

Structural stigma and its impact on healthcare for borderline personality disorder: a scoping review

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Abstract

Background

People with Borderline Personality Disorder (BPD) and their carers/families continue to experience structural stigma when accessing health services. Structural stigma involves societal-level conditions, cultural norms, and organizational policies that inhibit the opportunities, resources, and wellbeing of people living with attributes that are the object of stigma. BPD is a serious mental illness characterized by pervasive psychosocial dysfunction including, problems regulating emotions and suicidality. This scoping review aimed to identify, map, and explore the international literature on structural stigma associated with BPD and its impact on healthcare for consumers with BPD, their carers/families, and health practitioners.

Methods

A comprehensive search of the literature encompassed MEDLINE, CINAHL, PsycINFO, Scopus, Cochrane Library, and JBI Evidence-Based databases (from inception to February 28th 2022). The search strategy also included grey literature searches and handsearching the references of included studies. Eligibility criteria included citations relevant to structural stigma associated with BPD and health and crisis care services. Quality appraisal of included citations were completed using the Mixed Methods Appraisal Tool 2018 version (MMAT v.18), the Joanna Briggs Institute (JBI) Checklist for Systematic Reviews and Research Syntheses Tool, or the AGREE II: advancing guideline development, reporting, and evaluation in health care tool. Thematic Analysis was used to inform data extraction, analysis, interpretation, and synthesis of the data.

Results

A total of fifty-seven citations were included in the review comprising empirical peer-reviewed articles (n = 55), and reports (n = 2). Studies included quantitative, qualitative, mixed methods, and systematic review designs. Review findings identified several extant macro- and micro-level structural mechanisms, challenges, and barriers contributing to BPD-related stigma in healthcare systems. These structural factors have a substantial impact on health service access and care for BPD. Key themes that emerged from the data comprised: structural stigma and the BPD diagnosis; structural stigma surrounding health and crisis care services; and practitioner-patient interactions.

Conclusion

Narrative synthesis of the findings provide evidence about the impact of structural stigma on healthcare for BPD. Results of this review are anticipated to inform future research, policy, and practice in addressing BPD-related stigma in healthcare systems, as well as approaches for improving responsive care delivery for consumers with BPD and their carers/families.

Background

Consumers with a diagnosis of BPD and their carers/families are often confronted with structural stigma when accessing health services for their mental health condition [1–4]. Structural stigma is defined as the societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and wellbeing of the stigmatized” ([5] p.742). Stigma is a multi-level phenomenon that occurs within various interpersonal, organisational, and structural context; and causes health inequities in accessing services and supports [5], and poor health outcomes [6] for consumers with BPD [3, 7–9] and their carers/families [1, 2, 10, 11]. BPD is a serious mental illness associated with longstanding effects of five or more symptoms relating to persistent patterns of instability in psychosocial functioning including, problems regulating emotions, self-image, interpersonal relationships, impulsivity, and suicidality [12]. The global lifetime prevalence of BPD is up to 6% in the general population [13–16]; 10% of consumers in outpatient settings, and up to 22% of consumers in inpatient settings [13, 17, 18].

BPD is a complex and contentious diagnosis [19], partly because evidence is yet to determine the exact cause of the condition. However, the trajectory is likely to be linked to genetic and environmental factors including childhood abuse [20, 21] and insecure attachment. These traumatic experiences can have debilitating effects on the ability of consumers with BPD to form healthy trusting relationships and develop the resilience needed to cope with the pressures of everyday life [22]. Consumers with BPD are a high-risk group for suicide [23] as trauma can trigger heightened emotions, often resulting in repetitive cycles of intense distress, crises, and suicidality (i.e., self-harm, suicidal ideation, and suicide attempts) [24, 25]. Chesney et al. [26] conducted a meta-review on the risk for suicide mortality associated with major psychiatric disorders and found that the suicide risk among consumers with BPD was 45% greater than the general population, and disproportionately higher than other psychiatric disorders. Other studies investigating the prevalence of suicidality found that 75% of people with BPD attempted suicide [27], and up to 10% of people with BPD died by suicide [28].

Recurrent presentations to health services following suicidality among this population place increased demand on healthcare systems [27, 29]. This is particularly evident in emergency services; however, the care provided is often not adequate in meeting the complex needs of consumers with BPD [10]. A recent study investigating the prevalence of mental health presentations among consumers with personality disorders indicated that 20.5% of these consumers presented to emergency services, and 26.6% of consumers with personality disorders presented to inpatient services. Further, consumers with personality disorders were 50% more likely to access health services in crisis within 28 days of their last presentation, than consumers with other mental health disorders [30]. Another study investigating health service utilization found that specialist psychotherapy services, day treatments, residential programs, outpatient, and inpatient medical services were accessed at higher rates by consumers with BPD, than other consumers [29]. Findings from a community sample also found that 75% of people with BPD accessed help from a range of health professionals including physicians, therapists, and counsellors for their

mental illness [31]. The high prevalence of presentations to health services by consumers with BPD in crisis [15, 27, 28] has resulted in this disorder becoming one of the most highly stigmatized and marginalized mental health conditions in healthcare systems [32, 33].

There is a growing body of research exploring the experiences of BPD-related stigma among consumers with BPD [3, 7–9, 34, 35]; and their carers/families [1, 2, 11] when accessing health services. Consumers with BPD consistently reported receiving poor levels of care from health services including, being treated disrespectfully and not being believed [3]. These experiences reported by consumers with BPD appear to stem from the myths surrounding suicidality and BPD such as, deliberate self-harm being perceived as manipulative behaviour rather than a symptom of the disorder [36]. There are also reports of interactions between consumers with BPD, their carers/families, and health practitioners resulting in conflict [37]. In some instances, consumers with BPD report that they are refused treatment by health practitioners when presenting to health services in crisis [38, 39]. Carers/families of consumers with BPD have reported experiencing intense feelings of worry, grief, and social isolation associated with caring for their family member with BPD. Carers/families also experience substantial ongoing financial burdens [11, 40] in response to the costs of private health services (such as evidence-based therapies) and hospitalization of the person with BPD that they are caring for. Access to clinical and community-based services and supports for both consumers with BPD and their carers/families are limited, making it difficult to receive treatment and support when needed [3, 4].

There are also concerns regarding the inadequacy of existing health services' capacity to meet the complex needs of consumers with BPD and their carers/families [34, 35, 41]. These structural and service-related problems stem from the lack of funding allocated to research, health services and supports [42, 43], and insufficient education, training, and supervision for health practitioners dedicated to working with consumers with BPD in healthcare settings [44–54]. In addition, there are concerns regarding some health practitioners' negative beliefs, attitudes, and practices when working with consumers with BPD [38, 39, 53]. Ungar et al.'s [55] study examined mental health practitioners' beliefs and attitudes to treating consumers with BPD and found that more than 80% of staff agreed that consumers with BPD were more challenging to work with than consumers with other mental health disorders. Deans et al.'s [56] study found that 89% of registered psychiatric nurses (n = 47) agreed with the statement that consumers with BPD are manipulative. These findings are consistent with other studies exploring health practitioners' perspectives and behaviour towards BPD [57, 58].

While there is vast literature on the perspectives and experiences of stigma among consumers with BPD [3, 9, 34, 59–71], their carers/families [1, 2, 4, 10, 11, 40, 72], and health practitioners [19, 38, 50–54, 56, 73–90], currently there is limited knowledge about the structural mechanisms contributing to BPD-related stigma in healthcare systems, and the impacts these factors impart on the delivery of services and care to consumers with BPD and their carers/families. Exploring the body of literature addressing stigma in relation to BPD will allow us to identify the existing structural problems in healthcare systems and inform recommendations for attending to these significant public health concerns [29].

Aim and research questions

The aim of this scoping review is to identify, map, and provide a broad overview of the international literature on structural stigma associated with BPD and its impact on healthcare for consumers with BPD, their carers/families, and health practitioners. This includes understanding how structures in healthcare systems such as, institutional policies, cultural norms, and organizational practices affect the availability and accessibility of quality health services and care for consumers with BPD and their carers/families. The primary research question addresses: How does structural stigma relevant to the diagnosis of BPD impact on the provision of health services and care for people with BPD, their carers/families, and health practitioners? Secondary research questions were also explored to gain a deeper understanding of the mechanisms, challenges, and barriers influencing BPD-related stigma in healthcare systems, as follows: (1) What are the perspectives and lived experiences of structural stigma among consumers with BPD, their carers/families, and health practitioners? (2) What are the specific drivers influencing the manifestation and perpetuation of BPD-related structural stigma in healthcare systems, and the implications for research, policy, and practice? [91].

Methods

The scoping review was registered within the Open Science Framework (registration ID: (<https://osf.io/bhpg4>)). A scoping review methodology was chosen to achieve the aim of this review based on its broad application to mapping, exploring, and synthesizing extant international literature, and identifying gaps in knowledge [92]. Scoping review approaches are useful for understanding the complexity of concepts relating to healthcare and informing evidence-based practice [93]. The review process followed JBI guidelines for scoping reviews [94] and Arksey and O'Malley's [95] five-step process for scoping reviews framework: (1) identifying the research question; (2) identifying relevant studies; (3) study selection; (4) charting data; and (5) collating, summarizing, and reporting the results.

Identifying relevant studies

We undertook a comprehensive systematic search of electronic databases for peer-reviewed papers published from inception to February 28th 2022 using MEDLINE (Ovid), CINAHL (EBSCO Connect), PsycINFO (Ovid), Scopus (Elsevier), Cochrane Library (Wiley), and JBI Evidence-Based Database (Ovid). A search of grey literature using Google search engine was conducted to identify other relevant citations such as, clinical practice guidelines for BPD. The references of included citations from both the peer-reviewed and grey literature searches were hand-searched to identify any additional relevant citations. Additional file 1 presents the PsycINFO search strategy and the grey literature key words. Search terms were developed relevant to the three categories of search key terms: (a) BPD; (b) stigma; and (c) crisis care. Draft searches were executed in PsycINFO (Ovid) to test the search text word terms and subject heading combinations. Search terms were refined during iterative test searches resulting in a comprehensive search strategy to identify all existing peer-reviewed articles relating to BPD-related stigma in healthcare systems. Risk of selection bias was minimized by using the varied methods of study sourcing. The eligibility criteria (Table 1), based on the Population-Concept-Context (PCC) framework [94], guided the study selection process during screening.

Table 1 Eligibility criteria

Population, Concept, Context	Criteria
Population	Health practitioners including, psychiatrists, psychologists, social workers, mental health nurses, general practitioners, primary care nurses, and other mental health workers who treat people with BPD in healthcare settings such as, outpatients, inpatients, and community-based settings
Concept	Structural stigma specific to BPD and crisis care
Context	International peer-reviewed studies investigating educational interventions designed to modify health practitioners' attitudes and practice in treating people with BPD in healthcare settings
Inclusion criteria	Exclusion criteria
Articles included:	Articles excluded:
Evaluated educational interventions designed to modify health practitioners' attitudes and practice in treating people with BPD in an outpatient, inpatient, and community-based setting	Evaluated health practitioners' treating people with other mental illnesses
Evaluated structural stigma as an outcome in healthcare settings	Not reporting outcomes specific to borderline personality disorder and structural stigma
Original research including peer-reviewed publications on quantitative, qualitative, mixed-methods, and review designs	Not conducted in non-clinical settings such as, educational institutions
Written in English language only	Studies of low quality

Study selection

All citations identified from the search were collated and uploaded into Endnote V.9. Citations were then uploaded into Covidence and deduplicated by the lead author (PK). Citation screening and selection were undertaken using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement [96] (Additional file 2). Two independent reviewers (PK and AKF) screened the titles, abstracts, and full-text citations against the defined selection criteria to identify relevant studies. Full-text citations of selected studies were retrieved via Covidence and assessed against the inclusion criteria, with citations that were found to be ineligible omitted in accordance with the exclusion criteria (Table 1). Discrepancies in decisions regarding the inclusion of studies at both the title/abstract screening stage and the full-text stage were accessed and resolved by a third reviewer (SL) with clinical expertise in the field of mental health.

