

## **Minimisation and Medicalisation: How Modern Psychiatry Contributes to the Subjugation of Women's Self Expression and Experiences of Trauma**

This essay will discuss how modern psychiatric diagnoses can and have been used to manipulate society's perception of women's experiences and influence their self-expression. There are a number of diagnoses which are much more frequently ascribed to women, many of which have symptoms related to 'undesirable and inappropriate' expression of emotions. In a society in which women continue to be undervalued and disparaged, it is vital to confront any system which contributes to their subjugation. It is particularly significant in regards to diagnoses that pathologise outspoken or intense women, and have the potential to minimise their opinions and ideas. This essay will evaluate the origins and uses of a number of psychiatric diagnoses and how they affect the perception of women when expressing their emotions or opinions. In particular, it will discuss how the link between trauma and mental health diagnoses, while well established, is not always highlighted but instead the focus is put on individual psychiatric abnormality. This can again be used to shift public conversation away from important issues regarding abuse and prejudice towards women and towards placing blame on individuals for their 'inappropriate' response to trauma. I will discuss these issues through the lens of a number of different diagnoses in which women are over-represented and assess the ways in which they may be used to contribute to the control and subjugation of women.

### **The Control of Emotions**

This essay will begin by discussing the ways in which psychiatry has pathologised women's presentations of emotion and personalities and, thus, has been used to exert control over their self-expression. Female outward displays of emotions, in ways that are deemed either too masculine or too feminine, are those most likely to fall under the diagnostic criteria of a mental health disorder. It is important to evaluate the background and origin of such disorders, and the impact that gender bias has on their diagnosis, as well as the consequences of these labels on women's lives.

Traditionally masculine emotions, such as anger and irritability, displayed by women can be painted as inappropriate, undesirable and even lead to a mental health diagnosis. Premenstrual Dysphoric Disorder (PMDD) (previously Premenstrual Syndrome (PMS)) is a diagnosis commonly attributed to women who express irritability and anger around the time of their menstruation.<sup>1</sup> The use of PMDD has been criticised in the past for pathologising a normal biological process for cis-gender women, and medicalising women's experiences of their own bodies.<sup>2</sup> It has been suggested to only be deemed significantly unhealthy when the feelings and 'symptoms' begin to negatively affect those around the woman.<sup>3</sup> Many women themselves perceive certain potentially healthy behaviours as symptoms of their PMDD because of the way it is outwardly observed. For example, a study showed women describing their major symptoms of PMS as "not wanting or being able to provide unconditional care or support of others".<sup>4</sup> Another study indicated that many women attributed the "need to be alone" around the time of their menstruation to PMDD.<sup>3</sup> One might argue that it is normal to require some personal space and not be able to continuously provide unlimited care for others. However, several women have said that they feel that they are being selfish when they prioritise this self-care over their families or relationships.<sup>3</sup> The medicalisation of these symptoms is significantly linked to traditional gender roles, and society's expectations of women. A significant proportion of women (40%) experience moderate to severe PMDD, and even more experience mild symptoms, which indicates that it is a fairly common process for those who are menstruating, and that pathologising it is one way to minimise women's feelings and influence their positions in society.<sup>3</sup> Very little research has been done which supports the existence of a premenstrual illness, which is a common theme when considering diagnoses dominated by, or exclusive to, women. It is still common for women's emotions or opinions to be dismissed when experiencing menstruation and this diagnosis may be another way to negate their opinions and emotions. Psychologist Carol Tavris described the "dangers of reducing all our feelings, problems and conflicts to biological processes" in relation to PMS.<sup>5</sup> The risk of attributing feelings and opinions to hormonal changes allows even more opportunity for women's perspectives to be dismissed as just "PMS". Furthermore, the term "PMS" is still used as a downside for having women in positions of power or authority, as highlighted by the comments made about Hilary Clinton during the 2016 electoral campaign.<sup>6</sup> This diagnosis may still be colloquially used to disregard and discredit women who express feelings of anger or aggression, regardless of the cause, forcing women to modify their self-expression in order to be respected

and listened to. This is particularly significant as outspoken and influential women are one of the greatest threats to the patriarchy and, historically, labelling a woman as crazy was the easiest way to discredit her.

