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IJFAB: International Journal of Feminist Approaches to Bioethics, Volume 16, Number 2, October 2023, pp. 162-181 (Article)

Published by University of Toronto Press

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[Sun Dec 24 14:41:05 2023] Access provided at 24 Dec 2023 19:41 GMT from Georgetown University Library

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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 analyze 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 they can lead to experiences of testimonial injustice which impede 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

1. Introduction

Most healthcare fields rely on biologically based tests to confirm diagnoses.[1] The field of psychiatry is unique in that there are few, if any, biologically uncontroversial ways to test prevalent diagnoses, whether in relation to pharmacological interventions or not. Because one cannot reliably identify depression, for example, via biomarkers gathered from a basic metabolic panel or complete blood count test, X-ray, or MRI, CT, or PET scan, one must rely primarily on patient testimony to determine diagnosis, prognosis, and treatment. Given these constraints, mental health clinicians develop a range of communication skills. To care for their patients well, they must employ sophisticated ways of listening, understanding, and ultimately judging the problems that the patient is presenting through dialogue.[2] In short, what is or is not medically indicated will in large part be based on the interpretation of patient testimony. As important as these communication skills are, they will run aground if the diagnosis that results from such dialogue undermines therapeutic aims, including and in particular

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Vol. 16, No. 2 DOI: 10.3138/ijfab-2023-0008

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 therapeutic aims for patients in diagnostically relevant situations, which is to say, patients undergoing experiences such that they are candidates for this diagnosis.

We begin by reviewing contemporary critiques of BPD.[3] Providing historical as well as social-scientific evidence concerning BPD is essential in order to understand the larger implications of this paper's central argument. We turn to that argument in the next section, claiming that a BPD diagnosis can result in epistemic injustice; specifically, testimonial injustice. This is to say that 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 apt and needed space for patients to focus on healing from past traumas and regain a sense of self-worth, and denies credibility of important aspects of an individual's experience. We conclude by suggesting that the concerns of epistemic injustice related to BPD offer reasons to more strongly consider alternative diagnoses,[4] including complex post-traumatic stress disorder (cPTSD).[5]

2. 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* (DSM) in 1980. In its most recent incarnation, the DSM-5 demarcated three significant clusters of personality disorders (idem). 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. 2016, 496). BPD is considered a Cluster B personality disorder.

The DSM-5 identifies BPD through four major areas of dysregulation and dysfunction: affect dysregulation, poor behavioral control, interpersonal hypersensitivity, and an 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. It includes difficulty trusting others, moving through love-hate patterns toward others, and making frantic efforts to avoid abandonment. Individuals showcase an 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 and Paris 2012).

3. Problems with BPD

In this section, we explore the various problems with the diagnosis of BPD, which include diagnostic, demographic, and social considerations. First, research demonstrates that there is a worrying amount of misdiagnosis of cases of PTSD as BPD; this is likely due in part to the fact that the symptoms of BPD overlap with those of PTSD.[6] 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.[7]

Yet for BPD, clinicians typically take more control of the meaning-making process than for PTSD; they 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 cultivating a stable self-image.[8] Part of the reason for this turns not on guidelines or best practices, but instead the serious and significant social stigmas attached to a BPD diagnosis, especially vis-à-vis being "unstable," "crazy," and even "dangerous." It is the latter component—the claim of an unstable sense of self and the focus on its stabilization—that we find problematic.

Before elaborating further on this worry, we will provide historical context for BPD, especially with respect to its gendered application and conceptualization. The historical roots of BPD offer at least one explanation of why it is diagnosed significantly more in women than in men.[9] 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 and Proctor 2005, 484). This categorization delegitimized women's claims, impeding, when not nullifying, their efforts at progress towards equality (idem). The diagnosis of hysteria, widely accepted and deployed throughout the nineteenth 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, Freud often diagnosed hysteria to cover up a woman's experience of sexual abuse (Powell and Boer 1995). In addition to delegitimizing specific claims of abuse, the diagnosis of hysteria reinforced the view of women as irrational and emotional and, therefore, not to be trusted (Powell and Boer 1995). The diagnosis explained certain symptoms in terms of individual pathology that, when placed in their historical and political context, are better explained as pathologies of society. This is to say, and as numerous scholars have argued, what hysteria identified was not a given woman's psychological issues as much

as it identified their (reasonable) reaction to the misogynistic and oppressive structures of society (cf. Shaw and Proctor 2005).

