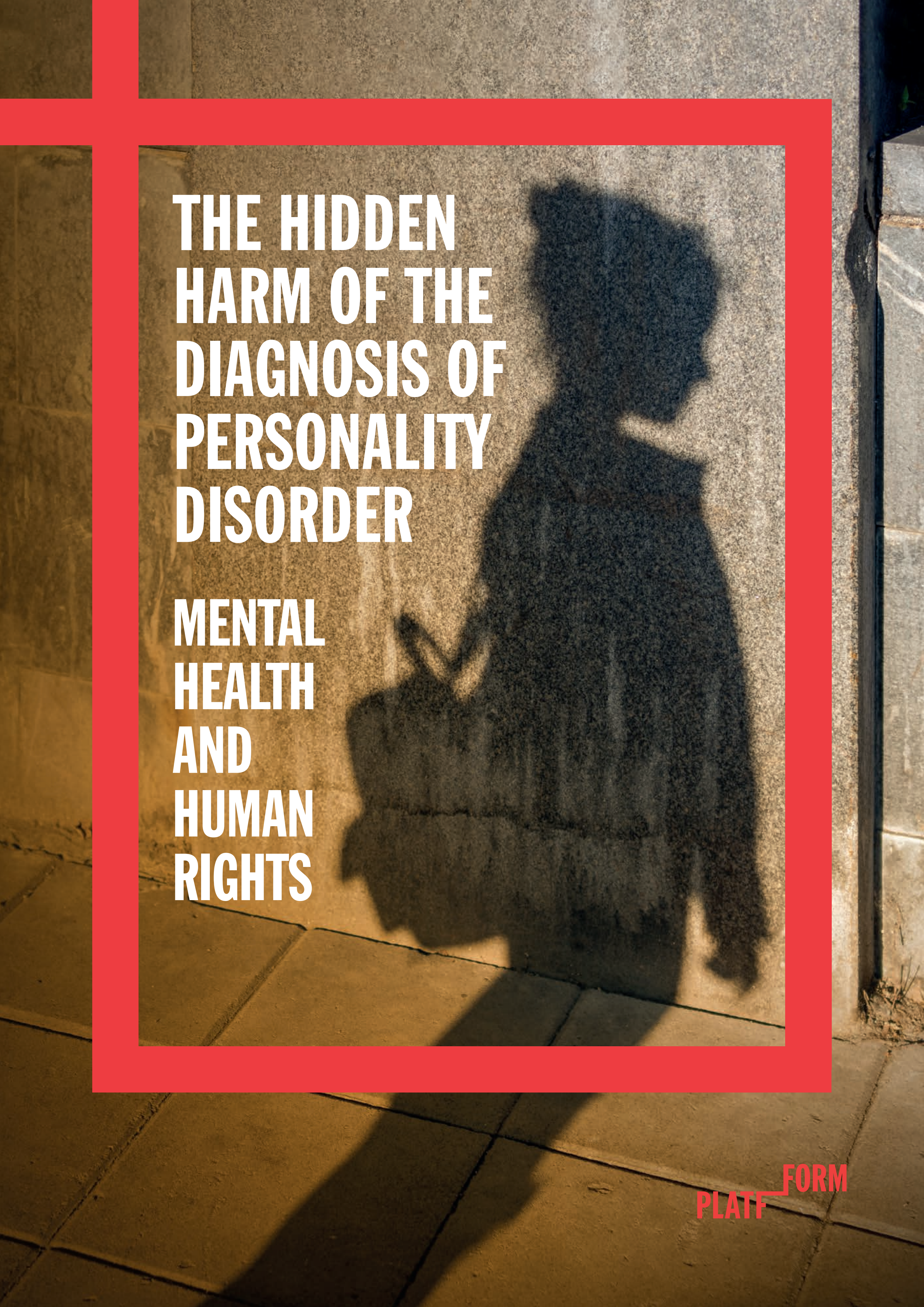

THE HIDDEN HARM OF THE DIAGNOSIS OF PERSONALITY DISORDER

MENTAL HEALTH AND HUMAN RIGHTS

PLATFORM

Images used throughout are of stock models. Quotes are from actual research participants.

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ABOUT PLATFFORM

Platfform is the charity for mental health and social justice, working with people and communities to increase belonging, meaning and wellbeing.

We have run mental health and community services for 35 years, and we have a portfolio of over 140 projects across the UK. In 2025 we supported over 16,500 people, including nearly 5,000 children and families.

Our projects and experience span mental health crisis services, supported housing and homelessness outreach, schools and youth services, employment and volunteering, talking therapies, community projects and workplace wellbeing.

FOREWORD

This report shines a necessary light on the diagnosis of 'personality disorder'. As the findings make starkly clear, this label often serves not as a gateway to support, but as a barrier to compassion.

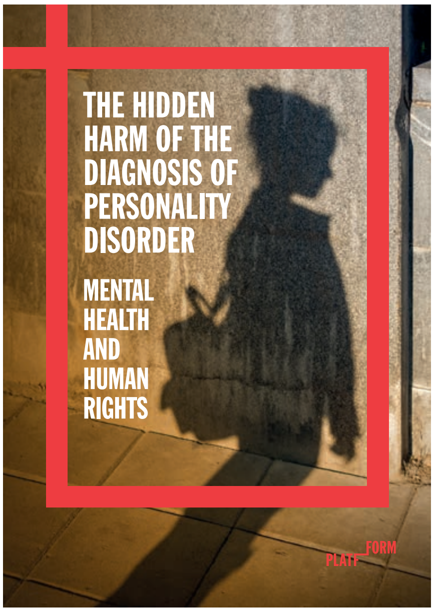
My own research (based on my own and others' experiences) into enforced isolation and objectification has shown me how these practices create unbelonging and destroy a person, and the stories collected here confirm that the PD diagnosis functions as a tool of that objectification.

