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REVIEW

Australian Indigenous Clients with a Borderline Personality Disorder Diagnosis: A Contextual Review of the Literature

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Abstract There is a paucity of research literature regarding Indigenous people diagnosed with Borderline Personality Disorder (BPD). This review focuses on analyzing the contextual issues arising from such a diagnosis, particularly when applied to Indigenous Australians, and on the social and historical contexts which might facilitate a more accurate interpretation of the symptoms of BPD. The literature on historical and social contexts of Indigenous Australians was reviewed, with particular emphasis on alternative views of self and of collective trauma likely impacting upon the diagnoses. Table 1 compares the DSM-IV discussion of the nine symptoms with alternative contextual interpretations. This review serves as a starting point for finding more positive and effective ways of working with people who present with BPD symptoms, and providing more detailed and more culturally appropriate contexts in which to view individuals.

Keywords Indigenous Australians · Aboriginal Australians · Borderline Personality Disorder · Collective trauma

Introduction

Australian Indigenous people are often given DSM-IV diagnoses because they appear to fit the criteria. Practitioners and academics have argued at times that factors exacerbating the individual's presentation for any diagnosis are often better explained within the cultural and social context of the life of the individual (Barrett 2003), but while this argument has often been raised as a general principle, not enough attention has been given to the details of how this might work for specific diagnoses. Some good progress has been made for a few diagnoses (Haswell-Elkins et al. 2009).

The DSM-IV diagnosis for Aboriginal and Torres Strait Islanders that is examined here is Borderline Personality Disorder ("BPD"), presenting with behavior which appears to fit within the DSM-IV criteria concerning a person's sense of self. It will be argued, however, that Aboriginal and Torres Strait Islander culture is collectivist (Gonzalez 2000; National Health and Medical Research Council 2003), so a sense of self is not experienced in the same way as in more individualist cultures. It will also be argued that issues such as collective trauma resulting from assimilation policies and the Stolen Generations will also affect Aboriginal and Torres Strait Islanders' views of self and identity (Vicary 2000), increasing the likelihood of a diagnosis of BPD that is perhaps incorrect, or at least without an appropriate contextual framework from which to view the individual and their treatment. The primary aim of this paper, therefore, is to review the extant literature so as to explore the meaning and validity of the diagnosis of BPD when applied to Indigenous Australians and to suggest ways in which it can be expanded contextually.

Borderline Personality Disorder

Diagnosis and Characteristics of BPD

BPD is characterized by the DSM-IV as having nine primary symptoms. It is defined as:

> *A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked*

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impulsivity beginning in early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
1. Frantic efforts to avoid real or imagined abandonment
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
3. Identity disturbance: markedly and persistently unstable self-image or sense of self
4. Impulsivity in at least two areas that are potentially self-damaging (e. g., spending, sex, substance abuse, reckless driving, binge eating)
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
6. Affective instability due to a marked reactivity of mood (e. g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
7. Chronic feelings of emptiness
8. Inappropriate, intense anger or difficulty controlling anger (e. g., frequent displays of temper, constant anger, recurrent physical fights)
9. Transient, stress-related paranoid ideation or severe dissociative symptoms
(American Psychiatric Association 1994, p. 654)

In practice, BPD is characterized by extreme emotional intensity and is often prompted by and occurs within the context of interpersonal relationships (Hoffman 2007), which frequently propels the sufferer of the disorder and their loved ones into a world that seems dominated by chaos.

There is an evidence base suggesting that assigning the label "Borderline Personality Disorder" is problematic, and that it is often more of a "moral" diagnosis than a clinical one (HREOC 1997). Frequently, there is stigma associated with this label within helping services: that these people are "difficult" to work with and resistant to treatment, and that their tendency to self-harm is nothing more than attention-seeking and manipulation (Nehls 1999; Warne and McAndrew 2007). The shame associated with this disorder, therefore, often intensifies the individual's feelings of self-hate and exacerbates their self-harming behaviors (Epstein 2008).

