A simple guide to avoid receiving a diagnosis of 'Personality Disorder'.

Disclaimer: unfortunately our suggestions above are not foolproof and we're not encouraging…

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1) Try not to be female (for BPD).

2) Do not argue your point of view with the professionals.

3) You cannot be seen to like some staff members more than others (this is SPLITTING behaviour).

4) Do not under any circumstances harm yourself. (This will more than likely be seen as a) manipulative b) attention seeking c) a communication of your distress caused by your underlying PD).

5) Do not make statements, which can be interpreted as black and white thinking. For example, the nurses all hate me. Try instead to make unrealistic, robot like, rational statements such as 'Enid, Mary, Silvia, John, Mark and Boteng have all shown epic disdain at my presence on the ward, but an agency nurse once smiled at me in 1992.'

6) Do not admire or pin any hope to a professional who appears to understand the social context of your distress (this is idealization, my dear).

7) Do not complain about anything. Ever.

8) Try to avoid working with professionals who look a bit tired. If they eventually go off sick you will inevitably be blamed for this. (Of course, because you are a difficult patient).

9) Things you can talk about: how medication is helping you, mood swings (BUT only extreme ones that last long enough to fit within a diagnosis of bipolar, that's an ok one as Stephen Fry made it a bit edgy), Do talk about how much the system is helping you, be eternally grateful to every professional you meet, tip your hat slightly to the side and say the words 'thanking you kindly for your 'help sir'.

10) Things you should not talk about: Abuse - of any kind, patterns in your relationships because of this abuse, existential dilemmas, perceived flaws in the system or anything to do with individual staff members.

11) You never ever; over/under eat, drink, exercise, and are never impulsive with sex, shopping, driving and you LOVE being alone.

12) If you are from cultures seen as "traditional", never say you even think about sex unless you are in a proper family approved heterosexual marriage.

13) To avoid BPD diagnosis you must not point out that the psychiatric teams are blaming you for their own inadequacies, their 'externalised locus of control' and 'refusal to take responsibility'.

14) Do not tell the psychiatrist you think you may have PTSD. (Don't be stupid now, everyone knows only soldiers can get this, are you a soldier?).

15) Try somehow not to be addicted to medication you are forced to take. Prepare yourself to be accused of lacking in coping skills when addiction inevitably does happen.

16) Talk with enthusiasm at the idea of being abandoned. Relish the idea whether it's real and/or imagined.

17) If you attempt suicide make sure you are successful or it will be deemed attention seeking.

18) If you do by chance happen to self harm, make sure it is a life threatening, Stephen King style canyon of a gash, anything less than this will be clinically defined as 'superficial' adding to the likely hood of the PD label being applied.

19) BPD diagnosis is a mirror to professionals' behavior, described as the personal characteristics of the service user.

20) Never phone the crisis team and say you'd like another visit (tick box dependency issues).

21) Hide any teddy bears or suchlike when they come round to visit ("too childish").

22) Never refer to your psychiatrist's affection for the DSM as 'ideas of reference'...

23) When they suggest cutting back on support, appointments etc, pause and think and then say, "yes, that's good, I feel I am ready to be more independent".

24) Be attractive but not 'coquettish'.

25) Do not at any point mention that you sometimes question who you are. You should know exactly who you are, be definite, unchanging about this (only people with PD ever question their identity).

26) Do not change your hair color too frequently. This will be interpreted as evidence of the above.

27) Always repeat when questioned that your attachment with your mother & father was always loving and supportive.

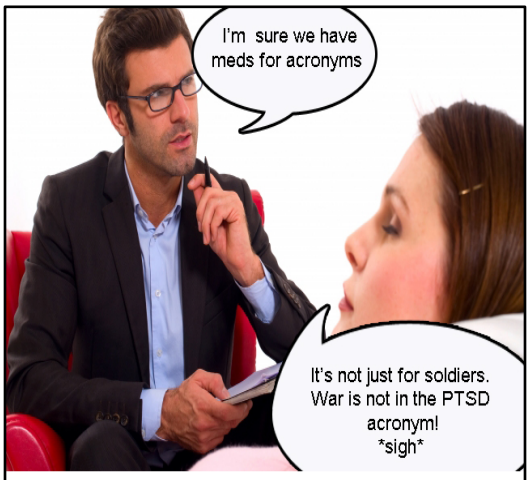
28) All depression, voice hearing and suicidality is ‘pseudo’ so please ensure the death certificate is recorded as ‘pseudo death’ and according to Joel Paris MD it was a ‘career’ so make sure your CV is updated posthumously.