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 because 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 fourteen and twenty-five who experienced some form of sexual violence (Akhtar and 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 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 toward women. Disordered eating is a behavioral pattern that is mostly seen in women, with 75 percent of both anorexia nervosa and bulimia nervosa diagnoses being attributed to women (Statistics & Research on Eating Disorders 2020). 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. It seems to us that there is no way that the criterion of impulsivity and its link with promiscuity can be judged objectively, for it is not evaluated in a vacuum and clinicians can be influenced, both explicitly and implicitly, by societal perceptions of women.[10]

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).[11] The first is externalizing anger. This is often characterized as a "masculine" projection of anger, including expressions such as raising one's voice. Internalized anger, on the other hand, is the more stereotypically feminine approach to anger management, and it takes two forms. In the first form of internalized anger, 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 can be considered inappropriate insofar as the clinician believes that the individual is afraid to show their anger. Externalized anger can also be seen as inappropriate insofar as it is "uncontrollable" (Berger 2014). It seems that however a woman might express her anger, she is doing it wrong.[12]

Given all of these concerns, the continued use of the BPD diagnosis suggests the following relative to larger societal-psychological norms: the diagnosis of BPD places women in a double bind in which they are punished for both conforming to and breaking away from societal stereotypes and expectations pertaining to femininity as linked to "stability" of self. That the criterion of BPD inherently places women in a double-bind demands a broader conversation about how this diagnosis is used to enforce a certain value-system on women or, at a minimum, relies on and further entrenches it (Crowe 2008). Given these considerations, we agree with the literature surveyed that, at a minimum, the symptomology and criteria behind BPD are too expansive. Not only do they pathologize an unreasonably broad set of behaviors, they do so in ways that can place patients in (highly gendered) double-binds.[13]

4. The harms of BPD

Given extant analyses 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 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 earlier, including the overlap of symptoms and heuristic assumptions based on sexual or gender-based differences, are unavoidable in a fields such as psychology and

psychiatry. 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 forms of depression. A recent study showed that individuals who were misdiagnosed as having unipolar depression had significantly lower recovery and remission rates (Nasrallah 2015). This is because 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 that the majority of research on BPD suggests that if mental health clinicians diagnose a patient with it, when PTSD, complex PTSD, or a mix of depression and anxiety would be more appropriate, it can actively impede the ability of their patients to recover.

So far, we have presented arguments that rely mainly on 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 understanding the larger implications of the central aim of this paper. That aim is to provide a new, independent reason to question the diagnostic category of BPD, and that reason is the way in which it brings about epistemic harms. In addition to being damaging in and of itself, we aim to show that these harms negatively impact therapeutic outcomes.

5. 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 healthcare, especially vis-à-vis conditions wherein reasons to doubt or at least significantly qualify a patient's testimony are part of diagnostic criteria.[14] 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 of the research that might be relevant to this discussion. 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.[15]

a. Testimonial injustice and epistemic privilege

Testimonial injustice refers to a situation in which 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 decides 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 first-hand knowledge of their experience, which in the context of the clinic is to say, first-hand 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 beginning 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 testimony, assessing their description of their symptoms, and working together to establish a diagnosis. In their paper "Epistemic Injustice in Healthcare: A Philosophical Analysis," Havi Carel and Ian James Kidd argue that while both clinicians and patients have epistemic privilege, "only the healthcare professionals' privileged epistemic status 'really matter(s)'" (Carel and Kidd 2014). Due to their position of power over patients, the clinician is given more epistemic trust and credibility by society, other treatment professionals, and even the patients themselves. The patients, who are in a position of vulnerability in multiple respects,[16] can become less confident in themselves and less comfortable challenging the clinician when they believe they are being misdiagnosed (Kidd and Carel 2017).[17] While clinicians certainly deserve apt epistemic privilege and credibility, the default assignment of epistemic privilege can result in not just patient-provider miscommunication, but injustices. This is especially the case when there is reason to believe that the diagnosis—whether in its clinical application, its uptake by the patient in and outside of the clinic, and/or its role in the larger culture—can perpetuate harms against the patient.[18]

One of the biggest problems with this system is that it creates an environment in which 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 from 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 (2017). Of course, even when clinicians try in good faith to listen fully to a patient, they

must still filter the 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. To understand how epistemic privilege and testimonial injustice operate vis-à-vis BPD in particular, it is important to understand how most nonpersonality disorder mental illnesses are diagnosed. Generally, clinicians believe that 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 this scenario, 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 the clinician in a position of authority and power, allowing the patient to have determinate control over their treatment and recovery process.

