Author/s:
Seal, EL;Kokanović, R;Flore, J;Borovica, T;Broadbear, JH;McCutcheon, L;Lawn, S

Title:
Talking about borderline personality disorder, shaping care: The multiple doings of narratives

Date:
2024-11-01

Citation:
Seal, E. L., Kokanović, R., Flore, J., Borovica, T., Broadbear, J. H., McCutcheon, L. & Lawn, S. (2024). Talking about borderline personality disorder, shaping care: The multiple doings of narratives. Sociology of Health and Illness, 46 (8), pp.1709-1729. https://doi.org/10.1111/1467-9566.13804.

Persistent Link:
https://hdl.handle.net/11343/351213

Received: 26 November 2023 | Accepted: 22 May 2024

DOI: 10.1111/1467-9566.13804

ORIGINAL ARTICLE

SOCIOLOGY OF HEALTH & ILLNESS

Talking about borderline personality disorder, shaping care: The multiple doings of narratives

Emma-Louise Seal[1] | **Renata Kokanović**[1] | **Jacinthe Flore**[2] | **Tamara Borovica**[1] | **Jillian H. Broadbear**[3,4,5] | **Louise McCutcheon**[6] | **Sharon Lawn**[7,8]

[1]School of Global, Urban and Social Studies, RMIT University, Melbourne, Victoria, Australia

[2]School of Historical and Philosophical Studies, University of Melbourne, Melbourne, Victoria, Australia

[3]Spectrum Personality Disorder and Complex Trauma Service, Eastern Health, Richmond, Victoria, Australia

[4]Eastern Health Clinical School, Monash University, Clayton, Victoria, Australia

[5]Personality Disorder and Complex Trauma Research and Innovation Centre, Richmond, Victoria, Australia

[6]Orygen, Melbourne, Victoria, Australia

[7]Discipline of Behavioural Health, College of Medicine and Public Health, Flinders University, Adelaide, South Australia, Australia

[8]Lived Experience Australia Ltd, South Australia, South Australia, Australia

Correspondence
Emma-Louise Seal.
Email: emma-louise.seal@rmit.edu.au

Abstract

This article focuses on the narratives that circulate about borderline personality disorder (BPD) in health-care settings in Australia and the effects such narratives can have on how people practice and seek out care. People with a BPD diagnosis frequently access health-care services, often encountering stigma and discrimination. Drawing on narrative theory, we critically unpack the circulation and capacities of BPD narratives and the ways they can often contribute to poor and troubling experiences. This article is based on qualitative interviews with people living with a BPD diagnosis, as well as health practitioners who work with people with a BPD diagnosis. Our findings identified insidious and powerful BPD narratives that circulate in health-care settings, particularly in short-term, acute, or non-specialist contexts, such as emergency departments and in-patient units. These narratives influenced the ways that participants both practiced and sought out care. To improve health

Funding information
Australian Research Council, Grant/Award Number: LP190100247

service quality for people with a BPD diagnosis, or those experiencing mental distress, it is important to challenge the sociocultural–political norms and relations that can influence approaches to care and practice. Disrupting and reframing negative BPD narratives and raising awareness about the impact of stories that are told about BPD have the potential to generate social change.

KEYWORDS
borderline personality disorder, healthcare practice, lived experience, narrative

INTRODUCTION

This article explores narratives that circulate about borderline personality disorder[1] (BPD) in health-care settings and, importantly, what these narratives do. Drawing from the work of Frank (2010), we examine how narratives concerning BPD have certain capacities and interrogate how these narratives shape practices of care. BPD is a highly contentious mental health diagnosis. It is depicted in psychiatric classification by nine criteria in DSM-V (Diagnostic and Statistical Manual of Mental Disorders) that aim to capture extreme sensitivity to interpersonal conflicts, an unstable or absent sense of self, intense and volatile emotions and impulsive emotions. Persistent suicidal ideation and acts of deliberate self-injury are commonly experienced by people with a BPD diagnosis (Chesney et al., 2014). Such experiences are often connected with feeling heightened emotions and repetitive cycles of intense distress resulting in patterns of frequent and recurrent support-seeking (Ansell et al., 2007).

BPD is increasingly questioned as a diagnostic category, including in the psychiatric literature (Mulder & Tyrer, 2023). Such debates and controversies are reflected in broader discussions of ‘personality disorders’ (PD). Historically, there has been considerable controversy within the field of psychiatry and beyond about the classification, diagnosis, and ‘treatment’ of personality disorders (Manning, 2001). The publication of the DSM-III in 1980 represented a significant shift in psychiatric classification of PDs to a systematic and categorical approach by defining specific diagnostic criteria for each ‘disorder’. DSM-III also introduced a ‘multiaxial’ diagnostic system, which coded PDs on a second axis, to indicate their pervasive and enduring nature (Campbell et al., 2020). The conceptualisation of PDs as enduring and psychiatrically untreatable set the trajectory to their becoming amongst the most stigmatised and contentious for people living with a PD diagnosis amongst health-care professionals (Campbell et al., 2020; Jones, 2023). Critical approaches from fields including sociology and medical humanities furthered our understanding of ‘personality disorder’ and contextualised these diagnoses within specific social, cultural, historical and political milieux (Johnson, 2021; Jones, 2023; Pickersgill, 2013; Shaw & Proctor, 2005).

Indeed, the concept of diagnosis and its use in practice has a long history of problematisation as reported by both social and clinical researchers. Jutel (2009) illustrates how ‘diagnosis’ is socially created and organised arguing for explorations of the social forces influencing the clinical process of diagnosis. Ultimately, diagnosis makes one legible to psychiatry, a prerequisite for receiving 'care', a process which attempts to segment the world to make sense of people's experiences of distress (Dobransky, 2011; Pickersgill, 2023). Brossard and Chandler's (2022) recent work argued that mental 'disorders', defined as an array of emotions and behaviours deemed 'pathological', should be considered through the unequal production of potentially stressful emotions, tied with politics of labelling and categorisation, and examined as an embedded aspect of social relations, organisations, identities and structures.

Such patterns of investigation are present in relation to examining the social and cultural production of BPD, which is one sub-branch of PD identified in the DSM and has been described as *the* diagnosis amongst personality disorders (Jones, 2023). Several key focus areas have emerged, including the gendering of BPD and why women are more likely to be diagnosed than men, as are people who are gender diverse (Ussher, 2013). Feminist scholars have concentrated on social, cultural and political interrogations, with a focus on how trauma and suffering become pathologised (Duff et al., 2020; Sulzer, 2015; Shaw & Proctor, 2005).

Concerns about the nosological clarity of BPD as a diagnosis and tensions over its nomenclature are also burgeoning areas of critical inquiry (Lamont & Dickens, 2019; Lawn & McMahon, 2015). A common focus here is on the high rates of co-occurring or multiple diagnoses, alongside the relationship between BPD and trauma. The aetiology of BPD remains unsettled, with some scholars questioning whether diagnoses such as post-traumatic stress disorder (PTSD) or complex PTSD are more clinically reliable than BPD (Frías & Palma, 2015), given the high levels of trauma experience by many people with a BPD diagnosis. However, evidence also suggests that trauma-based diagnoses and people's experiences of certain 'symptoms' can be distinguished from BPD (Powers et al., 2022). These themes illustrate the ongoing contestations in research literature and the importance of attending to the sociocultural processes and practices that shape diagnostic trajectories and influence people's day-to-day experiences of living with a BPD diagnosis (Jones, 2023).

Experiences of care and support in mental health and broader health-care systems are a burgeoning area of BPD-focused social science research. Stigmatisation, marginalisation and poor service quality that may be experienced by people diagnosed with BPD have been comprehensively reported (Klein et al., 2022a; Lawn & McMahon, 2015; Veysey, 2013). Studies have highlighted that day treatments, residential programmes, outpatient and in-patient services were accessed at higher rates and recurrently by people with a BPD diagnosis compared to other mental health diagnoses (Ansell et al., 2007; Broadbear et al., 2022). Patterns of frequent and recurrent support-seeking strongly suggest that some people with a BPD diagnosis are not having their support needs met and are receiving inadequate care and treatment when required. Given this frequent use of health-care services and experiences of stigma and discrimination, it is important to critically unpack what shapes such practices of care. Our article is located at the intersection of social, cultural and political forces that create the conditions in which people's challenging experiences of care are rooted.

