'You can't live like I did and grow up normal': An IPA study of how men diagnosed with borderline personality disorder (BPD) experienced their early childhood.

Introduction

Borderline personality disorder (BPD) features in the *Diagnostic and statistical manual of mental disorders* (DSM-5) (American Psychiatric Association [APA], 2013). More recently, the term, emotionally unstable personality disorder is (EUPD) used in the *international classification of diseases 11* (World Health Organization [WHO], 2019). BPD (or EUPD) is described as a serious psychological condition typified by emotional dysregulation, impulsive aggression, repeated self-injury, and chronic suicidal tendencies. Up to one in 10 people with BPD complete suicide at some point in their lives (Temes et al., 2019; Lazarus et al., 2014; Stepp et al., and Pilkonis, 2014).

Estimates of the prevalence of BPD vary between 0.7% and 2% of the general population. It is estimated to be present in 20% of individuals in psychiatric wards and between 10% and 30% of individuals in the community (National Institute of Clinical Excellence [NICE], 2009).

Challenging the BPD diagnosis

Though well-known and used amongst mental health professionals, the BPD diagnosis has been referred to as 'the most contentious of all the personality disorder subtypes' (NICE, 2009, p.7), noting considerable fluctuation of the number of criteria any one person can present with over time. Critics also note that over 50 per cent of people no longer meet criteria for borderline personality disorder five to 10 years after first diagnosis (Zanarini et al., 2003), which contradicts the general definition of personality disorders as stable over time.

Furthermore, BPD has been termed a 'motley diagnosis' (Tyrer, 1999) and a 'diagnostic dump' (Appignanesi, 2008) for anyone fitting five out of nine different criteria including fear of abandonment, unstable relationships, identity disturbance, impulsivity, recurrent suicidal behaviour, affective instability, chronic feelings of emptiness, anger management problems, transient dissociative states or paranoid ideation (APA, 2013).

BPD and early experiences

The connection between childhood adversity and the development of BPD is noted in the literature (Wingenfield et al., 2011; Zanarini, 2000). One commonly observed factor is a history of traumatic events during childhood and adolescence, including violence, sexual and emotional abuse, neglect, hostile conflict, and early parental loss or separation (Hengartner et al., 2015; Zanarini and Wedig, 2014). A disruption in attachment patterns has been reported in studies which show that compared to controls, those who have been diagnosed with BPD are much more likely to report fearfully avoidant, preoccupied, and disorganized attachment styles (Levy, 2005). The extent to which biology and social learning contribute to BPD aetiology is unclear (Gunderson, 2014), and it is likely that the risk factors of chaotic family life interact with temperamental expressions of genetic predispositions towards impulsivity and negative affect (Levy, 2005).

BPD and Stigma

Research shows that individuals who are diagnosed with BPD are subject to stigmatisation in the form of social rejection due to negatively perceived characteristics, (Dyson and Gorvin, 2017; Sheehan et al., 2016). Health care providers are more likely to judge those diagnosed with BPD as difficult, misbehaving and manipulative compared to people with other mental health problems (Loader, 2017; Ekselius et al., 2013). The public tends to believe that those with BPD diagnoses are to blame for their symptoms and thus are less deserving of psychiatric help (Sheehan, et al., 2016).

Traditional pharmacotherapies for BPD such as anti-psychotic or mood stabilisers have shown poor efficacy and traditional psychotherapeutic services are commonly followed by high rates of drop-out and relapse (Lazarus et al., 2014). These patterns tend to result in high utilisation of police, accident and emergency services and GP clinics (Tomko et al., 2013) which in turn reinforces ideas of people diagnosed with BPD as deliberately troublesome and wasting time (Lam et al., 2015; Black et al., 2011).

BPD and gender

Studies suggest that historically, BPD has been predominantly diagnosed in women, who outnumber men by a ratio of 3:1 (NICE, 2007). Consequently, much of the research on BPD has focused on women and their experiences of the condition (Jowett et al., 2020). This discrepancy has started to receive interest and debate with men being described as largely 'invisible' in the literature (Inckle, 2014). Recent research has attempted to redress this invisibility and shows that prevalence rates are much more similar than is commonly assumed (Silberschmidt et al., 2015; Gunderson et al., 2014). For example, research in the US showed that 5.6% of men and 6.2% of women were diagnosed with BPD (Grant et al., 2008).

