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'DEMONIC LITTLE MINI-SKIRTED MACHIAVELLI':
EXPERT CONCEPTUALISATIONS
OF COMPLEX POST TRAUMATIC STRESS DISORDER
AND BORDERLINE PERSONALITY DISORDER
IN FEMALE FORENSIC POPULATIONS

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Content

Summary of the research

This study considers whether the diagnosis Complex Post Traumatic Stress Disorder (C-PTSD) might replace Borderline Personality Disorder (BPD) as a less harmful alternative for women in forensic services. This paper investigates the perspectives of key informants with a high level of expertise in the fields of complex trauma and personality disorder. Semi-structured interviews were conducted with six participants and analysed using thematic analysis. Findings show contradictory perspectives and definitions for 'personality' and 'trauma'. These understandings were mediated by the perceived levels of agency associated with each diagnosis as well as non-medicalised narratives of trauma. Informants' preference for either a non-medicalised approach to trauma, C-PTSD or BPD depended on the associated levels of hopeless and the limitations of the forensic environment. C-PTSD was seen by some as reducing the victim-blaming phenomenon that can be generated and sustained by the application of a BPD diagnosis. Some participants raised concerns, however, that the diagnosis of C-PTSD implied a state of permanent victimhood. Furthermore, there were questions regarding women who do not identify as traumatised. Despite these concerns, it is concluded that the iatrogenic harm associated with a BPD diagnosis warrants a more ethical replacement.

Keywords: *C-PTSD; BPD; Offender pathway, OPD, female offending, personality disorder*

Introduction

Women have a minority status in the criminal justice system, occupying around 5% of the overall prison population in the UK. Approximately 13,500 women are imprisoned each year (Prison Reform Trust [PRT], 2017a) and they account for over half of all reported incidents of self-injury in prisons (PRT, 2017b).

There are clear etiological, criminological and gender specific considerations in relation to their offending behaviour (Bloom and Covington, 2008; Clinks, 2015; House of Commons Justice Committee, 2014; Light, Grant, & Hopkins, 2013). Women as a forensic population, are subjected to a high prevalence of childhood abuse, poverty, domestic abuse, sexual victimization and single parenthood (Bartells and Gaffney, 2011; Covington, 2007; Ministry of Justice [MOJ], 2012; PRT, 2017c; Javdani, Knight, Silva & Wolf, 2013; Wolf, Silva, Knight & Javdani, 2007; Williams, Poyser & Hopkins, 2012). Female prisoners are twice as likely to report post-traumatic stress (PTSD) symptoms than their male counterparts (Singleton, Gatward & Meltzer, 1998); manifestations of PTSD are also more severe in female populations (Sarkar & di Lustro, 2011) and childhood trauma has been implicated as a primary causal factor in offending behaviour in girls (Belknap, 2007).

Data collected regarding prisoners with mental health difficulties are incomplete (National Audit Office, 2017). However, evidence suggests that women in prison have high rates of complex and enduring mental health difficulties (Long, Fulton, & Hollin, 2008; MOJ, 2012; O'Brien, Mortimer, Singleton, & Meltzer, 2003); indeed they are five times more likely to suffer from mental health distress compared to women in the community (NAO, 2017).

Furthermore, there is evidence to suggest that incarcerated women's experiences of trauma are directly linked to the development of their mental health disorders (Alleyne, 2007; DeHart et al 2014; Jordan et al 2002; Laishes, 2003) and that the severity of their trauma may be directly related to offence type and seriousness (Karatzias et al, 2017).

In 2005, The National Reducing Re-offending Delivery Plan (NOMS, 2005) outlined seven pathways to reduce re-offending. However, this did not include victims of sexual violence and it was not until the Corston Report in 2007 that two further pathways were added which specifically addressed the unique needs of victims of rape/sexual assault and women who had been victimised by prostitution (Corston, 2007).

Although both of these pathways recognise the specific needs of women who have been subjected to these types of trauma, very few interventions addressing these issues have directly reached women in forensic services; indeed, there are some prisons that lack any type of support for women with these types of trauma (Women in Prison [WIP], 2017).

Nevertheless, in 2014, in growing recognition of the extensive, traumatic histories female offenders present, there was a national rollout across women's forensic services of Dr Stephanie Covington's trauma-informed staff training, 'Beyond Trauma' (Covington, 2015). Whilst this training shows some promise at reducing incarcerated women's distress in Switzerland (Fedock, Kubiak & Bybee, 2017), the impact of this training in the UK has yet to be robustly evaluated.

In a systematic review of mental health interventions for incarcerated women, Bartlett et al. (2015) found that trauma specific interventions and programmes produce significant mental health gains for female offenders. Unfortunately, much of their analysis focused on American based programmes due to the lack of trauma specific interventions in UK women's prisons. Nevertheless, there has been significant investment and allocation of resources into the area of personality disorder in the UK criminal justice system.

Personality disorder (PD) is currently defined as:

'Severe disturbances in the personality and behavioural tendencies of the individual; not directly resulting from disease, damage, or other insult to the brain, or from another psychiatric disorder; usually involving several areas of the personality; nearly always associated with considerable personal distress and social disruption; and usually manifest since childhood or adolescence and continuing throughout adulthood'

(World Health Organisation [WHO], 2013, p36)

In 2009, Lord Bradley was commissioned to review the effectiveness of diversion schemes for people with mental health disorders who ended up in the criminal justice system (Carter, 2007). The review noted the lack of provision for those diagnosed with personality disorder and recommended a 'coherent and agreed inter-departmental approach to the management of personality disorder within the criminal justice/health sector' (Bradley, 2009:16).

Offender personality disorders

The Offender Personality Disorder pathway (OPD) was established in 2011, following on from the failure and decommissioning of the dangerous and severe personality disorder units (DSPD), (O'Loughlin, 2014). The OPD pathway was allocated £64 million from NHS England and NOMS in order to create specialist pathways to manage high risk offenders whose personality disorder was believed to be directly linked to their risk profile (Skett, Goode & Barton, 2017).

There is currently insufficient data to elaborate on how much of the OPD budget has been allocated specifically to women's services but it is estimated that 1000 to 1500 women might be eligible for treatment within the women's OPD pathway at any one time; however, no current data are available regarding the precise number of women in treatment.

Between 50 and 65% of women in prison are believed to meet the criteria for at least one personality disorder (Fazel & Danesh, 2002; Ullrich et al, 2008) and the women's OPD pathway has been established to provide a range of evidence-based interventions to a previously excluded population of women who meet the set criteria for entry.

