Borderline Personality Disorder: A review of the use of the BSL-23 measure and an experimental study of detention decision-making by Approved Mental Health Professionals under the Mental Health Act.

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Thesis Portfolio Abstract

Background: Negative attitudes, biases and stigma towards the diagnosis of Borderline Personality Disorder (BPD) have been reported since the term 'borderline' originated. There is evidence that mental health professionals continue to hold negative attitudes, which lead to suboptimal treatment to clients with BPD. Research has attempted to look at factors which might be contributing to these stigmatised attitudes and what might help to look beyond the diagnosis.

Design: This thesis portfolio consists of the following components: (1) an introduction to the topic, (2) a systematic review examining the applications of a standardised measure used for measuring the symptomology of BPD – the Borderline Symptom List (BSL-23), (3) a bridging chapter, (4) a quantitative empirical research into decision-making of Approved Mental Health Professionals regarding detention of individuals diagnosed with BPD, compared to Complex-Trauma or no-stated diagnosis, and (5) a discussion and critical evaluation.

Results: The systematic result found two main applications of the BSL-23, symptom identification and enhancement of understanding BPD symptomology. There was an underrepresentation of gender and non-European countries. The empirical paper found no significant relationship between choice of detention and experimental condition (a manipulation on the vignette's diagnosis), with the only significant factor predicting detention being appraisal of risk to self. Significant predictors of an increased likelihood for detention were greater appraisals of risk to self and negative attitudes towards personality disorder.

Conclusion: The findings of the two papers indicate that biases and inconsistencies continue to be seen within the study and treatment of clients diagnosed with BPD. The influence of appropriate treatment due to attitudes in professional groups may vary and the extent to its effect should be studied further.

Table of Contents

List of Tables

Systematic Review

Empirical Paper

List of Figures

Systematic Review

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To my fiancé, thank you for your endless support and patience throughout this journey. To my family, I am grateful for your encouragement and belief in me, always motivating me to reach my goals.

Finally, to all the individuals who felt misunderstood, misdiagnosed or struggled within the system - I hope research continues to drive change, ensuring that we, as clinicians, provide the holistic and appropriate treatment that everyone deserves.
May you always be seen as a person and not just a diagnosis.

Chapter One: General Introduction

This chapter outlines recent changes to Borderline Personality Disorder diagnosis, the symptomology and the history of the 'borderline' label. Furthermore, it describes the clinical impact of attitudes and the intention to focus on Approved Mental Health Professionals as a professional group in the Empirical Research.

Borderline Personality Disorder

Borderline Personality Disorder (BPD) is a mental health diagnosis, recognised by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association (APA), 2013), previously known as Emotionally Unstable Personality Disorder (EUPD) in the International Classification of Diseases (ICD-10; World Health Organisation, 2013). In the revised ICD-11 the diagnosis has been updated to a general Personality Disorder, with an additional 'Borderline Pattern specifier' (World Health Organisation, 2024). For consistency, the term BPD will be used throughout this portfolio, as it is seen as the most common term used across general population, medical professionals and research.

To meet the DSM-5 criteria for BPD, an individual needs to experience patterns of instability in interpersonal relationships, distorted self-image, poor affect and behavioural impulsivity seen in a variety of contexts (APA, 2013). Individuals with a BPD diagnosis also report additional symptoms such as feelings of emptiness (Biskin, 2015; Miller, 1994), need for companionship conflicted with feeling unlovable, having the desire to live and desire to die (Perseius et al., 2005), feeling disconnected, numb, purposeless (Miller et al., 2021) and misunderstood by others (Nehls, 1999). However, according to some mental health professionals, individuals with BPD are "difficult" (Cleary et al., 2002; Koekkoek et al., 2006), "attention seeking" (Day et al., 2018), "manipulative" (Treloar, 2009) and "dangerous" (Woollaston & Hixenbaugh, 2008).

BPD is often described as a "complex" disorder (Chapman et al., 2024), but it is important to question what this complexity truly means. The symptoms of BPD are known to fluctuate based on the environment, mood, person or situation (Mulder & Tyler, 2023). Additionally, these symptoms frequently overlap with other disorders, making diagnosis and treatment more challenging (Mulder & Tyler, 2023). Co-occurring conditions such as substance misuse and eating disorders further complicate treatment, making it difficult to determine the right intervention at the right time. Unlike some other diagnoses, treatment for BPD is often lengthy and rarely straightforward. However, the challenge lies with the

professionals responsible for providing help, support and treatment. Labelling individuals with BPD as "manipulative" may reflect professionals' own struggles in working with individuals with BPD. Many professionals do not receive adequate training to understand and work with BPD, this lack of knowledge and skills can create perception of the clients being "complex". As a result, professionals may be less inclined to work with individuals with BPD, leading to negative attitudes and stigma.

While BPD symptoms, such as chronic suicidality, can be particularly challenging, it is important to recognise that these behaviours are maladaptive coping strategies. Similarly, other behaviours such as interpersonal conflict, substance misuse or actions perceived as "manipulative" may also serve as coping mechanisms. The push-pull patterns commonly seen in BPD can be difficult for professionals to navigate, yet consistency and stability in support systems are precisely what individuals with BPD need the most. Professionals' experiences and knowledge of mental health conditions naturally shape perceptions, which may lead to biases. Just as some professionals enjoy working with BPD clients, some do not. While attitudes and judgements are a natural part of human behaviours, they can potentially be influenced and reshaped through education, awareness and experience.

Attitudes Towards BPD

Negative attitudes towards BPD have been seen for a long-time. The term "borderline" was first developed in the 30's to describe patients who did not fit into existing diagnoses of psychosis and neurosis (Stone, 1977). Evidence shows that the term became stigmatising to those who received it. Patients, who were mostly women, received this diagnosis if they were seen as difficult, disliked or seen as untreatable (Stone, 1977) and described as poorly motivated, rule breakers, unreliable, not developing insight, leading chaotic lives, engaging in petty crimes and not easily establishing emotional contact (Schmindeberg, 1947). Others referred to the diagnosis as constitutional aggression (Kernberg, 1975), pseudo-neuroticism (Hoch & Polatin, 1949) and infantile personality (Stern, 1938).

Although, extensive research has been conducted to better understand BPD, studies found that negative attitudes toward the disorder persist (Cleary et al., 2002). However, some recent research suggests seeing a potential shift, reporting increased positive attitudes towards BPD from mental health professionals (Day et al, 2018; Egan et al., 2014).

Impact of Attitudes

The impact of health professionals' attitudes can significantly affect the treatment individuals with BPD receive. With an estimated prevalence of BPD in clinical settings as high as 22.6% (Korzekwa et al., 2008), and possibly even higher in recent years, many types of non-specialist clinicians are highly likely to work with BPD patients. Research has shown that negative perceptions can lead to suboptimal care (Aljohani et al., 2022), additionally, the diagnosis itself may be seen as an overall 'identity', preventing professionals treating the person holistically (Seal et al., 2024; Ukwuoma et al., 2024).

Not only mental and physical treatment can be affected by these attitudes, but the process of diagnosis itself. Studies have found that psychiatrists may diagnose patients with other disorders that are either easier to treat or carry less stigma (Hodges, 2003; Ibrahim et al., 2018; Kulkarni, 2017), potentially impacting the accuracy and effectiveness of care.

Due to the negative attitudes surrounding BPD, there is an ongoing debate around adolescent diagnosis. While it is reported that BPD symptoms typically emerge during adolescence (Chapman et al., 2024; Tiosano et al., 2022), the stigma associated with the diagnosis often makes clinicians hesitant to label young people with BPD. Instead, terms such as "emerging personality disorder" are commonly used (Adshead et al., 2018). Beyond stigma, the diagnosis of BPD in adolescents presents other challenges, such as determining whether the criteria can be validly applied in a younger cohort. Behaviours commonly associated with BPD, such as emotional instability, identity disturbance and interpersonal conflict, can overlap with typical adolescent development. Studies have shown that BPD symptoms often are seen to peak at age 12 for boys and 13 for girls, before declining in later adolescence (Bernstein et al., 1993). As the debate over adolescent diagnosis continues, our research primarily focused on adults.

Approved Mental Health Professionals

Approved Mental Health Professionals (AMHPs) have a crucial role in making decisions regarding detention under the Mental Health Act (MHA; 1983). The function and purpose of this role will be expanded in more detail in Chapter Three. Individuals with BPD who exhibit risky behaviours may find themselves subject to detention under the MHA. Given the negative attitudes towards BPD seen across many professionals, and knowing that these attitudes affect treatment, it is important to investigate whether AMHPs also hold negative attitudes toward this client group and whether these attitudes influence their

decisions regarding detention. If negative attitudes were found to significantly sway decision-making, it would raise concerns about the appropriateness of AMHPs making such critical decisions.

It is important to note that detention under the MHA is sometimes referred to as hospitalisation. While the term ‘detention’ is primarily used within the portfolio, ‘hospitalisation’ has remained in some of the research materials in the empirical paper.

Chapter Two: Systematic Review

A Systematic Review on the applications of Borderline-Symptom List (BSL-23) a self-report measure for adults with Borderline Personality Disorder.

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See Appendix A for author guidelines.

Abstract

Background: Borderline Personality Disorder (BPD) is characterised by fluctuating symptoms, making symptomatic measurements challenging. Diagnostic tools such as the Borderline Symptom List (BSL-23) have been developed to provide an objective measure of BPD symptomology. This review aims to synthesise current studies on the applications of the BSL-23.

Methods: A narrative systematic review was conducted by searching the PsychINFO and PsyArticles databases for studies published between 2009 and 2024, using the terms "Borderline Personality Disorder", OR "BPD", OR "Emotionally Unstable Personality Disorder", OR "EUPD" AND "Borderline Symptom List" OR "BSL-23". Studies included an adult BPD sample. Study quality was assessed using an adapted tool.

Results: Nineteen studies, comprising 2,186 participants, were included. The results found an underrepresentation of men and non-European countries. Most samples were outpatient populations with moderate to high BSL-23 severity range. The BSL-23 was primarily used for symptom identification or to enhance understanding of BPD symptomology.

Conclusion: The BSL-23 remains a versatile tool for assessing symptom in BPD. It has been applied in diverse settings and for various purposes. However, inconsistencies in reporting and the limited populations restrict its applicability and generalisability. Future studies should aim to include more diverse populations and ensure more consistency in reporting the BSL-23 across clinical and research contexts.

Keywords

Borderline Personality Disorder; BPD; BSL-23; Borderline Symptom List; self-report measure

Introduction

Borderline Personality Disorder

Borderline Personality Disorder (BPD; also known as Emotionally Unstable Personality Disorder or EUPD) is a mental health condition characterised by emotional and behavioural dysregulation, impulsivity, identity disturbances and difficulties in interpersonal relationships [1]-[2]. The diagnosis is often regarded as controversial due to (a) the pervasive stigma it carries, which can impact perceptions among the general public, health professionals [3]-[5] and those with the diagnosis themselves [6], and (b) the validity of the label or diagnosis itself which seems to be frequently changing as seen in the different versions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Diseases (ICD) [7], highlighting that perhaps there are still gaps in clearly understanding this diagnosis.

Given that BPD is identified in approximately 15-20% of inpatient and 10-30% out-patient mental health populations [8]-[9], the use of validated assessment tools is essential. Accurate symptom measurement not only ensures precise diagnosis and treatment but also helps limit potential biases toward the disorder.

Research indicates that negative attitudes of health professionals toward BPD [10]-[12] can lead to a reluctance to diagnose it, instead favouring alternative diagnoses like Bipolar Disorder (BD) or Complex Post-Traumatic Stress Disorder (CPTSD). These diagnoses may carry less stigma and may be more understood by clinicians compared to the complexities of BPD [13]-[15]. Although diagnostic confusion between BPD and BD is not uncommon given the symptomatic overlap between them [16]-[17], a significant difference between the disorders is their responsiveness to pharmacological treatments, with BD showing better outcomes [16], while no pharmacological treatment currently showing effectiveness to treat BPD pathology [18]. Consequently, diagnosis not only influences immediate treatment choices but can also have a lasting impact on the effectiveness of long-term care.

Diagnostic Tools and Measures

BPD is often referred to as a “complex” condition [2]. The fluctuating and changing symptomology and its effect on daily functioning can be difficult to capture. Some have argued that this lack of specificity reflects issues in characterising BPD as a personality disturbance which are conventionally seen as “constant” and “undisputed” [7]. Furthermore,

symptoms of BPD are similar to other disorders such as BD, anxiety and depression [7] therefore, there have been developments to ensure that diagnostic tools and measures capture the appropriate information, while accounting for environmental and biological factors. This led to the development of diagnostic tools such as the Structured Clinical Interview (SCID) and International Personality Disorder Examination (IPDE) [19].

Borderline Symptom List

The Borderline Symptom List-23 (BSL-23) is a widely used self-report tool for assessing BPD symptoms. In the UK, it has been used in clinical settings and has been recommended by the British Isles UK Training organisation. The BSL-23 was developed by Bohus and colleagues (2009) [20] as a short form of the Borderline Symptom List-95 (BSL-95). The BSL-95 was developed with input from clinical experts and BPD patients across multiple German hospitals and clinics, ensuring it reflects the lived experiences and challenges associated with BPD. However, given its length, the BSL-23 was developed to offer a more practical and less time-consuming measure, to better suit the needs of clinicians, researchers and patients.

This 23-item measure evaluates both the presence and intensity of BPD-related symptoms, structured around core features of BPD as per DSM-IV (1994) [21] criteria, covering affective dysregulation, self-perception issues, self-destructive tendencies, dysphoria, feelings of loneliness, hostility, and intrusive thoughts. Items are rated on a Likert scale from 0 (Never) to 4 (Very Much), and higher scores correspond to greater symptom severity.

The BSL-23 demonstrates strong internal consistency, with Cronbach's alpha values between 0.935 and 0.969, indicating high reliability across diverse samples [22]. Its practical applications extend to both clinical practices, for treatment evaluation and research studies, where it serves as a reliable BPD symptom measure. According to Kleindienst et al. (2022) [23], symptom severity in the BSL-23 can be classified as follows: 0-0.3 (None/Low), 0.3-0.7 (Mild), 0.7-1.7 (Moderate), 1.7-2.7 (High), 2.7-3.5 (Very High) and 3.5-4 (Extremely High). This categorisation aids clinicians and researchers in interpreting scores effectively and in tracking symptom changes over time, providing a robust measure for the assessment and ongoing management of BPD.

The BSL-23's validation process involved a sample of 659 individuals with a BPD diagnosis, predominantly female (89%), aged between 17 and 58. The BSL-23's reliability and validity were also confirmed by comparing scores with a control group of 275 individuals

diagnosed with other mental health conditions: schizophrenia, generalized anxiety disorder, Attention-Deficit Hyperactivity Disorder (ADHD) and PTSD, ranging in age from 18 to 77. This diverse sampling strengthens the BSL-23's capacity to assess symptoms which are more specifically associated with BPD, reinforcing its clinical utility and applicability across settings. Unfortunately, patient characteristics such as ethnicity and occupation were missing, limiting the ability to assess generalisability.

Although BPD is often labelled as a "female dominated diagnosis" [8], recent studies challenge the assumption that it predominantly affects women. The NHS' Adult Psychiatric Morbidity Survey [24] found that while more women screened positively for BPD characteristics, the difference between men and women was not statistically significant. Equal prevalence among men and women was also found by Grant and colleagues in a 2008 [25] National Epidemiologic Survey in the United States. These findings are important because, historically, BPD was assigned to women who were perceived as "difficult" or "untreatable" [26] and studies confirmed having a "subtle female gender bias" [27]. Davies et al., (2024) [28] highlighted that gender stereotypes continue to persist. Although, as more recent studies report a non-significant gender difference, it is important to acknowledge potential biases and a need for an objective, criteria-based approach to assessing BPD symptoms, ensuring that diagnoses and treatment decisions are based on clinical evidence rather than subjective perceptions.

Current Research

To the author's knowledge, there has not been a systematic review into how the BSL-23 has been used within the BPD population. Therefore, the current systematic review aims to understand and evaluate the use of the BSL-23 since 2009, when the measure was officially published, until 2024. The systematic review aims to answer the following questions:

(1) What contexts and population have the BSL-23 been applied to and its practical implications in clinical and research settings?

(2) How has the BSL-23 been used to monitor treatment outcomes based on symptom severity over time?

(3) What methodological approaches have been used in applying the BSL-23 and the influence of the interpretation of the results?

Methods

Registration

The study followed the protocol recommended by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines and was registered with the International Register of Prospective Systematic Reviews (PROSPERO) on March 25, 2024 (CRD42024521568).

Search Strategy

The databases APA PsychINFO and APA PsyArticles were searched in March 2024, covering the period between 2009 and 2024. These two databases provide substantial coverage of journal articles of interest to this review. Terms searched were: “Borderline Personality Disorder”, OR “BPD”, OR “Emotionally Unstable Personality Disorder”, OR “EUPD” AND “Borderline Symptom List” OR “BSL-23”.

Eligibility Criteria

Studies were included if they met the following criteria: (1) diagnosis of BPD, (2) adult sample (age 18+), (3) use of Borderline-Symptom List short-version (BSL-23), and (4) publication in English. Studies were excluded if they: (1) involved a mixed sample of adolescents and adults, (2) had a primary diagnosis other than BPD, (3) lacked a clear diagnosis of BPD or BPD traits, (4) use of long-version of the BSL (BSL-95) or (5) focused on the development of BSL in other languages.

Study Selection

Study selection was made by the main author, who independently screened titles, abstracts and full texts. Two independent authors (MW, JF) critically appraised the selected studies using pre-specified criteria. Any inconsistencies or ambiguities were discussed, and if consensus could not be reached, a third author (PB) was consulted.

Quality Assessment

The Consensus-based Standards for the Selection of Health Measurement Instruments (COSMIN) checklist was adapted to appraise the methodological quality of the studies. The studies were screened using this adapted tool by the main author (MW). A second author (JF) independently appraised 25% of the studies, and the two researchers compared their assessments, any discrepancies were discussed, and if no consensus was reached, a third author (PB) was consulted. Initial agreement between the two authors was 60%, which rose

to 100% after discussion. No studies required further consultation. Thirteen studies scored 50% and above on “Very Good” rating (full screening shown in Figure 2).

Data Extraction

To answer the broader research questions, data extraction was conducted based on two key areas: (1) context and population of the BSL-23 application and (2) applications of the BSL-23 in clinical and research settings, as summarised in the tables below. The tables are divided by country, for the ease of comparison. Although the studies in Spain and Mexico both used the Spanish version of the BSL-23, they were separated to account for cultural differences.

Provided BSL-23 scores were compared between: (1) individual scores in BPD population, (2) individual scores in healthy controls (HC) and clinical controls (CC), and (3) comparison of pre- and post- BSL-23 scores in BPD population. A difference was found in how the researchers reported the final BSL-23 score, some reporting the total score rather than the mean. For the ease of comparison, we calculated the means of BSL-23 scores for these studies [29]-[34]

Synthesis

The data were analysed using a narrative synthesis model following guidance by Popay et al., (2006) [35], to describe the current literature reporting on the use of the measure with adults diagnosed with BPD. The BSL-23 scores were plotted on graphs for ease of comparison.

