The Impact of Presenting Borderline Personality Disorder Using the Power Threat Meaning Framework Versus a Psychiatric Diagnosis on Laypersons' Stigmatizing Attitudes

Danielle L. Burnett and Phil Reed

School of Psychology, Faculty of Medicine, Health and Life Sciences, Swansea University, UK

Author Note

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Correspondence Address

Danielle L. Burnett, School of Psychology, Faculty of Medicine, Health and Life Sciences, Swansea University, Swansea, SA2 8PP, UK; e-mail: 953806@swansea.ac.uk

Abstract

People diagnosed with Borderline personality disorder (BPD) experience substantial social stigma, which is partly attributed to the diagnostic process. Shifting from psychiatric diagnoses labeling distress as disordered to recognizing distress as an understandable response to adversity may reduce stigma by improving mental health attitudes. One alternative to diagnosis is The Power Threat Meaning Framework (PTMF), which conceptualizes distress in a non-pathologizing manner and emphasizes the impact of adversity within a sociocultural and political context. Only one study has measured the stigma-reducing impact of the PTMF: Seery, Bramham, and O'Connor found that participants who read a PTMF conceptualization of psychosis exhibited significantly less stigma than those who read a psychiatric explanation. The current study is the first to test this for BPD, examining whether stigmatizing attitudes, measured by the Attribution Questionnaire Short Form (AQ-27) and Social Distance Scale (SDS), towards a hypothetical presentation of distress differed when distress was attributed to the PTMF, the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) BPD diagnosis, or through a combination of PTMF and DSM-5. Laypersons (N = 344) were randomly assigned to one of three vignettes (PTMF, BPD diagnosis, or PTMF with diagnosis). Desired social distance, blame, anger, fear, and perceived dangerousness were significantly lower among laypersons in the PTMF condition. Blame was the only stigmatizing attitude significantly reduced in response to a combination approach. These findings indicate that using a non-pathologizing approach to understanding distress can help reduce social stigma by mitigating stigmatizing attitudes.

Keywords**:** borderline personality disorder, stigma, diagnostic approach, the power threat meaning framework.

The Impact of Presenting Borderline Personality Disorder Using the Power Threat Meaning Framework Versus a Psychiatric Diagnosis on Layperson Stigmatizing Attitudes

People diagnosed with mental health conditions face significant institutional and social stigma, but this is particularly prevalent for those diagnosed with Borderline Personality Disorder (BPD; Markham & Trower, 2003, 2009). Healthcare professionals (HCPs) involved in the clinical care of people diagnosed with BPD often use pejorative labels, describing them as "manipulative," "dangerous", "attention-seeking," and "difficult to work with" (Bonnington & Rose, 2014; Deans & Meocevic, 2005; Koekkoek et al., 2006; Servais & Saunders, 2007). Compared to other highly stigmatized disorders, such as schizophrenia and depression, nurses are more likely to view individuals diagnosed with BPD as dangerous and personally responsible for their symptoms. They are also less optimistic about treatment outcomes, experience reduced sympathy, and have a greater desire to distance themselves socially (Markham & Trower, 2003, 2009). Such beliefs cause significant harm within healthcare settings, leading to poorer treatment outcomes, disempowerment among those diagnosed, and significant worsening of psychological distress (Aviram et al., 2011; Forsyth, 2007; Pearl et al., 2017; Stanley, 2006). These harmful implications highlight the urgent need to challenge stigmatizing narratives and beliefs about individuals diagnosed with BPD.

Individual differences in BPD stigma

Women diagnosed with BPD experience substantial social and institutional stigma, and BPD is viewed as a disorder most common in women, despite having a similar lifetime prevalence in men (Grant et al., 2008; Lenzenweger et al., 2007). It should be noted that the latter papers tend to refer to community samples, and the differences found in terms of

gender tend to apply to clinical samples. This gender stereotype is perhaps due to historical incidences of women being labelled as 'borderline' and 'hysterical' by clinicians when experiencing distress that was perceived as unpalatable and illegitimate (Dorfman & Reynolds, 2023); however, there is limited data on this issue, and a recent meta-analysis by Winsper et al. (2020) did not address potential gender influences.

Early research shows that when participants view an individual's gender as the gender typically associated with a condition, they are more likely to see symptoms as internally caused, experiencing more negative emotions toward that individual (Weiner et al., 1988). Although not specifically studied in BPD, this may explain why women diagnosed with BPD experience significant social stigma (Grant et al., 2008; Lenzenweger et al., 2007). While gender stereotypes may impact mental health attitudes, familiarity with people diagnosed with BPD has also been shown to reduce the extent to which individuals stigmatize those diagnosed. For instance, research demonstrates that clinicians who have a greater familiarity with people diagnosed with BPD demonstrate fewer stigmatizing attitudes (Baker & Beazley, 2022). This aligns with research on familiarity with distress more broadly, where direct or indirect contact with mental health services leads to fewer stigmatizing attitudes towards those experiencing distress (Corrigan et al., 2001; Corrigan & Nieweglowski, 2019; Steiger et al., 2022). Despite the negative impacts of BPD stigmatization, limited research has explored the public's attitudes towards those diagnosed and the impact of factors such as distress familiarisation and gender stereotypes, highlighting the importance of examining perceptions in this context.