When considering the use of mental health diagnoses to disparage women, one must discuss Borderline Personality Disorder (BPD), one of the most stigmatised mental health conditions, and one in which women vastly dominate (75%).<sup>7</sup> BPD has several diagnostic criteria which are traditionally seen as masculine or more appropriate in men, such as impulsive behaviour, aggression, and difficulty controlling anger.<sup>8</sup> Studies have shown that men are actually more likely to meet criteria for BPD than women, though women are far more likely to be given this diagnosis.<sup>8</sup> This may be due to the fact that some of these behaviours are more socially acceptable in men, and so are less likely to be viewed as pathological by clinicians. There has been a lot of discussion as to legitimacy of this disorder and whether it has become synonymous with “difficult woman”.<sup>9</sup> Is this, and some other psychiatric diagnoses, merely a label given to individuals who are exhibiting behaviours that our patriarchal society does not approve of? There are other aspects of BPD which are associated with traditionally feminine traits, such as fear of abandonment, self harm, and extreme expression of emotions. This has led to statements suggesting that women are in a catch-22 situation, with neither masculine nor feminine expressions of emotion being acceptable.<sup>10,11</sup> There has even been discussion that the diagnosis of BPD has been used as a punishment for angry women; one patient even said she was “only given a diagnosis of [BPD] when [she] started to stand up for [herself] as a person and a woman.”<sup>12</sup>

The intersection of gender and race must also be examined when considering those disadvantaged by the current use of certain psychiatric diagnoses. There is evidence that people of colour have been disproportionately wrongly diagnosed with mental health conditions, due to their clinician’s lack of understanding of the context of their lives and culture.<sup>13</sup> In the context of personality disorders, a psychiatrist makes the decision as to whether an expression of emotion or behaviour is “appropriate” given the situation. This is highly subjective and allows doctors’ experiences and prejudices to affect the use of the diagnosis of BPD and other personality disorders. The fact that there is little to no research about racial differences in the diagnosis of BPD is likely to further disadvantage women of colour with mental health diagnoses.<sup>13,14</sup> Owing to cultural differences, Black women’s expression of emotions may be pathologised, especially within the context of the reductive stereotype of the ‘angry Black woman’, which may echo the stereotype of the ‘difficult’ woman who are diagnosed with BPD.<sup>13</sup> There is also a risk that some psychiatric disorders are under-diagnosed and overlooked in Black communities owing to this stereotype, forming greater barriers to support. It is important for there to be further research into the presentation of personality disorders in women of colour, to ensure that clinician bias is not influencing their diagnoses, particularly given the under-representation of psychiatrists of colour.

While the symptoms of BPD and PMDD focus on intense or hostile outward expressions of emotions, women acting in an overly passive or sensitive way can also be at risk of psychiatric diagnoses. In 1983, Marcie Kaplan proclaimed that behaving in a stereotypically feminine manner could in itself lead to women receiving a psychiatric diagnosis.<sup>15</sup> Dependent Personality Disorder has many similarities to traditional female gender roles, with women 40% more likely to be diagnosed than men.<sup>16</sup> The diagnosis includes: avoiding disagreeing with others, acting passively, placing needs of their caregiver above their own, an inability to make decisions without the support of others.<sup>17</sup> The pathologising of these traits, which would have been praised and valued in women in the past, indicates the fickleness of some psychiatric diagnoses, and how they can and have been used to simply impress societal wishes on individuals. The proposal of ‘Masochistic Personality Disorder’ by male psychoanalysts for individuals who remain in abusive relationships, while not formalised, indicates that personality disorders have the potential to simply arise from a dislike or lack of understanding of people’s actions.<sup>18</sup> This is reinforced by past diagnoses for women which have fallen by the wayside, such as hysteria and nymphomania, as the expectations of women in society have changed.