As the Manager of the Restraint Reduction Network, I view this through a lens of human rights. We know that the diagnosis of personality disorder is frequently a precursor to the most restrictive and traumatic interventions in our psychiatric system. The belief that a person is 'disordered' rather than 'distressed' provides the ethical permission structure for staff to use restraint, seclusion, and forced medication. Instead of asking 'What happened to you?'... the system responds, 'there is something wrong with you!'... and then ostracises the core of your being, stating 'your personality is disordered'.

WHAT PLATFFORM HAS ACHIEVED WITH THIS REPORT IS AN ACT OF RECLAMATION.

By centring the 'Truth Project', they return the narrative power to where it belongs - the people who have lived the experience. The findings challenge the validity of the PD construct, exposing it as scientifically shaky and socially damaging.

But more importantly, the findings highlight the human cost. We are talking about lives interrupted, trust shattered and the compounding of trauma by the very institutions commissioned to heal.



I know intimately the fight to survive the system, and the perverse reality of needing to escape healthcare to find health; see my book *Unbroken* – (Quinn, 2018) and the podcast, *Patient 11*.

It should not be necessary to flee 'care' to find safety. The recommendations in this report point us toward a future where that is no longer the case - a future that moves away from pathologising distress and toward a rights-based, trauma-informed approach that honours the social determinants of health.

To the thirty individuals who shared their stories for this report: I hear you. I see you. Your refusal to remain silent is the catalyst for the change we so desperately need. This report is not just a collection of data; it is a testament to survival and a demand for a system that stops labelling people as having disordered personalities, and starts witnessing human beings.

Alexis Quinn

Survivor, psychotherapist, author and manager of the Restraint Reduction Network

OVERVIEW AND SUMMARY

Mental health and human rights: The diagnosis of personality disorder

For over 35 years, across our projects and services, we have listened to people's experiences of the mental health system. Time and time again, we've heard experiences where the mental health system causes people more harm than help, and stories of people's human rights not being upheld.

This is why we have made it an organisational mission to advocate for, and apply to our own services and influencing work, a holistic and social justice approach to mental health.

In this report we focus on the stories of the diagnosis of personality disorder.

Our findings

1 Health is compromised

Receiving the diagnosis of personality disorder had significant implication for the quality of care people received, and increased people's chances of being excluded from lifesaving care and support. In the mental health system, it is women that are predominantly impacted by the diagnosis as they account for 75% of the people that get given it.

2 Trauma experiences are ignored

Despite the strong emphasis on trauma-informed care from Welsh Government, participants' accounts revealed a widespread failure to acknowledge, assess, or understand individual trauma histories as part of routine clinical practice. When experiences were shared, they were often belittled or ignored.

3 The diagnosis of personality disorder can challenge human rights

Our findings give cause for concern that this diagnosis goes against international human rights law, the Convention on the Rights of Persons with Disabilities (CRPD) and the Welsh Government guidance on reducing restrictive practices. In doing so, the diagnosis discriminates against a person's rights to free and informed consent, privacy, liberty and security, personal integrity, and access to justice.

What can be done?

1. Ensure people have access to their human rights whilst in contact with mental health services.

2. Place the Reducing Restrictive Practices Framework on a statutory footing applicable across all public sectors.

3. Ensure the 2025 - 2035 Women's Health Plan for Wales gives equal consideration to women's mental health and their voice.

4. Ensure trauma is routinely asked about and that there are appropriate services available to support people.

5. Ensure people's right to an independent second medical opinion is upheld.

6. Ensure staff have the right conditions to work in a values-based way that supports their own wellbeing as well.

Building a campaign

We believe this is the start of the conversation around our mental health system. We'd love to continue the conversation with organisations and people with lived experience as to how the system has affected them and the impact of it on their lives.

SHAME DIES WHEN STORIES ARE TOLD, AND SO WE BELIEVE NOW IS THE TIME FOR MORE STORIES AROUND THIS DIAGNOSIS TO BE GIVEN LIGHT.

DEDICATION AND ACKNOWLEDGEMENTS

It is with a heavy heart we dedicate this report to Jennie Devereese, who is no longer with us. She was a catalyst for this project's creation and was a crucial part of the initial set up.

Without Jennie's bravery, commitment, and sense of justice, and her ability to articulate these things so well, this project would not have become what it is. We wish to bear witness to her loss, and that of the many others who have died by suicide while their experiences went unheard, their words went unbelieved and their needs went unmet.

We would like to extend our gratitude and thanks to everyone who has told their story, expressed an interest and been involved with us through this campaign.

It was and is our intention to create space for people to feel seen and heard. We would like to give a particular mention to our steering group.

We recognise that sharing your story is not an easy task. It requires vulnerability and bravery. We are honoured to have been able to meet so many articulate and compassionate people as part of this project.

INTRODUCTION

The Truth Project developed from hearing stories of harm caused through the diagnosis of personality disorder. At Platfform we are committed to challenging systems and language that contribute to that harm. We see in our work the powerful healing effect of being seen, heard, and treated with dignity and respect.

As we spoke to more people, we learnt that for many, being given a diagnosis is not always a step toward help or healing, but is instead the beginning of isolation, exclusion, and deepening distress. We hope this research offers a platform to amplify and validate those experiences.

What is a ‘personality disorder’?

According to the American Psychiatric Association, and as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM), ‘personality disorders’ are a class of mental health conditions characterised by enduring “maladaptive patterns” of behaviour, cognition, and inner experience, exhibited across many contexts and deviating from those that are culturally accepted.[1]

How this diagnosis is categorised changed in the ICD-11 2022 review, moving to a severity system: ‘personality difficulty’, ‘mild personality disorder’, ‘moderate personality disorder’ and ‘severe personality disorder’. The stories shared with us talked about either ‘borderline personality disorder’, ‘emotionally unstable personality disorder’ or ‘personality disorder’ generally. As such we have chosen to use the broader term ‘personality disorder’ throughout this report. The stories we captured all spoke to its use within the context of the NHS mental health system.

