

# The New Hysteria: Borderline Personality Disorder and Epistemic Injustice

Forthcoming in

*The International Journal of Feminist Approaches to Bioethics*

*This is a pre-print.*

*Please update any citations relative to the  
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*Abstract:* The diagnostic category of borderline personality disorder (BPD) has come under increasing criticism in recent years. In this paper, we contribute to that literature by analyzing the role and impact of epistemic injustice, specifically testimonial injustice, in relation to the diagnosis of BPD. We first offer a critical sociological and historical account, detailing and expanding a range of arguments that BPD is problematic nosologically. We then turn to explore the epistemic injustices that can result from a BPD diagnosis, showing how experiences of testimonial injustice within BPD can prevent patient engagement in meaning-making activities, thereby undermining standard therapeutic goals. We conclude by showing how our arguments bolster ongoing efforts to replace the diagnostic category of BPD with alternatives such as complex post-traumatic stress disorder.

*Keywords:* Epistemic Injustice, Sexism, Borderline Personality Disorder, Diagnosis, Post Traumatic Stress Disorder

Most healthcare fields rely upon biologically based tests to confirm diagnoses.<sup>1</sup> The field of psychiatry is unique in that there are few, if any biologically uncontroversial ways to test prevalent diagnoses, whether they lead to pharmacological interventions or not. Because one cannot reliably identify depression, for example, via biomarkers gathered from a BMP or CBC test, X-ray, or MRI, CT, or PET scan, one must rely primarily upon patient testimony to determine diagnosis, prognosis, and treatment.

Given these constraints, mental health clinicians develop a range of communicative skills, for in order to care well for their patients, they must employ sophisticated ways of listening, understanding, and, ultimately, judging the problems that the patient is presenting through dialogue.<sup>2</sup> In short, what is or is not medically indicated will in large part turn on the interpretation of patient testimony. As important as these communicative skills are, they will run aground if the diagnosis that results from such dialogue undermines therapeutic aims, including and in particular the possibility of future therapeutically useful dialogue. In this paper, we argue that the diagnosis of borderline personality disorder (BPD) can result in epistemic injustices that run counter to the therapeutic aims for patients in diagnostically-relevant situations, which is to say, patients undergoing experiences such that, today, they are candidates for that diagnosis.

We begin by reviewing contemporary critiques of BPD.<sup>3</sup> We find providing historical as well as social-scientific evidence concerning BPD

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<sup>1</sup> Geoffrey C. Bowker and Susan Leigh Star, *Sorting Things Out* (Cambridge, MA; London, UK: The MIT Press, 1999), <https://mitpress.mit.edu/books/sorting-things-out>; Annemarie Goldstein Jutel, *Putting a Name to It* (Baltimore: John Hopkins University, 2011), <https://jhupbooks.press.jhu.edu/title/putting-name-it>.

<sup>2</sup> Greg Horne, "Is Borderline Personality Disorder a Moral or Clinical Condition? Assessing Charland's Argument from Treatment," *Neuroethics* 7:2 (2014), doi: 10.1007/s12152-013-9199-3.

<sup>3</sup> For a very recent critique, see Roger Mulder and Peter Tyrer, "Borderline Personality Disorder: A Spurious Condition Unsupported by Science That Should Be Abandoned," *Journal of the Royal Society of Medicine* 116, no. 4 (April 1, 2023): 148–50, <https://doi.org/10.1177/01410768231164780>. The literature critiquing BPD is very large. Instead of providing an exhaustive lit review (which, given its size, is the task of a meta-analysis, not an article such as this), we will cite numerous pieces from this literature along the way as they prove relevant to the concerns and claims at hand.

essential in order to understand the larger implications of the central argument of this paper. We turn to that argument in the next section, claiming that the diagnosis of BPD can result in epistemic injustice, specifically testimonial injustice. That is to say, the diagnosis of BPD can degrade the worth and credibility of a patient's testimony concerning their experience and in ways that plainly undermine therapeutic aims. We detail the many impacts of such injustice, including the way it closes down the potential for dialogue, fails to give appropriate space for patients to focus on healing from past traumas and regain a sense of self-worth, and denies credibility of the individual's experiences. We conclude by suggesting that the concerns of epistemic injustice related to BPD offer reasons to more strongly consider alternative diagnoses,<sup>4</sup> including complex post-traumatic stress disorder (cPTSD).<sup>5</sup>

## 1. Borderline Personality Disorder: Background and Criteria

BPD was first described in 1938 in the United States by Adolph Stern (National Collaborating Center for Mental Health, 2009) and added to the Diagnostic and Statistical Manual for Mental Disorders in 1980. In its most recent incarnation, the DSM-5 demarcated three significant clusters of personality disorders (National Collaborating Center for Mental Health, 2009). Cluster A personality disorders are defined by "odd" or "eccentric" behaviors, cluster B by "dramatic" and "erratic" behaviors, and cluster C personality disorders by "anxious" and "fearful" behaviors (Sue et al. 2005, 496). BPD is considered a cluster B personality disorder.