BACKGROUND

Health-care practitioners' perspectives of BPD

Within the health sociology literature focused on BPD-related health-care practices, there is a plethora of research covering a broad array of topics. One key area is the investigation of the attitudes and perceptions of health practitioners across a range of health-care settings and roles. Generally, previous research studies have demonstrated a concerning level of stigma (Bonnington & Rose, 2014), negative attitudes (Commons Treloar, 2009) and negative judgements (Deans & Meocevic, 2006) by some practitioners providing care for people with a BPD diagnosis. Various 'myths' associated with BPD foster the negative attitudes and judgements exhibited. These include that BPD is untreatable (Sulzer, 2015), that people are exaggerating their distress and being 'manipulative' (Deans & Meocevic, 2006; Sulzer et al., 2016) and beliefs that long-term treatment approaches are the primary option for support, which they are unable to offer (particularly in emergency department (ED) settings) (Lamont & Dickens, 2019). Furthermore, some common patterns associated with BPD, such as acts of self-injury and suicide attempts, can contribute to practitioner discomfort and reinforce stigma (Chandler, 2015). These practices can foster perceptions that people with a BPD diagnosis are challenging to work with, which can lead health practitioners to display limited empathy and understanding, and intensify the challenges people experience when attempting to access care and support (Day et al., 2018; Redikopp & Smith, 2022). Chanen (2021) argued that harmful attitudes, beliefs and practices held and enacted by health practitioners remain impervious to a substantial body of evidence, highlighting that people can be successfully 'treated' and lead lives they find meaningful.

The prevalence of stigma has also emerged as a significant area of literature focus. Research studies have indicated that health professionals commonly report experiencing anger, frustration and feelings of inadequacy, with their knowledge and skills being challenged when treating people with a diagnosis of BPD, which can reinforce stigmatising perceptions (Ring & Lawn, 2019). In a recent comprehensive review of stigma in relation to healthy-care and BPD, Klein et al. (2022a) demonstrated that structural stigma specific to BPD is pervasive in health systems, woven into the fabric of care. They argued that many macro- and microlevel factors are embedded within institutional policies, cultural norms and practices, perpetuating the inadequacy of service delivery.

A common response to addressing these systemic problems is to develop and implement education-based interventions that aim to 'change' practitioner attitudes and thereby improve care practices. Examples include the development of anti-stigma campaigns (Knaak et al., 2015) and education-based interventions (Commons Treloar & Lewis, 2008) that target practitioners in a range of settings including EDs, in-patient units and community services. While these approaches have become more popular, evidence of their efficacy is mixed. Dickens et al. (2016) conducted a systematic review of interventions devised to improve the responses of practitioners to people diagnosed with BPD, concluding that there is limited evidence of any meaningful impact on practice. They argued that interventions aimed at cognitive adjustment are inadequate in the face of ongoing social and cultural inequalities.

An updated review of BPD-focused educational interventions by Klein et al. (2022b) also concluded that targeting behavioural change alone produced limited improvement. However, their research study suggested that there is an opportunity to effect positive changes to practitioner responses if educational interventions are brief, grounded on evidence-based approaches for BPD, and tailored to clinical settings. The inference is that the type of education delivered and pedagogical approach adopted are important considerations, alongside having specificity for the cultural and organisational context of practitioners' workplaces. Notwithstanding these interventions, negative perceptions of BPD and poor health-care experiences endure, suggesting that a different approach is required, one that goes beyond the targeting of attitudinal change at the individual level. While such approaches might have some localised impact, we have broadened the focus to include the sociocultural norms and relations that shape support and care practices.

Lived experience of accessing health-care systems and services

Accompanying the expansion of research studies investigating health practitioners' experiences is a growing body of critical social science literature focused on experiences of receiving care by people with a BPD diagnosis. What is emerging are ongoing controversies related to the diagnosis, accessing safe and ongoing support and approaches to care practices (Duff et al., 2020; Sulzer, 2015). Experiences of stigma and discriminatory practices are common; lived experience research clearly highlights that people with a diagnosis of BPD face significant challenges in receiving appropriate support and feel misunderstood by health-care practitioners (Klein et al., 2022a; Ring & Lawn, 2019). Moreover, after receiving a BPD diagnosis, people often feel that the care they receive worsens (Bonnington & Rose, 2014; Sulzer, 2015). Consequently, people become selective about what diagnoses they disclose, to whom, and when (Kokanović & Philip, 2014), often preferring to reframe their experiences in terms of trauma or complex PTSD to obtain more empathic treatment (Ng et al., 2019).

Research studies have also interrogated perceptions regarding 'treatability' and 'recovery' for people with a BPD diagnosis. Sulzer (2015) argued that narratives of untreatability about BPD are perpetuated by health practitioners and ripple out to individuals. Lam et al. (2016) reported that people with a BPD diagnosis received a significantly more negative prognosis, particularly from mental health nurses and psychiatrists. Challenges also materialise when it comes to giving a BPD diagnosis, with reports of practitioner ambivalence both making and communicating this. Sulzer et al. (2016) reported that many people did not receive a direct diagnosis, which inhibits transparency of communication and impairs the person's understanding of their experiences and discussion about appropriate treatment options. Health-care experiences for many people with a diagnosis of BPD continue to be deeply problematic and seemingly resistant to meaningful change, despite similar recommendations for improvement being continually proposed (Proctor, et al., 2021).

The contribution of this article to sociological research on health-care and BPD is two-fold. First, we explore the experiences of people with lived experience of a BPD diagnosis, as well as those of health-care practitioners. Our approach is unique; studies seldom incorporate the experiences of both groups to inform practice-based change. By contrasting these disparate but related experiences, we aim to unpack probable sources of ruptures in support practices for people accessing health services. Second, by conceptualising narratives told as performative we examine the settings and social circumstances in which narratives about BPD are produced to interrogate how they work on people and for people, influencing how individuals either practice or seek out care (Frank, 2010).

THEORETICAL FRAMING

Narrative inquiry is a rich and dynamic field within the social sciences literature on health and illness, comprising a wide variety of theoretical applications and orientations. We are approaching narrative as both theory and method, recognising the relational role of stories as a mechanism for individuals to remember, argue, justify and engage (Riessman, 2008). Further, we are interested in how narratives operate more broadly as 'sense-making tools that inevitably do things—for people, for social institutions, for culture and more' (Freeman, 2002, p. 2). According to Frank (2010), stories differ in their capacity to impact lives and systems, and are connected to wider power relations. They can deal with human troubles and make trouble for humans, that is, they can activate and enact.

In this article, we are interested in the *performative* aspect of narratives. Narratives shape the beliefs, feelings, and actions of those who are caught up in them, affecting their lives in ways that can be positive, generative, limiting and dangerous (Frank, 2010). We are interested in BPD-related narratives that circulate both within health-care spaces and about health-care practices, looking beyond what is said, in a representational way, to examine their performative potential. Such an approach affords space to examine the sociocultural and historical contexts that shape what is said about BPD and how this is understood by others. As Llewellyn-Beardsley et al. (2023) assert, it is important to attend to narratives in a way that is alert to structural contexts to examine why particular stories might be told and what happens because of this telling. They argue that in the context of mental health research, where there are discernible power hierarchies, it is vital to pay close analytic attention to emergent epistemes at work as the narrative(s) is 'co-constructed at immediate/micro and socio-structural/macro levels' (Llewellyn-Beardsley et al., 2023, p. 2). Rather than focussing on generating narrative patterns, we see interpretation instead as an ongoing dialogue within the story (Russo, 2016). That is, stories are not passive reflections of people's lives, but are active players affecting lives in both 'positive', 'dangerous' and ongoing ways (Caddick et al., 2015). Narratives are performative speech acts, they are cultural phenomena among the mechanisms and resources through which society and culture are shaped (Atkinson, 2009).