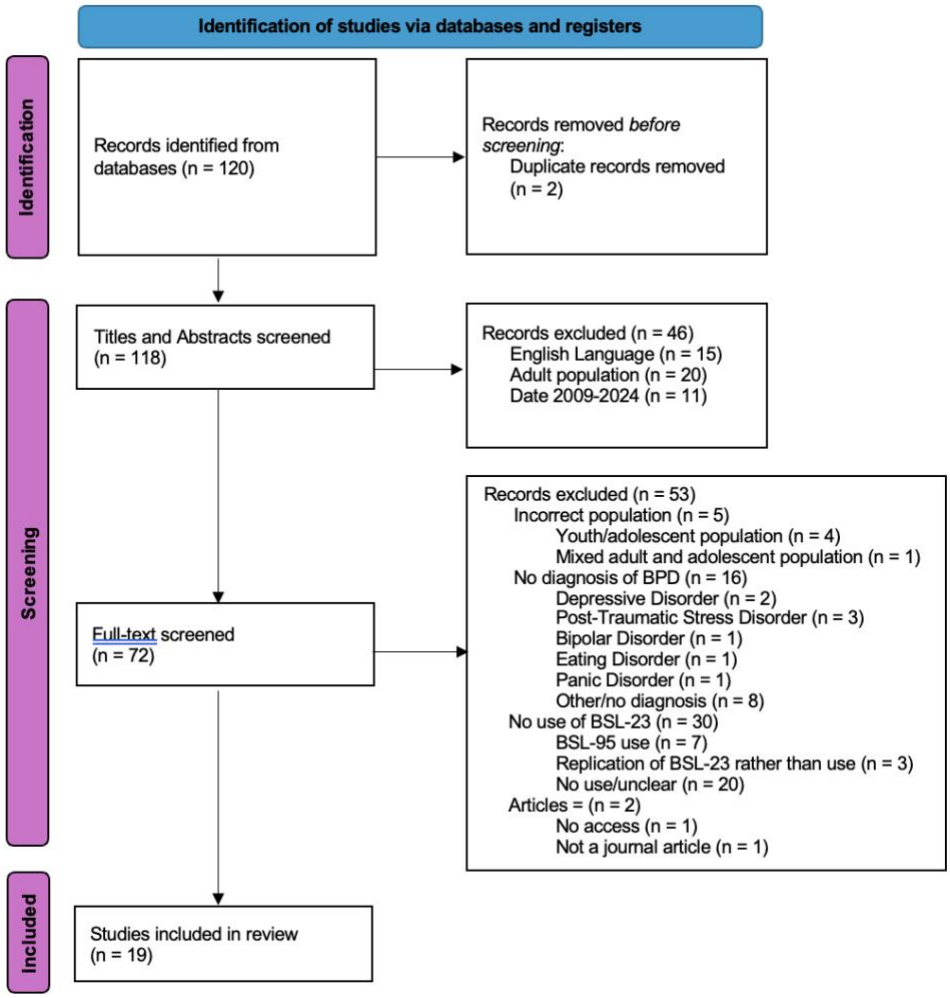
Results

Search Results

A total of 120 articles were identified through the search. Following de-duplication, 118 were retained for title and abstract screening, after which 46 were excluded for clearly not meeting the inclusion criteria. 72 articles were therefore considered for full-text review, after which a further 53 were excluded due to having a population of under 18s or mixed adult and adolescent population ($n = 5$), not measuring the diagnosis of BPD ($n = 16$), no clear use of the BSL-23 ($n = 30$), not having access to the article ($n = 1$) and being a letter rather than an article ($n = 1$). Therefore, 19 studies met the inclusion criteria and have been included in the current review. Figure 1 shows the PRISMA flow-chart.

Figure 1

PRISMA Flow-chart



Participant Characteristics

Samples were collected in a range of countries, Germany being the most common. Samples were recruited from outpatient services ($n = 10$), inpatient hospitals ($n = 4$), unspecified mental health services ($n = 2$) and volunteers ($n = 3$). See Table 1 and Table 2 for more details.

Quality Summary

See Figure 2 for summary of the quality assessment. Although there was variability in the quality of studies, the majority scored ‘very good’ or ‘adequate’. The main areas of weakness were a lack of clear descriptions of how participants were supported to be stable in between contacts and unclear descriptions of the sampling methods used. Inadequate explanation of how missing data were handled was seen in 21% of the studies. A particular strength seen across studies was the description of appropriate analyses.

Table 1

Context and population of the BSL-23 application (studies are ordered by country and alphabetically)

Year	Reference	Country (language)	Setting	Sample Size and Gender	Ethnicity (%)	Age (SD)	Diagnosis (%)
2018	Robinson et al. [36]	Canada (not stated)	Outpatients	N = 97 90% Female 10% Male	Not stated	Not stated	BPD (100%)
2019	Signer et al. [37]	Canada (French)	Not available	N = 50 Standard sample N = 23 83% Female 17% Male Responsive sample N = 27 52% Female 48% Male	Not stated	Standard sample 31.96(9.43) Responsive sample 34.7(9.62)	BPD (100%)
2022	Sverak et al. [34]	Czech Republic (Czech *assumed)*	Not available	N = 14 79% Female 21% Male	Not stated	23.57(4.73)	BPD (100%)
2021	Hilden et al.[33]	Finland (Finnish *assumed)*	Outpatients	Total N = 35 Schema Therapy N = 23 92% Female 8% Male TAU N = 12 100% Female	Not stated	Schema Group + TAU 31(8.8) TAU 27(3.7)	BPD (100%)
2020	Kleindienst et al. [38]	Germany German *(assumed)*	Recruited by Clinical Research Unit (recruited via volunteer sample university, hospital, clinic and residents' registration office)	Total N = 1,090 BPD_CAL N = 241 83% Female 17% Male BPD_VAL N = 317 100% Female CC N = 176 61% Female 39% Male HC N = 356 79% Female 21% Male	Not stated	BPD_CAL 29.43(8.15) BPD_VAL 28.52(7.91) CC 41.44 (no SD available) HC 27.68(6.88)	BPD (51%) Clinical Control (axis-I disorders with no BPD; schizophrenia, delusional disorder, major depressive disorder, other affective disorders, anxiety disorder, obsessive affective disorders, eating disorder) (16%) HC 33%)
2021	Kleindienst et al. [39]	Germany German *(assumed)*	Outpatients	N = 54 100% Female	Not stated	25.5(10.6)	Dual diagnosis of BPD + PTSD (100%)
2019	Metz et al.[40]	Germany (German)	Inpatients, Outpatients Volunteer sample for HC	Total N = 78 100% Female	Not stated	BPD 27.87(4.34)	BPD (23%)

				BPD N = 18 PTSD N = 20 HC N = 40		PTSD 29.67(9.33) HC 28.65(7.27)	PTSD (26%) HC (51%)
2020	Nenov-Matt et al.[41]	Germany (German *assumed)*	Unclear	Total N = 140 BPD N = 36 53% Female 47% Male PDD N = 34 44% Female 56% Male HC N = 70 49% Female 51% Male	Not stated	BPD 28.8(9.2) PDD 38.2(12.3) HC Age and gender matched BPD and PDD.	BPD (26%) PDD (24%) HC (50%)
2016	Paret et al.[42]	Germany *confirmed via direct email to authors)* (German *confirmed via direct email to authors)*	Volunteer sample via media and websites	Total N = 36 100 % Female BPD N = 21 HC N = 15	Not stated	BPD 27(6.7) HC 25.1(3.7)	BPD (58%) HC (42%)
2023	Plett et al. [43]	Germany (German *assumed)*	Inpatient	Total N = 40 Gender not stated BPD N = 20 Matched controls with BPD N = 20	Not stated	Not stated	BPD (50%) Matched controls with BPD (50%)
2019	Probst et al. [44]	Germany (German *assumed)*	Inpatient	N = 33 75% Female 25% Male	Not stated	30.16(9.39)	BPD (100%)
2019	Schauer et al. [45]	Germany (German *assumed)*	Inpatients, Outpatients Volunteer sample for HC	Total N = 40 BPD N = 18 95% Female 5% Male HC N = 22 82% Female 18% Male	Not stated	BPD 28.28(5.8) HC 26.27(4.9)	BPD (45%) HC (55%)
2021	Calderon-Moctezuma et al. [31]	Mexico (Spanish)	Outpatients	N = 14 Active N = 7 71% Female 29% Male	Not stated	Active 24(6.29) Sham 28.14(8.31)	BPD (100%)

				Sham N = 7 57% Female 43% Male			
2021	Frias et al. [29]	Spain (Spanish)	Outpatients	N = 25 84% Female 16% Male	Not stated	35.80(9.90)	BPD (100%)
2021	Lorca et al. [46]	Spain (Spanish)	Unspecified Mental Health Services	N = 102 74% Female 26% Male	Not stated	37.67(12.59)	BPD (100%)
2021	Marco et al. [47]	Spain (Spanish; *confirmed via direct email to authors)*	Unspecified Mental Health Centres	N = 250 94% Female 6% Male	Caucasian (100%)	29.55(10.40)	BPD (77.9%) CC: Personality disorders (Cluster A, Cluster B, Unspecified) (22.1%)
2014	Martín-Blanco et al. [32]	Spain (Spanish)	Outpatients	N = 8 92% Female 8% Male	Not stated	36.7(8.4)	BPD (100%)
2020	Navarro Gómez et al. [30]	Spain (Spanish)	Outpatients	Total N = 49 BPD+RR N = 23 95.5% Female 4.5% Male BPD-RR N = 26 96.2% Female 3.8% Male	Not stated	BPD+RR 38.65(6.46) BPD-RR 38.88(9.38)	BPD (100%)
2017	Kramer [48]	Switzerland (*confirmed via direct email to authors)* French	Outpatients	N = 31 87% Female 13% Male	Not stated	34.5(9.6)	BPD (100%)

Key

SD: standard deviation; BPD: Borderline Personality Disorder; CC: clinical controls; BPD+RR: Borderline Personality Disorder within a romantic relationship; BPD-RR: Borderline Personality Disorder without a romantic relationship; TAU: treatment as usual; BPD_cal: Borderline Personality Disorder calibration group; BPD_val: Borderline Personality Disorder validation group; HC: healthy controls; PTSD: post-traumatic stress disorder; PDD: persistent depressive disorder

Table 2

Applications of the BSL-23 in clinical and research settings (studies are ordered by country and alphabetically)

Year	Reference	Broad Aims	Research design	BSL version (internal consistency)	BSL Use	Description of BSL administration	BSL Mean (SD)	Summary of findings	Response rate
2018	Robinson et al. [36]	Aims to evaluate the effectiveness of an MDT team administrating the DBT programme.	Longitudinal observational study (assumed)	No internal consistency for current sample.	Measures compared at 3-, 6- and 12-month intervals to evaluate the effectiveness of intervention.	Filled out self-report measures at 3-, 6- and 12- months.	pre- 2.36(0.78) 3-mths 2.33(0.78) 6-mths 1.64(0.86) 12-mths 1.36(0.99)	Results showed significant decline in BPD symptoms as measured by the BSL-23. Analyses also showed that coping behaviours have improved as assessed by DBT-usage in DBT-WCCL.	81%
2019	Signer et al. [37]	Evaluation of social interaction patterns and therapist responsiveness in a responsive treatment compared to a standard treatment.	RCT with an add-on design to compare two treatments	French (Cronbach's $\alpha = 0.94$).	Completed at intake and discharge.	Not explained	Standard pre- 1.72(1.06) post- 1.40(1.06) Responsive pre- 1.9(0.88) post- 1.57(0.92)	Social interaction patterns in standard treatment showed no relationship to outcome or therapeutic alliance. Higher social interaction patterns in the responsive treatment predicted better interpersonal problems outcomes and lower therapist ratings of alliance.	100%
2022	Sverak et al. [34]	Investigation of the impact of rTMS over the right dorsolateral prefrontal cortex on impulse control, emotion regulation, anxiety and depression in a BPD sample.	Open single-arm study	Czech(assumed) No internal consistency for current sample.	Completed before and after.	Not explained how	pre- 43.29(22.28) post- 33.64(19.68)	Lack of Premeditation and Lack of Perseverance in the UPPS-P impulsivity scale, improvement in emotion regulation (DERS), reduction of depressive symptoms (MADRS), and borderline significant reduction of anxiety symptoms (SAS) was seen as significantly reduced after rTMS. No significant change was found in the BSL-23 scores, negative and positive urgency, or errors in the go/no go task.	100%
2021	Hilden et al.[33]	Feasibility and effectiveness of a 20-week schema group for BPD.	Randomised, parallel-arm prospective intervention study	Finnish(assumed) No consistency for current sample.	Not stated	Not explained how	Schema group pre- 39.0(15.1) post- 32(16.4) TAU pre- 55.7(14.9) post- 42.6(18.8)	The study was unable to provide information that the 20-week schema group was more effective than TAU. There has been a decrease in BSL-23 scores in both groups.	83%
2020	Kleindienst et al. [38]	Provide a severity classification for BSL-23.	Cross-validation study (assumed)	German(assumed) No consistency for current sample.	BPD_val and CC filled out BSL-95 from which the 23 questions were calculated. Measures were included if 21 out of 23 questions were completed.	Not explained how	BPD_cal 1.87(0.8) BPD_val 2.34(0.86) CC 1.08(0.79) HC 0.12(0.17)	Six grade classifications were established regarding the severity of symptoms: non/low, mild, moderate, high, very high and extremely high.	100%
2021	Kleindienst et al. [39]	Evaluating whether CPT or DBT treatment for PTSD is better able to are reduce symptoms of dual diagnosis of PTSD and BPD.	Subgroup analysis from an RCT	German(assumed) No consistency for current sample.	Not stated	Not explained how	No BSL-23 scores reported	Both CPT and DBT groups showed significant improvement as a treatment for dual diagnosis of BPD and PTSD. Between-group analysis found greater improvement of PTSD symptoms, BPD symptoms and dissociation in the DBT group compared to CPT, whilst there were no differences in improvements in depression and global functioning.	58%

2019	Metz et al.[40]	Analysis of RSFC in hippocampus and amygdala, after administration of 10mg of steroid medication hydrocortisone or placebo.	Placebo-controlled cross-over study	German No consistency for current sample.	Used to compare samples in the study.	Patients were asked to rate their symptoms.	HC 0.10(0.10) PTSD 1.34(0.84) BPD 1.75(0.80)	There was a difference between HC and both patient groups showing reduced positive RSFC between the hippocampus and dmPFC, with no difference between patient groups. No RSFC was found between hydrocortisone and placebo groups.	100%
2020	Nenov-Matt et al.[41]	Improve understanding of loneliness regarding symptom burden, social network characteristics, cognitive biases and childhood maltreatment in PDD and BPD client groups, compared to matched HC.	Cross-sectional	German(assumed) No consistency for current sample.	Unclear	Not explained	PDD 1.0(0.7) BPD 2.0(0.9) HC(PDD) 0.2(0.2) HC(BPD) 0.2(0.2)	PDD and BPD groups showed significantly higher levels of perceived loneliness compared to their matched HC, with BPD being higher than PDD. Clinical groups also scored higher on depressive symptoms, borderline symptoms, rejection sensitivity and rejection sensitivity. With PDD group reporting more emotional abuse, emotional neglect and physical neglect compared to HC, whilst BPD reported higher on all subscales compared to HC.	100%
2016	Paret et al.[42]	Evaluating whether presence of emotional stimuli affected operant conditioning in individuals with BPD compared to matched HC.	Correlational study	German *(confirmed via email)* (Cronbach's $\alpha = 0.83$).	Prior to experiment.	Not stated	HC 0.12(0.10) BPD 2.35(0.56)	No group interactions between aversive and neutral stimuli were found, therefore performance was not affected by emotional stimuli. Higher emotional arousal and higher dissociation were associated with worse acquisition. BPD sample performed worse in reversal task.	97%
2023	Plett et al. [43]	Evaluating the difference in short-term therapeutic outcome, subjective well-being and salivary cortisol and oxytocin in human-guided skills training for BPD compared to animal-assisted skills training.	Comparative intervention study (assumed)	German(assumed) No internal consistency for current sample.	Pre- measures and post-measures after the 6-week interventions.	Participants filled out on day 1 but not said how.	animal pre- 2.35(0.53) post- 1.82(1.0) human pre- 2.03(0.56) post- 1.57(0.81)	Both interventions showed a significant reduction in cortisol and a non-significant increase in oxytocin. There was a significant reduction of symptom severity in both groups.	100%
2019	Probst et al. [44]	Evaluate symptom reduction and emotion regulation in a BPD sample after a 5-week DBT in an inpatient setting.	Pre-post intervention study (assumed)	German(assumed) No internal consistency for current sample.	Pre- treatment measures and post- treatment measures.	Not explained	pre- 1.91(0.94) post- 1.48 (0.92)	Significant improvement in BPD symptoms and emotion regulation after the 5-week DBT.	69%
2019	Schauer et al. [45]	Investigating whether alpha and low-beta frequency of oscillations occur in BPD clients.	Comparative study (assumed)	German(assumed) No internal consistency for current sample.	Not stated	Not explained	No BSL-23 scores reported	Individuals with BPD diagnosis significantly placed a "higher bet" compared to control. Differences between groups in the alpha frequency range were not significant. Significant positive correlation between valence different score (gain – loss) for induced low-beta and symptomology measured with BSL-23.	91%
2021	Calderon-Moctezuma et al. [31]	Evaluation of clinical and neuropsychological effects on the DMPFC after 15 sessions of rTMS.	Single-blind crossover RCT	Spanish No consistency for current sample.	Measured at baseline, weekly and post-treatment.	Weekly administration unclear whether self-reported.	Active pre- 52.29(22.91) post- 29.14(32.71) Sham (BPD control) pre- 41.86(23.31) post- 37.71(35.44)	Significant improvements between-groups seen in impulsiveness (CGI-BPD) and anxiety. Within-group analyses showed significance in overall BPD scores (CGI-BPD), abandonment, paranoid ideation, total BEST scores, depression and anxiety but no statistical differences in impulsiveness in either group (BIS, CGI-BPD). Neuropsychological domains found decision making significant in the active group and IGT in the sham group.	65%
2021	Frias et al. [29]	Determining the usability and satisfaction of a new app (B-RIGHT) designed	Pilot Study	Spanish (No consistency for current sample.	BSL was used to assess severity of borderline	The BSL was distributed when attending a group session.	48.16(21.02)	Moderate levels of borderline symptoms were found after using the app for a month,	100%

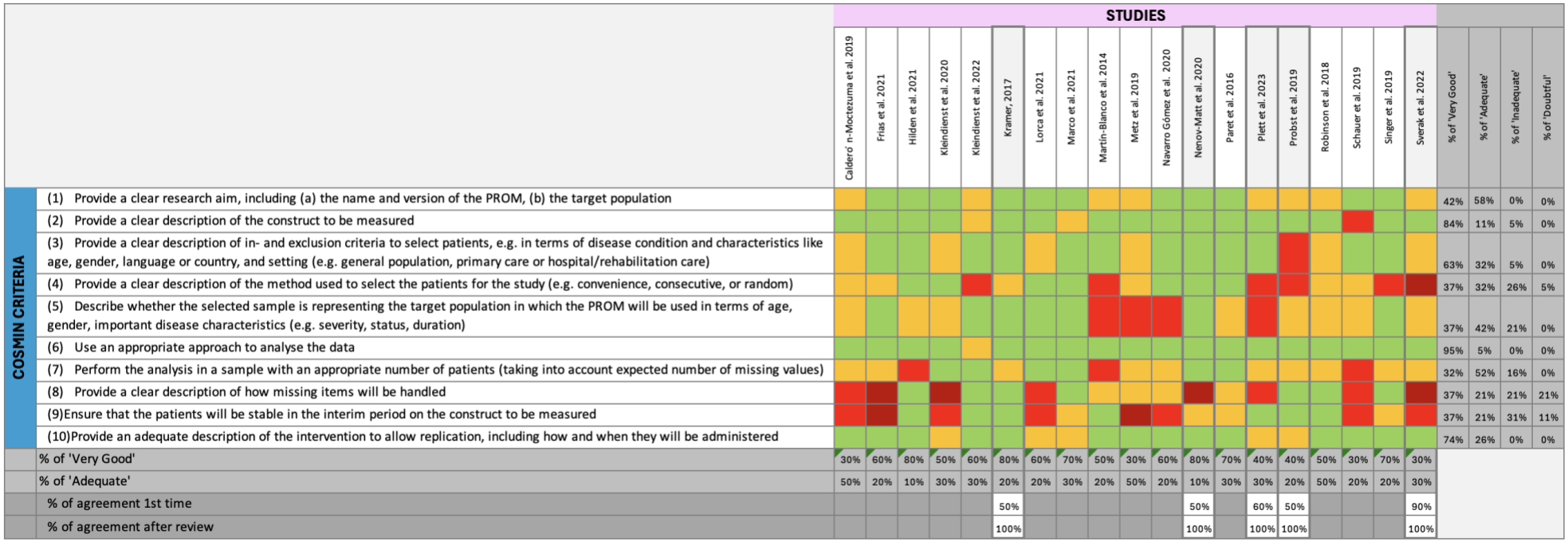
		using an AI algorithm to support with self-managing crises.			symptoms after the use of the app.			with reports of an ease of use and satisfaction.	
2021	Lorca et al. [46]	Evaluating whether the three dimensions of meaning of life (coherence, purpose and significance) predict BPD symptomology.	Cross-sectional study	Spanish (Internal consistency x = .95).	BSL was given during the assessment stage.	Participants filled out the BSL-23 questionnaire, in the second session.	1.67(0.95)	Borderline symptoms were negatively associated with meaning of life. Significant predictors of BPD were comprehensibility, vital goals and meaning and satisfaction. Manageability was seen as not significant.	100%
2021	Marco et al. [47]	Using the ERQ with clinical samples of BPD clients, to confirm the factorial structure and analyse its psychometric properties against BSL-23 and DERS.	Validation Study *(confirmed via direct email to authors)*	Spanish (Internal consistency α = .97).	Completed at the beginning of the study to have a baseline.	Completed in one of the 2 assessment sessions. Not explained how.	No BSL-23 scores provided	Study found good internal consistency of the Spanish version of EQR. Cognitive reappraisal scale of the EQR had a significant negative correlation with the BSL-23 in a whole PD population, and significant negative correlation with the BSL-23 in a BPD population. Emotional suppression found a positive significant correlation with the BSL-23.	100%
2014	Martín-Blanco et al. [32]	Assessment of the efficacy, security and tolerability of the antipsychotic drug Asenapine as treatment for BPD.	Observational open-label, uncontrolled study	Spanish No consistency for current sample.	Used to evaluate the efficacy of the drug.	Not explained how	pre- 55 post- 44.3	Significant improvement was seen in the CGI-BPD scores and the impulsivity, affect instability and emptiness subscale. Significant decrease was seen in BSL-23 and BPRS.	66%
2020	Navarro Gómez et al. [30]	Comparing the clinical profile of BPD individuals who maintained a Romantic Relationship (RR) versus those who did not have a RR.	Case control-study	Spanish (Internal consistency α = .97 *uncertain whether for the measure or current sample).*	Self-administered questionnaires were administered after a week, in the 2nd session.	Completed individually in the session with support from interviewers if any doubts occurred.	BPD+RR 61.68(22.64) BPD-RR 48.52(32.40)	No significant symptom severity was found between the two groups. RR group showed higher level of aggression, higher traumatic childhood episodes, poorer physical, higher psychological health levels and lower self-esteem compared to sample with no RR. Physical aggression was the most relevant predictor of marital status of BPD.	89%
2017	Kramer [48]	Exploring whether 20 sessions of DBT skills training (SKILLS) alongside TAU affects change in coping.	Process-outcome study	French (Cronbach's α = 0.89).	Competed at baseline and at end of treatment. BSL was one of a two measures used to evaluate intervention factors which predicted symptom change.	Completed at intake and discharge.	*Intake only* SKILLS 1.79(0.88) TAU 1.88(0.74)	Individuals with SKILLS showed an increase in adaptive coping in relatedness domain and decreased frequency in non-adaptive coming in the autonomy domain, compared to TAU. Reduction was seen on the BSL-23 despite the condition.	100%

