The Name That Holds You Together Might Also Hold You Back

Borderline personality disorder, dimensional psychiatry, and the cost of finally having an answer.

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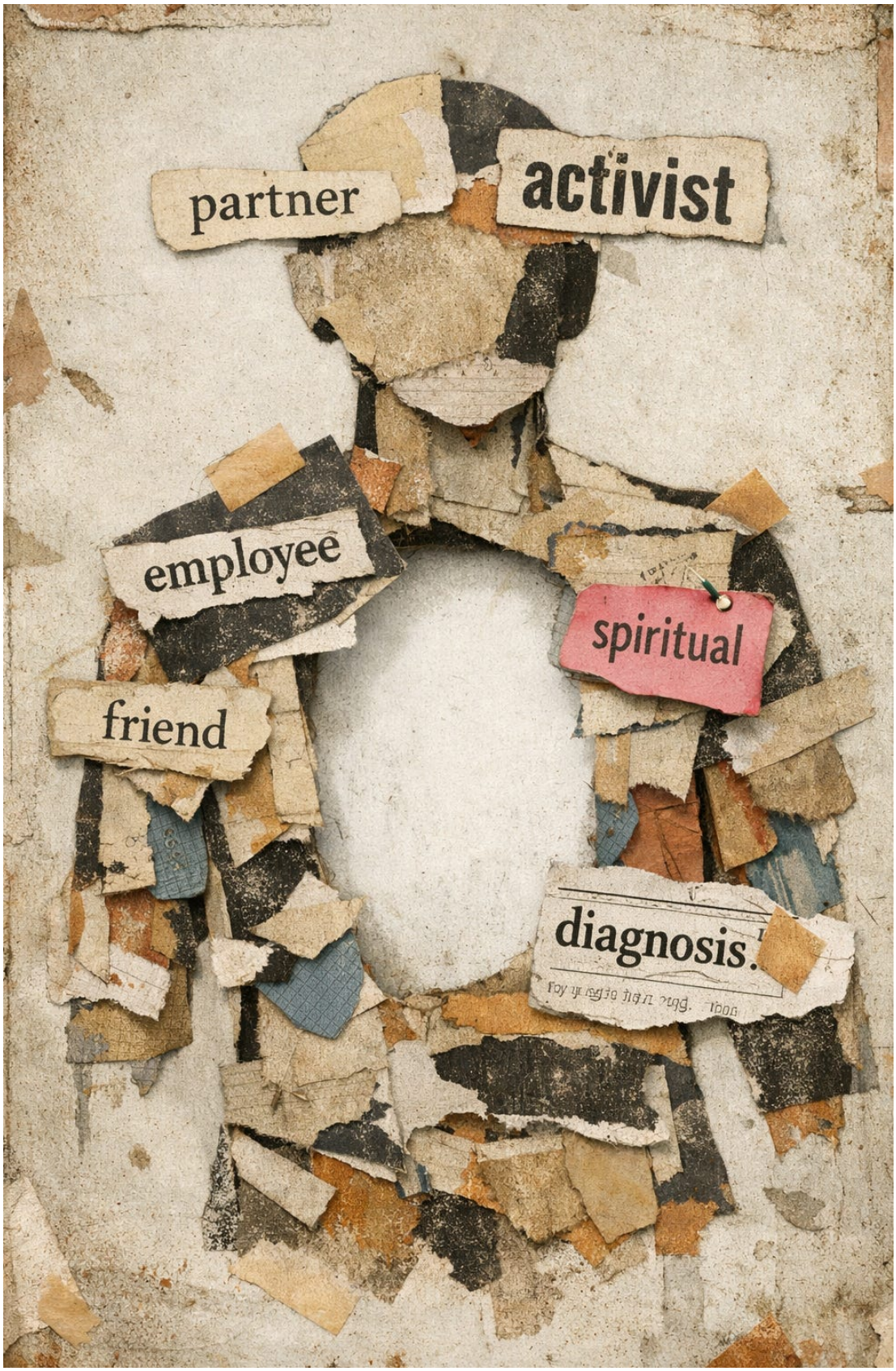
There is a particular kind of exhaustion that comes with building yourself out of borrowed materials.