Histrionic Personality Disorder (HPD) has been described as “essentially a caricature of over-exaggerated femininity”, with patients exhibiting symptoms such as rapidly shifting emotions, exaggerated expression of emotion, sensitive to criticism, sexually provocative behaviour, and wanting to be the centre of attention.<sup>9</sup> HPD originated from the historical diagnosis of Hysteria, which developed into Hysterical Personality Disorder then, finally, Histrionic Personality Disorder. There is an amount of gender bias in regards to this diagnosis, with clinicians at risk of over-diagnosing it in female patients due to “the close relationship of histrionic symptomology to stereotypically female behaviours”.<sup>19</sup> Sexual aggression may also lead to over-

diagnosis in women, as this behaviour is generally less socially acceptable and more at risk of judgement and pathologisation. There have been a number of psychologists and psychiatrists who have shared the opinion that HPD should be removed from the DSM due to its gender bias and lack of specificity in its symptoms. Neuroscientist, Bethany Stennett, Clinical Psychologist, Roger Blashfield, and behavioural psychologist, Shannon Reynol said in 2012 that HPD was “sex-biased” and “a negative diagnosis assigned to ‘difficult’ female patients” and thus should be removed from the DSM.<sup>20</sup> Carol Gould suggested in 2011 that HPD was not a pathological disorder but a cultural one.<sup>16</sup> It seems that with a constantly evolving and multi-cultural society, we cannot label a women’s personality as disordered merely because she does not fit within it. The historical background and the modern-day criticism of this diagnosis seem to suggest that it plays a significant role in controlling women’s self-expression by pathologising feminine traits.

The female dominated disorders of which I have touched upon in this section share the symptom of expressing emotions in an “inappropriate” way. This is a highly subjective assessment and it is unreasonable to expect clinicians to not allow their personal feelings and experiences to affect their use of these diagnoses. There has also been significant discussion about personality disorders being “cultural disorders” as opposed to “psychiatric disorders”.<sup>16,21</sup> In a society in which culture and gender norms are constantly evolving, using societal assumptions or expectations of women to define psychiatric diagnoses appears to open them up to further prejudice, as has occurred in the past. It is also important to acknowledge that, within the context of our society, women’s displays of opinions and emotions are under particular scrutiny. While it is important to acknowledge individuals who may require increased support with their mental health, this essay highlights that some diagnoses focus on an individual’s psychological abnormality, as opposed to the situations or environment which may have cultivated these difficulties in self-esteem, relationships and emotional expression. While support and help may be required, the stigma surrounding these diagnoses and the way they can be used against women indicate that the label may be more damaging than beneficial for patients. The ‘inappropriate’ label for aggressive, passionate or intense displays of emotion by women is a way in which they can be silenced or subjugated, especially when expressing opinions that are ill-received. The stereotype of the ‘crazy women’ has been used throughout history to discredit or belittle women and it is possible that some of these modern psychiatric diagnoses act in a similar way.

### The Perception of Trauma

This essay will now turn to assessing specifically how the perception and expression of women’s trauma is pathologised and thus controlled. This contributes to minimisation of women’s experiences of trauma, and shifts the focus from the cause of trauma to the individual disorder, which is damaging to individuals and perpetuates systems which cause trauma. I will also explore how use of psychiatric diagnoses themselves can contribute to traumatising women, and how this is likely to reinforce power dynamics which control women. The two diagnoses that I will mainly focus on here are Post Traumatic Stress Disorder (and its complex counterpart) and Borderline Personality Disorder, diagnoses intrinsically linked to traumatic life events.

Post Traumatic Stress Disorder is a diagnosis developed from the concept of “Shell Shock”, a term originally used to describe “nervous and mental shock” suffered by soldiers during World War One.<sup>22</sup> It was recognised as an official disorder post the Vietnam War in the 1970s, and entered the DSM in 1980.<sup>23</sup> The origins of the diagnosis have led to residual perceptions that PTSD is an illness of war veterans (statistically more likely to be men), despite the fact that there is significant data to show that women are more likely to experience PTSD than men.<sup>24,25</sup> In the 1987 DSM IV, the diagnosis of PTSD included the condition that the trauma was “outside the range of usual human experience”, which was criticised for excluding experiences such as sexual assault, domestic abuse, and traumatic childbirth, all of which are relatively common experiences for women.<sup>23</sup> This was changed in 2013 for the DSM V, to an experience which included “actual or perceived threat of death or serious injury”.<sup>23</sup> This still may make it difficult for women who are victims of emotional abuse, financial abuse, or insidious sexual abuse to have their trauma recognised in the context of this diagnosis. This is highly significant as there is evidence to show that women who are victims of psychological abuse are more likely to experience PTSD than those who experience physical abuse.<sup>26</sup> There is also vastly less research into PTSD in women following sexual assault or difficult childbirth as opposed to that of war veterans, which minimises the importance and effect of these traumatic life events, which disproportionately affect women, and means there is less understanding of how to treat PTSD following these events. Furthermore, women have PTSD symptoms for an average of 4 years before diagnosis and

