "attention-seeking" are easy to single out because they are clearly pejorative. However, it is critical to be thoughtful and precise about more subtle language choices we use to describe the symptoms and experiences of people with BPD. Subtle word choices can serve to amplify stigma, even if done unintentionally. For example, the word "dramatic" is commonly used to describe people with BPD (e.g., Brazandeh et al., 2018), as are "immature" (e.g., Brazandeh et al., 2018) and "hysterical" (Kramer et al., 2013). Other examples of problematic language choices include "flailing" (Conklin et al., 2006; Southward et al., 2018) and the choice to describe suicide attempts or statements as "gestures" (see Heilbron et al., 2010), which suggests a lack of seriousness, attention-seeking, or manipulation.

Consequences of Stigma

Stigma may be particularly harmful for people with BPD who already struggle with a high degree of shame and generally negative self-concept (Rizvi et al., 2011; Rüsçh et al., 2007). They may be more susceptible to self-stigma, which is associated with both *experienced* public stigma and *anticipated* public stigma (Hing & Russell, 2017). The attribution of negative experiences

to aspects of one's identity is a key characteristic of shame (Tangney, 1995), which potentially explains associations between shame-proneness and greater self-stigma related to mental-health problems (Hasson-Ohayon et al., 2012). Thus, people with BPD are exposed to both the magnified public stigma of BPD and an escalating cycle between self-stigma and the shame they commonly experience.

Stigma also has other, more tangible consequences for these individuals. For instance, self-stigma and anticipated stigma can impede help-seeking and disclosure among people with mental illness (Corrigan, 2004; Heflinger & Hinshaw, 2010). Indeed, many people may avoid seeking treatment to avoid the label of mental illness (Corrigan & Bink, 2016), whereas lower internalized stigma is linked to seeking care (Cooper et al., 2003). Moreover, deleterious effects of stigma on help-seeking may be differentially impactful across ethnic groups (Horwitz et al., 2020; Loya et al., 2010) that are notably historically excluded in BPD research and clinical science more broadly. Importantly, disclosure about negative life events and their emotional consequences protects against longer-term emotional distress among people with BPD (Schoenleber et al., 2014), so stigma-induced barriers to disclosure may be particularly harmful.

Structural stigma likewise has concrete negative consequences for people with BPD, such as limiting access to appropriate care. Although people with BPD are overrepresented (9%) among emergency-department visitors (Pascual et al., 2007), emergency departments and other medical providers are not often trained to identify BPD or provide appropriate referrals (Cases et al., 2020). Furthermore, although evidence-based treatments for BPD are difficult to access for a range of reasons (e.g., treatment duration, cost, waiting lists; Lawn & McMahon, 2015; Tusiani-Eng & Yeomans, 2018), pervasive pejorative professional attitudes toward BPD can also interfere with access to specialized care. For instance, low treatment access is further exacerbated by a dearth of trained providers because relatively fewer trainees pursue specialized training in treatment for BPD than for other disorders (Iliakis et al., 2019; Tusiani-Eng & Yeomans, 2018). This may be due to the cost and time associated with learning BPD treatments. In addition, trainees are likely also discouraged from pursuing training because of negative connotations associated with the diagnosis that are perpetuated not just in clinical settings but also through academic texts and commentary offered by faculty and clinical supervisors.

Pejorative professional attitudes may also contribute to systemic barriers to accessing BPD diagnoses or treatment. For instance, some have asserted that several insurers in the United States will not accept BPD as a billable diagnosis or classify it as a serious mental

illness (Tusiani-Eng & Yeomans, 2018). Additionally, lack of expertise in BPD and public stigma may lead clinicians to refrain from diagnosing BPD when it is present. Indeed, clinicians are often reluctant to diagnose BPD (Paris, 2007) or to disclose the diagnosis. Many patients with BPD (38% in one study; Lawn & McMahon, 2015) carry a diagnosis for years without receiving an adequate explanation for what it means. Although some may argue that diagnostic labels inherently stigmatize, when delivered appropriately, the BPD diagnosis often provides validation and relief and is identified by patients as crucial to conceptualizing their experiences (Ng et al., 2019). It is also critical for connection to appropriate treatment and forming realistic expectations (Gunderson et al., 2006).