Why are the term and description problematic?

Research has consistently shown that clinicians treat patients who are given a diagnosis of personality disorder as more difficult and less deserving of care.[2] Women make up most of the people given this diagnosis at a rate of 3:1, but there is no pathological or clinical explanation for this.

While it isn’t everyone’s experience, research shows that over 80% of people diagnosed with personality disorder have experienced abuse or neglect.[3] Despite this, services do not routinely enquire about trauma or consider other explanations, for example neurodevelopmental differences, in their assessments before labelling someone with a diagnosis of personality disorder.[4,5] Often an assessment isn’t even formally carried out.

This leads to diagnostic overshadowing of trauma and neurodevelopmental difference.[6] People experiencing the effects of abuse, neglect, and violence are often told their reactions and responses are ‘symptoms’ of a personality disorder. Denial of this experience can retraumatise those seeking help and have lasting consequences, sometimes leading to loss of life.

THIS PRACTICE HIDES AN EPIDEMIC OF ABUSE AND HINDERS PATIENTS’ ACCESS TO APPROPRIATE AND LIFE-SAVING CARE.

It also gets used by courts to determine outcomes of domestic and sexual violence cases, with often detrimental effects.

At the same time the utility, validity and reliability of the diagnosis have been questioned by clinicians and researchers[7]. There are no identifiable causes associated with this disorder. There are no biomarkers or other biomedical tests that can be used to diagnose the disorder[8]. It is simply a descriptive category, and while some people find it helpful, others do not.

Mental health and human rights

Mental health is a basic human right for all people, and a human rights approach to mental health emphasises this.Everyone has the right to the highest attainable standard of mental health, regardless of their background, and governments, health services, and institutions are legally bound to uphold these rights under frameworks like the Human Rights Act.

A human rights approach calls for mental health systems to be inclusive and community-based, and for rights to be respected. This means moving away from coercive, restrictive and punitive approaches and practices. The recent WHO and UN *Mental Health, Human Rights and Legislation: Guidance and Practice* report calls for an urgent shift in approach and provides a template and key information on how to adopt a non-coercive and human rights informed approach.[9]

> **PEOPLE SEEKING MENTAL HEALTH SUPPORT MUST BE TREATED FAIRLY, WITHOUT STIGMA OR DISCRIMINATION, AND BE INCLUDED IN DECISIONS ABOUT THEIR OWN CARE. PRACTICES SUCH AS FORCED TREATMENT, INSTITUTIONALISATION, OR NEGLECT ARE HUMAN RIGHTS ABUSES, AND SHOULD NOT HAPPEN.**

People seeking mental health support must be treated fairly, without stigma or discrimination, and be included in decisions about their own care. Practices such as forced treatment, institutionalisation, or neglect are human rights abuses, and should not happen.

The international human rights framework, particularly the Convention on the Rights of Persons with Disabilities (CRPD), calls for a significant shift away from biomedical approaches, and towards a support paradigm that promotes personhood, autonomy and community inclusion. The UN International Covenant on Economic, Social and Cultural Rights (ICESCR) also includes the right to health. The ICESCR is a key international treaty that commits its parties to work towards granting economic, social, and cultural rights to all individuals, including rights to health, education, and an adequate standard of living.

Over the past 150 years, legislation on mental health has legitimised, and in some instances facilitated, human rights violations., Early laws consolidated paternalism and the concept that people with mental health conditions are ‘dangerous’ and must be controlled in their acts. The echoes of this are still seen in the stories present in this report.

The biomedical model(which focuses predominantly on diagnosis, medication and symptom reduction) overshadows the role that social determinants play in people’s mental health. Rather than focusing on social change, diversity and inclusion, the biomedical model implies that it is persons with a mental health condition or psychosocial disability themselves that need to change. . This has led to disempowerment, discrimination and institutionalisation.

The widespread human rights violations and harm caused by the mental health system have led to a legacy of trauma that impacts many individuals and communities, spanning generations.

What are coercive and restrictive practice?

Coercive practice refers to actions that compel individuals to act involuntarily through threat or force. It is often associated with coercive control, a pattern of behaviour that intends to minimise a victim’s freedom and violates their rights.

Restrictive practice can be more subtle and informal. It is often less visible and covert. Restrictive practice does not necessarily require the use of force; it can also include acts of interference, for example moving someone’s walking frame out of reach or turning someone’s wheelchair battery off. Any act of restrictive practice has a potential to interfere with a person’s fundamental human rights.

Both terms relate to acts of physical restraint, chemical restraint, mechanical restraint, seclusion, social restraint, psychological restraint, and long-term segregation.

The difference between coercive and restrictive practices is largely related to the level of control exerted over an individual. Coercive practices involve formal measures such as seclusion, restraint, and involuntary treatment, which are supposed to be regulated and monitored in healthcare settings. These practices aim to influence a person's behaviour and limit their movement.

In September 2022 the National Institute for Health and Care Excellence (NICE) published an update to its guideline on '"Self harm: assessment, management and preventing recurrence". It outlined that discriminatory and unevidenced beliefs regarding people with "complex mental illnesses" and "high intensity needs" must be challenged. Examples of practices that it says need to end include:

- Labelling of patients by professionals as 'manipulative' and 'attention seeking'.
- Telling patients that they have capacity to take their own life.

Furthermore, it states:

> "Do not use aversive treatment, punitive approaches or criminal justice approaches such as community protection notices, criminal behaviour orders or prosecution for high service use as an intervention for frequent self-harm episodes."

NICE states that these amount to malpractice.