Key

BSL: Borderline Symptom List; SD: standard deviation; AI: artificial intelligence; BPD: Borderline Personality Disorder; ERQ: Emotion Regulation Questionnaire; DERS: Difficulties in Emotion Regulation Scale; PD: Personality Disorder; CGI-BPD: Clinical Global Impression for BPD; BPRS: Brief Psychiatric Rating Scale; BPD+RR: Borderline Personality Disorder within a romantic relationship; BPD-RR: Borderline Personality Disorder without a romantic relationship; TAU: treatment as usual; CC: clinical controls; BPD_cal: Borderline Personality Disorder calibration group; BPD_val: Borderline Personality Disorder validation group; HC: healthy controls; CPT: Cognitive Processing Therapy; DBT: Dialectical Behavioural Therapy; PTSD: post-traumatic stress disorder; RCT: random controlled trials; RSFC: Resting State Functional Connectivity; dmPFC: dorsomedial prefrontal cortex; PDD: persistent depressive disorder; MDT: multi-disciplinary team; DBT-WCCL: DBT ways of coping checklist; rTMS: repetitive transcranial magnetic stimulation; MADRS = Montgomery and Åsberg Depression Rating Scale; SAS: Zung self-rating Anxiety Scale: BEST: Borderline Evaluation of Severity over time; BIS: Bratt's Impulsiveness Scale; IGT: Iowa Gambling Test; SKILLS: TAU+DBT skills training group

Figure 2

Adapted COSMIN Tool



COSMIN CRITERIA	STUDIES																				% of 'Very Good'	% of 'Adequate'	% of 'Inadequate'	% of 'Doubtful'
	Calderó n-Moctezuma et al. 2019	Frías et al. 2021	Hilden et al. 2021	Kleindienst et al. 2020	Kleindienst et al. 2022	Kramer, 2017	Lorca et al. 2021	Marco et al. 2021	Martín-Blanco et al. 2014	Metz et al. 2019	Navarro Gómez et al. 2020	Nenov-Matt et al. 2020	Paret et al. 2016	Plett et al. 2023	Probst et al. 2019	Robinson et al. 2018	Schauer et al. 2019	Singer et al. 2019	Sverak et al. 2022					
(1) Provide a clear research aim, including (a) the name and version of the PROM, (b) the target population																					42%	58%	0%	0%
(2) Provide a clear description of the construct to be measured																					84%	11%	5%	0%
(3) Provide a clear description of in- and exclusion criteria to select patients, e.g. in terms of disease condition and characteristics like age, gender, language or country, and setting (e.g. general population, primary care or hospital/rehabilitation care)																					63%	32%	5%	0%
(4) Provide a clear description of the method used to select the patients for the study (e.g. convenience, consecutive, or random)																					37%	32%	26%	5%
(5) Describe whether the selected sample is representing the target population in which the PROM will be used in terms of age, gender, important disease characteristics (e.g. severity, status, duration)																					37%	42%	21%	0%
(6) Use an appropriate approach to analyse the data																					95%	5%	0%	0%
(7) Perform the analysis in a sample with an appropriate number of patients (taking into account expected number of missing values)																					32%	52%	16%	0%
(8) Provide a clear description of how missing items will be handled																					37%	21%	21%	21%
(9)Ensure that the patients will be stable in the interim period on the construct to be measured																					37%	21%	31%	11%
(10)Provide an adequate description of the intervention to allow replication, including how and when they will be administered																					74%	26%	0%	0%
% of 'Very Good'	30%	60%	80%	50%	60%	80%	60%	70%	50%	30%	60%	80%	70%	40%	40%	50%	30%	70%	30%					
% of 'Adequate'	50%	20%	10%	30%	30%	20%	20%	30%	20%	50%	20%	10%	30%	30%	20%	50%	20%	20%	30%					
% of agreement 1st time						50%						50%		60%	50%				90%					
% of agreement after review						100%						100%		100%	100%				100%					

Key: *Green = very good; Amber = adequate; Red = doubtful; Burgundy = Inadequate*

Research Question 1: What contexts and population have the BSL-23 been applied to and its practical implications in clinical and research settings?

Setting

The majority of the studies used outpatient samples ($n = 8$). Kleindienst et al., (2020) [38] used a Clinical Research unit containing volunteers, universities, hospital clinics and registration offices to recruit clinical samples and HC. Metz et al., (2019) [40] and Schauer et al. (2019) [45] used mixed outpatient and inpatient settings for their sample. Two studies used only inpatient samples [43]-[44]. Most HCs were recruited via a volunteer sample, with one study using volunteers for both clinical and HC [41] . Five studies did not specify the setting [34], [37], [41], [47].

Studies originated in seven countries: Germany ($n = 8$), Spain ($n = 5$), Canada ($n = 2$), Finland, Czech Republic, Mexico and Switzerland ($n = 1$ in each). The total number of participants in this review was 2,186, of which 1,378 came from a clinical BPD population, 285 from other clinical populations (CC) and 523 HC. The largest sample size was from Germany ($n = 1{,}511$). CC were found in Spain ($n = 55$) and Germany ($n = 230$), while HC were only recruited from Germany. Figure 3 and Figure 4 show the total sample size of the population and the BPD sample size, per country.

Figure 3

Total sample per country

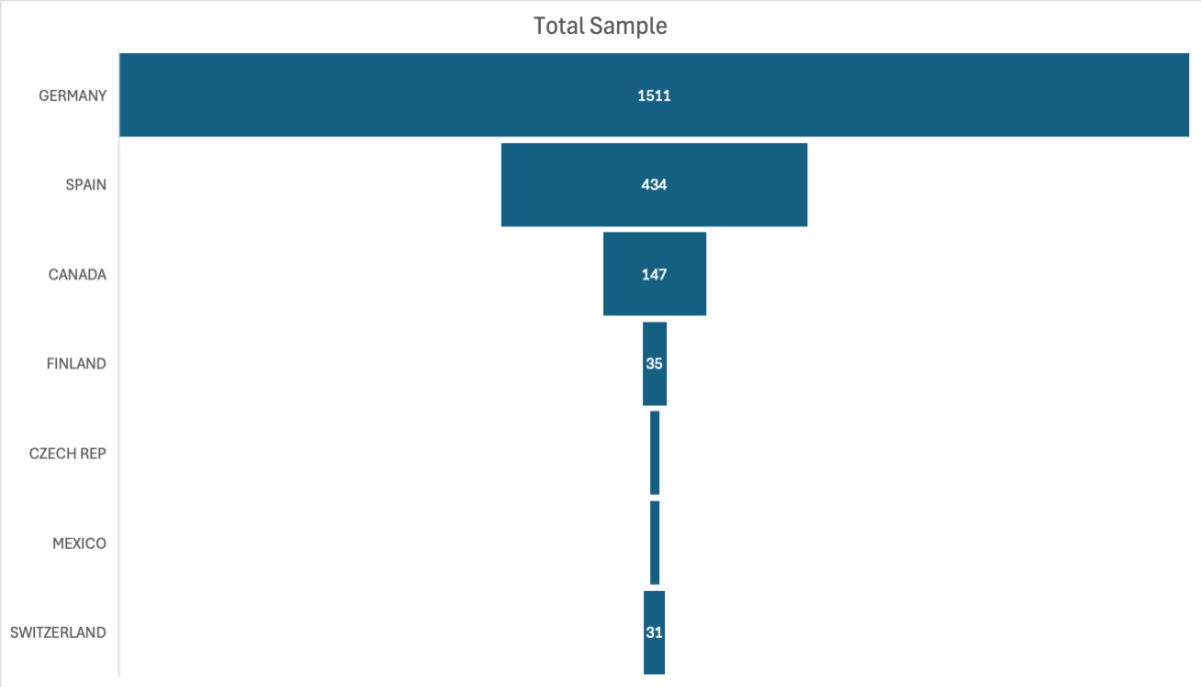
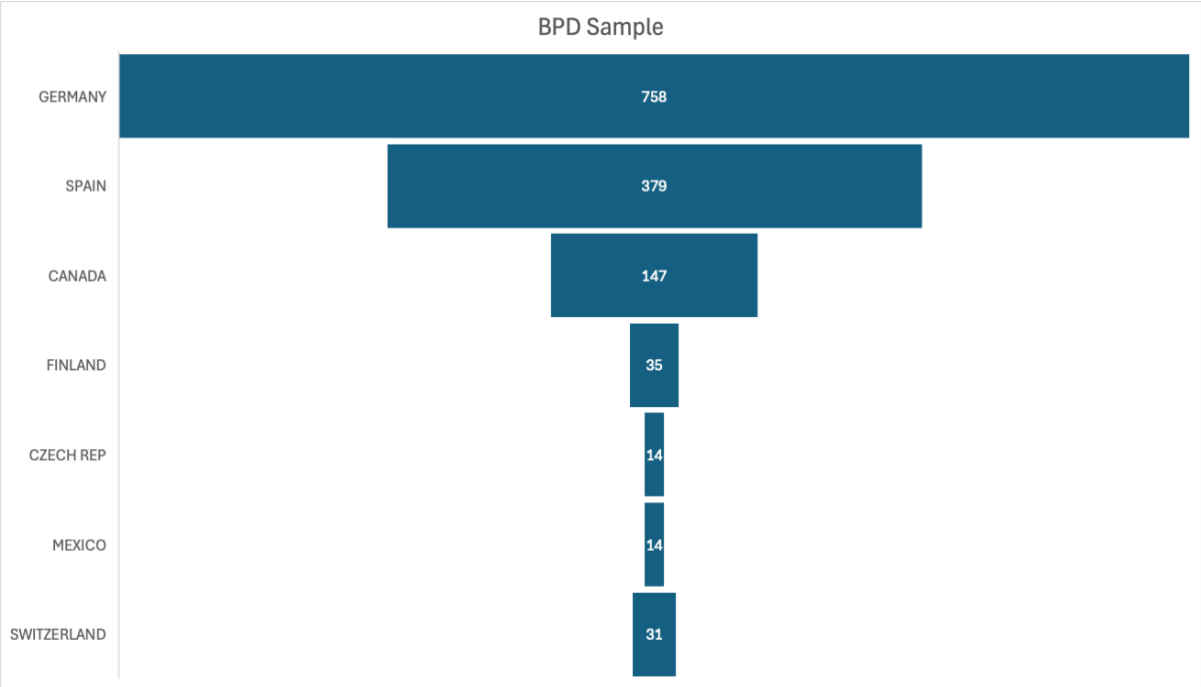


Figure 4

Total BPD sample per country



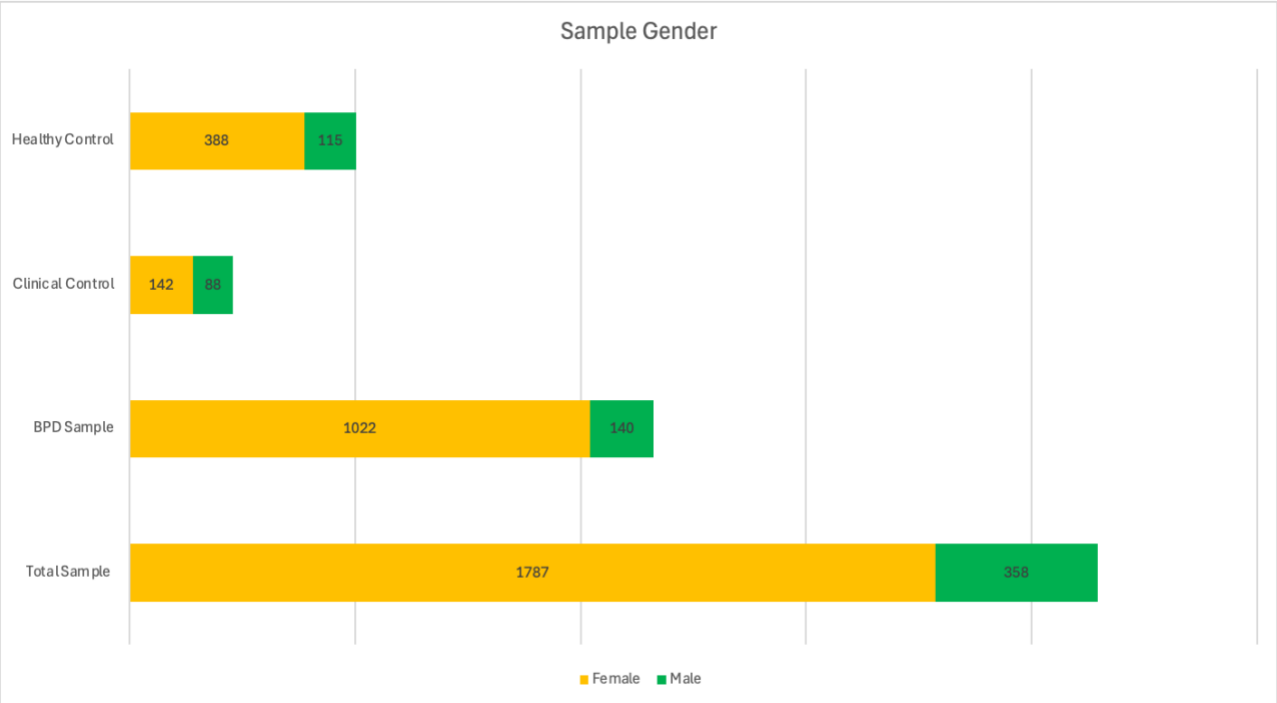
Population

In the total 2,186 participants recruited, the average age was 31.02(4.99), compared to 30.86(4.76) in the BPD population, 36.44(6.08) in the CC and 29.12(4.67) in the HC sample. Two studies did not state their sample age [36], [43].

Most of the participants were women ($n = 1{,}787$; men $n = 358$). One study did not state the gender of their sample [43]. The same gender pattern was observed in the clinical BPD population, with an even greater female bias, ($n = 1{,}015$; 88%; men $n = 134$; 12%). Two studies did not state the gender of their BPD population [43], [47] The proportions were similar in the CC and HC groups as shown in Figure 5. No studies reported other genders.

Figure 5

Sample divided by gender and groups



Utilisation of BSL-23

There appeared to be two main purposes for the implementation of the BSL-23 in these studies. The first was for the purpose of measuring symptomology after an 'intervention' (including therapy and drugs) or development of a 'service' (any development e.g. intervention), the second being to improve understanding of BPD symptomology.

Measuring Symptomology

Commonly, BSL-23 was used to look at the symptoms in the population to measure the effectiveness of an intervention. Many of the interventions were Dialectical Behavioural Therapy (DBT) focused. One study [33] looked at measuring the effectiveness of a 20-week schema group, while others considered the effectiveness of DBT [36], [39], [44], [48]. One study [39] specifically looked at comparing Cognitive Processing Therapy (CPT) to DBT, while another [44] evaluated a short version of DBT in inpatient settings. Kramer (2017) [48] evaluated whether DBT skills training was effective alongside treatment as usual (TAU), while Robinson et al. (2018) [36] evaluated DBT delivered by a multi-disciplinary team (MDT).

BSL-23 scores were also used to evaluate implementation of drugs for BPD (*Asenapine* [32], *hydrocortisone* [40]). Two studies looked at the impact on BPD symptomology after administration of Repetitive Transcranial Magnetic Stimulation (rTMS) [31], [34].

Studies also used the BSL-23 to compare groups. One study [43] compared animal assisted-treatment group to a standard group, while another [37] compared patient groups which either received usual or more responsiveness from therapists.

Three studies used BSL-23 to measure BPD symptomology after development of services. The first study evaluated the symptomology after introducing a phone application to support with crises usually seen in BPD [29]. Second used BSL-23 to support with the development of a new measure [47]. The third used the current BSL-23 to develop BSL-23 severity classification [38].

Improving understanding

Lorca et al. (2021) [46] focused on evaluating dimensions of meaning of life to predict BPD symptomology. Navarro-Gómez et al. (2020) [30] compared two BPD groups, one in romantic relationships compared to ones without, to understand differences between them. One study [41] looked at improving understanding of the symptom of loneliness in BPD compared to HCs and another [42] compared BPD to HCs by looking at whether presence of emotional stimuli affects operant conditioning. Lastly, Schauer et al. (2019) [45] examined alpha and low-beta electroencephalogram (EEG) frequency patterns in patients with BPD compared to controls.

Effectiveness of implementation of BSL-23

There were four distinct ways in which the studies used the BSL-23 to measure effectiveness of interventions. Two studies looked at one single total score of the BSL-23 measure in a BPD population and classified clients according to the level of symptomatology in the sample [29], [46].

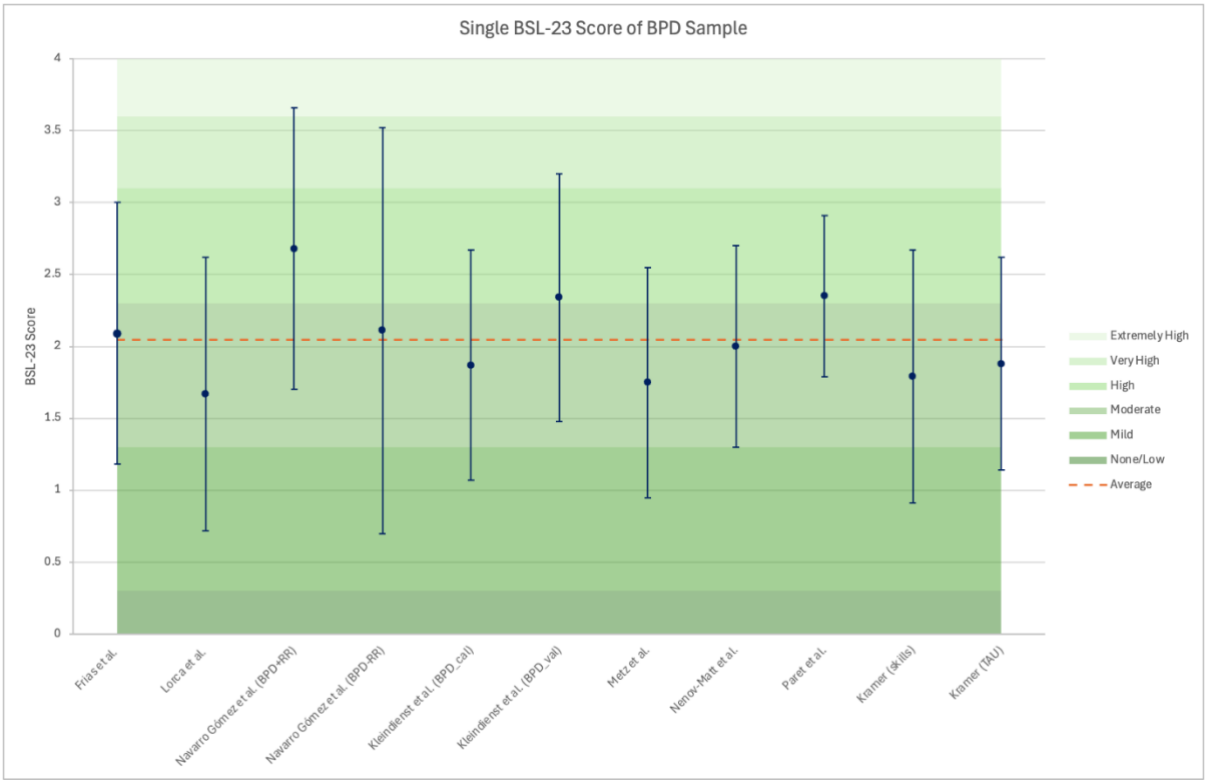
Seven studies used the BSL-23 to compare two BPD samples [30], [31], [36]-[39], [43], [48]. All studies followed a similar pattern of randomly assigning their sample to either an intervention group (treatment, intervention or drug) or TAU. Figure 6 illustrates the BSL-23 scores obtained from these papers, coded by severity levels as reported by Kleindienst et al. (2022) [23]. The figure demonstrates the variability of symptomology found between studies.