Charting the data

Data identified for inclusion in this review were extracted into a charting table following meetings held by the research team (PK, AKF, SL) where the type of information to be extracted from the eligible citations were discussed and consensus reached. The charting table of included studies used the following fields: Author, year, Country; quality rating; population data; aim/purpose; study design; methods; and main findings (Table 2). Data extraction was led by the first author (PK) and checked and revised by the second author (AKF).

Quality appraisal

Quality appraisal of all citations was undertaken to reduce the risk of bias. The MMAT v.18 checklist [97] was used to determine methodology quality of the quantitative, qualitative and mixed methods studies for inclusion into this review. The JBI Checklist for Systematic Reviews and Research Syntheses tool [98] was used to appraise methodological rigor of the reviews; and the AGREE II: advancing guideline development, reporting, and evaluation in health care tool [99] was used to appraise the Clinical Practice Guidelines for the treatment and management of BPD (from here on known as Guidelines). Meetings were held by the research team (PK, AKF, SL) to discuss the items within the quality appraisal tools and processes for assessing the methodological quality of the included citations. This included establishing an agreed cut-off criteria for excluding low quality studies in accordance with the eligibility criteria. Initially, one reviewer (PK) conducted the quality appraisals of the citations. Two reviewers (PK and AKF) then met to review the quality appraisals of the studies and highlight any concerns; where issues were identified, resolution was achieved through discussion. A third reviewer (SL) was available to resolve any discrepancies between the two reviewers; however, no further resolution was required.

Collating and summarizing the findings

Data were collated, analysed, and synthesized using Braun and Clarke's [100] Thematic Analysis. Results of the review were synthesized into a narrative summary of the study aims, research questions, and eligibility criteria (PCC). Data analyses involved: (1) quantitative data being summarized using

Table 2

Data extraction of study characteristics on borderline personality disorder related structural stigma in healthcare systems

Author, Year, Country	MMAT v.18/ JBI Quality Rating*	Population data	Aim/ Purpose	Study design	Methods/ Intervention	Main Findings
Acres et al. 2019, AUS [10]	JBI, Level 1.b/ Level 4*	Carers (N = 1891). Emergency care settings. Sources of evidence (N = 10): research studies (n = 7), advocacy brief (n = 1), clinical practice guideline (n = 1), action plan (n = 1)	Explore, locate, and compile literature detailing the perspectives of family carers of people with BPD in Emergency Departments (ED) with a focus on nursing practices	Scoping review	Review of the literature	Carers perceived ED as the only option for emergency care in a crisis. Carers require information on how to manage a crisis with their loved one. Carers are often not consulted with by health professionals; and perceive that health professionals lack understanding of consumers distress and BPD - a key barrier to effective crisis care.
Bodner et al. 2011, IL [75]	***	Health practitioners (N = 57): Males (n = 35), females (n = 65) Age, range (25–65 years old). Psychiatric hospital settings	Develop and use inventories that measure cognitive and emotional attitudes of health practitioners toward patients with BPD	Quantitative study	Surveys	Psychologists scored lower than psychiatrists and nurses on antagonistic judgments; nurses scored lower than psychiatrists and psychologists on empathy. Analyses conducted on the three emotional attitudes separately showed that suicidal tendencies of BPD patients explained negative emotions and difficulties in treating these patients.
Bodner et al. 2015, IL [76]	****	Health practitioners (N = 710): Age, range (40–47 years old). Years of service, range (11–21 years). Psychiatric hospitals (N = 4)	Improve Bodner et al 2011 sample; inspect if nurses' tendency to express more negative attitudes toward BPD is evident in a larger sample	Quantitative study	Surveys	Nurses and psychiatrists reported higher number of patients with BPD, exhibited more negative attitudes, and less empathy toward these patients than other professions. Negative attitudes were positively correlated with caring for greater numbers of patients with BPD. Nurses expressed the greatest interest in studying short-term methods; psychiatrists expressed interest in improving professional skills for BPD.
Borschmann et al. 2014, UK [7]	****	1. People with BPD (N = 41). 2. Males (n = 7, 17%), female (n = 34, 82%). Mean age (SD) 36, (11). Community services	Examine crisis care preferences of community-dwelling adults with BPD	Qualitative study	Thematic Analysis of crisis plans	Participants gave clear statements in their crisis plans about the desire to recover from the crisis and improve their social functioning. Key themes included: the desire to be treated with dignity and respect; to receive emotional and practical support from clinicians; and preferences for treatment refusals during crises such as, psycho-tropic medication and involuntary treatment.
Buteau et al. 2008 [1]	*****	Carers of people with BPD/ families (N = 12). Males (n = 2), and females (n = 10)	To learn from families what their experiences have been in four key areas: (1) knowledge about BPD, (2) BPD treatments, (3) coping with BPD, and (4) reasons for hope	Qualitative study	Semi-structured interviews	Families identified five key areas of concern: (1) difficulty accessing current evidence-based knowledge about BPD/ treatments, (2) a stigmatizing health care system, (3) prolonged hopelessness, (4) shrinking social networks, and, (5) financial burdens. To improve the quality of services for families affected by BPD, social workers must educate themselves on BPD, BPD treatment options, information, and resources.

Author, Year, Country	MMAT v.18/ JBI Quality Rating*	Population data	Aim/ Purpose	Study design	Methods/ Intervention	Main Findings
Carrotte et al. 2019, AUS [61]	*****	A total of 12 participants comprising, people with BPD (n = 9), carers (n = 3)	Identify treatment and support services accessed by people with BPD and their carers; perceived benefits and challenges associated with these services; and recommended changes to services	Qualitative study	Semi-structured interviews, focus groups	Themes revealed: identity and discovery; (mis)communication; complexities of care; finding what works; an uncertain future; and carer empowerment. Participants described community-based psychotherapy as critical for reducing symptoms of BPD and improving services. Macro- and micro-levels relating to costs, service access, and clinician-client factors were discussed.
Clarke et al. 2015, UK [54]	****	Health practitioners (N = 44): Years of service, range (1–10 years or more). Inpatient setting	To assess whether training in neurobiological underpinnings of BPD could improve knowledge and attitude change of staff	Within-subjects, quantitative survey design	Surveys relating to delivery of 'The Science of BPD' training	Attendance at the training session was associated with significant increases in theoretical knowledge, perspective taking and mental health locus of origin. There were no changes observed in empathic concern. A brief training session utilizing a neurobiological framework can be effective in facilitating knowledge and attitudinal change among health practitioners working with BPD.
Commons Treloar et al. 2008, AUS [84]	****	Medical and health practitioners (N = 140). Males (n = 48), females (n = 92). Years of service, range (1–16 years). Emergency care, Mental health services settings	To assess the attitudes of clinicians towards patients diagnosed with BPD	Quantitative study	A purpose-designed survey	Significant differences were found among emergency medical and mental health staff in their attitudes to people with BPD. The strongest predictor of attitudes to self-harm were whether the practitioner worked in emergency medicine or mental health, years of experience, and training in BPD.
Commons Treloar et al. 2009a, AUS [83]	*****	Medical and health practitioners (N = 140). Males (n = 48), females (n = 92). Emergency medicine, Mental health services settings (N = 3)	To explore health practitioners' experiences and attitudes in working with patients with BPD	Qualitative study	Qualitative survey	Results revealed four themes: BPD patients generate an uncomfortable personal response in health practitioners, characteristics of BPD contribute to negative health practitioner/service responses, inadequacies of the health system in addressing BPD patient needs, and strategies needed to improve services for BPD. Findings suggest that interpersonal and system difficulties may have impacted the services for BPD.
Commons Treloar et al. 2009b, AUS [52]	***	Registered health practitioners (N = 65). Males (n = 26, 40%), females (n = 39, 60%). Years of service (1 year or more). Psychiatric hospital settings	To examine two theoretical educational frameworks (cognitive-behavioural and psychoanalytic), compared with no education to assess subsequent differences in health practitioners' attitudes to deliberate self-harm behaviours in BPD	A randomized comparative quasi-experimental study	Surveys/ 'Cognitive Behavioural Therapy Program', 'Psychotherapy Program' training	Compared with participants in the control group (N = 22), participants in the cognitive-behavioural program (N = 18) showed significant improvement in attitudes after attending the training, as did participants in the psychoanalytic program (N = 25). At six-month follow-up, the psychoanalytic group maintained significant changes in attitude. Results support the use of brief educational interventions in sustaining attitude change to working with this population.

Author, Year, Country	MMAT v.18/ JBI Quality Rating*	Population data	Aim/ Purpose	Study design	Methods/ Intervention	Main Findings
Day et al. 2018, AUS [85]	***	3. Mental health practitioners (N = 66). Males (n = 22, 33.3%), female (n = 44, 66.7%). Public health service settings	To investigate mental health practitioners' attitudes to individuals with BPD where attitudes were compared over time	Longitudinalmixed methods design	Surveys, Semi-structured interviews	The 2000 sample (n = 33) endorsed more negative descriptions (e.g.,) 'attention seeking', 'manipulative', and the 2015 sample (n = 33) focused more on treatment approaches and skills (e.g.,) 'management plan', 'empathy'. The 2015 sample endorsed more positive attitudes than the 2000 sample. This positive attitudinal shift may reflect a changing landscape of the mental health system and greater awareness and use of effective treatments.
Deans et al. 2006, AUS [56]	****	Registered psychiatric nurses (N = 47). Males (n = 14, 30%), females (n = 34, 70%). Age, range (21–60 years old). 15 years or more (53%) of service. Psychiatric inpatient and community services	To describe psychiatric nurses' attitudes to individuals with BPD	Quantitative study	Survey	Results show that a proportion of psychiatric nurses' experience negative reactions and attitudes to people with BPD, perceiving them as manipulative, and feeling angry towards them. One third of nurses reported they 'strongly disagreed' or 'disagreed' that they know how to care for people with BPD.
Dickens et al. 2016, UK [51]	JBI, Level 1.b/ Level 4*	Mental health nurses (N = 1197). 9 studies across 6 Countries	To collate evidence on interventions devised to improve the responses of mental health nurses to people with BPD	Systematic Review	Review of the literature	Eight studies were included in this review, half of which were judged to be methodologically weak, and the remaining four studies judged to be of moderate quality. Only one study employed a control group. The largest effect sizes were found for changes related to cognitive attitudes including knowledge; smaller effect sizes were found in relation to changes in affective outcomes. Mental health nurses hold the poorest attitudes to people with BPD.
Dickens et al. 2019, UK [50]	****	4. Mental health nurses (N = 28, training and pre-and post- surveys; N = 16, 4-month survey; N = 11, focus groups). Inpatient and community settings	To evaluate mental health nurses' responses and experiences of an educational intervention for BPD	Mixed methods	Surveys, Focus Groups/ 'Positive about Borderline' training	Results revealed some sustained changes consistent with expected attitudinal gains in relation to the perceived treatment characteristics of this group, the perception of their suicidal tendencies and negative attitudes. Qualitative findings revealed hostility towards the underpinning biosocial model and positive appreciation for the involvement of an expert by experience.
Dunne & Rogers, 2013, UK [2]	*****	Carers (N = 8). Community Personality Disorder Service	To explore carers' experiences of the caring role, and mental health and community services	Qualitative study	Focus groups	The first carers' focus group exploring the role of mental health services produced four super-ordinate themes. The second carers' focus groups experiences in the community produced six super-ordinate themes. It seems carers of people with BPD are often overlooked by mental health services, and subsequently require more support to ensure their own well-being.

