

Dismantling the Diagnostic Construct of Borderline Personality Disorder: An Abolitionist Perspective

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Abstract

This paper presents a perspective grounded in critical psychiatry and decolonial epistemologies, synthesising interdisciplinary scholarship and lived experience testimony to interrogate the diagnostic construct of borderline personality disorder (BPD) as a site of iatrogenic harm and epistemic violence. Clinical discourse commonly positions long-term therapeutic engagement as a risk factor for “dependence,” framing care recipients as the locus of complication. Rather than accepting this premise, we locate harm within systemic, relational and epistemic practices embedded in psychiatric culture. We argue that conditionality, pathologising interpretations of support needs and punitive framings of self-advocacy produce iatrogenic harm, whereas consistent and validating therapeutic relationships foster safety and autonomy. Using a decolonial theoretical lens, this work critiques the misogynistic origins of the “dependence myth” and traces how Western attachment theory has been universalised to pathologise kinship forms outside nuclear family

models, particularly in Indigenous, Black, migrant and collectivist communities. We further highlight how sensory processing differences are neglected in BPD discourse despite their significant role in self-injury, suicidality and embodied distress, calling for an expanded framework beyond relational psychodynamic explanations. Diagnostic bias toward sexually and gender diverse people is examined as a continuation of psychiatry's historic regulation of gender and sexuality through personality pathology paradigms. Ultimately, we contend that the BPD construct functions less as a neutral clinical category and more as a colonial, cisheteronormative, and neuronormative governance technology that produces pathology through stigma, epistemic control, and carceral logics. Reframing BPD as a diagnostic instrument of social regulation rather than a disorder located within individuals opens space for care grounded in relational justice, cultural flexibility, sensory attunement, human rights, and epistemic humility, rather than the castigating of Western social nonconformity and the enforcement of compliance with normative behavioural conditioning.

Key words: borderline personality disorder, psychiatry, iatrogenic harm

Introduction

The psychiatric diagnosis of Borderline Personality Disorder (BPD) is widely treated as a clinically meaningful category that requires management, containment, or behavioural correction. In contemporary discourse, the supposed complications of psychotherapy for BPD are framed as consequences of patient pathology, such as dependency, relational excess, and emotional dysregulation (Swan et al., 2025; McPhate et al., 2021). These narratives do not

emerge in a vacuum. They reflect a broader diagnostic logic in which distress is individualised, structural suffering is psychiatrised and further marginalised, and support needs are patronised and reinterpreted as risk factors to be regulated.

This paper adopts an abolitionist stance. BPD is not treated as a neutral diagnosis but as a carceral and colonial technology of psychiatric governance that regulates distress through surveillance, categorisation, and conditional care. Rather than asking how complications in treatment might be reduced, we ask a different and more fundamental question. What forms of harm are generated by the continued existence of the diagnostic construct itself.

We argue that BPD functions as a regulatory category of social control that disciplines critical and independent thinking, social nonconformity, trauma, gender and sexual diversity, and culturally specific forms of relationality into a narrow hierarchical model of behavioural morality. Within this framework, calls for "treatment pauses," or preventing "dependency" (see Swan et al., 2025; McPhate et al., 2021), are not simply clinical preferences. They are extensions of a psychiatric governance logic that shapes who is deemed deserving of care and under what conditions.

By shifting analytic attention away from the individual and toward the diagnostic construct and its ideological foundations, this paper reframes BPD not as a clinical entity but as an instrument that polices social norms and enforces behavioural conformity. It operates within a longer lineage of coercive psychiatric practice shaped by misogyny, colonialism, neuronormativity, and cisheteronormative pathologisation. Rather than attempting to refine BPD treatment guidelines or superficially "destigmatise" the label, this paper interrogates the construct itself as a producer of pathology through epistemic violence. We contend that dismantling BPD as a diagnostic category is a necessary precondition for forms of care that are relationally safe and accountable, sensory-informed, and culturally responsive and just.