Examples of restrictive and/or harmful practice they highlighted include:

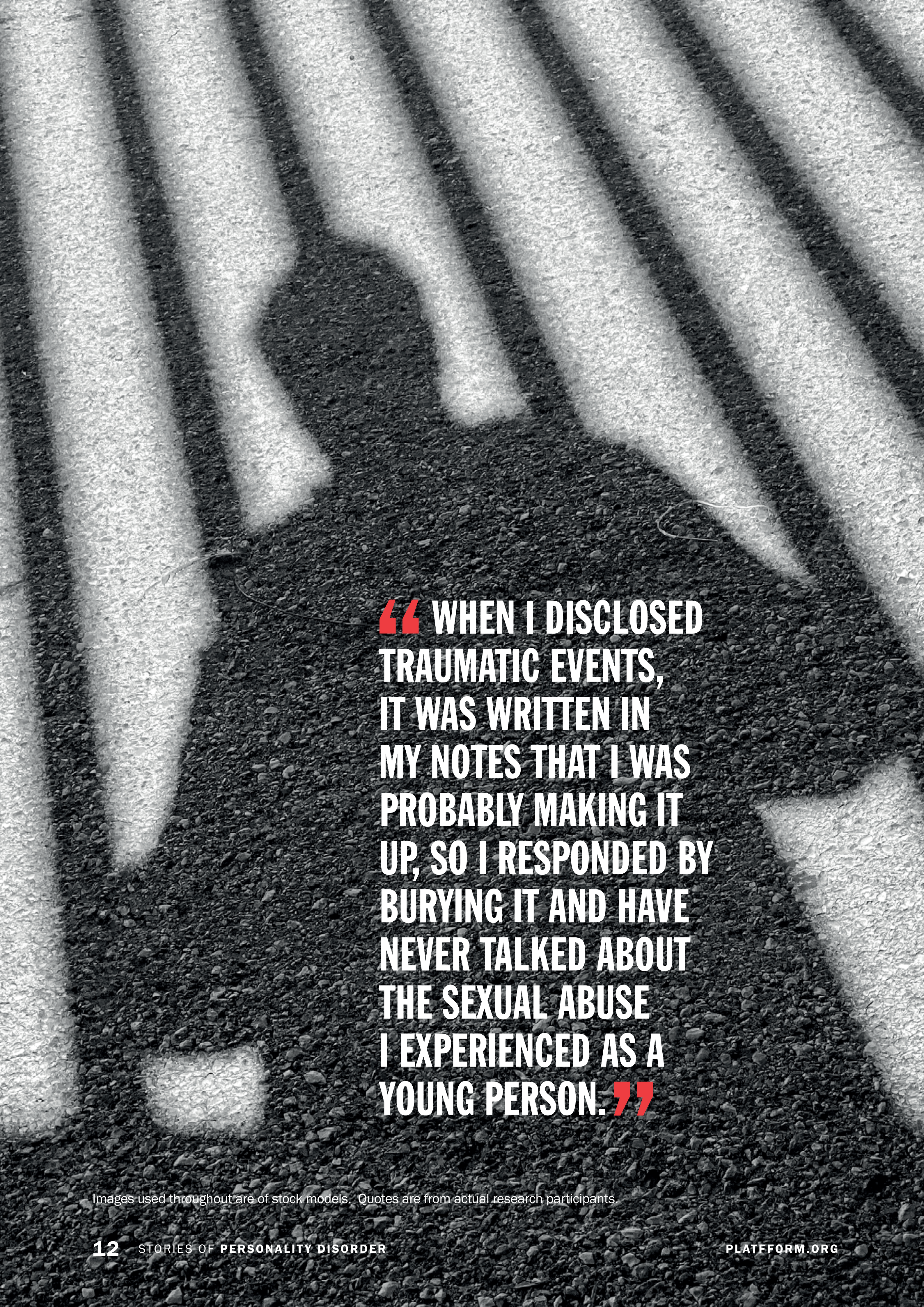
- Behavioural contracts or similar: making patients sign contracts about how they will behave (for example with threat of removing access to services if they do not comply)
- Threat of withholding or withdrawing services as a deterrent, or more broadly to elicit desired behaviour
- Anticipatory care plans which instruct mental health staff or other agencies not to see a patient during psychiatric or medical emergencies
- Criminal sanctions (for example, community protection orders, behaviour orders, bail conditions, arrests, charges, cautions, prosecutions or imprisonment) applied in response to people presenting to health services, or deemed to be doing so, regularly.

Why does it matter?

Abusive practice worsens mental health: Violations such as discrimination, coercion, or neglect can deepen existing conditions or create new ones.

Rights-based care improves recovery: Respecting autonomy and dignity fosters trust, empowerment, and better health outcomes.

A need for an evolution in approach: Both the UN and WHO emphasise the need to shift from a biomedical model to a rights-based approach that prioritises inclusion and equality.



> “WHEN I DISCLOSED TRAUMATIC EVENTS, IT WAS WRITTEN IN MY NOTES THAT I WAS PROBABLY MAKING IT UP, SO I RESPONDED BY BURYING IT AND HAVE NEVER TALKED ABOUT THE SEXUAL ABUSE I EXPERIENCED AS A YOUNG PERSON.”

Images used throughout are of stock models. Quotes are from actual research participants.

WHAT WE DID AND WHAT WE FOUND

To understand people's experience across Wales and the wider UK today, we collected stories of this diagnosis from people who have received it, family members and professionals.

We collected 30 stories which we then analysed. Below are the key findings from that research, and you can find the full stories at platfform.org/truthproject.

From the thematic analysis three key themes emerged from the stories which we have summarised below.

Health is compromised

The research we conducted found that rather than offering safety, healing, or support, mental health services were frequently described by participants as spaces that caused further harm, amplified trauma, intensified distress, and reinforced feelings of helplessness.

Participants' experiences suggest that services as currently structured not only fail to support recovery, but actively contribute to cycles of fear, mistrust, and suffering. A profound sense of mistrust emerged across participant narratives, often rooted in past experiences of being dismissed, misjudged, or harmed by professionals.