Author, Year, Country	MMAT v.18/ JBI Quality Rating*	Population data	Aim/ Purpose	Study design	Methods/ Intervention	Main Findings
Ekdahl et al. 2015, SE [72]	*****	5. Carers/ significant others (N = 19). Of the 19, 11 were involved in focus groups. Males (n = 5), females (n = 14). Age, range (43–75 years old). Psychiatric and health service settings	To describe significant others' experiences of living close to a person with BPD and their experience of psychiatric care	Qualitative study	Qualitative Survey, Focus groups	Results revealed four categories: a life tiptoeing, powerlessness, guilt, and lifelong grief, feeling left out and abandoned, and lost trust. The first two categories describe the experience of living close to a person with BPD, and the last two categories describe encounters with psychiatric care.
Fallon 2003, UK [64]	****	People with BPD (N = 7). Psychiatric services	To analyse the perspectives and lived experiences of participants with BPD contact with psychiatric services	Qualitative study	Unstructured interviews	Results found that people with BPD valued contact with psychiatric services despite negative staff attitudes and experiences. Relationships with others was vital in containing their distress despite trusting issues. Overcoming this was achieved by consistent long-term involvement with staff, containing relationships, encouraging participants to contribute to their care, and improving understanding of BPD.
Hauck et al. 2013, USA [87]	****	Psychiatric nurses (N = 83) Males (n = 8, 9.6%); females (n = 75, 90.3%). Age, range (21–65 years old). Psychiatric hospitals (N = 3)	To explore the attitudes of psychiatric nurses to patients with BPD experiencing self-harm	Descriptive, correlational Design	Surveys	Psychiatric nurses had positive attitudes toward hospitalized BPD patients with deliberate self-harm. Psychiatric nurses with more years of nursing experience and self-reported need for further BPD education had more positive attitudes.
Horn et al. 2007, UK [67]	*****	6. People with BPD (N = 5). Male (n = 1), female (n = 4). Age, range (23–44 years old). Mental health services	To explore user experiences and understandings of being given the diagnosis of BPD	Qualitative study	Semi-structured interviews	Analysis identified five themes: knowledge as power, uncertainty about what the diagnosis meant, diagnosis as rejection, diagnosis is about not fitting, hope and the possibility of change. Positive and negative aspects to these themes were apparent.
James et al. 2007, IL [101]	***	Psychiatric nurses (N = 157). 7. Males (n = 21, 32%), 8. females (n = 44, 68%). 9. Age, range (< 25->50). Years of service (< 2->15 years old). Various Psychiatric services	To describe the experiences and attitudes of nurses who deliver nursing care to people with BPD	Descriptive survey research design	Surveys	Results indicated that most nurses have regular contact with clients with BPD and nurses on inpatient units reported more frequent contact than nurses in the community. Eighty per cent of nurses viewed clients as more difficult to care for than other clients and believe that the care they receive is inadequate. Lack of services was the most important factor contributing to the inadequate care and the development of a specialist service as the most important to improve care.

Author, Year, Country	MMAT v.18/ JBI Quality Rating*	Population data	Aim/ Purpose	Study design	Methods/ Intervention	Main Findings
Keuroghlian et al. 2006, USA [49]	****	Medical and health practitioners 10. (N = 297). Males (n = 25, 25.3%), females (n = 75, 74.7%) 11. Mean years of service (SD) (17 years old (12). Medical centres, hospitals	To assess the effectiveness of Good Psychiatric Management workshops at improving clinicians' attitudes to BPD; to assess if attitude changes relate to years of experience; and, compare the magnitude of change after GPM workshops to those from STEPPS workshop	Pre-post (repeated measures) design	Surveys/ 'Good Psychiatric Management' training	Participants reported a decrease in the inclination to avoid, or dislike, patients with BPD, and belief that the prognosis is hopeless. were Participants also reported increased feelings of professional competence, belief that they can make a positive difference, and that effective psychotherapies do exist. Findings demonstrate Good Psychiatric Management's potential for training health practitioners to meet the needs of people with BPD.
Knaak et al. 2015, CA [48]	***	Health practitioners (N = 187). 12. Males (n = 28, 15%), female (n = 159, 85%. Mean age (39.1 years old). Mean years of service (22.2). Health services	To identify whether a generalist or specialist approach is the better strategy for anti-stigma programming for stigmatized disorders, and to examine the extent an intervention led to change in perceptions of people with BPD and mental illness	Pre-post design	Surveys/ 'Dialectical Behaviour Therapy' training	Results suggest that the intervention was successful at improving healthcare provider attitudes and behavioural intentions towards persons with BPD. The results further suggest that anti-stigma interventions effective at combating stigma against a specific disorder may also have positive generalizable effects towards a broader set of mental illnesses.
Koehne et al. 2012, AUS [19]	*****	Medical and health practitioners (N = 15). (Psychiatric hospitals (N = 3). Child and Adolescent Mental Health Services	Do mental health clinicians share diagnostic information about BPD with their adolescent clients, and if so, how? What are the factors that guide clinical practice in the decision to disclose or to withhold a diagnosis of emerging BPD to adolescents?	Qualitative study	Semi-structured interviews	Findings found that doctors, nurses, and allied health practitioners resisted a diagnosis of BPD in their work with adolescents. We delineate specific social and discursive strategies that health practitioners displayed including: team rules discouraged diagnostic disclosure, the lexical strategy of hedging when using the diagnosis, the prohibition and utility of informal 'borderline talk' among health practitioners reframed the diagnosis with young people.
Lawn et al. 2015a, AUS [3]	***	13. People with BPD (N = 153). Age, range (18–65 years and older) 14. 15.	To explore the lived experiences of health service access from the perspective of Australians with BPD	Quantitative study	Survey	Responses from 153 consumers with BPD showed that they experience significant challenges and discrimination when accessing public and private health services. Seeking help from emergency departments during crises was challenging. Community support services were perceived as inadequate to meet patient needs.
Lawn et al., 2015b, AUS [4]	***	Carers (N = 121). Males (n = 24, 25.5%), female (n = 78, 76.5%). Age, range (mostly 50-60s). Various health and community services settings	To explore their experiences of being carers, attempts to seek help for the person diagnosed with BPD, and their own carer needs	Quantitative study	Surveys	Responses from 121 carers found carers experience significant challenges and discrimination when accessing health services. Comparison with consumers' experiences showed that carers/families understand the discrimination faced by people BPD, largely because they also experience exclusion and discrimination. Community carer support services were perceived as inadequate. General Practitioners (GP) were an important source of support however, service providers need more education and training to support attitudinal change that addresses discrimination, recognizes carers' needs, and provides support.

Author, Year, Country	MMAT v.18/ JBI Quality Rating*	Population data	Aim/ Purpose	Study design	Methods/ Intervention	Main Findings
Lohman 2017, USA [88]	*****	People with BPD (N = 500)/ BPD Resource Centre	To build on the BPD services knowledge base by characterizing the experiences of consumers, caregivers, and family members seeking BPD resources	Qualitative study	Retrospective data analysis of brief unstructured interviews (N = 500)/ Data from resource centre transcripts (N = 6,253)	Results found that primary services and resources requested were: outpatient services (51%) and educational materials (13%). Care-seekers identified family services, crisis intervention, and mental health literacy as areas where available resources did not meet demand. Factors identified as potential barriers to accessing appropriate treatment for BPD included stigmatization and marginalization within mental health system and financial concerns.
Ma et al. 2009, TW [102]	*****	Mental health nurses (N = 15). Females (n = 15). Age, range (20->40). Years of service (4-10 years). Various health and community service settings	To explore the contributing factors and effects of Taiwan's mental health nurses' decision-making patterns on care outcomes for patients with BPD	Qualitative study	Semi-structured interviews	The informants' caring outcomes for BPD patients were involved with interactions across five themes: shifting from the honeymoon to chaos stage, nurses' expectations for positive vs. negative outcomes, practicing routine vs. individualized care, adequate or inadequate support from healthcare teams and differences in care outcomes.
Markham 2003, UK [103]	***	16. Mental health nurses (N = 71). Males (n = 18), females (n = 47). Mental health inpatient facilities	To evaluate the effects of the BPD label on staff attitudes and perceptions	Repeated Measures Factorial design	Surveys	Registered mental health nurses expressed less social rejection towards patients with schizophrenia and perceived them to be less dangerous than patients with BPD. Staff were least optimistic about patients with a BPD and were more negative about their experience of working with this group compared to the other patient groups.
Markham et al. 2003, UK [104]	***	17. Mental health nurses (N = 48). Males (N = 12, 25%), females (N = 33, 69%). Mean age (SD), 38 (9.3). Mean years of service (SD), 12.7 (8.9). Mental health inpatient facilities	To investigate how the BPD label affects health practitioners' perceptions and causal attributions about patients' behaviour	Within-participants survey design	Survey	Patients with BPD attracted more negative responses from nurses than those with a label of schizophrenia. Causes of their behaviour were rated as more stable and they were thought to be more in control of their behaviour, then patients with other mental illnesses. Nurses reported less sympathy towards patients with BPD and rated their personal experiences as more negative than experienced with other patients.
Masland et al. 2018, USA [47]	****	18. Mental health practitioners, researchers (N = 193). Mean age (SD), 48.84 (13.47). Mean years of service (SD), 18.12, (12.37). Various health services	To examine if the 1-day training can change health practitioners' attitudes to BPD, which persist over time	Repeated Measures Design	Surveys/ 'Good Psychiatric Management' training	Staff attitudes did not change immediately after training, but 6-months later had changed significantly. Findings indicated that brief training fosters improvements in health practitioners' attitudes and beliefs about BPD.
McGrath et al. 2012, IE [105]	*****	Registered psychiatric nurses (N = 17). Males (n = 5), females (n = 12). Mean years of service (n = 16). Community mental health service settings	To identify themes from an analysis of the nurses' interactions with people with BPD, and to describe their level of empathy to this patient group	Qualitative study	Semi-structured interviews	Results found four themes: challenging and difficult, manipulative, destructive and threatening behaviour, preying on the vulnerable resulting in splitting staff and service users, and boundaries and structure. Low levels of empathy were evident in most participants' responses to the staff-patient interaction response scale. Findings provide further insight on nurses' empathy responses and views on caring for people with BPD.