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<sup>4</sup> In the end, we disagree with those who find the diagnosis of BPD defensible, even if construed as a question of the disruption of narrative abilities. Cf. Anna Bortolan, "Narratively Shaped Emotions: The Case of Borderline Personality Disorder," *Journal of Medicine and Philosophy*, no. 2 (2020), <https://doi.org/10/ggwr6>. Cf. also Allan Køster, "Narrative Self-Appropriation: Embodiment, Alienness, and Personal Responsibility in the Context of Borderline Personality Disorder," *Theoretical Medicine and Bioethics* 38, no. 6 (2017): 465–82, <https://doi.org/10/gcnj58>.

<sup>5</sup> It should be noted that, currently, the DSM does not recognize complex PTSD (c-PTSD). However, the 11th International Classification of Diseases (ICD-11) does, and there is expectation that the DSM 6 will.

The DSM-5 identifies BPD through four major areas of dysregulation and dysfunction: affect dysregulation, poor behavioral control, interpersonal hypersensitivity, and unstable sense of self. Affect dysregulation is characterized by suicidal ideation, persistent feelings of emptiness and numbness, and intense and uncontrollable or inappropriate anger. Poor behavioral control is seen through volatile emotions that cycle within days or hours, impulsivity, and reckless behaviors. Interpersonal hypersensitivity is seen through intense and unstable interpersonal relationships. This includes difficulty trusting others, moving through love-hate patterns towards others, and making frantic efforts to avoid abandonment. Individuals showcase unstable sense of self through uncertainty about themselves and their place in the world. Individuals with BPD also have recurrent suicidal and self-harm tendencies (Biskin & Paris 2012).

## 2. Problems With BPD

In this section, we explore the various problems with the diagnosis of BPD, which include demographic and diagnostic considerations. First, research demonstrates that there is a worrying amount of misdiagnosis of cases of PTSD as BPD; this is likely in part due to the fact that the symptoms of BPD overlap with those of PTSD.<sup>6</sup> The major overlaps are as follows: experience of poor emotional regulation, low self-esteem and poor self-image, self-harm, suicidality, and high levels of interpersonal problems and stress. In both disorders, these symptoms stem from first or second-hand experiences of traumatic events.<sup>7</sup> In order to highlight the

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<sup>6</sup> Cf. Carol Steinberg Gould, "Why the Histrionic Personality Disorder Should Not Be in the DSM: A New Taxonomic and Moral Analysis," *IJFAB* 4(1): 2011, 26-40, <https://doi.org/10/ggwr5>; Marie Crowe, "Personality Disorders: Illegitimate Subject Positions," *Nursing Inquiry* 15, no. 3 (September 2008): 216-23, <https://doi.org/10/d5rdjk>; John Wilson, Matthew McDonald, and Tina Pietsch, "Ontological Insecurity: A Guiding Framework for Borderline Personality Disorder," *Journal of Phenomenological Psychology* 41, no. 1 (January 1, 2010): 85-105, <https://doi.org/10/fb2gzp>.

<sup>7</sup> Rebekah Bradley, Drew Westen, "The psychodynamics of Borderline Personality Disorder: A Review of Developmental Psychopathology," *Development and Psychopathology* 17(4):927-57, 2005, doi:10.1017/s0954579405050443; Hodges, Shannon. "Borderline Personality Disorder and Post Traumatic Stress Disorder: Time for Integration?" *Journal of Counseling and Development* 81(4): 409-

difference between the two disorders, Amy Dierberger and Nina Lewis-Schroeder argue that the root of the issues is different: in BPD the symptoms stem from an unstable sense of self, while in PTSD the symptoms stem from the trauma itself (Dierberger & Lewis-Schroeder, 2017).<sup>8</sup>

Dierberger and Lewis-Schroeder further argue that there are different treatment goals and strategies for BPD and PTSD. For PTSD, there are three stages of treatment: stage one involves working with the patient on safety, coping skills, and self-care while creating a stabilized and structured treatment environment. Stage two focuses on the traumatic event itself, which includes grieving, remembrance, processing, and meaning-making. Stage three focuses on reconnecting and reintegrating back into general society from the psychiatric unit (Dierberger & Lewis-Schroeder, 2017). For BPD, the first stage remains the same, as it overlaps heavily with the typical treatment methods of cognitive behavioral therapy (CBT) and other such talk therapies. However, in BPD, the clinician takes control of the meaning-making process. Clinicians tend to focus on helping patients understand their various emotional and mental states, maintaining safety through a reduction of suicidal and self-harm behaviors, and, crucially, *cultivating a stable self-image*.<sup>9</sup> We find this treatment strategy flawed. How can clinicians parse out which symptoms are caused by unstable self-image versus traumatic events? Doesn't an

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417, 2003. Of course, the similarities in symptomology may, in some cases, be indicative of PTSD and BPD being comorbid.