But cases of personality disorder upset this balance, for a personality disorder suggests that the patient may be unaware of their personality inconsistencies or presence of dysregulation and maladaptive tendencies (Balsis et al. 2018). 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 centring of the testimony and expertise of the clinician and downgrading the credibility of the patient.[19] 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 of paternalistic explaining and interpreting on behalf of the patient; rather, their job is 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. In the case of personality disorders such as BPD, however, clinicians can be encouraged to instead frame aspects of patient testimony in terms of ignorance—a patient is, for example, not noticing 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, it 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, it becomes possible for patients diagnosed with BPD to quite literally lose control of their narrative.[20]

b. Societal stigmas and their interaction with BPD

It is also important to understand that the diagnosis of BPD functions as a stigmatized identity in societies already primed to disbelieve a woman's experience of sexual assault. As we identified earlier, 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 behaviors that are made as accusations 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 harboured by many that women who bring forward allegations of sexual assault are only doing so for the attention 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).

c. Testimonial smothering

Another epistemic impact of the personality-based focus of BPD is what Kristie Dotson describes as "testimonial smothering" (Dotson 2011). It refers to situations in which an individual must change the content of their testimony to ensure that the individual to which they are speaking will understand and accept their testimony (Dotson 2011, 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, 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, including their expressed sense of self, 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, 248). It goes without saying that this is a particularly important skill for mental health clinicians to excel at because their job revolves around the capacity to hear and understand patient testimonies.

Testimonial smothering with respect to a BPD diagnosis 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 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 earlier, 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 (Sulzer 2018; cf. Glyn and Appleby 1988). Furthermore, individuals with BPD are commonly thought of as "people-pleasers" who will do anything to keep their clinicians happy. Insofar as this is true, when a people-pleaser senses the rigid expectations of others, they will frequently attempt to conform to the expectations rather than fight against them. This means that instead of correcting the clinician's interpretation of their symptoms and trauma history, they might allow the clinician to dictate their conceptualization of self and larger life narrative. This feeling of being trapped and judged by their treatment providers can lead 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 argument from Shaw and Proctor is that the diagnosis of BPD inevitably de-emphasizes the trauma that an individual experienced (2005). When a clinician diagnoses BPD, they are identifying the root of the 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 rise 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.

Note that this can happen even if the clinician, in collaboration with the patient, is developing a case conceptualization of which a BPD diagnosis is just a component, for BPD is an increasingly common diagnostic label used in common socio-cultural spaces.[21] Its meaning is not just oversaturated by social and cultural factors, it's highly and specifically stigmatized.[22] This is especially relevant as talking openly about one's mental health diagnosis(es) is increasingly practised while the prevalence of society-wide stigmatization around mental health diagnoses (especially stigmatized ones) is not decreasing in lockstep.[23]

6. Conclusion

The core contention of this paper can be stated simply: We find the detriments of the use of a BPD diagnosis to outweigh its benefits. More specifically, the diagnosis of BPD can too easily lead mental health clinicians to undermine a patient's authority in understanding their life and experiences and can do so in ways that hinder optimal therapy. We first detailed research from the history of medicine as well as the social sciences suggesting that BPD is a diagnosis rooted in patriarchal and heteronormative standards. We followed a host of other scholars in claiming that the diagnosis of BPD too easily leads to pathologizing the coping strategies that many women might hold in light of dominant gender-based norms and experienced trauma.[24] We then turned to the central argument of the paper: the diagnosis of BPD can lead clinicians to commit testimonial epistemic injustices and that due to the socio-culturally entrenched meaning of BPD, this can happen even when the diagnosis is part of an otherwise nuanced, trauma-informed approach. 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. The concern about epistemic injustice dovetails with longstanding claims made by critics of BPD that the larger theoretical framework invoked by such a diagnosis underestimates the role and impact of stigmas attached to BPD and fundamentally misinterprets the clinical situation insofar as it places undue focus on individual personality traits as opposed to experienced trauma, leading to suboptimal therapeutic outcomes. The concern about epistemic injustice cannot be overcome by a "better" version of the label since, on our view, it cannot be disentangled from the persistent and serious stigmas attached to BPD in the wider culture and to which neither patients, nor clinicians are immune.