You meet someone and suddenly you are the person who loves them. You start a new job and you are the person who does that work. You find a cause, a subculture, a friend group, a spiritual practice, and for a while the world has edges again. You know who you are because this thing, this person, this role tells you. Then something shifts. The relationship falters, real or imagined. The job loses its shape. The identity you constructed around that external anchor collapses, and what's left is not some stable self underneath. What's left is emptiness. Fear. A desperate scrambling for the next thing to organize a life around.


partner
activist
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diagnosis.

This cycle can repeat for years. Each time the stakes feel higher because each collapse confirms what you already suspected: that there is nothing solid at the center. That everyone else has some durable sense of who they are and you are borrowing yours, temporarily, from whatever is closest.

When someone lives inside that cycle, a diagnosis can feel like the first stable thing they've ever been handed. But the same name that finally answers the question "what is wrong with me" can quietly become the only answer to "who am I." And that is not the same as getting better.

What the label gives

In a systematic review of qualitative studies on the experience of receiving a BPD diagnosis, Lester et al. (2020) found that when the diagnosis was delivered with care, people consistently described the experience as clarifying. Containing, even. One participant called it "a light at the end of the tunnel." Another described "an enormous sense of relief that there was an explanation for the way I was" (p. 271).

Horn et al. (2007) captured something more specific. Andrea said that for years she had "sort of like floated" without a label. Danielle said she finally "had something that I could firmly grasp." Carol put it plainly: "I've been diagnosed and I feel safe" (p. 260).

The relief makes a particular kind of sense when you consider identity disturbance. If you have spent years cycling through borrowed selves, each one collapsing when its external source disappears, a diagnostic name offers something different. It does not depend on another person. It does not require a relationship to stay intact. It is a piece of self-knowledge that holds regardless of circumstances. For maybe the first time, you know one true thing about yourself: that this pattern has a

name, that other people share it, that it has been studied and described and treated.

The stakes here are not abstract. Most people with BPD will attempt suicide at least once in their lifetime, and the diagnosis accounts for a quarter of all psychiatric inpatients (Choi-Kain et al., 2022). For many of these individuals, the validation of a name is what keeps them in treatment long enough for treatment to work.

The label also builds community. It connects people to advocacy organizations, to online spaces, to a shared vocabulary for experiences that are otherwise almost impossible to articulate.

Cano and Sharp (2023) found that patients and families rated categorical and hybrid diagnostic reports as more informative and useful than purely dimensional ones on nearly every measure of clinical utility. People wanted something they could *say*. “I have borderline personality disorder” is a sentence that opens a conversation. “I have elevated emotional lability loading on the internalizing distress subfactor” is a sentence that ends one.

And there is a political reality. DBT was built for BPD. So was MBT. So was transference-focused psychotherapy. Herpertz et al. (2017) warned that eliminating the categorical diagnosis risks orphaning an entire

treatment literature. What happens to a patient who needs DBT when her diagnosis is “moderate personality dysfunction with elevated impulsivity and separation insecurity”?

What the label costs

But here is the thing about handing a stable identity to someone who has been desperate for one. They may hold on too tight.

The diagnosis can slot into the exact same role that the relationship or the job or the subculture used to fill. It becomes the organizing principle. The thing you build yourself around. And when your personality is the disorder, the question of where the disorder ends and you begin gets harder and harder to answer.

Horn et al.’s (2007) participants were clear about this. Gary described the diagnosis as “the killing of hope,” leaving him feeling like “your hands are tied, your cards laid and your fate set” (p. 262). Danielle said that “disorder kind of suggests permanency to me, it really does” (p. 263). Brenda internalized the label as confirmation she was “a nutter.” Not mentally ill. Just wrong


NEA
BPD
"We are whole people, not labels."

Across Lester et al.'s (2020) review, the pattern repeated. When the diagnosis was delivered poorly, without context, without information, sometimes discovered by accident in medical records, it became just another version of the cycle: attach to something external, let it define you, suffer when it turns out to carry pain alongside meaning. Participants called BPD a "dustbin label," handed out when clinicians didn't know what else to do. Others described a cycle: the rejection they felt from the diagnosis made them reject services, which confirmed clinicians' belief that they were "difficult," the very word BPD patients hear most often, right alongside "manipulative" and "attention-seeking."