<sup>8</sup> Andrea Nicki, "Borderline Personality Disorder, Discrimination, and Survivors of Chronic Childhood Trauma," *IJFAB* 9(1): 2016, 218-245, <https://doi.org/10/ggbbqt>. Some, like Bailey et al, have suggested that these individuals who fit the criteria for PTSD would be better treated with trauma-focused therapies. We return to such claims in the conclusion of this paper. Bailey, Tyson D., and Laura S. Brown. "Complex Trauma: Missed and Misdiagnosis in Forensic Evaluations." *Psychological Injury and Law* 13(2): 2020, 109–23, <https://doi.org/10.1007/s12207-020-09383-w>.

<sup>9</sup> Malda, Castillo, Javier, Claire Browne, and Algorta, Guillermo Perez. 2019. "Mentalization-based Treatment and Its Evidence-base Status: A Systematic Literature Review." *Psychology & Psychotherapy: Theory, Research & Practice* 92 (4): 465–98. doi:10.1111/papt.12195.; May, Jennifer, Toni Rachardi, and Kelly Barth, "Dialectical behavior therapy as treatment for borderline personality disorder," *The Mental Health Clinician* 6(2): 62–67, 2016. doi: 10.9740/mhc.2016.03.62.

unstable self-image often emerge precisely due to traumatic events? Furthermore, insofar as this process forecloses on certain patient self-narratives, it can render certain understandings of *self-as-survivor* unavailable to patients. Before elaborating further on this worry, we will turn to provide historical context for BPD, especially with respect to its gendered application and conceptualization.

In order to understand why BPD is diagnosed significantly more in women than in men, it is worth exploring its historical roots.<sup>10</sup> In their paper “Women at the Margins: A Critique of the Diagnosis of Borderline Personality Disorder,” Clare Shaw and Gillian Proctor traverse the history of women’s madness and its connection with BPD. They show that one of the first conceptualizations of women’s madness was witchcraft, which was attributed to women who were deemed “difficult” and threatened the patriarchal norms of the time (Shaw & Proctor, 2005, p. 484). This categorization delegitimized women’s claims, impeding, when not nullifying, their efforts at progress (Shaw & Proctor, 2005, p. 484). The diagnosis of hysteria, widely accepted and deployed across the 19<sup>th</sup> century, marked the next large historical shift in conceptualizations of women’s madness. Hysteria was characterized by anxiety, depression, insomnia, irritability, and various somatic symptoms such as fainting spells (Tasca et al., 2012). But it also played other explanatory roles and served other social functions—for example, hysteria was often diagnosed by Freud in order to cover up a woman’s experience of sexual abuse (Powell & Boer, 1995).

In addition to delegitimizing specific claims of abuse, the diagnosis of hysteria reinforced the view of women as always irrational and emotional and, thereby, not to be trusted (Powell & Boer, 1995). The diagnosis, on its face, explained certain symptoms in terms of individual pathology that,

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<sup>10</sup> By using the distinction between “women” and “men” throughout, we are neither committing to that binary, nor to binaries of or connotations between questions of sex, gender, and/or sexuality more generally. We are instead using those terms in a pragmatic sense: picking out those who typically take up such terms as a self-designation and those to whom such terms are typically applied in relevant ways in the situations/contexts under discussion.

when placed in their historical and political context, are better explained as pathologies of society. That is to say, and as numerous scholars have argued, what “hysteria” picked out was not a given woman’s psychological issues as much as it picked out their (reasonable) *reaction* to the misogynistic and oppressive structures of society (cf. Shaw & Proctor 2005, pp. 484).

This all leads to Shaw and Proctor’s argument that BPD is little more than a continuation of sexist understandings of women’s mental illness exemplified by previous diagnoses such as hysteria. First, they argue that the diagnosis of BPD is very much influenced by problematic and misogynistic cultural standards for women that persist today. They also point to the fact that BPD and hysteria both have one defining experience in common: both are regularly characterized by *the experience and subsequent societal neglect of the ramifications of a woman’s sexual assault*. This is an important point, as both hysteria and BPD can be used to cover up and discredit a woman’s experience of sexual assault. BPD reinforces certain ideals of women’s behavior, just as accusations of witchcraft and diagnoses of hysteria historically did.

To further motivate Shaw and Proctor’s view, consider that individuals diagnosed with BPD will frequently conform to a specific model. The paradigmatic BPD patient will be a female between the ages of 14 and 25 who experienced some form of sexual violence (Akhtar & Doghramji, 1986). More often than not, this sexual violence will be protracted, meaning there will either be multiple abusers or one individual who continued to abuse her over a period of time (de Aquino Ferreira et al., 2018). After this event, it is likely that she will self-harm and exhibit body image and self-esteem issues. She will have multiple suicide attempts and have been hospitalized at least once for suicidal ideation (Paris, 2019). This paradigmatic case illustrates some of the fundamental issues associated with BPD as a diagnostic category, which we will now further explore.

