Borderline Personality Disorder and Domestic Violence Legal Responses by

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Hurt people hurt people. . . . [Individuals will often] look back . . . [at] all the different ways that [they] might have experienced harm. And[,] if [they] come from an environment in which [they] haven’t had the opportunity to really heal from that harm, it goes unprocessed [and] the likelihood is that *that trauma turns inward and folks start to hurt themselves, or trauma can turn* *outwards and people hurt other people.[[1]](#footnote-2)*

Pain, suffering, and hopelessness during childhood increases the risk for developing borderline personality disorder (BPD), effectively paving the way for a lifelong pattern of revictimization and perpetration of abuse.[[2]](#footnote-3) BPD remains the most stigmatized and misunderstood personality disorder, and often bleeds into domestic violence proceedings to effectively discredit and villainize individuals.[[3]](#footnote-4) While mental illness diagnosis does not excuse IPV, the BPD label should not be used to discount an individual’s experiences nor define their credibility.

By not acknowledging the unique complexities of psychiatric evidence and the impact of stigma on those who have been diagnosed with BPD, courts contribute to a legal system that reinforces, rather than reverses, society’s stigma towards BPD. Given the high rates of suicide, self-harm, and IPV amongst individuals with BPD, it is imperative to reduce stigma towards this population through education and treatment, rather than discipline, to help reduce the number of domestic violence perpetrators and victims and to break their cycles of abuse and violence.

The DSM defines BPD as patterns that pervasively deviate markedly from the expectations of the individual’s culture through unstable interpersonal relationships, self-image, and affects, and marked impulsivity.[[4]](#footnote-5) BPD emerges upon interaction of biological vulnerabilities and adversarial environmental circumstances that occur during childhood.[[5]](#footnote-6) Eventually, this trauma causes intense fears of abandonment, heightened sensitivity to nonverbal cues and mental state, instable self-image, and chronic feelings of emptiness.[[6]](#footnote-7) As a result, individuals cycle between feelings of rage and helplessness that trigger impulsive behaviors. This increases the risk towards forming traumatic bonds, or powerful emotional attachments to others that eventually turn abusive. As a result, individuals with BPD are likelier than individuals without BPD to be in abusive relationships that result in legal proceedings, both as the victim and the perpetrator.[[7]](#footnote-8) Likewise, due to the overlap in etiology and symptoms, Post-Traumatic Stress Disorder (PTSD)[[8]](#footnote-9), or vice versa, due to the broad overlap in symptoms and abuse etiology.[[9]](#footnote-10)

When a client with BPD lacks a tenacious advocate, they feel intimidated, discouraged, and ultimately hopeless. Nevertheless, legal blogs and scholarship caution attorneys to “avoid[ ] or minimiz[e]” interacting with “borderline clients” to “prevent wasted time and discomfort.”[[10]](#footnote-11) Further, BPD characteristics and tendencies are often written identically to tactics used by abusers of domestic violence.[[11]](#footnote-12) Conversely, scarce—if any—scholarship highlights the high risk between domestic violence victims and BPD.[[12]](#footnote-13)

Similarly, many domestic violence proceedings allow BPD diagnosis to be admitted to discredit or villainize a party’s character.[[13]](#footnote-14) This is despite the DSM-5’s warning of the high risk for diagnostic information to be misused or misunderstood in forensic settings due to the “imperfect fit between questions of ultimate concern to the law and the information contained in a clinical diagnosis.”[[14]](#footnote-15) Commenters have suggested that courts and expert witnesses avoid admitting BPD diagnosis as circumstantial evidence, especially given evidence that juror’s rarely adhere to limiting instructions that they not rely on stereotypes and stigmas.[[15]](#footnote-16) In fact, one study found that referring to a defendant as having “severe personality disorder (borderline pattern)” in a criminal domestic violence case led lay jurors to endorse stigmatizing beliefs that the defendant was more dangerous and needed more coercive and segregated treatment.[[16]](#footnote-17)