Misogyny and the Dependence Myth

A core claim often encountered in the BPD literature is that intensive or long-term therapeutic engagement risks fostering dependence, thereby undermining autonomy and self-management in people diagnosed with BPD (Swan et al. 2025; McPhade et al., 2021; Bornstein et al., 2010). This position reproduces what has been described as the longstanding “dependence myth,” a paternalistic trope rooted in misogynistic discourses that characterise patients, particularly women, as “attention seeking,” “manipulative,” and “clingy” (see Dorfman and Reynolds, 2023; Shaw and Proctor, 2005). For example, Kernberg (1975) pathologises relational nonconformity as failure of integration and frames care needs as regressive dependency. In fact, emerging evidence suggests that iatrogenic harm most often occurs when care is inconsistent, abruptly withdrawn, punitive, or invalidating (Lawson and Farquharson, 2025; Aves, 2024). The idea that patients must be “weaned off” care in order to prevent dependency represents a continuation of historic patronising, infantilising, and punitive care models rather than a genuinely human rights-based and trauma-informed approach.

A substantial proportion of individuals diagnosed with BPD have histories of trauma, commonly related to sexual abuse (de Aquino Ferreira et al., 2018; Shaw and Proctor, 2005). When BPD was formally introduced into the third version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980, sexual victimisation, including rape and childhood sexual abuse, was not yet recognised in psychiatric nosology and discourse as a causal contributor to post-traumatic stress responses. As Landecker (1992) observes, “BPD attributes symptoms solely to characterological dysfunction without recognizing their adaptive nature in the face of childhood trauma.”

Relatedly, when BPD was codified in DSM-III, its construction took place within a highly circumscribed epistemic environment dominated by White male psychiatrists. The DSM-III Task Force, led by Robert Spitzer, drew disproportionately on an elite network of male clinicians, largely affiliated with East Coast institutions and the St. Louis School of Psychiatry (Mayes and Horwitz, 2005; Kirk and Kutchins, 1992). Only two women, Jean Endicott and Lee Robins, are documented as having notable technical input, and even their contributions were largely backgrounded in official histories, with intellectual credit accruing to their male colleagues (Wilson, 1993). This gendered concentration of diagnostic authority matters: the introduction of BPD occurred not in a trauma-informed or feminist clinical context but within a masculinised institutional apparatus that pathologised women's distress and trauma while erasing structural, predominantly male-generated, violence as causative. As Kirk and Kutchins (1992) argue, DSM-III did not emerge through broad professional consensus but through a tightly controlled process that framed psychiatric categories as neutral science while consolidating diagnostic power in the hands of a small, homogeneous group. That the diagnosis most disproportionately applied to women, particularly those with histories of sexual abuse, was formalised under these conditions speaks to the gendered politics of psychiatric naming, where women's survival responses to male-induced harm were recoded as "personality pathology" rather than recognised as trauma adaptations to sexism and sexual violence (Shaw and Proctor, 2005).

This has profound implications for clinical practice. For instance, Swan et al.'s (2025) proposal that "treatment pauses" are therapeutic reflects a continued reliance on behavioural and operant conditioning paradigms. While framed as promoting resilience and autonomy, these strategies risk replicating damaging relational dynamics in which care and validation are made contingent upon compliance. Conditional support is analogous to grooming tactics, where withholding care functions as a form of behavioural control that mirrors the

interpersonal dynamics underpinning many patients' experiences of sexual abuse. As Beale (2022) notes, "Clinicians learn the art of self-delusion, convincing ourselves we are not letting patients down but, instead, doing the clinically appropriate thing. Well-meant initiatives become misappropriated to justify neglect." In contrast, stable, validating, relationally secure care environments are repeatedly associated with increased long-term autonomy, affect regulation, and self-efficacy (Kuo et al., 2022; Klein et al., 2022). The evidence suggests that consistency, not withdrawal, is protective, and that autonomy is not the product of enforced or coercive independence but of reliable, stable, and non-punitive relational safety.

Sensory Processing

Sensory processing differences are similarly marginalised through epistemic hierarchies that privilege certain ways of conceptualising and understanding distress. Indeed, the literature on BPD conceptualises non-suicidal self-injury (NSSI) primarily, if not exclusively, as an expression of unmet attachment needs and emotional dysregulation, a framework rooted in psychodynamic theory (Swan et al., 2025; Baptista et al., 2021; Kernberg, 1975). While these relational and affective dimensions are relevant, this account is reductive and fails to capture the diverse range of factors underlying NSSI. In particular, this framing overlooks a growing body of research identifying sensory processing differences as significant predictors of NSSI across psychiatric diagnostic categories. Differences in interoceptive sensibility and awareness, sometimes referred to as alexisomia, have been shown to predict both the presence and severity of NSSI as well as suicidality in clinical populations (Duffy et al., 2021; Reid-Russell and Nock, 2025; Rogers et al., 2021; Forsberg et al., 2025). Likewise, alexithymia, which is closely linked to atypical interoceptive processing, is associated with increased vulnerability to NSSI due to its impact on an individual's capacity to identify, label,