treatment in comparison to 1 year for men.<sup>27</sup> This may be related to a differing presentations of PTSD in women or it may be indicative of healthcare professionals (or the women themselves) minimising their traumatic experiences, or still assuming that PTSD is caused by experiences in combat. There is evidence that the everyday experience of sexism that women endure can in itself lead to symptoms of PTSD, and trauma scholars have pushed for the definition of trauma to include oppression and discrimination, such as sexism and racism.<sup>28</sup> It is important to raise awareness that women are at risk of PTSD and it can be caused by many different forms of trauma, including those which are subtle or insidious.

I have discussed how race may play a part in the misinterpretation of women of colour's expressions of emotions, causing them to be labelled with a mental health diagnosis. It is also very important to acknowledge the trauma which comes with systemic racism, and how this may lead to mental health issues such as PTSD. Unfortunately, the DSM still only considers a diagnosis of PTSD in relation to a discrete racist event that meets the criteria for trauma.<sup>29</sup> Insidious racism, such as microaggressions and discrimination, may not be acknowledged by clinicians as traumatic, or may not even be inquired about, leading to the underdiagnosis of PTSD caused by racial trauma. Evidence has shown that gendered racism is more likely to cause psychological stress, and that both sexism and racism were correlated with increased levels of PTSD symptoms.<sup>30,31</sup> It is particularly important for clinicians to be aware of this in regards to women of colour, who are likely to suffer from racism and sexism and must have their experiences of trauma recognised and supported.

Trauma, specifically abuse, is also strongly linked to a diagnosis of Borderline Personality Disorder in women, with 81% of those diagnosed having experienced past abuse.<sup>32</sup> One of the concerns surrounding the diagnosis of BPD is that it shifts the focus away from the abuse, and places the emphasis on the victim and their "disordered personality". Several BPD sufferers have explained how they felt that their past trauma was frequently overlooked despite large amounts of evidence linking abuse and BPD.<sup>33</sup> Sly Sarkisova, a psychotherapist who focuses on trauma, described BPD as "a label that is often misused and applied especially to women, or people who were assigned female at birth, to pathologise them for emotional expressions of suffering."<sup>34</sup> Many other psychologists have voiced concerns over the fact that BPD diminishes the suffering of women by giving them pejorative psychiatric labels that take the focus away from a society which is rife with traumatic experiences for women. Clare Shaw said that "the real issue is pervasive abuse of women and girls in this society coupled with the continuing silencing and invalidation of women's experience."<sup>35</sup>

The diagnosis of Complex PTSD shares a large number of similarities with BPD, such as emotional dysregulation, negative self-cognitions, and difficult interpersonal relationships, but its focus is on trauma, as this is a diagnostic criteria for Complex PTSD but not for BPD.<sup>31</sup> While there has been shown to be discriminant validity between these two diagnoses, there is very high co-morbidity with 25-58% of BPD sufferers being diagnosed with Complex PTSD.<sup>36,37</sup> With the relatively recent introduction of complex PTSD, having first been described in 1980 and not yet an official diagnosis in the DSM-V, the knowledge of clinicians is likely to be at a lower level, and the risk of misdiagnosis is high.<sup>38</sup> Therefore, PTSD, as well as Complex PTSD, is often misdiagnosed as BPD in women, due to the overlapping symptoms and clinicians' implicit bias. The evidence that women with a history of abuse are more likely to be assigned a "personality disorder" label, as opposed to one which is sympathetic to their traumatic past, highlights the focus on women's "inappropriate" emotional reactions rather than the situations which allowed them to experience trauma.