People with BPD also face significant barriers to other forms of care, including medical interventions. Significant consequences in medical settings for people with BPD and comorbid disabilities result from the notions that people with BPD are manipulative, attention-seeking, and unbelievable reporters of their experience. One research review, written to provide pain-management recommendations for medical practitioners who treat people with comorbid BPD and chronic headaches or related painful phenomena, described them as patients who manipulate, exaggerate, and distort (Saper & Lake, 2008). This type of belief is particularly concerning in light of evidence that BPD is associated with a higher prevalence of disabilities and chronic illnesses such as arthritis, diabetes, cardiovascular disease, stroke, and chronic pain conditions (Barber et al., 2020; Chen et al., 2017; El-Gabalawy et al., 2010; Sansone & Sansone, 2011), as well as higher rates of other physical-health symptoms, such as colds and coughs (Gratz et al., 2017). The exclusion of disability-informed research and widespread stigma may contribute to medical neglect and poor quality of medical care for people with BPD.

Clearly, nonpejorative, compassionate, rigorous empirical work focused on BPD and its treatment is needed. Yet the profound stigma associated with BPD may extend beyond patients themselves and may even hamper the production of such empirical work. This may be due to "courtesy stigma," also referred to as "stigma by association," whereby stigma accrues to an individual or community because of a connection to a stigmatized group (Goffman, 1963). Although not well studied, such stigma by proxy could also impact researchers who study stigmatized diagnoses or groups, leading to negative evaluations of BPD-related research. Research on BPD is substantially underrepresented in terms of studies funded by the National Institutes of Health (NIH; Zimmerman & Gazarian, 2014). For example, although BPD and bipolar disorder are comparably prevalent, impairing, and life-threatening, research

focused on BPD has received less than 10% the amount of NIH funding relative to bipolar disorder (Zimmerman, 2015; Zimmerman & Gazarian, 2014). Pejorative attitudes toward BPD and their consequences permeate all levels of research and care, from the grant funding that informs treatment development, to treatment researchers, and the clinicians who administer treatments.

Such negative attitudes may even extend to the individuals conducting BPD research. Just as mental illness stigma hampers disclosure broadly (Corrigan et al., 2016), institutional stigma associated with BPD may inhibit those within the field from disclosing personal experience in professional contexts, thus increasing the apparent divide between people living with BPD and the researchers who study them. Lived experience of psychopathology is common for researchers and clinicians and can be in many ways a valuable asset (Victor et al., 2022). Recently, a scholar summarized a range of publications advising graduate school applicants not to disclose personal experiences of mental illness generally and speculated that “me-search,” a pejorative term referring to conducting research related to one’s own experience of illness, may have been a “kiss of death” for his research proposal (Devendorf, 2022). Indeed, it was only toward the end of her extraordinary research career that Marsha Linehan, a groundbreaking BPD researcher and developer of dialectical behavior therapy, publicly acknowledged her own personal history of mental illness (Carey, 2011). It may be harder for people with BPD to trust the science and treatments arising from a community that does not seem to include their voices, and this false dichotomy might discourage some in the field from being open about their personal experiences with BPD.

Recommendations

It is clear that negative, pejorative, and often sexist views of BPD continue to proliferate in ways that stymie research progress and further harm people with the disorder. What can be done? Moving forward, researchers, authors, reviewers, and editors in clinical psychology and other subdisciplines can take active steps to study the important topic of BPD without exacerbating its stigmatization. Likewise, those who are responsible for research training are in positions to combat stigma development during formative times.

Recommendations for researchers

1. Research on BPD should be grounded in robust, empirically sound theories and hypotheses that are not influenced by judgment, stereotypes, or biases. Researchers are encouraged to consider

whether invocations of BPD in theories rely on actual diagnostic criteria of BPD (e.g., affective instability) or prior empirical research (e.g., findings of heightened levels of subjective experiences of shame, anger, and rejection sensitivity in BPD). If not, it is worth considering whether the theory invokes unfounded stereotypes of BPD (e.g., “people with BPD are manipulative”). This is especially important when the academic work is not challenging that idea (e.g., a study questioning whether a commonly held stereotype is actually valid) but rather stating it as a presupposition to a different hypothesis (e.g., testing a theory about a “hot/crazy” matrix with the assumption that BPD features are prototypes for the “crazy” label).

2. Avoid sex- and gender-related biases in theories, research design, and language. Does the framing of BPD-related work hold up if applied to more than one gender? If the language does not generalize well to men, for example, it may indicate biased ideas or language. If components of the study are explicitly gendered, is there an empirical reason for that choice, or is it based on assumptions? Consider also whether the work pathologizes behaviors that might be considered dysfunctional only in the context of some genders (e.g., having more sexual partners in women) or behavior that might represent a valid sexual orientation or gender identity (e.g., framing being bisexual or gender-fluid as identity disturbance; Eubanks-Carter & Goldfried, 2006; Rodriguez-Seijas et al., 2020). Moreover, it is readily apparent that the majority of research on BPD, from basic to applied studies, has focused almost exclusively on White women who are (or are presumed to be) heterosexual and cisgender. The inclusion of other gender identities and sexual orientations in research samples is critical for moving beyond gendered notions of BPD and helping people across the gender spectrum. When gender distributions are skewed at the conclusion of data collection, this should be recognized as a limitation, and researchers should consider whether they are adequately powered to detect gender differences. Researchers should also assess gender comprehensively (for guidelines, see Puckett et al., 2020), recognizing that even if underpowered to detect differences between groups, it is still important to allow participants to accurately describe their gender and to describe samples correctly.
3. Use targeted recruitment methods to broaden representation of minoritized and underrepresented