interpret, and express internal bodily signals (Norman et al., 2020; Karaca Dinç et al., 2021). Meta-analytic findings further demonstrate that sensory processing differences, including exteroception, operate transdiagnostically, cutting across formal psychiatric categories (van den Boogert et al., 2022), which strengthens the argument for sensory-informed pathways as a core dimension in understanding NSSI and suicidal ideation rather than a peripheral factor.

Furthermore, such a unidimensional interpretation of NSSI narrows clinical imagination and sidelines sensory and embodied forms of distress, particularly those common among autistic populations whose experiences of mental ill-health, including suicidality, NSSI and post-traumatic stress, can be triggered by prolonged exposures to aversive sensory input rather than solely through relational terms (Chen et al., 2024; MacLennan et al., 2022; Lewis and Stevens, 2023; Doherty, 2025; Kerns et al., 2022). Accounts of autistic adults repeatedly document experiences of gaslighting, where reports of noise, light or touch as intolerable are dismissed as behavioural resistance, defiance, attention seeking, overreactions or exaggerations, or emotional dysregulation rather than as credible testimony (Rosas-Pérez et al., 2025). This minimisation is not diagnostically neutral but reflects psychiatry's broader pattern of epistemic control, in which certain forms of knowing and interpreting distress, namely psychodynamic and relational, are coercively legitimised and universally enforced, while others are pathologised or deemed irrelevant to clinical formulation.

When sensory suffering is retranslated into attachment language, lived experiences of sensory-based distress are not simply overlooked but actively overwritten, constituting a form of hermeneutical injustice wherein the frameworks available to make sense of distress exclude sensory processing as a valid explanatory schema (Fricker, 2007). In contrast, integrating sensory-informed frameworks into therapeutic practice has the potential to expand intervention repertoires (Wright et al., 2025; Doroud et al., 2025; Molloy et al., 2025). Rather

than treating sensory-based suffering as a secondary feature of emotional dysregulation, sensory processing differences can be understood as an alternative epistemic orientation toward distress, one that incorporates the complexity of perceptual overwhelm and embodied threat responses.

Attachment Theory

Attachment theory developed from research conducted with white, middle-class, nuclear families in Britain and the United States (Bowlby, 1973; Ainsworth, 1978). From these narrow observations, Western caregiving norms such as one-to-one maternal care, verbal expression of distress, and early assertions of autonomy were uncritically elevated as universal markers of secure attachment. The BPD construct inherits this lineage, both through historical influence from Bowlby (1973) and subsequent theorists, and conceptually through its focus on fear of abandonment, disrupted bonds, and internal working models of self and other.

Indigenous and decolonial scholars have long cautioned that attachment theory privileges a dyadic, mother and infant template that does not reflect the caregiving ecologies of many communities outside the West. In many Indigenous, Black, migrant and collectivist contexts, caregiving is shared across kinship networks and grounded in community responsibility and connection to Land or Country rather than centred on an isolated caregiver and child dyad. When attachment frameworks assume Western caregiving as the default, other caregiving practices are misinterpreted as boundary violations or interpersonal instability. Child protection and legal systems have repeatedly applied attachment constructs in this way, treating departures from Eurocentric caregiving as evidence of deficit or pathology (Choate et al., 2019).

In settler-colonial settings, attachment discourse has been used to justify the abusive removal of Indigenous and racialised children on claims that they lacked secure attachment (Sinclair, 2007; Choate et al., 2019; Wright et al., 2024). When psychiatry frames BPD as the product of failed or disordered attachment, it reinforces the same logic. Responsibility is assigned to nonconformity toward Western social norms, while the structural conditions that generate trauma, including colonisation, displacement, poverty and systemic racism, are minimised or ignored, a concern that is seldom addressed in the BPD literature (see Swan et al., 2025; Miller et al., 2024).