Aboriginal and Torres Strait Islanders and BPD

Data pertaining to Indigenous people with diagnoses of BPD is scarce. Some data suggest low numbers (3–4 %, Nagel 2005), but the problem is that few people are *hospitalized* on the diagnosis of BPD; they are hospitalized under other codes such as self-harm, psychosis induced by drugs, etc. The authors' personal observations of interactions between Indigenous people and a local mental health service suggest that personality disorder labels are more frequently given to Indigenous people presenting to mental health services than hospitalization records indicate. This was also discussed in the *Bringing Them Home* report (Human Rights and Equal Opportunities Commission, HREOC 1997). In Part 5 (Chapter 18) of that report on mental health services, the issue was raised that while the immediate situation is often taken into account in diagnoses, the more detailed historical and cultural contexts are rarely considered. If, for example, a person had been abusing substances, had interacted with the judicial system, or had been living in highly chaotic circumstances, it is far easier to give them a label of BPD, implying that they are "beyond help," than to work through the multiple contexts that might involve several other family and community members.

Personality disorders are generally given a low level of validity and reliability among mental illnesses due to the ever-present nature of social and cultural factors within them (Alarcon and Foulks 1995). In fact, a DSM axis dedicated to culture and cultural profiles assigned to personality disorders has been proposed, providing a context in which to place the person rather than assigning labels without a cultural context (Petchkovsky et al. 2004). These authors also argued that the DSM does not refer to symptoms or syndromes resulting from political oppression, invasion, colonization, or forcible "deculturation." As such, personality assessments are sometimes considered inappropriate for Aboriginal people (Westerman and Wettinger 1997).

While providing cultural and other context to such assessments applies to many groups, to date there has been little to no research conducted on the diagnosis of Borderline Personality Disorder (BPD) for Indigenous Australians. The implications of this are that they might be given treatments that are neither effective nor appropriate when considered within a cultural context, thus leading to increased negative mental health outcomes.

Aboriginal History and Aboriginal Conceptions of Mental Health

The *Bringing Them Home* report (HREOC 1997) outlined a multitude of trickle-down effects from assimilation policies and the Stolen Generations, similar in many ways to other Indigenous groups around the world (Deloria 1999; Henderson et al. 1998; Moody 1988; Waldram 2004). Grief and loss were strong themes permeating all of the stories, as were increased mental health problems, reduced parenting skills, and youth suicide. More recent statistics indicate that Indigenous people are almost twice as likely to be hospitalized as a result of mental illness and behavioral disorders as other Australians, with Indigenous males almost three times as likely and Indigenous females more than three times as likely

to die as a result of mental health issues than their non-Indigenous counterparts (Garvey 2008).

HREOC (1997) also outlined many incidents of physical, sexual, and emotional abuse of Aboriginal children within institutional care as a result of the Stolen Generations, and demonstrated overwhelming evidence of inappropriate care of children, including neglect, inadequate medical treatment, and racism by delegated "caregivers" (Atkinson 2005). This provides one link to BPD, since childhood abuse and neglect is known to be highly prevalent among people with a diagnosis of BPD, and an absence of a maternal or appropriate primary caregiver is also a known risk factor for the development of BPD (Chanen et al. 2007). It seems likely, therefore, that Indigenous people who were removed from their families and placed in institutions as a result of such policies would be more likely to show symptoms of BPD.

HREOC (1997) also reported that Aboriginal people experience higher levels of social and economic disadvantage, have lower levels of employment, and have less access to stable housing. There is an overrepresentation of Indigenous people among those incarcerated, with approximately 17 % of inmates identifying as Indigenous. Approximately 57 % of these offenses were violent crimes, and 25 % were property crimes (Dudgeon 2000). Indigenous males and females are between 6 and 33 times more likely to be hospitalized as a result of assault than their non-Indigenous counterparts (Australian Bureau of Statistics 2008).

Despite such alarming statistics, the Aboriginal and Torres Strait Islander population is underrepresented as mental health services clients (HREOC 1997). This is believed to be the case not because of fewer mental health problems, but because access to these services is limited for many Aboriginal people, and mainstream services lack appropriate knowledge and understanding of Aboriginal culture, causing Aboriginal people to be less likely to access them (HREOC 1997; Westerman 2004). Additionally, Aboriginal people often report a fear of accessing mainstream services due to historical factors such as a fear of being "locked up" or hospitalized away from country, and the impact of medications upon the individual, often stemming from experiences of other family members (Ypinazar et al. 2007).