The OPD pathway does not require women to be formally diagnosed with personality disorder; formulation and risk screening is used to maximise eligibility and treatment potential (Skett et al., 2017). The women's OPD strategy does not specify interventions and, to date, no robust evaluation has been completed of the pathway. It therefore remains unclear whether the interventions delivered are effective (Bartlett et al, 2015). In her review of the OPD women's pathway, Player (2017) raises concerns about diverting community resources into forensic services via a single, diagnostic frame of reference through which many traumatised women's experiences are now understood. Traumatic life experiences are frequently positioned as inextricably connected to the personality disorder construct and there is on-going debate about the extent to which traumatic life experiences play an etiological role in the development of the disorder (Lewis & Grenyer, 2009).

Personality disorder and trauma

One specific personality disorder, emotionally unstable PD (also referred to as borderline personality disorder or BPD or EUPD) has a well-established relationship with traumatic life events (Ball & Links, 2009; Moskovitz, 2001; Timmerman & Emmelkamp, 2001; Zanarini et al., 1997; Yen et al., 2002). Some studies suggest that child abuse and neglect are associated with up to 90 per cent of women who have a diagnosis of BPD (Battle et al., 2004). It is estimated that between to 25% - 55% of women in prison currently meet the criteria for BPD (Black et al., 2007; Singleton et al., 1998).

In recognition of the effects of interpersonal violence and trauma on women, Herman (1992) conceptualised an alternative diagnosis to BPD: Complex Post Traumatic stress disorder (C-PTSD).

C-PTSD is now currently being evaluated for inclusion in the latest International Statistical Classification of Diseases and Related Health Problems (WHO, 2013). The potential inclusion of this diagnostic category raises important questions in relation to our understanding and treatment of traumatised women in forensic settings. This is particularly relevant to women with the diagnosis of BPD in light of a recent community-based report which revealed that many service users felt that their 'untreated trauma' had been obscured rather than assisted by receiving a BPD diagnosis (NCISH, 2018). However, there is only limited forensic literature exploring the differences between the BPD and C-PTSD constructs (Browne, 2017) and there is considerable debate in the community-based literature (Lewis & Grenyer, 2009, Miller, 2016).

Some of the debate may be due to the fact that both diagnoses appear to share some core features such as self-harm, suicidality, hearing voices, alterations in sense of self and states of consciousness, amnesia, depersonalization, chronic dysregulation, relational destabilization, and phobic avoidance of traumatic experiences (Browne, 2017; MacIntosh, Godbout, & Dubash, 2015; Mosquera & Steele, 2017).

Furthermore, there is significant overlap between trauma and personality disorder narratives within forensic environments (Bohle & de Vogel, 2017).

Some researchers suggest that C-PTSD has important, separate symptomology to BPD, specifically highlighting the presence of impulsivity and abandonment fear as distinctive clinical features (Browne, 2017; Cloitre, Garvet, Weiss, Carlson & Bryant, 2014; Knefel, Tran & Lueger-Shuster, 2016). However, Landy, Wagner, Brown-Bowers & Monson (2015) and Driessen et al., (2002) suggest that it is better to understand C-PTSD primarily as the disorder of BPD with features of PTSD. Laporte, Paris, Guttman & Russell (2011) also propose that complex trauma interacts with genetic predisposition to sensitivity and affect to produce the type of symptomology associated with BPD. In relation to this, Bornovalova et al., (2013) found a genetic tendency to internalise/externalise abuse experiences directly related to the emergence of BPD symptomology in later life. However, they also acknowledged a direct positive correlation between severity of complex trauma and BPD trait severity.

'Borderline personality disorder' is trauma

Whilst it appears that there is some evidence to treat complex trauma and BPD as separate diagnostic constructs, other literature would suggest that BPD is indistinguishable from a construct of complex trauma (Driessen et al., 2002; Ford & Courtois, 2014, 2016; Herman, 1992; Kulkarni, 2017; McLean & Gallop, 2003; Pagura et al., 2010; Sara & Lappin, 2017).

Some neurobiological evidence also supports a lack of distinction between the two constructs: neurochemical and neurostructrual changes observed in individuals diagnosed with extreme PTSD are identical to those found in individuals with a diagnosis of BPD and C-PTSD (Meewisse et al., 2007; Krause-Utz & Elzinga, 2018; Kulkarni, 2017; Sherin & Nemeroff, 2011).

Furthermore, there is some evidence to indicate that conceptualising BPD and C-PTSD as distinct categories increases the prejudice and stigma toward those assigned a BPD diagnosis (Becker & Lamb, 1994; Becker, 2000; Miller, 2016). In a review of the literature, MacIntosh, Godbout, & Dubash, (2015) suggest that due to the similarities in symptom manifestation between BPD and C-PTSD, further research efforts should focus on exploring how these two diagnostic constructs are used and the extent to which trauma mediates both constructs.

The degree to which BPD and C-PTSD are separate diagnoses, requiring different approaches and treatment priorities, remains a current topic of debate in community settings (Ford & Courtois, 2014; Giourou et al., 2018). Thus far, the discussions do not appear to have reached UK forensic settings. This is of particular concern given the high rates of trauma observed in female forensic populations and where the application of diagnostic constructs has the potential for more serious outcomes with regard to sentencing, mitigation and treatment pathways.

One reason for exploring the potential role of C-PTSD in a female forensic population is the increasing concern regarding the BPD diagnosis. BPD has been heavily criticised for its lack of validity, inflated co-morbidity rates and general unreliability (Lewis & Grenyer, 2009; Pilgrim, 2001).

Indeed, some researchers have questioned whether the construct exists at all (Godsi, 2004; Kinderman, 2015; Kroll, 2003; Samuel & Bucher, 2017;). The criticisms and controversy surrounding the diagnosis are of particular relevance to a population of incarcerated and vulnerable women because BPD is a gendered diagnosis, predominantly applied to women (Bjorklund, 2006; Flanagan & Blashfield, 2005).

The gender bias inherent to the BPD construct is not only a concern in terms of diagnostic legitimacy but also implies an inherent bias in the research literature and evidence base surrounding the diagnosis (Widiger, 1998). The gendered nature of the construct has also attracted much criticism from feminist researchers (Cahn, 2014; Langer, 2016; Maidment, 2006; Nyquist Potter, 2009) and Leising, Scherbaum, Packmohr, & Zimmermann (2017) show that clinicians often diagnose BPD in women based on judgments regarding her perceived social desirability.

Impact of a BPD diagnosis on women

Forensic-specific feminist arguments highlight concerns that diagnosing women in forensic services with BPD may decontextualise female offending behaviour (Player 2017; Pollack, 2004). This, in turn, enables a lack of scrutiny of oppressive social structures, including the structural violence of the prison system itself.

