

Rachel Rowan Olive 22/1/19 - feminist critiques of “BPD”

I’m going to talk about some of the feminist issues surrounding BPD and why getting this diagnosis is like the world’s least fun game of bingo, with a shit prize at the end. There might be things in my presentation that are painful or difficult to hear, especially stuff around self harm and suicide and the way those are responded to in mental health services, so consider this a trigger warning and feel free to leave at any time if you need to without feeling the need to explain yourself.

I’m going to go through some issues with existing research on “BPD”, then take a look at some of the diagnostic criteria and finally have a think about some of the proposed alternatives.

In a perverse sense I’m one of the lucky ones with this diagnosis: at least I have a care co-ordinator who doesn’t seem to hate me because of my it. She works in a community “personality disorder service”. But that hasn’t shielded me from being treated with disdain by other clinicians because of it.

More than stigma

So it might not be professionally acceptable to call us manipulative or attention seeking these days, but those opinions haven’t gone away. Often what we experience at the hands of clinicians is described as “stigma” but I don’t think that does the experience justice. When I said to the crisis team that I could not keep myself safe overnight, and they said ok, see you tomorrow, and I left and made a suicide attempt which I survived thanks to the intervention of a stranger – that wasn’t stigma. It was neglect.

So if we still experience this after all these policy initiatives and anti-stigma campaigns – maybe it’s time to admit this diagnosis is irredeemable?

Research bias

A lot of research in this area is somewhat problematic because the validity of the diagnosis is contested ground and relatively little research does more than pay lip service to acknowledging that. 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. It’s very easy to accidentally adopt a biased

position. From inside the university, it takes more work to find the people for whom this is a diagnosis of exclusion, or people who work in different terms as there is less consensus.

Another issue is that university ethics committees' and service users' perceptions of what matters are often quite different: ethics 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: it shuts out people who are excluded from services and/or those who have difficult relationships with clinical teams.

Hysterical women 1

So how does a diagnosis get made? In theory, it's based on either DSM-5 or ICD-10 criteria. When we look at those diagnostic criteria in more detail, I want you to bear in mind the contextual information that a) 75% of people diagnosed are women and b) you only have to tick 5 of 9 diagnostic boxes to get a diagnosis.

There are 2 possible feminist critiques of BPD that can be made in response to the huge gender variation in diagnosis. You can either say "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 you can say "BPD" represents a (poorly named) but valid construct which occurs more often in women because women's life experiences mean that we develop its "symptoms" as coping strategies for trauma or in response to punishment for not fitting social norms.

Hysterical women 2

I don't think those are entirely mutually exclusive – the range of people given this label is so wide that there may well be people for whom either or both of those are true.

And it's important to be clear that this is not a diagnosis you get without experiencing some kind of very real despair, which needs to be recognised and supported.

But when you look closer at the diagnostic criteria you start to see how problematic and subjective they are, and how they let in certain societal expectations of women into what is viewed as pathological and what isn't.

How is a diagnosis really made?

Before we go on to some of the particularly problematic criteria, I just want to say something about how people are in practice given this diagnosis. I had an assessment over several sessions with a clinical psychologist – but by the time I had that assessment, I had already been given a "Provisional" diagnosis with no formal assessment which was listed on my notes and which was treated as my diagnosis for all purposes other than actually getting me on a waiting list for therapy, which required a more thorough assessment. Funny how the part of diagnosis which gets you access to help that costs money involves a much more thorough process than the part where it's just a clinician's unjustified opinion that doesn't get you access to any support at all. I never consented to that "provisional diagnosis" being

made, and I only found it was actually on my notes because I overheard one clinician telling another on the phone.

Before I got anywhere near a specialist service, a psychiatrist who assessed me after an overdose wrote in a letter to my GP that I had a history consistent with “personality difficulties”, whatever that is supposed to mean. There’s a whole constellation of vocabulary like this, things like “difficulties consistent with” or “traits of” bpd, which effectively mean “we can’t be bothered to do an actual assessment or we know it doesn’t really fit, but will stick you with this label anyway.” If people are getting the diagnosis and not being told about it, who is the diagnosis even for? It becomes something made by clinicians, for clinicians, for the sake of relieving their anxieties and justifying their prejudices.

The reason I’m mentioning this today is that there’s no point analysing support in this area if we pretend that the diagnosis is implemented in practice the way it is conceived in theory. We have to look at what is actually happening.

Outrage

So, on to the actual diagnostic criteria. One of the most problematic is “inappropriate, intense anger or difficulty controlling anger”. Who gets to decide when anger is inappropriate? It’s unlikely to be the service user / patient. There have been times when I raged against iatrogenic abuse and this was attributed to my disordered personality – because it’s impossible that the clinician could be doing anything that might make someone angry. Then there’s the wider context we are all living in. Have you seen the global political trashfire at the moment? Have you seen what’s happening to the welfare state? Jesus, if you’re not angry and suicidal I just don’t think you’re paying attention. I think now, after the me too movement and everything that’s followed, it’s time we stopped telling women their anger is pathological and start looking at what it is that is making us rage.

Emotional regulation & trauma

Another of the criteria is often described as “emotional dysregulation” or “lability”. There’s a complicated relationship between this and trauma. [Emily Cutler in this autobiographical piece writes that we idealise restraint; you can be seen as a victim if you are quiet and restrained about it. I think we also have to see this criterion in the context of a long and noble tradition of pathologising women’s emotions dating back to the idea of hysteria as our wombs detaching and floating around inside our bodies (cheers, Plato).