The extent to which gender has influenced the conceptualisation of BPD has received much debate and interest (Scherpiet et al., 2014). Explanations for gender differences in diagnosis can be understood in many ways and are likely to be multi-faceted. Women are much more likely to seek help across a range of mental and physical health issues which could go some way to understanding why they are more likely to get diagnosed with BPD. An additional and more complex factor is the possibility that the diagnostic criteria are closely aligned to traditional stereotypes of women, including emotional instability and lack of emotional control (Scherpiet et al., 2014). As men are not traditionally associated with these characteristics, it becomes much more difficult for BPD to be recognised in men (Sharp et al., 2014).

It could be argued that men show emotional dysregulation in more traditionally acceptable male ways such as aggressive and risky behaviours which are more likely to attract diagnoses of anti-social personality disorder rather than manifestations of BPD (Samuel et al., 2014).

This has led to concern about gender bias in the assessment and diagnosis of personality disorders generally (Sharp, et al., 2014). Using case vignette methodology, research showed that clinicians tended to diagnose women using the histrionic personality disorder categories and men using anti-social diagnoses (Samuel et al., 2014). In a study by Bardeen et al., (2013), clinicians did not diagnose an emotional disorder such as BPD in men despite the presence of convincing evidence for this diagnosis to be made.

Research aim

The research reported is part of a larger IPA study which contributed to a professional doctorate in counselling psychology, focusing on the experiences of men who have been diagnosed with BPD.

This paper presents an extract of the research in which men talk about their early experiences in the context of their BPD diagnoses. One superordinate theme is presented: '*You can't live like I did and grow up normal'* along with two corresponding subordinate themes: '*It certainly wasn't the Walton's house'* and '*I thought I was going to die'.*

Method

Participants

Six participants were included in the study. These were adult men (aged between 27 and 46 years old). All men were current or past patients of an NHS mental health trust in the UK (two were currently receiving therapy and four were not). They had all received diagnoses of BPD from appropriately qualified practitioners (psychiatrists and psychologists) at some point during the last 11 years. Four described themselves as white British, one white Irish and the other as mixed heritage black and white British.

Participants were identified and recruited through professional networks known to one of the researchers. These included community forensic teams, community mental health teams, third sector day services for homeless or vulnerably housed people and other psychologists the researcher worked with. Participants were excluded if they were judged to have high-relapsing cycles or to pose unacceptably high- risk profiles when distressed.

Ethical considerations

The study received ethical clearance from the relevant university and the NHS. Appropriate measures with GPs and keyworkers were put in to place to support the participants involved. Careful considerations of potential adverse outcomes that might occur as a result of interviewing patients with complex trauma histories were made and systems of support were put into place. These included informing other health professionals such as GPs and care coordinators of their patients' participation and raising awareness with local crisis intervention teams in case participants needed their intervention post interview.

All names used next to quotations in the study have been changed to protect anonymity.

Data collection

A semi-structured interview schedule was utilised to gather data. Each interview was held with a single participant and lasted no more than one hour.

All interviews were digitally recorded and transcribed in full whilst taking care to anonymise pertinent parts of the transcripts.

Data analysis

IPA was used to analyse the interview data as it was felt to be the most appropriate methodology to explore how the men had made sense of their early experiences (Smith et al., 2009, Smith, 2011). It should be noted here that the research was carried out prior to the updated IPA terminology (Smith et al., 2022) therefore the original concepts of 'Superordinate' and 'Subordinate' themes are used instead of 'Personal Experiential themes' and 'Group experiential themes.' Transcripts were read and re-read thoroughly, and any points of interest noted. Emerging themes that reflected each participant's understanding and the researchers' reflections of these were then noted. Connections across themes were made repeatedly for each transcript. Any connections between themes were identified and finally patterns across the data sets were explored and documented. As thematic connectedness developed, it became possible to conceptualise individual accounts contextually and to see how these were shared by participants in this study.