For many, this mistrust became a barrier to seeking help, leading to disengagement from services altogether. Participants reported being routinely labelled as manipulative, dramatic, or attention-seeking, particularly when expressing distress or suicidal ideation.

This labelling had a profound impact on trust. Many participants internalised these messages, felt punished for being vulnerable, or worse, were made to feel as though they were the problem, highlighting the impossibility of meeting the system's contradictory expectations.

To promote a sense of agency and safety we did not ask participants to provide demographic details. We are therefore unable to identify the sex or gender of those that took part. However, from the broader literature it is clearly documented that women make up approximately 75% of the people given a diagnosis of personality disorder in NHS mental health settings.[7]

Previous research has also found that gay and bisexual men are also more likely than heterosexual men to be given this diagnosis.[10] The connection between misogyny and homophobia is a complex and multifaceted issue. Research indicates that these two concepts are deeply intertwined.[11]

At the same time, there is another story paying out in the prison system where the prevalence of personality disorder in criminal justice settings is thought to be very high, with 60% to 70% of people in prison.[12]. Men make up 96% of the prison population.[13]

Receiving the diagnosis of personality disorder had significant implication for the quality-of-care people receive and increases people's chances of being excluded from lifesaving care and support. In the mental health system, it is women that are predominantly impacted by the diagnosis as they account for 75% of the people that receive it.

> **"I am met with remarks that I am selfish, dramatic, a liar, a drain on the system and not worth medical treatment. They twist my intelligence into being manipulative, my anger as inappropriate, and my distress becomes attention-seeking."**

> “He told me I was turned away for a reason and said “you don’t really want to die, you just want to make a statement”. He said this is a cry for help and was not anything serious”

> “There is a very narrow margin in which someone can be just the right amount of trusting... to fall slightly too far either end would make you ‘disordered’”

Systemic harm and denial

Systemic harm and professional denial contributed further to participants’ sense of marginalisation. Participants were keenly aware of the structural problems within mental health services, from chronic underfunding to toxic workplace cultures. Some acknowledged that individual staff might be overwhelmed or trapped in a broken system. However, there was also frustration with professionals’ unwillingness to acknowledge the harm being caused.

Another common experience was being labelled as “too complex” or “difficult”, which many participants interpreted as code for ‘beyond help.’ This language was often used to justify limited or withdrawn care. The label not only excluded participants from care but also invalidated their lived experiences, reducing multifaceted trauma to simplistic diagnoses or behavioural judgments. The feeling of being misunderstood or misrepresented compounded the original distress, leading many to feel abandoned by the system entirely.

Several participants described treatment itself as re-traumatising, especially when it was rigidly applied, punitive, or dismissive of their individual needs. DBT (Dialectical Behaviour Therapy) was the most frequently referenced intervention in relation to this. While some acknowledged its potential, many described it as ineffective, shaming, or even harmful.

Many participants described the diagnosis as a turning point in how they were perceived, often for the worse. This captures the multiple ways in which the diagnosis shaped how participants were treated by services, how they saw themselves, and how they were perceived by others. Rather than opening appropriate support, the diagnosis became a barrier, obscuring trauma, silencing distress, and reinforcing assumptions of being ‘difficult’ or manipulative. Some reported being denied treatment, excluded from services, or treated as undeserving of help simply because of the diagnosis.

Several people felt their diagnosis was based less on clinical assessment and more on stereotypes. The diagnosis, in many cases, legitimised a culture of blame and dismissal, allowing professionals and systems to discredit and devalue those labelled with it.

> “I believe some of these issues stem from the NHS/social care services being underfunded and staff being overworked, leaving little energy to consider the underlying causes of behaviours they observe.”

> “Services do not want to acknowledge that they could possibly be part of the issue, or that there is a toxic culture at the root of it.”

> “I was eventually given a year of DBT therapy which I experienced as victim blaming and gaslighting. I was informed that I could use a telephone service for support but that it would be cut off for 72 hours if I self-harmed – needless to say, I never called.”

Stigma

Many participants described the profound impact of stigma on their self-image, with significant feelings of shame. The diagnosis became something they internalised: a symbol of being broken, flawed, or unworthy.

The identity imposed by the diagnosis affected not just how people were treated, but how they came to view themselves, contributing to further mental distress.

There was a strong sense of distress towards the system, with people experiencing betrayal, abandonment and a feeling of being trapped. When they expressed anger or confusion, it was used against them, reinforcing the very stereotypes that led to the diagnosis in the first place.

A major outcome of the diagnosis was withdrawal and disengagement from services due to a loss of safety and trust. Participants reported disengaging from care not because they didn't want support, but because the trust wasn't there, and because care became a source of further distress.

Participants described the diagnosis itself, and how they were treated because of it, as directly contributing to worsening mental health, increased risk and suicidality, and trauma. The lack of compassion, dismissal of distress, and punitive treatment responses left many without safe, validating systems to turn to. Over time, participants were placed in progressively more dangerous and unsupported positions, where the very act of seeking help often intensified feelings of hopelessness, shame, and abandonment.

Rather than being understood as individuals in pain, participants were seen through the lens of risk and manipulation, leading to denial of care in moments of crisis.

This makes visible how suicidality was not simply a clinical symptom but a consequence of systemic harm. When support was denied and needs were invalidated, people were left more isolated and unsafe, with the diagnosis itself becoming a barrier to survival rather than a pathway to help.

