POWER, SELFHOOD, AND IDENTITY: A FEMINIST CRITIQUE OF BORDERLINE PERSONALITY DISORDER

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Abstract

This paper presents new perspectives on the conceptualization and treatment of Borderline Personality Disorder (BPD). This is achieved by first outlining current modes of classification, diagnosis, and treatment. Second, the current understanding is critiqued by deconstructing modern notions of selfhood and identity from which the BPD diagnosis is derived. A feminist critique is also explored as women comprise the majority of those diagnosed with BPD. Last, narrative therapy is discussed as a new treatment direction for BPD, and implications for clinical social work practice are discussed.

Borderline Personality Disorder (BPD) is currently conceptualized as an intense instability in mood, affect, and relationships. Named for the borderline between psychosis and neurosis, distinguishing traits of BPD include disturbances in self-image and chronic feelings of emptiness (Paris 2007; American Psychiatric Association 2013). Linehan (1993) has clustered BPD symptoms into five core areas of dysregulation: emotions, interpersonal, behavioral, sense of self, and cognition. People diagnosed with BPD experience chaotic interpersonal relationships and intense fears of abandonment. Impulsive, self-damaging behaviors are also common, such as reckless driving, spending, or sexual activity. Self-injury and suicide attempts are also characteristic traits (American Psychiatric Association 2013).

The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) broadly defines personality disorders as "enduring pattern[s] of inner experience and behavior that deviate markedly from the expectations of the individual's culture" (American Psychiatric Association 2013). BPD is therefore found in the Dramatic, Emotional, and Erratic

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cluster of the Personality Disorders section of the DSM-5, along with Antisocial, Histrionic, and Narcissistic Personality Disorders.

A BPD diagnosis is often based on self-reported information from the client and the clinician's observations (NCCMH 2009). Several structured interviews and assessments exist to guide the clinician's diagnosis, but outpatient settings most often rely on unstructured interviews, even though inter-clinician reliability on the BPD diagnosis is poor (Mellsop et al. 1982; NCCMH 2009). In the United States, 75 percent of those diagnosed with BPD are women, and BPD can only be diagnosed in someone under 18 years if features have been present for more than one year (American Psychiatric Association 2013).

Evidence-based treatments for BPD include dialectical behavior therapy, mentalization-based therapy, transference-focused psychotherapy, and general psychiatric management, including psychotropic medication (Gunderson 2011). Increasing emotion-regulation skills and tolerance to negative emotions tend to be the primary goals of the psychotherapeutic treatment of BPD.

A CRITIQUE OF CURRENT PRACTICES

In this section, I will offer a critique of the current conceptualization of BPD by addressing three primary areas. First, I will address the role of power in the diagnostic and clinical processes. Next, I will explore the particular conception of selfhood and identity that underlie and inform the diagnosis. Finally, because women are a great majority of those diagnosed, a feminist critique of BPD will be offered.

Diagnoses are a matter of classification and categorization (Foucault 1982; Madigan 1992). BPD is currently understood through an arrangement of human behavior that classifies like individuals into typologies of deficit. A personality disorder diagnosis declares the deficit to be a fundamental feature of a person rather than a transient state. When a clinician, armed with this model and definition, makes a diagnosis of BPD, for instance, the power to classify derived from this knowledge can influence how individuals view themselves in relation to societal standards. In Foucault's (1982) sense, the client may therefore internalize the problem discourse and come to understand themselves as deficient and that deficiency as a fundamental quality.

The etiology of BPD is a highly studied field by researchers, and even critics of BPD have adopted a causal model that names childhood abuse as a risk factor for BPD (Shaw and Proctor 2005). The public comes to think that BPD is the understandable and inescapable result of a stressor, when in fact it is a diagnosis dependent on the mere judgment of a clinician.

This is to say, "there is no disorder . . . unless somebody with authority applies a psychiatric conceptualization" (Burstow 2005, 1299).

Of importance here is that a BPD diagnosis is situated within the dominant Western discourse on identity, a conception of selfhood that values autonomy and goal-directed behavior. These characteristics are closely tied to cultural norms of self-provision through work. In order for members of society to be self-sufficient and goal-directed, personality and identity must be conceptualized as relatively stable, inherent aspects of oneself that emerge through behaviors, traits, and other external manifestations (White 1999; Bradley and Drew 2006). In traditional treatment, clinicians decode and interpret these manifestations in relation to their deviation from society's norms for behavior (Madigan 1992).