In this way, we find Chandler's (2015, 2022) research at the intersection of mental health and narratives of self-injury particularly instructive in arguing for narrative approaches that do not neglect the interpersonal and structural contexts in which talk occurs, instead recognising the importance of tracing the operation of power and broader norms and forces. Chandler contends that understandings of practices should be treated as artefacts of social interaction, of contexts and relationships, and of socially constituted meanings. Such an orientation focuses on the effects that stories can have, while recognising that they are not produced in a vacuum (Riessman, 2008). The health-care troubles, discrimination and inequalities encountered by people with a BPD diagnosis are ongoing. We build on current academic literature by thinking through how the telling of different stories may have the capacity to produce *new* narratives in health-care settings, ones that are less stigmatising and more empathetic. Stories can be mobilised into action for progressive social change; individuals can challenge or resist dominant cultural narratives by telling and living counter stories (Riessman, 2008).

In social science research studies on BPD, narrative approaches have been used to examine people's lived experiences. However, as far as we are aware, these have largely conceptualised narrative as a form of identity construction, used to understand how people make sense of their lives and themselves through the stories they tell, and be an avenue for therapeutic intervention (see Adler et al., 2012; Bois et al., 2023; Schmidt & Fuchs, 2020). In doing so they often view a BPD diagnosis unproblematically, leaving unexamined the nuanced social, cultural, historical and political factors that shape our understandings of mental and emotional distress. Our work uses a different approach; by focussing on the circulation and power of stories in everyday health-care contexts, we aim to illuminate what narratives circulate and what impacts they have.

METHOD

Recruitment and participants

This article is based on an interdisciplinary qualitative study exploring the experiences of people living with a diagnosis of BPD. The study was guided by an advisory group, including lived experience advisors, representatives from mental health NGOs and services, and researchers with relevant content expertise. The research team, in collaboration with people with lived and living experience, developed the study design, research materials and the analytical approach. Ethics approval was obtained through the Melbourne Health Human Research Ethics Committee (HREC) based in Victoria, Australia. Recruitment occurred via social media platforms including Twitter (now 'X') and Facebook, and the websites of relevant service organisations. Participants were provided with study details, including study aims and confidentiality protocols. All provided written informed consent. Interviews were conducted with participants who had lived experience of a BPD diagnosis, as well as health practitioners whose work includes people diagnosed with BPD. The interviews took place between February 2022 and May 2023. All participants resided in Victoria, Australia. Interviews were conducted via a digital meeting platform, audio-recorded and lasted between 60 and 120 min. The recordings were transcribed professionally, de-identified and participants were sent their transcripts for review and approval. NVivo 12 software (Lumivero, 2017) was used to assist data management and analysis.

Lived experience participants

Twenty-four interviews were conducted with participants who identified as having a BPD diagnosis. Participants came from diverse backgrounds and recounted varied experiences. They were aged between 22 and 63 years at the time of their interviews; 17 were women, three were men, and four people were non-binary or gender fluid. Eleven participants were heterosexual and 13 were sexually diverse. All had received a BPD diagnosis during contact with the healthcare system apart from one participant who self-identified as having BPD. At the time of interview four participants had been diagnosed over 10 years prior and the remaining participants were diagnosed between nine and two years prior to the interview. Interviews focused on experiences of being given a BPD diagnosis; impact of this diagnosis on everyday life; wellbeing and practices of self-care; experiences of care within health services; social care and support received in the community; and their views about the future. In the following sections 'LE' denotes lived experience participants and 'HP' stands for health practitioner.

Health practitioner participants

Twenty-one interviews were conducted with health practitioners, who were aged between 34 and 56 years at the time of interview. Practitioners' educational backgrounds included the completion of graduate diplomas, bachelor degrees, master's degrees, doctor of philosophy and doctor of medicine degrees. When an initial analysis was conducted on the participant data, it became apparent that contextual differences and disparate organisational cultures across various settings were integral to shaping practitioners' experiences. Therefore, this article focuses on nine interviews with health practitioners working in short-term, acute, non-specialist settings such as EDs and in-patient units. We recognise that the narratives that circulate and the effects they have will potentially differ when compared to long-term, more specialist therapeutic settings. However, these acute settings are the contexts in which practitioners are more likely to encounter people with a BPD diagnosis experiencing acute mental distress. They are often the settings where practitioners are less likely to have received specialist training to assist with BPD care provision where stigma is often more prevalent (Klein et al., 2022a). They are the places in which people are often experiencing the greatest need of urgent and empathetic care and support. We also acknowledge that this group of practitioners are not necessarily giving the initial diagnosis of BPD, which could influence the relationship and interactional encounters they have with the person seeking care. Health practitioners routinely involved in the process of diagnosis are more likely to have received specialist training, which could reduce negative judgements and improve their approach (Ring & Lawn, 2019). However, as discussed earlier, it should be recognised that there are ongoing challenges associated with giving a BPD diagnosis (Bonnington & Rose, 2014; Lamont & Dickens, 2019). This indicates that there are likely different types of *trouble* when it comes to differences in health practitioner approaches, which are influenced by context and circumstances.

Participants represented the following professional groups: mental health nurses, psychiatrists, ED doctors and nurses, social workers, occupational therapists, general practitioners and in-patient service managers. They were aged between 34 and 56 years at the time of their interviews. Eight people were women and one was a man. The interviews with health practitioners focused on experiences of caring or supporting people diagnosed with BPD; experiences with the process of diagnosis; providing pharmacological and/or psychosocial interventions and support; and perceptions about the stigma that can accompany a BPD diagnosis.

Analysis

An iterative, thematic approach was initially used to interpret the data, taking place concurrently alongside data collection. The first and fourth author read and reviewed the transcripts to map key themes and develop an initial coding framework. The resulting themes and framework were reviewed by co-authors and continuously refined as more interviews were completed, enabling adjustment during fieldwork. These discussions focused on identifying patterns, differences and singular cases. We aimed to achieve rich interpretations of meaning to draw out instances of ambiguity and nuance. The first author took these insights and reviewed the transcripts using a structural and dialogical narrative analysis approach (Riessman, 2008), which we will now unpack further.

A variety of different approaches can be used for narrative analysis; Riessman (2008) refers to this as a family of methods that share a focus on stories, with the primary branches being thematic, structural and dialogic or performative. Given our interest in viewing stories as actors that have capacities and do things, we engaged in a dialogic/performative analysis (see Frank, 2010; Riessman, 2008). We were also interested in key moments and elements contained within the shared stories, which led us to consider *what* was said as is customary in a more traditional form of thematic analysis. As Frank (2010) notes, a dialogical approach studies the mirroring between what is told in the story—the story's content—and what happens as a result of telling that story—its effects. Riessman (2008) emphasises that this kind of dialogical analysis makes use of elements of both thematic and structural analysis but adds other dimensions. Therefore, the examination of *what* is said, *why* it might be said, and what *effects* there could be, are all intertwined questions that can be interrogated by bringing together these different strands (Sparkes & Stewart, 2019).

The contour for conducting a dialogical narrative analysis can be viewed as cyclical and iterative opposed to linear and fixed with no prescribed set of steps (Smith & Monforte, 2020). Frank (2010) argues that any notion of method needs to be considered as that which initiates a *movement of thought*. This opens up the analysis to incorporate storytelling practices, creating anchor points that the analysis can gravitate and build around. To help initiate such a movement of thought, we approached the data with a series of questions proposed by Frank (2012: 45–46) for examining the participant transcripts and the stories they told. Specifically, there were resource questions, circulation questions, affiliation questions, identity questions and what is at stake questions. Accordingly, we interpreted the stories shared by participants using concepts such as tellability, structuring, and the emergent mirroring effects. During this process, we brought into dialogue the stories of lived experience participants and health practitioners. This fostered a unique and deeper engagement with the small stories that were shared about participant experiences in health-care contexts. Stories about BPD and health-care practices are organised in particular ways (i.e., narratives) and have particular effects, which are shaped by broader sociocultural–political relations. It is at this nexus that our analytical approach and discussion is situated, guided by our interest in how these narratives can influence health-care practices.