One of the defining diagnostic criteria for BPD involves “impulsivity in at least two areas that are potentially self-damaging” (De Zutter et al., 2018). Explicit examples of impulsive and self-destructive behavior given in the DSM and the surrounding literature include excessive spending, promiscuous sex, substance abuse, reckless driving, and forms of disordered eating (especially binge eating and self-starvation). While reckless driving and substance abuse are more common among men, the majority of these criteria are explicitly targeted towards women. Firstly, disordered eating is a behavioral pattern that is mostly seen in women, with 75% of both anorexia nervosa and bulimia nervosa diagnoses being attributed to women (Statistics & Research on Eating Disorders, 2020). Secondly, the identification of promiscuity in women is incredibly problematic. It is well known that women are harshly and unfairly judged for having sexual partners in a way that men are not (Marks et al., 2018). This criterion also pathologizes a woman’s decision to have consensual sex. There is no way that the criterion of impulsivity and its link with promiscuity can be judged objectively, as it is not evaluated in a vacuum and clinicians can be influenced, both explicitly and implicitly, by societal perceptions of women.<sup>11</sup>

Finally, women’s anger is pathologized through the evaluative framework of BPD. There are two forms of anger that are encompassed in BPD: uncontrollable and inappropriate anger, and there are two dominant ways that anger management is conceptualized (Berger, 2014).<sup>12</sup> The first is

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<sup>11</sup> Furthermore, if a woman identifies as bisexual, the diagnosis of BPD can not only pathologize an LGBTQI identity, but also stigmatize it. This diagnosis adds credibility to the beliefs surrounding bisexual women, such as the idea that bisexual women are “slutty” and untrustworthy. The idea of bisexual women as untrustworthy and attention-seeking serves to delegitimize the individual’s sexual identity. Furthermore, the perception of bisexual women as “slutty” may also influence the overdiagnosis of LGBTQI populations with BPD. Keeping in mind that another diagnostic criterion for BPD is promiscuity, the still prevalent stereotype that bisexual women are inherently promiscuous likely increases the rate at which they are diagnosed. Bisexuality is largely not accepted by both the LGBTQI and heterosexual communities, and the linkage between the LGBTQI community and BPD makes identifying as bisexual even more stigmatized (“Bisexual People Face Discrimination and Violence”, 2016).

<sup>12</sup> Expectedly, each of these are inflected by considerations of race, as a wide body of research details (Ahmed 2017; Wendy 2014).

*externalizing* anger. This is seen as at more typically “masculine” projection of anger, and it is characterized by physical expressions like raising one’s voice. Internalized anger is the more stereotypically feminine approach to anger management, and it takes two forms. The first form of internalized anger is where one hides one’s anger and refuses to show it to others. The second form is more common, and it occurs when an individual takes their anger against someone else and turns it inwardly, being angry at themselves rather than at someone else. A diagnosis of BPD encapsulates both internalized and externalized anger. Internalized anger is considered inappropriate insofar as the clinician believes that the individual is afraid to show their anger. Externalized anger is also seen as inappropriate insofar as it is “uncontrollable” (Berger, 2014). This leads one to wonder: if both are ultimately inappropriate or at least signs of an underlying problem, how are women supposed to show and process their anger? It seems that however a woman expresses her anger, she is doing it wrong.<sup>13</sup>

Given these concerns, the continued use of the diagnosis of BPD suggests the following relative to larger societal-psychological norms: the diagnosis of BPD places women in a double bind where they are punished for both conforming to and breaking away from societal expectations of femininity. Furthermore, that the criterion of BPD inherently places women in a double-bind demands a broader conversation about how this diagnosis is used in order to enforce a certain value-system on women.<sup>14</sup> Given these considerations, we agree with the literature surveyed that, at minimum, the symptomology and criteria behind BPD are too expansive, for not only do they pathologize an unreasonably broad set of behaviors, but they do so in ways that can place patients in (highly gendered) double-binds.<sup>15</sup>

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<sup>13</sup> There is much to be said about how anger can become pathologized, especially against marginalized groups. For example, consider work of Myisha Cherry, *The Case for Rage: Why Anger Is Essential to Anti-Racist Struggle* (Oxford, New York: Oxford University Press, 2021). Due to space and the aims at hand, we unfortunately cannot take up those concerns here.

<sup>14</sup> Crowe, “Personality Disorders.”

<sup>15</sup> A particularly egregious example of this double bind can be seen in Christine Lawson’s identifications of the four subtypes of BPD. Though this is a “pop psychology” book, it is written by a clinician and we find it to helpfully illuminate the larger socio-political import and impact of

### 3. The Harms of BPD

Given extant analysis concerning the diagnostic criteria, symptomology, and demographic data of individuals diagnosed with BPD, we find one hard-pressed to argue that BPD picks out a distinct, nosologically-defensible set of symptoms. One might object that with even a cursory engagement with the history of medicine, it is a given that diagnoses are historically variable, that many have porous, vague boundaries, and that many are and have been rooted in problematic assumptions about various groups of people, especially along lines of sex, gender, and sexuality. Neither nosological, nor historical considerations alone determine the value of a given diagnostic category because insofar as its application opens fruitful (even if imperfect) avenues for treatment, it might be worth keeping. One might further object that the more specific concerns detailed above, including overlap between symptoms and heuristic assumptions based upon sexual or gender-based differences, are unavoidable in a field such as psychology. In short, some highly problematic diagnoses are nevertheless clinically useful.