populations. In addition to recommendations for including gender and sexual diversity, we urge researchers to focus on underserved populations. We know very little about differential impacts, mechanisms, treatment outcomes, and experiences of BPD for non-White populations, a problem that is not limited to BPD but persists more broadly in clinical science (Adams & Miller, 2022; Wilkins et al., 2020). This recommendation also applies to those researchers interested in stigma itself because stigma likely has significant intersectional influences.

4. Avoid language with a moralistic or otherwise judgmental approach to labeling behavior. As scientists, we are most accurate and clear if we frame our work in nonjudgmental, functional language that is as close to the evidence as possible. For example, regarding “manipulative” behavior, we can consider whether that label goes beyond the evidence. If we are describing someone’s repeated behavior that has a negative impact on others but do not know the intent or degree of forethought behind the behavior, surely it serves our understanding of the disorder and of psychology best to use the most precise language to operationalize what we observe. Labeling these behaviors as maladaptive, urgent, reactive, or even aggressive may be more accurate and allow for better consideration of the phenomena and its impact on others and, accordingly, lay the foundation for better science. BPD researchers may wish to draw on work from forensic psychology, in which the avoidance of inappropriate inferences about clients’ intentions is a central component (G. M. Willis, 2018).
5. Particular care and consideration should be given to the impact of titles and abstracts, including their impact when considered outside of the context of the full article. Although as academics our hope is always that people read the entirety of our work, we need to accept the reality that our article titles and abstracts carry particular weight given that many people will only go that far in their engagement or may not have access to full articles. If paragraphs within the article are needed to contextualize a title or abstract as not harmful or pejorative toward a vulnerable group, then we suggest rewording, even if the resulting title is less attention-grabbing. One suggestion is to write titles and abstracts with the full expectation that participants in the study, or a loved one with BPD, will read them.
6. Seek collaboration with people who have high levels of experience working with people with BPD, as well as people with lived experience. Interest in including service users in psychological science has increased in recent years (e.g., Brown & Jones, 2021; Jones et al., 2020, 2021; Moreno et al., 2020). It is critical that services users with BPD are included in this push. We suggest this for all academics, particularly those new to the topic of BPD. Collaborate in all aspects of work, from study design and implementation to reviewing language and framing choices. If BPD is a central component to a study, it likely improves the study to involve these voices from the beginning of the project, especially if the investigative team lacks clinical expertise and either lived experience or close contact with communities with personal experience. Researchers should also consider collaborating with professional organizations (e.g., National Education Alliance for BPD, Emotions Matter) with BPD expertise. These organizations may facilitate connections to people with lived experience and/or provide consultation to ensure that research is sensitive and nonstigmatizing.
7. It is important for all researchers to understand that asking an empirical question and producing scientific knowledge are not neutral actions and not inherently useful pursuits. Rather, asking helpful questions, with sensitivity and benevolence, is a characteristic component of good research. For example, one *could* ask how BPD and perceived attractiveness interact to influence men’s dating preferences. However, asking this question may legitimize sexist and pejorative ideas about BPD, especially if alternative hypotheses are not included. Researchers are encouraged to consider: Who is impacted by my asking this question? Does answering this question help people or advance science meaningfully? Have I ruled out alternative explanations for this finding?
8. Do not exclude participants on the basis of personality disorders or histories of self-injurious behaviors. If clinical science is to inform practice, this is critical given the prevalence of BPD in clinical settings. Moreover, excluding participants on the basis of personality disorders or self-harm not only risks misrepresenting the complex nature of mental illness but also sends an implicit message that people with these histories are somehow “other” or to be avoided. Likewise, it is important to assess for the presence of BPD when characterizing clinical

samples in which this diagnosis is likely to be overrepresented (e.g., in research on populations with trauma histories).