The Role of Diagnostic Process in Stigmatization

For several conditions, it has been suggested that, in part, the diagnostic process may be responsible for the stigma associated with mental health difficulties, as it reduces

an individual's psychological distress to a set of rigid negative criteria, emphasizing "what is wrong" with an individual (Corrigan, 2007; O'Connor et al., 2022; Johnstone & Boyle, 2018). According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), a person must present with at least five out of nine symptoms to be diagnosed with BPD. These include unstable interpersonal relationships, impulsive behavior, inappropriate or intense anger, chronic feelings of emptiness, and persistent fears of real or imagined abandonment (APA, 2013; Garland & Miller, 2019). The BPD diagnosis, along with other personality disorder diagnoses, is perhaps particularly negative due to implying inherent character flaws, which may explain why people diagnosed are particularly vulnerable to stigma when compared to other mental health conditions (Bergen, 2018; Stalker et al., 2005; Markham & Trower, 2003, 2009).

Clinicians report avoiding diagnosing individuals with BPD despite prominent presentations and opting for euphemistic labels, such as "emotional dysregulation" (Perkins et al., 2018). Similarly, individuals presenting with behaviors associated with the BPD diagnosis may avoid seeking a formal diagnosis or treatment due to fears of social stigmatization (Corrigan et al., 2014; Lohman et al.,2017). Despite this, the extent to which stigma is influenced by the diagnostic label alone or the diagnostic criteria remains unclear. Label avoidance among service users and clinicians may suggest that diagnostic labels contribute to stigma by cueing negative stereotypes and beliefs associated with the condition (Corrigan, 2007; Corrigan & Matthews, 2003; Link et al., 1989).

Researchers have attempted to measure the stigmatizing impact of diagnostic labels by exposing participants to vignettes of hypothetical individuals with varied presentations, either with or without a diagnostic label. While the presence of a diagnostic label may increase stigma for some conditions, such as attention deficit hyperactivity disorder (ADHD;

e.g., Jastrowski et al., 2007) and schizophrenia (e.g., Mittal et al., 2014), the BPD label surprisingly decreases stigmatization when attached to a vignette detailing challenging behaviors associated with the BPD diagnosis. Specifically, participants report less desire for social distance and weaker negative emotions, such as anger, when challenging behaviors (e.g., substance use, verbal aggression) are paired with a BPD diagnosis (Masland & Null, 2022; O'Connor & Murphy, 2020). Moreover, the diagnostic criteria for BPD are associated with greater public stigma than the diagnosis itself (Amestoy, Best, Ruocco, Uliaszek, 2024). Thus, the BPD diagnostic criteria may elicit more stigmatizing attitudes than the diagnostic label alone. Despite this, participants report greater stigmatizing attitudes when a BPD diagnosis is presented following a description of behavior unrelated to the BPD diagnostic criteria, such as common relationship difficulties (e.g., feeling irritated due to disagreements), than when no diagnosis is present (Amestoy, Best, Ruocco, Uliaszek, 2024). This suggests that the BPD label itself may lead to negative attitudes, particularly when applied to individuals who do not display behaviors or psychological distress that are associated with the diagnosis.

While diagnostic labelling and the criteria associated with BPD can contribute to negative public attitudes, it is perhaps the broader misunderstanding of people diagnosed that leads to reductionist and stigmatizing beliefs. Substantial evidence links experiences of adversity, such as abuse and neglect, to the development of distress that is often labelled as BPD (Porter et al., 2020; Yen et al., 2002; Zanarini et al., 2006). However, psychiatric diagnosis overlooks these contextual and sociocultural factors, reducing complex presentations of distress and attributing them to a single "disorder" (Johnstone & Boyle 2018; Hawkins et al., 2014). Consequently, challenging behavior and psychological distress may be viewed as caused by something intrinsically wrong with the individual rather than an

understandable response to adversity (Johnstone & Boyle, 2018; O'Connor et al., 2022). Reframing “symptoms” as an adaptive response to sociocultural adversity rather than abnormal traits driven by a disorder may lessen social stigma by providing a deeper and more compassionate understanding of the origins of distress (Bonnington & Rose, 2014; Johnstone & Boyle, 2018; Sheehan et al, 2016; Trippany et al., 2006).

An Alternative Non-stigmatizing Approach to Understanding BPD Distress

One alternative approach is the PTMF, which rejects labeling distress as symptoms of a disorder and instead conceptualizes distress as an adaptive and understandable response to social, psychological, or biological adversity (British Psychological Society, 2018; Johnstone & Boyle, 2018). The framework shifts from the diagnostic narrative of “What is wrong with you? to What has happened to you? How did it affect you? What sense did you make of it, and what did you do to survive?”. Clinicians typically apply this framework to help individuals understand why they think, feel, and behave in a certain way, helping to de-mystify their distress by shifting its origins from the individual to the adversity. While this may resemble alternative non-diagnostic approaches, such as psychological formulations (see British Psychological Society, 2011), the PTMF conceptualises distress within a broader sociocultural and political context and explicitly rejects the use of diagnosis altogether. Although, from this perspective, psychological formulation encourages a holistic view of distress, they are often used to rationalize diagnostic labels, promoting the pathologization of distress (Johnstone, 2018).