This essay will now discuss how perception and treatment of mental health diagnoses play a part in subjugating women. Psychiatric diagnoses are still being used in the workplace, in court, and in families to discredit and manipulate women. It is still common practice for the mental health records of victims in rape trials to be used in an attempt to invalidate their account.<sup>39</sup> Despite the fact that there is significant evidence to show that women (and men) with a mental health diagnosis are much more likely to be victims of sexual or domestic abuse, it is still used as a weapon against the victim's credibility.<sup>40</sup> In 2012, Jessica Engle and William O'Donohue suggested that several mental health diagnoses, including Borderline Personality Disorder and Histrionic Personality Disorder, were "pathways to false accusations of sexual assault". Despite citing no references that suggest that those with these diagnoses are more likely to falsely claim sexual assault, they described how those with BPD "represent a 'perfect storm' of symptoms in which an impulsive, emotionally dysregulated individual who is demonising someone and has loose contact with reality and who

is seeking attention and revenge makes a false allegation of sexual assault.” They also describe how false assault claims may be used to benefit people with Histrionic Personality Disorder by gaining them attention and providing a new and interesting situation for them.<sup>41</sup> It is markedly problematic and stigmatising to indicate that these disorders in and of themselves are linked to false accusations. There is no data to indicate that these individuals are more likely to falsely report sexual assault, and false accusations are often very difficult to reliably prove, as many women withdraw sexual assault accusations due to the retraumatisation of the legal proceedings. Spohn and Tellis found that unfounding was nearly 10 times more likely if the victim had mental health issues, which is likely influenced by the stigma surrounding mental health and its frequent use to invalidate individuals’ experiences.<sup>42</sup> The use of mental health diagnoses to discredit women in legal proceedings regarding sexual assault and domestic abuse, is yet another way that women are subjugated and held in positions of weakness.

Unfortunately, there are also several ways in which the treatment for psychiatric illnesses can itself be damaging and traumatising, particularly for women. The diagnosis of BPD following a history of abuse, can be retraumatising as it is likely to cause self-esteem issues and guilt in the victim, as the emphasis is placed on their individual pathology and shifted from their formative background.<sup>43</sup> Furthermore, the intense stigma that BPD sufferers experience at the hands of mental health professionals contributes significantly to their feelings of shame and low self-esteem. In the USA and Victoria, Australia, services have consistently refused to see women with BPD as a primary diagnosis, which reinforces to these women that they are unwanted and undeserving of help<sup>12,44</sup> Many studies into the opinions of healthcare professionals about BPD shows that they are likely to deem them to be “annoying”, “manipulative”, “undesirable”, which is no doubt likely to seep into their treatment of these patients, either overtly or subconsciously.<sup>44</sup> This is a particular issue in emergency departments, where Borderline Personality Disorder patients are often likely to seek care for self-harm or suicidal ideations. There has been evidence that the stigma and lack of education around BPD has led to negative attitudes about these patients presenting to A&E and the poor treatment of them. Some patients have described having sutures for self-harm without local anaesthetic because they were told that they “did it because they liked the pain.”<sup>33</sup> This treatment of patients with BPD can be incredibly degrading and likely to damage the doctor-patient relationship, as well as the mental health of the patient. This unsympathetic view of patients with BPD underlines how, even those with education about mental health issues, are still at risk of diminishing the importance of the patient’s background and blaming them for their negative symptoms.

The significant link between trauma and mental ill-health, particularly in women, is vitally important when considering the consequences of inpatient psychiatric treatment. The proportion of female psychiatric inpatients who have experienced violence, trauma or abuse is large. Agenda, an alliance for women and girls at risk, found that in 2017, around 1 in 5 women were being restrained physically in psychiatric units, despite national guidelines that this should only be used as a last resort. Girls in mental health facilities were more likely than boys to be physically restrained (17% vs 13%), and they were more likely to be held face down. Face down restraint has been widely criticised, and many have suggested that it be outlawed due to its potential physical harm and mental trauma. In the UK, 32 women died following physical restraint in mental health facilities in five years, indicating the excessive force that may be being used. Restraint, especially face down, is a particularly re-traumatising and triggering experience for patients who have been victims of violence, sexual assault, or abuse.<sup>46</sup> As has been previously discussed in this essay, a large proportion of women and girls with mental health diagnoses have been victims of abuse or trauma, and thus it is vitally important that mental health services include routine enquiring into previous trauma, including sexual assault and abuse, and adopt a trauma-centred experience for both men and women who are in psychiatric inpatients.