9. Researchers who work with trainees at any level (e.g., undergraduate students, graduate students, interns, residents, fellows) should avoid perpetuating biases about BPD, and clinical researchers should ensure that training includes accurate information about BPD. In our experience, stigmatizing myths about BPD are often transmitted in training environments through both subtle and overt messaging. Careful attention to the validity and tone of discussions about BPD is warranted. Researchers should strive to use non-judgmental and behaviorally specific language. In addition, given the prevalence of BPD, clinical researchers are extremely likely to work with people with BPD even if they attempt to exclude participants on the basis of personality disorders (a practice we do not recommend). Exposure to accurate information about BPD should be an integral component of training curricula.

Recommendations for the editorial process

1. Journals should provide specific guidance with respect to nonstigmatizing language around all mental-health conditions, including BPD, and instructions to peer reviewers should include reference to these guidelines. Pejorative language and ideas should be evaluated during peer review and, if not addressed through the revision process, serve as grounds for manuscript rejections. Further, if pejorative language is identified after publication, clear editorial policies should exist such that readers who identify problematic language have a way to indicate this to the editorial board for correction. In addition, although many journals provide guidance regarding the need for respectful and professional language, little clarity exists for how these guidelines are interpreted, applied, and enforced. For this reason, journals should develop training for editorial teams who oversee peer review.
2. People with BPD and other mental-health conditions should be consulted in the development of such policies and approaches. For journals regularly publishing content about personality disorders, creating a consulting board of people with lived experience, with compensation, may be the most ethical and appropriate way to involve these key voices in this conversation. Others have outlined useful recommendations for engaging service user participation in the mental-health system (e.g., Brown & Jones, 2021; Daya et al., 2020). In the context of BPD specifically, organizations that center people with the disorder (e.g., National Education Alliance for Borderline Personality Disorder, Emotions Matter) may be useful for connecting to people with lived experience. Because the BPD community is large and diverse, consultation should include multiple voices. These individuals could be called on to help craft language guidelines, screen policies for sensitivity, suggest research areas to spotlight, and brainstorm additional measures to eliminate stigmatization. Journals could also consider developing their own work group or board dedicated to integrating lived experience perspectives into research, as was initiated by *Psychiatric Services* this year.
3. For any article about BPD or that uses it as a phenotype, at least one reviewer should have BPD expertise, even for journals in other sub-disciplines. Consideration should be given as to whether a clinical perspective may be important, even for a nonclinical article. Moreover, given the extent to which BPD is often stigmatized more so even than other mental illnesses, a broad clinical perspective may not suffice—BPD-specific expertise should be sought from researchers and/or clinicians who have a demonstrated history of nonstigmatizing practices.
4. Clinicians, researchers, and editors should make use of existing journal mechanisms to call attention to problematic research practices. Most journals have options to write letters to the editor (which may or may not be published) as well as commentaries on published articles. As a community of researchers, we should all help to hold ourselves and each other accountable by using these mechanisms to draw attention to stigmatizing research that makes it through the editorial process and encouraging our community to do better. Where possible, this should be done in a manner that calls the researchers and editors into the conversation as collaborators in improving the research process.

Conclusion

Many of the people with BPD in our personal lives or with whom we have worked professionally are among the most caring, bright, fun, and creative people we know. As is true for people with any psychological

disorder, they deserve research dedicated to the betterment of their lives and reduction of suffering. Although psychological science has made important advances in understanding and treating BPD, the field must come to terms with a long-standing history of stigmatizing language, study framing, and research practices. Clinical psychological science and psychiatry should take the lead in correcting this history given their proximity to BPD, yet other subdisciplines also play a critical role. Many of the recommendations we have made will not only help to destigmatize BPD and BPD symptoms but also are likely to make research more robust and impactful in general. Moreover, even small changes to research practices (e.g., how a question is framed or the language used) can make an important difference. This is a call to action for us to remember the people behind the numbers. The sound production of science and its thoughtful dissemination are paramount. Although the recommendations outlined may require considerable effort to enact successfully, they are all achievable. Cultivating awareness and willingness to examine our own biases and limitations will help catalyze improvements in research and editorial processes and ensure that we meet the moral imperative to use science to promote understanding and human flourishing.

Transparency

Action Editor: June Gruber

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K. L. Dixon-Gordon and S. L. Rizvi receive royalties for books on dialectical behavior therapy and compensation for training in dialectical behavior therapy.

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Note

1. Some have argued that the disorder's name should be changed to better reflect its phenomenology and evolving

evidence. Although a name change will not likely eliminate the convergence of structural, public, and self-stigma, changes to other disorder names have been useful. For example, changing the name of schizophrenia in Japan to more accurately reflect the modern concept resulted in nearly twice as many patients receiving the diagnosis within 3 years (Sato, 2006). We have not included arguments about the name of the disorder here, primarily because we believe the push for name change should arise from a collaborative effort that includes people with borderline personality disorder and is informed by their preferences and evolving evidence.

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