Author, Year, Country	MMAT v.18/ JBI Quality Rating*	Population data	Aim/ Purpose	Study design	Methods/ Intervention	Main Findings
Millar 2012, SC [106]	****	Psychologists (N = 16). Females (n = 16). Years of service, range (1–32 years)	To explore psychologists' experiences and perceptions of clients with BPD	Qualitative study	Focus groups	The following themes emerged from the analysis: negative perceptions of the client, undesirable feelings in the psychologist, positive perceptions of the client, desirable feelings in the psychologist, awareness of negativity, trying to make sense of the chaos, working in contrast to the system, and improving our role.
Morris 2014, UK [107]	*****	People with BPD (N = 9). Males (n = 2), females (n = 7). Age, range (18–65 years old). Various voluntary sector organisations in the North-West of England	To explore people with BPD's experience of mental health services to understand what aspects of services are helpful	Qualitative study	Semi-structured interviews	Three themes were generated including: the diagnostic process influences how service users feel about BPD, non-caring care, and it's all about the relationship. Participants identified practical points which services could implement to improve the experiences of service users.
National Health and Medical Research Council 2012, AUS [16]	Agree II Instrument level 6	Health practitioners	To provide current evidence for the effective treatment to improve the diagnosis and care of people with BPD in healthcare services in Australia	Clinical Guidelines	Treatment and crisis management	Health professionals at all levels of the healthcare system and within each type of health service should recognize that BPD treatment is a legitimate use of healthcare services. Having BPD should never be used as a reason to refuse health care to a person. A tailored management plan, including crisis plan, should be developed for all people with BPD who are accessing health services.
Nehls 1999, USA [108]	*****	People with BPD (N = 30). 30 Females (N = 30). Psychiatric, outpatient, and community services	To generate knowledge about the experience of living with the diagnosis of BPD	Qualitative study	Semi-structured interviews	Three themes were identified: living with a label, living with self-destructive behaviour perceived as manipulation, and living with limited access to care. The findings suggest that mental health care for persons with BPD could be improved by confronting prejudice, understanding self-harm, and safeguarding opportunities for dialogue.
Nehls 2000, USA [109]	*****	19. Case managers (N = 17). Community mental health centre	To study the day-to-day experiences of case managers who care for persons with borderline personality disorder	Qualitative study	Semi-structured interviews	The analysis showed a pattern of monitoring self-involvement. The case managers monitored themselves in terms of expressing concern and setting boundaries. These practices highlight a central and unique component of being a case manager for persons with BPD, that is, the case manager's focus of attention is on self. By focusing on the self, case managers seek to retain control of the nature of the relationship.
Ng 2016, AUS [110]	JBI, Level 1.b/ Level 4*	People with BPD (N = 1122), carers and health practitioners' perspectives reflected in consumer studies	To review the literature on symptomatic and personal recovery from BPD	Systematic review	Review of the literature	There were 19 studies, representing 11 unique cohorts meeting the review criteria. There was a limited focus on personal recovery and the views of family and carers were absent from the literature. Stigma associated with the diagnostic label hindered trust formation and consumers ability to fully engage.

Author, Year, Country	MMAT v.18/ JBI Quality Rating*	Population data	Aim/ Purpose	Study design	Methods/ Intervention	Main Findings
O'Connell 2013, IE [111]	***	Community psychiatric nurses (N = 15). Years of service, range (3–15 years). Irish adult community mental health service	To explore the experience of psychiatric nurses who work in the community caring for clients with BPD	Qualitative study	Semi-structured interviews	The nurses' understanding of BPD and their experiences of caring for individuals with the condition varied. Participants identified specific skills required when working with clients, but the absence of supervision for nurses was a particular difficulty, and training on BPD was lacking.
Perseus et al. 2005, SE [8]	*****	People with BPD (N = 10). Age, range (22–49 years old)	To investigate life situations, suffering, and perceptions of encounters with psychiatric care among patients with BPD	Qualitative study	Semi-structured interviews	Findings revealed three themes: life on the edge, the struggle for health and dignity, a balance act on a slack wire over a volcano, and the good and the bad act of psychiatric care in the drama of suffering. Theme formed movement back and forth, from despair and unendurable suffering to struggle for health and dignity and a life worth living.
Pigot et al. 2019, AUS [46]	*****	20. Mental health practitioners (N = 21). Males (n = 10), female (n = 11). Mean age, 39.5 (9.7). Public mental health services	To understand the facilitators and barriers to implementation of a stepped care approach to treating personality disorders	Qualitative study	Semi-structured interviews / 'Stepped Care approach' training	Participants identified personal attitudes, knowledge, and skills as important for successful implementation. Existing positive attitudes and beliefs about treating people with a personality disorder contributed to the emergence of clinical champions. Training facilitated positive attitudes by justifying the psychological approach. Findings suggests specific organizational and individual factors may increase timely and efficient implementation of interventions for people with BPD.
Proctor et al. 2020, AUS [112]	***	People with BPD (N = 577), comprising 153 consumers in 2011, and 424 consumers in 2017	To understand Australian consumer perspectives regarding BPD	Quantitative study	Surveys	Many people diagnosed with BPD experience difficulties when seeking help, stigma within health services, and barriers to treatment. Improved general awareness, communication, and understanding of BPD from consumers and health professionals were evident.
Ring et al. 2019, AUS [34]	JBI, Level 1.b/ Level 4*	People with BPD (N = 12), Health practitioners (N = 18) across 30 studies in total	To compare and contrast what stigma looks like within mental health care contexts, from the perspective of patients and mental health professionals' and how it is perpetuated at the interface of care	Literature review	Review of the literature	Thirty studies were found: 12 on patient's perspectives and 18 on clinician's perspectives. Six themes arose from the thematic synthesis: stigma related to diagnosis and disclosure, perceived un-treatability, stigma as a response to feeling powerless, stigma due to preconceptions of patients, low BPD health literacy, and overcoming stigma through enhanced empathy. A conceptual framework for explaining the perpetuation of stigma and BPD is proposed.
Rogers 2012, UK [68]	*****	People with BPD (N = 7). Male (n = 1), female (n = 5). Age, range (22–66 years old)	To explore the experience of service users being treated with medication for the BPD diagnosis	Qualitative study	Semi-structured interviews	The main themes to emerged were: staff knowledge and attitudes, lack of resources and the recovery pathway for BPD. Service users felt that receiving the BPD diagnosis had a negative impact on the care they received, with staff either refusing treatment or focusing on medication as a treatment option. The introduction of specialist services for this group appears to improve service user satisfaction with treatment and adherence to the National Institute for Clinical Excellence guidelines.

Author, Year, Country	MMAT v.18/ JBI Quality Rating*	Population data	Aim/ Purpose	Study design	Methods/ Intervention	Main Findings
Shaikh et al. 2017, USA [33]	JBI, Level 1.b/ Level 4	Health practitioners (N = 5136). 56 studies. Emergency care	To review the advice to physicians and health-care providers who face challenging BPD patients in the ED	Systematic review	Review of the literature	Results found that crisis intervention should be the first objective of health practitioners when dealing with these patients in emergency departments. Risk management processes and developing a positive attitude and empathy towards these patients will help them in normalizing in an emergency setting after which treatment course can be decided.
Sitsti 2016, USA [113]	****	Psychiatrists (N = 134). Male (n = 88, 65.7%), females, (n = 46, 34.3%). Years of service, range (0->20). Psychiatric services	To examine whether Psychiatrists had ever withheld/not documented patients' BPD diagnosis	Quantitative study	Survey	Fifty-seven percent of participants indicated that they failed to disclose BPD to their patients, and 37 percent said they had not documented the diagnosis. For those respondents with a history of not disclosing or documenting BPD, most agreed that either stigma or uncertainty of diagnosis played a role in decisions.
Stapleton et al. 2019, UK [70]	JBI, Level 1.b/ Level 4	People with BPD (N = 90) across all 8 studies. Age, range between 21 and 61 years. Acute Psychiatric inpatient wards	To conduct a meta-synthesis of qualitative research exploring the experiences of people with BPD on acute psychiatric inpatient wards	Meta-synthesis	Review of the literature	Eight primary studies met the inclusion criteria. Four themes included: contact with staff and fellow inpatients, staff attitudes and knowledge, admission as a refuge, and the admission and discharge journey. Opportunities to be listened to and to talk to staff and fellow inpatients, time-out from daily life and feelings of safety and control were perceived as positive elements of inpatient care. Negative experiences were attributed to a lack of contact with staff, negative staff attitudes, staff's lack of knowledge on BPD, coercive involuntary admission, and poor discharge planning.
Stroud et al. 2013, UK [39]	*****	21. Registered Community Mental Health Nurses (N = 4). Male (n = 1, female (n = 3). Age range (30-22. 59 years old). Community Mental Health team	To gain a fuller understanding of how community psychiatric nurses make sense of the diagnosis of BPD and how their constructs of BPD impact their approach to this client group	Qualitative study	Semi-structured interviews	Results suggested that participants ascribe meaning to the client's presentation 'in the moment'. When they had a framework to explain behaviour, participants were more likely to express positive attitudes. As participants were deriving meaning 'in the moment', there could be fluidity with regards to participants' attitudes, ranging from 'dread' to a 'desire to help', and leading participants to shift between 'connected' and 'disconnected' interactions.
Sulzer 2015, USA [114]	*****	23. Mental health practitioners (N = 22). Inpatient and out-patient settings	To evaluate how health practitioners describe patients with BPD, how the diagnosis affects the treatment provided, and the implications for patients	Qualitative study	Semi-structured interviews	Findings suggest patients with BPD are routinely labelled difficult, and subsequently routed out of care through a variety of direct and indirect means. This process creates a functional form of demedicalization where the actual diagnosis of BPD remains de jure medicalized, but the treatment component of medicalization is harder to secure for patients.
Sulzer 2016a, USA [115]	*****	Mental health practitioners (N = 22). BPD activists	To understand how health practitioners communicate the diagnosis of BPD with patients, and to compare and evaluate these practices with patient communication preferences	Qualitative study	Semi-structured interviews	Most participants sampled did not actively share the BPD diagnosis with their patients, even when they felt it was the most appropriate diagnosis. Most patients wanted to be told that they had the disorder, as well as have their providers discuss the stigma they would face. Patients who later discovered that their diagnosis had been withheld consistently left treatment.