## **Conclusion**

Through the discussion of the psychiatric diagnoses of which the majority of sufferers are women, this essay has highlighted how fluctuant and inconsistent the assessment of female mental health can be. DSM diagnoses could be argued to be “not based on medical knowledge but on social and political factors of acceptable behaviour for women”.<sup>47</sup> This is also true for other marginalised groups, evidenced by the presence of homosexuality in the DSM for many years. Historically, a large proportion of research and medical models have been based on men, specifically white men, and thus there has been evidence that normal female behaviour may be considered pathological, as it does not fit the model of ‘healthy male behaviour’. This is particularly true to women of colour and LGBTQ+ women, about whom there is little

research. The personality disorders which have been discussed (BPD, HPD, DPD) are all diagnoses with strong statistical links to trauma and abuse. The effect of discrimination and long-term inequality on mental health remains significantly under-researched, and the psychological impact of these societal biases is not appropriately acknowledged, on an individual or societal scale. It is also important for this research to be done to assess the subjugation of people of colour, members of the LGBTQ+ community and other minorities through similar means. There has been discussion that the personality disorders in which women dominate may simply be rational reactions to increased stressors that occur from being the subjugated sex. Without the legitimisation of race or gender related trauma, traditional power dynamics and their influence on the subjugation of women and people of colour will continue within psychiatry and impact their wider position in society. It is not only important in terms of the correct treatment of these patients, but it is vital to shine a light on the circumstances which continue to allow these traumatic events to occur. Focusing on pathologising women's responses to trauma has negative effects not only on an individual's mental health, self-image and treatment, but also on society's perception and priorities in regards to gender and racial prejudices. Furthermore, this essay has called attention to the ways in which psychiatric diagnoses have been actively used to silence or discredit women, as well as further traumatise them. I believe this essay has shown that some longstanding diagnoses, particularly personality disorders, may need to be modified or even have their use in a society questioned as they have origins in subjugating women that continue to influence their use today.