Despite BPD being the most commonly misdiagnosed and misunderstood disorder amongst psychiatrists, medical professionals readily offer testimony courts. Unlike clinical psychiatrists and their patients, forensic psychiatrists’ are not required to avoid harming litigants.[[17]](#footnote-18) For instance, during the recent Depp v. Heard trial,[[18]](#footnote-19) Depp attempted to undermine the credibility of his ex-spouse, Heard, through certain diagnosis.[[19]](#footnote-20) His expert witness[[20]](#footnote-21) (who never treated Heard) testified, after a 12-hour assessment, that Heard was misdiagnosed with PTSD and had BPD instead.[[21]](#footnote-22) The witness then testified that BPD was predictive of violence and manipulation.

Given the above, it is unsurprising that the majority of BPD litigants tend to be unsuccessful in their cases and are less likely to have their abuse deemed a crime, result in a charge, proceed to trial, or result in a conviction.[[22]](#footnote-23) Like those with PTSD, BPD, are survivors of previous abuse that turns into a cycle of repeated violence and reincarceration, as evident by the extraordinarily high rate of BPD symptoms amongst inmates.[[23]](#footnote-24) Individuals with BPD who are sentenced to prison are at heightened risk for self-harm and suicide, given their struggle for adequate treatment and in ”special housing” that is, if not quite solitary confinement, close to it.[[24]](#footnote-25)

In 2013 Tiffany Rusher was sentenced to prison.[[25]](#footnote-26) Upon assessing Rusher, medical staff informed guards that her diagnoses put her at risk for self-harm and that she needed to spend time outside her cell. Nonetheless, the guards *punished* her for subsequent self-harm attempts by forcing her into solitary confinement with 24-hour surveillance, confiscating all her personal belongings, and cancelling weekly therapy sessions. Tragically, Rusher killed herself after spending months alone in a cell the size of a small bathroom.[[26]](#footnote-27)

Despite common misconception (even among psychiatrists), treatment for BPD is available. Indeed, individuals who engage in therapeutic intervention often show improvement within the first year and no longer meet the criteria after about ten years.[[27]](#footnote-28) The intensive, long-term treatment required to effectively treat BPD treatment is rarely available in prisons nor is it readily available upon reentry into the community.[[28]](#footnote-29) However, those with BPD can successfully engage in treatment to help them manage their intense emotions and abandonment fears.[[29]](#footnote-30) Inmates should have access to specific treatment plans that are backed by empirical evidence and services to prepare them for community reentry, including efforts to ensure continuity of care for those suffering from the disorder. In the long-term, this will lead to lower rates of recidivism and hopefully reduce instances of IPV.

Furthermore, studies show that people with greater social supports adjust to life changes better than those experiencing the same events but with fewer supports. While the ADA and VAWA have set aside funding for programs and shelters for disabled victims of domestic violence, shelters, like prisons, tend to be unequipped to effectively meet the needs of individuals with BPD. Reducing stigma through educating these places may encourage those with BPD to seek treatment and lessen their likelihood of perpetrating or experiencing IPV in their relationships.

Moreover, legal scholarship needs to update its descriptions of BPD accurately explain the behavioral manifestations, scope, implication, emotion, and cognition of BPD, particularly that it is the result of trauma, and that “bad behavior” may not be entirely volitional. It should also be emphasized that IPV victimization, as well as perpetration, are associated with individuals with BPD. A better understanding will stimulate development of programs to treat those with BPD and facilitate their successful integration into the community.