This stigma is measurable. Hein et al. (2024) found that among healthcare providers, DSM-5 categorical labels were rated as the most stigmatizing classification system, while HiTOP's dimensional labels were rated as the least. These are not neutral scientific terms. They carry moral weight, and that weight presses down hardest on the people they describe.

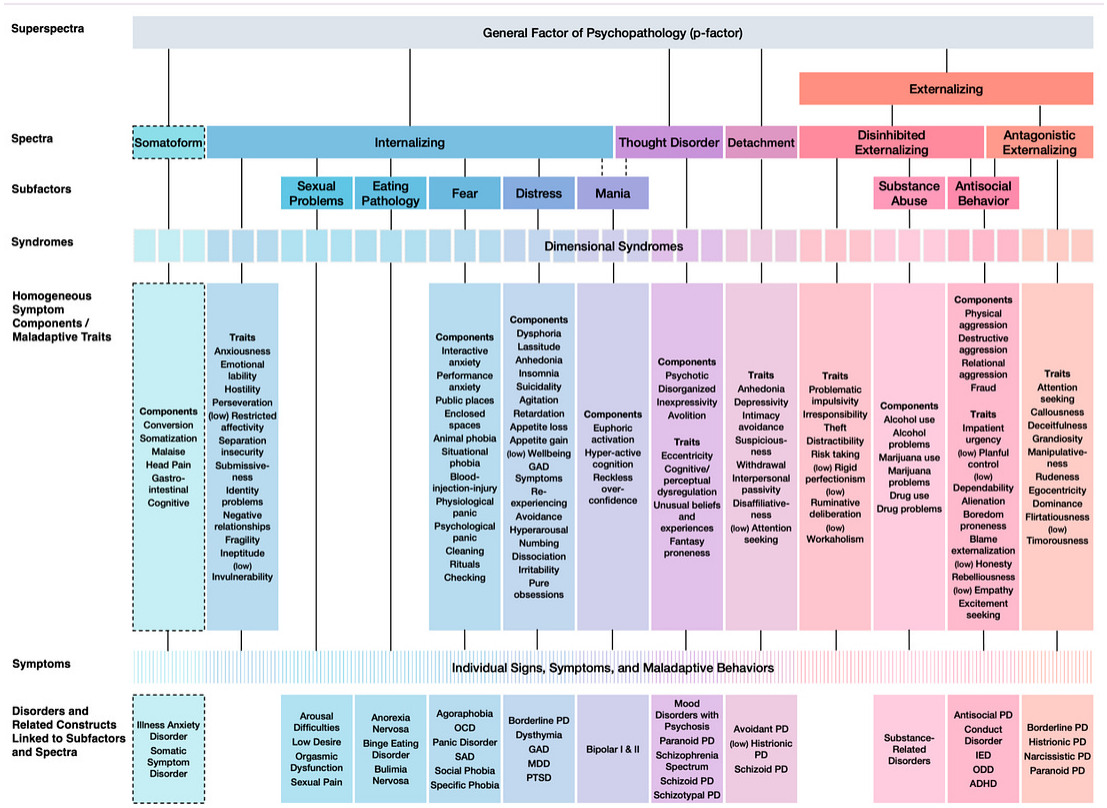
A categorical label might contain the chaos at first. But over months and years, the container becomes a cage.

The dimensional turn

It is precisely this tension, the relief of a name and the danger of becoming that name, that drives the push toward dimensional models.

The Hierarchical Taxonomy of Psychopathology (HiTOP) dissolves categorical boundaries entirely, organizing all psychopathology along continuous, empirically derived dimensions (Kotov et al., 2021). Under HiTOP, there is no BPD. There are elevations on trait dimensions: emotional lability, anxiousness, separation insecurity, hostility,

impulsivity. These load onto broader spectra, which load onto a general psychopathology factor.



The advantages are real. Dimensional models address the fact that 256 different combinations of criteria can produce the same BPD diagnosis. They handle comorbidity naturally. They eliminate the arbitrary cutoff separating four symptoms from five, even though a single BPD symptom predicts significant impairment (Choi-Kain et al., 2022). And they normalize personality difficulties by placing them on a continuum with ordinary human variation, which should, at least in theory, reduce stigma.