RESULTS AND DISCUSSION

Talking about BPD

It was apparent from participant accounts that there are insidious and powerful narratives about people with a diagnosis of BPD circulating in health-care settings. From a health practitioner perspective, these narratives often portrayed people with a BPD diagnosis as dangerous, attention-seeking and lacking control over, or embellishing, their behaviours to achieve a particular result. For example, threats to self-injure, or frequently attending an ED on multiple occasions after self-injuring. These narrative patterns were most discernible in the stories told by practitioners working in acute mental health settings and EDs. Lived experience participants also reflected on narratives they claimed to overhear in these health-care settings. It was in these 'small stories' (Phoenix & Sparkes, 2009) about mundane and everyday occurrences we were most interested. Reflections on fleeting conversations and everyday talk hold crucial understandings. Consider the reflection made by a practitioner about their own and colleagues' reactions when they see a BPD diagnosis on a person's notes:

> I think there's a degree of judgement and bias. With BPD, you always cluster them according to the mad, the bad and the sad. So, oftentimes, I mean, not just me as well, other clinicians also have that same bias, where, as soon as you see the term BPD on someone's name, in triage, often you go, oh dear, this is gonna be a challenging assessment, there is a real possibility things will escalate into something bad. (HP03, ED doctor).

The narrative of the person with a BPD diagnosis as dangerous (bad), unstable, requiring additional resources and time, is fully evident in the framing of interactional encounters in the ED. This reflects stigmatising perceptions associated with BPD, as described by Bonnington and Rose (2014). The reflections made by HP03 exemplify how these narratives are created and circulated in health-care settings. The appeal to the listener, '*not just me*' operates to implicate others in this type of talk and distance the participant from being alone with such sentiments. Arguably, distancing and co-implication are techniques mobilised to manage the narrative's tellability. For Ochs and Capps (2001) tellability is one dimension of narratives, negotiated by the teller and listener in particular local or micro contexts. In such negotiations, participants draw upon a repertoire of stories that they recognise and share while considering which story fits which occasion, who wants to hear a particular story and when, and how to react when a certain story is told (Sparkes & Stewart, 2019). Norrick (2005) argues that certain stories or narratives can merge into the no-longer tellable category because changing societal sentiments make them too embarrassing or troubling. Narratives concerning BPD, such as the one above, might be highly tellable in backstage health-care settings, but what also transcends is an awareness that stories like this could be perceived unfavourably outside of these spaces. The deep-rootedness of these narratives is also highlighted during a routine handover:

> This is probably the worst I'd ever heard is an Acute Nurse Unit Manager so the nurse managing the floor for that day handing over to the night staff and they referred to one of the consumers as a BPD C-U-N-T. So stuff like that, just literally handing over. This is a consumer that we should be treating like everybody else and then calling them a BPD C-word.
>
> (HP14, Mental health nurse)

The openness with which this occurred during an everyday part of the organisational routine is indicative of the pervasiveness of negative BPD narratives. While the participant reflects critically on this incident [in the present], they described feeling more on board with such perceptions at the time, '*everyone throwing around terminology that definitely isn't very helpful*, *that soaking into my psyche and then me becoming with that kind of culture*' (HP14, Mental health nurse). Descriptions of 'soaking' and 'becoming with' these BPD narratives illustrates their transferability. Further, 'second-hand' narratives overheard by or told to lived experience participants when they were in these settings also highlights their distinct tellability. For example, LE19 describes a conversation between their mum and a nurse, demonstrating the attention-seeking, manipulative narrative at work:

> There's been times when my mum has told me that a nurse or someone has said, I'm only doing certain behaviours or presenting to emergency because I'm attention seeking. I guess the best way to explain that is that you wouldn't seek support if you didn't need it. I guess that's never the aim, it's just how it can look.

As is evident from these accounts, there are distinct, everyday narratives about BPD that circulate. These can be highly tellable (in the 'right' contexts) and insidious, permeating organisational cultures. These narratives can in turn influence the support offered to a person with a diagnosis of BPD, reinforcing the pervasive perception that it can be challenging to provide meaningful care for people in acute settings. Consider the below reflection:

> They [people with diagnosis of BPD] come into ED almost as a last resort when they don't know what other avenues they have left. Sometimes I feel for them in the sense they want help to contain themselves or they're trying to seek other avenues. Certainly, what we can do in the emergency or hospital setting is quite limited. They need long-term care and support be it in the form of some form of psychotherapy, ongoing learning strategies, teaching them how to regulate behaviour, you know, feelings.
>
> (HP03, ED doctor)

It is apparent that limited consideration is given to the kinds of support that might be offered in an ED setting, with the embedded assumption that the only form of meaningful care that can be provided is outside, in other contexts, by other people. The description of '*sometimes*' feeling for people is telling and could indicate a lack of empathy for people trying to access care. However, when drawn into dialogue with lived experience narratives, it becomes apparent that these can be places where people find helpful support:

> That one really positive experience was [in ED] a doctor... she was great, she took all the time and care in the world. She actually talked with me and was genuine and kind of authentic with me about her not understanding and wanting to understand why I'd done what I done [self-injury]. She was offering me different kinds of options in terms of care and not necessarily being sure I wanted to go home in terms of my family situation, in terms of my safety. I think there was always a little bit of hope when I showed up [to ED] that I'd have another experience like that.
>
> (LE15)

The emphasis on being authentic and offered care options is a contrasting narrative pattern to HP03 where these affective experiences were not mobilised; these are not the narratives that usually circulate. While ED settings are busy and practitioners are time poor, this account highlights the importance of interrogating narratives at the everyday, relational level (Chandler, 2022). This is where health practitioners can shape immediate care effects and potentially operate as gatekeepers to other support sources in the health-care system. There are ongoing tensions about the 'best' approach to treating and supporting people with a diagnosis of BPD (Duff et al., 2020). Generally, what is increasingly recognised as important is adopting a person-centred approach, being empathetic and validating and building a trusting relationship with the person, regardless of the setting and practitioner speciality (Donald et al., 2017; Lamont & Dickens, 2019; Veysey, 2013). Our research takes this up by considering what is happening during everyday clinical encounters and the narratives that influence them.

Shaping care: Empathy burn-out

Moving on from what stories are told, this section further develops the focus on the doings of such narratives and their capacities to shape care practices and people's experiences. As previously highlighted, Frank (2010: 28) argues that 'stories have the capacity to deal with human troubles, but also the capacity to make trouble for humans'. We are interested in these unfolding troubles by not focussing on what was told in the story but on what happens as a result of telling that particular story, the mirroring between a story's content and its effects

(Sparkes & Stewart, 2019). There are various patterns that were apparent in health practitioner and lived experience accounts when describing approaches to practice, or experiences of practice.