Self-Reflection and Accountability

Research about BPD often warns of the dangers of “over-introspection” or “hyper-mentalising” among patients (Swan et al., 2025; Bateman and Fonagy, 2006; Allen et al., 2008), suggesting that excessive self-scrutiny may be a marker of pathology. While it may hold validity in some contexts, this framing neglects a parallel and equally significant issue: clinicians’ “under-introspection.” Failures in professional accountability, including reluctance to acknowledge, take responsibility, or apologise for iatrogenic harm are well documented in the history of psychiatry and remain largely unaddressed (see psychiatric survivor movement; Adame et al., 2017).

Despite the removal of homosexuality from diagnostic manuals, neither the American Psychiatric Association (APA) or the Royal Australian and New Zealand College of Psychiatrists (RANZCP) has issued a formal apology that acknowledges institutional responsibility for the generational harms caused by decades of pathologising and inhumanely persecuting sexual minorities (e.g., forced psychosurgery and castration; Hodges, 2014; Smith, 2004, 2010; Raz, 2013; Bloch and Chodoff, 1991). Scholarly accounts of the APA’s decision-making in 1973, such as Bayer’s (1981) political history and the oral history

compiled by Drescher and Merlino (2007), document a reclassification process framed in scientific rather than reparative terms, with no accompanying apology or institutional acknowledgment of harm. Similarly, while the RANZCP has released position statements condemning conversion practices and supporting lesbian, gay, bisexual, transgender, queer or questioning, intersex, and asexual (LGBTQIA+) mental health (RANZCP, 2021a, 2021b), these are forward-looking policy documents rather than retrospective acts of accountability and mea culpa.

Parallel concerns about transparency and accountability extend to current psychiatric practices. Psychiatrists continue to administer involuntary electroconvulsive therapy (ECT) in multiple countries, including Australia and the United Kingdom, despite the World Health Organization's 2023 report stating that international human rights standards classify non-consensual ECT as a violation of human rights and a practice that amounts to torture or ill-treatment. A recent large-scale study involving 1144 ECT recipients reported that nearly half (49 percent) experienced a deterioration in quality of life after treatment, with 22 percent describing it as "much worse" and 27 percent as "very much worse" (Read et al., 2025a). Yet patients routinely encounter the minimisation of risks by psychiatrists (Read et al., 2023; Read et al., 2025b) and overstated, outdated, claims of effectiveness (Funk et al., 2025).

Patterns of minimising harms, overstating benefits, and dismissing patient-reported iatrogenic suffering have also been documented in relation to antidepressants (Horowitz et al., 2025; Guy et al., 2020; Rennwald and Hengartner, 2025; Healy and Mangin, 2024). A substantial body of evidence shows that antidepressant efficacy has been and continues to be significantly overstated while associated harms have been and still are downplayed through selective publication of positive trials, short-term outcome windows, financial conflicts of interest, misclassification of protracted withdrawal as relapse, the silencing of lived

experience accounts, and diagnostic expansion that reframes systemic inequalities and psychosocial distress as individual pathology requiring pharmacological intervention (Kirsch et al., 2008; Turner et al., 2008; Horowitz and Taylor, 2019; Oostrom, 2024; Davies and Read, 2018; Almohammed et al., 2022).

Long-term or irreversible antidepressant-induced sexual dysfunction that persists after discontinuation (Cardoso and Mota, 2025) has been documented since 1991, yet it was not formally recognised in academic literature until the mid-2000s (Healy, 2020). Many people with lived experience of persistent sexual dysfunction following antidepressant discontinuation report a lack of informed consent on the basis that they were not warned about this potentially life-limiting effect by prescribing clinicians (Healy et al., 2018), despite acknowledgement from governmental oversight bodies that this risk remains underreported and requires close attention (Therapeutic Goods Administration, 2024).

These practices compromise informed consent, which is both an ethical and legal obligation, and erode public trust in psychiatric services. The resulting sense of institutional betrayal and disillusionment among lived experience communities fractures therapeutic relationships and contributes to disengagement from care (Aves, 2024; Downs, 2025; Elwyn, 2023). Such mistrust and disengagement are then frequently reframed by psychiatrists as evidence of “attachment issues,” “hysteria,” “anger issues,” “emotional dysregulation,” or “personality pathology,” reinforcing a cycle in which legitimate protest, concern, critical thinking, and self-protection are recast as symptoms of disorder (Downs, 2025; Elwyn, 2023; Aves, 2024). Trust cannot be summoned by virtue of holding an academic title; it must be earned through a consistent and unwavering commitment to honesty, humility, accountability, and transparency.