Finally, harsh judgment comes from a place of misunderstanding.[[30]](#footnote-31) While no one should have to endure IPV from their partner, complex trauma from abuse, which is common in both individuals with BPD and those perpetrating violence, robs energy from the development processes that support emotional regulation and cognitive engagement.[[31]](#footnote-32) Imagine then, not a grown adult perpetrating violence, but a little boy who has grown big arms and legs and has spent his whole life dominated by pain and suffering, either from infliction of abuse or from impending threat thereof. As those responsible for determining the fate of individuals who have endured the hardest of battles, it is important to remember that trauma does not need to remain a permanent state of being, but instead be shaped into merely a chapter that does not necessarily have to dominate the rest of the story.

1. The Prison Within [↑](#footnote-ref-2)
2. Annegret Krause-Utz, Lea J. Mertens, Julian B. Renn, Pauline Lucke, Antonia Z. Wöhlke, Charlotte C. Van Schie, & Joanne Mouthaan, *Childhood Maltreatment, Borderline Personality Features, and Coping as Predicators of Intimate Partner Violence,* 36 J. of Interpersonal Violence, 6693, 6721 (2021). [↑](#footnote-ref-3)
3. Lindsay Sheen, Katherine Nieweglowski, & Patrick Corrigan, *The Stigma of Personality Disorders,* The Am. Psych. Ass'n., 1, 1-3 (2016). [↑](#footnote-ref-4)
4. The American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 663, (5 ed., 2012), [hereinafter DSM-5] determines how mental illnesses are defined and is the key to insurance coverage, special services in schools, disability benefits and treatments. *See,* Alexandra Shimo, *Are sexual abuse victims being diagnosed with a mental disorder they don’t* *have?,* The Guardian, (Mar. 27, 2019) https://www.theguardian.com/lifeandstyle/2019/mar/27/are-sexual-abuse-victims-being-diagnosed-with-a-mental-disorder-they-dont-have. Although defined as a discrete category in the DSM-5, ample evidence suggests that symptoms of BPD occur along a continuum. Courtney Conn, Rebecca Warden, Jeffrey Stuewig, Elysha H. Kim, Laura Harty, Mark Hastings, & June P. Tangeney, *Borderline Personality Disorder Among Jail Inmates: How Common and How* *Distinct?,* 35(4), Correct Compound 6, 7, (2010).DSM-5 at 663. [↑](#footnote-ref-5)
5. 81% of those diagnosed with BPD reported severe child abuse, including sexual and/or neglect, usually before age 7. *Briefing on BPD and the labelling of survivors of abuse and violence,* Platform, (2022) https://platfform.org/BPD [↑](#footnote-ref-6)
6. DSM-5 at 663. [↑](#footnote-ref-7)
7. IPV encompasses any physical, sexual, or psychological harm inflicted by a current or former significant other. Michelle A. Jackson, Lauren M. Sippel, Natalie Mota, Diana Whalen, & Julie A Schumacher, *Borderline personality disorder and related constructs as risk factors for intimate partner violence perpetration*, Aggression & Violent Behavior, 96 (2015); Lindsay Sheean, Katherine Nieweglowski, & Patrick Corrigan, *The Stigma of Personality Disorders*, The American Psych. Ass., 1, 1-3, (2016); D. Kelly Weiseberg, Domestic Violence: Legal and Social Reality, 49-50, (2d ed., 2019) (describing the “Psychopathology Theory,” which suggests psychodynamic factors as the cause of IPV); [↑](#footnote-ref-8)
8. PTSD occurs after exposure to one or more traumatic events that result in characteristic symptoms such as recurrent, involuntary, and intrusive recollections of the event(s), efforts to persistently avoid stimuli associated with the event(s), negative alterations in cognitions or mood associated with the event that begin or worsen following event(s) and marked alterations in arousal and reactivity associated with the event(s). DSM-5 at 271-76. [↑](#footnote-ref-9)
9. 40% of BPD patients reported an earlier misdiagnosis compared to only 10% of patients with other disorders. Camilo J. Ruggero, Mark Zimmerman, Iwona Chelminski, and Diane Young, *Borderline Personality Disorder and the Misdiagnosis of Bipolar Disorder*, 44(6) Nat. Inst. of Health, 1, 3 (2011); One study suggests that many health practitioners operate under the misguided belief that BPD is a character flaw—rather than a legitimate illness—and that those with BPD are responsible for and in control of their actions. Pauline Klein, A. Kate Fairweather, & Sharon Lawn, *Structural stigma and its impact on healthcare for borderline personality disorder: a scoping review,* 16 International J. of Mental Health Systems, 48, 48 (2022). Interestingly, while lawyers in domestic violence proceedings often try to avoid their client’s BPD diagnosis getting disclosed to a court, they often are zealous to disclose the client’s Battered Woman Syndrome (BWS), a component of PTSD since “BPD tends to carry a more *negative* connotation among lay people than PTSD, which may instead be viewed as *supportive* of a [survivor’s] claim.” [↑](#footnote-ref-10)
10. § 25:71.10. Identifying borderline personality disorder in a party or witness, 2 Attorneys Medical Deskbook (4th ed., 2022) (explaining that individuals with BPD “try to manipulate you into feeling sorry for them . . . [even when] they sabotage their own situation,” “lie freely and make unreasonable demands,” “feel no remorse for the harm they do,” and “create unnecessary emergencies [with] their irrational and self-destructive behaviors.”).