Five studies compared BPD sample to CC [38], [40]-[42], [47], which included mental health disorders such as PTSD, persistent/major depressive disorder (MDD), schizophrenia, delusional disorder, other affective disorders, anxiety disorder, obsessive affective disorders and eating disorders. One study included cluster A, cluster B and unspecified personality disorders and analysed it combined with the BPD sample [47]. Five studies compared BPD sample to HC [31], [38], [40]-[43] .

Eight studies used the BSL-23 as a comparative measure, providing a score prior to their research and at the end, comparing the effectiveness of BSL-23 scores over time [31]-, [34], [36][37], [43]-[44]. Four studies compared this with TAU or control of another BPD sample [31], [33], [37], [43]. Two studies did not report a BSL-23 score [45] [47].

Figure 6

Graph illustrating single score of BSL-23 for the BPD sample. Error bars represent ± one standard deviation.

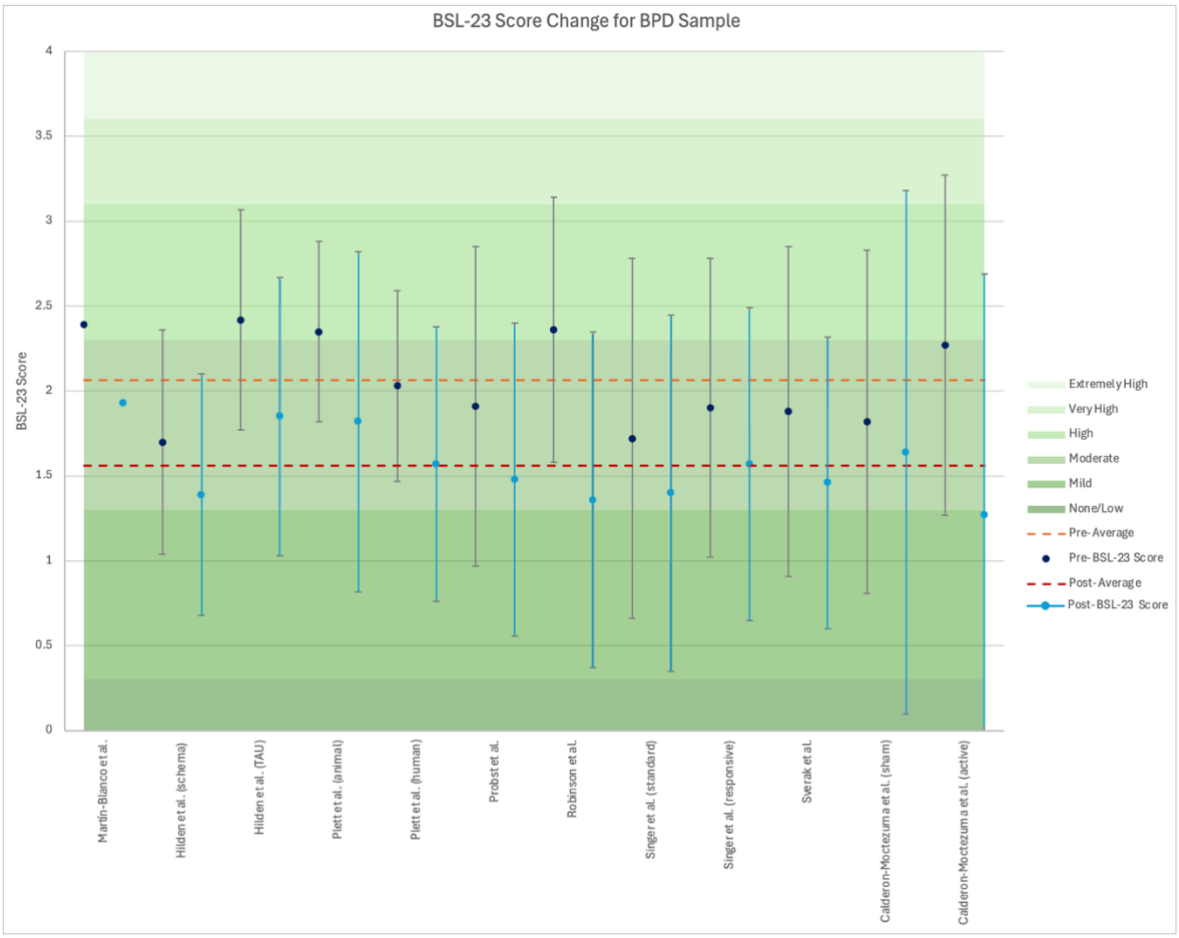


Score change

Studies which reported pre- and post- scores appear to show that the BSL-23 can detect change over time. Figure 7 represents the pre- and post- scores for all BPD groups. The figure also illustrates the variability of scores between studies, which appears to be of at least a similar magnitude to changes which occurred over time. In both pre- and post- conditions, the majority of studies reported average scores within moderate to high severity levels. It is important to note that even TAU groups show a decrease in BPD symptoms as measured by the BSL-23 (sham [31]; TAU [33]; standard [37]).

Figure 7

Graph illustrating pre- and post- BSL-23 scores for the BPD sample. Error bars represent ± one standard deviation.



Research Question 2: How has the BSL-23 been used to monitor treatment outcomes based on symptom severity over time?

Studies typically administered the BSL-23 before an intervention (pre-) and after (post-). One study additionally administered the measure in-between [36] and one administered it weekly [31]. This allows for score change to be tracked, with reduction of symptoms indicating lower symptomology of BPD. This can be effective to track therapeutic progress. CC and HC samples have been reported to fall in the none/low or mild list. Looking at Figure 7, all studies reported a decrease of BSL-23 scores, with one study falling into the mild severity (mean 1.64) [31].

The difference between the scores is important to help identify the direction and size of any change. The largest change was made by 1 full score which was reported by two studies [31], [36] and the smallest difference was 0.18 (sham group) [31].

The length of time and intensity of the interventions varied across studies, which may impact on the change of severity of symptoms. Robinson et al., (2018) [36] had the highest reported score difference and their intervention took up to 12-months, with group sessions, individual therapy and phone coaching. Other interventions lasted 5-weeks [44], 6-weeks [43], 8-weeks [32] and 20-weeks [33]. Two studies had 15 sessions of intervention, once a day, five times per week [31], [34], while one study had 10-sessions, without specificity of the length of time for these sessions [36].

Research Question 3: What methodological approaches have been used in applying the BSL-23?

Design

A range of study designs have been used, which were grouped into six distinct categories: (1) experimental designs which included randomised controlled trials (RCT), single-blind crossover RCT, placebo-controlled cross-over study, randomised parallel-arm prospective intervention study, comparative intervention study and pre-post intervention study. (2) Observational studies included cross-sectional study, longitudinal observational study, case-control study, observational open-label uncontrolled study and open single-arm study. (3) Validation and methodological studies contained two studies, a validation and cross-validation study. Subgroup analysis from an RCT and process-outcome study fell into (4) secondary or subgroup analyses. (5) Comparative and correlational studies included one comparative and one correlational study. Lastly (6) Preliminary or Feasibility studies included one pilot study.

Sample Characteristics

There was a variety of sample sizes, with the largest having a total of 1,090 participants [38]. The smallest sample size had 8 participants, all with BPD [32]. The size difference across studies may affect the generalisability of the results.

Exclusion criteria of the samples included other diagnoses such as BD, addictions, MDD, psychosis and anorexia nervosa (AN) [34], [40]. Other studies focused on the presentation of symptoms rather than diagnosis, such as severe depressive symptoms, manic symptoms, substance intoxication, psychotic symptoms [36]. and suicide attempts in the past

two months [39]. One study's only exclusion criterion was animal hair allergy [43]. Although some studies excluded comorbid diagnoses, many noted the comorbidities found in their BPD sample, such as agoraphobia, adjustment disorder, AN, binge-eating disorder, bulimia nervosa, generalised-anxiety disorder, obsessive-compulsive disorder, panic disorder, PTSD and social phobia [40]-[42], [47]. Kleindienst et al., (2021) [39] focused purely on individuals who had a dual diagnosis of BPD and PTSD.

Versions of the BSL-23

There were a range of BSL-23 versions used which had been adapted for cultural purposes. Eight studies used the original German measure, the Spanish version was used six times, the French version twice and Czech once.

Analytical Methods

Two studies reported neither total nor mean BSL-23 score. Both studies reported a correlation coefficient instead, one as a comparison of BSL-23 and another measure [36] while the second reported a Spearman's Rho value related to EEG [45].

Internal Consistency

Internal consistency for the BSL-23 for the obtained sample was reported by 6 studies [30], [37] [42], [46][48], all falling in the 'good' or 'excellent' consistency, with values ranging from 0.83 to 0.97.

Discussion

This systematic review analysed 19 published journal articles which used the BSL-23 to assess adults diagnosed with BPD. The primary aim was to identify the context, populations, practical implications and methodological approaches to symptom monitoring using the BSL-23. The studies reviewed demonstrated diverse applications of the measure.

Key findings revealed that a high percentage of the study samples consisted of females, with the largest studies conducted in Germany. Most studies utilised clinical outpatient samples, with the primary purposes being to identify BPD symptoms or enhance understanding of the disorder. The BSL-23 was applied in various ways, such as examining single scores, comparing interventions for BPD with TAU, making comparisons to CC or HC and analysing pre- and post- intervention scores.

The primary application of the BSL-23 in Germany remains consistent with its origins as a German-developed measure. Whilst BSL-23 in other languages (e.g. Spanish, French) demonstrates the measures cross-cultural applicability, research using the BSL-23 in non-European countries was relatively small, although it is also noted that the number of English-speaking countries is also small, with the UK entirely un-represented. This may have implications for the use of the BSL-23 in English speaking cultures and may suggest that research to validate English language versions is a priority. Although translations exist, the reviewed studies did not consistently report on the quality of these translations and adaptations. As highlighted by Thirkettle et al., (2025) [49], although measures can be translated to other languages, there may be little consideration for cultural adaptations, raising concerns about whether the measure adequately captures culturally specific symptoms.

The predominance of female participants across the studies reflects the long-standing perception that BPD is a female-dominated diagnosis [24]. The BSL-23's validation process also involved a predominantly female sample (89%), with a similar proportion of gender split seen in studies included in this review. Although research reported a shift in this gender split in BPD [24]-[25], the female representation in studies raises concerns about generalisability of the BSL-23 to men and other genders. With growing evidence of gender stereotypes towards BPD, further research is needed to validate the measure in more diverse samples.

The predominance of outpatient populations in the review aligns with prevalence rates reported in previous literature, which highlight that BPD is commonly observed in 10-30% of outpatient mental health settings [8]-[9]. As outpatient populations often reflect a broad range of symptom severity, it is a good setting to implement tools such as BSL-23 to monitor symptoms over time. However, smaller inclusion of inpatient populations may overlook the challenges and symptomology of individuals with more severe or acute manifestations of BPD. Interestingly, the two inpatient-only samples showed baseline BSL-23 scores falling between moderate to high severity, the same as outpatient and mixed groups.

The ability to track symptom change using the BSL-23 is particularly beneficial when working with individuals in clinical settings where understanding of their “fluctuating” symptoms can be challenging to measure consistently [7]. However, it is also important to comment that these symptoms may also change and fluctuate depending on the environment, clinician, situation and emotional state.

Limitations

Some limitations were acknowledged within this review. Firstly, the limited number of databases searched may have excluded some relevant articles on the BSL-23. However, the databases chosen, cover a large proportion of relevant journals, as described by Löhönen et al. (2010) [50], providing a broad range of sources, yielding an appropriate number of studies for a systematic review of this scale. As noted, no representation of UK studies was found, therefore additional search was conducted to determine whether UK studies were missed. No UK studies were found within this search, which may have implications for the use and validity of the BSL-23 in the UK. This gap may be due, in part, to service-related pressures, such as limited time and resources for research and publication in a clinical setting, although these may not be unique to the UK. Another factor could be a lack of clear guidance and consistent practice around reporting the use of this measure in clinical and research settings. Additionally, the BSL-23 may have been adopted without further validation due to assumptions that the English version is applicable in the UK. This may reflect a tendency to overlook the need for cross-cultural validation when measures are translated into English. Although the BSL-23 has been widely used in DBT-based research and recommended by the UK's largest DBT training organisation (British Isles DBT Training), the lack of UK studies highlights the need for further validation of the English version.

Secondly, the inclusion criteria in this review focused primarily on the use of the BSL-23 in individuals with BPD as their primary diagnosis, which limits understanding of its applicability for individuals with other primary diagnoses. Thirdly, the sample size and characteristics of the included studies were relatively narrow, with a high proportion of women in their 30s and those whose symptom severity fell in the moderate to high range. This raises questions about the applicability of the BSL-23 in populations of men, other age groups and those with high to extremely high symptom severity.

Conclusion and Recommendations

The BSL-23 is a versatile tool for assessing symptom severity in adults with BPD. This systematic review highlights its application across various settings, populations and purposes, demonstrating its effectiveness in measuring symptom severity, tracking changes over time and facilitating comparison between groups and interventions. However, methodological inconsistencies, such as gaps in reporting internal consistency and variation in study design, limits its applicability. Addressing these issues through standardised approaches and consistent psychometric reporting will enhance its reliability in clinical and

research contexts. Further studies should expand its use to diverse populations, including those with non-BPD primary diagnoses and underrepresented genders, to improve the generalisability.

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Chapter Three: Bridging Chapter

The overall theme of BPD, including the fluctuating symptoms and the stigma surrounding it, led to the development of the systematic review, which focused on a specific measure of BPD symptomology and its applications. The findings of the systematic review highlighted the variation in the applicability of the BSL-23 measure across research and clinical settings. The review indicates that standardised measures, such as the BSL-23, are widely used in both clinical and research settings to accurately assess BPD symptoms. These standardised diagnostic tools play a critical role in mitigating stigma and biases among mental health professionals when working with adults diagnosed with BPD. The measures structure also provides valuable guidance for interpreting changes in BPD symptomology over time.

While the BSL-23 has proven effective in measuring BPD symptoms and tracking change over time, the fluctuating nature of these symptoms remains a challenge for professionals. This variability continues to contribute to negative stigma and attitudes, which can further affect treatment and care.

Research into the negative attitudes towards BPD prompted a further question into the extent to which these attitudes may impact treatment and care. To explore this, in the Empirical Paper we focused on a specific group of mental health professionals to investigate whether their attitudes influence their role, treatment and decisions. We specifically examined how attitudes may affect Approved Mental Health Professionals (AMHPs) when they are required to make decisions around detention under the Mental Health Act (MHA). This seemed significant as individuals with BPD are frequent users of A&E and often present in crises, which may require a MHA assessment.

AMHPs are regarded as “the most experienced and well-trained members of staff within the health and social care workforce” (Skills for Care, 2024, pg. 2). AMHPs are responsible for ensuring that the MHA, 1983 is upheld, prioritising human rights and the least restrictive options for treatment. Prior to 2007, this role was solely filled by social workers under the title of Approved Social Worker (ASW). The 2007 amendments to the MHA broadened the role to include mental health nurses, occupational therapists and clinical psychologists. The MHA provides the legal frameworks for compulsory admissions and detentions to psychiatric hospitals.

An individual's need for a MHA assessment requires two medical recommendations for detention however, the AMHPs make the final decision. AMHPs have the authority to disagree with medical recommendations and recommend more appropriate treatment if admission is deemed unnecessary. This significant responsibility highlights the importance of basing decisions on legal frameworks, ensuring that personal attitudes do not interfere with objective decision-making.

Therefore, the Empirical Paper aimed at answering the question, whether AMHPs' attitudes towards BPD (either positive or negative) influence their assessment, evaluation and decision-making regarding hospital admission under the MHA.

Chapter Four: Empirical Study

Approved Mental Health Professionals (AMHPs) decision-making regarding detention of adults diagnosed with Borderline Personality Disorder (BPD).

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See Appendix B[1] for author guidelines.

[1] Appendices appearing in the text will be removed as per guidelines and replaced by 'Supplementary Material' as necessary.

Abstract

Context: Patients diagnosed with Borderline Personality Disorder (BPD) have experienced stigma and discrimination in clinical settings. The current study looks at whether the diagnosis of BPD influences choice of detention for treatment under the Mental Health Act (MHA) made by Approved Mental Health Professionals (AMHPs).

Research Design: The study employs a vignette-based, between-subject design, distributed via an online survey. **Sample:** The sample compromised of AMHPs ($n = 101$) across England and Wales. The sample was randomly assigned to one of three vignettes (condition). Each vignette was identical, with the only difference being the manipulation of diagnostic information (BPD, Complex-Trauma, no-stated diagnosis). **Data collection:** The data were collected via an online questionnaire, asking participants to make a choice regarding detention of the client in the vignette. Attitudes to Personality Disorder Questionnaire (APDQ) was utilised to determine underlying attitudes. Other factors such as appraisal of risk to self and others, likelihood of detention and opinion of best treatment were also evaluated. **Analysis:** A 2x3 Fisher-Freedman-Halton exact test was used to examine the relationship between condition and choice of detention. Multiple lineal regression was calculated to predict likeliness of detention based on condition.

Results: There was no significant relationship between choice of detention and condition ($p = .978$). The only significant factor predicting choice of detention was appraisal of risk-to-self ($p < .001$). Factors which significantly predicted likelihood of detention were appraisal of risk-to-self ($p < .001$) and APDQ ($p = .046$), with lower APDQ scores correlating with higher likelihood to detain.

Discussions: Seeing a diagnosis of BPD did not influence the decision AMHPs made regarding detention. Risk-to-self was the main factor which predicted detention, in line with previous literature. However, baseline attitudes towards people with personality disorder did affect the likelihood to which they support or oppose detention. Further research is needed to explore the role of individual factors such as experience, training and risk tolerance in shaping detention decisions.

Keywords: Borderline Personality Disorder, Approved Mental Health Practitioners, Mental Health Act, Attitudes, Decision Making

Teaser: Research has shown that individuals with Borderline Personality Disorder (BPD) often face bias and stigma from healthcare professionals, which can affect their treatment. In our study, we focused on Approved Mental Health Professionals (AMHPs) who decide whether someone should be admitted to hospital (detained) under the Mental Health Act. A sample of 101 AMHPs completed an online survey, in which they were randomly allocated to one of three vignettes. The vignettes were identical with one difference, the stated diagnosis of the patient (BPD, Complex-Trauma, no-stated diagnosis). After reading the vignette, AMHPs were asked whether they would make an application for detention. Other factors like perceptions of risk and attitudes towards BPD using the Attitudes to Personality Disorder Questionnaire (APDQ) were also collected. Our findings show that knowing the diagnosis, did not affect the decision to detain. The factor that did influence this decision was perceived risk-to-self and likelihood of detention was additionally influenced by their APDQ score, with lower scores indicating more likelihood to say yes to detention.