For example, self-injury and suicidal behaviors—two diagnostic criteria of BPD—are seen as pathological actions that undermine the valued sense of selfhood. Disrupting the dominant narrative of goal-directed behavior, the self-directed injury is seen as an inability to be an agentic, goal-directed individual. Some types of self-harm—such as overworking at one's place of employment to the point of causing physical ailments, neglect of interpersonal relationships, and loss of sleep—are not seen as pathological because these acts resonate with cultural values, such as self-sacrifice for a greater goal. But because the self-directed nature of self-injury cannot be reconciled with other cultural norms, self-injury is seen as a manifestation of severe pathology; the person must be viewed as disordered for such an action to make sense (Madigan 1992).

Studies of BPD offer us reasons to rethink these dominant conceptions of pathological behavior and the supposed stability of identity. We know now that BPD symptoms diminish over time such that "after about 10 years, as many as half of the individuals no longer have a pattern of behavior that meets full criteria" for BPD (American Psychiatric Association 2013). Another study showed that among an adult cohort, 73 percent were in remission from symptoms after six years (Zanarini et al. 2003), which undermines the narrative that personality is largely unvarying. Furthermore, many symptoms of BPD are normative during adolescence, such as chaotic relationships, recklessness, and extreme emotional shifts, but deemed unacceptable in adulthood.

Feminist critics of BPD offer an alternative perspective, generally viewing the diagnosis of BPD as pathologizing the ways that women respond to gendered abuse and oppression. Shaw and Proctor (2005) theorize the diagnosis as a form of social control: "[BPD] can be applied to women who fail to live up to their gender role because they express anger and aggression. Conversely, the diagnosis is also given to women who conform 'too strongly,' by internalizing anger, and expressing this through self-focused behavior such

as self-injury" (485). They show how the diagnosis of BPD presents a double-bind: women with BPD who engage in behaviors that are not stereotypically feminine—self-injury, multiple sexual partners, external expressions of anger—are cast in the archetype of the overemotional hysterical woman.

Here, it is evident that the feminist framework, like other radical frameworks, ties the individual problem to a broader political context. Rather than a pathology that is endogenous to the individual, a feminist perspective theorizes these behaviors as a response to, or relationship with, gendered power relations.

TREATMENT ALTERNATIVES FOR SOCIAL WORKERS

An alternate approach will offer new possibilities to the conceptualization and treatment of BPD. This section will detail new possibilities for conceptualizing BPD through the discussion of narrative therapy as an alternative treatment approach.

Narrative therapy, which rose to prominence with Michael White, offers a new framework for clinical treatment. White was an Australian social worker who, along with his colleague David Epston of New Zealand, drew upon Foucault's idea of *internalized personal discourses* and in turn promoted a narrative therapy that emphasizes externalizing practices and re-authoring. Narrative therapy begins by viewing the problem not as BPD or inappropriate behaviors, but as the client's retelling of the problem, which is centered around an internalized negative identity. It involves *storifying* events and other surface phenomena into alternate storylines to help clients more richly describe the alternate stories of their lives.
The goal of therapy is not to reduce symptoms or increase emotional regulation skills, but to assist clients in generating narratives that feel truer and more meaningful to them than the problem-saturated account.

In narrative therapy, the social worker's task is to help the client re-author their story, and the client's role shifts from the therapeutic subject to the creator of the story. Again, because many people diagnosed with BPD have internalized the dominant, deficit-based narrative of the diagnosis, exploring other possibilities beyond the problem-saturated narrative becomes imperative. *Externalizing practices* are a primary practice of narrative therapy, with the intended effect of disentangling deficit-based and problem-saturated narratives. In summarizing the practice of externalizing, White and Epston (1990) write:

> Externalizing is an approach to therapy that encourages persons to objectify and, at times, to personify the problem that they experience as oppressive. Those problems that are considered to be inherent, as well as those relatively fixed qualities that are attributed to persons and to relationships, are rendered less fixed and less restricting. (38)

By separating the problem from the individual and objectifying or personifying it into a character, externalizing practices challenge dominant narratives and "encourage a dramatic reengagement with life and with history, and provide options for people to more fully inhabit their lives and their relationships" (White 2005).