When reflecting on their experience of receiving care in health service settings, it was apparent that for lived experience participants, a BPD diagnosis and other people's awareness of this diagnosis through disclosure, medical notes or handover routines, had distinct effects on the treatment they received, particularly with respect to empathy. Consider the reflection by this lived experience participant about the polarised nature of their experience pre and post diagnosis:

> Before [receiving BPD diagnosis] that point, I didn't have a lot of issues accessing the health system. Or, when I accessed it, I received a level of care that felt safe to me. But as soon as I got this diagnosis, I felt very rejected. I was actively rejected from that point. It felt like people thought I was doing it for attention.
>
> (LE13)

The participant describes a palpable shift in their experience of accessing health-care after their BPD diagnosis. Presentations were reframed, narrated as '*attention seeking*' and having behavioural roots, rather than their having a genuine need for care (Bonnington & Rose, 2014). In this way, BPD-based narratives are making trouble by negatively impacting the care people receive. Such polarity is also clear here:

> Once I got that [BPD] diagnosis on my file then particularly in emergency departments, it got to the point where people would just be really frustrated if I was there. Even though I was often there because I had to be, and it was an assessment order or something. They wouldn't stitch up my self-harm or they wouldn't use anaesthetic as they were doing it. Or security would be quite threatening.
>
> (LE10)

LE10's reference to the care received after being given a BPD diagnosis again illuminates the deterioration in interactions and treatment experiences. The lack of pain mitigation when suturing stitches and invalidating emotional responses from practitioners, such as frustration, resulted in LE10 feeling upset and confused because, '*I didn't think I'd changed*'. While poor treatment experiences have been highlighted in previous research studies (Lawn & McMahon, 2015; Sulzer, 2015), the participant's reflection that they had not changed as a person is indicative of how BPD-based narratives can create challenges, potentially reducing empathy, time afforded and consequently the quality of care received. The description of a threatening security presence also conjures notions of dangerousness (Johnson, 2021; Markham, 2003), limiting the compassion expressed for a person's needs. Ultimately, it is the narratives about the person that have changed, rather than the person themselves. As argued by Redikopp (2018), it is important to reframe how we understand BPD, and its diagnosis and the impact this has on health-care. The account illuminates the epistemic violence that may be enacted on a person seeking help to manage their overwhelming emotions. This suggests a fundamental need to revalue the knowledge people with a BPD diagnosis hold, rather than twisting their motivations or behaviours to align with medicalised understandings, a 'compassionate contextualisation' (Redikopp, 2018, p. 90) is required.

When brought into dialogue with practitioners' reflections on their own practice and past experiences, it is unsurprising that people with lived experience felt these shifts and tensions. The following description of backstage clinical talk that often occurs prior to an interactional encounter with a person diagnosed with BPD, highlights how 'challenges' are anticipated:

> You say personality disorder, and straightaway people's mind goes to, it's their fault. We can't medicate them. We need buy in from them, which they don't have, there's a mountain to climb before you even meet the person. People I've worked with have said things about patients without even having a conversation with them.
>
> (HP06, ED nurse)

The negative approach to practice conveyed here with an expected, '*mountain to climb*' and with the locus of control or causation held within the individual, '*it's their fault*' highlights how practitioner empathy might be reduced prior to engaging with a person. When probing stories told with circulation questions (who tells which stories to whom) and affiliation questions (who will share a common understanding of a particular story) as suggested by Frank (2010), it is apparent that these stories become the go-to narratives about BPD in backstage health-care spaces. The narrative ritual is so meticulously rehearsed to the extent that HP06 comprehensively lists off the initial responses that are triggered when a person with a BPD diagnosis presents in these settings. Such BPD narratives generate distinct effects on empathy, impacting how practitioners approach care provision and engagement with people seeking their help. Another practitioner shared similar reflections:

> I had a lot of compassion fatigue around that [BPD] diagnosis, especially on the acute unit. You feel like you're getting burnt out from it. But, being away from the acute unit, looking a lot more into complex trauma, and thinking about it from that perspective has helped me shift my own perspective about how the path I was going down was not a positive one for my views towards people with BPD and having time away from a culture that is very blamey and shamey.
>
> (HP14, Mental health nurse)

The focus on culture indicates that the participant's interactional experiences with service users did not change, rather it was the dialogue and stories HP14 was exposed to. Distance from the narratives of '*blame and shame*' that can be weaponised in health-care settings fostered a renewed sense of compassion. The recognition of being on a negative pathway that was not of value for them personally nor for people with a BPD diagnosis that she cared for is indicative of how distance from damaging narratives can positively influence a person's delivery of quality care and support. The doings of such stories and how they permeate the culture of groups of practitioners is also described here:

> Experienced clinicians that have been around for a while often have negative ways of conceptualising BPD. I think that influences the teams that you work in especially when you're more senior staff, if you're junior staff and you're coming into those teams and you've got more experienced clinicians talking in a certain way that culture rubs off and becomes a culture of the team and influences your own perception of BPD.
>
> (HP13, Social worker)

The temporality of these stories is apparent. The perceptions created by the sharing of stories that work to '*judge people*', as well as the stories themselves, are in a perpetual state of replication (Moen, 2006), passed along and circulated from one generation of practitioners to the next. The resulting narratives hold such strong currency that their capacity to effect is demonstrated by being retold across time and place. Participants emphasised how these perceptions are embedded from their earliest experiences of being on placement, or employed, in health-care settings:

> It may have started even before we started work. When we have clinical placements, and sometimes you hear, some offhand comments, like, this person [with a BPD diagnosis] has come in again, this is gonna be very difficult, you hear these things in the background. Then you just watch how, other clinicians interact with that particular person and how things escalated really quickly.
>
> (HP03, ED doctor)

The inevitability that such interactions will be a challenge is also expressed. The assumption of difficulty, with consequent escalation, is told unambiguously, as though there could be no alternative outcome. Following Riessman's (2008) recognition of narratives as a vehicle for social advocacy, it could be helpful to actively disrupt such stories during the initial stages of health practitioner training or clinical rotations, when people are first exposed. While previous work has focused on the concept of stigma as an analytical way to frame negative experiences encountered by people with a diagnosis of BPD (Bonnington & Rose, 2014; Klein et al., 2022a), we are arguing that shifting this conceptual lens to narratives offers a different understanding of these challenges. Such a reframing creates space to identify and interrogate how *stories* create effects.

Boundary making

The setting and reinforcing of relational boundaries were additional strong manifestations of how narratives have the capacity to shape health-care practices and people's experiences. One of the pervasive stereotypes associated with BPD is that people with this diagnosis are manipulative (Sulzer, 2015) and require careful management (i.e., setting clear boundaries) by practitioners offering support. This participant describes how practitioners often respond to a person with a BPD diagnosis by reinforcing the boundaries within the relationship, whether that is in the context of long-term therapy or during an acute period of care:

> I see it all too often, as soon as someone has a diagnosis of a personality disorder, that restrictions are placed on that person or limits and boundaries without much explanation, or reason as to why. It makes me really sad for them. I really understand and I think boundaries are important, but I think personally, I think it's more about our boundaries and our limits are about us being able to say what we can do within the context of the therapeutic relationship.
>
> (HP07, Occupational therapist)

Referring to how common this practice is and how they feel 'sad' about this, highlights how a BPD diagnosis can lead to reduced empathy and consequences that are unhelpful. Another practitioner described the sense of abandonment that a person with a diagnosis of BPD might feel if they perceive that strong boundaries are being erected. They also added how this can contribute to unhelpful negative judgements on the part of the practitioner, '*I think if you don't have an understanding of the formulation but also BPD in general it's easy to jump to wow, they're being, over the top or manipulative and I think that's where a lot of this dialogue comes from*' (HP12, Psychologist). Narratives framing people as being 'over the top' and conniving, influence practice by instigating greater boundary making. The description of 'jumping to conclusions' and how this can be 'easily done' highlights how these narratives are fully ingrained, limiting other conclusions available for practitioners to *jump to*.