Moreover, the PTMF was developed in collaboration with individuals who have previously used mental health services, who report that abandoning the medicalization of mental distress helps conceptualize their experience in a non-stigmatizing way (Johnstone

et al., 2018). While there are anecdotal accounts that support the PTMF potential to reduce stigma, only one study has examined this empirically. Seery et al. (2021) used a vignette-based research design and randomly assigned 351 laypersons to either a PTMF or a DSM-5 case study of a hypothetical individual demonstrating a presentation of psychosis. Participants self-reported a stronger desire to socially distance when reading the DSM-5 case study compared to the PTMF. The current study expands on Seery et al. (2021) by examining whether framing BPD through non-pathologizing means can reduce laypersons' stigmatizing attitudes. The majority of previous research has focused on HCPs' attitudes that may be potentially stigmatizing, and attitudes toward BPD in the general population are currently uncertain, hence, the current research focuses on laypersons' stigmatizing attitudes.

Study Overview

This research is exploratory in nature and investigated whether individuals experience different stigmatizing responses depending on whether BPD is presented using the PTMF or the DSM-5. Laypersons' stigmatizing attitudes were measured when a PTMF is introduced alongside a brief BPD diagnosis. Although presenting a PTMF alongside a diagnosis may be regarded as contradictory, as PTMF rejects labeling (Johnstone & Boyle, 2018), understanding the social implications of combining both approaches is important, as they may be used concurrently in practice. For instance, clinicians may explore the sociocultural origins of their distress using the PTMF, while still relying on diagnosis to structure care (Omur, 2023). Additionally, the diagnostic framework remains the dominant approach to conceptualizing distress within the mental health system and is deeply embedded in policy and treatment guidelines (Johnstone & Boyle, 2018). Due to this, the PTMF will likely be implemented slowly alongside existing methods rather than

entirely replacing the diagnostic framework. Furthermore, the impact of gender stereotypes was explored as we examined whether participants who perceived the vignette client (Riley) to be female experienced different stigmatizing responses than those who perceived Riley to be male. From this, three hypotheses were developed:

Hypothesis 1 is that stigmatizing attitudes will be significantly greater among laypersons who read the DSM-5 than those who read the PTMF.

Hypothesis 2 is that a diagnosis alongside the PTMF will lead to more stigmatizing responses than the PTMF alone, and participants who know someone diagnosed with BPD will experience fewer stigmatizing attitudes than those with no personal familiarity.

Hypothesis 3 is that participants who perceive Riley as female will demonstrate significantly greater stigmatizing responses compared to those who perceive Riley as Male.

Method

Participants

An a priori power analysis was performed using G* Power to ascertain the minimum sample size required to produce meaningful results. Using G-power, the minimum required sample size was 258 participants (86 per group), which allowed 80% power for determining a medium effect size with a rejection criterion of $p < .05$. In the current study, 344 laypersons were recruited through the study advertisements on the university's online participant pool, and two social media websites (Facebook, Instagram). Recruitment was carried out during the spring and summer of 2022. Participants recruited from social media shared the study advertisement with their peers. Data from 295 participants with complete responses were included in the analysis; 100 (33.9%) were

randomly allocated to the DSM diagnostic condition; 98 (33.2%) to the PTMF without diagnosis condition; and 97 (32.9%) to the PTMF plus DSM diagnosis condition. The university departmental ethics committee approved the recruitment of participants and distribution of the research. University participants received a study link via the participant pool and received one-course credit for their participation.

Questionnaires

Demographic items. Participants completed demographic items that asked for their age, gender, and student status. Student participants also provided information regarding which university they attended and their current year of study. See Table 1 for demographic information about the participants, which did not differ significantly across the three groups: Age, $F<1$; Gender, $X^2(6)=8.137$, $p=.228$; Student Status, $X^2(8)=12.229$, $p=.141$.

Table 1

Demographic Characteristics of Participants

Sample Characteristics	n	%	*M*	*SD*
Age Range				
18-79	258	100%	32.20	15.40
Gender				
Male	56	19		
Female	230	78		
Non-binary or third gender	6	2%		
Prefer not to say	3	1%		

Student status		
Undergraduates	131	50.8%
Master's students	22	7.5%
PhD Students	2	0.2%
Non-students	103	48.5%

Questionnaires

Social Distance Scale (SDS). Bogardus's (1992) Social Distance Scale measures participants' desire to distance socially from people from various social groups. Participants reported how comfortable they felt performing twelve behaviors that involved interacting with the hypothetical case (e.g., "have lunch with Riley," "recommend Riley for a job"). Each behavior was rated on a 7-point Likert scale (0 = "not at all comfortable"; 7 = "very comfortable"), and the 12 items were summed to create a single measure of SDS (lower ratings indicate higher desired social distance). The SDS has been adapted and applied across various populations and contexts and demonstrates good internal consistency and validity (e.g., Jonáš et al., 2023; Ruth et al., 2014; Shi et al.,2024). Reliability analysis for the current research demonstrated excellent internal consistency (Cronbach's α = .943).