## References

1. Hantsoo, L., & Epperson, C. N. (2015). Premenstrual Dysphoric Disorder: Epidemiology and Treatment. *Current psychiatry reports*, 17(11), 87. <https://doi.org/10.1007/s11920-015-0628-3>
2. Chrisler, J. C., & Caplan, P. (2002). The strange case of Dr. Jekyll and Ms. Hyde: how PMS became a cultural phenomenon and a psychiatric disorder. *Annual review of sex research*, 13, 274–306.
3. Ussher, J. M. (2003). The ongoing silencing of women in families: An analysis and rethinking of premenstrual syndrome and therapy. *Journal of Family Therapy*, 25(4), 388-405.
4. Ussher, J. M. (2008). Challenging the positioning of premenstrual change as PMS: The impact of a psychological intervention on women's self-policing. *Qualitative research in psychology*, 5(1), 33-44.
5. Tavis, C. (1993). The Mismeasure of Woman. *Feminism & Psychology*, 3(2), 149–168. <https://doi.org/10.1177/0959353593032002>
6. Doyle, S. (2016) Hillary Clinton and our long, sexist tradition of using women's bodies to disqualify them from power. Retrieved from <https://qz.com/783723/hillary-clinton-and-our-long-sexist-tradition-of-using-womens-bodies-to-disqualify-them-from-power/> on 28/09/20.
7. Shaw, C., & Proctor, G. (2005). I. Women at the margins: A critique of the diagnosis of borderline personality disorder. *Feminism & Psychology*, 15(4), 483-490.
8. Nicki, A. (2016). Borderline personality disorder, discrimination, and survivors of chronic childhood trauma. *IJFAB: International Journal of Feminist Approaches to Bioethics*, 9(1), 218-245.
9. Ussher, J. M. (2013). Diagnosing difficult women and pathologising femininity: Gender bias in psychiatric nosology. *Feminism & Psychology*, 23(1), 63-69.
10. Potter, N. N. (Ed.). (2009). *Mapping the edges and the in-between: A critical analysis of borderline personality disorder*. Oxford University Press.
11. Lester, R. J. (2013). Lessons from the borderline: Anthropology, psychiatry, and the risks of being human. *Feminism & Psychology*, 23(1), 70-77.
12. Epstein, M. (2006). The emperor's new clothes: On being invisible and neglected within the mental health system—a gendered perspective from a “borderline pioneer”. In Keynote address THEMHS conference.
13. DeArth-Pendley, Gina. (2012). *Racial Disparity and the Pathologizing of People of Color in Mental Health Diagnoses and Psychological Assessment*.
14. Johansen, E. B. (2020). *Therapists' Experiences Working with Women of Color with Borderline Personality Disorder* (Doctoral dissertation, Widener University).
15. Kaplan, M. (1983). A woman's view of DSM-III. *American Psychologist*, 38(7), 786.
16. Gould, C. S. (2011). Why the histrionic personality disorder should not be in the DSM: A new taxonomic and moral analysis. *IJFAB: International Journal of Feminist Approaches to Bioethics*, 4(1), 26-40.
17. Bornstein, R. F., Denckla, C. A., & Chung, W. J. (2015). Dependent and histrionic personality disorders.
18. Fuller, M. D., & Kenneth, A. (1986). Masochistic personality disorder: A diagnosis under consideration. *Jefferson Journal of Psychiatry*, 4(2), 4.