We find this objection unconvincing. Consider a different diagnostic case: bipolar depression. Bipolar depression is frequently misdiagnosed as unipolar depression due to the overlap in symptoms between the two. A

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BPD as a diagnostic category that is centered on a patient's personality as opposed to their experienced trauma. In *Understanding the Borderline Mother*, Lawson explains that there is the Waif, who is characterized by helplessness and reliance on others; the Hermit, who is fearful and avoidant; the Queen, who is controlling and manipulative; and the Witch, who is sadistic (Lawson, 2016). Obviously, these categories are sexist. Not only does Lawson use incredibly gendered language, but she is also playing directly into gender stereotypes and expectations. The four types of BPD that Lawson created can be sorted into two categories: (1) conforming with gender expectations (as seen with the Hermit and the Waif) and (2) breaking away from gender expectations (as seen with the Queen and the Witch). Women who fall into category one will conform to the generalized societal expectation of women as needing help, protection, and guidance from men. On the other hand, women who fall into category two break away from social norms by being more self-confident and self-reliant and displaying more aggressive and assertive behaviors. Women are punished for both adhering to and breaking away from their expected gender roles which raises the question mentioned above: how should one behave in order to be classified as symptom free? Having said all this, as we argue below, the problem with BPD as a diagnosis goes much deeper.

recent study showed that individuals who were misdiagnosed as having unipolar depression had significantly lowered recovery and remission rates (Nasrallah, 2015). This is due to the fact that the patients were given the incorrect pharmacological and psychotherapeutic treatments, which exacerbated their symptoms and did little to teach them good coping mechanisms; the misdiagnosis also increased negative health outcomes, including worsening symptoms, increased rates of substance abuse, and increased suicidal behaviors or gestures (idem). In similar ways to misdiagnoses of bipolar depression, we find the majority of research on BPD to suggest that if mental health clinicians diagnose a patient with it, when in fact complex PTSD, PTSD, or a mix of depression and anxiety would be more appropriate, they can actively impede the ability of their patients to recover.

As a reminder: we have so far presented arguments that rely upon social, historical, and political considerations to question BPD as a diagnostic category. This has all been in some sense a propaedeutic, for we take the historical and social scientific research engaged so far to be essential in order to understand the larger implications of the central aim of this paper. That aim is to provide a new, independent reason to question BPD and that reason is the way in which it brings about *epistemic harms*. In addition to being bad in and of themselves, we aim to show that these harms negatively impact therapeutic outcomes.

#### **4. Epistemic Injustice**

While analyses of epistemic injustice have been effectively utilized in a wide range of fields spanning far beyond social epistemology to address epistemic aspects of oppression faced by marginalized groups, this concept has been comparatively less discussed in relation to mental health care, especially vis-à-vis conditions wherein reasons to doubt or at least significantly qualify a patient's testimony are part of diagnostic criteria.<sup>16</sup>

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<sup>16</sup> Of course, there are some exceptions. See, e.g., Michalis Kyratsous and Abdi Sanati, "Epistemic Injustice and Responsibility in Borderline Personality Disorder," *Journal of Evaluation in Clinical Practice* 23(5): 974-80, 2017, <https://doi.org/10/gb2h9c>.

The literature on epistemic injustice has grown exponentially since the publication of Miranda Fricker's *Epistemic Injustice* in 2007, and there is no hope of engaging all the research that might be relevant to this discussion. On the contrary, we will restrict our focus to the most basic type of epistemic harm (on Fricker's account), testimonial injustice, and will begin by discussing its relationship to psychological and psychiatric care more generally.<sup>17</sup>

#### *4.1 Testimonial Injustice and Epistemic Privilege*

Testimonial injustice refers to a situation where someone is harmed in their capacity as a knower through prejudicial downgrading or discrediting of their testimony. Closely related to the concept of testimonial injustice is epistemic privilege, which picks out who is seen and treated as an authority and whose testimony is afforded credibility in a given situation (Janack, 1997). In clinical work, there are at least two basic sources of knowledge: the patient and the clinician. The patient is in a position of epistemic privilege in the sense that they have firsthand knowledge of their experience, which in the context of the clinic is to say, firsthand knowledge of the experiences relevant to their illness. Patients know their symptoms, how the illness affects them, and the relevant social context of the impact of their illness in ways that others do not. The clinician, on the other hand, has epistemic privilege due to their training, expertise, and institutional position as well as highly specialized contemporary knowledge of disease and disease processes.