Attribution Questionnaire Short Form (AQ-27). Corrigan et al.'s (2003) Attribution Questionnaire Short Form was used. It is a 27-item scale measuring levels of different stigmatizing interpersonal responses. The scale has nine subscales (i.e., blame, anger, pity, help, dangerousness, fear, avoidance, segregation, coercion). Each subscale contains three statements rated on a 9-point Likert scale (e.g., "I would think that it was Riley's fault that they are in the present condition," "I would feel aggravated by Riley," "I would feel pity for Riley,"). Items for each subtype are summed, with scores ranging from (1-7) and higher scores representing greater endorsement of the stereotype. The AQ-27 is a well-validated

scale demonstrating good validity and internal consistency across multiple contexts and populations (e.g., Corrigan et al., 2003; 2004; Pingani et al., 2012). The current research conducted a reliability analysis for each subscale, demonstrating acceptable internal consistency for anger, pity, help, dangerousness, fear, avoidance, and segregation; Cronbach α ranged from .709 to .842. Blame and segregation showed low Cronbach α scores (.286 and .586, respectively) but were still used during data analysis.

Gender attribution. Participants stated which biological sex (male or female) they thought Riley was. ***Type of relationships.*** Participants were asked to disclose if they encountered someone who experienced similar difficulties to Riley (O'Connor & Murphy, 2020). Participants were asked to "select as many of the following types of relationships you have had with individuals with similar difficulties to Riley." Options included: yourself, your child, your parent, your sibling, your spouse, your extended family member, your friend, your co-worker, not applicable, prefer not to say. Due to time constraints, a new variable was developed and used in the data analysis entitled "contact," which indicated whether participants had encountered an individual with similar difficulties to Riley (options: yes or no).

Procedure

Participants were directed to the Qualtrics survey via the university participant's subject pool or social media advertising. Upon clicking the link, participants were directed to the research information page. Participants were asked to email the researcher if they had any questions regarding the study. Once the information sheet was read, participants were directed to the consent form, where they could either click "Yes" or "No" to consent to the study. Participants who clicked no were redirected to the end of the study. For those

who provided consent, the study commenced. All participants were required to complete the study in one sitting. However, some may have left the study open on their devices and completed it later. Participants first completed demographic items before proceeding to the rest of the study.

A between-groups double-blind experimental vignette-based design was used. Participants were then randomized, using Qualtrics' randomization tool, to read one of three vignettes (see supplementary material for full details): 1) a vignette of Riley's difficulties using the DSM-5 classification for BPD; 2) a vignette of Riley's difficulties using the PTMF; or 3) A vignette of Riley's difficulties using PTMF, but containing a brief formal diagnosis of BPD. The study was double-blind, meaning that neither the participants nor the researchers involved were aware of which experimental conditions the participants were randomized to. Before the study, vignettes were reviewed by a clinical psychologist independent of this research.

Following reading their assigned vignette, participants completed the outcome measures. Finally, participants were debriefed and thanked for their participation. On average, participants took approximately 9 minutes to complete the study.

Data Analysis

Data was entered and analyzed in the Statistical Package for the Social Sciences (SPSS v26). Dependent measure outliers were checked. Although the box plot demonstrated potential outliers, comparing 5% trim means did not vastly differ from mean values and thus likely did not impact the data set. Therefore, outliers were not removed. Pearson correlations were conducted to examine bivariate associations between the AQ-27 subscales and the SDS. Between-group multivariate analyses of variances (MANOVAs) were conducted to examine the effects of the experimental vignettes on AQ-27 and SDS mean

scores. Pillai's Trace was employed due to its robustness (Tabachnick & Fidell, 2007). Tukey's Honest Significant Difference (HSD) was conducted to examine group mean differences. The main effects of contact and gender on A9-27 and SDS mean scores were examined. We tested for interactions among sex attribution, experimental conditions, and dependent measures (A9-27 & SDS mean scores). The interaction effects of contact, experimental conditions, and dependent measures were also examined.

Results

Overall Stigmatizing Attitudes

Table 2

Descriptive statistics (Mean and Standard Deviations) of continuous variables across each experimental condition.

	Experimental Conditions					
	DSM-5 diagnosis (*n* = 100)		PTMF (*n* = 98)		PTMF & DSM diagnosis (*n* = 97)	
Continuous Variables	*M*	*SD*	*M*	*SD*	*M*	*SD*
Social Distance Scale (SDS)	50.00	16.24	58.82	14.19	59.96	15.05
Attribution Questionnaire Short Form (AQ-27) subscales						
Blame *	9.69	3.64	8.56	3.39	7.90	3.11
Anger *	8.60	4.48	6.14	3.35	5.95	3.47
Pity *	19.33	5.24	21.64	4.19	20.78	4.80
Dangerousness *	9.39	4.66	6.73	3.61	6.59	3.56
Fear *	8.36	4.55	5.82	3.56	5.42	3.33
Avoidance	12.34	5.95	10.56	4.87	10.23	5.15
Help	20.73	4.92	22.19	4.74	21.52	5.06
Segregation	6.51	3.65	5.83	3.24	5.39	3.14

Coercion	10.55	4.87	10.49	4.21	10.77	4.68

Note. DSM-5 = Diagnostic and Statistical Manual of Mental Disorders, PTMF = Power Threat Meaning Framework. * = $p < .05$. Higher SDS indicates lower levels of desired social distance.