> **"My physical health and my child's physical health were put at risk because people couldn't see past a label I'd been given."**

> **"I was treated so poorly by all medical staff who saw it on my notes and the contrast to how I am treated now with different words next to my name is shocking and shows the level of stigma and blame and disdain and overt lack of compassion for, particularly young distressed women, who may be perceived as difficult people."**

> **"Partially in a desire to find an end to the torture and pain, but equally under the pressure from all, including the mental health team, I began to doubt my own reality and truth."**

Context and past history are ignored

A predominant theme across people's narratives was the critical importance of recognising and understanding their trauma histories. Many participants disclosed significant histories of trauma, coercive control, and systemic injustices that were frequently overlooked, minimised, ignored or misunderstood within their diagnostic and treatment journeys.

Participants expressed that their trauma was often overshadowed by the diagnosis of personality disorder, which subsequently shaped the care and interventions they received. Importantly, participants highlighted that trauma disclosures were sometimes met with disbelief or dismissal.

Beyond trauma histories, participants pointed to the neglect of broader contextual factors influencing their responses, behaviours and life circumstances such as chronic illness, disability, brain injury, and significant personal losses were frequently ignored by services. This failure to consider contextual realities limits the quality ofcare people receive.

A further complexity raised by participants involved crossover with other diagnoses, such as the diagnosis of autism, diagnosis of ADHD, diagnosis of bipolar and diagnosis of complex PTSD, which were often undetected or misattributed under the personality disorder label.

Overall, these narratives highlight that understanding trauma and the wider contextual factors are essential to avoiding restrictive practices that can arise from an over-reliance on personality disorder diagnoses. A lack of trauma acknowledgment and contextual sensitivity perpetuates restrictive care environments, contributing to ongoing distress and marginalisation for those affected.

> “I was feeling everything that comes from experiencing rape, assault, coercive control, unjust treatment by mental health services, family court, social services, the justice system, the church, and the continuation of this treatment”.

> “When I disclosed traumatic events, it was written in my notes that I was probably making it up, so I responded by burying it and have never talked about the sexual abuse I experienced as a young person.”

> “I survived a Traumatic Brain Injury 43 years ago… this affected my mental health, but community mental health teams have no experience or knowledge of the challenges and complications faced following an Acquired Brain Injury”

The diagnosis of personality disorder can challenge human rights

Participants’ stories revealed a consistent and distressing sense of powerlessness in their interactions with mental health services, particularly following a personality disorder diagnosis.

This power imbalance manifested in various ways. The denial of second opinions, the invalidation of participants’ perspectives, and the persistent positioning of professionals as knowing best, even in the face of participants’ own knowledge about their trauma and mental health were all key themes. Many described this dynamic as silencing, disempowering, and in direct conflict with person-centred care principles.

Rather than being engaged as partners in their care, many participants described having to actively fight against a diagnosis they believed to be inaccurate or harmful. These accounts highlight how the label of personality disorder can function as a barrier to dialogue and validation, reinforcing the idea that the system is closed to feedback and resistant to challenge.

Participants spoke of a deep loss of agency, where professionals’ authority was prioritised over their own lived experiences, feeling as if “the system knows best”. Many described a dynamic in which professionals made assumptions, defined their needs, and prescribed treatment without listening or collaboration.

This imbalance was experienced as frustrating. Participants’ knowledge and insights were systematically dismissed.

> “I told the psychiatrist I was not mentally ill but terrified and needed help. I begged him to believe me. It was immediately assumed that my denial was evidence of mental illness.”

> “The more I tried to tell people I was not mentally ill or lying, the more it was treated as ‘evidence’ of how ill I was and that it was clear evidence I was a liar.”

> “The change in the police’s attitude toward me after they spoke with the mental health team was stark. They treated me like dirt and massively abused their position of power.”

Poor communication and lack of informed consent

There was also a profound lack of communication and involvement in decisions related to diagnosis and care planning. Participants reported that diagnosis was often made and recorded without their knowledge or consent, and that they were excluded from both the assessment process and subsequent decisions about their treatment. This exclusion represents a clear form of restrictive practice, limiting autonomy and undermining trust in services. The right to free and informed consent is a fundamental element of the right to health.

Many participants only became aware of their diagnosis incidentally, often years later, when reading their medical notes or during unrelated interactions with health professionals. For some, this revelation was deeply distressing and led to a loss of trust.

This lack of transparency and denial of access to one’s own mental health information significantly restricted participants’ ability to understand, question, or influence their own care. Participants also described a lack of clarity or consistency around the diagnostic process itself. Many stated they were not formally assessed, nor given information about what criteria were used or how conclusions were reached.

Such experiences contributed to widespread confusion and uncertainty, often leaving participants feeling that the diagnosis was based on subjective interpretation rather than clinical rigour or collaboration. Even when assessments did occur, participants reported significant barriers to participating fully. Shame, fear, and mistrust, often linked to previous experiences of trauma, made disclosure difficult.

Several described seeking second opinions, only to be denied or dismissed without consultation.

> “My doctor read out my notes and the diagnosis of ‘EUPD’ was there. I had continually asked verbally and in writing as to whether I had this diagnosis from the age of 16. I’d apparently been diagnosed when I was 17.”

> “Years later… I found that this doctor, having only seen me once, and not having asked any questions related to my behaviour, had signed a document ‘diagnosing’ me with emotionally unstable personality disorder. I was not informed of this diagnosis.”

> “I didn’t have an assessment for EUPD. I wasn’t asked a series of questions or asked to fill out a form or test, nor did I have the opportunity to have a meaningful conversation with the psychiatrist about my difficulties.”

Diagnosis as a restrictive practice

These testimonies suggest that the diagnosis of personality disorder itself may be understood as a form of restrictive practice. The stories and accounts highlight how psychiatric labels can also function restrictively, limiting access to care, constraining autonomy, and causing long-term psychological harm.

There were lasting personal, clinical, and systemic impacts of receiving a personality disorder diagnosis. While diagnoses are often intended to guide care and improve outcomes, the testimonies here illustrate how the label of personality disorder became a source of harm, shaping not just care pathways, but relationships, self-esteem, access to treatment, and even survival.