Imagine what this might feel like from the other side of the desk. Instead of hearing “you have borderline personality disorder,” you hear that you score high on emotional sensitivity and low on distress tolerance, that your attachment style creates specific interpersonal patterns, and that these are dimensions everyone falls somewhere on.

The message shifts. You are not a different kind of person. You are a person with more of certain things and less of others. Mullins-Sweatt et al. (2020) proposed that this framing could transform treatment planning, mapping therapeutic techniques onto specific trait elevations rather than monolithic categories.

For someone who has spent years building and losing identities, there is something genuinely freeing about a system that refuses to hand you another one. Dimensions do not become you. They describe where you are, not what you are.

But the consumer research keeps pulling in the other direction.

Cano and Sharp's (2023) patients and families rated the purely dimensional report last on every meaningful index. What they wanted was not precision. It was legibility. A name their mother could understand. A label their insurance would recognize. A word that connects them to people who understand.

Herpertz et al. (2017) put the concern bluntly: the purely dimensional approach risks putting clinicians in the position of telling someone that something is wrong with their personality without being able to say what. That is not an improvement. That is a different kind of harm.

Where I land (for now)

I think the AMPD gets closest to what people actually need.

It preserves the categorical BPD label. It keeps the name, the community, the treatment literature, the communicable thing. And it wraps that label in a dimensional framework: Criterion A captures impairments in identity, self-direction, empathy, and intimacy; Criterion B captures specific maladaptive traits. Widiger et al. (2019) found that these two components overlap substantially but each contributes

something the other cannot. Criterion A, the part about identity disturbance and chaotic intimacy, captures the *core* of the BPD experience in a way that trait scores alone never quite reach. Its focus on functioning rather than dispositional labels may also offer a less stigmatizing way to describe personality pathology, a possibility that becomes sharper when you consider what Criterion B still gets wrong.

The longitudinal data offer further reason for cautious optimism. Virtually all participants in the McLean Study achieved at least two years of symptom remission by the 16-year follow-up (Choi-Kain et al., 2022). But remission in that context means dropping below the diagnostic threshold on a symptom count. It does not necessarily mean the person feels recovered. The same study found that functional recovery, meaning sustained engagement in work and at least one emotionally sustaining relationship, was far more fragile, with nearly half of those who achieved it subsequently losing it. The gap between no longer meeting criteria and actually feeling whole is exactly the kind of gap that a classification system should be honest about.

Maybe the ideal approach gives people a name when they need one, when they are drowning and need something to hold onto, and then gradually shifts the emphasis as stability grows. From the category to the dimensions. From *what you have* to *where you are*. From a fixed identity to a moving point on a continuum. The goal, after all, is not to replace one fixed self-concept with another. It is to build the kind of internal stability that does not depend on any label at all.

But if we are going to build that system, we need to be honest about the one we have. “Manipulativeness” is a Criterion B trait in the AMPD. So is “attention seeking.” These are the same terms that Hein et al. (2024) found people with lived experience rated as among the most stigmatizing in any classification system. Think about what that means. The model I am arguing is the best available option formalizes some of the most pejorative language in the clinical lexicon and codes it as science. It names identity disturbance with one hand and calls people

manipulative with the other. It builds a dimensional framework sophisticated enough to capture the nuance of human personality and then populates it with words that flatten the people it describes into caricatures of their worst moments.

This is not a footnote to the classification debate. It is the center of it. Better factor structure will not fix this. More precise measurement will not fix this. The words themselves need to change, and they need to change because the people those words describe have been saying so for decades, in qualitative study after qualitative study, and the field has mostly responded by refining the math and leaving the language untouched.

The research on diagnostic delivery shows, over and over, that *how* someone receives a diagnosis matters as much as *which* diagnosis they receive (Lester et al., 2020). When clinicians take time, offer context, and treat the person as more than a label, people do better. When they don't, the diagnosis becomes another wound. Whatever system we end up with, that truth doesn't change. A diagnosis should be something a person can use, not something they have to become.

I don't think we've built that system yet. But I think the conversation about how to get there is one worth having in public, not just in classification committees.

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