Table 2 displays the mean scores and standard deviations for the stigmatizing attitudes measures for the three experimental conditions. Overall mean scores demonstrated that stronger stigmatizing attitudes were observed in participants exposed to the DSM-5 diagnosis condition. In comparison, lower levels of stigmatizing attitudes were observed in participants who were in the PTMF and DSM diagnosis condition. One-way between-groups MANOVA demonstrated a statistically significant difference between groups in overall SDS scores and the AQ-27's nine subscales combined (blame, anger, pity, help, dangerousness, fear, avoidance, segregation & coercion), F (20,568) = 3.98, $p < .001$; Pillai's Trace = .25; (η_p^2) = .12.

Social Distance Scale (SDS)

One-way ANOVAs revealed significant differences between groups for SDS scores, $F(2,292)=12.76$, $p<.001$; $\eta_p^2=.080$. Tukey's Honestly Significant Difference (HSD) tests were used to test the pairwise comparisons between the groups. These revealed that the DSM-5 group ($M=50$, $SD=16.24$) experienced significantly more desire for social distance than the PTMF group ($M=58.82$, $SD=14.19$), and significantly more desire for social distance than the PTMF+DSM group ($M=59.96$, $SD=15.05$). These results support hypothesis 1. However, there were no significant pairwise group differences in SDS mean scores. Thus, attaching a DSM-5 diagnosis to a PTMF explanation did not significantly alter participants' desire to distance themselves from Riley socially.

Attribution Questionnaire Short Form (AQ-27) Subscales

One-way ANOVAs revealed significant differences between groups for: blame, $F(2,292)=7.06$, $p=.001$; $\eta_p^2=.0.46$; anger, $F(2,292)=14.93$, $p<.001$; $\eta_p^2=.093$; pity, $F(2,292)=5.59$, $p=.003$, $\eta_p^2=.039$; dangerousness, $F(2,292)=15.54$, $p<.001$; $\eta_p^2=.096$; and fear, $F(2,292)=16.90$, $p<.001$; $\eta_p^2=.104$. However, there were no group differences for: avoidance, $F(2,292)=4.46$, $p=.012$, $\eta_p^2=.030$; segregation, $F(2,292)=2.80$, $p=.063$; $\eta_p^2=.019$, help, $F(2,292)=2.21$, $p=.112$; $\eta_p^2=.015$; and coercion, $F<1$; $\eta_p^2=.001$.

Tukey's HSD tests were conducted on each of the dimensions that revealed a group difference. The DSM group projected significantly more blame ($M=9.69$, $SD=3.64$) than the PTMF+DSM group ($M=7.90$, $SD=3.11$), but no other group differences were significant, contrary to Hypothesis 1. Anger was greater in the DSM group ($M=8.60$, $SD=4.48$) compared to both the PTMF ($M=6.14$, $SD=3.5$), and PTMF+DSM ($M=5.95$, $SD=3.47$), groups, supporting hypothesis 1. There were no differences in anger between the PTMF and PTMF+DSM groups. Consequently, incorporating a DSM-5 diagnosis into a PTMF explanation did not

significantly impact participants' levels of anger. Dangerousness was greater in the DSM group (*M*=9.39, *SD*=4.66) than either the PTMF (*M* = 6.73, *SD* =3.61) or PTMF+DSM (*M*=6.59, *SD*=3.56) groups, but did not differ significantly between PTMF and PTFM+DSM groups. There was significantly more fear for the DSM group than either the PTMF (*M*=8.36, *SD*=4.55) or PTMF+DSM (*M*=5.42, *SD*=3.33) groups, but fear scores were not significantly different between PTMF and PTMF+DSM groups. Pity was impacted differently from the other aspects, as more pity was experienced by the PTMF group (*M*=20.78, SD=4.80) than the DSM group (*M*=19.33, *SD*=5.24), but did not differ between PTMF and PTFM+DSM groups.

Type of Relationships

Across all three conditions, 177 (60%) participants stated that they had either experienced themselves or encountered someone who has experienced similar difficulties to Riley, leaving 118 (40%) who either preferred not to disclose or had not had these experiences. Within the options, 72 (24.4%) stated that they, themselves, know somebody with similar difficulties: 43 (14.6%) had a parent; 38 (12.9%) had a sibling; 57 (19.3%) a partner; 72 (24.4%) a co-worker; and 70 (23.7%) an extended family member. 95 participants (32.2%) stated that the question did not apply to them, and 27 (9.2%) preferred not to disclose this information. A two-way MANOVA was conducted to examine the effect of contact (yes or no) and conditions on all continuous variables (SDS & AQ-27 subscales). Contrary to Hypothesis 2, an insignificant main effect of contact on the dependent variables was observed, F (10,280) = 1.25, p =.262, meaning that participants who encountered someone with similar difficulties to Riley did not experience significantly stronger stigmatizing responses. There was an insignificant interaction between condition

and contact on dependent variables, $F(20,562) = 1.40$, $p = .116$, meaning the effect of condition on stigmatizing responses was not significantly altered by contact experience.