Arguably, these repeated narrative patterns have a distinct function (Frank, 2012; Smith & Monforte, 2020) and serve practitioners by offering some rationale and justification for their approaches to care. In this case, if interactions are always going to be challenging, strong boundaries are always going to be required, and there might not be any solutions (or hope) on offer. Consider this health practitioner's account that as a junior doctor, they attempted to avoid encounters with people diagnosed with BPD, '*perhaps, at the beginning [of career], you don't have the experience, you feel confronted, you don't like to manage these cohorts, I tried to avoid them or minimise contact when I was very junior* (HP03, ED doctor). At work is the creation of narrative patterns that have distinct effects; that make trouble (Frank, 2010). These narrative patterns and processes help to absolve responsibility and do not challenge health service approaches that often fail people who are seeking support, as highlighted in the literature (Duff et al., 2020; Klein et al., 2022a). Boundary building (as a practitioner response) is also reflected in people's lived experience as they describe feeling shifts in how practitioners managed relational encounters:

> I became more aware [after a diagnosis] that I can't have, well I can't show emotions without them [health practitioners] being like "oh, that's inappropriate", or "you can't show emotions that way". I'm naturally a loud person so when I'm too loud, people see that it's BPD or being disruptive or stuff like that, and a lot of the time it's just me voicing my opinions or thoughts.
>
> (LE06)

LE06 discusses having a greater awareness, post-BPD diagnosis, of ways in which emotions carried a different set of responses and reactions, with greater policing around how they were displayed. LE09 adds, '*you hear that psychologists don't want to work with people with personality disorders, or psychiatrists I have experienced dismiss you, I don't understand why there's such need for boundary setting, or being careful of splitting—I'm not aware of how we got here*'. Similarly, here, reference is made to the creation of boundaries and the confusion around this, particularly in relation to the idea of splitting. Splitting is a psychoanalytic term referring to a psychological mechanism allowing the person to tolerate difficult and overwhelming emotions by seeing others as either good or bad, idealised or devalued, with no 'grey area' in between (Gunderson, 2011). It has gained currency in relation to BPD and has taken on different discursive meanings across various settings including online communities, such as Tumblr and Reddit, and health-care contexts (Hendry, 2020).

When considering the doings of narrative and how stories can be performative and carry particular functions, while certain actions and associated dialogue might be perceived by a health practitioner as being manipulative, the framing by a person with lived experience is that of seeking connection and validation:

> As soon as I got this [BPD] diagnosis, I felt very rejected. I was actively rejected from that point. It felt like people thought I was doing it for attention. And in a way I was, but it wasn't attention for the fun of it. Well, it's not even attention. I was seeking connection. I was seeking a safe space and seeking support, in minimising the distress I was feeling, but I felt very rejected.
>
> (LE13)

When boundary building is used as a response to a person seeking validation and empathy, it results in experiences of care that are mis-attuned with what the person might need. As demonstrated above, there is a narrative tension between seeking connection (as told by those with lived experience) and seeking attention (as told by a health practitioner). It becomes apparent that such narratives or scripts are unavailable for practitioners to draw on as the existing repertoire of narratives associated with BPD have been created in the current sociocultural–political context (Chandler, 2015). That is, in certain health-care settings these are not the 'go to' stories, rather existing narratives prevail, which shape care responses. Reframing the narrative, from seeking attention to seeking connection, shifts the focus and highlights the need to amplify relational support mechanisms. As LE13 further explains, '*sometimes I wouldn't need treatment [for self-injury]. Other times I would*, *and then they would send me home again*, *just because it was seen as very behavioural*, *and they didn't offer extra care*'. The emphasis placed on behavioural troubles is a signifier that challenges are to be dealt with at the individual level, with limited additional support or follow-up care offered.

CONCLUDING DISCUSSION

Our study of narratives that circulate about BPD in health-care settings reveals some of the stories that are told and importantly what these do. The present study drew on the lived experience of people with a diagnosis of BPD and the experiences of health practitioners, to highlight the patterns, structure and capacities of these narratives within health-care contexts. We examined the settings and social circumstances in which such narratives are produced to demonstrate how they shape the ways that individuals both practice and seek out care.

Our work highlights how 'BPD' and lived experiences associated with the diagnosis are produced and (re)produced in certain health-care settings. Brossard and Chandler (2022:3) argue for research studies to continue to probe what they refer to as 'mental health apparatus—the set of institutions, actors, knowledges and discourses that interact to manage certain emotions or behaviours deemed pathological or unhealthy'. The narratives that permeate care practices are political and contribute to the social norms and relations of power that circulate. Shared and relational understandings of BPD are generated by these narratives, mobilising stigma and associated tropes, such as that people with a BPD diagnosis are untreatable and difficult to manage (Deans & Meocevic, 2006; Sulzer, 2015). This conceptual lens can identify (and potentially contest) the norms generated by mental health professionals through their categorisations and work practices, to foster more socially situated understandings of people's lived experience of mental distress and accessing health-care (Brossard & Chandler, 2022).

We also focused our analysis on the doings of narrative, highlighting the performative aspects of narrative and what can happen because of telling particular stories in specific moments, and what that means for people with a diagnosis of BPD and BPD-associated health-care practices (Frank, 2010; Sparkes and Smith, 2019). Narratives are a social resource offering a partial insight into talk practices that can work to sustain judgement, inequalities and poor care practices associated with the BPD diagnosis, in particular settings. While previous work has focused on the concept of stigma as an analytical way to frame negative experiences encountered by people with a diagnosis of BPD (Bonnington & Rose, 2014; Klein et al., 2022a; Knaak et al., 2015), we are arguing that shifting this conceptual lens to narratives offers a different understanding of these challenges. By conceptualising narrative as theory and method, we build on existing BPD-orientated literature at the intersection of sociology, medical humanities and critical mental health studies, arguing that greater attention be paid to tracing the complex everyday relations and norms shaping lived experiences (Campbell et al., 2020; Duff et al., 2020). We also further develop the potential of dialogical or performative approaches to narrative that have been applied in the context of critical mental health studies. These findings have several practice-based implications, recognising that narratives can be a site for social change and transformative action (Riessman, 2008).

First, while educational initiatives are commonly used to instigate social or workplace change, these need be delivered in appropriate and context-specific ways to enhance their effectiveness (Klein et al., 2022b). To assist with the reframing of BPD narratives in order to disrupt them, it is imperative to bring lived experience perspectives or lived experience educators into practitioner training environments (Lamb et al., 2018). This is likely to create more empathetic and powerful pedagogic models that will potentially be more impactful to ongoing practice. As our findings demonstrate there is a critical need for new narratives to be generated that are different to the ones currently circulating in certain health-care settings.

Second, it is apparent that such narratives can have a profound influence on practice from health professionals' earliest exposure to the norms in these spaces, particularly in acute, short-term health-care contexts. Negative and inaccurate narratives can perpetuate poor approaches to care and treatment that people with a diagnosis of BPD often experience. Challenging narratives 'early on' during university-level education programmes and clinical rotations, by making more senior practitioners aware of how the stories told in these spaces have the potential to influence junior practitioners, could be a way to unsettle and subsequently change these. Disrupting and reframing narratives using lived experience pedagogic models and educational approaches, alongside raising awareness about their impact, are potential ways to improve current sociocultural–political relations.

AUTHOR CONTRIBUTIONS

Emma-Louise Seal: Conceptualisation (lead); methodology (lead); data curation (equal); investigation (equal); formal analysis (lead); writing—original draft (lead); writing—review and editing (equal). **Renata Kokanović**: Supervision (lead); funding acquisition (lead); investigation (equal); data curation (equal); writing—review and editing (equal). **Jacinthe Flore**: Funding acquisition (equal); investigation (equal); data curation (equal); writing—review and editing (equal). **Tamara Borovica**: data curation (equal); investigation (equal); formal analysis (equal); writing—review and editing (equal). **Jillian Broadbear**: writing—review and editing (equal). **Louise McCutcheon**: funding acquisition (supporting); writing—review and editing (equal). **Sharon Lawn**: writing—review and editing (equal).

ACKNOWLEDGEMENTS

This research study was funded by an Australian Research Council Linkage Project grant [LP190100247]. We would also like to acknowledge the contribution to this project by wider members of the research team, research participants who generously shared their experiences with us, and project partners for their invaluable support.

Open access publishing facilitated by RMIT University, as part of the Wiley - RMIT University agreement via the Council of Australian University Librarians.

CONFLICT OF INTEREST STATEMENT

The authors declare no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

DATA AVAILABILITY STATEMENT

Research data are not shared.

ETHICS STATEMENT

Ethics approval was obtained through the Melbourne Health Human Research Ethics Committee (HREC) based in Victoria, Australia, approval number: HREC/65990/MH-2020.

ORCID

Emma-Louise Seal https://orcid.org/0000-0001-8476-9201

ENDNOTE

[1] We know people with lived experience have different views about a diagnosis of BPD. In this article, we use the phrase 'people living with a BPD diagnosis' to indicate the lived experience of people who have received a diagnosis of BPD and people who identify aspects of their lived experience with symptoms associated with BPD (with or without a formal diagnosis). Our focus is on the lived and living experience of individuals navigating this complex terrain.