Author, Year, Country	MMAT v.18/ JBI Quality Rating*	Population data	Aim/ Purpose	Study design	Methods/ Intervention	Main Findings
Sulzer 2016b, USA [116]	****	24. Mental health practitioners (N = 39). Men (n = 15), female (n = 24). Various public and private health services	To examine how clinicians navigate providing treatment to BPD in the context of the DSM 5, deinstitutionalization, and the biomedical model.	Qualitative study	Semi-structured interviews	Health practitioners faced pressures to focus on biomedical treatments. Treatments which emphasized pharmaceuticals and short courses of care were ill-suited compared to long-term therapeutic interventions. This contradiction is the 'biomedical mismatch'; Gidden's concept of structuration is used to understand how health practitioners navigate care. Social factors such as, stigma and trauma, are insufficiently represented in the biomedical model of care for BPD.
National Institute for Health and Care Excellence, 2009 UK [117]	Agree II Instrument level 5	Targeting Health practitioners	To advise on the treatment and management of BPD	Clinical guidelines	Treatment and crisis management	Findings provide evidence-based guidance on interventions for health practitioners supporting people with BPD and families/carers. People with BPD should not be excluded from accessing health services because of their diagnosis or suicidality. Health practitioners should build a trusting relationship, work in an open, engaging, and non-judgmental manner, and be consistent and reliable when working with people with BPD and carers.
Vandyk et al. 2019, CA [118]	*****	People with BPD (N = 6). Emergency care settings	To explore the experiences of persons who frequently present to the ED for mental health-related reasons.	Qualitative study	Semi-structured interviews	Two broad themes included: the cyclic nature of ED use, coping skills and strategies. Unstable community management that leads to crisis presentation to the ED often perpetuated access by participants. Participants identified a desire for human interaction, feelings of loneliness, lack of community resources, safety concerns following suicidality as the main drivers for visiting ED. Participants identified strategies to protect themselves against unnecessary ED use and improve health.
Veysey 2014, NZ [71]	*****	25. People with a BPD (N = 8). Male (n = 2), female (n = 7). Age, range (25–65)	To explore people with BPD encounters of discriminatory experiences from healthcare professionals	Qualitative study	Semi-structured interviews	Themes found that discriminatory experiences contributed to participants' negative self-image and negative messages about the BPD label. A history of self-harm appeared to be related to an increased number of discriminatory experiences. Connecting with the person and 'seeing more' beyond an individual's diagnosis and/or behaviour epitomized helpful experiences.
Warrender 2015, UK [44]	*****	26. Nurses (N = 9). Acute mental health wards, hospital setting (N = 1). Health services	To capture staff perceptions of the impact of health. Mentalization-based therapy skills training on their practice when working with people BPD in acute mental health	Qualitative study	Focus groups/ 'Mentalization-based Therapy skills training	Mentalization-based Therapy Skills training promoted empathy and humane responses to self-harm, impacted on participants ability to tolerate risk and changed some perceptions of BPD. Staff felt empowered and more confident working with people with BPD. The positive implication for practice was the ease in which the approach was adopted and participants perception of Mentalization-based Therapy skills as an empowering skill set which also contributed to attitudinal change.

Author, Year, Country	MMAT v.18/ JBI Quality Rating*	Population data	Aim/ Purpose	Study design	Methods/ Intervention	Main Findings
Warrender et al. 2020, UK [35]	JBI, Level 1.b/ Level 4	Health practitioners 27. 46 studies. A total of N = 3714 participants comprising: people with BPD (n = 2345), carers (n = 184), Health practitioners (n = 1185). Various healthcare settings	To explore the experiences of stakeholders involved in the crisis care of people diagnosed with BPD	Integrative review	Systematic review of the literature	Four themes: crisis as a recurrent multidimensional cycle, variations and dynamics impacting on crisis intervention, impact of interpersonal dynamics and communication on crisis, and balancing decision making and responsibility in managing crisis.
Wlodarczyk et al 2018, AUS [41]	*****	A total of 22 participants comprising GP (N = 12); research team (n = 5); People with BPD (n = 2); Carers, 3. GPs: Males (n = 6), females (n = 6). GP Partners Australia	To explore the nature and difficulties for GP, examine the reasons that caring for people with BPD in primary care is difficult and not well managed, and explore what strategies and actions might assist with improving the care of their patients with BPD	Qualitative study	Focus Groups	Key themes identified were: challenges regarding the BPD diagnosis, clinical complexity, the GP-patient relationship, and navigating systems for support. Health service pathways are dependent on the quality of care provided and GP capacity to identify and understand BPD. GP need support to develop the skills necessary to provide effective care for BPD patients. Structural barriers obstructing attempts to address patients with BPD were discussed.
Woolaston et al. 2008, UK [119]	*****	Nurses (N = 6). Males (n = 4), females (n = 2). Age, range (20-40 years old). Years of service, range (2-17 years). Various hospital and community health services (N = 6)28.	To explore nurses' relationships with BPD patients from their own perspective	Qualitative study	Semi-structured interviews	Results identified the following themes: destructive whirlwind', idealized and demonized, and manipulation and threatening. The study concludes that nurses experience BPD patients negatively. This can be attributed to the unpleasant interactions they have with them and feeling that they lack the necessary skills to work with this group. Nurses report that they want to improve their relationships with BPD patients.

*MMAT v.18 quality rating: low = 1 to 2 stars; moderate = 3 stars; moderately high = 4 stars; high = 5 stars [97]. *JBI Quality rating for level of evidence for effectiveness is level 1.b systematic review of RCTs and other study designs; and the level of meaningfulness is 4 - systematic reviews of expert opinion [120]. *Agree II Instrument quality rating scale [99]: 1 = lowest possible quality, through to, 7 = highest possible quality. #BPD = Borderline Personality Disorder; #ED = Emergency department.

descriptive statistics and frequencies [121]; and (2) Thematic Analysis of qualitative data to organize, categorize, and interpret key themes and patterns emerging from the data [100]. Trustworthiness and rigor of data abstraction and synthesis was established using a data analysis table that captured the categories, codes, and key findings/themes on the impact of structural stigma on healthcare for consumers with BPD, their carers/families, and health practitioners. Triangulating the perspectives and lived experiences of the relevant populations (i.e., consumers with BPD, their carers/families, and health practitioners) has been identified as an effective approach to establishing a comprehensive understanding of the complex nature of healthcare systems [122] within the context of BPD.

Results

Data characteristics

The initial database searches yielded 4132 publications. An additional thirty-three (n = 33) records were identified via other sources. Following the removal of duplicates, citation titles and abstracts were screened (n = 3566), and full-text records (n = 135) were retrieved and assessed for eligibility. Of these records, seventy-eight (n = 78) were excluded when assessed against the inclusion criteria and the quality appraisal criteria. In total, fifty-seven (n = 57) citations that aligned with the inclusion criteria and study aims were incorporated into this review. Search results including reasons for excluding citations are presented in a PRISMA Flow Diagram (Fig. 1).

All citations in this review focused on structural stigma relevant to BPD and healthcare services, including crisis care (n = 57). Of these, most of the citations comprised peer-reviewed published studies (n = 55), and two (n = 2) non-published reports. The majority of the citations examined health practitioners'

stigmatizing attitudes and practice specific to BPD (n = 36, 63%). Some citations focused on BPD-related educational interventions designed to modify health practitioners' attitudes and practice in treating BPD (n = 9, 5%) [44, 46–52, 54]. Table 2 presents data characteristics of included citations. Table 3 summarizes study characteristics of included studies.

Methodological quality

Critical appraisal of citations was undertaken for all included citations. Quality ratings of the quantitative studies were moderate (n = 9), [3, 4, 48, 52, 75, 103, 112, 117, 123], and moderately high (n = 8) [47, 49, 54, 56, 76, 84, 87, 113]. Most qualitative studies were rated high (n = 24)

[1, 2, 8, 19, 39, 41, 44, 46, 61, 67, 68, 71, 72, 83, 88, 102, 105, 107–109, 114, 115, 118, 119], or moderately high in quality (n = 4) [7, 64, 106, 116]. One (n = 1) qualitative study was deemed moderate in quality [111]. Critical appraisal of mixed methods studies (n = 2) was determined as moderate [85] and moderately high [50]. Reviews were moderate quality (n = 6) [10, 33, 35, 51, 70, 110], and high quality (n = 1) [34]. Reports were moderately high in quality (n = 2) [16, 117] (Table 2).

Key findings

Synthesis of the review findings identified several extant macro- and micro-level structural mechanisms, challenges, and barriers influencing BPD-related stigma in healthcare systems. Structural problems were evident across multiple levels of healthcare including system/service-, practitioner-, and consumer-levels. These results highlight the complex and contentious nature of BPD and healthcare

Table 3 Summary of key study characteristics

	N	%
Participants	17,406	100
<u>Study methodologies</u>		
Quantitative studies	18	32.0
Qualitative studies	28	49.0
Mixed methods study	2	3.5
Reviews/meta-synthesis	7	12.0
Clinical Practice Guidelines	2	3.5
<u>Countries</u>		
Australia	16	28.0
Israel	3	5.0
United Kingdom	17	30.0
Sweden	2	3.3
United States of America	11	19.0
Canada	2	3.3
New Zealand	1	2.0
Ireland	2	3.3
Scotland	1	2.0
Taiwan	1	2.0
Unknown	1	2.0
<u>Population Groups*</u>		
Health Practitioners	37	65.0
Consumers with BPD	15	25.0
Carers/families	6	10.0
<u>Healthcare settings</u>		
Mental Health Services	19	31.0
Emergency departments	13	21.0
General hospital and health services	14	24.0
Community-based services	14	24.0
<u>Health Professions</u>		
Medicine/Psychiatry	18	30.0
Nursing	26	42.0
Allied Health	17	28.0

*Some citations included more than one population group, healthcare setting, and health profession.

across the following broad themes (and sub-themes) comprising: structural stigma and the BPD diagnosis (subthemes - legitimacy of the BPD diagnosis, reluctance to disclose a BPD diagnosis, discourse of untreatability); structural stigma surrounding health and crisis care services; and practitioner-patient interactions. Each of these themes and subthemes are discussed below.

Structural stigma and the BPD diagnosis

This theme is centred around the dominant stigma discourse and misconceptions in healthcare systems regarding the BPD diagnosis, its disclosure, treatment, and recovery from the perspectives of health practitioners [16, 19, 33, 34, 106, 110, 113–116], consumers with BPD [3, 34, 61, 67, 107, 108, 110], and carers/families [4, 10, 61, 110]. The main structural challenges and barriers associated with the BPD diagnosis in healthcare systems include: the uncertainty regarding BPD as a legitimate mental illness [19, 83, 114–116, 119]; concerns regarding the disclosure of a BPD diagnosis [64, 113, 115]; and BPD as an untreatable condition [114, 116, 119]. Consequently, consumers with BPD are often denied treatment [3, 4, 114–116] and routed out of care through a process called demedicalization - making it difficult for these consumers to access medical treatment [114].

Legitimacy of the BPD diagnosis

The BPD diagnosis and its legitimacy as a mental illness is highly contested in healthcare systems [19, 35, 114], which acts as a barrier to consumers with BPD and their carers/families accessing quality health services and care [16, 117]. Sulzer et al.'s [114] qualitative study found that health practitioners viewed consumers with BPD from a moral stance, i.e., as *difficult* and *manipulative*, rather than genuinely *sick*; and subsequently denied these consumers treatment. Participants described consumers with BPD as morally deviant and believed that their self-harming behaviour was an attempt to gain attention, rather than viewing it as a symptom of their mental illness requiring concerted attention. Nehls et al.'s [108] qualitative study found that health practitioners perceived consumers with BPD as having an attitude problem reflective of their character, rather than being ill. Health practitioners also believed consumers with BPD were responsible for their condition and more in control of their actions than consumers with other mental health conditions [108, 114]. These misconceptions regarding the validity and reliability of the BPD diagnosis stem partly from the DSM-linked categorization of BPD in Axis II [12], comparative to other conditions (such as schizophrenia) which have a clear biological aetiology and response to medication [114]. Psychiatrists working with adolescents in Child and Mental Health Services also expressed concerns regarding the legitimacy of the BPD diagnosis for adolescents given the DSM criteria is adult-specific and does not account for the developmental stages of adolescents [19].