Table 3: Pearson correlation matrix for continuous dependent variables

	1	2	3	4	5	6	7	8	9	10
Social Distance Scale (1)	1									
Attribution Questionnaire Short Form (AQ-27) subscales										
Blame (2)	-.238**	1								
Anger (3)	-.432**	.381**	1							
Help (4)	.549**	-.234**	-.379**	1						
Dangerousness (5)	-.604**	.256**	.610**	-.348**	1					
Fear (6)	-550**	.229**	.536**	-.349**	.849*	1				
Avoidance (7)	-726**	.210**	.405**	-.582**	.566*	.534*	1			
Segregation (8)	-.384**	.254**	.416**	-.276**	.594**	.553**	.474**	1		
Coercion (9)	-.266**	.244**	.299*	-.138*	.430**	.357**	.300**re	.523**	1	
Pity (10)	.119*	-.202**	-.103	.313**	.025	-.004	-.066	.041	.077	1

Note. ** = significant at $p < .01$, * = significant at $p < .05$.

Table 3 displays the Pearson correlations between all dependent variables (social distance scale scores and AQ-27 subscales). Higher SDS scores indicate higher comfortability with the prospect of interacting with Riley; hence, SDS scores are negatively correlated with all stigmatizing attitudes except pity and help. Stigmatizing attitudes generally were positively associated with each other, meaning participants who endorsed one negative stigmatizing attitude were likely to endorse another. For example, participants who blamed Riley for their distress also endorsed avoidance, segregation, coercion, and dangerousness attitudes and experienced higher levels of anger and fear towards Riley.

They were also less likely to want to help Riley and experienced lower levels of pity. On the contrary, participants who felt more pity towards Riley demonstrated weaker stigmatizing attitudes—such as desiring less social distance, blame, and increased helpfulness intentions.

Table 4: Perceived sex of Riley for each of the three groups

		DSM	PTFM	PTFM+DSM
Perceived Sex Riley	Male	45 (46%)	36 (38%)	33 (35%)
	Female	52 (54%)	60 (62%)	62 (65%)

Table 4 shows the number (percentages) of participants in each group who perceived Riley to be either male or female. Inspection of these data shows little difference in these attributions between the groups, and this was confirmed by a nonsignificant ch-square performed on these numbers, $X^2(2)$=2.987, p=.225.

Discussion

The PTMF may help mitigate mental health stigma by expanding and conceptualizing our understanding of the development of psychological distress rather than simply labeling the individual as disordered (Johnstone & Boyle, 2018; Read &

Harper, 2022; Seery et al., 2021). This could be particularly true for individuals diagnosed with BPD, as they are often viewed negatively due to their diagnosis (Bonington & Rose, 2014; Deans & Meocevic, 2005; Koekkoek et al., 2006; Servais & Saunders, 2007). Despite this, no study before the current one has examined whether using the PTMF with individuals who meet DSM criteria for BPD reduces social stigmatization.

However, previous research has demonstrated that presenting a case of psychosis using the PTMF was shown to reduce stigmatizing attitudes (Seery et al., 2021). Thus, we predicted that a similar effect would occur for those diagnosed with BPD. These predictions were partly fulfilled: participants demonstrated greater stigmatizing attitudes towards a hypothetical case of an individual named 'Riley' when Riley's distress was presented using the DSM diagnosis of BPD, compared to the PTMF. Specifically, when presented with Riley's BPD diagnosis, they experienced more anger and fear toward Riley, desired more social distance, perceived Riley as more dangerous, and projected more blame onto Riley. Pity was the only factor that benefited from the diagnostic approach, with lower levels of pity observed among laypersons in the DSM diagnosis condition. Thus, the traditional diagnostic approach to BPD may elicit significantly more stigma among laypersons relative to a PTMF narrative of BPD, but it may also reduce pity.

In addition, the impact of combining a brief BPD diagnosis and the PTMF explanation of BPD was measured to account for situations where both may be used. Interestingly, participants demonstrated fewer overall stigmatizing attitudes towards Riley when presented with the combined approach, although blame was the only stigmatizing factor meaningfully affected. Specifically, participants blamed Riley significantly less when Riley's distress was understood using the combined PTMF and DSM approach compared to the DSM approach alone. PTMF without a DSM diagnosis did not elicit significantly

different blame levels than using a DSM diagnosis alone. When BPD is understood using the DSM diagnosis alone or environmental origins alone, participants are more likely to blame Riley for their condition. However, combining both approaches reduces blame, suggesting that medical and environmental causal attributions may be required to mitigate blame.