REFERENCES

Adler, J. M., Chin, E. D., Kolisetty, A. P., & Oltmanns, T. F. (2012). The distinguishing characteristics of narrative identity in adults with features of borderline personality disorder: An empirical investigation. *Journal of Personality Disorders*, *26*(4), 498–512. https://doi.org/10.1521/pedi.2012.26.4.498

Ansell, E. B., Sanislow, C. A., McGlashan, T. H., & Grilo, C. M. (2007). Psychosocial impairment and treatment utilization by patients with borderline personality disorder, other personality disorders, mood and anxiety disorders, and a healthy comparison group. *Comparative Psychiatry*, *48*(4), 329–336. https://doi.org/10.1016/j.comppsych.2007.02.001

Atkinson, P. (2009). Illness narratives revisited: The failure of narrative reductionism. *Sociological Research Online*, *14*(5), 196–205. https://doi.org/10.5153/sro.2030

Bois, C., Fazakas, I., Salles, J., & Gozé, T. (2023). Personal identity and narrativity in borderline personality disorder: A phenomenological reconfiguration. *Psychopathology*, *56*(3), 183–193. https://doi.org/10.1159/000526222

Bonnington, O., & Rose, D. (2014). Exploring stigmatisation among people diagnosed with either bipolar disorder or borderline personality disorder: A critical realist analysis. *Social Science & Medicine*, *123*, 7–17. https://doi.org/10.1016/j.socscimed.2014.10.048

Broadbear, J., Rotella, J.-A., Lorenze, D., & Rao, S. (2022). Emergency department utilisation by patients with a diagnosis of borderline personality disorder: An acute response to a chronic disorder. *Emergency Medicine Australasia*, *34*(5), 731–737. https://doi.org/10.1111/1742-6723.13970

Brossard, B., & Chandler, A. (2022). *Explaining mental illness: Sociological perspectives*. Bristol University Press.

Caddick, N., Smith, B., & Phoenix, C. (2015). Male combat veterans' narratives of PTSD, masculinity, and health. *Sociology of Health & Illness*, *37*(1), 97–111. https://doi.org/10.1111/1467-9566.12183

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

Chandler, A. (2015). *Self-injury, medicine and society*. Palgrave Macmillan.

Chandler, A. (2022). Masculinities and suicide: Unsettling 'talk' as a response to suicide in men. *Critical Public Health*, *32*(4), 499–508. https://doi.org/10.1080/09581596.2021.1908959

Chanen, A. M. (2021). Bigotry and borderline personality disorder. *Australasian Psychiatry*, *29*(6), 579–580. https://doi.org/10.1177/10398562211045151

Chesney, E., Goodwin, G., & Fazel, S. (2014). Risks of all-cause and suicide mortality in mental disorders: A meta-review. *World Psychiatry*, *13*(2), 153–160. https://doi.org/10.1002/wps.20128

Commons Treloar, A. J. (2009). Effectiveness of education programs in changing clinician's attitudes towards treating borderline personality disorder. *Psychiatric Services*, *60*(8), 1128–1131. https://doi.org/10.1176/appi.ps.60.8.1128

Commons Treloar, A. J., & Lewis, A. J. (2008). Targeted clinical education for staff attitudes towards deliberate self-harm in borderline personality disorder: Randomised controlled trial. *Australian and New Zealand Journal of Psychiatry*, *42*(11), 981–988. https://doi.org/10.1080/00048670802415392

Day, N. J., Hunt, A., Cortis-Jones, L., & Grenyer, B. F. (2018). Clinician attitudes towards borderline personality disorder: 15-year comparison. *Personality and Mental Health*, *12*(4), 309–320. https://doi.org/10.1002/pmh.1429

Deans C., and Meocevic E. (2006) 'Attitudes of registered psychiatric nurses towards patients diagnosed with borderline personality disorder'. *Contemporary Nursing*, *21*(1), 43–49. https://doi.org/10.5172/conu.2006.21.1.43

Dickens, G. L., Hallett, N., & Lamont, E. (2016). Interventions to improve mental health nurses' skills, attitudes, and knowledge related to people with a diagnosis of borderline personality disorder: Systematic review. *International Journal of Nursing Studies*, *56*, 114–127. https://doi.org/10.1016/j.ijnurstu.2015.10.019

Dobransky, K. (2011). Labelling, looping, and social control: Contextualising diagnosis in mental healthcare. *Sociology of Diagnosis: Advances in Medical Sociology*, *12*, 111–131.

Donald, F., Duff, C., Lawrence, K., Broadbear, J., & Rao, S. (2017). Consumer perspectives on personal recovery and BPD. *The Journal of Mental Health Training, Education and Practice*, *12*(6), 350–359. https://doi.org/10.1108/jmhtep-09-2016-0043

Duff, C., Kokanović, R., Flore, J., Thomas, S., Callard, F., & Blackman, L. (2020). Perspectives on person-centred care for borderline personality disorder: A critical research agenda. *Health Sociology Review*, *29*(1), 1–15. https://doi.org/10.1080/14461242.2020.1715815

Frank, A. W. (2010). *Letting stories breathe*. The University of Chicago Press.

Frank, A. W. (2012). Practicing dialogical narrative analysis. In J. Holstein & J. Gubrium (Eds.), *Varieties of narrative analysis* (pp. 33–52). Sage.

Freeman, M. (2002). The burden of truth: Psychoanalytic *poiesis* and narrative understanding. In W. Patterson (Ed.), *Strategic narrative: New perspectives on the power of personal and cultural stories* (pp. 2–27). Lexington Books.

Frías Á and Palma C. (2015). Comorbidity between post-traumatic stress disorder and borderline personality disorder: A review. *Psychopathology*, *48*(1), 1–10, https://doi.org/10.1159/000363145

Gunderson, J. (2011). Borderline personality disorder. *New England Journal of Medicine*, *364*(21), 2037–2042. https://doi.org/10.1056/nejmcp1007358

Hendry, N. (2020). New ways of seeing: Tumblr, young People, and mental Illness. In A. McCracken (Ed.), *A Tumblr book* (pp. 315–325). University of Michigan Press.

Johnson, M. L. (2021). Neuroqueer feminism: Turning with tenderness toward borderline personality disorder. *Signs: Journal of Women and Culture in Society*, *46*(3), 1–28. https://doi.org/10.1086/712081

Jones, D. (2023). A history of borderline: Disorder at the heart of psychiatry. *Journal of Psychosocial Studies, Online first*, *16*(2), 117–134. https://doi.org/10.1332/147867323X16871713092l3

Jutel, A. (2009). Sociology of diagnosis: A preliminary review. *Sociology of Health & Illness*, *31*(2), 278–299. https://doi.org/10.1111/j.1467-9566.2008.01152.x

Klein, P., Fairweather, A. K., & Lawn, S. (2022a). Structural stigma and its impact on healthcare for borderline personality: A scoping review. *International Journal of Mental Health Systems*, *16*(1), 48–89. https://doi.org/10.1186/s13033-022-00558-3

Klein, P., Fairweather, A. K., & Lawn, S. (2022b). The impact of educational interventions on modifying health practitioners' attitudes and practice in treating people with borderline personality disorder: An integrative review. *Systematic Reviews*, *11*(1), 108. https://doi.org/10.1186/s13643-022-01960-1

Knaak, S., Szeto, A. C., Fitch, K., Modgill, G., & Patten, S. (2015). Stigma towards borderline personality disorder: Effectiveness and generalizability of an anti-stigma program for healthcare providers using a pre-post randomized design. *Borderline Personality Disorder Emotional Dysregulation*, *5*(1), 2–9. https://doi.org/10.1186/s40479-015-0030-0

Kokanović, R., & Philip, B. (2014). Emotional talk: Depression, diagnosis and disclosure. In M. Davis & L. Manderson (Eds.), *Disclosure in health and illness* (pp. 56–71). Routledge.