Results

Superordinate (over-arching) theme: *'You can't live like I did and grow up normal'.*

All men in the study talked about having challenging lives when they were growing up. Early experiences were described as chaotic and sometimes terrifying, yet at the same time there was an acceptance and normalising of events. Despite attempts to initially express emotion, men were left unattended to or even punished, resulting in a sense of powerlessness and lack of agency to change their situations. In this way BPD is described as an inevitable result of emotional and physical abuse and neglect. It has deep impact on men's lives and subsequent relationships with others.

> *It's like the beginning of my life wasn't right…. right from birth I was destined to be like this…. you can't live like I did as a kid and grow up normal…. this is what people don't get with me…. I've tried so hard to change the way I react to stuff, and I can't …. I just don't have the rules that everybody else does... (Gary)*

Subtheme 1: ***'It certainly wasn't the *Walton's house'.***

Participants in this study talked about chaotic family backgrounds with extreme physical and emotional neglect. Within the family home, and outside the home, life was reported to be unpredictable with very poor relationships with care givers and at times high- levels of risk and danger:

> *I can't remember a time when life wasn't like chaos…home …. children's home…. school…streets …. hostels…. they were places of chaos…. anger…danger…I learnt at home that life was dangerous. (Nick)*

> *Most of my life I've been scared…… mostly of other people. (Shaun)*

Participants Nick and Lee lived with parents with substance misuse problems. They recount how their primary carers were absent and neglectful and that their drug habits took precedence over their needs as children. They did not feel that they were the priority in their parents' lives:

> *My house was crazy anyway….my ma was an addict…used heroin all the way through my childhood. There were times when she were all right like …. But most of the time she was more interested in scoring or being with her junkie mates than having anything to do with her kids. (Lee)*

> *Can't remember my mum but was told that she was a drug addict and kept leaving me on my own. The reports I read said that neighbours reported me crying and crying ……. for hours. I can't remember much and sometimes thinking about it makes me angry. (Nick)*

There is an understanding that the participants' needs as children were not attended to and parents were unable to respond to signals of distress. Nick articulates that he struggles to comprehend his mother's behaviours towards him as a baby. His image of the crying baby unable to be consoled was very distressing for him to recall and his addition of '*for hours'* underlines the level of distress and lack of comfort he experienced and recalls.

Abandonment and neglect was just one aspect participants disclosed during the interviews, all participants spoke of other events that contributed to their sense that the world and people in it were not safe. In addition, some of the men recounted being so afraid of what they were witnessing as children they describe trauma responses such as freezing:

> *My mother was a drug addict and pretty much died in front of me…. twice I remember her falling to the floor when I was about 8 or 9 and I froze…. I couldn't move…. I remember trying to get away and I couldn't …. then a mate of hers came into the room and started hitting her face …. shouting at her to wake up……I remember watching it all as if I was in a movie. (Gary)*

Gary refers to 'watching it as if it was in a movie' which seems akin to a dissociative state which is typical of a response to trauma (Van der Kolk, 2015*).*

Though extreme and traumatic, participants alluded to these events as reminiscent of a kind of normality to which they needed to adapt.

> *It was chaos…. every day I wasn't sure what was going to happen…. whether I would eat…. have clothes to wear….be spoken to…. have a parent who was alive and a brother who want intent on snuffing me out one way or another. (Gary)*

> *Me and my sister used to do what we wanted …. Never a bed time…. never had meal times…. sometimes there want even food …. I always felt out of control. (Lee)*

Men in the study articulate that the severity of the neglect instilled in them a sense of feeling out of control yet having to be in control from an early age. A sense of trust, stability in home and community life, are key primary processes for children to begin to develop a sense of belonging and of identity and personal security (Bartsch et al., 2015). It could be argued that the chronic abuse and an absence of adults who would protect them disrupted their developmental processes and restricted their capacity to develop personal resources such as emotional regulation, resilience and self-soothing.