These findings can be explained by Corrigan's (2003) attribution model, which suggests that causes that are out of an individual's control, such as genetic factors or adversity, reduce how much responsibility is placed on the individual. Thus, combining both approaches may redirect the responsibility from Riley to multiple uncontrollable causes unrelated to Riley's character. However, these interpretations should be treated with caution, given that the blame subscale demonstrated low internal reliability.

A combination approach produces lower levels of pity relative to PTMF alone; however, less pity was experienced towards Riley when Riley's distress was understood using the DSM-5 BPD diagnosis. Therefore, attributing distress using the BPD diagnosis may reduce one facet of stigma (Masland & Null, 2022). Although pity is considered a stigmatizing response within the AQ-27, it was positively associated with helpfulness intentions. Participants who pitied Riley felt more desire to help Riley. Therefore, despite pity's negative connotations, it may motivate positive intentions to alleviate another's suffering. Alternatively, the pity subscale may not accurately measure pity, as the items used to measure pity (e.g., 'How much concern would you feel?') could also be interpreted as reflecting non-stigmatizing responses such as empathy. Thus, reduced pity scores in the DSM-5 condition may reflect reduced levels of positive emotional responses such as empathy, rather than reduced stigma.

Moreover, it is important to acknowledge the theoretical incompatibility of combining the DSM-5 BPD diagnosis with the PTMF, as the PTMF rejects the idea that distress should be labelled as a disorder. The PTMF aims to completely move away from psychiatric diagnosis and towards an understanding that distress is an adaptive response to adversity. Combining both undermines the PTMFs by reinforcing the pathologization of distress. Despite this, it is still important to measure how the integration of both approaches influences stigmatization, particularly given the likelihood that the PTMF will be gradually integrated into clinical practice as a supplement to, rather than a replacement for, the diagnostic approach (Omur, 2023).

It was also posited that those familiar with an individual with similar difficulties to Riley might experience different stigmatizing attitudes. This effect was also not demonstrated within the current study; whether participants had any contact with someone with similar difficulties to Riley did not significantly reduce stigmatizing attitudes in response to each vignette. These findings are inconsistent with previous research on attitudes towards various clinical disorders, where familiarity reduced stigmatizing attitudes for non-healthcare professionals (Steiger et al., 2022). However, how familiarity was measured and analyzed may explain these findings. Participants were asked to report if they had encountered individuals facing similar difficulties to Riley, specifying the type of relationship (e.g., a family member, partner or colleague). During data analysis, the impact of a specific type of relationship (e.g., a partner) on stigmatizing attitudes was not examined. Instead, contact was measured generally as participants were required to state whether they had or had not encountered someone with similar difficulties to Riley. It is possible that looking at each relationship independently may yield different results. Thus,

future research exploring the effect of each type of relationship may find that familiarity with a specific person impacts stigmatizing attitudes.

Early research has shown that when gender attribution coincides with the stereotyped gender, more negative emotions toward the individual are experienced (Weiner et al., 1988, as cited in Masland & Null, 2022). However, this was not the case for the current study. Participants who believed Riley to be female, the gender commonly associated with BPD, did not experience stronger negative emotions towards Riley than those who attributed Riley's gender to be male.

When comparing the current studies' main findings to previous similar research, similar findings were observed by Seery et al. (2021), where participants self-reported greater desired social distance towards a vignette detailing a DSM-5 psychosis diagnosis relative to a PTMF vignette. BPD and psychosis are stigmatized disorders, and understanding them through the lens of the PTMF may be an appropriate way to mitigate this stigma. However, unlike the current study, Seery et al. (2021) found that the PTMF did not significantly decrease stigmatizing attitudes, such as blame and perceived dangerousness. There are two potential explanations for this: differences in the vignettes and dependent measures and variations in general attitudes towards people diagnosed with BPD versus people diagnosed with psychosis. Concerning methodological differences, a shortened version of the Attribution Questionnaire- short form (AQ-27), the AQ-9, was used by Seery et al. (2021). In the AQ-9, only one question is used to measure each stereotype, whereas in the AQ-27, three questions are used; thus, the AQ-9 is perhaps less sensitive to attitude change than the AQ-27. However, it should be acknowledged that the blame and segregation subscales of the AQ-27 in the current study had low internal reliabilities, which may have impacted the results. Additionally, the

current study vignettes contained more information on the environmental etiology of symptoms and explicitly contained most of the features of the nondiagnostic conceptual system of the PTMF (See Johnstone et al., 2018). In contrast, Seery et al.'s (2021) vignettes contained concise explanations of the individuals' psychosis. More detail could have led to a better understanding of the origins of distress, which may mitigate stigmatizing attitudes (Johnstone et al., 2018). Alternatively, differences in attitude change between psychosis and BPD may suggest that attitudes towards BPD are more flexible compared to those with psychosis.

The findings of the current study have several positive implications. The PTMF is presented as an alternative to the traditional diagnostic approach and may offer a more appropriate way to understand distress by reducing stigma. The PTMF could be implemented in current clinical and nonclinical settings, helping to alleviate the associated negative consequences, such as poorer treatment outcomes and reduced well-being (Johnstone et al., 2018; Sickel et al., 2014). However, the pathologization of distress is currently deeply ingrained in clinical practice. Thus, replacing the diagnostic approach with the PTMF would require significant shifts in practice, such as restructuring treatment protocols and a broader change in mindset and culture.