By identifying introspection as a clinical problem for patients while failing to apply the same reflective demands to psychiatric practice, BPD discourses reinforce an asymmetry of responsibility that is deeply embedded in the profession. This asymmetry is not only relational but also epistemic. People with a BPD diagnosis frequently encounter testimonial injustice, where their accounts of their own experiences are treated as unreliable or exaggerated, and hermeneutical injustice, where available psychiatric constructs fail to validate or adequately represent their lived realities (Kyratsous and Sanati, 2017; Watts, 2024). When clinician accountability is minimised, these injustices are compounded: patients' ways of thinking, feeling, behaving, and making sense of themselves and the world are closely scrutinised and systematically pathologised, while the harms generated by clinical practice remain shielded by institutional authority. The result is a disempowering structural imbalance in which those most impacted by iatrogenic harm are positioned as least credible in naming and challenging it.

A therapeutic approach grounded in reciprocal reflexivity is required. Just as patients may need support in softening self-critical reflection, clinicians and psychiatric institutions must engage in their own sustained reflexive practice, characterised by humility and genuine engagement with lived experience expertise and epistemological pluralism, even when that engagement is uncomfortable or destabilising to professional certainties. Without this relational symmetry, the discourse of patient “over-introspection” risks recasting self-reflection itself as pathological while leaving the epistemic and institutional power structures of psychiatry unexamined.

Homophobia and Transphobia

The overapplication of BPD diagnoses to members of the LGBTQIA+ community raises serious ethical, ideological, and clinical concerns, yet much of the literature on this topic

makes no reference to this issue (see Swan et al., 2025). Research demonstrates that clinicians frequently assign a BPD diagnosis to transgender and gender diverse (TGD) individuals and to sexual minority patients in ways that are not necessarily reflective of psychopathology. For example, a recent study found that “clinical providers appear inclined to assign a BPD diagnosis to TGD patients that may not correspond with group differences in underlying personality pathology” (Rodriguez-Seijas et al., 2024). Similarly, another study concluded that “clinicians may be predisposed to provide a BPD diagnosis to sexual minority patients that is independent of presenting psychopathology” (Rodriguez-Seijas et al., 2021). These findings highlight a troubling diagnostic bias whereby gender identity and sexual orientation themselves, rather than empirically demonstrable psychopathology, become the basis for a BPD diagnosis.

This diagnostic tendency cannot be separated from psychiatry’s longer history of pathologising LGBTQIA+ identities. In the DSM-I, homosexuality was explicitly categorised as a “Sociopathic Personality Disturbance” (Bayer, 1981; Drescher, 2015), signalling psychiatry’s early use of personality disorder frameworks to police and punish diversity and social nonconformity. Likewise, gender variance was later codified under “Gender Identity Disorder,” a category emerging directly from the same diagnostic lineage of personality pathology and framed as a failure to achieve a coherent or “stable” identity (Drescher, 2010; Davy and Toze, 2018). The APA’s own historical account shows how “Gender Identity Disorder” in DSM-III and DSM-IV situated gender divergence within psychiatric surveillance and paradigm of self-disorganisation (Byne et al., 2018). In both cases, psychiatry deployed personality disorder diagnostic technologies not as neutral classificatory tools but as mechanisms of normative enforcement, medicalising differences through the language of “personality deviation” and “failed selfhood.”

Some psychiatrists continue to interpret expressions of gender diversity through the diagnostic lens of “personality pathology,” including BPD, construing trans and gender diverse identities as indicators of “unstable self-concept” or “identity diffusion,” rather than as valid expressions of selfhood. This framing does not operate neutrally, it functions to legitimise diagnostic gatekeeping and the withholding of gender-affirming care under the guise of clinical prudence (Goldhammer et al., 2019; Amos, 2024). For example, Amos (2024) reframes gender not as an autonomous and self-determined truth but as a clinical object whose validity and legitimacy must be adjudicated through psychiatric expertise and authority, claiming that “personality pathology” may be implicated in the “development of gender diversity.” From this position, Amos (2024) proposes that a declaration of nonconforming gender identity from someone previously diagnosed with a “personality disorder” may constitute a symptom of psychopathology rather than an authentic identity position, positioning gender affirmation without psychiatric diagnostic clearance as ethically questionable. We contend, instead, that it is the weaponisation of “personality pathology” to police marginalised identities that constitutes the true ethical violation.