The conflicts that arise for the men in this study as a result of these experiences are manifold, but primarily it is their understanding at such an early age that they will have to cope alone, hide their emotions and tolerate uncertainty, experience hunger and a general lack of care. John's memory of his mother is one of disengagement and detachment. His corresponding response is suggestive of an avoidant attachment style (Bowlby, 1988):

> *…there was never any emotion or affection……you know like when parents throw a ball….or roll a ball across a carpet the kid would crawl across and get it and bring it back ….there was none of that….and if she*

> *left the room I wouldn't cry and when she came back I didn't show any kind of affection. (John)*

Subtheme2: ***'I thought I was going to die'.***

All participants reported multiple incidents of physical and sexual abuse within their family environments where they experienced terror and, in some cases feared for their survival.

Prominent in the interviews was an acknowledgement by participants of the extreme aggression and violence they experienced from other men. For some it was from male siblings for others from adult males in the family unit:

> *I mean my older brother was so aggressive with me …. when I was four, he stabbed me with a kitchen knife….it was an accident he didn't mean to…. I don't think he realised it would go through my skin …. He was only seven at the time ……. I mean, where do you go from there? (Lee).*

> *Home was a mess most of the time….my dad was a drunk…. all he ever did was get up and get pissed then beat us and mum …never knew when…. but it would happen…at first, I used to cry …but it made him madder….so in the end we all learnt to fall down, and it would stop pretty soon after that. (Paul)*

All men talked about experiences of sexual abuse (often by more than one abuser) and largely in a way that depicted it as routine rather than one off experiences. This is illustrated in Paul's words that also suggest his insight into how this had affected his development and relationships with others:

> *…Kids in the home…. men in hostels when I was younger like …now I'd f*** anyone up if they tried that s*** …. the list goes on….it f***** you up. (Paul)*

Participants described a process of normalising these extremely terrifying experiences. Nick describes threat so extreme that he thinks he 'was going to die'. Yet no one seemed to notice they were being abused or offer them help. Typically, participants report an adaptation to abuse by closing down emotions as a way of coping:

> *From about eight I was sexually abused by lots of different people……the first time it happened I thought I was going to die……and for days I never spoke to anyone. But no one asked me if I was ok or if something was wrong….so I disappeared and cried it out. After that it was normal, so I got less and less upset about it. (Nick)*

Similarly, Gary (below) discusses the routine nature of his abuse and talks about his process of adaptation to it by gaining control by charging men for sex:

> *…Sexual abuse was quite usual in my house……both from some friends of mums to my brother…. I felt better getting paid for it though. (laughs) (Gary)*

The laughter that follows his disclosure of abuse within the family may suggest an attempt to reduce shame but also to avoid being disempowered by the abuse.

Discussion

Acknowledging vulnerability

All men in the study reported adverse and abusive early experiences yet came to the conclusions that they would need to cope alone. This view may be somewhat understood with reference to Connell and Messerschmidt's (2005), model of contemporary masculinities where men with mental or physical health issues are generally devalued by hegemonic and complicit male groups because they are perceived as weak. In response, the model suggests that men in these categories may seek to increase their visibility by developing their hegemonic status through substance misuse, extreme violence and risky behaviours. Unfortunately, this kind of behaviour supports the focus on men as perpetrators of physical and sexual violence, rather than the victims, taking them further away from appropriate psychological interventions.

It could be argued that BPD or EUPD might be better diagnosed as trauma related presentations needing interventions which address complex abusive early experiences reported by the majority of individuals concerned (Elliott, and Ragsdale, 2022; Perry et al., 1990). Furthermore, there is growing acknowledgement that gender differences in diagnosis of men and women with BPD needs further attention. This study has been able to give voice to men who have received the diagnosis of BPD and bring attention to how they see their early experiences. As women are much more likely to be diagnosed with BPD, it is important to consider the relevance of the diagnosis for men. However, to do this, diagnostic criteria need to more accurately capture men's presentations of early trauma and corresponding coping mechanisms.