In spite of these concerns, some women in forensic services find a diagnosis of BPD helpful. Shepherd, Sanders & Shaw (2017) conducted 41 qualitative interviews exploring the lived experience of recovery of individuals diagnosed with personality disorder. They identified that a BPD diagnosis could contextualise current behaviour alongside past distress. It could also provide a sense of validation and legitimacy for women who felt that their distress was not taken seriously enough in the prison environment. However, the same study also identified women who were placed at significant disadvantage due to the application of a BPD diagnosis and that it had harmful consequences in terms of women's self-esteem. Some women found themselves having to manage both the stigma associated with an 'offender' identity as well as an identity of being 'personality disordered' (Shepherd, Sanders & Shaw, 2017).

Whilst this research provides useful insight into some of the different ways women in forensic services experience a diagnosis of BPD, most of the literature that explores the diagnosis originates from community-based studies. For example, a recently published consensus statement revealed that the diagnosis might enable individuals to access certain types of treatment or care (Mind, 2018). However, it also concluded that most service users would like to abandon the term 'personality disorder' entirely, stating that *'the label is controversial…. it is misleading, stigmatizing and masks the nature of the problem it is supposed to address, adding to the challenges which people experience'* (ibid, p4).

There are urgent, ethical concerns in view of the fact that many women find the diagnosis and resulting treatment to be an iatrogenic process (Berger, 2014; Bonnington & Rose, 2014; Gary, 2018; Nicki, 2016; Shaw & Proctor, 2005; Veysey, 2014). Despite the policy document, 'Personality Disorder: No Longer a Diagnosis of Exclusion' (National Institute for Mental Health in England, 2003), it appears that many people who receive a diagnosis of

BPD continue to experience poor response and exclusion from services (Gary, 2018; NCISH, 2018; Westwood and Baker, 2010).

In fact, patients with a BPD diagnosis appear to be viewed more negatively and treated poorly in comparison to any other psychiatric patient (Hersh, 2008; King 2015; Markham & Trower, 2003; Newton-Howes, Weaver & Tyrer, 2008; Weight and Kendal 2013; Woollaston & Hixenbaugh, 2008).

Some researchers suggest that this negative response and poor treatment are the result of behaviour exhibited by this particular group (Bodner et al, 2015). Conversely, there is evidence to show that irrespective of patient behaviour, clinicians still exhibit prejudicial attitudes towards those with a BPD diagnosis (Lam, Poplavskaya, Salkovskis, Hogg, & Panting, 2015; Lam, Salkovskis, & Hogg, 2016).

These findings suggest that the construct itself may be generating stigmatising and unhelpful preconceptions.

The present study

In light of this and of recent requests made by community-based service users to abandon the diagnosis of BPD (Mind, 2018), it is important to explore less harmful alternatives, particularly in relation to a more vulnerable, female forensic population. It is also of interest to recognise and explore the role of medicalization in women's responses to trauma. As discussed, there is evidence that the apparent symptomatology and distress associated with chronic trauma is, at times, indistinguishable from that conceptualised under the diagnosis BPD. This raises important questions with regards to the treatment of women in forensic services, especially in light of the continuing stigmatisation and victim blaming associated with the diagnosis.

Given the interest in expansion of the OPD pathway and the critiques which caution against commissioning programmes that may promote pathologised and individualized understandings of offending behaviour (Player, 2016), it is essential to consider how women in forensic services who have experienced high rates of trauma might best be understood and supported.

To date, there has been no forensic research to examine key informant perspectives on BPD in relation to the imminent inclusion of the diagnosis C-PTSD. This study aimed to qualitatively explore the complexity and implications of traumagenic and personality disorder discourses within forensic contexts. The study also aimed to provide insight into potential future directions for supporting women in forensic services who have survived multiple traumatic experiences.

Method

The study adopted a key informant approach that was conducive to collecting high quality data over a short timeframe (Marshall, 1996). Key informants have been shown to produce reliable reports in relation to a forensic PD population (Keulen-de-Vos, Bernstein, Clark, Arntz, Lucker, & De Spa, 2011). As recommended by Tremblay (1957), key informants selected for the research were highly observant and deeply reflective knowledge sharers who could accurately convey information and opinion on the selected community of interest. The community of interest in this study was a forensic female population. Key informant interviewing involved the interpretations of individual informants as well as the primary researcher's final interpretation (Crabtree & Miller, 1999). A qualitative approach was utilized in order to explore the meanings and thought process associated with the research aims.

Materials and Procedure

Data was collected in interviews which focused on exploring participants' perspectives of the role and provision for trauma in female forensic populations, perspectives of BPD as a diagnosis and perspectives of C-PTSD as a diagnosis. Interviews lasted approximately two hours each. Interviews were transcribed verbatim and then analysed using thematic analysis. Ethical approval for the research was obtained from Middlesex University Psychology Department Ethical Committee.

Reflexivity

It is important to reflect on the fact that I am a researcher with lived experience of having previously been given a diagnosis of BPD. In addition to this I have conducted research in the field of personality disorder and I have worked with women in prison services who had a diagnosis of BPD. These multiple experiences and identities helped to enrich my understandings of the subject matter as I was approaching the topic from multiple positions.

It is important to note, however that these identities may have also introduced some degree of bias into the research. On reflection, my motivations for conducting this study originated from my treatment in psychiatric services and from witnessing a state of confusion in women I worked with in prison settings who conveyed a lack of understanding around the diagnostic process. I chose not to disclose my lived experience status to participants due to the potential for demand characteristics. I did not wish to influence how participants responded.

The research was conducted in a reflexive manner in accordance with Finlay and Gough (2003) whereby personal thoughts and feelings which arose during the research and analysis process were kept in a personal diary and reflected upon throughout the research process.

Participants

Participant recruitment involved expert and snowball sampling techniques. The aim was to recruit participants from different professional perspectives (see Table 1). Initially, a forensic psychotherapist was invited to take part via email invitation. This psychotherapist then

recommended the study to other experts in the forensic field. In addition, invitation emails and information sheets were sent to a forensic trauma specialist and a criminologist with expertise in female penology. A total of six participants took part in the study. All participants had worked in their specialist area for over 15 years.

Table 1: Description of key informants and corresponding number

Participant number	Gender Male (M) Female (F)	Primary Occupation
P1	F	Criminologist
P2	M	Forensic psychotherapist
P3	F	Forensic psychiatrist
P4	F	Forensic specialist in trauma
P5	F	Forensic psychotherapist
P6	F	Consultant forensic nurse

Results and analysis

The following section describes the findings from the thematic analysis. The superordinate themes were:

- perspectives of trauma
- definitions and meanings
- responsibility and blame

These are presented in Table 2 along with corresponding subordinate themes.