The ongoing politics of identity regulation and weaponising of “personality pathology” among queer, trans, and gender diverse people can be read as a form of homophobia and transphobia. Although the overt pathologisation of sexual and gender diversity was removed from diagnostic manuals, the persistence of BPD overdiagnosis within LGBTQIA+ groups suggests that psychiatry has not fully reckoned with its colonial legacy of policing and enforcing hetero-and cisnormativity.

The clinical and social consequences of this are significant. A BPD diagnosis often carries stigma not only in the broader community but, and perhaps to a greater extent, also within healthcare systems themselves. For LGBTQIA+ individuals, who already face

disproportionate barriers to affirming care, the addition of a stigmatising label compounds minority stress, erodes trust in providers, and can fuel service avoidance. Porter et al. (2023) illustrate how diagnostic overreach in this context is not merely a matter of academic debate but a lived reality that directly undermines the dignity and wellbeing of the vulnerable individuals subjected to it.

Framing BPD as a default diagnosis for TGD individuals and sexual minorities, based on the assumption that gender variance and sexual diversity reflect “identity confusion” or an “unstable sense of self,” risks obscuring and erasing the structural and sociopolitical conditions that underpin poor mental health in these populations. Such framing places responsibility for distress within the individual rather than locating it within broader systems of discrimination and marginalisation. Minority stress theory demonstrates that discrimination, rejection, and violence are key drivers of mental ill-health among LGBTQIA+ people (Velez et al., 2021; Mongelli et al., 2019). When clinicians reduce these complex, socially produced experiences to “borderline” pathology located within an individual’s “personality,” they erase the role of external, structural harms that demand collective accountability and systemic redress rather than individual diagnosis and isolated treatment. These diagnostic practices become doubly iatrogenic: first through the injury inflicted by the label itself, and second through the denial of recognition of the true sources of distress and trauma.

In sum, the disproportionate application of BPD diagnoses to LGBTQIA+ populations should be understood as part of psychiatry’s dark legacy of enforcing conformity and compliance through diagnostic categories and practices. The historical pathologisation of homosexuality as a personality disturbance and the contemporary tendency to label gender diverse and trans people’s identities as “unstable” are not separate phenomena but interconnected expressions

of the same underlying epistemic injustice and colonialism. Indeed, there is ample evidence that dichotomous normative assumptions of masculinity and femininity are historically rooted in White supremacy and Western colonialism (Dias et al., 2024; O’Sullivan, 2021; el-Malik, 2013).

While a strict and inflexible understanding of gender and sexual binarism is characteristic of modern Western biomedical, Judeo-Christian/biblical, and colonial epistemologies, gender diversity and plurality have been historically widespread across cultures and eras. Evidence from classical antiquity shows that the Galli priesthood in ancient Rome occupied a recognised third-gender position within Roman religious life (Hallett, 1997; Roscoe, 1996; Sapsford, 2025). Similarly, Mesopotamian temple archives associated with the cult of Inanna/Ishtar describe ritual specialists such as the *assinnu* and *kurgarrū*, who were explicitly marked as gender-transgressive figures (Foster, 1995). Beyond the Mediterranean and Near East, anthropological literature documents a wide range of nonbinary and gender-plural social roles across Indigenous societies prior to colonial disruption, including among Native North American Two-Spirit communities, South Asian hijra, Samoan *fa’afafine*, and other third-gender positions (Herdt, 1994; Nanda, 2021). Acceptance and ceremonial integration of gender variance continue to be observed in many Indigenous and non-Western contexts worldwide, where gender is governed not by rigid binary and psychopathology logics but by relational, spiritual, and communal roles (Roscoe, 1991; Driskill, 2010; Morgensen, 2011; Reddy, 2005; Schmidt, 2003; Oyěwùmí, 1997).

Therefore, addressing stigma and iatrogenic harm in the context of “personality pathology” requires more than technical reform, it demands a fundamental recognition that psychiatric nosology itself can reproduce social stigma under the guise of “medical neutrality” and “scientific objectivity.” Rather than pathologising difference through a narrow Eurocentric

frame, mental health systems must shift toward culturally flexible, socially accountable models that affirm identity, centre lived experience expertise, and rigorously interrogate the epistemic power psychiatry holds in deciding whose personalities, identities, and forms of self-expression are classified as disordered. This includes confronting psychiatry's historical and ongoing role in legitimising and operationalising abusive and discriminatory practices.