Treating early trauma involves long-term strategies that will redress attachment issues and rebuild trusting relationships where frightening thoughts and experiences can be tolerated leading to a process of maturation. Understanding that this could be a possibility for men requires clinicians to experience a shift in their conceptions of men as dangerous to include the idea of men as also vulnerable and traumatised (Levy and Orlans, 2014).

To better serve the mental health needs of boys and men it needs to be acknowledged that men can be vulnerable and in need of help with emotional regulation and early trauma. This is more likely to happen if it can be recognised that BPD as a diagnostic category needs to embrace manifestations of dysregulation more broadly to include responses that are likely to be given by men and women. From this perspective, it seems much more likely that men can begin to access long term therapeutic programmes to address their emotional needs and abuse histories.

In this way, it is important to consider that the expression of BPD manifests differently in men and women and that the diagnostic criteria need to be developed to encapsulate men and women's experiences and presentations if men are to receive appropriate intervention. For example, men may express dysregulation by impulsivity rather than affective instability and present with comorbid externalising behaviours such as substance misuse (Grant et al., 2008).

Limitations

As the research presented here is part of a larger project, it was not possible to fully contextualize men's stories in this article, specifically to hear about their journeys from various diagnoses prior to gaining BPD diagnoses, and what these diagnoses meant to participants. Although we have made the argument here for acknowledging trauma and vulnerability in men, it must be borne in mind that hegemonic masculinity is likely to be a barrier for many men to acknowledge their difficulties in these terms, even if mental health practitioners are more engaged in this way. Few studies have focused on men from black and minority ethnic backgrounds who have been diagnosed with BPD (e.g., Jani et al., 2016; Selby and Joiner, 2008). Future work with participants from these groups is necessary to broaden the field of knowledge and to facilitate cultural competence for counselling psychologists.

Implications for counselling psychologists

The men in this study have survived exceptionally challenging experiences over their lifetimes and reported extremely poor relationships in and out of their family environments. Counselling psychologists trained in relational psychotherapy and CBT are well placed to develop with individuals' secure bases from which trauma focused work can develop and recovery take place.

Increasingly, counselling psychologists are beginning to break into complex NHS services such as forensic settings and psychiatric intensive care wards where men with BPD are more likely to found. The importance of counselling psychology's commitment to social justice is well established (Cutts, 2013) and Cooper (2009) argues that the counselling psychologist's role is to '*welcome the other* and engage with the un-engageable in a genuinely valuing and respectful manner' (p120).

To this end, it seems appropriate for counselling psychologists to turn their attention to and develop their skills to work with highly marginalised groups, such as men with BPD, who have traditionally found it difficult to have their needs recognised and attended to (Sheehan, et al., 2016).

References

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders: DSM-5.* 5th ed. Washington, D.C.: American Psychiatric Publishing.

Appignanesei, L. (2008). *Mad, Bad and Sad: Women and the Mind Doctors*. London: Virago.

Bardeen, J.R; Dixon-Gordon, K.L; Tull, M.T; Lyons, T.A; Gratz, K.L. (2013). An investigation of the relationship between borderline personality disorder and cocaine-related attentional bias following trauma cue exposure: the moderating role of gender. *Comprehensive Psychiatry, 55*(1), 113-122.

Bartsch, D.R., Roberts, R.M., Davies, M. and Proeve, M. (2015). Borderline personality disorder and parenting: clinician perspectives. *Advances in Mental Health, 13*(2), 113.

Black, D.W., Pfohl, B. and Blum et al., (2011). Attitudes toward borderline personality disorder: a survey of 706 mental health clinicians. *CNS Spectrum*, *16*(3), 67-74.

Bowlby, J. (1988). *A Secure Base: Parent-Child Attachment and Healthy Human Development*. Tavistock professional book. London: Routledge.

Connell, R.W. and Messerschmidt, J.W. (2005). Hegemonic masculinity rethinking the concept. *Gender & Society, 19*(6), 829-859.

Cooper, M. (2009). Welcoming the other: Actualising the humanistic ethic at the core of counselling psychology practice. *Counselling Psychology Review, 24*(3-4), 119 - 129.