Introduction

Borderline Personality Disorder (BPD; also known as Emotionally Unstable Personality Disorder (ICD-10) or Personality Disorder with Borderline specifier (ICD-11) is one of the most stigmatised mental health conditions (Masland et al., 2023). A high proportion of negative attitudes have been reported in healthcare professionals, (Kulkarni, 2017; Loader, 2017; Markham, 2003; Newton-Howes et al., 2008; Sansone and Sansone, 2013), describing individuals as "difficult" (Cleary et al., 2002; Koekkoek et al., 2006), "attention seeking" (Day et al., 2018), "manipulative" (Treloar, 2009) and "dangerous" (Woollaston and Hixenbaugh, 2008). These attitudes affect the treatment and care provision for those diagnosed with BPD (Aviram et al., 2006; Rüsch et al., 2008).

The prevalence of BPD in inpatient hospitals is approximately 15-25% (Leichsenring et al., 2011). Symptoms of BPD such as self-harm, impulsiveness and suicide attempts (American Psychiatric Association, 2001) makes this patient group frequently requiring medical care (Lazzari et al., 2018). Individuals with BPD are fifty times more at risk to die by suicide compared to the general population (Leichsenring et al., 2011), with one in ten dying by suicide (Paris, 2004). Limited resources in the community, may lead to professionals feeling unable to manage this risk safely, prompting a Mental Health Act (MHA; 1983) for hospital admission (Hörz et al., 2010).

Mental health hospitals are designed to provide treatment, care, stabilisation and risk management, a level of support which some patients with BPD may require frequently. However, research found that chronic suicidality, as seen in BPD, is not effectively treated in hospitals (Paris, 2004). In fact, hospital admissions can be adverse and hinder therapeutic progress. Unintended consequences may include increasing self-harm on the ward, help seeking behaviours and risk of suicide both on the wards and in the post-discharge period (Chung et al., 2017), with an overall hospital experience being traumatic (Coffey et al., 2017; Frueh et al., 2005). Discharges may also be challenging, especially if symptoms of BPD persist during the inpatient stay, leading to a reluctance to discharge, greater use of healthcare resources, increased staff burnout and limited effectiveness of inpatient treatment (Lazzari et al., 2018). Despite the negative consequences, detention remains essential for this client group, requiring careful consideration for detention by Approved Mental Health Professionals (AMHPs), carefully balancing immediate risks of harm and the wider risk of iatrogenic harm that may follow detention.

AMHPs in England and Wales have the responsibility to make the application for a hospital admission, when supported by two medical recommendations, under the MHA, 1983. The profession is often described as being stressful, with high levels of burnout and emotional exhaustion present in AMHPs (Evans et al., 2005; Hemmington, 2024b; Stevens et al., 2018). Between 2023 and 2024, approximately 52,458 detentions occurred under the MHA in England (NHS Digital, 2024). Due to the increasing demands for hospital beds and reducing supply of such beds, the pressures around decision-making for detention is even higher. AMHPs may often be in a position of choosing from a range of sub-optimal choices, risking moral distress about the choices they need to take or the role they have been 'pushed' into (Hemmington et al., 2021; Hemmington et al., 2024a). Hence, being responsible to determine the most appropriate, least restrictive care and balancing risk-taking with risk-minimisation might feel increasingly challenging (Nolan and Quin, 2014; Simpson, 2024).

Current statistics found that approximately 77% of AMHPs are female and 95% are social workers (Skills for Care, 2024), with other professionals such as occupational therapists, clinical psychologists and mental health nurses underrepresented in this field. Professional background, training and experience influence job roles and with AMHPs it has been seen to shape the way assessments are conducted and decisions are made (Stone, 2019; Vicary et al., 2020). Additional personal limits to what constitutes as a tolerable risk and what feels comfortable in terms of taking accountability in the event of an adverse outcome, may also contribute to decision-making choices (Stone, 2019). As negative attitudes are commonly observed among mental health professionals, it raises the question to what extent AMHPs' attitudes toward BPD influence their decision-making.

Negative attitudes, stigma and controversy around BPD have stemmed ongoing debates (Chapman et al., 2024; Yun et al., 2024). The continuous changes and adaptations made to the diagnosis can make it feel "complex" (Chapman et al., 2024). As symptoms of BPD are described as 'fluctuating' over time, situational and dependent on relationships with others, they can be seen as more challenging for professionals to work with. Additionally, there is a debate over the conceptualisation of the disorder, as the symptoms closely overlap other diagnoses, such as Autism Spectrum Disorder (Tamilson et al., 2025), Attention and Deficit Hyperactivity Disorder, Bipolar Disorder and other mood disorders (Mulder and Tyrer, 2023), making it challenging to diagnose, or lead to misdiagnosis (Porr, 2017; Ruggero et al., 2010; Tamilson et al., 2025). These fluctuating symptoms and lack of clarity in conceptualisation can make it harder for AMHPs to assess risk accurately, further complicating an already demanding decision-making process.

BPD symptoms can also contribute to further challenges and potential development of negative attitudes. It has been reported that individuals with BPD can evoke intense emotions and hinder therapeutic rapport due to their difficulties with interpersonal relationships (Sansone and Sansone, 2013). Evidence also shows that some mental health professionals exhibit more prejudice and judgement towards individuals with BPD compared to other mental health disorders (Klein et al., 2022), express less optimism towards their treatment progression and show less empathy towards them (Markham and Trower, 2003). For example, Bodner et al., (2015) compared the attitudes of BPD, Major Depressive Disorder or Generalized Anxiety Disorder in psychiatrists, psychologists, social workers and nurses. Their study found that nurses exhibited more negative attitudes towards BPD compared to other clinicians and social workers were more likely to view detention as necessary, despite nurses' appraisal of suicidal risk associated with admission. Similarly, a classic study by Lewis and Appleby in 1988, investigated the attitudes of psychiatrists by presenting them with one of six randomly assigned vignettes, which were manipulated by diagnosis (personality disorder (PD), depression or no-diagnosis), gender (male or female) and additional details (client was referred to as a "solicitor" or expressed interest in getting diagnosed). They found significant differences in psychiatrists' responses, with those in the PD group displaying notably more negative attitudes. A more recent replication by Chartonas et al (2017) has highlighted a relative lack of change in such attitudes.

Literature reviews found similar evidence of biased attitudes. Sansone and Sansone (2013) found that clinicians reported increased negative feelings toward clients with BPD, with clinicians feeling less comfortable, more anxious, challenged by clients with BPD, higher frustration, more apathy and feeling less caring. Likewise, a systematic review by Baker and Beazley (2022) found presence of biases towards clients with BPD among clinical and non-clinical staff, highlighting that these negative attitudes remain in healthcare settings.

Despite the ongoing negative attitudes reported by researchers, there is some evidence of improvements in attitudes. Day et al. (2018) compared mental health staff' attitudes in 2000 and 2015, which found staff moving away from descriptions such as "attention seeking" and "manipulative" to being more focused on treatment approaches, management plans, "skills" and "empathy". With factors such as specialist training (Egan et al., 2014), improved understanding (Davies, 2013; Shanks et al., 2011) and space for case consultation (Knauer et al., 2017; Masland et al., 2023; Ramsden et al., 2014) contributing to fostering more positive attitudes towards BPD. While we may see gradual changes emerging in healthcare, there is a plethora of studies which continue to report biases, stigmatisation and negative attitudes

towards BPD (Baker and Beazley, 2022; Bodner et al., 2015; Masland and Null, 2022; Moltu et al., 2023; Sansone and Sansone, 2013).

The ongoing debates around BPD has arguably helped to create opportunities to reduce negative attitudes towards BPD (Kulkarni, 2017; Loader, 2017; Markham, 2003; Masland et al., 2023; Newton-Howes et al., 2008b; Sansone and Sansone, 2013). For example, studies found BPD can be seen as conceptualised in terms of childhood adversities (Ibrahim et al., 2018) and the term 'complex post-traumatic stress disorder' (C-PTSD) has been proposed as a less stigmatising alternative. Kulkarni (2017) argued that the lack of clear differentiation between C-PTSD and BPD, coupled with the high stigma surrounding BPD, makes C-PTSD a viable alternative diagnosis to reduce stigma and promote trauma-informed care. However, simply changing the diagnosis may not remove the stigma associated with the symptomology and may risk the stigma being associated with C-PTSD over time.

There is a lack of research into how underlying attitudes in AMHPs may affect their decision-making related to patients with BPD. Studies found that even unconscious judgements may lead to ineffective and invalidating care (Koekkoek et al., 2011), which can be significant regarding hospital admissions. There is no research outlining whether negative attitudes towards BPD may increase or decrease the likelihood of detention and how other factors may affect these choices. Therefore, this study aims to investigate whether AMHPs exhibit negative attitudes towards BPD and whether these impact on decisions regarding detention under the MHA. To the best of the researcher's knowledge, no studies to date have explored the role of attitudes on decision-making of adults diagnosed with BPD under Section 3 of the MHA (1983). This study further aims to examine whether factors such as age, gender and experience can predict the likelihood of detention.

Hypotheses

The following hypotheses were explored:

(1) The presence of BPD diagnosis (compared to diagnosis of Complex-Trauma and no-diagnosis) will affect the decision to recommend detention, with either an increase or decrease in detention recommendations.
(2) Higher individual stigma towards personality disorder will be more likely to result in a recommendation to detain.
(3) Additionally, the study will investigate whether potentially relevant factors such as years of experience, age, gender and perceived risk factors, may predict or interact with the above hypotheses.

Methods

Design

This project used a quantitative, between-group, vignette-based design with three groups: (1) control, (2) BPD and (3) Complex-Trauma. All three groups were presented with the same mock AMHP report on a fictious client who was subject to a referral for assessment for potential detention under the MHA. The control group received a description of the client's presentation, without a specified diagnosis, while the other two groups were provided additional information indicating a diagnosis of either BPD or Complex-Trauma. Data were collected through online surveys.

Participants

The sample included 101 AMHPs. Inclusion criteria required currently practicing as an AMHPs in England or Wales, retired AMHPs were excluded. Participants were recruited through a convenience sample via email and social media platforms (AMHP Leads Network, Facebook and LinkedIn, see Appendix C). Participants had the opportunity to enter into a prize draw and to receive a summary of the findings.

A power analysis was calculated using G*Power (Appendix D) to determine the appropriate sample size for statistical significance. A 3x2 Chi-square analysis was used, with a power of 0.8 and a medium Cohen's effect size of 0.3, resulting in a minimum target sample of 108 participants, 36 per group (BPD, Complex-Trauma, no-diagnosis).

Ethics

Ethical approval for this study was granted by the University of East Anglia Ethics Committee[2] (ETH2324-0089; Appendix E). Participants were provided with an Information Sheet (Appendix F) before beginning the survey and were required to give consent to proceed. Leaving the survey indicated withdrawal, therefore no incomplete or partial data were used. No identifiable information was collected during the survey and thus participants were advised they could not withdraw their responses after submission. This meant that the final dataset was not subject to GDPR (General Data Protection Regulation) considerations.

The vignettes and questions were relevant to participants' professional roles, therefore not expecting adverse reactions. The Debrief contained contact information for support services, the option to receive a summary of the results and to enter a prize draw (Appendix G). A separate platform (MsForms) was used to collect email addresses for the prize draw

[2] Due to the journal requiring this to be anonymous, this will be removed for the final journal submission.

and summary, to ensure the data could not be linked to survey responses. These emails were securely stored in a password-protected system, accessed only for the prize draw and results summary and were destroyed after.

Materials

Case Vignettes

Case vignettes (Appendix H) were created by researchers with extensive experience in working with BPD, Mental Health Law and leading AMHP training. The vignettes were created to resemble a mock AMHP Mental Health Report, simulating a real-life assessment conducted by an AMHP. The vignettes intended to resemble a typical situation of which an individual could find themselves in, with patient characteristics commonly described in literature (young female, dysregulated mood, limited engagement, ambiguity regarding triggers and risk-to-self). The vignettes described a 21-year-old female, Karrie Harris, presenting with self-harm, suicidal ideation, a history of risk behaviour and non-engagement with professionals. Ethnicity was not directly stated to avoid it exerting an influence on judgements.

The use of vignettes allowed control over the exposure of information presented to participants, enabling manipulation of the variable in question – diagnosis. The vignettes were identical, with the only difference being diagnosis. Vignette (1) served as the control and described Karrie's symptoms and presentation without stating a diagnosis, vignette (2) and (3) included a diagnosis of BPD or Complex-Trauma. The vignettes were intentionally minimal with purposeful errors and ambiguities, such as Karrie's next of kin being listed incorrectly, to keep the focus on the presenting difficulties and diagnosis.

Vignette Questions

Participants were asked questions (Appendix I), designed to understand their choice of detention (yes or no), the likelihood of detention (scored on a Likert-scale opposing and supporting detention), appraisal of risk-to-self and others and their opinion on best-treatment.

Attitudes to Personality Disorder Questionnaire (APDQ)

The APDQ (Appendix J), developed by Bowers and Allan (2006), is a 37-item questionnaire designed to measure attitudes to PD. It was originally developed for nurses in England and was considered suitable for use with the current professional sample. The items assess participants' feelings, reactions and approaches to individuals with PD, using a 6-point

Likert Scale ranging from 1 (Never) to 6 (Always). The APDQ has strong test-retest reliability (a = 0.94; Bowers and Allan, 2006). A total score is calculated to assess overall attitudes, with higher scores indicating more positive attitudes. The questionnaire also measures five factors: (1) enjoyment/ loathing, (2) security/ vulnerability, (3) acceptance/ rejection, (4) purpose/ futility and (5) enthusiasm/ exhaustion.

With the permission from the authors (Appendix K), minor wording changes were made in this study, replacing the term “clients” with “individuals” to align with terminology used across different mental health professionals.

Procedure

The study was conducted via an online survey. Eligible participants were recruited between January and September 2024 through a research advertisement poster shared via emails and social media platforms. The poster outlined the study’s aims – to understand decision-making regarding detention of adults, under the MHA. It mentioned the opportunity to win a voucher.

Upon accessing the survey, participants were presented with an information sheet and consent form, which needed to be completed before proceeding. To prevent bots, participants required to complete a puzzle.

Demographic information was collected, including age, gender, ethnicity, profession, location and AMHP experience in years. Participants were then randomly assigned to one of three vignettes using an online software (PsychToolkit). They were instructed to carefully read the scenario and imagine being involved in the assessment, answering questions related to the vignette. Following this, participants completed the APDQ.

At the end of the survey, participants were debriefed on the study’s aim - to explore whether a diagnosis of BPD influences AMHP decision-making regarding detention. The debrief also provided a link to enter the prize draw and request a summary of the study’s findings. The median time to complete the survey was twelve minutes.

After data collection, participants who entered the prize draw were selected using a random number generator, where each email was assigned a number for confidentiality purposes. Six winners received a £20 gift card via email.

Survey responses relating to the vignette were stored anonymously on the PsychToolkit platform. Once data collection was completed, the data were exported to SPSS Statistics (version 29.0.1.0; IBM Corp, 2023) for analysis. Partial or missing data were

excluded from analysis. Post-analysis, participants who requested a study summary received an email outlining the results, after which all emails were destroyed.

During data collection, an unexpected software update of PsyToolkit caused a loss of approximately 10 data sets, due to incomplete server backups. Significant efforts were made to retrieve the data, including liaison with the system team, however the data were unable to be retrieved. Additionally, during the data collection, the groups were becoming unequally split, with one group having significantly more responses. To address this, the questionnaire was replicated to target the other two groups. The original survey continued to be active. Data from both surveys were later combined.

Data Analysis

The primary 2x3 analysis compared the three condition groups (control, BPD, Complex-Trauma) and the choice of detention (yes/no), to determine whether presence of condition influenced decision-making.

The three conditions were analysed using a logistic regression to determine whether relevant factors predict the choice of detention, the following factors were entered: age, gender, years of AMHP experience, perception of risk and APDQ total.

Further analysis was conducted to determine the predictability of the likelihood of detention. Entering the same factors as above, in a step-wise linear regression.
Step 1: condition of BPD and Complex-Trauma. Step 2: risk-to-self and APDQ total score. Step 3: age, gender and years of AMHP experience.

Results

A total of 101 participants took part in this study (control, $n = 34$; BPD, $n = 36$; Complex-Trauma, $n = 31$). The majority of participants were white (91.1%), female (68.3%) social workers (94.1%). The mean age of participants was 47.53 ($SD = 10.35$). There was broad representation of AMHPs across the country, with the highest percentage from South West England (17.8%) and the lowest from London (5%). The modal range of AMHP experience was 1 to 4 years (29.7%). Sample demographic characteristics are presented in Table 1.

Table 1

Demographic Characteristics of the AMHP Sample

Characteristics	Total	
	n = 101	%
Gender		
Female	69	68.3%
Male	32	31.7%
Ethnicity		
Asian/Asian British	3	3%
Black/ African/ Caribbean/Black British	4	4%
White British, White Irish, White Other	92	91.1%
Profession		
Social Worker	95	94.1%
Nurse	4	4%
Occupational Therapist	1	1%
Other	1	1%
Location		
East of England	14	13.9%
East Midlands	7	6.9%
London	5	5%
North East England	7	6.9%
North West England	12	11.9%
South East England	11	10.9%
South West England	18	17.7%
Wales	11	10.9%
West Midlands	9	8.9%
Yorkshire and the Humber	7	6.9%
Years of Experience		
<1 year	9	8.9%
1-4 years	30	29.7%
5-10 years	19	18.8%

11-19 years	25	24.8%
20+ years	18	17.8%

The data revealed that the majority of AMHPs (86.1%) chose not to detain the client presented in the vignettes, with low variability limiting the ability to truly predict decision-making patterns effectively.

While 44.6% of participants somewhat opposed detention, 14.9% supported it overall. The perceived risk-to-self was rated as "moderate" by most (61.4%), followed by "high" (29.7%), while risk-to-others was seen as "low" (87.1%). The most common treatment options were "crisis/home treatment team" (52.5%), "hospitalisation" (15.8%) and "community care" (14.9%).

Primary Analysis

Condition and detention

A 2x3 Chi-Square test was initially conducted to examine the relationship between condition and choice of detention. However, it showed 50% of cells having an expected count less than 5. Therefore, the Fisher-Freeman-Halton exact test was used and showed no significant association between condition and choice of detention ($p = .978$), suggesting that the observed differences between the groups are likely due to chance and therefore we fail to reject the null hypothesis. This finding indicates that when AMHPs decide whether to detain an individual, the presence of the diagnosis does not influence their decision.

A logistic regression analysis found that condition, APDQ score, years of experience, age and gender were non-significant predictors of detention. However, due to skewed data, these results should be interpreted with caution, as they may not fully reflect true relationships. Risk-to-self was a significant predictor of detention decisions ($odds\ ratio = 5.81, p < .001$), indicating a substantial impact on decision making for detention.

Secondary Analysis

Likelihood of detention and predictive factors

A hierarchical multiple linear regression was conducted to predict the level of detention support (strongly oppose detention, somewhat oppose detention, undecided/unsure, somewhat oppose detention and strongly oppose detention) based on condition (control, BPD, Complex-Trauma), total APDQ score, perceived risk-to-self, gender, age and years of experience. The predictors were added in three steps (see Table 2).

Step 1 included the condition as a predictor, to determine whether the presence of diagnoses has an effect. The model did not find condition as significant ($R^2 = .003$, $F(1,99) = .264,\ p = .608$).

Step 2 added APDQ and perceived risk-to-self, alongside condition. This significantly improved the model fit, explaining an additional 27% of the variance ($R^2 = .273,\ F(3,97) = 12.132,\ p < .001$). Perceived risk was seen as a positive predictor for detention ($\beta = .443, p < .001$), meaning higher perceived risk-to-self was associated with a greater likelihood of recommending detention. Similarly, total scores on the APDQ showed a negative association with supporting detention ($\beta = -.013, p = .015$), suggesting that more positive attitudes toward PD were linked to a decreased likelihood of endorsing detention.

Step 3 added years of experience, gender and age as additional predictors. This model fit was also seen as significant although the improvement was relatively small ($R^2 = .010$, $F(6,94) = 6.172,\ p < .001$). However, the only significant predictors remained to be perceived risk-to-self ($\beta = .449, p < .001$) and APDQ score ($\beta = -.013, p = .016$).