29) Remember that inequality does not exist; it is your perception that is flawed.

30) Never, if you can manage it, express anger to MH professionals. Even when it’s understandable, genuine and valid!

31) The appropriate response following an OD to the question 'how much did you take' is ‘clearly not enough'. This is also likely to get you sectioned.

32) Never become a 'skilled' Service User. Understanding the games that nurses play will only get you described as 'playing games'.



Act dumb as intelligence is viewed as a facet of PD

33) Your mental health team believes in its adequacy, despite all evidence. Do not do or say anything that threatens professionals' fixed delusional beliefs, they may 'decompensate', becoming either coldly punitive and violent or weirdly smiley and dissociative, forcing you to have too much 'service' and then none at all.

34) Don’t ever ask a MH prof to ‘see you all the time and kiss your cuts better’ (as stated by a PD expert).

35) Act dumb as intelligence is viewed as a facet of PD (unlike psychosis where its assumed you’re less intelligent).

36) Failure to respond to medication or recover (or the CMHT needs to reduce numbers with discharges) means reclassification to PD.

Recovery In The Bin™

This User Led group is for MH Survivors and Supporters who are fed up with the way colonised 'recovery' is being used to discipline and control those who are trying to find a place in the world, to live as they wish, trying to deal with the very real mental distress they encounter on a daily basis. We believe in human rights and social justice!

We want a robust 'Social Model of Madness, Distress & Confusion', from the left of politics, placing mental health within the context of the wider class struggle.

We consider "UnRecovered" is as valid and legitimate as "Recovered", and we accept and respect the political and social difference. So some of us have accepted a new word / signifier "UnRecovered". However, this doesn't mean we want to stay 'unwell' or 'ill' (whatever that means), but that we reject this new neoliberal intrusion on the word 'recovery' that has been redefined, and taken over by marketisation, language, techniques and outcomes.

We recognise that the growing development of MH 'Recovery' in UK/US, during the past decade or so has been corrupted by neoliberalism and capitalism is the crisis!. Some of us will never feel "Recovered" living under these intolerable and inhumane social pressures.

We believe that there are core principles of ‘recovery’ that are worth saving, and that the colonisation of ‘recovery’ undermines those principles, which have hitherto championed autonomy and self-determination. These principles cannot be found in a one size fits all technique, or calibrated by an outcome measure.

We ask that mental health services should never put anyone under any pressure to 'recover', by over emphasising or even imposing 'Recovery Stars' or WRAP's. We stand opposed to mental health services using 'recovery' ideology as a means of masking greater coercion.

Notes

Another Disclaimer

“You do not have the right to say anything without it being used against you. Anything you say can and will be used against you. You have the right to legal assistance. If you cannot afford legal assistance, you are buggered. Do you understand the rights I have just read to you? With these rights in mind, do you wish to engage in our therapeutic relationship?”

Critical articles:

http://fap.sagepub.com/content/15/4/483.extract

http://www.sistersinside.com.au/media/papermepstein.pdf

http://discursiveoftunbridgewells.blogspot.co.uk/.../bord...

http://pb.rcpsych.org/content/31/5/194.1

Shaw, C. & Proctor, G. (eds.) (2004) Women at the Margins: Special Issue on women and Borderline Personality Disorder. Asylum magazine 4(3).

Sulzer (2015) Does "difficult patient" status contribute to de facto demedicalization?

https://www.madinamerica.com/.../scarlet-label-close.../

http://www.haringey.gov.uk/equilibrium_magazine_issue_46...

page 23 'The most savage insult'

http://www.scie-socialcareonline.org.uk/.../a1CG0000000Gg...

Refs:

Between 3 and 4.07 mins "you want me to see you all the time and kiss your cuts better": https://www.youtube.com/watch?v=kasiSXppCVA

Joel Paris: Half in love with easeful death:

https://drive.google.com/.../0B2o15rQwZLh7MlRjc2F.../view...

Linehan: https://www.nimh.nih.gov/news/media/2011/linehan.shtml

For the research funding she had to choose between BPD and Major Depression as the named mental disorder – she chose BPD, the diagnosis was attached to fit the intervention for the funding. She wanted the most difficult & challenging patients. So who was in the control group?

http://www.rcpsych.ac.uk/pdf/Wilkinson%20Paul%20Sept14.pdf

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