Cutts, L.A. (2013). Considering a social justice agenda for counselling psychology in the UK. Counselling Psychology Review, *28*(2), 8-15.

Dyson, H. and Gorvin, L. (2017). How Is a Label of Borderline Personality Disorder Constructed on Twitter: A Critical Discourse Analysis. *Issues in Mental Health Nursing, 38*(10), 780-790.

Ekselius, L. (2018). Personality disorder: a disease in disguise. *Upsala Journal of Medical Sciences, 123*(4), 194-204.

Grant, B.F., Chou, S.P., Goldstein, R.B., Huang, B., Stinson, F.S., Saha, T.D., Smith, S.M., Dawson, D.A., Pulay, A.J., Pickering, R.P. and Ruan, W.J. (2008). Prevalence, correlates, disability, and comorbidity of DSM-IV borderline personality disorder: results from the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions. *The Journal of Clinical Psychiatry*, *69*(4), 533-545.

Gunderson, J.G. (2014). *Handbook of Good Psychiatric Management for Borderline Personality Disorder*. Washington, DC: American Psychiatric Publishing.

Hengartner, M.P., Wyl, A., Tanis, T., Halmi, W., Galynker, I. and Cohen, L.J. (2015). Severity of personality disorders and domains of general personality dysfunction related to attachment. *Personality and Mental Health*, *9*(3), 195-207.

Inckle, K. (2014). Strong and Silent: Men, Masculinity, and Self-injury. *Men and Masculinities*, *17*(1), 3-21.

Jani, S., Johnson, S., Banu, S., Shah, A. (2016). Cross-cultural bias in the diagnosis of borderline personality disorder. Bulletin of the Menninger Clinic, *80*(2), 146–165.

Jowett, S., Karatzias, T., and Albert, I. (2020). Multiple and interpersonal trauma are risk factors for both post-traumatic stress disorder and borderline personality disorder: A systematic review on the traumatic backgrounds and clinical characteristics of comorbid post-traumatic stress disorder/borderline personality disorder groups versus single-disorder groups. *Psychology and Psychotherapy: Theory, Research and Practice*, *93*, 621–638.

Lam, C.K., Salkovskis, P.M. and Hogg, l. (2016). 'Judging a book by its cover': An experimental study of the negative impact of a diagnosis of borderline personality disorder on clinicians' judgements of uncomplicated panic disorder. *British Journal of Clinical Psychology*, *55*, 253–268.

Lazarus, S.A., Cheavens, J.S., Festa, F. and Zachary Rosenthal, M. (2014). Interpersonal functioning in borderline personality disorder: A systematic review of behavioral and laboratory-based assessments. *Clinical Psychology Review*, *34*(3), 193-205.

Levy, K. N. (2005). The implications of attachment theory and research for understanding borderline personality disorder. *Development and Psychopathology, 17*, 959–986.

Levy, T.M. and Orlans, M. (2014.) *Attachment, Trauma, and Healing: Understanding and Treating Attachment Disorder in Children, Families and Adults*. London: Jessica Kingsley Publishers.

Loader, K. (2017). What are the effects of nurse attitudes towards patients with borderline personality disorder? *British Journal of Mental Health Nursing, 6*(2), 66-72.

National Institute for Health and Care Excellence. (2009). *Borderline Personality Disorder: recognition and management*. Available at: http://www.nice.org.uk/guidance/CG78

Perry, J.C., Herman, J.L., Van Der Kolk, B. and Hoke, L.A. (1990). Psychotherapy and Psychological trauma in borderline personality disorder. *Psychiatric Annals*, *20*(1), 33-43.

Elliot, M. and Ragsdale, J. M. (2022). Stress exposure and well-being: correlates of meeting criteria for bipolar disorder, borderline personality disorder, or both. *Social Psychiatry and Psychiatric Epidemiology 57,* 1885–1896.

Samuel, D.B., South, S.C. and Griffin, S.A. (2014). Factorial Invariance of the Five-Factor Model Rating Form Across Gender. *Assessment, 22*(1), 65-75.