Nonetheless, Individuals who wish to disclose their difficulties to friends, family, and employers could use the PTMF instead of the diagnostic approach to help reduce negative social responses (Seery et al., 2021). Moreover, therapists could use the framework to reduce stigmatizing attitudes, improving client-therapist interactions and treatment outcomes. However, future research should use healthcare-based population samples to test the generalizability of the current study's findings, given that HCPs have been shown to stigmatize those diagnosed with BPD. Furthermore, individuals diagnosed

may experience high levels of self-stigma where they have internalized the negative beliefs associated with BPD (Dubreucq et al., 2021). Thus, diagnosed individuals who experience high levels of self-stigma may benefit from reframing their distress using the PTMF. Further research involving people who experience distress commonly labelled as BPD is needed to establish whether the PTMF can reduce self-stigma.

Several research limitations should be considered. Although vignette-based research designs allow for higher experimental control than real-life interpersonal interactions, simply reading a hypothetical case study does not represent the complexity of real-life interpersonal interactions. This means that emotions, thoughts, and feelings, typically experienced during real-life interactions, may not have been experienced by participants when reading Riley's vignette. Future research could use visual or auditory stimuli such as video tapes to increase mundane realism (O'Connor et al., 2022). Similarly, self-report questionnaires that measure stigmatizing responses do not represent real-life stigmatizing behavioral responses. For instance, the social distance scale measures the extent to which someone feels they want to avoid that person in certain circumstances, not whether they will avoid that person in real life. Thus, whether the findings apply to real-life interactions is uncertain.

The current study was based on one hypothetical case of BPD, and such presentations are often heterogeneous, so different presentations may elicit varying degrees of stigmatization (Chapman, 2019). Thus, more research is needed to measure the impact of the PTMF conceptualization of varied distress presentations to determine the framework's effectiveness in reducing stigma.

The current study could not discern which factors of the PTMF are responsible for reducing BPD-related stigma, or why they had a stigma-reducing effect. It remains unclear

whether the avoidance of pathologizing language or the deeper understanding of the origins of distress is primarily responsible for the stigma reduction. Comparing stigmatizing responses to a psychological formulation that also aims to make distress understandable could help determine whether the PTMF uniquely mitigates stigma.

The four dimensions of the PTMF: Power ("What happened to you?"), Threat ("How did it affect you?"), Meaning ("What sense did you make of it?") and Threat ("What did you do to survive?") – along with strengths- were presented in Riley's PTMF vignette. This contrasts with Seery et al. (2021), who presented the PTMF in a single paragraph. Although the PTMF used is more detailed than Seery et al. (2021), it remains a simplified version of the PTMF. "What is your story/ How does this all fit together?", which helps individuals develop a narrative-based understanding of their distress, was omitted.

Additionally, Riley's case study only included two sociocultural power influences – relational and social – in the context of parental invalidation, sexual trauma, and social isolation. Other important contextual factors that often contribute to the development of distress, such as poverty, racial discrimination, and migration, were not explored. Future research should present the PTMF with all its elements and include other sources of power and adversity to better understand the PTMF's impact on mental health stigma.

Moreover, Riley's strength in seeking mental health services may seem incongruent with the PTMF, given that mental health services are structured mainly on the diagnostic model. Although mental health services are increasingly using non-pathologizing approaches, other forms of support, such as peer support groups, community support activities, or rituals, should not be overlooked.

Despite noted limitations, the current research was the first to demonstrate the potential stigma-reducing effects of the PTMF for people diagnosed with BPD.

Implementing the PTMF in clinical or non-clinical settings may help reduce mental health stigma, consequently improving the lives of those whose distress is associated with BPD.

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Appendices

Exploratory analysis

Attributed gender

Table 3: Frequency and percentage of participants who attribute Riley's biological gender to either male or female.

	Gender			
	Female		Male	
Condition	Freq.	Pct.	Freq.	Pct.
All	174	59	114	38.6
DSM-5	52	53.6	45	46.4
PTMF (without a diagnosis)	60	62.5	36	37.5
PTMF (with a diagnosis)	62	65.3	33	34.7

Note. Freq and Pct are frequency and percentages abbreviated, respectively. Condition "all" refers to overall gender attribution across all conditions.

A total of 288 out of the 295 analysed participants disclosed what biological gender they assumed Riley to be, leaving 7 participants who did not disclose any biological gender. As demonstrated in table 2, for all three conditions, most participants perceived Riley to be female. A two-way MANOVA revealed an insignificant difference between Riley's perceived gender and all continuous variables, $F(10,273) = 2.28$, $p = .014$, (η_p^2) .077, meaning that gender attribution did not significantly alter continuous variables scores. Subsequently, there was a non-significant interaction between gender attribution and condition on all continuous variables, $F < 1$, (η_p^2) .026, meaning that participants' gender attribution was not related to stigmatizing responses. These results did not support hypothesis 3.