Granted, getting rid of the diagnosis of BPD will unfortunately not eradicate negative perceptions of certain patients. To ensure that they are acting with compassion, empathy, and in the best interests of the patient, clinicians must consider holistically the way they treat patients, especially women patients, who present with significant past-traumatic experiences.[25]

By arguing that a BPD diagnosis can hinder the treatment and recovery of patients through epistemic harm in particular, we neither claim that BPD

has zero diagnostic or clinical value, nor claim any malpractice on the part of those who utilize the diagnosis.[26] On the contrary, we hope that our discussion and arguments will contribute to further consideration on the part of clinicians whether the diagnostic criteria for and the diagnostic label of BPD are in the best therapeutic interests of patients. Our concerns over the epistemic injustices involved in BPD offer fodder for those who argue that c-PTSD—introduced into the International Classification of Diseases-11 (ICD-11) effective February 2022—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 extend beyond that category of PTSD.[27] 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.[28] 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.[29] While some have claimed diagnoses of c-PTSD are more accurately diagnosed as PTSD with concordant BPD, there has also been found discriminant validity between diagnoses of BPD and c-PTSD, suggesting that c-PTSD is more defensible diagnostically.[17] 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.[30] We hope that this paper adds not simply to the chorus of scholarship criticizing the diagnosis of BPD as well as the larger chorus criticizing personality-based disorders, but also calls for qualitative work examining the relationship between the use of a BPD diagnosis and epistemic injustice, as we outline the problem here, in real-world clinical settings.

ACKNOWLEDGMENTS

Special thanks to Nicholas G. Evans, Brian D. Earp, Alex J. Feldman, and two anonymous reviewers at *IJFAB* for their detailed and constructive feedback.

NOTES

1. See Bowker and Star's *Sorting Things Out* and Jutel's *Putting a Name to It.*
2. See Horne's "Is Borderline Personality Disorder a Moral or Clinical Condition?"
3. For a very recent critique, see Mulder and Tyrer's "Borderline Personality Disorder." The literature critiquing BPD is very large. Instead of providing an exhaustive literature review (which, given its size, is the task of a meta-analysis and not an article such as this), we will cite numerous pieces from this literature along the way as they prove relevant to the concerns at hand.
4. 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. Compare Bortolan's

"Narratively Shaped Emotions" to Køster's "Narrative Self-Appropriation: Embodiment, Alienness."

5. It should be noted that the DSM-5 does not recognize complex PTSD or cPTSD. However, the 11th International Classification of Diseases (ICD-11) does, and this may impact whether DSM-6 will.
6. Compare Gould's "Why the Histrionic Personality Disorder Should Not Be in the DSM" with Crowe's "Personality Disorders: Illegitimate Subject Positions" and Wilson, McDonald, and Pietsch's "Ontological Insecurity."
7. See Bradley and Westen's "The Psychodynamics of Borderline Personality Disorder," and Hodges' "Borderline Personality Disorder and Post Traumatic Stress Disorder." Of course, the similarities in symptomology may in some cases be indicative of PTSD and BPD being comorbid. See Nicki's "Borderline Personality Disorder, Discrimination, and Survivors of Chronic Childhood Trauma." Some, including Tyson Bailey and Laura Brown, have suggested that 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. See Bailey and Brown's "Complex Trauma."
8. See Castillo, Javier, and Algorta's "Mentalization-based Treatment"; and May, Rachardi, and Barth's "Dialectical behavior therapy." For example, May and colleagues write, "Linehan's DBT manual explains that the skills training group is designed to target behavioral skill deficits that are common to patients with BPD, including an unstable sense of self, chaotic relationships, fear of abandonment, emotional lability, and impulsivity" (63). Note that there is not unanimity concerning the target of "cultivating a stable self-image" relative to DBT. Later, we explain in more detail why our concerns are not simply limited to this particular target or consensus (in theory or practice) among dominant approaches such as DBT. See also note 23 concerning the relationship between our critique of the diagnosis of BPD, on the one hand, and specific methods (such as DBT, MBT, etc.) of treatment strategies for patients with said diagnosis, on the other hand.
9. By using the distinction between "women" and "men" throughout, we are neither committing to that binary, nor to binaries of or conflations between questions of sex, gender, and/or sexuality 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.
10. Furthermore, if a woman identifies as bisexual, the diagnosis of BPD can not only pathologize an LGBTQI+ identity, it can stigmatize it. This diagnosis adds credibility to the beliefs about 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 still today largely not accepted by both the LGBTQI+ and heterosexual communities, and the link between the LGBTQI+ community and BPD makes identifying as bisexual even more stigmatized. (See "Bisexual People Face Discrimination and

Violence.") We assume, though do not have space here to defend, that these claims apply *mutatis mutandis* to pansexual women.