Consumers with BPD [3, 7, 64, 68, 70, 71, 108, 118] and their carers/families [1, 2, 4, 10, 41, 61, 72, 110] have consistently raised concerns regarding their lived experiences of discrimination and stigma in health services in response to the BPD diagnosis. Discrimination and stigma have been identified in the literature as prominent structural mechanisms that manifest and perpetuate challenges and barriers to accessing appropriate health services and care for consumers with BPD and their carers/families [3, 4, 16, 117]. Lawn et al.'s [3, 4] quantitative studies found that consumers with BPD reported experiencing high levels of anxiety associated with discrimination due to their BPD diagnosis (58%, n = 67) and not being taken seriously (71%, n = 82) by health practitioners. In addition, carers/families of people with BPD also reported that the discrimination against consumers with BPD in relation to the BPD diagnosis (53%, n = 36) and not being taken seriously (44%, n = 30) were major barriers to accessing health services and support. Carers/families also reported feeling stigmatized by association (i.e., stigma placed on family members based on their relationship with the person that they care for) and feeling blamed for their family members' condition. These discriminatory experiences are contrary to best practice guidelines for treating BPD which describes BPD as a valid mental illness and a legitimate use of healthcare resources; and recommends against consumers with BPD being discriminated against, or withheld treatment based on the BPD diagnostic label [16, 117].

Reluctance to disclose a BPD diagnosis

Studies examining BPD-related stigma in healthcare systems have highlighted health practitioners' reluctance to disclose a BPD diagnosis to consumers [33, 34, 110, 113, 114, 116]. Sisti and colleague [113] undertook a quantitative survey and found more than half of psychiatrists (57%, n = 77) participating in the study chose not to disclose a BPD diagnosis to their patients; and over a third of psychiatrists (37%, n = 49) did not document the diagnosis in their patient's medical charts. Respondents in this study reported stigma (43%) and uncertainty regarding the diagnosis (60%) as the main reasons for withholding a BPD diagnosis from patients. Respondents (n = 12) in Lawn et al.'s [3] survey suggested that General Practitioners (GP) did not appear to take notes on BPD or believe in the disorder. Koehne et al.'s [19] qualitative study explored health practitioners diagnostic and disclosure practices among adolescents and found that practitioners decisions regarding diagnostic disclosure were often influenced by cultural norms embedded within their professional teams. Findings further indicated that health practitioners used discursive strategies to avoid disclosing the diagnosis to their patients. This involved hedging (i.e., vague terms used by practitioners to distance themselves from the discussion at hand) and reframing the condition in terms of emerging traits or symptoms, rather than naming the actual diagnosis.

Similarly, Sulzer et al. [115] found most health practitioners (81%) diagnosed patients with an alternate disorder such as, post-traumatic stress disorder or depression. Practitioners' reported reasons for providing patients with an alternative diagnosis included: fear of patients rejecting the diagnosis; protecting patients from stigma, shame, and blame associated with the disorder; and, providing an alternative diagnosis to enhance patients' likelihood of receiving responsive treatment. These findings are consistent with responses of the patients with BPD in this study, which indicated that they had not been informed about the BPD diagnosis by their health practitioner at the time of the diagnosis. Only a few health practitioners (9%) in the study reported fully disclosing a BPD diagnosis to their patients. The reasons these participants gave for disclosing the diagnosis was to ensure that they were complying with their professional duties regarding informed consent, and that providing an accurate diagnosis enables consumers to access appropriate treatment for their specific condition.

Contrary to health practitioners' beliefs, most consumers with BPD in Sulzer et al.'s [115] study reported that they wanted to be informed of their diagnosis and to discuss the disorder and its associated stigma with their health practitioner. Consumers stated that they experienced relief when they received the diagnosis, and that they found the diagnostic process therapeutic. Only a few consumers with BPD (n = 3) reacted negatively to receiving their diagnosis. These findings are consistent with other studies that found consumers with BPD appreciated being informed of the diagnosis by their health practitioner [34, 61]. In addition, Morris et al.'s [107] qualitative study suggested that the diagnostic process and way in which people are informed about the diagnosis impacts how they feel about BPD. It appears that consumers with BPD who were informed of their diagnosis from a health practitioner who was optimistic about effective treatments and recovery prospects were more likely to feel positive about BPD than consumers who had had a negative experience associated with learning about their diagnosis. Further, Sulzer et al. [115] observed consumers with BPD whose health practitioner did not openly discuss their diagnosis with them subsequently ceased to engage in treatment.

Consumers with BPD also reported that receiving BPD-related information and education from their health practitioner was helpful [107, 108] as it assisted them to understand their symptoms and behaviours [64], and to see their condition from a disease perspective rather than as a personality flaw [34]. Other studies have found consumers with BPD who did not receive sufficient information from their health practitioner had limited knowledge and understanding of BPD [3, 67]. These findings are concerning given Lawn et al. [3] found that 45% of consumers with BPD reported not receiving adequate information about the disorder from their health practitioner. These non-disclosure practices present major structural challenges and barriers to consumers with BPD receiving adequate knowledge with which to understand their condition, as well as treatment to meet their specific needs [16, 117].

Discourse of untreatability

The dominant biomedical approach to healthcare and the DSM category for BPD has been identified as important structural mechanisms driving the challenges and barriers to responsive services and care for BPD. The controversial debates in the literature regarding the effectiveness of the biomedical approach in treating BPD centre on the reliance upon conventional treatments such as, short-term therapy and medication. These therapeutic strategies are viewed by health practitioners as ill-suited for treating BPD [106, 116]. Further, social factors contributing to stigma and trauma are not considered in the biomedical approach, and have consequently created the unintentional downstream effects of crisis reinstitutionalization (i.e., the repetitive use of brief, intensive crisis interventions) and the discourse of untreatability [116]. High rates of health service utilization among BPD populations including emergency and mental health services have been linked to the inability of the biomedical approach to effectively respond to the complex needs of consumers with BPD [110, 116]. However, health practitioners working with this population continue to experience considerable pressure to align their practice with the dominant biomedical discourse, partly due to the need to conform with the medical profession or insurances policies and procedures [116]. These structural challenges have had a detrimental effect on the delivery of appropriate treatment and recovery pathways for BPD, as well as contributed to health practitioners stigmatizing attitudes and practices to BPD [16, 34, 35, 39, 49–52, 56, 75, 76, 83–85, 102–106, 109, 116, 117, 119, 123].

Sulzer et al.'s [116] qualitative study highlighted that health practitioners perceived BPD negatively and preferred not to work with consumers with BPD. This was further qualified by another qualitative study [83] identifying health practitioners were less likely to provide an objective assessment of consumers' needs, and often refused to treat consumers with BPD. Alarming, some health practitioners (n = 2) [105] revealed that they avoided providing any (or minimal) level of care to consumers with BPD. Similarly, consumers with BPD reported that health practitioners' preconceived ideas and attitudes to BPD made them feel as though they were being, "labelled and judged" rather than, "diagnosed and treated" for BPD ([108] p.288). Participants further stated that they believed a diagnosis of BPD could be useful in guiding treatment, although the BPD label was unhelpful in supporting their treatment and recovery [108]. A number of studies (n = 9) recounted consumers' experiences of health services, detailing incidences of being denied treatment by health practitioners when they attempted to access healthcare [3, 7, 61, 64, 67, 88, 107, 108, 116]. Carers/families of people with BPD also reported witnessing the person they were caring for being refused treatment when presenting to health services in crisis [4]. These findings indicate that the myths surrounding the untreatable nature of BPD and its impact on practice (i.e., denying treatment) persist despite evidence of effective therapies for BPD such as, Dialectical Behavioural Therapy and mentalization based approaches [16, 114, 117].

In summary, the stigmatizing discourse and misconceptions surrounding the legitimacy of BPD, the diagnostic and disclosure practices, and its treatability, serve to compound and perpetuate existing structural problems creating challenges and barriers to effective delivery of health services and care for BPD. The prominent structural mechanisms identified in the literature were: BPD-related discrimination and stigma; the Biomedical model of care; and the DSM categorization. The specific challenges and barriers inhibiting effective service delivery for BPD were identified as: uncertainty of the BPD diagnosis; anti-diagnostic and disclosure practices to BPD; crisis reinstitutionalization; and the discourse of untreatability.

Structural stigma surrounding health and crisis care services

Consumers with BPD and their carers/families frequently access health services in crisis [3, 4, 10, 64] and consequently, experience widespread discrimination, prejudice, and stigma in healthcare systems [1–4, 7, 8, 10, 16, 19, 33–35, 39, 41, 44, 46–52, 54, 56, 61, 64, 67, 68, 70–72, 75, 76, 83–85, 87, 88, 101–119]. A recent review described crisis in relation to BPD as a recurrent multidimensional cycle of suicidality, help-seeking, and health service utilization, linked to the experience of distress among consumers with BPD, their carers/families, and health practitioners [35]. The experience of crisis for consumers with BPD appears complex; and has been described by consumers as a sudden onset of overwhelming emotions in response to negative internal and/or external stimuli such as, feelings of depression or anxiety, dissociative experiences, or interpersonal conflicts. Carers/families of people with BPD also experience distress associated with their dependents' crises [35], along with feelings of intense worry, powerlessness, and frustration in the midst of a crisis [72]. Health practitioners similarly report experiencing distress when working with consumers with BPD in crisis [35, 44] where the threat of suicide is considered the most distressing [105]. Feelings of frustration, inadequacy [83], uncertainty [44], and the desire to avoid working with consumers with BPD [75, 76, 105] were consistent experiences described in the literature by health practitioners. Practitioners further perceived that crisis among consumers with BPD was an ongoing concern [68, 83, 109], which often necessitated crisis intervention and referrals to intensive home treatment teams [35] or other community-based services [3, 4].

Stigma related to BPD and suicidality have been identified in the literature as the pivotal structural mechanism driving the inadequacy of health and crisis care services for BPD [3, 4, 61]. The associated challenges and barriers identified in the literature are mostly related to the significant gaps in the availability, accessibility, and affordability of services and supports for consumers with BPD and their carers/families [3, 4, 8, 33, 35, 41, 64, 71, 72, 83, 84, 102, 107, 108, 110–112, 118]. Lawn et al.'s [3] studies found that 50% of consumers with BPD reported that they were unable to access support services when they needed them; and 63% (n = 48) of carers/families [4] reported that they could not access support services, with 51.4% (n = 37) reporting that their GP had not supported them in their caring role.

In the context of healthcare systems, primary health care providers experienced difficulties navigating services and referral pathways for BPD given the limited health services, crisis care programs, and supports available across the hospital and community interface [41]. There are also inconsistencies in decision making processes and practices for treating BPD [56, 77, 85, 87, 101, 105] in emergency and inpatient mental health services despite the development of Guidelines [16, 117] providing best practice approaches for the treatment and management of BPD in clinical settings. This includes discrepancies associated with hospital admissions of consumers with BPD who present to emergency services following suicidality [3, 4, 35, 44].

Typically, community health services and supports for people with BPD are limited with long waiting times for specialist psychiatric services such as, psychotherapy [3, 4, 41]. Financial barriers relating to the expense of accessing private specialist services often places significant economic demands on consumers with BPD and their carers/families [3, 4, 72]. Other structural challenges and barriers impacting the provision of health services and care for BPD

included: limited funding allocated for BPD-specific resources such as, specialist therapeutic services [101]; lack of health literacy [1, 3, 4, 7, 34, 35, 61, 88]; concerns regarding insurance coverage and finance [88]; problems with discharge planning/continuity of care [8, 64, 107]; and the lack of effective crisis interventions [35].