Table 2

Hierarchical Multiple Linear Regression

Factors	Model 1							Model 2							Model 3						
	B	SE	β	t	*p*	95% CI		B	SE	β	t	*p*	95% CI		B	SE	β	t	*p*	95% CI	
						LL	UL						LL	UL						LL	UL
Constant	2.382	.176		13.516	<.001	2.033	2.732	3.224	.873		3.694	<.001	1.492	4.956	2.826	1.065		2.653	.009	.711	4.942
Condition = BPD**	-.271	.246	-.128	-1.104	.272	-.759	.217	-.355	.212	-.167	-1.677	.097	-.776	.065	-.393	.218	-.185	-1.804	.074	-.825	.039
Condition = Complex-Trauma**	-.124	.255	-.056	-.487	.627	-.631	.382	-.242	.220	-.110	-1.101	.274	-.680	.195	-.260	.223	-.118	-1.166	.246	-.702	.183
Risk-to-self								.445	.086	.452	5.188	<.001	.275	.615	.452	.087	.459	5.219	<.001	.280	.624
APDQ_total								-.013	.005	-.217	-2.494	.014	-.023	-.003	-.013	.005	-.219	-2.482	.015	-.024	-.003
Age															.001	.011	.011	.100	.921	-.020	0.22
Gender[a]															.240	.197	.109	1.217	.227	-.151	.630
Yrs_ experience															-.013	.086	-.016	-.151	.881	-.185	.159

Dependent Variable: detention
Note, N = 101, CI = Confidence interval, LL = lower limit, UL = upper limit
**condition compared to control (no diagnosis)
Risk_self = perceived risk-to-self score
APDQ_total = total score on APDQ
[a]Male = 1, Female = 2
Yrs_experience = years of experience as a practicing AMHP

Sensitivity Analysis

In the analysis above, we treated the dependent variable as continuous, consistent with guidance by Williams (2020). However, given this is in fact an ordinal variable, an ordinal regression was additionally performed as a sensitivity analysis. The results were consistent with those of the multiple linear regression, identifying perceived risk-to-self ($p < .001$) and APDQ scores ($p = .001$) as the only two significant predictors of supporting detention. This consistency across both models suggests that the relationships between APDQ scores, perceived risk-to-self and supporting detention are robust and not dependent on the choice of regression model (see Appendix L for full output).

Additional information

The majority (73.3%) of people felt that they did not have enough information to make a 'yes' or 'no' decision for detention. The qualitative data from participant responses relating to the question "... what additional information could have been helpful" was quantified into themes (See table 3). The quantity represents the number of times a certain theme was identified. The most common theme was the involvement of a crisis or home treatment team ($n = 24$), followed by liaison and involvement of the community team ($n = 23$).

A Chi-Square test, showed that individuals who were not provided a diagnosis in the vignette, were more likely to feel they were provided with sufficient information to make a decision (51.9%) compared to those with diagnosis of BPD (22.2%) or Complex-Trauma (25.9%), with an almost significant result ($x^2(2, N = 101) = 5.757, p = .056$).

Table 3

Additional information identified to support decision-making by AMHPs

Themes	Total
	n = 268
Crisis/HTT involvement	24
Community team involvement	23
Accessing alternative support	21
Accessing previous admission history and its benefits	20
Psychologists' views	19
Evaluating current risks	18
Hearing client's views and wishes	18
Reviewing safety plans and risk management	12
Medical history, medication information and management	11
Purpose and treatment plan for new admission	10
Things which were helpful in the past	9
Clients' engagement in treatments	9
Protective factors/ interests	8
View from carers'	7
Establishing current triggers	7
Accessing previous risk history	6
Others' views	6
Exploration of diagnosis	6
Other	6
s2 MHA consideration	5
Current care and treatment plan	5
Clarifying nearest relative	5
Client's capacity	4
Engagement in meaningful activities	4
Relationship with carers	3
Use of recreational drugs	2

Discussion

The purpose of this study was to explore whether the presence of the diagnosis of BPD influenced AMHPs' decisions for detention, under Section 3 of the MHA, compared to the diagnosis of Complex-Trauma or no-stated diagnosis. Additionally, it examined whether factors such as age, gender, years of AMHP experience, risk appraisal and attitudes towards personality disorders, could predict the likelihood of detention.

This study found that 86.1% of AMHPs chose not to detain the client, regardless of the diagnosis. No significant difference was found between the three diagnostic conditions, suggesting that the diagnosis itself did not directly influence the decision to detain the individual. Factors which were found to predict the choice of detention and likelihood of detention were appraisal of risk-to-self and attitudes towards PD, measured by the APDQ. Higher perceived risk-to-self was associated with an increased likelihood of detention across all conditions. Additionally, AMHPs who scored lower on the APDQ, indicating more negative attitudes, were more likely to support detention, regardless of diagnosis.

These findings suggest that presence of a specific diagnosis did not influence AMHPs decisions. This is a positive outcome, as it indicates that detention decisions are not being disproportionately swayed by diagnostic labels. However, as the results showed the majority choosing not to detain (86.1%) compared to those choosing detention (13.9%), this distribution could be due to random variation rather than a definitive underlying factor. As such, we cannot conclusively determine what influences these outcomes beyond the identified predictors.

One interpretation of these findings is that there may be a shift in attitudes among mental health professionals. Lewis and Appleby's (1988) study highlighted negative attitudes toward BPD among psychiatrists. However, our study suggests that while baseline differences in attitudes still exist, they do not appear to influence detention decisions. As the decision is ultimately made by AMHPs, with medical recommendations, and while AMHPs are aware of the diagnosis, it may not be their primary focus, instead, they focus of the immediate risks. While systematic reviews such as Baker and Beazley (2022) found evidence that these biases persist to exist in both clinical and non-clinical staff members, it is crucial to examine the extent to which they impact care and treatment provided to individuals with BPD.

Additionally, AMHPs undergo specialised training that may influence their attitudes and decision-making. While they come from diverse clinical backgrounds, their AMHP

training equips them with additional skills and knowledge to navigate complex situations and make informed decisions. As highlighted in the literature, specialist training has been shown to improve understanding of BPD (Davies, 2013; Egan et al., 2014; Shanks et al., 2011) potentially helping to reduce negative attitudes towards this patient group.

Moreover, much of the existing research has focused on mental health nurses and psychiatrists, whose clinical roles may shape different attitudes toward BPD. In contrast, the present study predominantly sampled social workers, aligning with the professional representation of AMHPs. Social workers may assess risk differently from hospital-based professionals, considering broader social and environmental factors. Previous research suggests that social workers are more inclined to view detention as necessary, regardless of risk appraisal (Bodner et al., 2015). However, our findings indicate that the presence of a BPD diagnosis did not influence AMHPs' decisions to detain, suggesting that their approach may be less affected by diagnostic labels than previously assumed.

Other variables can also play a significant role, which have not been measured in this study, for example personality traits of AMHPs. Traits such as authoritarianism and punitiveness could influence the decisions regarding detention and what is seen as "punitive" by the individual (to detain or not to detain). Particularly, appraisal of risk, which was found as the salient factor, could be influenced by personal traits such as authoritarianism, leading to detention choices. Furthermore, other factors such as burnout and personal emotional reactions to individuals with BPD may be of importance. As mentioned in Winnicott's study (1994), countertransference is commonly observed in work with individuals with BPD. Winnicott describes how the environment plays a significant part in treatment and how countertransference is often seen as a "normal" reaction to the client's behaviour and personality, often evoking "hateful" (or negative) feelings towards the client. Winnicott highlights how such feelings and countertransference are essential for analysis by clinicians and should be acknowledged rather than defended or denied.

Similarly, Thomas Main's work on therapeutic communities and dynamics (1957) describes the emotional strain on psychiatric hospital staff, especially when working with individuals with chronic and severe mental health difficulties, often with slow or incomplete recovery. Main describes the nature of psychological workload within such settings and client group, and how these can impact the clinician - often leading to unconscious responses, anxiety, guilt, impatience and even resentment. These responses would lead clinicians to manage behaviours such as using increased sedatives, not to manage the patients' behaviour but to cope with their own distress. Alike our study, more negative responses and choices of

detention could be influenced by the AMHPs emotional responses, stress and burnout, whether conscious or unconscious. Furthermore, the influence and pressures on service level can also lead to different choices, such as local policies and availability of beds available nationally, leading AMHPs to be less prone to apply for detention.

Our findings suggest that AMHPs base their decisions on factors such as risk appraisal and alternative treatment, rather than solely on diagnosis. This aligns with AMHP guidelines, which emphasise selecting the least restrictive, most suitable treatment, while balancing risk-taking and risk-minimisation for both the individual and others (Davis, 1996). At the same time, individual differences play a significant role in decision-making and risk predictions (Stone 2019; Vicary et al., 2020). Experience in assessing individuals with similar presentations may influence AMHPs' confidence in deciding whether or not to detain. Additionally, variations in risk appraisal were particularly evident in response to the likelihood of supporting or opposing detention. AMHPs who are more comfortable tolerating uncertainty and potential adverse outcomes (Stone, 2019) may be more inclined to opt against detention. However, as we did not collect specific data on tolerance for uncertainty, this remains a possibility rather than a confirmed finding, highlighting the need for further research into how individual differences influence decision-making. Additionally, exposure to serious incidents such as suicide, was not measured in this study. Such experiences could influence decisions by AMHPs being more risk avoidant and choosing to detain an individual by potentially appraising the risk as higher.

Strengths and Limitations

Although the present results suggest that the presence of diagnosis did not affect the choice of detention made by AMHPs, it is appropriate to recognise several limitations. Firstly, due to the difference of individuals choosing whether to detain the individual or not, it is difficult to determine the factors which may predict this decision. The small variability of decision making makes it difficult to analyse, with 13.9% answering 'Yes' to detention, compared to 86.1% saying 'No'. The analysis of predictable factors would make it easier to determine if the data were to have an equal split (50/50).

Although there sample of AMHPs in our sample was primarily white (91.9%), female (68.3%) and having a core profession as a social worker (94.1%), it is representative of the AMHP population in England and Wales. A further strength of the sample was the wide range of locations, covering all areas of England and Wales. Additionally, the wide range of experiences as an active AMHP, helped us determine whether potentially more recent

AMHPs were to show more positive attitudes towards BPD, compared to those with more experience, or vice versa. Which the results stated not being significant, indicating similar attitudes across all.

Lasty, although the study was designed based on previous AMHP reports, the methodology of the study raises questions about ecological validity. The survey did not subject the sample to the same pressures that they may experience in the 'real world', which could affect their choices. Furthermore, the lack of important information, which AMHPs would usually be able to seek out during an assessment stage, could have left them feeling uncertain about the choices.

Future Research

Although, this study supports the idea that AMHPs' decision-making is not influenced by diagnosis, it raises several important areas for future research. For example, prior experience working with individuals with BPD has been linked to more positive attitudes (Egan et al., 2014). Given AMHPs' extensive experience and training, it would be beneficial to explore whether AMHPs currently in training would replicate these findings or show different patterns of decision-making.

Additionally, a longitudinal study could examine whether attitudes toward personality disorder change over time within this professional group. Investigating whether specific training modules or real-world exposure influence attitudes and decision-making could provide further insights. Future research could also explore how AMHPs balance risk-taking and risk minimisation in more complex, real-life assessments, where additional information is available, unlike in a controlled vignette study. Furthermore, qualitative research could help uncover the reasoning behind AMHPs' decision-making processes, offering a deeper understanding of the factors influencing detention choices beyond risk appraisal and diagnosis.

Conclusion

This study examined whether the presence of diagnosis of BPD compared to Complex-Trauma and no-stated diagnosis in a vignette affects the choice of detention made by AMHPs under Section 3 of the MHA. This study provides evidence that seeing a diagnosis did not affect the choice of detention. The study also highlighted that the most significant factor which predicts detention is appraised risk-to-self, showing that the higher

perceived risk-to-self, the more likely the person is to be detained. Furthermore, attitudes towards personality disorder, measured by APDQ showed higher negative attitudes can also significantly impact the likelihood of being detained.

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Chapter Five: Discussion and Critical Evaluation

This portfolio sought to contribute to the continuously growing research into BPD including symptomology, attitudes and the impact on clinical practice. The aim of the systematic review was to synthesise the characteristics, applications and findings of the BSL-23 measure, in studies reported between 2009 and 2024. The empirical paper aimed to explore whether the presence of a BPD diagnosis would affect detention choices made by AMHPs under the MHA, and whether factors such as age, gender, years of AMHP experience, risk appraisal and attitudes towards personality disorders, could predict the likelihood of detention.

There are ongoing debates and controversies around the diagnosis of BPD and contemporary research continue reporting negative attitudes, biases and stigmatisation (Baker & Beazley, 2022; Bodner et al., 2015; Masland & Null, 2022; Moltu et al., 2023; Sansone & Sansone, 2013; Zimmerman & Balling, 2021). Underlying biases and attitudes lead to suboptimal clinical practice (Aljohani et al., 2022; Rusch et al., 2008). This chapter will summarise findings of the two papers, outline strengths and limitations and consider theoretical and clinical applications.

Summary of Findings

To the authors' knowledge, this systematic review is the first to examine report on the application of the BSL-23 measure for adults diagnosed with BPD. Despite the author's clinical experience indicating the use of the BSL-23 in the United Kingdom (UK) and the recommendation of its use by the British Isles DBT Training UK, the review found no studies from the UK or United States of America (USA). Most studies originated from Germany, where the measure was developed. The BSL-23 was applied across clinical and research settings, primarily for symptom identification and understanding BPD. The review also highlighted demographic patterns, including a high proportion of female participants and an overrepresentation of studies from European countries. The BSL-23 was used in various ways, comparing scores to CC and HC, assessing within-group changes post-intervention or analysing single BSL-23 scores. However, methodological inconsistencies, such as gaps in reporting internal consistency and variation in study design, limits its applicability. Despite these limitations, the BSL-23 remains a versatile tool for assessing BPD symptoms in adults within clinical and research settings.

The empirical paper expanded existing research on attitudes towards BPD by focusing exclusively on AMHPs and manipulating the diagnosis (BPD, complex-trauma, no-stated diagnosis) within the conditions. Contrary to the initial hypothesis, there were no significant differences between the diagnostic conditions and the decision to detain, with the majority participants (86.1%) choosing not to detain the client. The only significant factor influencing detention decisions was the appraisal of risk-to-self, with higher perceived risk predicting detention. Further analysis of the likelihood of detention identified both the appraisal of risk-to-self and attitudes toward personality disorder (measured by the APDQ) as significant predictors, with lower APDQ scores, indicating more negative attitudes, associated with a higher likelihood of supporting detention, regardless of the diagnosis. Additional data revealed that AMHPs generally preferred alternative choices to detention, such as crisis/home treatment teams, community teams or other alternative support, for the client described in the vignettes. Given the uneven distribution of responses, with most AMHPs choosing not to detain, the results should be interpreted with caution.

Strengths and Limitations

Both research papers provide valuable insight into understanding and working with clients diagnosed with BPD. A key strength of the systematic review lies in its contribution to assessing the robustness of the BSL-23 measure, enhancing the broader discussion on the conceptualisation of the diagnosis. The measure was validated across a large client group and against other mental health presentations, offering a reliable tool for distinguishing BPD symptoms. However, a limitation of the review is the reliance on self-report measures, which are inherently susceptible to bias such as negative response bias or even malingering (Giromini et al., 2022). Additionally, due to the significant stigma surrounding BPD, research has shown that individuals diagnosed with BPD often experience negative impacts on their own attitudes (Masland et al., 2023). This stigma could further distort self-reporting, particularly as the entire sample in the systematic review consisted of individuals with a BPD diagnosis.

Although the systematic review did not search an extensive range of databases, which could be seen as a potential limitation, the selected databases generated a sufficient number of studies for the review. By not expanding the database search further, the scope of the research question remained focused. However, it is possible that gaps exist, particularly regarding the global use of the BSL-23 measure. Notably, no studies from the UK or USA were included in the review, despite these countries typically being overrepresented (Baker &

Beazley, 2022; Holmes & Beazley, 2024). Which raises questions about the validity of the BSL-23 in the UK, which may be explained by potential service-related issues, such as limited time, resources, clear guidance and consistent practice around reporting the use of such measures.

The studies included in the systematic review displayed significant gender underrepresentation, with all groups (BPD, HC and CC) showing a majority female sample. No other genders were reported, without clarity whether the studies allowed for responses from other genders or if women were simply more likely to engage with such studies. This gender bias should be considered when interpreting the generalisability of the findings. Additionally, the BSL-23 was predominantly validated with a BPD sample that was 89% female. BPD as a diagnosis has historically been overrepresented in women, which likely influences the gender composition of the studies in the review. This raises the question of whether the BSL-23 is equally effective in assessing BPD symptoms in men as it is for women. Given that contemporary research has acknowledged a reduction in the gender disparity in BPD, future studies could benefit from employing stratified sampling methods to ensure a more balanced representation of genders, thereby enhancing generalisability of the results.

An adapted tool was developed to assess the quality of the studies. The authors were unable to identify an existing tool that would adequately evaluate the studies in relation to the aims of the review. The COSMIN checklist was the closest match to be used for one measure. To adapt this to the needs of the systematic review, the author and primary supervisor adapted the existing checklist by selecting the questions most relevant to the review's objectives. A key strength of the process was the involvement of a second reviewer, who independently appraised 25% of the studies and verified that all included studies met the inclusion criteria. Quality appraisals were discussed between reviewers, with the option to consult a third reviewer if no consensus was met. This ensured that bias and potential errors in the appraisal process were minimised.

A strength of the empirical paper was the focus on AMHPs as a distinct professional group. As studies have reported negative attitudes towards BPD, most samples comprised a mixed professional group, often with a high proportion of nurses (Cleary et al., 2002; Loader, 2017; Markham, 2003; Newton-Howes et al., 2008a). Fewer studies have included social workers, possibly because many are employed by local authorities rather than the NHS. Existing literature largely explored decision-making related to personality disorders in general, but to the author's knowledge, no research has specifically examined decision-

making around detention influenced by diagnostic manipulation. Focusing on AMHPs addresses this gap, highlighting an underrepresented group that plays a vital role in treatment and care decisions.

A limitation of the empirical study was the ecological validity. While the vignettes were designed to resemble a real-life situation, they could not fully capture the complexities of how AMHPs operate when assessing cases for hospital admissions under the MHA. As identified by our sample, there was a lack of sufficient information. In practice, AMHPs would typically seek additional information before making a hospital decision, which is something the vignettes did not allow. Despite this, the use of vignettes is well-established in research for assessing responses to a controlled scenario, providing consistency across participants and allow for manipulation of variables. The vignettes were carefully designed to replicate the information that might be provided in a medical report that would significantly contribute towards their decision-making. The primary aim of the study was to investigate whether diagnostic labels influenced decision-making, specifically comparing responses to BPD. The ability to control vignettes was a particular strength, as it isolated the impact of the diagnosis on decision-making, providing valuable insights into potential biases in relation to decision-making. Moreover, the findings in relation to the importance of perceived risk are also important in this context; the fact that all participants received the same information (beyond the diagnostic manipulation), yet appraised risk rather differently and then used this information in their decision-making, suggests a potential risk of practitioners over-emphasising the validity of their own internal appraisals of risk and a need to support professionals to utilise more objective risk appraisals.

The empirical study provided limited exploration of participants' decision-making processes. While a text box was provided for qualitative input on alternative treatment choices, these responses were later quantified, restricting deeper insight into it. Although the study provided options to identify factors influencing decision making, this approach is somewhat limited in capturing the complexity of thought processes. An alternative method, such as qualitative interviews could provide a richer insight into the rationale behind decisions regarding detention and the extent to which a diagnosis influences those choices.

Implications and Further Research

The key themes explored throughout this portfolio around attitudes, stigma and biases, have significant theoretical and clinical implications. The ongoing debates surrounding BPD, its diagnostic criteria and validity continue to shape how it is understood

and treated. Studies have highlighted issues such as misdiagnosis or reluctance to diagnose BPD due to the stigma attached to the disorder. While the empirical paper did not find significant results in detention choices, it did reveal that the likelihood of supporting detention was influenced by negative attitudes toward BPD within the AMHP sample. It also highlighted that perceived risk was important to decision-making.

This debate over whether individuals should be diagnosed with BPD is driven by concerns about the negative consequences of the stigma associated with the diagnosis. However, this raises an important question: is the issue with the diagnostic label itself, or is it the professional attitudes and lack of understanding which fuel these debates? The ongoing discussion about whether BPD should be conceptualised as C-PTSD remains relevant, but it is important to note that not all individuals with BPD exhibit complex-trauma symptoms and what constitutes as a 'traumatic' event is highly individual. This suggests that simply changing the name of the disorder may not effectively reduce negative attitudes or improve treatment outcomes. Ultimately, the challenge lies not with the diagnostic label, but in changing professionals' attitudes toward the disorder.