19. Cassels, B. W. (2018). *HPD: Examining the Histrionic Personality from the Intersection of Gender Politics, Masculinity, and the DSM*. Pacifica Graduate Institute.
20. Blashfield, R. K., Reynolds, S. M., & Stennett, B. (2012). The death of histrionic personality disorder. In T. A. Widiger (Ed.), *Oxford library of psychology. The Oxford handbook of personality disorders* (p. 603–627). Oxford University Press.
21. Bjorklund P. (2006). No man's land: gender bias and social constructivism in the diagnosis of borderline personality disorder. *Issues in mental health nursing*, 27(1), 3–23.  
<https://doi.org/10.1080/01612840500312753>
22. Jones, E., & Wessely, S. (2005). *Shell shock to PTSD: Military psychiatry from 1900 to the Gulf War*. Psychology Press.
23. Lazaroff, A. M. (2006, September). The role of the Diagnostic and Statistical Manual of Mental Disorders in the maintenance of the subjugation of women: Implications for the training of future mental health professionals. In *The Forum on Public Policy* (Vol. 1, pp. 1-32).
24. Luxton, D. D., Skopp, N. A., & Maguen, S. (2010). Gender differences in depression and PTSD symptoms following combat exposure. *Depression and anxiety*, 27(11), 1027-1033.
25. Simmons, C. A. (2007). Speculation as to why women “get” PTSD more often than men. *Women & Therapy*, 30(1-2), 85-98.
26. Pico-Alfonso, M. A. (2005). Psychological intimate partner violence: The major predictor of posttraumatic stress disorder in abused women. *Neuroscience & Biobehavioral Reviews*, 29(1), 181-193.
27. Hu, J., Feng, B., Zhu, Y., Wang, W., Xie, J., & Zheng, X. (2017). Gender differences in PTSD: susceptibility and resilience. In *Gender Differences in Different Contexts* (pp. 21-42). BoD–Books on Demand.
28. Matheson, K., Foster, M. D., Bombay, A., McQuaid, R. J., & Anisman, H. (2019). Traumatic Experiences, Perceived Discrimination, and Psychological Distress Among Members of Various Socially Marginalized Groups. *Frontiers in psychology*, 10, 416. <https://doi.org/10.3389/fpsyg.2019.00416>
29. Miller, G. H. (2009). Commentary: The trauma of insidious racism. *Journal of the American Academy of Psychiatry and the Law*, 37(1), 41.
30. Carter, R. T. (2007). Racism and Psychological and Emotional Injury: Recognizing and Assessing Race-Based Traumatic Stress. *The Counseling Psychologist*, 35(1), 13–105.  
<https://doi.org/10.1177/0011000006292033>
31. Berg, S. H. (2006). Everyday sexism and posttraumatic stress disorder in women: A correlational study. *Violence Against Women*, 12(10), 970-988.
32. Ford, J. D., & Courtois, C. A. (2014). Complex PTSD, affect dysregulation, and borderline personality disorder. *Borderline Personality Disorder and Emotion Dysregulation*, 1(1), 9.
33. Veysey, S. (2014). People with a borderline personality disorder diagnosis describe discriminatory experiences. *Kotuitui: New Zealand Journal of Social Sciences Online*, 9(1), 20-35.
34. Shimo, A., 2019. Are Sexual Abuse Victims Being Diagnosed With A Mental Disorder They Don't Have?. [online] the Guardian. Available at: <<https://www.theguardian.com/lifeandstyle/2019/mar/27/are-sexual-abuse-victims-being-diagnosed-with-a-mental-disorder-they-dont-have#:~:text=%E2%80%99CBPD%20is%20a%20label%20that,of%20suffering%2C%E2%80%9D%20Sarkisova%20says.>> [Accessed 4 October 2020].
35. Epstein, M. (2008). Let's face it! She's just too f\*\*\*\* d": The politics of borderline personality disorder. *Sisters Inside*.
36. Golier, J. A., Yehuda, R., Bierer, L. M., Mitropoulou, V., New, A. S., Schmeidler, J., ... & Siever, L. J. (2003). The relationship of borderline personality disorder to posttraumatic stress disorder and traumatic events. *American Journal of Psychiatry*, 160(11), 2018-2024.
37. Harned, M. S., Rizvi, S. L., & Linehan, M. M. (2010). Impact of co-occurring posttraumatic stress disorder on suicidal women with borderline personality disorder. *American Journal of Psychiatry*, 167(10), 1210-1217.
38. Schewecke, L. H. (2011). Beyond childhood sexual abuse: Ritual abuse-torture and human trafficking. *Journal of psychosocial nursing and mental health services*, 49(1), 8-10.
39. Hebert, J. L. (2004). Mental Health Records in Sexual Assault Cases: Striking a Balance to Ensure a Fair Trial for Victims and Defendants. *Tex L. Rev.*, 83, 1453.
40. Khalifeh, H., Moran, P., Borschmann, R., Dean, K., Hart, C., Hogg, J., . . . Howard, L. (2015). Domestic and sexual violence against patients with severe mental illness. *Psychological Medicine*, 45(4), 875-886. doi:10.1017/S0033291714001962

41. Engle, J., & O'Donohue, W. (2012). Pathways to false allegations of sexual assault. *Journal of Forensic Psychology Practice*, 12(2), 97-123.
42. Spohn, C., White, C., & Tellis, K. (2014). Unfounding sexual assault: Examining the decision to unfound and identifying false reports. *Law & Society Review*, 48(1), 161-192.
43. Warner, S., & Wilkins, T. (2004). Between subjugation and survival: Women, borderline personality disorder and high security mental hospitals. *Journal of contemporary psychotherapy*, 34(3), 265-278.
44. Bogod, E. (2002). Borderline Personality Disorder Label Creates Stigma. *Mental Health Matters On-line Journal*. Retrieved Dec, 12, 2006.
45. Sheehan, L., Nieweglowski, K., & Corrigan, P. (2016). The stigma of personality disorders. *Current Psychiatry Reports*, 18(1), 11.
46. Agenda, the alliance for women and girls at risk (2018). Women in Crisis: How women and girls are being failed by the Mental Health Act. Retrieved from: <https://weareagenda.org/wp-content/uploads/2018/08/Women-in-Crisis-Agenda-report-.pdf> on 04/10/20.
47. Little, J. (2015). "Frailty, thy name is woman": Depictions of Female Madness.