As we discussed in the opening of this article, clinicians in psychiatry and psychology must rely even more significantly on the knowledge of their patients than in other fields. This means listening closely to patient

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<sup>17</sup> Miranda Fricker, *Epistemic Injustice: Power and The Ethics of Knowing* (Oxford; New York: Oxford University Press, 2007). It is clear that hermeneutical injustice is also at play in a BPD diagnosis and all that can follow. On that topic, see, e.g., Pohlhaus, G., Jr., "Relational Knowing and Epistemic Injustice: Toward a Theory of Willful Hermeneutical Ignorance," 27(4): 715-735, 2012, <https://doi.org/10.1111/j.1527-2001.2011.01222>. For reasons of space, we are saving those arguments for a future paper.

testimony, assessing their description of their symptoms, and working together in order to establish a diagnosis. In their paper “Epistemic Injustice in Healthcare: A Philosophical Analysis,” Havi Carel and Ian James Kidd explain that while both clinicians and patients have epistemic privilege, “only the healthcare professionals’ privileged epistemic status ‘really matter(s)’” (Carel & Kidd, 2014, p. 535). Due to their position of power over patients, the clinician is given more epistemic trust and credibility by society, other treatment professionals, and even patients themselves. The patients, who are in a position of vulnerability in multiple respects,<sup>18</sup> can become less confident in themselves and less comfortable challenging the clinician when they believe they are being misdiagnosed (Kidd & Carel, 2017).<sup>19</sup> While clinicians certainly do deserve apt epistemic privilege and credibility, the default assignment of epistemic privilege can result in not just patient-provider miscommunication, but injustices, and especially when there is reason to believe that the diagnosis can perpetuate harms against the patient.<sup>20</sup>

This hand-off of epistemic privilege and credibility has a significant impact, especially for mentally ill individuals seeking care. One of the biggest problems with this system is that it creates an environment wherein the patient’s testimony—especially when seemingly untethered to the “issues at hand”—can be seen as unimportant and tedious, leading clinicians to miss important details in the patient’s narrative. Kidd and Carel explain that the average time between when a patient begins talking and the clinician interrupts for the first time is eighteen seconds, which can be interpreted as supporting the idea that providers too often discount the detailed testimony of patients (Kidd & Carel, 2017). Of course, even when clinicians try in good faith to listen fully to a patient, they must still

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<sup>18</sup> Cf. Wendy Rogers, Catriona Mackenzie, and Susan Dodds, “Why Bioethics Needs A Concept Of Vulnerability,” *IJFAB* 5:2 (2012): 11–38, <https://doi.org/10/gf9f9w>.

<sup>19</sup> This is not to say that patients can diagnose themselves. Rather, patients are capable of understanding their own illness experiences and the hand-off of epistemic privilege can disempower patients from having a central role in understanding and explaining their own experiences.

<sup>20</sup> We have focused on hysteria as a historical example of such a diagnosis, though one could look to other examples ranging from drapetomania to homosexuality.

filter that patient's testimony through the sieve of medically actionable information.

The epistemic power dynamic that exists between patient and provider is even more visible and impactful for patients with BPD. In order to understand how epistemic privilege and testimonial injustice operate vis-à-vis BPD in particular, it is first important to understand how most non-personality disorder mental illnesses are diagnosed. Generally, clinicians believe that in order to get an accurate diagnosis that reflects the suffering and experiences of the patient, the patient must be an integral part of deciding the diagnosis. This includes focusing on the symptoms that the patient is most bothered by, allowing the patient to take the lead on treatment goals and processes, and thoroughly discussing all potential diagnoses with the patient. In a scenario like this, the clinician is relying on the patient as a substantive source of knowledge. This treatment framework relies on the epistemic privilege of the clinician, of course, but it places the patient alongside them in a position of authority and power, allowing them to have determinate control over their treatment and their recovery process.

But cases of personality disorder upset this balance, for a personality disorder suggests that the patient is unaware of their personality inconsistencies or presence of dysregulation and maladaptive tendencies.<sup>21</sup> The assumption that patients are unaware of their behaviors and emotions can be interpreted as in and of itself an epistemic injustice, for it leads to the centering of the testimony and expertise of the clinician and downgrading in credibility that of the patient.<sup>22</sup> Another impact of testimonial injustice in BPD is that the patient-provider dynamic changes. Most mental health treatment professionals believe that their job is not one

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<sup>21</sup> Balsis, Steve, Evan Loehle-Conger, Alexander J. Busch, Tatiana Ungredda, and Thomas F. Oltmanns. "Self and informant report across the borderline personality disorder spectrum." *Personality Disorders: Theory, Research, and Treatment* 9(5): 429-436, 2018, doi: 10.1037/per0000259.

<sup>22</sup> To be clear, we are not claiming that such an assumption is unwarranted with respect to some patients or with respect to some diagnoses. We are claiming that this assumption is prima facie unwarranted for those diagnosed with BPD.

of paternalistic explaining and interpreting on behalf of the patient; rather, they believe that it is their job to try to understand and help give clarity to the suffering individuals. The approach that most clinicians take in mood or anxiety disorders are organized such that the patient gets to establish their own narrative of the events in their lives and understand the context of their symptoms through their own cognitive framework. This is not the relationship individuals that with BPD have with their clinicians. In the case of personality disorders like BPD, clinicians believe that the patient does not notice that they are exhibiting certain symptoms until the symptoms are *explained* and *taught* to them. Not only is this scenario full of paternalism and condescension, but it also creates an environment primed to allow epistemic injustices by shifting interpretive standing from an interaction between patient and clinician to solely that of the clinician. BPD situates clinicians in the position of being the “true” knower of the personal experiences of the patients in a way that does not happen with many other disorders. Due to the clinician’s position of epistemic privilege, patients diagnosed with BPD can quite literally lose control of their narrative.