Research on Aboriginal conceptions of mental health has also shown that Aboriginal people consider the holistic nature of the person to be vitally important, and that the Diagnostic and Statistical Manual of Mental Disorders holds little or no relevance or meaning to the Aboriginal community (Brown 2001). Garvey (2008) argued that imposed labels often come with prejudiced judgments, and therefore add to the "shame" and stereotypical views of mental health.

The concept of "social and emotional well-being" rather than "mental health" (or "ill health") is therefore often applied, as it has a much more positive or strength-based focus. Social and emotional well-being encompasses all aspects of the social and emotional context of the person and their family, the historical and economic factors, including racism, oppression, trauma, grief, loss in its many forms, and the sequelae of the Stolen Generations, and it therefore allows for a more holistic framing of mental health (Vicary and Westerman 2004; Ypinazar et al. 2007). Connection to land and country is also of extreme importance in the Aboriginal conception of mental health, and if a person is to be away from their land, they can become "sick for country." Finally, physical health is also conceptualized by Indigenous Australians as closely tied to social and emotional well-being.

When working with Aboriginal people, therefore, it is important to be mindful of these contexts of social and emotional well-being, rather than working from a strictly individualistic mental health framework. This also encompasses the two major impacts on "mental health" that are most relevant to Indigenous Australians and which, it will be argued, set them apart from many other Australians—a differing sense of self and the impact of collective trauma.

Alternate Views of Self

Aboriginal identities are diverse and complex. Here we will outline just two components of Aboriginal identity that must be taken into consideration for context to be applied to diagnoses. One is the identity to which the group or family subscribe and identify, in conjunction with the associated customs, group norms, and beliefs. The second component is the identity imposed on the Aboriginal community by non-Aboriginal people. This includes stereotypes, the after-effects of the Stolen Generations, and the assumption that all Aboriginal people are the same (Dudgeon 2000).

Kinship systems within Aboriginal culture are important. They are based on long-term systems of order and continuity, and dictate to the individual where they belong within their families and communities (Atkinson 2002). Kinship systems provide a sense of self within the family context, and often provide direction as to the individual's place within that context. With the breakdown of traditional Indigenous culture, kinship systems have often been diluted or rendered practically non-existent, leaving the individual without a clear framework from which to formulate their identity. It may be argued that many Indigenous individuals have a blurred sense of identity due to a lack of cultural direction. Some people may still feel an obligation to this traditional kinship system, yet are torn between modern Western values and their own cultural expectations (Atkinson 2002; Lette et al. 2000).

Second, Aboriginal people today must not only understand and live with their own conception of their identity, but must also contend with imposed identity from non-Indigenous Australia (Dudgeon 2000). Aboriginal people today are forced to "walk in two worlds," the world of their own culture and the one that is that imposed upon them. Aboriginal culture is often

viewed as homogenous and stagnant by the non-Indigenous, and there is a distinct lack of appreciation for its dynamic and diverse nature. Stereotypes with regard to the cycle of substance abuse, welfare dependency, and resistance to white authority are also ever-present (Clark 2000). Indigenous Australians must find a way to integrate or resist these imposed negative identities and to maintain their own positive cultural aspects.

Collective Trauma

The concept of collective trauma was first introduced by Erikson (1976) following the disaster at Buffalo Creek (USA) in February 1972 during which a dam broke its banks, and 125 people were killed, 1,121 were injured, and over 4,000 were left homeless. The effects of this disastrous event were long-lasting and wide-reaching.

Erikson contrasted individual trauma and collective trauma as closely related but separate, and each capable of existing without the other. *Individual trauma* was the personal sense of shock that instills a sense of fear and makes it difficult for a person to respond appropriately, whereas *collective trauma* was "the blow to the tissues of social life that damages the bonds linking people together and impairs the prevailing sense of communality" (Erikson 1976, p. 302). Other examples where collective trauma has affected large groups of people include the September 11 attacks, Hurricane Katrina, and the Holocaust (Updegraff et al. 2008).

According to Erikson (1976), the specific indicators for collective trauma were:

> *Demoralization*, which may include a deep sense of mistrust for systems, close family members, and even self; this is characterized by a sense of apathy, loss of hope for the future, and failure to engage in activities that they once did.
> *Disorientation*, which is characterized by confusion; the individual is unable to orient themselves where they once belonged. They are unsure of their current place in life and of their identity.
> *Loss of connection:* the breakdown of cultural/social norms, social isolation.

