Feminist critiques of “BPD”

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More than “stigma”

• Multiple studies, nearly 20 years apart: clinicians less optimistic about patients with same presentation if they have a “BPD” diagnosis & see patients with “PD” diagnosis as less deserving of care. ([Lewis & Appleby 1988; Lam et al 2016; Chartonas et al 2017](#)).

• Particular problem among mental health nurses ([Dickens et al 2015](#)).

• 2 major policy initiatives aimed at improving treatment took place in the time between these studies (“No longer a diagnosis of exclusion”, 2003; “Meeting the challenge, making a difference”, 2012).

• What some people experience as a result of this diagnosis goes way beyond stigma – there is clinical neglect & concrete discrimination.

• Perhaps this diagnosis is irredeemable?
Research bias

• There are established avenues for recruiting people to studies and / or finding research literature which accept the construct as valid – e.g. via “PD” services or search terms relating to personality disorder.

• From inside the university, it takes more work to find the people for whom this is a diagnosis of exclusion, or people who work outside the construct – people & services who don’t accept it are more dispersed & don’t work on a single alternative model.

• Research ethics committees often want patient participants to have a clinical team to “manage risk” and/or interviews to happen on NHS premises.

• This is not a neutral position: shuts out people who are excluded from services and/or those who have difficult relationships with clinical teams.
In theory, diagnosis in the UK is based on ICD-10 or DSM-5. However, DSM-4 formulation of symptoms also often quoted.

75% of people diagnosed with BPD are women.

Very little research focused on queer populations and BPD.

2 possible critiques in response to this:

“BPD” does not stand up to scrutiny as a construct; it represents the pathologizing of stereotypically “feminine” traits and/or a means of exerting social control over those who don’t fit gender norms.

OR “BPD” represents a (poorly named) valid construct which occurs more often in women because women’s life experiences mean that we develop its “symptoms” as coping strategies for trauma / in response to punishment for not fitting social norms.
Hysterical women

• Not entirely mutually exclusive – the diagnosed population is diverse enough to include people whose experiences reflect both of these. Remember only 5 of 9 criteria need to be met to diagnose.

• Nobody gets this diagnosis without experiencing utterly soul-sapping despair, and that pain is real and needs care.

• But many of the diagnostic criteria are deeply problematic and extremely subjective – there has to be a better way to frame it than this.

Featured in Asylum magazine & The Book of Hands (self-published zine, 2017)
How is a diagnosis (really) made?

- Little research on how service users in the UK actually receive a BPD diagnosis.
- Might assume people are diagnosed via formal diagnostic assessment – but this is often not the case.
- Use of euphemisms / coded terms like “BPD traits” or “personality difficulties”.
- Many people aren’t told this diagnosis has been given.
- Obviously twitter polls aren’t the world’s soundest methodology – but in the absence of formal studies they can flag areas for further investigation.
If you’re not outraged, you’re not paying attention

• DSM 4: “Inappropriate, intense anger or difficulty controlling anger.”
• DSM 5: “Persistent or frequent angry feelings.”
• ICD-10: “A tendency to quarrelsome behaviour and to conflicts with others, especially when impulsive acts are thwarted or censored.”
• Who decides when anger is appropriate?
• After the women’s marches, after #MeToo – perhaps it is finally time to listen to women’s rage?
“Emotional dysregulation” and trauma

“Notes on victimhood”, from “Notes on the Unfathomable” by Emily Sheera Cutler (experimental autobiographical writing – quoted with permission)

Who is recognized as having been legitimately victimized?

People who are perceived to have a greater degree of restraint = more recognized as victims

People who are perceived to have a greater degree of restraint = perceived as more deserving of care

Mad people, fat people, unattractive people, people of color = perceived as lacking restraint - excessive, insatiable, manipulative

This is one reason Anorexia Nervosa is seen as being at the top of the hierarchy of psychiatric disability - seen as evidence of restraint

[...]

Borderlines = perceived as lacking restraint over their own emotions to such a strong degree that they will manipulate you into caring about them

Borderlines = illegitimate victims
The myth of a stable identity

so many selves (so many fiends and gods
each greedier than every) is a man
(so easily one in another hides;
yet man can, being all, escape from none)

e.e. cummings
Black & white thinking / idealisation & devaluation

6. Do not admire or pin any hope to a professional who appears to understand the social context of your distress (this is idealisation, 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. (Naturally, 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 okay 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/madam’.

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?
Adding insult to (self) injury

• Self harm often seen as a way of managing intense emotions and associated with impulsivity (linked via “BPD” diagnosis which has both impulsivity and self harm as diagnostic criteria).

• While sometimes true, this is quite a superficial explanation of its function.

• Often neglected areas are e.g. self harm as a form of negotiation or compromise with intrusive thoughts or voices; self harm as (re)claiming control over the body; self harm as punishment for perceived wrongdoing.
CPTSD – an alternative to “BPD”?

“... may develop following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (e.g., torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse). The disorder is characterized by the core symptoms of PTSD; that is, all diagnostic requirements for PTSD have been met at some point during the course of the disorder. In addition, Complex PTSD is characterized by 1) severe and pervasive problems in affect regulation; 2) persistent beliefs about oneself as diminished, defeated or worthless, accompanied by deep and pervasive feelings of shame, guilt or failure related to the traumatic event; and 3) persistent difficulties in sustaining relationships and in feeling close to others.”
CPTSD – an alternative to “BPD”?  

- Overly prescriptive about what “counts” as trauma & how it can show itself.  
- Omission of structural, iatrogenic, intergenerational trauma – we will not reach understanding if we police trauma experiences, if we make people hold up the worst experiences of their lives to a stranger and ask “Was this bad enough to justify how difficult I am?”  
- Risk of simply transferring the prejudices associated with “BPD” to a new name.  
- Risk of simply imposing a different framework.  
- Handle with care to avoid denying people support in the process of change.  
- Maybe a step in the right direction - but definitely not the whole solution.  
- Models can’t help anyone outside of their implementation & implementation is messy; no point saying “We acknowledge the role of trauma in your difficulties” if you then just carry on as usual.  
- Sweeney & Taggart (2018): (Mis)understanding trauma-informed approaches in mental health: “There is an inevitable risk of co-option: that trauma-informed approaches will come to mean little more than treatment as usual repackaged as trauma-informed.”
Language matters, but so does who’s using it – and what they mean
In times of austerity, it is not possible to practice ethically without supporting benefits claimants through appeals, work capability assessments, etc.

Women have borne the brunt of austerity (86% of direct impact of welfare cuts).

DWP decision makers unlikely to be experts in mental health & may well expect claimants to have a diagnosis & be on medication.