Lam, D. C., Poplavskaya, E. V., Salkovskis, P. M., Hogg, L. I., & Panting, H. (2016). An experimental investigation of the impact of personality disorder diagnosis on clinicians: Can we see past the borderline. *Behavioural and Cognitive Psychotherapy*, *44*(3), 361–373. https://doi.org/10.1017/S1352465815000351

Lamb, N., Sibbald, S., & Stirzaker, A. (2018). Shining lights in dark corners of people's lives: Reaching consensus for people with complex mental health difficulties who are given a diagnosis of personality disorder. *Criminal Behaviour and Mental Health*, *28*(1), 1–4. https://doi.org/10.1002/cbm.2068

Lamont, E., & Dickens, G. E. (2019). Mental health services, care provision, and professional support for people diagnosed with borderline personality disorder: Systematic review of service-user, family, and carer perspectives. *Journal of Mental Health*, *30*(5), 619–633. https://doi.org/10.1080/09638237.2019.1608923

Lawn, S., & McMahon, J. (2015). Experiences of care by Australians with a diagnosis of borderline personality disorder. *Journal of Psychiatric and Mental Health Nursing*, *22*(7), 510–521. https://doi.org/10.1111/jpm.12226

Llewellyn-Beardsley, J., Rennick-Egglestone, S., Callard, F., Pollock, K., Slade, M., & Edgley, A. (2023). "Nothing's changed, baby": How the mental health narratives of people with multiple and complex needs disrupt the recovery framework. *SSM Mental Health*, *3*, 100221. https://doi.org/10.1016/j.ssmmh

Lumivero. (2017). NVivo (Version 12). www.lumivero.com

Manning, N. (2001). Psychiatric diagnosis under conditions of uncertainty: Personality disorder, science and professional legitimacy. *Sociology of Health & Illness*, *22*(5), 621–639. https://doi.org/10.1111/1467-9566.00223

Markham, D. (2003). Attitudes towards patients with a diagnosis of 'borderline personality disorder': Social rejection and dangerousness. *Journal of Mental Health*, *12*(6), 595–612. https://doi.org/10.1080/09638230310001627955

Moen, T. (2006). 'Reflections on the narrative research approach. *International Journal of Qualitative Methods*, *5*(4), 56–69. https://doi.org/10.1177/160940690600500405

Mulder, R., & Tyrer, P. (2023). Borderline personality disorder: A spurious condition unsupported by science that should be abandoned. *Journal of the Royal Society of Medicine*, *116*(4), 148–150. https://doi.org/10.1177/01410768231164780

Ng, F. Y. Y., Townsend, M. L., Miller, C. E., Jewell, M., & Grenyer, B. (2019). The lived experience of recovery in borderline personality disorder: A qualitative study. *Borderline Personality Disorder and Emotional Dysregulation*, *6*(10), 1–9. https://doi.org/10.1186/s40479-019-0107-2

Norrick, N. R. (2005). The dark side of tellability. *Narrative Inquiry*, *15*(2), 323–343. https://doi.org/10.1075/ni.15.2.07nor

Ochs, E., & Capps, L. (2001). *Living narrative: Creating lives in everyday storytelling*. Harvard University Press.

Phoenix, C., & Sparkes, A. C. (2009). Being Fred: Big stories, small stories and the accomplishment of a positive ageing identity. *Qualitative Research*, *9*(2), 219–236. https://doi.org/10.1177/1468794108099322

Pickersgill, M. (2013). How personality became treatable: The mutual constitution of clinical knowledge and mental health law. *Social Studies of Science*, *43*(1), 30–53. https://doi.org/10.1177/0306312712457722

Pickersgill, M. (2023). Stalling or oiling the engines of diagnosis? Shifting perspectives on the DSM and categorical diagnosis in psychiatry. *Sociology of Health & Illness*, *46*(S1), 132–151. Online first. https://doi.org/10.1111/1467-9566.13682

Powers, A., Petri, J. M., Sleep, C., Mekawi, Y., Lathan, E. C., Shebuski, K., Bradley, B., & Fani, N. (2022). Distinguishing PTSD, complex PTSD, and borderline personality disorder using exploratory structural equation modeling in a trauma-exposed urban sample. *Journal of Anxiety Disorders*, *88*, 102558. https://doi.org/10.1016/j.janxdis.2022.102558

Proctor, J., Lawn, S., & McMahon, J. (2021). Consumer perspectives from people with a diagnosis of BPD, on BPD management – how are the Australian NHMRC BPD guidelines faring in practice? *Journal of Psychiatric and Mental Health Nursing*, *28*(4), 670–681. https://doi.org/10.1111/jpm.12714

Redikopp, S. (2018). Borderline knowing: (Re)valuing borderline personality disorder as (counter) knowledge. *Word and Text: A Journal of Literary Studies and Linguistics*, *8*(1), 77–92.

Redikopp, S., & Smith, S. (2022). Interrogating nonsuicidal self-injury disorder through a feminist psychiatric disability theory framework. *Sociology of Health & Illness*, *45*(6), 1205–1222. https://doi.org/10.1111/1467-9566.13560

Riessman, K. (2008). *Narrative methods for the human sciences*. Sage.

Ring, D., & Lawn, S. (2019). Stigma perpetuation at the interface of mental health care: A review to compare patient and clinician perspectives of stigma and borderline personality disorder. *Journal of Mental Health*, *12*, 1–21. https://doi.org/10.1080/09638237.2019.1581337

Russ, J. (2016). In dialogue with conventional narrative research in psychiatry and mental health. *Philosophy, Psychiatry, and Psychology*, *23*(3), 215–228. https://doi.org/10.1353/ppp.2016.0021

Schmidt, P., & Fuchs, T. (2020). The unbearable dispersal of being: Narrativity and personal identity in borderline personality disorder. *Phenomenology and the Cognitive Sciences*, *20*(2), 321–340. https://doi.org/10.1007/s11097-020-09712-z

Shaw, C., & Proctor, G. (2005). Women at the margins: A critique of the diagnosis of borderline personality disorder. *Feminism & Psychology*, *15*(4), 483–490. https://doi.org/10.1177/0959-353505057620

Smith, B., & Monforte, J. (2020). Stories, new materialism and pluralism: Understanding, practising and pushing the boundaries of narrative analysis. *Methods in Psychology*, *2*, 100016. https://doi.org/10.1016/j.metip.2020.100016

Sparkes, A. C., & Stewart, C. (2019). Stories as actors causing trouble in lives: A dialogical narrative analysis of a competitive cyclist and the fall from grace of lance Armstrong. *Qualitative Research in Sport, Exercise and Health*, *11*(4), 460–477. https://doi.org/10.1080/2159676X.2019.1578253

Sulzer, S. (2015). Does difficult patient status contribute to defacto demedicalization? The case of borderline personality disorder. *Social Science & Medicine*, *142*, 182–189. https://doi.org/10.1016/j.socscimed.2015.08.008

Sulzer, S., Jackson, G., & Yang, A. (2016). Borderline personality disorder and the biomedical mismatch. *Advances in Medical Sociology*, *17*, 263–290. https://doi.org/10.1108/S1057-629020160000017011

Ussher, J. M. (2013). Diagnosing difficult women and pathologising femininity: Gender bias in psychiatric nosology. *Feminism & Psychology*, *23*(1), 63–69. https://doi.org/10.1177/0959353512467968

Veysey, S. (2013). People with a borderline personality disorder diagnosis describe discriminatory experiences. *Kōtuitui: New Zealand Journal of Social Sciences Online: New Zealand Journal of Social Sciences*, *9*(1), 20–35. https://doi.org/10.1080/1177083X.2013.871303

How to cite this article: Seal, E.-L., Kokanović, R., Flore, J., Borovica, T., Broadbear, J. H., McCutcheon, L., & Lawn, S. (2024). Talking about borderline personality disorder, shaping care: The multiple doings of narratives. *Sociology of Health & Illness*, 1–21. https://doi.org/10.1111/1467-9566.13804