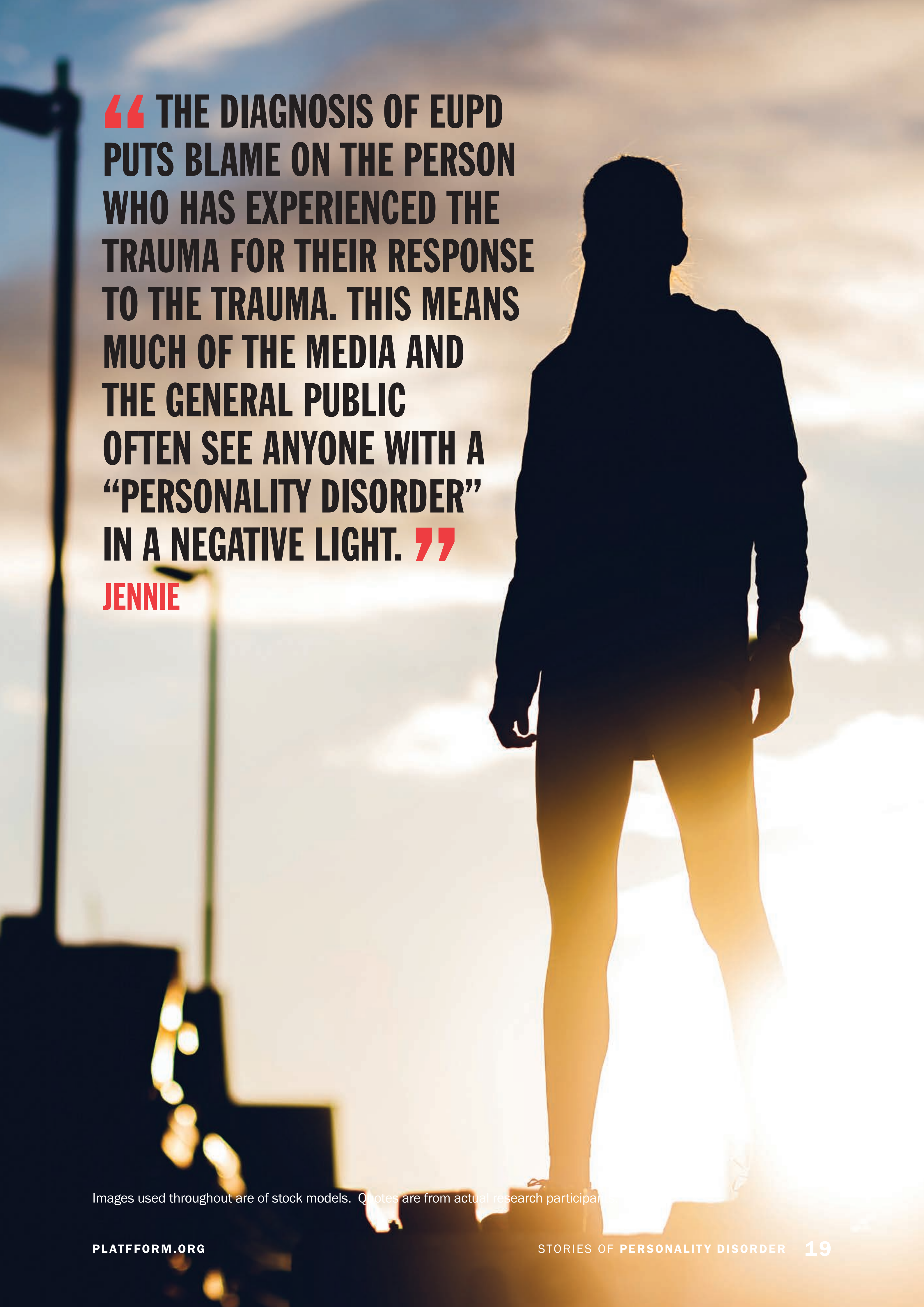
The personality disorder label was experienced as a long-term burden with life-limiting consequences, and with damaging impacts on employment, identity, self-worth, and life chances. Some described the diagnosis as permanently limiting, creating a future shaped by exclusion and stigma, rather than healing or growth.

For some, having the diagnosis removed or challenged brought access to new forms of support and a sense of hope. However, even when removed, the legacy of the label remained embedded in participants’ records, experiences, and sense of self.

> “I found the diagnosis and treatment more traumatic than the rape or family deaths. I still have flashbacks of “treatment” and get panic attacks if I’m in any sort of clinical room that looks like the ward I was on.”

> “When I asked for a review of my diagnosis, the psychiatrist responded with what he thought was the diagnosis... He then told me not to challenge the situation ‘as it could get worse’ for me.”

> “When I made a formal complaint I met with the head of the team who explained that informed by DBT, the team do not talk to people who are expressing an active wish to kill themselves.”



> **“ THE DIAGNOSIS OF EUPD PUTS BLAME ON THE PERSON WHO HAS EXPERIENCED THE TRAUMA FOR THEIR RESPONSE TO THE TRAUMA. THIS MEANS MUCH OF THE MEDIA AND THE GENERAL PUBLIC OFTEN SEE ANYONE WITH A “PERSONALITY DISORDER” IN A NEGATIVE LIGHT. ”**
>
> **JENNIE**

Images used throughout are of stock models. Quotes are from actual research participants.

WHAT DO WE NEED TO DO NEXT?

Mental health, human rights and legislation are inextricably linked. We see this research and its outcomes as a vital piece in helping us move towards better standards of care and in supporting us to taking a holistic and human rights approach to mental health.

To deliver the Welsh Government's aspiration for mental health transformation we will need to unhook ourselves from outdated and oppressive practices and legislation. This will be vital in the ambition of becoming a trauma-informed society.

We want to explore how practitioners and people who use mental health services can work together towards a solution.