#### *4.2 Societal Stigmas and Their Interaction with BPD*

It is also important to understand that the diagnosis of BPD functions as a stigmatized identity within societies already primed to disbelieve a woman’s experience of sexual assault. As we mentioned above, the single biggest predictor of a diagnosis of BPD is past sexual trauma, and it seems problematic to identify traumatized women with a disorder characterized by manipulation, attention seeking, and being dramatic when these are all things of which women are accused *in order to* delegitimize their reports of sexual assault (de Aquino Ferreira et al., 2018). These labels take power away from women, as they reinforce the way that assault allegations are already perceived. Women who choose to file lawsuits or publicly come out with allegations of sexual assault are bombarded with questions of what they were wearing at the time of assault, if they were asking for it in some way, and why they’re choosing to report it now (Murphy-Oikonen

et al., 2020). The latter conveys the attitude harbored by many that women who bring forward allegations of sexual assault are only doing so for the attention that they will receive. Furthermore, some studies have linked BPD with making false rape allegations (De Zutter et al., 2018). One such study explains that women who made false rape accusations were “motivated” by their BPD and wanted the “emotional gain” of framing men for rape (De Zutter et al., 2018). This study also explained that women with BPD who file false assault allegations may be acting in accordance with their mental illness and looking for attention and sympathy (De Zutter et al., 2018).

#### *4.3 Testimonial Smothering*

Another epistemic impact of the personality-based focus of BPD is what Kristie Dotson describes as “testimonial smothering” (Dotson, 2011). Testimonial smothering refers to situations wherein an individual must change the content of their testimony in order to ensure that the individual to which they are speaking will understand and accept that testimony (Dotson, 2011, pp 244). Testimonial smothering occurs when any of these three factors are present: the content of the testimony is unsafe, the hearer does not demonstrate testimonial competence, or when there is pernicious ignorance on the part of the hearer (Dotson, 2011 p. 244). In the instance of BPD, the hearer (the clinician) may not demonstrate testimonial competence to the patient insofar as they hold that the patient’s narrative about themselves is incorrect. A further concept that Dotson introduces concerning testimonial competence is that of *accurate* intelligibility, which is the ability of the hearer to understand the speaker’s testimony accurately as well as know when they are failing to understand (Dotson, 2011 p. 248). It goes without saying that this is a particularly important skill for mental health clinicians to excel at, as their job revolves around the capacity to hear and understand patient testimonies.

Testimonial smothering with respect to a diagnosis of BPD can operate in two ways. First, it can close down options for communication due to its narrowing of the line of questions that the clinician chooses to ask. More specifically, if a clinician fails to understand the connection between the traumatic experience and the symptoms that the patient is exhibiting, they will likely fail to demonstrate testimonial competence in the eyes of the patient. Once this happens, one would expect that they will become less likely to try to bring up certain topics again. Second, it can lead the clinician to interpret their patient's testimony relative to a very specific and rigid framework. It has been shown that patients could tell when a clinician was frustrated with them or was attempting to get them to understand their symptoms through a specific diagnostic framework (Miller Tate, 2019).

One of the reasons that testimonial smothering is so powerful once a BPD diagnosis is established is that treatment for individuals with BPD is difficult—and perceived to be difficult—to begin with. As discussed above, clinicians view individuals with BPD as difficult to treat and manage, meaning they are less likely to accept these patients into their practice in the first place (Sulzee, 2018; cf. Glyn & Appleby, 1988). Furthermore, individuals with BPD are also frequently “people-pleasers” who will do anything to keep their clinicians happy. When a people-pleaser senses the rigid expectations of others, they will frequently attempt to conform to the expectations rather than fighting against them. This means that instead of correcting the clinician's interpretation of their symptoms and trauma history, such individuals might allow the clinician to dictate their conceptualization of self. This feeling of being trapped and judged by their treatment providers leads individuals diagnosed with BPD to adapt their testimony.

One of the more pernicious effects of testimonial smothering is that it can lead clinicians to neglect the societal features of the individual's disorder. A key insight from Shaw and Proctor is that the diagnosis of BPD inevitably deemphasizes the trauma that an individual experienced

(2005). When a clinician diagnoses BPD, they are identifying the root of the problem of emotional disturbance for the individual who is suffering. The diagnosis can have the effect of shifting focus from examining the particular social structures or events in the individual's life that would cause such problems to the patient's "inadequate" social and coping skills to function as well as to a paternalistic approach to that patient's sense of self. This framework can lead clinicians to be unlikely to interpret BPD behaviors as adaptive behaviors that allow the individual to survive through traumas—for example, the individual attempting to get power back from their rapist through "risky behaviors." The epistemic injustices that can arise from a diagnosis of BPD are not just any epistemic injustices, then, they are epistemic injustices that feed directly into a long history of misogyny in medicine and society at large.