AMHPs must carefully balance risk-taking with risk-minimisation when assessing individuals for potential hospital admission. Previous studies have suggested that AMHPs' decisions are influenced by their personal values and moral judgements about what constitutes as appropriate course action (Stone, 2019; Vicary et al., 2020). The results of the empirical study revealed that fewer participants "strongly opposed" or "strongly supported" detention, instead they were more likely to select a "somewhat" or "unsure" responses. This might reflect that decision-making around detentions are fundamentally difficult. Somewhat and unsure responses would need to be resolved in a 'real life' situation to ensure an appropriate choice is made. As described before, individual differences may affect these decisions and even the way people appraise risk. The concept of positive risk-taking, particularly when working with clients diagnosed with BPD, has been discussed in the literature, highlighting the complexities of making detention decisions in this context.

The results further highlighted differences in attitudes towards PD. While personal attitudes and judgements are natural human phenomena, this study emphasises the importance of their potential impact. Specifically, negative attitudes can significantly influence clinical practice and treatment. Although such attitudes may still persist, adopting a person-centred approach, as seen in our AMHPs study, is essential to ensure that personal biases do not affect the quality of care and treatment provided to clients.

The empirical paper highlights ongoing debates about the role of diagnoses in clinical practice. Our findings showed no significant difference in the outcomes between conditions with or without a diagnosis, while MHA define criteria in terms of a 'mental health diagnosis', our results suggest that a description of symptoms may be just as effective. This relates to ongoing debates over working with mental health diagnoses versus formulation-based approach. As described by Seery et al., (2021), intervention related to understanding of the clients' presentation may reduce the stigma related to the diagnosis itself, which can be helpful in relation to BPD.

The study also aligns with the principles of the Right Care, Right Person Bill (Home Office and Department of Health and Social Care, 2024), which aims to improve access to the right professionals with the necessary skills, training and experience to address mental health crises for individuals with health and/or social care needs. The empirical paper's findings emphasise the crucial role of AMHPs, who often respond to mental health crises and are equipped with the appropriate skills to assess risk and determine the best treatment. Their ability to assess risk and collaborate with other agencies ensures that best treatment options are considered.

This portfolio emphasises the importance of further training in shaping attitudes and treatment approaches. While AMHPs receive specialist training on complex presentations, risk and risk factors, there may be a lack of further training for other professional groups, where negative attitudes towards BPD may be more prevalent. Therefore, it is recommended that deeper understanding of BPD, its presentations and associated risk factors be integrated into regular discussions and training, especially considering ongoing changes and adaptations to the diagnosis.

The empirical paper suggests several potential avenues for further research, particularly in exploring negative attitudes of mental health professionals. The study focused solely on AMHPs, and it would be valuable to study other healthcare professionals separately to assess their attitudes. Separating professional groups rather than using a mixed sample could provide a clearer understanding of any variations. This approach could help identify areas where further training is needed to improve professionals' understanding of working with this client group and support a reduction in the negative attitudes that have been reported.

Replicating this study with a different research approach could improve valuable insights. As noted in the limitations section, there was a lack of qualitative exploration into AMHP decision-making. Future research could benefit from applying a mixed-methods

approach, incorporating individual interviews or focus-groups to better understand the reasoning behind these decisions. Additionally, instead of using an online AMHP report, a mock video assessment, featuring an AMHP interviewing the client and their family, while reviewing medical recommendations, could enhance the ecological validity of the study, offering a more realistic scenario for AMHPs.

As previous studies have reported positive changes over time, further longitudinal research could help assess whether these changes have continued. This would be particularly relevant in a European sample, especially given the diagnostic shift from EUPD to Personality Disorder with Borderline Pattern Specifier (ICD-11). This diagnostic change could potentially influence the attitudes of mental health professionals.

Additionally, in relation to the systematic review, further studies could replicate the review by focusing on other measures of BPD symptomology and their application. Future studies could also focus on the gender split in BPD research and the validity of measures for men and other genders. Specifically, measures that report on gender-specific scores could provide valuable insights into how well these tools assess BPD across different genders, helping to ensure greater accuracy and inclusivity in diagnosis and treatment. As there was a lack of studies reporting the BSL-23 in UK samples, it is recommended for services to submit evidence of their use of the BSL-23 and its findings. Moreover, measurement properties of the translated BSL-23 measure could also be explored.

Conclusion

This thesis portfolio aimed to contribute to the understanding of BPD. The systematic review explored the application of the BSL-23 measure for assessing BPD symptoms in both clinical and research contexts. The empirical paper examined whether the presence of a BPD diagnosis influenced AMHPs decisions regarding detention under the MHA. The findings contribute to the ongoing debates surrounding BPD, including its conceptualisation, symptomology and the impact of negative attitudes. The portfolio highlights the need for continuous and further training to equip professionals with the necessary skills to work effectively with this client group. This would ensure appropriate treatment and care, ultimately reducing negative attitudes observed in the professional workforce.

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Appendices

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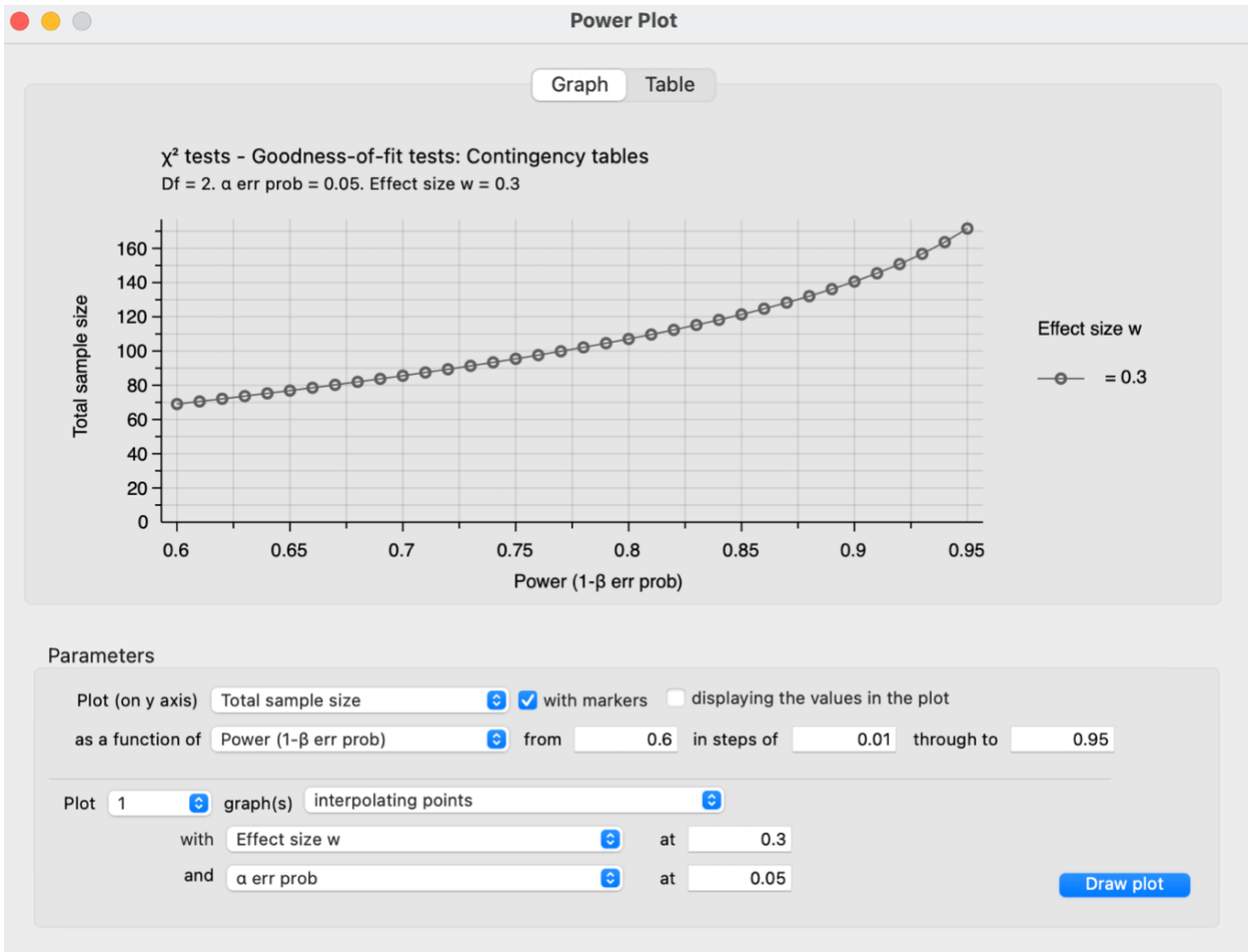
Appendix C: Recruitment Advertisement

Appendix D: G* Power Calculation Plot



Appendix E: Ethics Approval

Ethics ETH2324-0089 : Miss Milena Wolak

Date Created	21 Aug 2023
Date Submitted	14 Nov 2023
Date of last resubmission	09 Jan 2024
Date forwarded to committee	10 Jan 2024
Researcher	Miss Milena Wolak
Category	PGR
Supervisor	Dr Peter Beazley
Faculty	Faculty of Medicine & Health Sciences
Current status	Approved after amendments made

Ethics application

Applicant and research team

Principal Applicant

Name of Principal Applicant
Miss Milena Wolak

UEA account
ysq22qgu@uea.ac.uk

School/Department
Norwich Medical School

Category
PGR

Primary Supervisor

Name of Primary Supervisor
Dr Peter Beazley

Primary Supervisor's school/department
Norwich Medical School

Other research team members

Name of any other member of the research team where applicable.
Mr Michael Butler

Name of research team member's organisation/institution where applicable.
UEA

Appendix F: Participant Information Sheet

Faculty of Medicine & Health Sciences
Norwich Medical School
University of East Anglia
Norwich Research Park
Norwich, NR4 7TJ
United Kingdom

Electronic Participant Information Sheet

Thank you for taking the time to consider taking part in this research study. Before you decide to complete the study, it is important for you to understand why the research is being conducted and what participation will involve. Please take some time to read the following information carefully and raise any questions you may have with our researchers (Milena Wolak: m.wolak@uea.ac.uk or Dr Peter Beazley: peter.beazley@uea.ac.uk).

(1) What is this study about?
This research study aims to understand the process of decision-making in Approved Mental Health Professionals (AMHPs) when it comes to hospitalising adults under the Mental Health Act (MHA), in particular under Section 3.

(2) Why have I been invited?
You have been invited to take part as you are an Approved Mental Health Professional currently working in England or Wales. Taking part, however, is entirely voluntary and you can choose not to participate in the study. You can stop at any time and not submit your answers.

(3) What will the study involve?
If you do choose to participate, you will be asked to complete an online questionnaire with 3 parts: answering a set of questions, reading a case vignette and answering further questions. The entire study will take approximately 15 minutes to complete. You can withdraw from the questionnaire at any time, by exiting the questionnaire and your data will not be recorded or included in the study. After completing the questionnaire and submitting your answers, you will not be able to withdraw from the study as the data will be completely anonymous.

After submitting your answers, there will be no further contact from the researches, unless you chose to provide your email address to be included in the prize draw

and/or to receive summary of the results. If you provide your email address, but no longer want to be included in the prize draw and/or receive a summary of the results, you can withdraw by emailing Milena Wolak directly via email (m.wolak@uea.ac.uk).

(4) Are there any risks and/or disadvantages with participating in this study?

There are no anticipated risks associated with participating in this study as we have aimed for it to be in line with your current role. However, we do understand that at times information presented in research questionnaires may bring your own experiences to mind and cause you some discomfort. If this is the case for you, there is no obligation for you to continue and you can stop at any time. Information regarding further support services will be made available at the end of the questionnaire should you feel that you require any additional support.

If you do wish to contact the us regarding this, please contact me by email (m.wolak@uea.ac.uk) to discuss any issues of concern.

(5) Are there any benefits associated with being in the study?

By participating, you can contribute to a better understanding of the factors influencing decision-making in AMHPs. There is also a chance to win 1 of 6 £20 Amazon vouchers for completing the study.

(6) Will I be told the results of the study?

A brief summary of the study and main results can be provided to you before the study is published. You will be asked to provide an email address so that a copy can be sent to you by the end of the study.

(7) What will happen to information about me that is collected during the study?

Your anonymous research data will be recorded using our online software and downloaded onto a secure server. Data will be stored securely for up to 10 years according to the General Data Protection Regulation Act (2018) and the University of East Anglia Research Data Management Policy (2019). Your anonymous data will be stored in a public repository.

If you choose to provide your email address, for the prize draw and to provide a summary of the results, this will be stored separately to preserve the anonymity of your data. Your email address will be deleted immediately after the prize draw is completed and summary of the results is provided.

(8) What if I would like further information, a complaint or concerns about the study?

For any further information about the research study, please do not hesitate to contact me at m.wolak@uea.ac.uk and raise any questions you may have.

If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent from the study, please contact Professor Sian Coker by email (s.coker@uea.ac.uk).

(9) Who is organising the study?

This research is being conducted by Milena Wolak, Postgraduate Researcher in the Doctorate in Clinical Psychology Programme at Norwich Medical School, UEA. The research is carried out under the supervision of Dr Peter Beazley. The research is funded by the University of East Anglia (UEA) and has been reviewed by the UEA Faculty of Medicine and Health Sciences Research Ethics Committee.

(10) Spreading the word.

We kindly ask for your help in spreading the word about this study. If you know any colleagues or friends who might be interested and meet the eligibility criteria, please feel free to share the link with them. Your assistance in reaching a wider audience is greatly appreciated.

Appendix G: Participant Debrief Sheet

University of East Anglia

Electronic Debrief

Dear Participant,

Thank you for your time in completing this study.

Study Aims

The aim of this study was to understand whether the diagnosis of Borderline Personality Disorder (BPD) influences an AMHPs' decision-making regarding hospitalisation under the Mental Health Act compared to a diagnosis of complex-trauma and no-diagnosis (control). Additionally, whether personal characteristics such as age, gender, years of experience as an AMHP and attitudes to personality disorders, predicts the direction of detention. The results are used to help understand whether the diagnosis of BPD alone affects the decision-making processes regarding hospitalisation.

Importance of the Study

BPD is the most diagnosed personality disorder in the UK (Mind, 2022). Despite this, studies have shown over the years that this diagnosis holds negative attitudes and biases, not only from the general public but also health care professionals (Loader, 2017; Markham, 2009; Newton-Howes, Weaver & Tyrer, 2008; Sansone & Sansone, 2013). Studies found that mental health professionals still hold negative attitudes towards the diagnosis of personality disorder (Klein, Fairweather and Lawn, 2022; Sansone & Sansone, 2013), which can lead to discrimination and effect the appropriate care and treatment provided for this client group.

However, recent studies (Day et al. 2018) have found that there has been a shift towards more positive attitudes towards this diagnosis. Although, there is no specific explanation why, some research suggests that over time the understanding, knowledge and training can help reduce negative attitudes and biases.

By investigating the above factors, this study can gain insight into whether the diagnosis of BPD alone may lead to being more or less likely to be detained. As well as, whether there are any other potential factors that may affect an AMHPs decision-making process.

Important to Note

Although these findings provide insights into whether and how mental health professionals may have biases towards specific disorders. It is crucial to remember that everyone, including practitioners, can be influenced by biases. We want to assure you that the study does not suggest that there is a 'right' or 'wrong' answer.

We understand that making decisions about detaining individuals based on mental health assessments can be really difficult and complex. We do not want to discourage or blame you for your answers, but allow a reflection of how our own biases might affect our work.

The study results can help us understand this further and improve the quality of care we provide. Your participation has contributed to these ongoing discussions and the way we can shape our understanding moving forward.

Thank you once again for your valuable participation in this study.

Prize and Summary

If you would like a chance to enter the prize draw to win 1 of 6 £20 Amazon vouchers, and/or to receive a summary of the study results, please click the link below. Your email address will be stored separately so that your responses remain anonymous.

https://forms.office.com/e/67HAm2C4Tq?origin=lprLink

Further Information

If you want to know more information, please see the resources below. If you feel impacted by the study, due to the sensitive information, please contact one of the help sites mentioned below.

NICE Suicide Prevention Quality Standard

Information on ways to reduce suicide and help people bereaved or affected by suicides.

https://www.nice.org.uk/guidance/qs189/documents/194

The National Suicide Prevention Alliance (NSPA)

An alliance of public, private, voluntary and community organisations in England working to reduce and prevent suicide and support those affected by suicide.

Website: https://www.nspa.org.uk/

Harmless

Centre providing support for self-harm, suicide crisis, suicide bereavement and suicide prevention. Offering support and advice to professionals including training, as well as individuals affected.

https://harmless.org.uk/

Samaritans

Samaritans are available 24 hours a day for anyone struggling to cope and provide a safe place to talk where calls are completely confidential.

Phone: 116 123

https://www.samaritans.org/

National Educational Alliance for Borderline Personality Disorder (NEABPD)

Information and training for the public to understand BPD decrease stigma, promote research, and enhance the quality of life of those affected by BPD.

https://www.borderlinepersonalitydisorder.org/

Blue Knot Organisation

Information and resources for the public and anyone affected by complex trauma. Aims to provide understanding of trauma and abuse, coping strategies and healing through free resources including fact sheets and videos.

https://blueknot.org.au/

Appendix H: Study Vignettes

MENTAL HEALTH ACT AMHP REPORT

DETAILS	
Title	Miss
Surname	Harris
Forename	Karrie
Gender	Female
Age	21
Assessor	Approved Mental Health Professional
Patient's nearest relative	
Has the nearest relative been identified?	Yes
How was the nearest relative been identified?	Karrie has a good relationship with her mother and father. Karrie's parents have separated four years ago. She currently lives with her mother and brother - who is currently at university accommodation. I identify Mr Harris as Karrie's father as her nearest relative as per s. 26(3) MHA.
Consultation with nearest relatives and other carers/relatives	I spoke to Mrs Harris at length on the 12/12/2023, and both Mrs and Mr Harris were present for part of the MHA Assessment at Karrie's home address. Both parents have been worried about Karrie's mental health over the past few months, although identified that she has been having trouble with her mental health since her teenage years. Mrs Harris mentioned that Karrie has been isolating more, locking herself in her room and self-harming by cutting. Mrs Harris told me that she has taken away scissors and razors from Karrie's room to keep her safe. Mrs Harris has been particularly worried about her daughter ending her life. In Mrs Harris' opinion, Karrie should be admitted to the hospital, but Mr Harris disagrees. Mr Harris said that he does not think admissions have been helpful in the past and has felt Karrie didn't improve during the last hospital admission. Although Mrs Harris disagreed.
Reason for referral	
Patient referred by	Dr Arden, GP
Reason for referral	Request for Mental Health Act Assessment by Dr Arden, GP at City Surgery. Dr Arden said he saw Miss Karrie Harris on the 10/12/2023 along with her mother Mrs Harris, who was unsure who to escalate the difficulties she experiences with Karrie. Dr Arden advised that Karrie experiences frequent mood swings, suicidal thoughts and self-harms by cutting and bashing her head. In the past 4 months Karrie started to openly speak about wanting to end her life and locking herself in her bedroom, barricading the door. Karrie has taken overdoses in the past, which is a risk. She (additional information here as follows: has a diagnosis of Borderline Personality Disorder/ Complex Trauma) and is currently in therapy with Dr Merlyn, CMHT but Mrs Harris feels this is not helping.
Have the DIST/CRHT team been contacted?	Yes – Did not attend as no capacity

Background	
Psycho-social history	Karrie was seen by CAMHS from the ages of 14 (2016) to 18 (2019). The initial referral stated that Karrie was experiencing depression from severe bullying, which led to Karrie needing to change schools. Karrie was transferred to ACMHS at the age of 18 and is still open to them. Karrie had two formal admissions, 28/04/2016 – 01/11/2016 after taking a mixed overdose of over-the-counter medication. The second in 06/09/2020 – 07/01/2020 after severe self-harm, after ending an abusive relationship.
Social network and social circumstances	Karrie has always lived with her parents and older brother. Her parents separated in 2019, but her dad is still local; this was a difficult time for Karrie as he "walked out during Christmas dinner" as according to GP notes. Karrie has an older brother who is currently living at university; he is in his last year of studying a Computer Science degree. Karrie reported not having a close relationship with her brother. Karrie has a couple of close friends Molly and Greg who she speaks to often. Karrie has met Molly during her first hospital admission and Greg via a gaming platform. Karrie said her friends also have mental health difficulties, so they can understand her. Karrie is not currently in employment or education.
Has a full Mental Health Act Assessment been completed?	Yes
Interview	
Interviews and views of the patient	Karrie was seen at her home address at 10 am on Friday 13/12/2023. Karrie's parents Mr and Mrs Harris were present for the majority of the assessment. The purpose of the assessment was explained. Karrie did not initially want to speak about the current situation. Karrie was asked to explain what things look like on a daily basis; she mentioned that she goes to sleep every night hoping she does not wake up, which has been the case for a number of years. She struggles going to sleep and often goes to sleep late at night and wakes up in the afternoon. She said that thoughts about ending her life are present and that she self-harms by cutting her body with anything sharp which she can find. Karrie was asked what she does when she locks herself in the room, but she declined to answer. When asked about having plans to end her life, Karrie said she does not have any current plans. She was indifferent about an admission to hospital. Karrie said that she has recently started psychological therapy, which she finds helpful but she struggles to speak about her emotions as she constantly experiences mood swings. Karrie mentioned there are times where she enjoys being at home but did not elaborate.
Risk assessment including positive risk taking	Risk to physical health/death by misadventure; Karrie has continuous suicidal thoughts about ending her life. She currently cuts her body with objects which may lead to infections. Visual observations showed deep, fresh cuts on her arms.
Views/recommendations of the doctors	"There has been a significant deterioration in Karrie's mental health in the past 4 months. She has symptoms of withdrawal, current self-harm, suicidal thoughts, and potential plans to end her life. Her limited engagement with the assessment leads to the inability to conclude about the severity of current risk."