The Diagnostic Construct as a Source of Harm

Perhaps the most significant omission in much of the clinical and academic discourse on BPD, including Swan et al. (2025), is the failure to engage with the growing body of evidence that the diagnostic construct itself generates tremendous harm. Research tends to focus on treatment outcomes or symptom reduction, largely neglecting the profound iatrogenic consequences that arise from being given this diagnosis, including its impact on identity, self-concept, and help-seeking. Qualitative studies consistently show that the BPD label functions not as a neutral clinical descriptor but as a source of secondary trauma. It can erode self-worth, intensify shame, and increase suicidality (Aves, 2023; Jones and Lomani, 2023; Hartley et al., 2022; Harding, 2020). Many report that the diagnosis becomes a heavier burden than the initial distress that led them to seek mental health support. Instead of facilitating care, it often acts as a barrier, reshaping both clinical encounters and self-narratives in damaging ways (Beale, 2022; Miller et al., 2024; Tyrer and Mulder, 2024; Mulder and Tyrer, 2023; Porter et al., 2025).

The diagnosis of BPD has long been criticised for its vagueness and heterogeneity. The diagnostic criteria span a wide range of experiences including impulsivity, low self-esteem, fear of abandonment, emotional dysregulation, sensitivity to rejection, suicidality, and self-injury. These features overlap with many other trauma-related presentations (Walker and Kulkarni, 2019). From the perspective of those diagnosed, the lack of conceptual clarity fuels

uncertainty and pathologisation that can feel like a direct assault on character and personhood. Being told that one's "personality" is disordered is experienced by many as a form of character erasure and moral judgment (Porter et al., 2023, 2025; Harding, 2020; Hartley et al., 2022; Aves, 2023, 2024). In their systematic review and qualitative meta-synthesis, Stiles et al. (2023) report that the stigma attached to BPD often damages how individuals see themselves. Some internalise negative narratives ("I'm flawed," "I'm unworthy") or feel shame, guilt, or self-doubt because of the label (Stiles et al., 2023). When a diagnostic category is elastic enough to be applied to almost any intense emotional expression or relational differences and is demonstrated to directly cause stigma and harm, it ceases to function as a meaningful clinical construct and instead becomes a catch-all label castigating those perceived as critical and independent thinkers, nonconformist, demanding, inconvenient, or complex.

Stigma, discrimination, and systemic neglect remain among the most corrosive features of the BPD construct. Numerous studies and service user accounts describe clinicians viewing those with the diagnosis as manipulative, untreatable, or unworthy of care. These attitudes contribute to exclusion from healthcare services, medical neglect, gaslighting, and even explicit refusals of crisis intervention (Aves, 2023, 2024; Hartley et al., 2022; Downs, 2025). Rather than acting as a gateway to therapeutic support, the label is frequently used to justify withholding care to those in need of assistance (Hartley et al., 2022). At the same time, the most widely promoted treatment approach, Dialectical Behaviour Therapy (DBT), has been reported to cause harm for a significant number of people (Lawson and Farquharson, 2025), yet these reports are rarely acknowledged within mainstream discourse. Given the high rates of self-injury and suicidality associated with the diagnosis, this dynamic is particularly dangerous. If the presence of the label itself triggers both self-stigma and exclusion from

healthcare services, then the diagnosis directly contributes to the very risks it claims to address.

The harms associated with BPD are not only relational but structurally produced and perpetuated. At the systemic level, the diagnosis legitimises discriminatory practices by embedding stigma into assessment pathways and service policies. Upholding a category that is both scientifically contested and socially stigmatised enables a cycle in which marginalised people are blamed for their distress while simultaneously being denied care. In doing so, psychiatry reproduces epistemic injustice: the perspectives of those with lived experience are discredited not because of evidential weakness, but by virtue of the label itself. When people report iatrogenic harm arising from the diagnosis, their accounts are frequently reinterpreted through diagnostic logic where self-advocacy is reframed as “defiance,” and “defiance” is pathologised as further evidence of pathology. This circular reasoning functions as a mechanism of silencing, compounding the trauma and invalidation that many already carry into services. This is also diagnostic recursivity: psychiatry perpetuates the very harms it later cites as confirmation of “personality pathology.” D’Agostino and Ruffalo’s (2025) article clearly illustrates this circular reasoning and diagnostic recursivity:

The anti-BPD movement carries the risk of fueling mystification and chaos, as well as group defensive processes of splitting and projective identification. Borderline may be viewed as a witch to be burned at the stake, with clinicians who proffer this label becoming the perpetrators and those who proffer an antilabel becoming the saviors. There has been a proliferation of communities of angry patients on social networks that refer to the Mad in America website and exist to fight back against the pathologization and the use of labels. Such trends demonstrate en masse the very psychodynamics that characterize BPD.