Beyond these system-level factors, practitioner-level challenges and barriers affect the delivery of health and crisis care services, in particular, health practitioners pervasive stigmatizing attitudes and practices to BPD and suicidality [1–4, 7, 8, 10, 16, 19, 33–35, 39, 41, 44, 46–52, 54, 56, 61, 64, 67, 68, 70–72, 75, 76, 83–85, 87, 88, 101–119]. BPD and suicidality have been judged harshly by health practitioners [88], with practitioners reporting that they find treating consumers with BPD experiencing suicidality confronting [84]. Health practitioners also viewed consumers with BPD who engaged in self-harming behaviour as simply *acting out* [8], trying to gain attention [8, 105], or being manipulative in their attempts to control others [56]. Further, although health practitioners understood that consumers with BPD engaged in self-harming behaviour as a means of expressing emotional distress, nonetheless they considered these behaviours to be a habitual response by consumers with BPD [84]. In contrast, consumers with BPD argued that they are misunderstood by health practitioners: their self-harming behaviour is not intended to gain attention or manipulate and control other people; but rather, it is used as a method for releasing intense emotional pain [3, 8]. When recounting their impulsive self-harming behaviour, consumers with BPD reported feeling remorse following self-harm or a suicide attempt and then seeking crisis intervention from health services [58] with the hope to recover from the crisis, and their mental health condition [7].

Research suggests that BPD-related stigma in healthcare systems has, to some extent, been manufactured and perpetuated within healthcare professions [115]. Studies examining BPD-related stigma by practitioner type indicated that nurses, including psychiatric nurses, exhibit higher levels of stigmatizing attitudes and practices, and lower levels of empathy towards consumers with BPD, than other health practitioners [51, 103, 105, 114]. Woollaston et al.'s ([119] p705) qualitative study observed nurses viewing consumers with BPD as, "Destructive whirlwinds, powerful, dangerous, unrelenting, and an unstoppable force which leaves a trail of destruction in its wake". Following nurses, psychiatrists were found to express high levels of stigmatizing attitudes and behaviours to consumers with BPD [83].

This evidence proposes that health practitioners negative reactions to consumers with BPD is linked to a lack of knowledge, confidence, and skills in delivering the standards of care required to meet the complex needs of this population [46–52, 54, 56, 75, 77, 87]. Deans et al.'s [56] quantitative study revealed that one third of nurses (34%) reported that they did not know how to care for consumers with BPD. Respondents in Lawn et al.'s [3] study stated that their GP was not confident in treating BPD. Other studies [83, 101] indicated that health practitioners themselves reported that consumers with BPD receive inadequate care from health services. These findings highlight the need for BPD-specific education and training to assist health practitioners to better understand BPD and effectively treat consumers with this condition. A recent review [124] found promising results regarding the capacity of BPD-specific educational interventions positively modifying health practitioners' attitudes and practice to BPD. Further, health practitioners reported that they wanted to receive education and training in BPD and crisis interventions to enable them to effectively deliver care to consumers with BPD. Insufficient staff-to-patient ratios to meet workload demands and time constraints are also major barriers to the delivery of responsive care for BPD in emergency and mental health services [83]. This finding reflects the need for increased investment in staff resources and education to meet better the rising demand for healthcare among consumers with BPD [83, 88].

Consumer-related factors influencing the challenges and barriers experienced with accessing health and crisis care services were identified as: persistent suicidality [84, 88] and problems with interpersonal communication and conflicts [61, 83, 85]. A large-scale quantitative survey [3] undertaken in Australia revealed that consumers with BPD exhibited high rates of suicidality. Survey results revealed that all participants (100%, n = 99) had had thoughts of ending their lives, 94 (99%) of participants had engaged in self-harming behaviours, and 83 (85.6%) of respondents had had a previous serious attempt at ending their life. Despite these findings, consumers with BPD [3, 7, 84] and their carers/families [4, 7] have reported receiving poor quality care such as, being refused treatment or hospitalization by health practitioners when trying to seek help for suicidal thoughts and behaviour. Consumers with BPD have also shared their experiences of being excluded from services or having their care withdrawn because of their BPD diagnosis [67]. These findings are consistent with reports of health practitioners witnessing their colleagues refusing to treat consumers with BPD [83]. Consumers with BPD and their carers/families describe treatment refusal or being dismissed by health practitioners as traumatic; and these experiences exacerbate their distress [16, 112]. Further, consumers with BPD have been found to fall through service gaps [71], or cease to engage in further treatment or care following negative encounters with health practitioners [115].

Studies exploring the perspectives and lived experiences of carers/families of people with BPD reveal that carers live with constant stress and anxiety regarding the well-being and safety of their dependent [4, 35, 72]. Carers/families reported that they lacked knowledge of BPD [35], and the skills to help the person they care for during a crisis [2]. Access to health services, support, and health literacy to assist carers/families to cope and care for themselves as well as their dependent are lacking [1, 4, 61, 72, 88]. Carers/families further disclosed that they experienced feelings of hopelessness, powerlessness, and social isolation when attempting to gain support from family [1] and healthcare practitioners [1, 2, 4, 10].

A lack of consultation with health practitioners regarding the dependent persons care plans detailing the treatment and management of BPD was identified as a major barrier by carers/families as it affected their ability to care for their loved one [10]. Further, carers/families perceived BPD-related stigma, lack of support, and financial concerns as major barriers to accessing health services and supports for the person that they cared for and themselves. Consequently, the gaps in service provision for BPD places ongoing pressure on Emergency Departments as consumers with BPD and their carers/families have few other service options [10, 118]. Consumers with BPD have reported viewing hospital admissions as a refuge and means by which to keep themselves safe due to the lack of available community services and supports when feeling suicidal [70].

Despite consumers with BPD ongoing attempts to seek help from hospitals during times of crisis,

there are conflicting views among health practitioners as to whether, or not, hospital admissions are effective for consumers with BPD at risk of suicide [16, 35, 56, 76, 83, 85, 105, 117]. While existing guidelines recommend that consumers with BPD be assessed and admitted to hospital for a short stay (up to 3 days) if they are at immediate risk of suicide [16, 117], approaches to hospital admissions among health practitioners varied considerably. Deans et al. [56] found that

89% of health practitioners reported that consumers *should be* managed in hospital; and 14.9% of health practitioners reported that consumers with BPD *should not be* admitted to hospital. Whereas other studies found most health practitioners *do not view* hospitalization as an effective strategy [85, 101, 105]. For example, in James et al. [101] study, 64% of respondents reported that they agreed with the statement '*patients with BPD should not be hospitalized*'. This perspective reflects health practitioner's beliefs regarding hospital services and care not being appropriate for consumers with BPD [101, 105]. The main decisions driving *not to hospitalize* consumers with BPD (unless at immediate risk of suicide) appear to be based on these consumers' reputation for creating interpersonal conflict, such as splitting staff or negatively influencing other consumers on the wards [105].

In summary, stigma associated with BPD is the structural mechanism identified as impacting the delivery of adequate health and crisis care services for BPD. Several structural challenges and barriers to responsive care were identified across various levels of healthcare, these included: system/service-, practitioner-, and consumer-level. Deficiencies in the availability, accessibility, and affordability of health services and supports, the stigmatizing culture, attitudes, and practices, inconsistencies in hospital admission procedures/practices, and insurance/financial costs associated with accessing health services for BPD have been identified as key structural problems impacting the delivery of appropriate care for this population.

Practitioner-patient interactions

This theme is centred around existing literature exploring the interpersonal dynamics and encounters between health practitioners, consumers with BPD, and their carers/families [3, 4, 7, 47, 48, 50, 64, 71, 84, 102–104, 106, 119]. Health practitioners have been described in the literature as having an important mediating influence upon consumers with BPD [35]. For instance, qualitative studies found that interactions with health practitioners either relieved or increased consumers with BPD distress [8]; that is, upon whether practitioners' responses were helpful or discriminatory [71]. Consumers with BPD indicated that they felt socially isolated and rejected when health practitioners were unapproachable [64], or treated them abrasively. Indeed, Lawn et al. [3] found that more than half of the consumers with BPD (53%, n = 60) recalled being treated disrespectfully by health practitioners. Similarly, carers/families of consumers with BPD reported being treated disrespectfully [4] or made to feel as though they were to blame, or responsible for, their dependents condition [35]. Consumers with BPD also indicated that they needed to stand up for themselves when interacting with health practitioners [61]. These interpersonal conflicts have been found to retraumatize consumers with BPD and their carers/families and catalysing a crisis [35, 115]. Despite these negative encounters, consumers with BPD reported that they valued their connection with health practitioners, and wanted to have positive working relationships with practitioners [115].

Extant literature suggests that health practitioners believe consumers with BPD are typically difficult to engage and interact with [114]. Psychiatric nurses perceived consumers with BPD as resistant to treatment, which made it stressful for the nurses to engage these consumers and build rapport [85]. James et al. [101] found 75% of health practitioners considered consumers with BPD were moderately or very difficult; and 80% of participants believed that consumers with BPD were more difficult to engage than other consumers. Health practitioners also reported experiencing strong emotional reactions including, feeling uncomfortable, powerless, and professionally challenged when interacting with these consumers [83]. GP [41] and Allied Health staff [109] also reported being concerned about their ability to effectively manage countertransference and practitioner-patient boundaries with consumers with BPD. These negative reactions and encounters create major barriers [85] to the development of effective communication and practitioner-patient relationships [33, 48] between health practitioners, consumers with BPD, and carers/families. Similar to consumers, health practitioners also reported that they wanted to improve their relationships with consumers with BPD and carers/families [75]. Figure 2 presents the various macro- and micro-level structural mechanisms, challenges, and barriers impacting healthcare for health practitioners, consumers with BPD, and carers/families. Additional file 3 outlines the structural factors influencing BPD-related structural stigma in healthcare systems across the relevant populations (i.e., health practitioners, consumers with BPD, and carers/families).

In summary, positive interpersonal communication and encounters are important for effective practitioner-patient relationships. However, results of this review indicated that much headway is needed to improve the interpersonal dynamics and negative encounters experienced by health practitioners, consumers with BPD, and their carers/families. Paradoxically, despite the array of evidence highlighting existing conflictual relationships, both health practitioners and consumers with BPD expressed a desire to develop positive working relationships.

Discussion

This scoping review systematically mapped and synthesized a narrative summary of international literature addressing structural stigma relevant to BPD in healthcare systems. Results confirmed that BPD remains a highly stigmatized and contested mental illness in healthcare systems [1–4, 34, 35, 48, 51, 64, 67, 72]. Consumers with BPD and their carers/families face many adversities when seeking help from health services [1–4, 10, 64, 72]. These adversities stem from several macro- and

micro-level factors influencing the existing inadequacies in health services and care for BPD [34, 35, 41, 46, 89, 113–116, 125]. The prominent structural mechanisms impacting on the delivery of responsive health services and care for BPD comprised: discrimination and stigma towards BPD [19, 34, 35, 48, 71, 104, 112, 126]; the Biomedical model of care [114, 116]; and the DSM grouping for BPD [12, 116]. The specific challenges and barriers affecting the delivery of care for BPD were identified as: the limited availability, accessibility, and affordability of BPD-related health services and supports [3, 4]; inadequacies in treatment and recovery pathways including, health and crisis care services for BPD [35, 41]; the lack of effective crisis interventions [35]; and the pervasive stigmatizing culture, attitudes, and practices to BPD in health services [34, 35, 74, 87]. Literature suggests that these structural problems partly stem from the mismatch between BPD and the biomedical model's framework, which does not accommodate consumers with BPD social and trauma determinants, and interpersonal relationship problems [115, 116]. Overall, these structural factors have had a profound impact on health systems capacity to deliver adequate health services and care to this population.