The trauma that is perpetrated upon the individual can also be repeated. For example, it has been suggested that past violent behaviors inflicted upon an individual through Stolen Generations is often recreated by them; because it becomes a learned coping mechanism, the cycle of violence is doomed to be repeated. Dudgeon (2000, p. 69) refers to this as "violence turned inwards." In addition, re-traumatization often occurs as people are taken back to their own experiences of violence. Similarly, the lack of appropriate parenting and nurturance provided to a member who was stolen is often further extended to their own children, as the ability to provide appropriate attachment is related to their childhood experiences (Atkinson 2005). Once again, this may lead to further removal of children by welfare agencies.

Due to the racist assimilation policies of past Australian governments and the subsequent sequelae of the Stolen Generations, it can be argued that many Indigenous Australians suffer from something resembling collective trauma (Krieg 2009). The world view that once existed for Indigenous cultures no longer exists, and they are often unable to find meaning and make sense of their own vulnerabilities and are much more likely to experience existential crises. Indigenous people are more likely to be aware of their own mortality and be "on alert" to sources of trauma.

Possible Aboriginal and Torres Strait Islander Contexts for the BPD Symptoms

It has thus far been argued that due to factors such as collective trauma, intergenerational transmission of hurt, dilution of culture, blurring of identities, and breakdown of acceptable social norms, the protection or anxiety buffer that culture often provides is not as present or is less effective in Aboriginal people than in other Australians. This would mean that they are less able to cope with stressors that come into their lives, including violence, substance abuse and self-harming behaviors, and develop ineffective coping mechanisms. These will then present as symptoms that may appear to be the same as those of other Australians but which have a different etiology and therefore need different treatment.

The final section of this paper will discuss each of the nine symptoms leading to a diagnosis of BPD in terms of the factors discussed above. While tentative and preliminary to more solid research and clinical documentation, these ideas will allow a better contextual analysis of what may be happening with Aboriginal and Torres Strait Islander clients who present with BPD-like symptoms in the hope that this can lead to better ways of treating these clients.

1. *Frantic efforts to avoid real or imagined abandonment*

The DSM-IV (APA 1994) outlines an integral component of the BPD diagnosis as frantic efforts to avoid real or imagined abandonment, stating that the "perception of impeding separation or rejection, or the loss of an external structure, can lead to profound changes in self-image, affect, cognition and behavior" (APA 1994, p. 650).

In this light, and given all that has been outlined above regarding collective trauma, it is not surprising that many Indigenous people experience issues of entrenched separation anxiety from caregivers, family, and their culture as a result of decades of forced separation. Atkinson (2002) argued that

following traumatization, the single most important factor to recovery is supportive family. If the family has been broken down, traumatized, or is simply no longer there to provide the support, recovery will be hampered. The individual is likely to fear and attempt to avoid further abandonment and rejection, be it real or perceived.

We can see, therefore, that the symptoms displayed by Indigenous Australians showing imagined abandonment are likely to come from different origins than those of other Australians, and treatment should be adapted to this etiology.

2. *A pattern of unstable and intense interpersonal relationships*

As discussed in the Buffalo Creek disaster, interpersonal relationships become strained and often break down following traumatic events. People become isolated and have to rely on their own personal resources to cope, often only later realizing that the strength of the community was greater than the sum of its parts but is now gone (Erikson 1976). In a similar way, it is argued, the assimilationist policies and forcible removal of children have led to many individuals being unable to form appropriate attachments with primary caregivers. The after-effects of generations of children being taken from primary caregivers and placed in non-nurturing environments did not stop once these people passed on, and the cycle of inappropriate attachment in relationships in all aspects of people's lives was perpetuated. Issues of trust, abandonment, substance abuse, and domestic violence often result in relationships being centered on chaos, violence, abuse, and fear of abandonment.

HREOC (1997) outlined numerous case studies in which people were unable to form close, stable, nurturing relationships with others and that their issues of trust, abandonment, and personal identity prohibited them from entering into any appropriate long-term arrangement. One such expert testified to the *Report* that many of the individuals see themselves as completely worthless, and fall into cycles of learned helplessness, where they enter one abusive relationship after the other, allowing themselves to continue to be abused or exploited (HREOC 1997).