Table 2. Primary themes and Subthemes in analysis

Superordinate themes	Subordinate themes
1: Perspectives of Trauma	Understanding trauma
	Medicalised-non-medicalised
	C-PTSD- Compromising and contextualising
2: Definitions and Meanings	Defining personality
	Defining the 'other'
3: Responsibility & Blame	Agency vs. infantalization
	Victim blaming vs. victim empowering
	Blame and agency

1) Perspectives on trauma

Participant perspectives of the diagnosis C-PTSD appeared to be mediated by three factors. These were: participants' individual understandings and conceptualisations of the word 'trauma'; their beliefs about the extent to which these understandings should be addressed within a medicalized framework; their considerations of the potential for a CPTSD diagnosis as either a compromise or compromising.

a) Understanding trauma

Some participants understood trauma as a response to socio-political oppression and made reference to environmental and economic stressors as a way of contextualising women's distress. There was a description of how our current understandings of what constitutes trauma or traumatic could be too constricted. Any experiences that can generate feelings of shame and humiliation were identified as potentially traumatic for individuals:

I think social inequality is hugely traumatic as well. That's, I guess, one of our other theories here that violence comes out of experiences of long-term humiliation of which social humiliation is one. Poverty can be deeply traumatic. **Professional 5**

All of this is complex when you look at them. We shouldn't say, "Let's just look at your debt. Let's just look at your education deficits." It should all be looked at as a whole, all these things are traumatic. **Professional 1**

In addition to concerns about constricted understandings of trauma, there were also participants who cautioned against the use of the term with regards to imposed meanings. One participant drew attention to its potential to invalidate women's own understandings:

What happens if you don't identify with it? I have sat with people who really, really get pissed off about their stories being constructed in terms of trauma. The associations, connotations of traumatized are a bit loaded sometimes aren't they? **Professional 2**

Imposing understandings on vulnerable populations could be seen as unethical and touches on what Fricker (2007) describes as a type of 'epistemic injustice' committed against women. Epistemic injustice refers to a process whereby a person is wronged in terms of what they are allowed to know, or a bias in the information they have been given with which to understand a particular phenomenon. Becker-Blease (2017) explains that historically, trauma has been inextricably connected to systemic power and oppression. Victims or survivors of trauma are vulnerable to having their identities and meanings

defined by powerful groups, with little attention paid to the impact that those group definitions have on them.

The imposition of a trauma framework was questioned by some participants who felt that women might resist the idea of being traumatised as a psychological defence. Some felt that women's understandings of what constitutes 'traumatic' may be too narrowly defined and did not include distress arising from developmental or attachment trauma:

Women who use forensic services have experienced histories of trauma – including attachment trauma and the norm is for this to have been complex in nature – for example, multiple and prolonged traumatic experiences during early development and for some, going on into adult life. **Professional 6**

Whilst some participants incorporated wider social and political contexts/constructs into their understandings of trauma, a contradictory perspective positioned trauma as separate and distinct from these. Thus, the participant below does not understand poverty as traumatic, conveying the idea that offending behaviour could, at times, be understood via a pragmatic lens whereby trauma appeared to be less relevant:

You have to break it down because they're different. It's not all about trauma, for example acquisitive offending, it's all about poverty and social status and very little to do with childhood adversity. It has a lot to do with culture you come from and you can say some very simple things, "Do I have enough money to live on?" and people who've got no money and have got a baby will steal, it's as straightforward as that. They may never have suffered much trauma at all they may simply work it out that it's easier and safer to steal than anything else. **Professional 3**

The recognition that not all women in the criminal justice system had experienced trauma was coupled with an aversion to use of a traumatological framework in relation to offending behaviour. However, other participants challenged this reasoning by highlighting the probability of having a traumatic history and ending up in the criminal justice system.

Now there may be some people that say, 'Well why is it that not everybody who is sexually abused turns out to be a client in criminal justice system?' You can turn that actuarialism against them, and say, 'Okay well look, your own actuarial method will show you that the probability of these people with these traumatic backgrounds turning up in prison, being predominant in the offender population, by chance, by statistical chance, the probability is so low.' It's way beyond what statisticians would regard as significant statistically. You can turn the statistical argument against them. **Professional 1**

Much of the tension and contradiction around the use of the term trauma appear to be connected to the conflict for professionals between the women's status as both victims and perpetrators. Victim and perpetrator status was related to perspectives of agency and responsibility that will be discussed later on in this research.

b) Medicalise vs. non-medicalise

Some participants felt that a medical framework was not the best way to conceptualize women's responses to trauma. They defined medicalisation as incorporating trauma responses into both BPD and C-PTSD constructs, neither of which was seen as ideal. Participants stressed the importance of validating women's responses as rational within the context of irrational circumstances:

Well, the thing about that, as I say is that, you're behaving in the way you are now, because something terrible happened. You reacted to something that happened. It doesn't have to be such a medical label… however you can make those links, you can see a rational developmental and it is important it's not medicalised. **Professional 1**

This resistance to the medicalisation of trauma responses seemed to be situated in an awareness of and desire to avoid 'othering'. Lister (2004) refers to 'othering' as a progression of differentiation whereby the demarcation of a subject as different leads to the denial of a subject's similarity to us. The phenomenon of 'othering' occurs within the context of power differentials, when a dominant group defines, and therefore generates, an inferior group (Fine 1994).

The dominant group in this context would be any forensic professional who, due to their profession and free status, is the definer via diagnosing of the 'other'. Participants had concerns that some of the traumatic experiences women experienced often left them feeling isolated and separate, a feeling which then may be compounded by the application of any psychiatric label. There was a sense that de-medicalising responses to trauma experiences may reduce this process of othering, increasing empathy for and reducing social distancing of the 'othered'.

