The triple f**k syndrome:

medicine and the systemic oppression of people born into poverty

A HARMFUL LABEL

The 'triple f**k disorder' describes a triple interlocking societal oppression where medicine holds the key for the final padlock. The first f**k occurs by exposing children to trauma caused by poverty; the second is created by blaming those children as they grow into adults for displaying behaviours caused by that trauma; and the final f**k is the pseudo-scientific medical construct of personality disorder (PD). This final f**k belongs to the cruellest of oppressions, as it robs the victim of both their core existential selves and the one factor that could allow them to resist oppression: the social perception of their sanity.

This article argues, first, that PD is a confused and confusing medical construct that has no demonstrable pathological disease basis; second, that the behaviours associated with both borderline and antisocial PDs (BPD and ASPD) may be caused not by internal dysfunction but just as plausibly by the effects of childhood adversity and poverty; and, third, that the diagnosis of PD is harmful to the health of those so labelled.

1. Personality disorder is a nebulous illness and arguably not a disease at all

*'Diseases exist when underlying natural pathological processes produce particular sets of symptoms.'*¹ These pathologies are identified pre-mortem using scans, microscopes, or laboratory evaluation of blood or other bodily fluids; or post-mortem on the mortuary slab. Many, if not most, psychiatric diagnoses are based on symptoms and have no identifiable pathology.

The diagnostic criteria for PD are nebulous. Aside from the uncommon

PD post-brain injury, there is no proven pathology associated with any PD variants. The diagnosis is often made without complaint of distress or malaise by the patient. The physician must identify a combination of vague, difficult-to-define, cognitive, and emotional social constructs (for example, markedly impoverished self-identity/deceitfulness/interpersonal hypersensitivity/manipulativeness/instability in goals, aspirations, values, or career plans/callousness) that depend on subjective evaluation and lack any element of objectivity required by a scientific-based discipline.

There are a total of 256 combinations of the criteria for diagnosing BPD, implying that two people can be diagnosed with BPD while sharing only one behavioural criteria.² The criteria for differing PD and other mental illnesses overlap to the extent that most of those with a diagnosis of PD

could also be diagnosed with an alternative PD or mental illness.³ Yet the diagnosis is made in between 5–13% of people in Western countries.³

2. The behavioural features of personality disorder are most strongly related to childhood trauma and poverty, and not internal aberration

Low socioeconomic status and child adversity are the two strongest associations with having a BPD/ASPD diagnosis. This is not surprising as the behaviours that are central to a BPD/ASPD 'diagnosis' are independently associated with coming from a background of poverty or childhood trauma (for example, childhood behavioural and emotional difficulties, criminal, violent, or addictive behaviours). There is a direct correlation between both socioeconomic status and number of adverse childhood events with the severity of PD symptoms/behaviours. Unsurprisingly, a reduction in social stressors leads to a diminution of the features of PD. As people coming from poverty are much more likely to have experienced childhood adversity than their affluent counterparts, in fact, it is difficult to disentangle these two factors.^{4,5}

Shifting the causation from socioeconomic status/childhood adversity to personal fallibility feeds an unjust blame attribution to the individual affected. At the very least this excuses society from any duty to help those who cannot be helped and labels people as 'faulty' rather than 'damaged'.

"The criteria for differing personality disorder (PD) and other mental illnesses overlap to the extent that most of those with a diagnosis of PD could also be diagnosed with an alternative PD or mental illness ... A perverse outcome of this labelling is that we deflect society's attention from the most likely causes for these behaviours, including the effects of trauma, sexism, and social inequity."

3. The diagnosis of PD is harmful to the health of those diagnosed

It has been argued that by framing behaviours, such as those found in PD, as mental illnesses, we reduce the stigma and open up therapeutic as opposed to punitive societal mechanisms for their management. By contrast, Lebowitz and Ahn argue: *'biological accounts of psychopathology can exacerbate perceptions of patients as abnormal, distinct from the rest of the population, meriting social exclusion, and even less than fully human.'*⁶

The diagnosis of PD results in a dehumanisation, in that patients become abnormal and non-deserving of the respect afforded to other humans. It is well recognised that PD is associated with social exclusion, higher unemployment rates, homelessness, crime, violence, and addiction. Patients diagnosed as having PD have been described as the most stigmatised in society.^{2,7}

The social stigma of PD is intensified within health services. Veysey elicited that those diagnosed with BPD were viewed as *'liars; attention-seeking; unreasonable/difficult; manipulative; a waste of time/hopeless [particularly as they did not/could not get better]; too hard to deal with, and were taking resources from other patients'*.² This stigma results in patients being excluded from health care or if they gain entry they obtain substandard clinical care.^{2,7} Patients who self-harm report not being taken seriously while doctors describe them as being manipulative. This is despite the high rates of eventual suicide (6–10%) in this population.²

A more sinister interpretation of the PD construct is that it represents the medically institutionalised oppression of marginalised people and of women. Feminist critics have described the label of BPD as misogynistic. Becker describes BPD as *'little more than shorthand for a difficult, angry female client'*.⁸

PD could also be added to the list of descriptors for 'Difficult Patient Hatred', including heartsink, manipulative, wilful, and attention-seeking patients.⁹ Koekkoek *et al* found that PD was mentioned four times more than any other diagnosis when doctors discussed difficult patients.⁹

It has been found that PD is much more common in surveys of patients attending medical services than in community surveys, ranging from 30% in general practice to 70% in psychiatric outpatient departments.³ It is possible that this higher prevalence is related to doctors' likelihood to label patients that they find difficult as

PD. Meeting doctors may be bad for one's health.

IN CONCLUSION

The perverse injustice that lies at the heart of the triple f**k argument is that, when we apply the term PD, it is as if we denigrate the person's core existential self. The person is converted from a complex interwoven matrix of thoughts, feelings, experiences, beliefs, and relationships into a medically dehumanised category that no person would like applied to themselves or their loved ones. This is the process of dehumanisation.² Rather than using the label 'social inequity disorder' or 'poverty disorder', we actually nail the responsibility for these behaviours right to the core personality.

Labels matter when they attribute or remove blame. A perverse outcome of this labelling is that we deflect society's attention from the most likely causes for these behaviours, including the effects of trauma, sexism, and social inequity.¹ As Kelly notes, *'focussing blame individually is a moral diversion from morally and causally relevant factors'*.¹⁰

What is the alternative? It is simple. First, we must recognise that childhood adversity and poverty have profound effects on adults' emotional and behavioural expression. I would additionally suggest we ditch the label 'personality disorder'. If we need a label to focus support and treatment, let us label the symptoms and their cause, for example, behavioural disturbance resulting from childhood trauma, emotional disturbance arising from childhood poverty, and so on.

Second, we must provide the affected people with whatever supports we have (social, therapeutic, or medical), to enable them to live healthier and more fulfilling lives. Finally, we must seek to reduce the risk of children having to experience poverty or adversity, thus increasing their chances of having a happy and healthy life. This is the triple action plan.

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