On the epistemic injustices of personality disorders

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To Jay Watts (and anyone else who is interested in my response),

I have read with interest your recent paper on 'The epistemic injustice of borderline personality disorder' at the BJPsych International (Watts, 2024). I fundamentally agree with your thesis that borderline personality disorder (BPD) is, for the most part, an epistemically unjust diagnosis——because it undermines, distorts, or otherwise negates patients' narratives. At the same time, however, I feel that many of the solutions you proposed are either logically inconsistent or can readily lead to undesirable consequences (such as more iatrogenic harm than good). In the spirit of advancing your commendable argument, I would like to briefly suggest my own view on how to address the epistemic injustices of not only the 'borderline personality' diagnosis, but all personality diagnoses more broadly.

To begin with, it is worth summarizing Watts (2024) main argument. Watts leverages the idea of 'epistemic injustice' to suggest that the (currently, *de facto*) diagnosis 'borderline personality disorder' (BPD) could be weaponized by clinicians to undermine patients' narratives. This form of injustice can come in two ways: first and foremost, as an outright form of '***testimonial injustice***'——by which a patient's narrative is dismissed because it is assumed to have lower credibility (due to their psychiatric diagnosis). Second, as an indirect form of '**hermeneutical injustice**' ——by which a patient's narrative is not even able to be formulated in the first place because society (and clinical practice) lacks the necessary concepts for a patient to make sense of their (clinical) experiences (see Fricker, 2007). Watts (2024) argues that the label BPD promotes both of these injustices and suggests that a way to address these problems is to: (a) 'move beyond the straitjacket of the BPD label' and (b) embrace 'more validating alternative diagnoses, such as autism, bipolar disorder, premenstrual dysphoric disorder, and complex PTSD' (p.82).

I have several reservations with both proposed solutions, but I will constrain myself to an outline of their three fundamental limitations. The first limitation is logical and concerns the fact that a complete negation of the BPD concept is actually a form of epistemic injustice itself. To elaborate, although it is the case, as Jay Watts outlines, that a large number of patients categorically reject the BPD label, it is also the case that for every such patient there exists at least another who categorically endorses this label (and sometimes actively seeks to be diagnosed with it, e.g., see Lamph et al., 2022). This dialectic of partly-rejecting and partly-accepting attitude paints a much more nuanced picture than the one-sided picture Watts (2024) has painted and suggests that any removal of the BPD concept without an appropriate replacement amounts to a form of epistemic injustice: specifically, the hermeneutical injustice of not allowing a certain contingent of patients to leverage this concept in order to make sense of their experiences.

Second, it may of course be argued that to avoid this conundrum, the BPD concept could simply be replaced by the various other diagnoses that Watts (2024) has outlined——including 'autism, bipolar disorder, premenstrual dysphoric disorder, and complex PTSD' (Watts, 2024, p.82). If these diagnoses can account for the entire clinical territory that the 'borderline' diagnosis covers, then its replacement by them would be both epistemically just and clinically valid. Alas, this solution also does not add up, because although the evidence points to a considerable overlap between these conditions and BPD, that overlap is not complete.

To elaborate, **autism** rates in those with BPD fall within population estimates (1-5%) and are either reflective of true comorbidities or misdiagnoses in females——that is, female autism being conflated with BPD which is a major issue in clinical practice, but not enough to warrant a re-diagnosis of all women with BPD as instead having autism because not all of them have neurodiversity; see Zavlis & Tyrer, 2024 for a recent commentary). Likewise, although **bipolar disorder** could be sometimes preferred over a BPD diagnosis, such a differential diagnosis would only apply for patients who have predominantly mood problems, not problems with identity and ways of relating to others (see Paris et al., 2007; Paris & Black, 2015; Ruggero et al., 2010). Finally, a similar conclusion applies for **premenstrual dysphoric disorder** (which is an emotional disorder that would only be applicable for menstruating people, missing women with amenorrhea, all men, and several gender minorities) and **complex PTSD** (which would only be applicable for severe cases of BPD, missing all patients that may not have had (severe) traumatic experiences but may still exhibit BPD-related problems; Cloitre et al., 2014; Ford & Courtois, 2014, 2021) (see also Lamph et al., 2022, who document how some patients agree that the term 'complex PTSD might minimize their experiences by "*putting people in subgroups of 'worthy' and 'not worthy' based on the subjective experience of trauma*").

In short, these syndromes cannot account for all clinical populations affected by BPD symptoms (neither in isolation nor in combination). Suggesting, therefore, that BPD can be outright replaced by these syndromes commits both forms of epistemic injustice, at once, since (a) it dismisses the narratives of those who consistently tell us that this syndrome (and not any other mental syndrome) fits their experiences the best and (b) it does not enable (future) sufferers to make sense of their experiences using the nuances of the BPD concept——nuances which are not covered by other diagnostic concepts (with the exception of dimensional personality disorder, of course; Tyrer et al., 2019).