Appendix I: Decision-making Questions

Based on the information provided, would you make an application for Karrie to be detained for treatment under Section 3 of the Mental Health Act?
- Yes
- No

Do you feel like you had enough information to make a decision about hospitalisation?
- Yes
- No

If you selected 'no', what additional information could have been helpful.
[textbox]

To what extent do you support the individual's detention under Section 3 of the Mental Health Act?
- Strongly Oppose Detention
- Somewhat Oppose Detention
- Undecided or Unsure
- Somewhat Support Detention
- Strongly Support Detention

From reading the vignette, how would you rate the risk to self?
- Low
- Moderate
- High
- Very High
- Uncertain or Unable to Determine

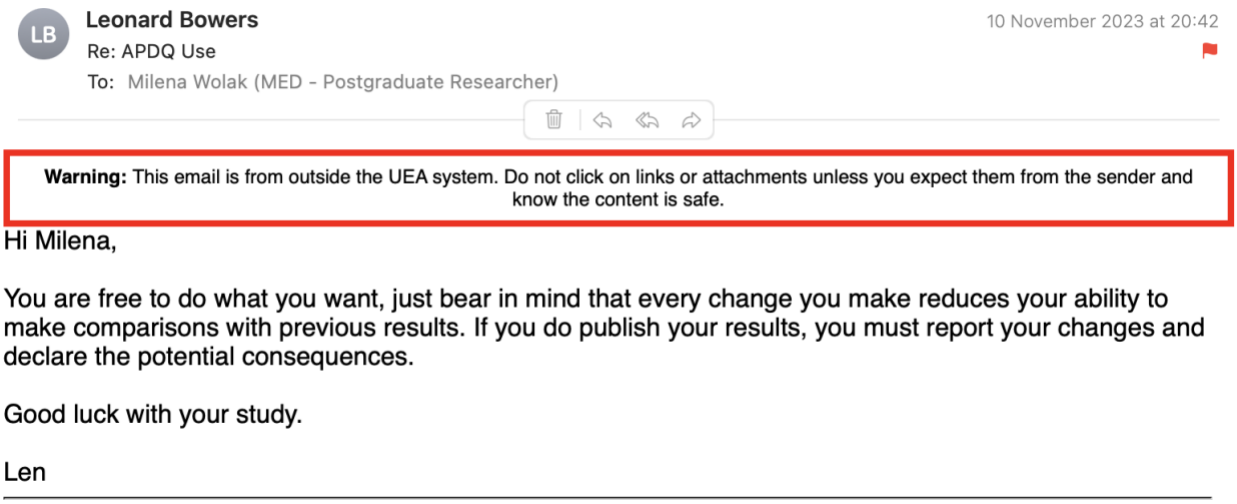
From reading the vignette, how would you rate the risk to others?
- Low
- Moderate
- High
- Very High
- Uncertain or Unable to Determine

In your opinion, what do you believe would be the most suitable treatment option for the individual?
- Hospitalisation
- Day-care
- Community care
- Crisis/Home treatment team
- Charity/other organisations (e.g. Samaritans, Mind)
- Other [textbox]

Appendix J: Attitudes to Personality Disorders Questionnaire (APDQ)

		Never	Seldom	Occasionally	Often	Very often	Always
1	I like PD people	1	2	3	4	5	6
2	I feel frustrated with PD people	1	2	3	4	5	6
3	I feel drained by PD people	1	2	3	4	5	6
4	I respect PD people	1	2	3	4	5	6
5	I feel fondness and affection for PD people	1	2	3	4	5	6
6	I feel vulnerable in PD people company	1	2	3	4	5	6
7	I have a feeling of closeness with PD people	1	2	3	4	5	6
8	I feel manipulated or used by PD people	1	2	3	4	5	6
9	I feel uncomfortable or uneasy with PD people	1	2	3	4	5	6
10	I feel I am wasting my time with PD people	1	2	3	4	5	6
11	I am excited to work with PD people	1	2	3	4	5	6
12	I feel pessimistic about PD people	1	2	3	4	5	6
13	I feel resigned about PD people	1	2	3	4	5	6
14	I admire PD people	1	2	3	4	5	6
15	I feel helpless in relation to PD people	1	2	3	4	5	6
16	I feel frightened of PD people	1	2	3	4	5	6
17	I feel angry towards PD people	1	2	3	4	5	6
18	I feel provoked by PD people behaviour	1	2	3	4	5	6
19	I enjoy spending time with PD people	1	2	3	4	5	6
20	Interacting with PD people makes me shudder	1	2	3	4	5	6
21	PD people make me feel irritated	1	2	3	4	5	6
22	I feel warm and caring towards PD people	1	2	3	4	5	6
23	I feel protective towards PD people	1	2	3	4	5	6
24	I feel oppressed or dominated by PD people	1	2	3	4	5	6
25	I feel that PD people are alien, other, strange	1	2	3	4	5	6
26	I feel understanding towards PD people	1	2	3	4	5	6
27	I feel powerless in the presence of PD people	1	2	3	4	5	6
28	I feel happy and content in PD people company	1	2	3	4	5	6
29	I feel cautious and careful in the presence of PD people	1	2	3	4	5	6
30	I feel outmanoeuvered by PD people	1	2	3	4	5	6
31	Caring for PD people makes me feel satisfied and fulfilled	1	2	3	4	5	6
32	I feel exploited by PD people	1	2	3	4	5	6
33	I feel patient when caring for PD people	1	2	3	4	5	6
34	I feel able to help PD people	1	2	3	4	5	6
35	I feel interested in PD people	1	2	3	4	5	6
36	I feel unable to gain control of the situation with PD people	1	2	3	4	5	6
37	I feel intolerant. I have difficulty tolerating PD people behaviour	1	2	3	4	5	6

Appendix K: Communication with authors



LB **Leonard Bowers** 10 November 2023 at 20:42

Re: APDQ Use

To: Milena Wolak (MED - Postgraduate Researcher)

Warning: This email is from outside the UEA system. Do not click on links or attachments unless you expect them from the sender and know the content is safe.

Hi Milena,

You are free to do what you want, just bear in mind that every change you make reduces your ability to make comparisons with previous results. If you do publish your results, you must report your changes and declare the potential consequences.

Good luck with your study.

Len

Appendix L: SPSS Output

Regression Checking Assumption for 2x3 analysis

Frequency Table

risk_self

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Low	2	2.0	2.0	2.0
	Moderate	62	61.4	61.4	63.4
	High	30	29.7	29.7	93.1
	Very High	4	4.0	4.0	97.0
	Uncertain or Unable to Determine	3	3.0	3.0	100.0
	Total	101	100.0	100.0	

risk_others

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Low	88	87.1	87.1	87.1
	Moderate	5	5.0	5.0	92.1
	High	1	1.0	1.0	93.1
	Very High	1	1.0	1.0	94.1
	Uncertain or Unable to Determine	6	5.9	5.9	100.0
	Total	101	100.0	100.0	

treatment_choice

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Hospitalisation	16	15.8	15.8	15.8
	Day-care	2	2.0	2.0	17.8
	Community care	15	14.9	14.9	32.7
	Crisis/Home treatment team	53	52.5	52.5	85.1

	Charity/other organisations	3	3.0	3.0	88.1
	Other	12	11.9	11.9	100.0
	Total	101	100.0	100.0	

treatment_other

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		89	88.1	88.1	88.1
	Close monitoring and support in addition to psychological therapy	1	1.0	1.0	89.1
	Community care with a combined treatment offer of CRHTT and day treatment unit	1	1.0	1.0	90.1
	Consistent relationship based therapeutic input	1	1.0	1.0	91.1
	Continue with therapy and perhaps crisis team	1	1.0	1.0	92.1
	Crisis + therapy + safety plan	1	1.0	1.0	93.1
	crisis team or crisis house	1	1.0	1.0	94.1
	Depends what support she actually wants especially if she struggled to engage with the assessment	1	1.0	1.0	95.0
	exploration of referal to specialist community MH team such as complex needs services, who specialise in working with these types of presentation, or HTT/CRT as a back up to explore lesser restrictive options before admission is considered	1	1.0	1.0	96.0

	Explore crisis and informal admission first. Views are entirely clear. Is there a day hospital type support that can be accessed?	1	1.0	1.0	97.0
	I don't feel I am able to answer this question as there is not enough information for me, what about community options, what about medication and home treatment, has the less restrictive option been fully developed for her?	1	1.0	1.0	98.0
	possible voluntary admission or IHBTT	1	1.0	1.0	99.0
	therapeutic engagement with a specialist service designed around trauma (not many if any exist)	1	1.0	1.0	100.0
	Total	101	100.0	100.0	

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	1.844	.092		20.012	<.001
	condtion	.009	.043	.021	.208	.836

a. Dependent Variable: hospitalisation

Logistic Regression

Case Processing Summary

Unweighted Cases[a]		N	Percent
Selected Cases	Included in Analysis	101	100.0
	Missing Cases	0	.0
	Total	101	100.0

Unselected Cases	0	.0
Total	101	100.0

a. If weight is in effect, see classification table for the total number of cases.

Dependent Variable Encoding

Original Value	Internal Value
Yes	0
No	1

Categorical Variables Codings

			Parameter coding	
		Frequency	(1)	(2)
condtion	control	34	.000	.000
	BPD	36	1.000	.000
	complex-trauma	31	.000	1.000

Block 0: Beginning Block

Classification Table[a,b]

			Predicted		
			hospitalisation		Percentage
	Observed		Yes	No	Correct
Step 0	hospitalisation	Yes	0	14	.0
		No	0	87	100.0
	Overall Percentage				86.1

a. Constant is included in the model.
b. The cut value is .500

Variables in the Equation

		B	S.E.	Wald	df	Sig.	Exp(B)
Step 0	Constant	1.827	.288	40.247	1	<.001	6.214

Variables not in the Equation

			Score	df	Sig.
Step 0	Variables	condtion	.044	2	.978
		condtion(1)	.000	1	.995
		condtion(2)	.034	1	.853
	Overall Statistics		.044	2	.978

Block 1: Method = Enter

Omnibus Tests of Model Coefficients

		Chi-square	df	Sig.
Step 1	Step	.044	2	.978
	Block	.044	2	.978
	Model	.044	2	.978

Model Summary

Step	-2 Log likelihood	Cox & Snell R Square	Nagelkerke R Square
1	81.248[a]	.000	.001

a. Estimation terminated at iteration number 4 because parameter estimates changed by less than .001.

Classification Table[a]

			Predicted hospitalisation		Percentage Correct
	Observed		Yes	No	
Step 1	hospitalisation	Yes	0	14	.0
		No	0	87	100.0
	Overall Percentage				86.1

a. The cut value is .500

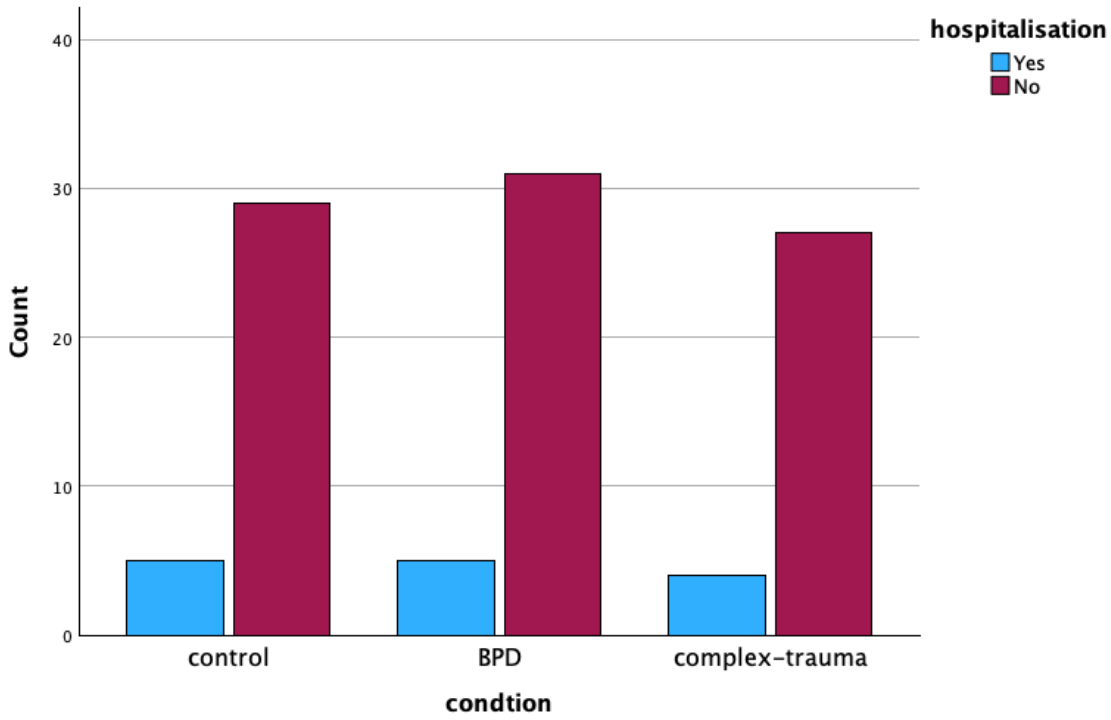
Variables in the Equation

		B	S.E.	Wald	df	Sig.	Exp(B)
Step 1[a]	condtion			.044	2	.978	

	condtion(1)	.067	.683	.010	1	.922	1.069
	condtion(2)	.152	.722	.044	1	.834	1.164
	Constant	1.758	.484	13.178	1	<.001	5.800

a. Variable(s) entered on step 1: condtion.

Graph



2x3 TEST

Crosstabs 2x3 Chi-Square Table

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
condition * hospitalisation	101	100.0%	0	0.0%	101	100.0%

condition * hospitalisation Crosstabulation

Count

		hospitalisation		
		Yes	No	Total
condition	control	5	29	34
	BPD	5	31	36
	Complex-Trauma	4	27	31
Total		14	87	101

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)	Point Probability
Pearson Chi-Square	.044[a]	2	.978	1.000		
Likelihood Ratio	.044	2	.978	1.000		
Fisher-Freeman-Halton Exact Test	.133			1.000		
Linear-by-Linear Association	.044[b]	1	.835	.861	.489	.138
N of Valid Cases	101					

a. 3 cells (50.0%) have expected count less than 5. The minimum expected count is 4.30.
b. The standardized statistic is .209.

HIERARCHICAL MULTIPLE LINEAR REGRESSION

Regression (hierarchical with 3 models)

Variables Entered/Removed[a]

Model	Variables Entered	Variables Removed	Method
1	condition=Complex-Trauma, condition=BPD[b]	.	Enter

2	apdq_total, riskNEW[b]	.	Enter
3	yrs_experience, gender, age[b]	.	Enter

a. Dependent Variable: detention
b. All requested variables entered.

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.111[a]	.012	-.008	1.028
2	.534[b]	.285	.255	.884
3	.545[c]	.297	.244	.890

a. Predictors: (Constant), condition=Complex-Trauma, condition=BPD
b. Predictors: (Constant), condition=Complex-Trauma, condition=BPD, apdq_total, riskNEW
c. Predictors: (Constant), condition=Complex-Trauma, condition=BPD, apdq_total, riskNEW, yrs_experience, gender, age

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	1.291	2	.646	.611	.545[b]
	Residual	103.520	98	1.056		
	Total	104.812	100			
2	Regression	29.864	4	7.466	9.563	<.001[c]
	Residual	74.948	96	.781		

	Total	104.812	100			
3	Regression	31.169	7	4.453	5.623	<.001[d]
	Residual	73.642	93	.792		
	Total	104.812	100			

a. Dependent Variable: detention
b. Predictors: (Constant), condition=Complex-Trauma, condition=BPD

c. Predictors: (Constant), condition=Complex-Trauma, condition=BPD, apdq_total, riskNEW
d. Predictors: (Constant), condition=Complex-Trauma, condition=BPD, apdq_total, riskNEW, yrs_experience, gender, age

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B	
		B	Std. Error	Beta	t	Sig.	Lower Bound	Upper Bound
1	(Constant)	2.382	.176		13.516	<.001	2.033	2.732
	condition=BPD	-.271	.246	-.128	-1.104	.272	-.759	.217
	condition=Complex-Trauma	-.124	.255	-.056	-.487	.627	-.631	.382
2	(Constant)	3.224	.873		3.694	<.001	1.492	4.956
	condition=BPD	-.355	.212	-.167	-1.677	.097	-.776	.065
	condition=Complex-Trauma	-.242	.220	-.110	-1.101	.274	-.680	.195
	riskNEW	.445	.086	.452	5.188	<.001	.275	.615
	apdq_total	-.013	.005	-.217	-2.494	.014	-.023	-.003
3	(Constant)	2.826	1.065		2.653	.009	.711	4.942
	condition=BPD	-.393	.218	-.185	-1.804	.074	-.825	.039

	condition=Complex-Trauma	-.260	.223	-.118	-1.166	.246	-.702	.183
	riskNEW	.452	.087	.459	5.219	<.001	.280	.624
	apdq_total	-.013	.005	-.219	-2.482	.015	-.024	-.003
	age	.001	.011	.011	.100	.921	-.020	.022
	gender	.240	.197	.109	1.217	.227	-.151	.630
	yrs_experience	-.013	.086	-.016	-.151	.881	-.185	.159

a. Dependent Variable: detention

Excluded Variables[a]

Model		Beta In	t	Sig.	Partial Correlation	Collinearity Statistics Tolerance
1	riskNEW	.477[b]	5.369	<.001	.479	.994
	apdq_total	-.269[b]	-2.763	.007	-.270	.996
	age	-.001[b]	-.005	.996	-.001	.988
	gender	.075[b]	.743	.460	.075	.986
	yrs_experience	-.031[b]	-.302	.763	-.031	.996
2	age	-.009[c]	-.099	.921	-.010	.978
	gender	.112[c]	1.289	.201	.131	.981
	yrs_experience	-.033[c]	-.384	.702	-.039	.996

a. Dependent Variable: detention

b. Predictors in the Model: (Constant), condition=Complex-Trauma, condition=BPD

c. Predictors in the Model: (Constant), condition=Complex-Trauma, condition=BPD, apdq_total, riskNEW

ORDINAL LINEAR REGRESSION

PLUM - Ordinal Regression

Case Processing Summary

		N	Marginal Percentage
detention	Strongly Oppose Detention	24	23.8%
	Somewhat Oppose Detention	45	44.6%
	Undecided or Unsure	17	16.8%
	Somewhat Support Detention	13	12.9%
	Strongly Support Detention	2	2.0%
condition	control	34	33.7%
	BPD	36	35.6%
	Complex-Trauma	31	30.7%
gender	Male	32	31.7%
	Female	69	68.3%
Valid		101	100.0%
Missing		0	
Total		101	

Model Fitting Information

Model	-2 Log Likelihood	Chi-Square	df	Sig.
Intercept Only	271.318			
Final	260.957	10.361	5	.066

Link function: Logit.

Goodness-of-Fit

	Chi-Square	df	Sig.
Pearson	369.568	395	.816
Deviance	260.957	395	1.000

Link function: Logit.

Pseudo R-Square	
Cox and Snell	.097
Nagelkerke	.105
McFadden	.038

Link function: Logit.