## **5. Conclusion**

We have argued that the diagnosis of BPD can lead mental health clinicians to undermine patient's authority in understanding their lives and experiences and that it can do so in ways that hinder effective therapy. In summary, we detailed historical and social scientific research suggesting that BPD is a diagnosis rooted in patriarchal and heteronormative standards. We then argued that the diagnosis of BPD can lead clinicians to commit testimonial epistemic injustices. We detailed the many impacts of such epistemic injustice, including the way it closes down the potential for dialogue, fails to give space for patients to focus on healing from past traumas and regain a sense of self-worth, and denies credibility of the individual's experiences.

In short, we find the diagnosis of BPD to pathologize the maladaptive coping strategies that many women might hold in light of dominant gender-based norms and ignore maladaptive coping patterns that many men might hold in light of such norms. We further find that the therapeutic framework resulting from a BPD diagnosis fundamentally misinterprets the clinical situation insofar as it places focus on individual personality traits as opposed to experienced trauma; this

misinterpretation leads to suboptimal therapeutic outcomes. These concerns dovetail with the larger stigmas attached to BPD. As we detailed above, many clinicians harbor negative views of patients diagnosed with BPD. This can lead to subpar treatment, especially due to stereotyping of these patients as fundamentally difficult and unreasonable.

To be clear, getting rid of the diagnosis of BPD will unfortunately not eradicate such perceptions of certain patients. Clinicians must consider holistically the way they treat patients, especially women patients, who present with significant past traumatic experiences to ensure they are acting in the best interests of the patient with compassion and empathy.<sup>23</sup> On our reading of the literature, engaging in reciprocal conversation and meaning-making about past traumatic events is the best way to heal from such experiences, and clinicians can too easily fail their patients when a BPD diagnosis leads them to instead take a personality-based approach.

By arguing that a BPD diagnosis can hinder treatment and recovery of patients through epistemic harm, we are not claiming that BPD has no diagnostic or clinical value; nor are we claiming any malpractice on the part of those who utilize the diagnosis.<sup>24</sup> On the contrary, we hope for our discussion and arguments to contribute to further consideration on the part of clinicians whether the diagnostic criteria for BPD are in the best therapeutic interests of patients.

Our concerns over the epistemic injustices involved in BPD offer fodder for those who have argued that c-PTSD, which was introduced in the International Classification of Diseases-11 (ICD-11), is often a better, more apt diagnosis for the sort of patients in question. This new diagnostic category was added due to the findings that individuals who experienced chronic, repeated, and prolonged traumas (including childhood sexual abuse) experience complex and extensive reactions that extended beyond

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<sup>23</sup> On our use of the term “women” and “men” in this article, please recall footnote ten above.

<sup>24</sup> Nor are we claiming that patients play no role. Our analysis leaves open the fact that, in some cases, at least some aspects of the EI problems we identify could stem from or at least be exacerbated by patient symptoms, whatever the patient’s diagnosis.

that category of PTSD.<sup>25</sup> In addition to the three clusters of symptoms experienced in PTSD (re-experiencing of trauma, avoidance of reminders, and vigilance), c-PTSD also includes disturbances in self-organization through issues of emotional regulation, negative self-conceptions, and relationship difficulties.<sup>26</sup> Importantly, while BPD and PTSD have significant issues of misdiagnosis due to similarities in diagnostic criteria, c-PTSD and PTSD have been shown to have discriminant validity.<sup>27</sup> While some have claimed diagnoses of c-PTSD are more accurately diagnosed as PTSD with concordant BPD, there has also been discriminant validity found between diagnoses of BPD and c-PTSD, showing that c-PTSD is more defensible diagnostically.<sup>17</sup> Whatever one thinks of the merits of c-PTSD as a replacement for BPD, we hope that appreciation of the epistemic injustices that can be brought about by a BPD diagnosis will lead clinicians to further, and even more critically, reflect on its use.<sup>28</sup>

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<sup>25</sup> As such, the diagnosis may not be applicable for all patients diagnosed with BPD. However, this diagnosis will capture the experiences of a larger proportion of patients.

<sup>26</sup> Cloitre, Marylène. "ICD-11 Complex Post-Traumatic Stress Disorder: Simplifying Diagnosis in Trauma Populations." *The British Journal of Psychiatry* 216(3): 129–31, 2020, <https://doi.org/10.1192/bjp.2020.43>.

<sup>27</sup> Discriminant validity is a measure to determine whether unrelated psychological constructs are unrelated to one other. For example, low discriminant validity implies that two constructs (i.e., diagnoses) are overlapping.

<sup>28</sup> See also Sara R. Masland et al., "Destigmatizing Borderline Personality Disorder: A Call to Action for Psychological Science," *Perspectives on Psychological Science* 182: 445–60, 2023, <https://doi.org/10.1177/17456916221100464>; Erika Sims, Katharine J. Nelson, and Dominic Sisti, "Borderline Personality Disorder, Therapeutic Privilege, Integrated Care: Is It Ethical to Withhold a Psychiatric Diagnosis?," *Journal of Medical Ethics* 48(11): 8-1-4, 2022, <https://doi.org/10.1136/medethics-2021-107216>.

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**Acknowledgments:**

Special thanks to Nicholas G. Evans, Brian D. Earp, and two anonymous reviewers at IJFAB for helpful feedback.