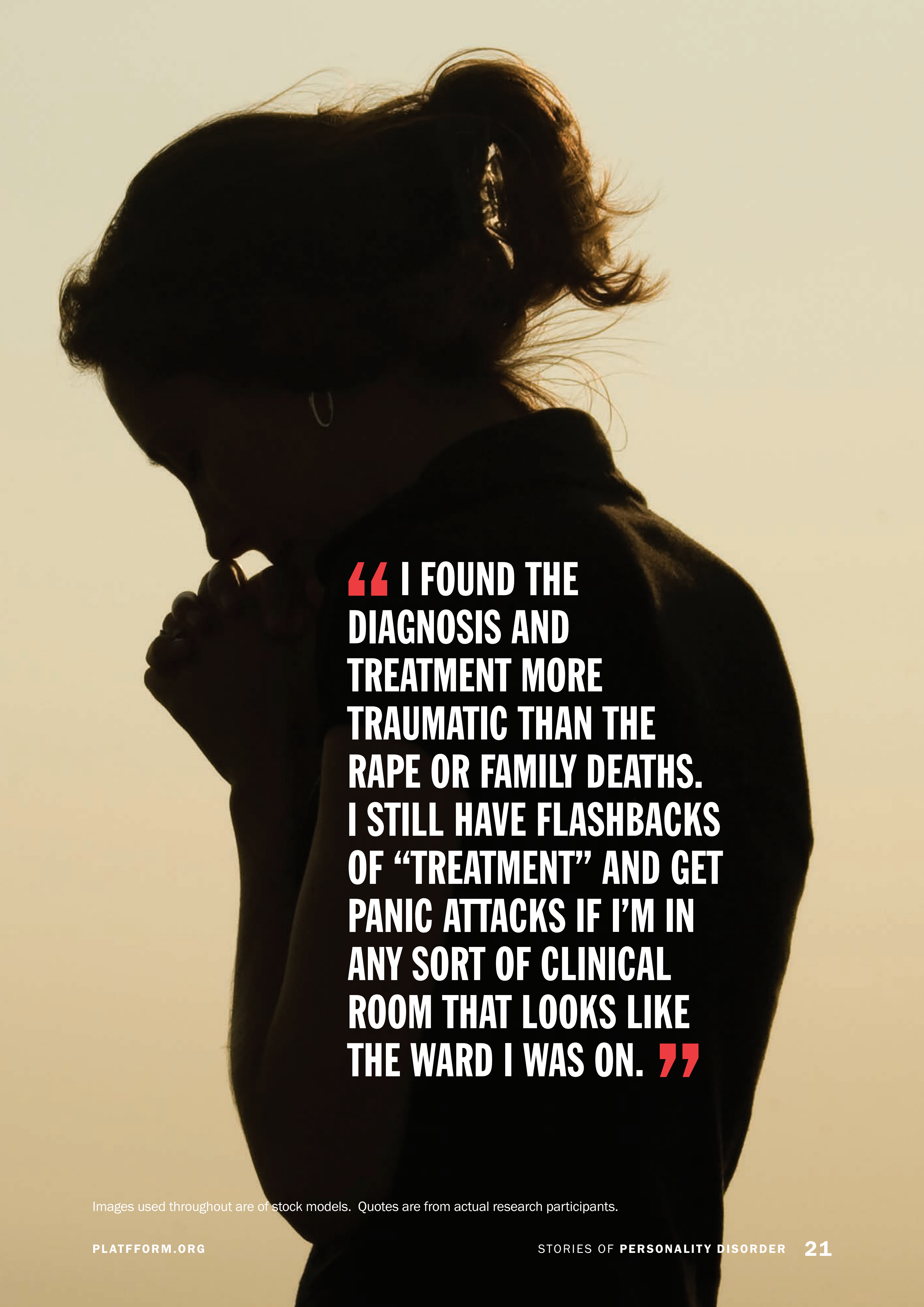
As a starting point, we can draw the following from the experiences we have heard and the research we have undertaken:

- **Ensure that people's human rights are respected whilst in contact with mental health services.**
- **Place the Reducing Restrictive Practices Framework on a statutory footing applicable across all public sectors.**
- **Ensure the women's health plan gives equal consideration to women's mental health and voice.**
- **Ensure trauma is routinely asked about and that there are appropriate services available to support people.**
- **Ensure people's right to an independent second medical opinion is upheld.**
- **Ensure staff have the right conditions to work in a values-based way that supports their wellbeing as well.**

> “WE KNOW CHANGE WILL TAKE TIME, EFFORT AND COLLECTIVE ACTION. WE WANT TO MAKE SPACE TO REFLECT ON NEXT STEPS AND HEAR FROM THE PEOPLE IMPACTED BY THIS DIAGNOSIS, AND FROM OTHER PARTNERS, TO IDENTIFY WHAT NEEDS TO BE DONE NEXT.”

If you'd like to get involved in these conversations or help us campaign on these issues, please contact us at: campaigns@platfform.org

If you want support with having the diagnosis of personality disorder removed from your medical records please see: Getting personality disorder diagnosis removed in medical records



“I FOUND THE DIAGNOSIS AND TREATMENT MORE TRAUMATIC THAN THE RAPE OR FAMILY DEATHS. I STILL HAVE FLASHBACKS OF “TREATMENT” AND GET PANIC ATTACKS IF I’M IN ANY SORT OF CLINICAL ROOM THAT LOOKS LIKE THE WARD I WAS ON.”

Images used throughout are of stock models. Quotes are from actual research participants.

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> “THAT IS SO POWERFUL. TO SEE MY OWN WORDS IN PRINT, MY STORY THERE, RAW AND HONEST FOR PEOPLE TO EXPERIENCE HAS BROUGHT SUCH STRONG FEELINGS OF AGENCY AND THAT I AM STEPPING OUT OF THE **SHADOWS** AND **SHAME** I WAS FORCED INTO.”

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