Samuel, D.B. and Widiger, T.A. (2009). Comparative gender biases in models of personality disorder. *Personality and Mental Health*, *3*(1), 12-25.

Scherpiet, S., Brühl, A.B., Opialla, S., Roth, L., Jäncke, L. and Herwig, U. (2014). Altered emotion processing circuits during the anticipation of emotional stimuli in women with borderline personality disorder. *European Archives of Psychiatry and Clinical Neuroscience*, *264*(1), 45-60.

Selby, E.A. and Joiner, T.E. (2008). Ethnic variations in the structure of borderline personality disorder symptomatology. *Psychiatry Research, 43*(2), 115-123.

Sharp, C., Michonski, J., Steinberg, L., Fowler, J., Frueh, B. and Oldham, J. (2014). An Investigation of Differential Item Functioning Across Gender of BPD Criteria. *Journal of Abnormal Psychology*, *123*(1), 231-236.

Sheehan, L., Nieweglowski, K. and Corrigan, P. (2016). The Stigma of Personality Disorders. *Current Psychiatry Reports, 18*(11), 1-7.

Silberschmidt, A., Lee, S., Zanarini, M. and Schulz, S.C. (2015). Gender differences in borderline personality disorder: results from a multinational, clinical trial sample. *Journal of Personality Disorders*, *29*(6), 1-11.

Smith, J.A., Flowers, P. and Larkin, M. (2022). Interpretative Phenomenological Analysis: Theory, Method, Research (2nd ed.) London: Sage.

Smith, J., Flowers, P. and Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, method and research*. London: Sage.

Smith, J.A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review*, *5*(1), 9-27.

Stepp, S., Scott, L., Morse, J., Nolf, K., Hallquist, M. and Pilkonis, P. (2014). Emotion dysregulation as a maintenance factor of borderline personality disorder features. *Comprehensive Psychiatry*, *55*(3), 657-666.

Temes C.M., Frankenburg, F., Fitzmaurice, G., Zanarini, M.C. (2019) Deaths by suicide and other causes among patients with borderline personality disorder and personality-disordered comparison subjects over 24 years of prospective follow-up. *J. Clin. Psychiatry* 80(1)*, 22-31.*

Tomko, R.L., Trull, T.J., Wood, P.K. and Sher, K.J. (2014). Characteristics of borderline personality disorder in a community sample: comorbidity, treatment utilization, and general functioning. *Journal of Personality Disorder, 28*(5), 734-50.

Tyrer, P. (1999). Borderline personality disorder: A motley diagnosis in need of reform. *Lancet, 354 (9196)*, 2095-2096.

Van der Kolk, B. (2015). *The body keeps the score: Brain, mind, and Body in the healing of trauma.* London: Penguin.

Wingenfield, K., Schaffrath, C., Rullkoetter, N., Mensebach, C.,Schlosser, N.,, Beblo, T., Driessen, M., Meyer, B. (2011). Associations of childhood trauma in adulthood and previous-year stress with psychopathology in patients with major depression and borderline personality disorder. *Child Abuse and Neglect, 35*, 647-654.

World Health Organization (WHO). (2019). *ICD-11: International Classification of Diseases* (11th revision). https://icd.who.int/

Zanarini, M.C. and Wedig, M.M. (2014). Childhood adversity and the development of borderline personality disorder. In *Handbook of Borderline Personality Disorder in Children and Adolescents*. New York: Springer.

Zanarini, M.C., Frankenburg, F.R., Hennen, J., Silk, K.R. (2003). The longitudinal course of borderline psychopathology: 6-year prospective follow-up of the phenomenology of borderline personality disorder. *The American Journal of Psychiatry*, 160, 274-83.

Zanarini, M.C. (2000). Childhood experiences associated with the development of borderline personality disorder. *Psychiatric Clinics of North America*, *23* (1), 89-101.

**The Waltons was a television drama, broadcast in the 1970s which depicted an idealised version of a loving and supportive family life in 1930's America.*

‘You can’t live like I did and grow up normal’: An IPA study of how men diagnosed with borderline personality disorder (BPD) experienced their early childhood.