3. *Identity disturbance*

Perhaps one of the most pervasive indicators of BPD is an identity disturbance characterized by a marked and persistently unstable self-image or sense of self. As discussed above, Aboriginal people have more than one identity to which they must subscribe. Not only do cultural notions of kinship and reciprocity play an integral role in Aboriginal identity, but imposed identities from non-Indigenous people and the media are also a factor. The dissonance between going from a collectivist notion of self to an individualist notion leads to increased feelings of confusion and instability.

Wilkinson-Ryan and Westen (2000) argued that people who suffer from BPD experience identity diffusion, and that they have an inability to integrate both positive and negative schemas of self. As previously discussed, not only are there both individual and collective senses of identity for Indigenous Australians, but they are also forced to "walk in two worlds," and the "white" world often imposes negative stereotypes upon them. Clearly, facing these negative and positive representations on a daily basis would lead to a sense of dissonance, and more research is needed on this issue to determine the interplay among all of these factors.

4. *Impulsivity in at least two areas that are potentially self-damaging*

There is evidence that Aboriginal people are more likely to engage in impulsive and potentially self-damaging behaviors such as drug and alcohol abuse, gambling, and violence. While there has been little research on the prevalence of comorbidity issues between mental illness and substance abuse within Aboriginal communities, there is some evidence to suggest that this is a serious issue (Toomey 2007). Alcohol use is actually lower in Aboriginal communities than in the general population, but those who do drink usually do so at potentially damaging levels (O'Brien 2005).

As many have stated, however, alcohol abuse can be a symptom of the problem and not the cause (Kidd 1998). When examining effects of the Buffalo Creek disaster, there appeared to be an increase in alcohol intake and problem drinking, and there were rumors that drugs had entered their valley. An increased incidence of theft and juvenile delinquency also appeared to be manifestations of the disaster (Erikson 1976). In general, feelings regarding social standards of morality and decency deteriorated, and feelings of disconnectedness increased. Sufferers of BPD are often known to engage in self-destructing or impulsive behaviors. When viewed in the context of collective trauma (Krieg 2009) and when applied to Indigenous Australians, patterns resembling those of the Buffalo Creek disaster become more prevalent.

5. *Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior*

While statistics show that Aboriginal suicide has increased dramatically, suicide in Aboriginal cultures historically was uncommon (Kidd 1998; Hunter et al. 1999). Suicide and attempted suicide are very powerful acts, often symbolic in nature and intended to illustrate one's feeling of helplessness and futility, and the method used often embodies cultural as well as individual meaning (Hunter et al. 1999). For example, cutting and hanging have very powerful associated symbolic and significant themes. Hanging as a method of suicide has become a stereotype associated with Aboriginal deaths in

custody and is said to be a statement about justice and injustice (Hunter et al. 1999). Cutting, which is often used by people suffering from BPD, is used to provide a sense of release or relief to distract from or lessen the intensity of emotions.

Many Indigenous communities often engage in "Sorry Business" when a person of their community dies. This may include self-injurious behaviors, including "Sorry cuts." To clinicians who are unaware of the cultural aspects of Sorry Business, it may appear that the person is intentionally self-harming, and hence be included as a BPD symptom. In a cultural context, however, it is a normal and necessary behavior in some aspects (Sheldon 2001). Due to the fact that ceremonial business is sacred and often forbidden to be discussed with particular people, a client may cease an interview or become hostile if this subject is raised, and thus they are often also labeled as difficult or non-engaging.

6. *Affective instability due to a marked reactivity of mood*

The DSM-IV (1996, p. 651) states that individuals suffering from BPD will often experience intense feelings of dysphoria associated with anger, panic, despair, or anxiety, which are occasionally relieved by periods of satisfaction, and the DSM-IV theorizes that this emotional intensity is often inappropriately regulated by people suffering from BPD. Erikson (1976), however, described how many inhabitants of Buffalo Creek relied on each other as a point of reference prior to the disaster, and how each individual within the community was able to look to others as a guide for their behavior and actions. When the community was threatened, however, people were forced to utilize their own personal resources, which were often not sufficiently developed to act in isolation.