By casting anti-diagnostic resistance as a manifestation of “group defensive processes” or projective identification, D’Agostino and Ruffalo (2025) illustrate how psychiatry converts political dissent into clinical symptomatology. In this framing, resistance is not a rational or

legitimate critique of psychiatric discourse and power but a clinical sign confirming the need for diagnostic governance.

To meaningfully address iatrogenic harm in the context of BPD, it is not sufficient to refine therapeutic techniques within the existing framework without interrogating the diagnostic construct as a tool of colonial, cisnormative, misogynist, and heteronormative oppression.

What is required is a critical re-examination of the diagnostic construct itself. Unless practitioners and systems are willing to consider that the BPD label may be intrinsically outdated and harmful, efforts to reduce harm or “complications” will remain superficial and vain. Without this recognition, mental health services risk continuing to retraumatise those they claim to support. The label, along with the prejudicial assumptions it invites, functions less as a pathway to healing and more as an obstacle to compassion, dignity, safety, autonomy, and recovery.

Conclusion

To meaningfully reduce iatrogenic harm in the context of so-called "borderline personality disorder," it is not enough to refine treatment protocols or optimise therapeutic technique within an unreformed diagnostic regime. The diagnosis itself is not a neutral clinical descriptor that has been misapplied, but a colonial and carceral technology of behavioural governance that produces pathology through categorisation. Harm is not an unfortunate side effect of BPD diagnostic practice: it is an inherent and predictable output of a system designed to regulate, discipline and discredit those who do not conform to neuronormative, cisheteronormative, and culturally Western expectations of selfhood, relationality, and distress.

The call to “improve BPD services” without interrogating or dismantling the diagnostic construct functions as a containment strategy that preserves psychiatric authority rather than

transforming care. Rebranding the category under terms such as "complex emotional needs" or "emotion dysregulation syndrome" does not constitute justice, it is diagnostic futurism that sustains the same surveillance logics under softer language. Any attempt to preserve the diagnostic framework through euphemism, future-oriented reclassification, rebrandings, or "complex emotional needs" framings merely updates psychiatric containment logics without relinquishing their colonial and carceral foundations. Abolition requires more than trauma-informed reform; it requires epistemic disobedience, the rejection of selfhood and identity pathologising taxonomies, and the creation of care pathways that do not require submission to a stigmatised and biased construct in order to access mental health support or services.

If services are to move beyond the iatrogenic cycle of diagnosis, exclusion, and retraumatisation, they must stop positioning distress within individual pathology and instead centre structural violence, sensory oppression, minority stress, and institutional betrayal as core determinants of suffering. Care that is relationally stable, identity-affirming, culturally accountable, and sensory-informed does not emerge from diagnostic correction, it emerges from diagnostic refusal.

Abolishing the BPD construct is not an act of recklessness, but an act of clinical, ethical, and epistemic responsibility. It opens the possibility for care rooted in self-determination rather than compliance, compassion rather than suspicion, and justice rather than containment. Until psychiatry is willing to relinquish the diagnostic power to name certain personalities or identities as disordered, any conversation about "complications" in psychotherapy will remain fundamentally misdirected. The harm lies not in people's needs, emotions, or intensity, but in the diagnostic lens that renders those needs inherently pathological. Dismantling that lens is not merely desirable, it is necessary.

Abbreviations and Acronyms

APA: American Psychiatric Association

BPD: Borderline Personality Disorder

DBT: Dialectical Behaviour Therapy

DSM: Diagnostic and Statistical Manual of Mental Disorders

ECT: Electroconvulsive Therapy

LGBTQIA+: Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual

NSSI: Non-Suicidal Self-Injury

RANZCP: Royal Australian and New Zealand College of Psychiatrists

RCT: Randomized Controlled Trial

TGD: Transgender and Gender Diverse

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