This leads me to the final and arguably most important point: Namely, that an exclusive focus on the 'borderline' label is itself largely unproductive because, paradoxically, the issue is not with the label itself, but rather with what that label *represents*. To elaborate, the 'borderline' label is nothing more than a vessel: an adjective that signifies the archetype of those who do not fit normative ways of relating to themselves (e.g., self-harming) and others (e.g., being antagonistic; Zavlis, 2024). Importantly, these ways of being have been present throughout history, but were characterized in largely different ways, including 'witch' (in the Middel Ages), 'hysterical' (in the Victorian era), and 'morally insane' (in the 19th century; see Becker, 1997; Berrios, 1993). Focusing on these terms might be important for a historian who tracks their changes over time. However, what is important for the psychologist is an in-depth analysis of what these terms *signify*: that is, an analysis of the regularities in human experience that have led to the development of these (largely stigmatizing) concepts in the first place.

In my view, these regularities include perceptions of certain people as 'difficult' because the people in question have difficulty *relating themselves to others*——and, consequently, *others have difficulty relating back to them* (Fonagy et al., 2018; Hopwood, 2024, 2018; Lilienfeld et al., 2019; Wright et al., 2022; Zavlis, 2023, 2024). This, to me, is the crux of the matter: that there consistently exists, across time and space, a certain class of people that was always marginalized, stigmatized, and misunderstood simply because they had difficulties in relationships. The solution, then, is not to negate the 'borderline' concept—— because doing so would negate this entire class of people. The solution, instead, is to *radically transform* this concept so that it reflects the core difficulties of these patients in a much more accurate and humane manner.

I have elsewhere argued extensively that one way to achieve this aim is by moving beyond the 'borderline' category and re-conceptualizing *all* disorders of 'personality' as disorders of 'relationships' (Zavlis, 2023, 2024; Zavlis et al., 2024). Specifically, I have argued that ***personality disorders*** can be more accurately and perhaps also humanely viewed as ***relational disorders*** because their fundamental impairments include maladaptive ways of relating to the self (e.g., self-harming) and to others (e.g., intimacy problems; see Zavlis, 2023, 2024; Zavlis et al., 2024). This, in my eyes, is the most productive way forward: not to negate the concrete clinical problems that this class of patients experience, but rather to radically transform them in the eyes of many beholders so that they are no longer viewed as problems with 'who a person is,' but rather as problems with 'what a person does': maladaptively relate.

Importantly, and optimistically, there is evidence that relevant stakeholders already approve of this relational way of viewing putative disorders of 'personality.' Specifically, when asked directly what they think of the diagnosis 'personality disorder,' most clinicians suggest that this disorder simply indicates *problems in relationships*——including the relationship that a person has with themselves (i.e., their 'identity') and the relationship that they have with others (i.e., how they relate to their friends or romantic partners; Cohen et al., 2022). Crucially, people with lived experiences report similar sentiments by suggesting that they prefer a '*relational framing*' of their problems (see Lamph et al., 2022, p.31) (see also Fallon, 2003; Tedesco et al., 2024)——and, more anecdotally, my use of 'relational disorder' (than 'personality disorder') in the clinic is also largely met with enthusiasm and curiosity rather than defensiveness and criticism. Finally, both established treatment protocols for 'personality/relational disorder' and people with lived experience of this disorder emphasize the importance of *'relational practice'* (Trevillion et al., 2022): that is, the practice of first *establishing a solid patient-carer relationship* ***before*** *commencing therapy for core BPD difficulties*, such as emotion regulation difficulties (Linehan, 1993), mentalizing difficulties (Bateman & Fonagy, 2010), and post-traumatic stress difficulties (Zeifman et al., 2021).

Together, these pieces of evidence suggest that although labels matter, what matters even further is how those labels are ***re-presented*** within therapeutic contexts. When the 'borderline' and 'personality disorder' labels are represented in a relational manner (that signifies concrete problems in relationships), it appears that the therapeutic dyad can productively engage with psychological therapy (Trevillion et al., 2022). Conversely, when these labels are represented in a person-focused manner (that signifies an abstract and judgemental problem with 'who a person is'), it appears that the therapeutic dyad cannot effectively engage with psychological therapy (Lamph et al., 2022). Accordingly, my own conclusion is that the most productive way forward is not a complete negation of these abstract 'personality problems' (as Jay Watts (2024) suggests), but rather a radical transformation of them so that they come to signify (in both the clinician and patient consciousness) a more accurate and humane way of viewing them: specifically, a way of viewing them as 'relational' problems.

To conclude, I applaud Jay Watts for her attempt to elucidate the epistemic injustices of (borderline) personality disorder. At the same time, however, I remain sceptical of her recommendations to address such injustices because I think that those recommendations are neither based on a thorough reading of the available evidence nor do they have at heart the best interests of all relevant stakeholders (once again, patients with amenorrhea or patients who do experience relational problems but not because of severe trauma or neurodiversity). In an attempt, therefore, to correct this implicit epistemic injustice from Watts' (2024) end, I have (tentatively) suggested that a more productive way forward is not the negation of the clinical concept of 'personality disorder' but rather its transformation as a 'relational disorder'——a label that appears to be preferred by most relevant stakeholders, but one that needs to be further investigated to ensure that it does not perpetuate the epistemic injustices of its forerunner.

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