In a clinical setting with someone diagnosed with BPD, the externalization process can begin by asking the client how the problem has affected their lives and relationships. This may provoke a problem-saturated account of the person's life (White and Epston 1990). Next, the social worker might ask the client to describe how they have influenced the problem. This can also be achieved by asking the client about how they have resisted, navigated, or negotiated the problem. For example, Allison, a young woman who is diagnosed with BPD, believes herself to be an angry person, and frequently refers to herself as having an "anger problem." In externalizing conversations with the social worker, Allison details several stressful events where she resisted anger and did not become angry at all. Here, the social worker can integrate these profound discoveries by helping the client to redefine her relationship with the problem. The social worker can ask Allison more questions to help her ascribe meaning to the discovery, such as, "How had you managed to be effective against anger in that way? Does this give you any ideas on steps to take to reclaim your life from anger? What attributes were you relying on in those moments to resist anger? Knowing this now, do you think your view of this problem might change in the future?"

These discoveries or exceptions form the basis of re-authoring conversations. Re-authoring conversations help clients explore "neglected territories of their lives, and to become significantly acquainted with the knowledges and skills of their lives that are relevant to addressing the concerns, predicaments and problems that are at hand" (White 2001, 9).

One way of engaging in re-authoring conversations is to ask the client about the creation and maintenance of the problem, or problematic identity. For example, in the example presented above, the social worker might ask Allison about the first time the story of the anger problem was first told, whether the story ever changed, and which characters in her life influenced the story. Within this process, the social worker should listen for alternate ways that Allison understands herself and past events, or other stories she prefers to the story of her anger problem. These preferred stories can be explored further in future-oriented conversations about her hopes, dreams, intentions, or other commitments she has in mind for her future.

During these re-authoring conversations, the social worker is given the opportunity to explore events to which clinicians might often have negative reactions. For example, after establishing basic principles of safety, the social

worker can ask the client what happened in detail during a recent self-injury event. If clients have previously discussed these events with clinicians, it is unlikely that they have been able to explore their relationship with self-injury. It is therefore a unique opportunity for the social worker to encourage engagement with alternate future possibilities. This can be achieved by asking questions to encourage the client to generate new ideas for future action, to explore circumstances that would help facilitate these actions, and to discuss the potential outcomes of these actions (White 2001). Notice how this helps the client move from the therapeutic subject to the creator of an alternate storyline.

It is possible to connect a feminist approach with narrative therapy because both the perspective and the practice value cultural context—clients are seen as members of a social world with various ways of relating to it (McLeod 2004). Furthermore, feminism is alive within re-authoring processes. If a woman diagnosed with BPD is now engaged in re-authoring, this is inherently feminist work, as she is resisting the problem-saturated discourse of womanhood and creating a narrative that is meaningful for her.

CONCLUSION

In summary, while BPD has traditionally been defined as a disorder of extreme instability and deficit, there are crucial and vital alternatives that theorize the important role of power and knowledge in shaping our conceptions of identity, stability, and selfhood. Narrative therapy and feminist perspectives can help clients to distance themselves from problem-saturated accounts of their lives, and to identify new ways of understanding themselves through narratives. In externalizing and re-authoring conversations, clients and social workers integrate new storylines into alternate narratives that are truer and more helpful to the client than the original problem-saturated narrative.

One challenge of narrative therapy is its difficulty to facilitate in comparison to other therapies. In contrast, Dialectical Behavior Therapy—wherein the clinician instructs clients on ways to manage and regulate overwhelming emotions—is considered the easiest to learn of the evidence-based therapies for BPD (Gunderson 2011). Narrative therapy requires clinicians to move away from traditional theories of human behavior. Additionally, because the discussions and work of narrative therapy are quite divergent from traditional therapies, the practices may require explanation from the clinician in order to procure buy-in from the client.

In the same way, it is important to acknowledge that many people do not see feminism as relevant to their personal experiences. Clients who

feel that their lives are out of their control may feel an increased sense of helplessness if the therapeutic discussion centers on societal causes of BPD symptoms. In addition, clients may view the social worker's feminist framing as the imposition of another unwanted narrative.

Finally, narrative therapy presents important implications for clinical social work practice. As social workers continue to expand into independent clinical practice, it is imperative that the field continues its commitment to social justice through the exploration of alternative frameworks, such as anti-oppressive practice, feminist social work, and narrative therapy. By challenging the dominant deficit-based framework, narrative therapy aligns with core social work ethics and principles. Narrative therapy promotes social justice by collaborating with clients to disentangle from narratives that have been imposed upon them, exploring collaboratively how power and oppression have shaped their views of themselves. Furthermore, narrative therapy affirms the value of self-determination through the co-creation of new storylines that are meaningful for the client, regardless of labels, diagnostic categories, or the presumed power and expertise of the clinician.

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