11. As can be expected, each of these are determined by considerations of race and ethnicity, as a wide body of research details (Rogers 2012).
12. There is much to be said about how anger can become pathologized, especially against marginalized groups. For example, consider the work of Myisha Cherry's *The Case for Rage*. Due to the length and aims of this article, we unfortunately cannot take up those concerns here.
13. A particularly egregious example of this double bind can be seen in Christine Lawson's identifications of the four subtypes of BPD. Although this is a "pop psychology" book, it is written by a clinician, and we find that it helpfully illuminates the larger sociopolitical import and impact of BPD as a diagnostic category that is centred 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 plays 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 1 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 2 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, and this raises the question mentioned earlier: How should one behave to be classified as "symptom free"? Having said all of this, as we argue later on, the problem with BPD as a diagnosis goes much deeper.
14. Of course, there are some exceptions. See, for example, Kyratsous and Sanati's "Epistemic Injustice."
15. See Fricker's *Epistemic Injustice*. It is clear that hermeneutical injustice is also at play in a BPD diagnosis and all that can follow. On this topic, see, for example, Pohlhaus Jr.'s "Relational Knowing and Epistemic Injustice." Due to the space restraints of this article, we are saving those arguments for a future paper.
16. See Rogers, Mackenzie, and Dodds' "Why Bioethics Need a Concept of Vulnerability."
17. This is not to say that patients can diagnose themselves. Rather, patients are capable of understanding their own illness experiences, and the epistemic privilege of clinicians can disempower patients from having a central role in understanding and explaining their own experiences.
18. 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.
19. To be clear, we are not claiming that such an assumption is unwarranted with respect to some patients or some diagnoses. We are claiming that this assumption is prima facie unwarranted for those diagnosed with BPD.
20. One might object that even if our concerns with BPD qua diagnosis stand, the guidelines behind and clinical applications of dominant approaches—such as

dialectical behavioral therapy (DBT) and mentalization-based treatment (MBT)—do not (i) prove to be that different from how a patient with, say, PTSD, would be treated, and do not (ii) lead to the sort of epistemic injustice concerns that we outline. To better appreciate such an objection, consider the following comments on the relationship between DBT and trauma from Alex Feldman: "Both DBT and MBT take a complex view of the etiology of BPD. Linehan elaborates a 'biosocial theory' that draws on a dialectical and transactional approach to the relationship between social environment and biological factors. She recognizes the potential role of trauma, but also of experiences of traumatic invalidation that may not fit neatly into the way that trauma gets defined in the DSM. Likewise, Bateman and Fonagy emphasize disturbed attachment in childhood arising not only from trauma, but also neglect, rejection, and abandonment. Linehan repeatedly and approvingly cites Judith Herman, who is one of the early exponents of the idea that BPD is really better understood as CPTSD. In fact, Linehan, in *Cognitive-behavioral treatment of borderline personality disorder* (1993) explicitly mentions Herman's three-stage model of trauma treatment. Treating trauma is one of the behavioral targets in DBT, albeit a target that is supposed to come after the basic safety of the patient has been secured. Moreover, a number of protocols for integrating DBT with exposure-based trauma therapies have been developed." (Personal correspondence, 2022). Our argument allows us to take all of this to be the case. In fact, we could grant that the theories behind existing approaches to the treatment of BPD avoid our concerns entirely. What still remains, of course, is the social, cultural, and historical meanings attached to BPD and the way in which they can (a) impact how patients take up the diagnosis (which is rarely identical to how the clinician communicates to the patient about it) and the way in which they can (b) impact how clinicians—who, like all of us, are prone to implicit and explicit biases, one's socio-cultural milieu, and more—invoke, apply, and treat it.

21. See note 22.
22. There is a wealth of literature detailing how stigmatizing BPD is—including compared to other mental health diagnoses—vis-à-vis the attitudes and experiences of patients, clinicians, and also relative to society at large. For example, see Ring & Lawn 2019, Masland et al. 2023, and Klein et al. 2022.
23. This is why we simply disagree with those, such as Merri Lisa Johnson (2021), who believe that the goal should not be removing BPD as a diagnosis, but instead destigmatizing it. While destigmatization would certainly be wonderful, we neither have hope nor see good reasons to think that it is the most effective or plausible approach to the issues at hand.
24. See note 10.
25. On our use of the term "women" and "men" in this article, see note 10.
26. 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 epistemic injustice problems we identify could stem from or at least be exacerbated by patient symptoms, whatever the patient's diagnosis.
27. As such, the diagnosis may not be applicable for all patients diagnosed with BPD. However, this diagnosis will capture the experiences of a larger segment of patients.
28. See Cloitre's "ICD-11 Complex Post-Traumatic Stress Disorder."

29. Discriminant validity is a measure to determine whether unrelated psychological constructs are, in fact, unrelated to one other. For example, low discriminant validity implies that two constructs (i.e., diagnoses) overlap.
30. See also Masland, Victor, and Peters's "Destigmatizing Borderline Personality Disorder"; Sims, Nelson, and Sisti's "Borderline Personality Disorder, Therapeutic Privilege, Integrated Care."

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