People suffering from BPD are often living in a sphere of either perceived or real isolation. They may exhibit feelings of fleeting happiness when they are well, but often lapse into feelings of depression, increased anxiety, or anger when they feel they have been or are going to be abandoned. Without a stable point of reference or set of accepted community norms to provide guidance on how to act and feel, the individual must rely on their own resources, and developmental deficits often exist within an individual's ability to regulate emotional intensity. While we will not repeat them here, we have seen all of these factors play a role in the context of Indigenous Australian's mental health issues.

7. *Chronic feelings of emptiness*

As stated above, one of the symptoms of collective trauma is demoralization, the feeling of "What's the use?" (Krieg 2009). When feelings of connectedness are threatened, and people have lost so much that is important to them, they often develop feelings of apathy, that there is no good reason for doing anything. They often believe that their life is devoid of meaning, and they lack the motivation and energy to get on with doing the things that once meant so much to them (Atkinson 2002; Erikson 1976).

For Indigenous Australians with intergenerational trauma, this may be seen as a form of depression similar to Cawte's (1981) "vital depression." Cawte described vital depression as a loss of vitality, neurovegetative symptoms such as decreased sleep, appetite, and sex drive, as well as a decrease in motivation, all of which could be misinterpreted in a diagnosis of BPD. Atkinson (2002) described the depression of Indigenous Australians as feelings of no clear sense of their own worth as human beings, and feelings of being helpless and hopeless with respect to external forces that are no longer within their control.

The point here is that depression and emptiness can be related to issues of unresolved grief in their lives and the lives of their families as a result of the many family deaths and the trauma arising from historical events (Atkinson 2002, p. 185), and it is an issue that must to be dealt with as an all-too-regular occurrence. ABS (2008) indicated that in 2004/2005, approximately 42 % of Indigenous people surveyed reported that they, their family, or their friends had experienced the death of a family member or close friend in the preceding 12 months. Although this factor was not measured in 2004/2005 for non-Indigenous people, Aboriginal people in 2002 were twice as likely to have experienced the death of a loved one or close friend as non-Aboriginal people (ABS 2008). Recurrent experiences of death lead to existential crises, ruminations on the meaning of life, and often chronic feelings of emptiness—as experienced by BPD sufferers.

8. *Inappropriate, intense anger or difficulty controlling anger*

Communities who experience collective trauma not only feel a deep sense of grief and loss of their culture, but they also experience intense feelings of anger or rage toward those who have either threatened their way of life in the past or represent a current threat (Krieg 2009). In studies of an Ethiopian community's experience of violence and threat to life, Zarowsky (2000) found that anger was the most prevalent emotion experienced. She wrote that anger is a resultant emotion of feelings of unjustified hurt, but that anger provides a function in that it often causes a group of people to feel close or unified. Expression of anger is frequently an indication of group membership and validation, and it helps to clarify identity in circumstances that may otherwise be chaotic and difficult to understand.

Atkinson (2002) identified rage and anger as indicators of collective trauma for Indigenous Australians. In the case of racist policies and attempted assimilation, Aboriginal people were victimized and denied the right to their own identity.

Great anger is felt by Aboriginal communities toward past and present treatment of their people. There is also anger toward institutions and structures that continue to oppress Aboriginal people, such as the judicial, health, and education systems, and this includes the mental health system. The refusal of past Australian governments to acknowledge past hurts and the lack of recognition that Aboriginal people today are still suffering from historical factors continues to victimize Aboriginal people by compounding feelings of loss and grief (Atkinson 2002).

While none of this justifies anger or violence, it helps to contextualize that the anger is not isolated, nor does it occur purely due to the immediate situation. In a similar vein, many have reported that the cumulative effects of racism lead to inappropriate anger that is understandable—although not justified—based on previous events (e.g., Feagin 1991).

9. *Transient, stress-related paranoid ideation or severe dissociative symptoms*

There is evidence to suggest that collective trauma can result in episodes of dissociative symptoms and paranoid ideation. Ainslie and Brabeck (2003) conducted a study on a community following a particularly horrific racially motivated murder. From the evidence, it was argued that the community suffered collective trauma not only from the murder itself, but also from the outcomes—increased racial tension within the community, increased media exposure, and resultant judgments upon the morality of the community. Along with phobic symptoms, flashbacks, and externalization of blame, dissociation was found to be prevalent among community members, which was described as being an "unreal experience," like being "there, but not there" throughout the entire ordeal. Further, there were feelings of extreme fear, to the point of paranoia, that retribution for the murder would take place, which resulted in many people even refusing to leave their house.