In contrast to this perspective, there was a divergent view that increased medicalisation might result in increased validation of women's experiences of distress. Lack of perceived psychiatric validity was linked to poor attitudes of professionals towards those women diagnosed with BPD. Introducing a trauma narrative, inside or outside of the diagnostic framework was viewed negatively as an attempt to change attitudes by increasing sympathy:

If you made it more medical, if you actually made it more valid, you would actually get people to change their attitudes…I think that my worry about complex PTSD is it's trying to get professionals to change their attitudes by invoking their being sorry for the person, 'They can't help it. They can't help being irritating, and difficult, and demanding, and making you feel small, and stupid. They can't help it because they were traumatized as children.' **Professional 3**

Whilst some participants found increasing sympathy a less appealing way to change attitudes towards women who had been traumatised, others felt that a trauma narrative increased empathy and understanding.

c) C-PTSD- Compromising and Contextualising

In addition to reservations about the medicalisation of women's responses to trauma, there was an awareness and frustration expressed regarding the inherently traumatizing nature of forensic services. Participants spoke about the impact of iatrogenic trauma on women and the confusing, contradictory and frightening situations that staff are frequently trying to make sense of:

They (women) have been extremely poorly treated across these power differentials. These are banging, clanging, locked, noisy, high arousal, fear environments. People are afraid to get next to the women, they're afraid to leave them to their own devices and getting into terrible tangles about sexuality… then we're anxious to get them to take up agency, but we don't think of them as having agency either. **Professional 2**

In spite of participant concerns regarding iatrogenic harm and over-medicalization, there was a sense of resignation in relation to working within the limitations of forensic environments. Participants took a pragmatic approach that was coupled with feelings of inevitability and resignation:

I can see that this (pathologisation of women's reactions to abuse) is also accurate but feel removal of any kind of diagnosis is, in reality, too much to ask for in a culture that is heavily medicalised and where the medical model is so highly defended. **Professional 6**

Yes, CPTSD, it's a nicer phrase, but I just think it maybe too late in our lexicon to introduce something new. I think personality disorder just is here to stay really. **Professional 5**

Participants commented on the economic reality of working in forensic environments, acknowledging a functional requirement for categorization in order to prioritise funding for treatment allocation. For some participants, this sense of resignation led to the perspective

that C-PTSD could be seen as a compromise. The diagnosis could contextualise offending behaviour and cognitive behavioural treatments, which were seen by some participants as inherently over-responsibilizing women for their manifestations of distress:

It seems to me to have the potential to be much less damaging, a much more productive way forward. If you're going to continue with prisons and with cognitive programmes, it can contextualize these, which is something they just don't do, the current context of the cognitive programmes at the moment is a personality disorder, again, something wrong with you, your personality, your thinking, not why you think this way. **Professional 1**

The preference for C-PTSD as a diagnosis correlated with participants' negative perspectives of the diagnosis of BPD. In relation to the previously mentioned phenomenon of 'othering', some people felt that the diagnosis C-PTSD situated the 'other' in a context in which we are invited to take up a position of empathy. The social distancing created by the application of a disordered identity was felt to be attenuated, to some extent, by the acknowledgment that a woman became 'disordered' after externally situated trauma had been inflicted upon them.

What we're really saying (with C-PTSD) is, "You have had multiple events in your life that are wounding, that have been really challenging. That means there's a lot of complexity to your life. That means it's going to take multiple things to help you feel good again and get stabilized and safe." There's no stigma there. It helps us understand. Personality disorder says something else, that there's something disordered with your personality. "This is more about what happened to me." I just think it's easier and I think it's more empowering. To tell them, "There's things you can do. There's things we can help you to do, that are going to help you be in the world in easier way," versus, "We've got some ideas about how to change who you are so you're not so disordered. What a terrible message to give to a woman [laughs]. **Professional 4**

Other participants felt that BPD was simply a more judgmental and less compassionate construct that was applied to the same set of women who could just as easily meet the criteria for C-PTSD:

'I'm sold….it works for me as a formulation or diagnosis if you like… given the way that borderline personality disorder is in effect deployed in my view, a straight swap with complex PTSD could just be made. Just get rid of it. Call it complex PTSD. There'd be almost nobody left outside the box. **Professional 2**

Even though some participants conveyed that C-PTSD as a diagnostic framework might usefully contextualise women's offending behaviour, there were concerns that the diagnosis was essentially a linguistic step toward excusing criminal acts and vigilantism. There was a sense of fear that women's identities as perpetrators of violence were essentially compromised by the salient introduction of their victim status:

It's the distinction between trauma as a categorical event that you're going to deal with, as it were, as opposed to trauma that has informed you of the development of yourself and your personality. I think I'm less in favour of the former than the latter. I'm not at all convinced that a C-PTSD type of model in which, "Well, you suffered this trauma and this explains why you would do X, Y or Z," because as I've tried to articulate, it is quite complicated. **Professional 3**

Fears around the potential for diagnosis as a means of justifying violence emerged throughout the interviews with participants and will be revisited later in this analysis.

2) Definitions and meanings

The ways in which participants understood BPD were particularly important in relation to how they viewed the use of C-PTSD as an alternative. The interviews revealed complicated and contrasting definitions of personality and exposed a process of 'othering' in relation to the BPD construct.

a) Defining personality

Participant opinions regarding the use of the diagnosis of C-PTSD were not only related to their perceptions of BPD but also by their multiple and complicated understandings of the term 'personality'. There was a perspective that the term 'personality' described action rather than fixed states of being:

'…because your personality is something that you do. Your personality is something that you do in order to be a social animal. We all of us need a good enough level of personality functioning to do social life to a good enough level for human flourishing. If we can't do our personalities well enough then we're going to struggle... your personality isn't a feature of you. It's something that you're doing all the time. You're doing your personality. I'm doing my personality [laughs] now as I'm speaking to you.... It's not just a feature of me. **Professional 3**

Other participants understood the term personality as being a set of fixed characteristics that make us who we are. There was a perspective that any commentary on a woman's personality would inevitably be experienced as derogatory by her:

One of those basic things we say when we're talking about trauma is having staff and people change the question they're always asking which is, "What's wrong with her?" Get rid of that question, "What's wrong with her?" to "What happened to her?" When you use a diagnosis of borderline personality disorder it's automatically about, "What's wrong with her?" It's her. It's her personality. When you talk about trauma it's "What happened to her?" Those are two very different attitudinal stances. They're two different ways of approaching her and different ways of her thinking about herself. **Professional 4**

In line with Pilgrim (2001) a different perspective looked at 'personality' in relation to moral judgments and likeability, highlighting ethical concerns regarding the use of the term in any form of formulation or treatment. One participant explains the perlocutionary effect of using the term 'personality' irrespective of its locutionary intention:

I'm not interested in their personality, other than the fact that I almost invariably like my patients. What's that got to do with diagnosis and treatment? I'm not treating the personality. That would be wrong…because the personality disorder frame wrongly directs attention towards the personality. Okay, 'coming out with a new personality, being a new citizen'…. Well, that's not what I thought it was about?… just 'be' someone else for us? No. Let's clear away all the medical legal technologies and find out who you are, without the judgment, explore it, you could be anyone and that's nothing to do with personality at all. It's a complete misnomer. **Professional 2**

Some participants expressed frustration and anger at the perceived misapplication of psychoanalytical concepts in the context of staff and patients understandings of BPD. The interviews revealed a sense of alarm at identifying a process of perceived reverse victimization, where staff generated a caricature or stereotype of a woman with BPD that then obscured or reframed all of her engagements within the system. The misuse of psychoanalytical concepts within the BPD construct facilitated locating pre-existing and distressing team dynamics within the patient:

If the diagnosis is BPD, any moment now I'm going to hear that the person is splitting the team. It's that way around. It makes me so angry… splitting is not something that some demonic little mini-skirted Machiavelli does to a team and makes the team into a victim. Splitting is actually what happens within the team. The teams feel split, oh my God, do they feel split, they'll say "oh the patients on the ward are splitting us." No, they're not. The

patients are going about their habits and their patterns and their safety practices and their survival strategies and we're in a tangle….because the men and women in the team aren't talking to each other, because the doctors and the nurses in the team aren't talking to each other, because the psychologists and the occupational therapists aren't talking to each other, because the Nigerians and the Ghanaians aren't talking to each other, but not because Michelle is a mini skirted Machiavelli. **Professional 2**

Redirecting systemic issues by pathologising women was undoubtedly seen as systemically abusive and was understood as a step towards alienation and 'othering'.

b) Defining the 'other'

All participants made reference to the idea that women who had experienced extreme trauma were experienced as being too similar to 'us' and therefore made 'our own' sense of vulnerability intolerable. There was an understanding that traumatised women do not always behave in stereotypically 'mad' ways. They can appear articulate, intelligent, and questioning. Some participants reflected on their feelings of identification with women. They explored how negative attitudes and prejudice from staff towards traumatized women might serve a psychologically protective mechanism, which allowed them distance from stories of torture:

Yes, they all attract a tremendous amount of stigma and dislike partly from the way that they behave and the fact that they, if you like, are much more like us than people who are in very altered state of mind. I think we do everything we can to push them as far as possible. **Professional 5**

….so you see, people with personality disorder just don't do patient, biddable, cooperative, grateful, all that and different. They don't do the really important thing, which is to be different enough from the doctors and nurses in terms of function and articulacy, and intelligence. **Professional 3**

There was a perception that C-PTSD as a diagnosis was an attempt to 'be nicer' to women who had experienced trauma. Within the context of 'othering' some participants felt that renaming or redefining BPD was futile. It was felt that this would not ultimately enable us to reduce our perceptions of them as the 'other' and would therefore have no impact on potential negative treatment and attitudes of staff towards women with that label. Some participants felt that negative perceptions and treatment were entirely unrelated to the construct of BPD and instead, were located solely in the distancing phenomena that occurred between a trauma victim and staff:

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I'm always very interested in how our attempts to clean up the language doesn't really get down to the fundamentals underneath. You see that a lot in prisons, I'm sure you've come across that. You're no longer allowed to call prisoners 'cons' for instance. They need to be called 'mister so and so' rather than just by their surname. It doesn't mean they're treated any differently because the fundamental idea is that they're still the 'other.' In some ways, I think I'd go with the more negative term in a way, which is personality disorder.

Professional 5

Other participants felt that the construct and the label itself was derogatory in nature and contributed to women's experiences of iatrogenic harm. One participant expressed shock as they reflected on an encounter with a prison-based psychologist who made attempts to reframe the construct as a term of empowerment:

I said to her "I'm really concerned about labelling," and she said to me, "People can take labels and make them their own in really positive ways." I said, "Really!?" she said, "Yes." she said, "Don't you think it's interesting that in some countries you don't use the word 'nigger' if you're white, but you can use it if you're Black? A woman can use the word 'dyke' if she's a lesbian, but she doesn't want to be called one?" She said, "We could do the same thing with borderline personality disorder", and I was like-- [laughs]. I mean, to me, I was speechless because I thought, if she was trying to justify this and tell me that it's okay for a woman to be labelled in the same way that these other labels are used in a very derogatory way and somehow… "even if it's derogatory she can now use it in her own way, in a positive way". My idea is that, how about not just using derogatory labels? **Professional 4**

Some participants reflected on the way in which systemic 'othering' had combined with perceived evidence of BPD symptomology to create a disempowering and individualising discourse around women's behaviour. One participant expressed their sense of powerlessness as they described their own complicity in these processes. The participant observed how women's environments are structured in ways that generated responses that become understood as evidence of BPD pathology:

Women get diagnosed with borderline personality disorder because services are organized in such a way that people do have a reaction to changes and discharges from treatment. It does start to look like a frantic effort to avoid a real or imagined abandonment, in that awful phrase, but it's because we've invited people to depend on us in particular ways. People then might get triggered in all sorts of ways and we say, "What's this? Got a bit of a borderline feel to this, hasn't it?" but we've done it. Do you know what I mean? We've superimposed an agenda there. Made them dependant, made them trust, then withdrawn and labelled them for the reaction. **Professional 2**

Perhaps an important thing to note here is that women are frequently unaware of these kinds of processes in forensic services. As Budge (2016) reflects in her research into violence and aggression, forensic staff hold their own, un-communicated norms and idealized standards of what constitutes non-pathological behaviour. She observed that staff frequently misattribute these broken norms as 'boundary pushing' or as evidence of dysfunction within female patients, highlighting a greater need for transparency and communication between staff and women in forensic services. As we will see in the next section, this process of attributing systemic failings to patient pathology revealed serious implications in terms of what we might hold women accountable for in forensic services.

3) Responsibility and blame

Accountability and responsibility were integral to whether participants viewed BPD or C-PTSD as more or less helpful in framing women's manifestations of distress.

a) Agency or infantalization

Participant perspectives of BPD and C-PTSD contained themes relating to responsibility, agency and blame. One perspective was that C-PTSD implied a sense of permanent damage. This view was associated with archaic, misogynistic thinking regarding the esteemed purity of women and their perceived 'spoiled' status after experiences of sexual violation. The perception of permanent damage was also linked to women's potentially unhelpful over-identification with a victim identity, an identity that brought about feelings of hopelessness and a reduced sense of agency:

I mean it's a misogynistic, conservative, reactionary view, which is actually in relation to women, which is really pushing an idea that if your sexual parts have been touched by a man you are spoiled forever. You can see it even today, if you've been groped on the bottom, if your breast has been touched, that's it. You've been traumatized. Boy, are you damaged. You may never get over it. **Professional 3**

This participant elaborates on their perspective of agency revealing concerns regarding gender equality. The right for women to face the consequences for their actions was seen as a feminist concern and it was felt that BPD as a construct enabled this, as it was not associated with the mitigating effects of the victimisation status related to a C-PTSD diagnosis:

Stereotypes of femininity exclude anger, and agency, and that's the main reason in a way for my slight agitation about wanting women who've done violent things to be allowed to own

their anger, and their cruelty, and their hostility as agentic citizens like anyone else. I want them to face the same demands of responsibility as other citizens because that's what equality means. **Professional 3**

In contrast to this view, some participants felt that demanding agency without acknowledging context was disproportionally making women responsible for their actions. The diagnosis of C-PTSD was seen as a way of contextualising an individualising discourse that was seen as pervasive throughout the prison service and inherent to the construct of BPD. One participant proposed a human rights-based approach toward female offenders. They conveyed a sense of social injustice and unfairness with regards to our expectations of women in contrast to our expectations from the state. It also revealed how individualizing approaches can operate in opposition to a human rights-based approach resulting in women blaming themselves for their own abuse experiences:

The relevance of trauma it seems to me, is as an indication of how the state has …failed in its part of the social contract to protect girls and women. Therefore the state is now obliged once they (women) are now offenders…..these are citizens that have rights, that they are bound by the social contract, yes they're in prison because they've broken the social contract, but if we want to hold them responsible then we have also got to say that the state should also be held responsible for its failings and therefore it has an obligation to deliver services that acknowledge and address these traumatic experiences that the women have had. To enable them to….not just to think it's them, it's their pathologised personality, because so many of the women as I'm sure you know they blame themselves for a lot of the consequences of trauma but also the fact that they were abused in the first place. "There must be something about me," they'll very often say, "I pick abusive men why do I do that?" **Professional 1**

In addition to this perspective of social justice in relation to victimised women being 'owed' accountability and support from the state, there was also an understanding that forensic services inflict iatrogenic trauma on women in an unreflective way:

I think quite sadistically. You've been abandoned in early life, now let's discharge you in the most abandoning way possible. We move you between prisons without giving you any notice or chance to say goodbye. **Professional 5**

Perhaps the over-responsibilisation of women is a defence against the collective anxiety that we may have somehow contributed to both the violence committed and the violence survived. We may also simply not know how best to help deeply traumatised people and resort to responsibilisation narratives in order to feel less exposed or deskilled. This process

could be related to Crawford (1977) who revealed that victim-blaming occurs as a defence when critiques expose the limitations of medical frameworks, and Baer, Hays, McClendon, McGoldrick & Vespucci (1998) who argued that emphasising personal responsibility in health settings fosters a victim-blaming ideology which seeks to depoliticize socio-political determinants of poor health.

b) Victim blaming / Victim empowering

Part of the concern participants expressed regarding the use of the BPD construct was a negative view of the label's historical antecedents. They felt that term produced the perlocutionary action of judging victims of trauma as being morally flawed. There was a sense of shame associated with the historical application of these antecedents and a desire to move away from what was seen to be out-dated and judgmental ways of thinking about women's distress:

Systemically, personality disorder really means moral insanity- it derives from moral insanity in a straight line. Therefore, the habit and pattern of the pejorative attribution goes right back to its origins. It's complicated because on the one hand that was a move by the medical guilds to get a foothold in the criminal justice system. **Professional 2**

I actually was rather appalled that the criminal justice system had this personality disorder unit and pathway. I said, "You've got to be kidding me". That was my first response back when I first heard about it being introduced, a few years ago. I was like, 'We've spent years trying to get away from that kind of thinking and you've actually gone and institutionalized it. **Professional 4**

An alternative position with regards to victimisation related to the role of C-PTSD. In this instance, the emphasis on women's experiences of victimization was seen as potentially overshadowing other aspects of their personality. It was felt that over-identification with a victim identity could be disempowering for women. BPD was felt to be a more empowering diagnosis as it incorporates experiences of abuse without these being the most important aspects of a woman's identity:

At the end, you can say, "Yes. My dad did abuse me, it was very frightening and shameful. I hated him for many years. Now I understand that actually that was then, and this is now. I don't need to think about this if I don't want to. I have the space to make choices about how I think about it, rather than letting it define who I am. Yes, I was sexually abused by my dad, but I was also loved greatly by my mum. I was also pretty good in school, at sport. I am also somebody who is really good at being a friend. I'm actually really good at deep sea diving.

This doesn't have to define the story of my life. Is it possible that I learned something out of this terrible experience?" **Professional 3**

It was felt that experiences of abuse might be more easily reframed within the construct of BPD. C-PTSD was believed to convey a one-dimensional trajectory of hopelessness. The perspective that BPD could provide a sense of hope via increased agency was connected to the idea that mental health professionals would be able to impart specialist knowledge and understandings related to PD. There was a hesitation connected to C-PTSD due to the current lack of evidence-based treatments. One participant felt that the evidence base surrounding BPD could be used in a way to educate and thus empower women to change aspects of themselves that contributed to their experiences of victimisation:

For me, it makes sense to say my personality got distorted, or disorganized, or rendered dysfunctional by my childhood adversity. Now I need professional help to reorganize myself, to become more resilient and less vulnerable. Here are some of the ways that we can do that. **Professional 3**

However, some participants emphasised the importance of power dynamics when attempting to impart expert knowledge to this population. There was an acknowledgment that women in forensic services are rarely able to define their own distress and experience relentless interpretations of their behaviour. This can result in the replication of an abusive and disempowering dynamic:

When you look at it through a trauma lens, I just think it's less judgmental, less stigmatizing, more hopeful. I think it gives women a different level of understanding about themselves. They become more compassionate towards themselves versus judgmental. It's more empowering. There's something so disempowering about having somebody with some academic degree telling you who you are. I just don't see that as helpful at all. **Professional 4**

Webb (2016) suggests that a trauma framework can be seen as either empowering or disempowering depending on the participant's normative understanding about the malleability of their condition.

c) Blame and agency

Participants explored some of the reasons why they felt women with a diagnosis of BPD were treated poorly. One the themes centred on the idea that women were always aware of and therefore responsible for their actions. Although this perspective was associated with an increased capacity for agency, it also came with increased blame for manifestations of

distress. One participant role-played a scenario of a typical patient with BPD and how this presentation contributed to the patient's rejection:

If you don't admit me, I'm going to kill myself." "Well, I haven't got a bed to admit you." "Well, I don't fucking care. That's not my problem. It's your fucking problem. I'm going to kill myself. If you don't admit me, I'm going to kill myself. I've done it you know. You just don't care. You're just in it for the money. You just don't care, I can tell. What do people like you know? You don't care." After a bit the psychiatrist thinks, "All right. You're right. I don't care. [laughter] Sod off." **Professional 3**

This shocking excerpt reveals perhaps the effect of the diagnosis on practitioners' responses to traumatised patients. The perspective that women were always aware of their actions led participants to make assumptions about deliberate intention. Some felt that as a result of this apparent self-awareness women frequently attracted negative attributions, which had the impact of scapegoating:

'…your personality is disordered and our personalities aren't disordered. So there's always an attribution and a habit and a pattern, so then attention seeking, manipulative and deliberate self-harm and splitting just follow down that pathway. It's like as a neural pathway, associations.' **Professional 2**

Within the context of speaking about BPD, this participant goes on to explain how blame can be misattributed to women who are frequently trying to get their needs met in hostile environments with limited resources:

It makes me very angry. I imagine that if such and such a woman has grown up in institutional care since the age of three and is now coming to us at the age of 26, or 35, or 42. That probably, if they've survived at all, they've probably learned to go to worker B if worker A says no, because it's fucking important that they get their leave, or their cigarettes, or whatever it is that they're asking for. "Shit, I'm going to try someone else around here." This does not make them manipulative or splitting. **Professional 2**

Another participant noted the effect of the environment on women's distress levels, recognising that sometimes, attributing blame is a complex interaction involving both individuals' responses and structural oppression:

All too often services disempower to the point of dangerously infantilising women which activates deterioration. **Professional 6**

Participants engaged in discussions around the extent to which women could be held accountable for their violent actions, both towards themselves and others. One perspective was that women were able to prevent themselves from carrying out violent behaviour, such as self-harm, when sufficiently incentivised to do so. In contrast to this, some participants felt that the diagnosis of BPD obscured the extent to which trauma victims may experience dissociative phenomena and fear conditioned behaviours:

….they blacked out, they just weren't there, that's what's they say to me, that they're in stressful relationships which sometimes trigger memories which then they black out, they do this terrible thing but they completely shut down on that memory so they often don't have good memories of what happened after they stabbed the person. **Professional 1**

In contrast to the blaming discourse associated with BPD, some participants felt that the discourse associated with C-PTSD relocated the majority of blame outside of the individual woman:

Complex Post-traumatic stress exactly, it is complex but you're emphasizing it's not just this one off event and the fact there's a link to assumption that something isn't lacking in them, morally, that actually something has happened to them, that they have experienced, which doesn't place all of the responsibilisation on them. It seems to me to make a lot more sense kind of just intuitively as well that people will be responding to these certain events in their past. **Professional 1**

Conclusion

The aim of this study was to explore key informant perspectives on the potential role of C-PTSD in women diagnosed with BPD in forensic settings. The results of the analysis highlight several important areas to consider.

Firstly, views regarding trauma relate to the presence or absence of belief in the general medicalization of women's distress. Secondly, people may understand the term 'personality' differently which could account for some of the confusion and pejorative attributions associated with the diagnosis BPD.

Finally, the confusion around the concept of personality, coupled with over-responsibilisation and the iatrogenic impact of the BPD diagnosis result in the diagnosis of C-PTSD being viewed by some as an ethical compromise. This compromise forms a mid point between the medicalized BPD construct and non-pathologising ways of understanding and supporting women with trauma. In line with other research (e.g. Lee, 2017; Seagrave and Carlton, 2010), there was substantial resistance regarding the medicalization of women's responses to trauma.

However, C-PTSD was seen to contextualise and individualise women's offending and thus offered some acknowledgement of social responsibility in women's offending whilst acknowledging that at this time we cannot easily move away from a psychiatric discourse.

The concerns raised in this research about medicalizing responses to trauma are in line with a current paradigm shift in the community based psy-professions to move away from diagnosis towards more socio-politically focused forms of assessment (Duncan, Sparks & Timimi, 2018; Johnstone & Boyle, 2018; Thomas et al, 2005,). It would appear that psychiatry, as a discipline, is also making some attempt to incorporate challenging new evidence from the field of traumatology (Valent, 2018).

In some ways, the focus and findings of this research are in line with the work of Rose (1998), who encourages a move away from the use of medicalized technologies as means of social control, by exploring how diagnosis is being used and experienced within institutions irrespective of its locutionary intention.

Nevertheless, it is clear that some people in forensic contexts believe that abolishing the BPD construct might be futile. This perspective is upheld by the idea that the oppressive treatment of those with the label is a result of women's problematic behaviour coupled with our psychological need to create distance from trauma narratives.

Whilst these are important factors to consider in the iatrogenic harm committed against women with a BPD diagnosis, the current research reveals the construct itself to be inherently pejorative. It also shows that poorly understood psychoanalytical concepts are frequently amalgamated into staff understandings of the psychiatric construct producing

the perlocutionary function of locating systemic and staff failings as deficits within the women's own pathology.

Miller (2016) found that prompting staff to remember trauma histories associated with their patients diagnosed with BPD led to a direct and significant decrease in staff's negative attributions. This reveals that trauma engenders compassion but requires constant reminders to redirect or reframe defensive attributions.

Whilst it is important to avoid what Lamb (1996: 8) refers to as 'the over purification of victims', the diagnosis of C-PTSD could serve as a medically legitimised reminder or prompt in order to continually seek a more empathic, less blaming response from forensic staff. What is clear from the findings is that our current understanding of the term 'trauma' is too narrow and would need considerable investigation in order for the diagnosis of C-PTSD to be useful for women with different traumatic aetiology.

Limitations

This research cannot be argued to be generalisable given the small group of participants and the qualitative approach. Nevertheless, if the expertise and diverse backgrounds of the participants are acknowledged, this research does provide us with an overview of some of the current debates and tensions occurring within forensic services.

As a researcher with lived experience of having had a BPD diagnosis, I am inevitably influenced by my own experiences, both in terms of my research findings and my conclusions and it is important to acknowledge that neutrality in qualitative research does not exist (Braun & Clarke, 2006). I have attempted to mitigate the inevitable degree of bias inherent to this piece of qualitative research by presenting my analytical process in a clear and transparent way.

Implications and suggestions for future research and practice

Future research efforts should focus on exploring women's own descriptions of extreme distress and determine the potential harms associated with epistemic injustice in forensic contexts.

In addition, an ethical and robust evidence base should be sought for C-PTSD treatment pathways. One way to moderate the impact of women's traumatic experiences would be to offer informed choice regarding their preferences for C-PTSD, BPD or diagnosis in general.

However, this should only be implemented if women are made fully aware that a medicalized understanding of trauma is simply one way to frame their distress. In terms of forensic practice, professionals could have transparent and collaborative conversations with women about the debates surrounding diagnosis as a means of engaging women in trauma-informed therapeutic work.

Women have a right to the knowledge of the multiple limitations and iatrogenic harms occurring within forensic systems. It is only once we as practitioners can acknowledge and convey how these women have been failed that we can reasonably expect them to take responsibility for their actions and ultimate desistance in crime.

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