*See also,* Shimo, *supra* note 5 (discussing a defense lawyer using a witness’s BPD diagnosis to humiliate her by holding an open book of mental health disorders and suggesting that because she had BPD, she had behaved irrationally angrily and aggressively towards police); *Representing the Borderline Personality Client,* 1, 2 (“you wonder whether you will kill this client [with BPD] before the state can”). [↑](#footnote-ref-11)
11. Compare David Ward, *In Her Words: Recognizing and Preventing Abusive Litigation Against Domestic Violence Survivors,* 14 Seattle J. for Soc. Just. 429, 434-447, (2015) (listing the litigation tactics abusers use against survivors to include: seeking sole custody of child(ren), portraying themselves as the victim, making litigation long, expensive, and humiliating, bringing false allegations, and threats and retaliation against survivor or their loved ones) with David Crump & Joan S. Anderson, *Effects Upon Divorce Proceedings When A Spouse Suffers from Borderline Personality Disorder*, 43 Fam. L.Q. 571, 580-82, 586 (2009) (explaining that a spouse with BPD may take steps to induce a child to avoid the other parent, complain about the neutral or even courteous conduct of their significant others as malevolent, not cooperate with attorneys resulting in longer and more expensive proceedings, and believe that harm onto the other spouse is genuinely deserved). [↑](#footnote-ref-12)
12. e.g., low self-worth, feelings of guilt/shame, high levels of empathy, unwillingness to recognize abusive characteristics or behaviors, past trauma. Sarah M. Buel, *Fifty Obstacles to Leaving, A.K.A. Why Abuse Victims Stay,* Colo L., 1, 19 (1999). [↑](#footnote-ref-13)
13. For specifications on when BPD and other character evidence can be admitted, see Fed. R. Evid 404-405. [↑](#footnote-ref-14)
14. DSM-5 at 25; *see also,* F.R.E. 403 (allowing judges to exercise discretion in not allowing diagnoses to be admitted when it’s probative value will be “substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury.”) Unfair prejudice is any tendency to suggest a decision on an improper basis, commonly, though not necessarily, an emotional one. F.R.E. 403, adv. comm. notes. [↑](#footnote-ref-15)
15. DSM-5 at 25; Pauline Klein, A. Kate Fairweather, & Sharon Lawn, *Structural stigma and its impact on healthcare for borderline personality disorder: a scoping review,* 16 International J. of Mental Health Systems, 48, 51 (2022) (summarizing empirical evidence suggesting that jurors often cannot understand or refuse to follow instructions on the limitations of the evidence). Deirdre M. Smith, *The Disorder and Discredited Plaintiff: Psychiatric Evidence in Civil Litigation,* 31 Cardoza L. Rev. 749, 754, (2009) (“[Courts] certainly cannot expect jurors and judges to use evidence of alternate causation in a way that is consistent with psychiatric practices”). [↑](#footnote-ref-16)