So I suggest that Borderline Personality Disorder is a label given to women who fail to meet society’s standards for appropriately expressing emotion – we are too intense and too angry. This is often because those standards have failed to protect us from trauma and have not allowed us to speak about it. For many, that trauma was sexual abuse or domestic violence, or other horrors from the “Official” list of adverse childhood experiences – but just

as important is the day-to-day pain of difference and marginalisation that eats away at who you are – discrimination due to sexuality, gender and gender identity, race, neurodivergence, class, poverty. I'll come back to this later.

The myth of a stable identity

Then we have this idea that people with BPD have an unstable sense of self. But the idea that it is normal to have a stable sense of self which remains the same in different contexts and across our lives is contested, at best. It's not unusual to enact a different identity in a different context. Before I was mental I was a literature student – and honestly, people have been contesting and playing with the idea of a stable identity for as long as we've had written language, and as far as it's possible to tell, since before then. This Cummings poem is a nice example but it's by no means the only one.

Who doesn't question who they are and what they are doing with their lives, if they're really honest with themselves? I'm not saying it's necessarily entirely wrong to think that people have some kind of sense of self where aspects might remain stable, or that there can't be degrees to which people question this, but I am saying that psychiatry / psychology here is taking as a given something which is very much disputed ground in all other areas of thought.

Black & white thinking

This is from survivor / service user collective Recovery in the Bin's satire on the PD cluster of diagnoses. I would recommend reading it, it's very funny. I'm not going to read it out and it's not necessarily gender-specific here but I just want to draw attention to the point that it takes two to tango in a clinical relationship.

Insult to injury: I want to say a quick word about self harm as I'm fairly sure BPD is the only diagnosis to specify self harm as a diagnostic criterion. It's also more common in women and girls – there's been a fair amount about this in young women in particular in the news in the last year or so. The picture on the right is from a self-published zine I made a couple of years ago called A is for Awkward and it's a reflection of the very simplistic model of self harm which seems to be drawn on quite frequently by mental health professionals of various stripes. The expectation is that there's a trigger and you act on it immediately and impulsively – it's become linked to this idea of emotional dysregulation and impulsivity via the BPD construct. That's not really how it works for me (except on one or two occasions where the trigger has been the environment of a psychiatric ward). Generally it's much deeper and more complex than that and it's very frustrating to be expected to fit this neat narrative which matches up to the idea of BPD as "emotional dysregulation". The impact of this diagnosis bleeds out into other areas of clinical practice and shuts down thinking and clinical curiosity.

CPTSD: So if BPD is so deeply flawed, what do we do? Some have suggested switching to Complex Post Traumatic Stress Disorder, which is actually going in ICD-11 but separately to

the “personality disorder” section, which collapses the distinct pd diagnoses into one but with separate “patterns” including a “borderline pattern”. As you can see there’s quite a lot of overlap between the diagnostic criteria for CPTSD and BPD in terms of ideas around regulating emotion and relationships with others.

CPTSD 2: But while CPTSD might be less insulting than BPD, is it going to fix things? I think it has its own flaws. For one thing, I suspect that any diagnosis which has affect regulation issues on its list of symptoms will be disproportionately given to women. This might be less of an issue if the label didn’t imply that this was a personal flaw, but I do think there’s a risk of just transferring the same prejudices and iatrogenic traumas to a new name.

Like with the question of who decides that anger is inappropriate - who will get to decide whether an event or series of events is “extremely threatening or horrific”? Again, I think it’s unlikely to be the service user. The examples of trauma ICD-11 gives are quite specific - while they are just examples, in effect they are likely to function as a ticklist. But trauma is deeply personal, and can be insidious and isn’t always obvious. There’s been a lot of publicity around Adverse Childhood Events in the last few years and while they might be a useful starting point, most of the things in my life that I relate to my current difficulties aren’t on that list and sometimes it makes me feel like my trauma isn’t enough to justify how much of a fuckup I am.

The examples given are horrific things to live through. But there is also trauma in relationships which are not obviously abusive but which slowly erode who you are and how you cope. The way the things that happen to you individually map onto the wider social and political context has a major impact on how someone develops coping mechanisms in response. Whether someone receives meaningful support to manage the aftermath of trauma also has a huge impact on how complex and long-lasting their difficulties become - if the help you receive piles iatrogenic trauma on top then obviously things are going to become complicated, but there’s no acknowledgement of this.

To meet this definition, feelings of shame, guilt & failure have to be “related to the traumatic event” - but if you’ve internalised those feelings it might not feel or look like they are related at all. This is maybe particularly true if the details of someone’s trauma fall outside this list of examples. What makes trauma difficult to process and complex is that the links between cause and effect can get jumbled, and memory of trauma is a tricky thing.

Just a quick note on language – this picture is from Buffy the Vampire Slayer. In season 1, Buffy starts a new school and accidentally jumps on one of the popular kids because she thinks she’s a vampire (as you do). The popular kid’s response isn’t “what the hell is wrong with you” - it’s “God! WHAT IS YOUR CHILDHOOD TRAUMA?!” But I don’t think she means it to be particularly validating. Switching to language about trauma doesn’t automatically mean we’re treating people better.

Social justice & welfare

I wanted to finish by saying something about welfare and social justice because it's probably the single most urgent factor in most service users' mental state. That quote from the cptsd definition about horrific situations from which escape is impossible pretty much sums up the benefits system. I think when we are looking at anything in mental health research we have to consider the austerity context, the fact that most services are stretched way beyond capacity and that there have to be alternative, meaningful ways to access support. I worry sometimes that all my activism on this issue is just going to push towards closing specialist services for "PD" but without any alternative support to fill the gap.

So while I am tired of being pathologized and insulted I'm also wary of normalising the things I find hard, particularly in a context where thresholds for both emotional and financial support on the grounds of mental health are dangerously high.