Several key themes emerged from the data, including: structural stigma and the BPD diagnosis; structural stigma and health and crisis care services; and practitioner-patient interactions. Commonly held myths surrounding the legitimacy of the BPD diagnosis, its disclosure, and the discourse of untreatability are

interlinked, and combine to drive the perpetuation of stigmatizing culture, attitudes, and practices in health services [3, 4, 35, 71, 111, 112, 114, 116]. Debates continue to question the validity of BPD - framing its symptomatology as an immoral discourse (e.g., acts of self-harming behaviour are an attempt to gain attention), rather than a diagnosis positioned within a sickness discourse [35, 114]. This implies consumers with BPD are not truly sick or deserving of healthcare; and thus, justifying refusal of treatment. The notion that receiving healthcare is contingent on being sick [114] violates peoples' most fundamental right to access healthcare [16].

In contrast, evidence that health practitioners used to categorize consumers as not sick (including suicidal behaviour and manipulation) could also be used to justify these consumers' legitimate sickness and need for treatment [114]. Prolonged suicidality among consumers with BPD, which is often viewed by health practitioners as manipulative behaviour, could instead be interpreted as an indication that these consumers have not received effective treatment to assist their recovery, despite their ongoing attempts to seek help [108]. These findings highlight the discrepancies regarding the assumptions that consumers with BPD are manipulative and attention seeking, when in fact, they represent the patient group most at risk of suicide [28, 114]. Further, bias towards BPD is not specific to suicidal behaviour among consumers with BPD. For instance, Gremillin et al. [127] found that inpatients with BPD being treated for anorexia experienced the same stigmatizing discourse. It appears that consumers with BPD are required to meet standards of sickness beyond those of other consumers regardless of their presenting condition [114].

Structural stigma in healthcare systems has a substantial influence on health practitioners' diagnostic and disclosure practices regarding the BPD diagnosis [19, 114]. The complexity of BPD, its controversial nature [12, 19], and associated stigma have resulted in some health practitioners withholding a BPD diagnosis from their patients [19, 113, 114]; a perception that maintaining provision of this diagnosis would do more harm than good [115]. Conversely, this assumption has been refuted by other health practitioners [19, 110] and consumers with BPD who reported receiving a diagnosis of BPD gave them relief and was a positive step towards understanding BPD, its associated symptoms, and treatment options [115].

Findings relating to health practitioners' pervasive stigmatizing attitudes and practices to BPD underscore that structural problems are woven into the cultural fabric of healthcare systems [34]. Studies indicate that health practitioners operate with an undercurrent of prejudice towards BPD and suicidality, which limits practitioners' ability to explore and understand the underlying causes of self-harming behaviour among consumers with BPD [110]. Consumers with BPD experiences of ongoing crises are complex and multidimensional, and often compounds their level of distress, as well as the distress experienced by their carers/families and health practitioners [44]. Evidence suggests that health practitioners find these experiences challenging, they feel powerless in the context of self-harm, and overwhelmed by the chaotic and conflictual interactions because they lack the sufficient knowledge, strategies, and skills needed to manage crisis situations [34]. It is likely that health practitioners' stigmatizing attitudes and externalizing practices of blame and refusal of care, arise from being overwhelmed and uncertain about how to manage the situation [34]. This highlights the importance of increasing access to BPD-specific education, training, and supervision to assist health practitioners to better support consumers with BPD and their carers/families when they engage with health services in crisis [44, 53, 76, 88, 102, 105, 112].

Overall, the literature concerning carers/families of consumers with BPD suggest that carers experience stigma by association. This is a common phenomenon involving the stigma experienced by people with mental illness being shifted onto families merely because they are taking responsibility of a person with BPD [128]. This current review casts light on the poor treatment of carers/families of people with BPD including being socially excluded, not taken seriously, and experiencing financial stress regarding the cost of healthcare for their family member. Our findings are consistent with Remko et al.'s [129] study exploring families of people with mental illness experience of stigma and burden simply by association.

Further, the findings that nurses express greater levels of stigma and lower levels of empathy to BPD compared to other professions [50, 51, 87], indicates that the establishment of person-centred, compassionate, and caring relationships required for responsive care delivery are severely compromised. Sansone and Sansone [89] argued that nurses' negative reactions to consumers with BPD may simply reflect a normal human response to the complexity and pathological nature of these consumers. The extent to which the stigma of BPD is largely situated within healthcare professions, however, is an indication that the problems and solutions lie in the culture of care delivery and not the BPD diagnosis [59], and requires concerted effort to address the impact of structural stigma on the provision of responsive services and care for consumers with BPD and carers/families in healthcare settings [91].

This review has implications for health service design and delivery of responsive treatment and crisis interventions to better support consumers with BPD and their carers/families. There are several recommendations for addressing BPD-related structural stigma and improving health service delivery identified in the literature including, utilizing whole-of-system approaches to addressing structural stigma at both the macro- and micro-levels of healthcare institutions [34, 41, 46, 47, 51, 105, 109, 119]. This would involve implementing coordinated and targeted approaches to addressing the array of structural factors associated with institutional cultures, policies, and practices to BPD in healthcare systems [16, 46, 117]. Incorporating psychosocial approaches to care for BPD [59] and promoting the continued use of person-centred and compassionate approaches [35, 76] are highly recommended to address the identified service/practitioner level structural mechanisms, challenges, and barriers that inhibit the delivery of responsive care.

Clear recommendations have detailed the need for health services to not only treat the physical ailments associated with self-harm, but also, the underlying emotional problems driving suicidality among consumers with BPD [59]. These recommendations require holistic approaches to care delivery and increased access to longer-term specialized therapeutic services [41, 48]. In addition, given there are currently no Randomized Control Trials (RCT) confirming the effectiveness of existing crisis interventions for BPD [78], clinical decisions regarding evidence-based treatment and management of BPD are challenging, and warrants urgent instigation of high-quality research to investigate the efficacy of crisis interventions for BPD [35]. Further, there is great need for increased investment in education, training, and supervision to enhance health practitioners' knowledge, skills, and confidence in delivering quality standards of care to BPD populations. Moreover, at a system level, structural stigma relevant to BPD in healthcare systems must be addressed. Research investigating the various multi-levels and multifaceted components of BPD-related stigma is needed to explicate how each of these structural factors interact and operate (either separately or together) to impact the health and wellbeing of this population. This may include testing the specific effects of the structural mechanisms

identified in this review in relation to their impact on health service access, service delivery, and health outcomes of people with BPD and their carers/families [79].

Limitations

Limitations of the review involve the publications being limited to English only. BPD was the primary diagnosis explored within the context of structural stigma and its impact on healthcare therefore, data pertaining to experiences of structural stigma relating to other personality disorders were not captured. Also, some relevant publications may have been missed due to the exclusion of full-text publications that were unable to be accessed free of charge, and older publications that may not have been available for download. Further, there is a lack of high-quality Randomized Control Trials (RCT), serving to curtail the review findings such that inference of causality regarding the health impact of structural stigma [78] could not be applied, nor generalized to the broader population [9]. This includes the lack of effectiveness studies available to support the use of evidence-based crisis interventions for BPD [78].

Conclusion

Consumers with BPD and their carers/families experience ongoing crises and frequently seek help from healthcare services. Structural stigma specific to BPD remains pervasive in healthcare systems; and is reflected across many macro- and micro-level factors embedded in institutional policies, cultural norms, and practices. Key structural mechanisms impacting the delivery of adequate services for BPD were identified in the literature as representing discrimination and stigma towards BPD, and dominance of biomedical approaches to care. The specific challenges and barriers impacting the delivery of responsive care to consumers with BPD and their carers/families involved: the significant gaps in BPD-related health services, supports, and health literacy; the lack of effective crisis interventions; inadequacies in treatment and recovery pathways; and the pervasive stigmatizing culture, attitudes, and practices to BPD in healthcare systems. Implications for future practice and research were discussed, along with recommendations for addressing BPD-related stigma in healthcare systems including, the need for holistic system-wide approaches that are underpinned by biopsychosocial, person-centred, and compassionate frameworks for care.

Abbreviations

BPD: Borderline personality disorder; CINAHL: Cumulative Index to Nursing

and Allied Health Literature; Extension for Scoping Reviews: checklist and explanation

JB: Joanna Briggs Institute; MMAT: Mixed Methods Appraisal Tool 2018 version; PCC: Population-Concept-Context framework; PRESS: Peer Review of Electronic Search Strategies; PRISMA-ScR:

Preferred Reporting Items for Systematic Reviews and Meta-Analyses; Extension for Scoping Reviews: checklist and explanation; RCT: Randomized Controlled Trials.

Declarations

Ethics approval and consent to participate

Not applicable.

Consent for publication

Not applicable.

Availability of data and materials

Not applicable.

Completing interests

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Authors' contributions

PK conceptualized the review, designed, and conducted the comprehensive searches, analysed, and interpreted data, drafted the manuscript, and contributed to the manuscript revisions. PK and AKF completed the screening of the title, abstract and full-text citations, and SL resolved any discrepancies in the screening of the title, abstract and full-text citations. PK completed the quality assessment of potentially included citations and AKF assisted in resolving any discrepancies. PK completed data extraction of included citations and AKF checked the extraction of the data. AKF and SL contributed to discussions held, and advised on, important aspects of the review including, the draft PsycINFO search strategy, the screening, quality appraisal, data extraction, analysis,

interpretation, and critically revised and included intellectual content into the manuscript. The authors (PK, AKF, SL) read and approved the final version to be published.

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Figures

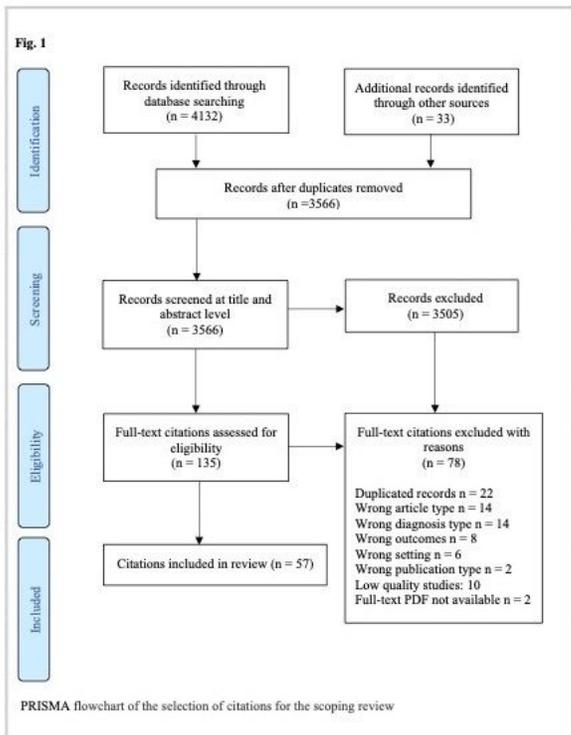


Figure 1

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Figure 2

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