16. James Baker, Ian Edwards, & Peter Beazley, *Juror decision-making regarding a defendant diagnosed with borderline personality disorder,* Psychiatry, Psych., & L., 526, 528 (2022); [↑](#footnote-ref-17)
17. Deirdre M. Smith, *The Disorder and Discredited Plaintiff: Psychiatric Evidence in Civil Litigation,* 31 Cardoza L. Rev. 749, 753, (2009). This is unlike clinical psychiatrists, who are obligated to avoid actions that will potentially harm their patients. *Id.* [↑](#footnote-ref-18)
18. This was a defamation trial, which typically does not include domestic violence allegations. However, defamation allows character evidence in the same way authorized in child custody proceedings. [↑](#footnote-ref-19)
19. Depp v. Heard, 107 Va. Cir. 80 (2021). [↑](#footnote-ref-20)
20. At the time of trial, Curry was a licensed but not board-certified psychologist, who was hired following a night of dinner and drinks at Depp’s house. Jerold J. Kreisman, *Hollywood Court Case Considers Who’s More Violent: Celebrity conflicts may increase stigma of mental illness,* Psych. Today (2022). [↑](#footnote-ref-21)
21. Randi Mazzella, *Depp v. Heard: Understanding Mental Health Implications,* Psycom, (May 26, 2022) https://www.psycom.net/mental-health-wellbeing/johnny-depp-amber-heard-trial. (“While there is no specific time frame for diagnosing these disorders, it would be rare to come to this type of conclusion as rapidly as Curry.”) [↑](#footnote-ref-22)
22. Platform, *supra* note 1. [↑](#footnote-ref-23)
23. Courtney Conn, Rebecca Warden, Jeffrey Stuewig, Elysha H. Kim, Laura Harty, Mark Hastings, & June P. Tangeney, *Borderline Personality Disorder Among Jail Inmates: How Common and* *Distinct?,* 35(4), Correct Compound 6, 7, (2010). [↑](#footnote-ref-24)
24. Bagenstoes, 328. [↑](#footnote-ref-25)
25. *Andrews v. Rauner*, 18-cv-1101 (C.D. Ill. Jan. 7, 2022); [↑](#footnote-ref-26)
26. Bruce Rushton, *Suicide in solitary,* Illinois Times, (Jun. 04, 2020) https://www.illinoistimes.com/springfield/suicide/ [↑](#footnote-ref-27)
27. DSM-5 at 665; *See also,* Marsha M. Linehan, DBT Skills Training Manual (2d ed., 2015). [↑](#footnote-ref-28)
28. Courtney Conn, Rebecca Warden, Jeffrey Stuewig, Elysha H. Kim, Laura Harty, Mark Hastings, & June P. Tangeney, *Borderline Personality Disorder Among Jail Inmates: How Common and How* *Distinct?,* 35(4), Correct Compound 6, 8-9, (2010). [↑](#footnote-ref-29)
29. While the tendency toward extreme emotions, impulsivity, and intensity in relationships is often lifelong, individuals with BPD who engage in therapeutic intervention often show improvement within just one year. After about ten years, most individuals no longer have a pattern of behavior that meets the full criteria for BPD. DSM-5 at 665; s*ee also,* Marsha M. Linehan, DBT Skills Training Manual (2d ed., 2015). [↑](#footnote-ref-30)
30. Matthew S. Bennett, Connecting Paradigms: A Trauma-Informed & Neurological Framework for Motivational Interviewing Implementation 12 (2017) [↑](#footnote-ref-31)
31. *Id.* at 12-13. [↑](#footnote-ref-32)