Gunderson (2006) similarly described how BPD sufferers often experience "lapses in reality testing," symptoms often associated with or similar to Posttraumatic Stress Disorder, and that they often experience this throughout periods of extreme stress. Increased social disadvantage, domestic violence, substance abuse, and breakdown of relationships create ongoing and consistent sources of stress from which people often have little or no respite. It is not surprising that when individuals are subjected to consistent stress, periods of dissociation or "lapses in reality testing" occur. Furthermore, without the point of reference that the Indigenous culture often provides for an individual, such as a spiritual visiting or experience, disconnection from this culture may result in a presentation of dissociation.

Table 1 Alternative possible interpretations of BPD symptoms for aboriginal Australians suggested from the review

DSM-IV TR Symptoms of BPD	DSM-IV TR Discussion	Alternative View/Origins
Frantic efforts to avoid real or imagined abandonment.	Constant feeling of being abandoned by caregivers and loved ones. Anticipation of rejection.	Ongoing culture of forced separation from care givers as children, Stolen Generation, loss of community and family structures.
Unstable and intense interpersonal relationships	Alternating between extremes of idealization and devaluation.	Alternative care as children, unable to form appropriate attachment relationships, cycles of learned hopelessness, abusive relationships.
Identity disturbance	Markedly and persistently unstable self-image or sense of self	Loss of cultural direction, walking in two worlds, racism
Impulsivity in at least two areas that are potentially self-damaging	Examples of spending, sex, substance abuse, reckless driving, binge eating	Social disadvantage, social isolation, loss of connectedness.
Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior	Cutting, suicide attempts, deliberate self-harm.	Traditionally uncommon, powerful symbolic statements, distraction from life, Sorry Business.
Affective instability due to a marked reactivity of mood	Intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days. Difficulty regulating emotional intensity.	Loss of community, no stable point of reference on how they should feel.
Chronic feelings of emptiness	Feelings of apathy, feelings of "what is the use?"	Apathy, "vital depression," grief and loss, increased personal trauma, existential crises.
Inappropriate, intense anger or difficulty controlling anger	For example, frequent displays of temper, constant anger, recurrent physical fights	Unjustified hurt, anger at loss of culture, government policy, indication of group membership, anger at institutions.
Transient, stress-related paranoid ideation or severe dissociative symptoms	May experience psychotic symptoms such as delusions or false beliefs, hear voices, or exhibit symptoms of paranoia.	Detachment from experience, communal trauma leading to feelings of disconnectedness. Lapses in reality testing.

Summary and Conclusions

This review has discussed each of the nine symptoms of BPD as outlined by DSM-IV in order to provide more contexts relevant to Indigenous Australians likely to be diagnosed with BPD, and these are summarized in Table 1. For all symptoms, it has been shown that there are many more local and contextual factors that can play a role and which need to be considered as part of any diagnosis and treatment. This review can also help us in making more sense of the "senseless" behaviors and symptoms of individuals labeled BPD, at least with respect to Indigenous clients.

To date, there is a paucity of contextual data relating to Indigenous Australians with BPD. This review, however, is merely a beginning. Clearly, more research in the area is needed, and it is our hope that this paper will serve as a first step toward providing a more holistic context, for not only the clinician but also for the individual, so that both can work together to make sense of their experience and make positive moves toward healing. While many declare that Indigenous Australians (and others) require a "holistic" approach in research and treatment, they usually fail to provide the details as to what this actually means (Lock 2007), and it is our hope that some of the details and causal paths briefly presented here will aid in the development of such contextual approaches, which can then be reported in more detail.

On the basis of what has been written here, it would actually seem unwise to treat an Indigenous client labeled as BPD without discussing their views of self, their illness, their family history, especially as it relates to Stolen Generations and trauma, their historical and current perceptions of racism, their cultural knowledge and attachment, current family issues, and social and emotional well-being. We hope that such yarning stories will assist us in developing a better Aboriginal and Torres Strait Islander viewpoint on BPD.

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