Women diagnosed with Borderline Personality Disorder and Current Interventions

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Abstract

"One cannot hope to understand the phenomena of psychological distress, nor begin to think what can be done about them, without an analysis of how power is distributed and exercised within society" (David Smail, in MacLachlan, McVeigh, Huss & Mannan, 2019.). This paper uses this quote as a starting point to offer a critical analysis of dominant discourses of mental distress. In doing so it aims to identify opportunities for social work responses and advocacy in relation to women diagnosed with borderline personality disorder.

Introduction

Biomedical understandings of mental distress that emerged from psychiatry, continue to dominate discourse in society and in practice. Social work as a profession has a commitment to social justice and is interested in dismantling oppressive power structures in order to achieve this. Patriarchy acts as an oppressive power structure and system that has dominated discourse and knowledge of acceptable behaviour of women. As a consequence, women's experience of oppression and inequality has been pathologised for centuries (Chesler, 1989). Biomedical interpretations of mental distress and patriarchy appear in the research regarding women diagnosed with Borderline Personality Disorder (BPD). This group of women can experience the diagnosis of BPD as a heavy burden (Becker, 1997). Shaw and Proctor (2005) discuss BPD as one of ten personality disorders and make a nuanced argument regarding BPD

being " ... a gendered diagnosis", with women diagnosed at a higher rate than men (p. 484). An analysis of power concerning dominant discourses of mental distress and patriarchy, is essential to understanding how BPD was constructed and why women are diagnosed more frequently. An exploration of opportunities for social work will be discussed to develop better advocacy strategies and alternative ways of understanding and working with women that have a BPD diagnosis.

The history that reveals the development of the Diagnostic Statistical Manual of Mental Disorders (DSM) is crucial to understanding how BPD was developed and the professional power that published it. Mental distress in society is predominantly understood through a biomedical lens. Lafrance and Mckenzie-Mohr (2013) assert that "distress is medicalized, understood as an expression of individual dysfunction" (p. 120). Although the dominant discourse is shifting in some professional spheres, The American Psychiatric Association (APA) constructed the first volume of the DSM in 1952 and as a result, set a powerful discourse in motion that would dominate future understandings of mental distress. The APA has used its significant power in the production of various volumes of the DSM to discuss types of human distress and forms subsequent diagnosis (Lafrance & Mckenzie-Mohr, 2013, p. 120). The DSM has been afforded legitimacy through its use of medical language that has become powerful enough to medicalise our own language regarding human suffering (Lafrance & Mckenzie-Mohr, 2013, p. 120).

Psychiatry has often been characterised as " ... a privileged upper class, white male profession" (Lazaroff, 2006, p. 6). The development of the DSM utilised predominately psychiatric knowledge, that is a male dominated industry, and has used their significant professional power to control the decision making process regarding the contents of the DSM (Lazaroff, 2006, p. 7). Marecek and Gavey (2013) outline that the DSM has been given legitimate power in bureaucratic settings; being able to determine who deserves government welfare and also legitimate the knowledge that is widely taught at an academic level (p. 4). Lazaroff (2006) outlines the possible collusion of the APA and the pharmaceutical industry through the way profits are attained from particular diagnoses and the prescription of certain medication. The

APA and the pharmaceutical industry have created a monopoly on the use and supply of medication for various mental disorders that generate large profits at the expense of vulnerable individuals. This powerful relationship and the industry that has been created has also meant that there is an overreliance on the use of medication in the treatment of various mental disorders (Lazaroff, 2006, p. 4). The dominant discourse that the APA has produced around understandings and treatment of people with mental distress has produced one concrete idea: that the causes and the remedies of mental distress lie within an individual. Social constructionism is crucial in offering a critique of the APA and the DSM, as it makes for alternative ways of knowing and understanding mental distress (Lafrance & Mckenzie-Mohr, 2013).

Chesler (1989) in her groundbreaking book 'Women and Madness', critically discusses the power that has been afforded to clinicians in psychiatry and psychology and the impact that this has had on women. Chesler (1989) expresses concern with the power of these professions to define who was unwell, the treatment that was required and the absolutism that applied (p. 62). The APA's membership in 1960 " ... totaled 11,083, of whom 10,100 were men and 983 were women" (p. 62). Chesler (1989) outlines that the patriarchal and male dominated field of psychiatry has developed the notion of "feminine 'hysteria', as well as our ambivalence about if whether such behavior is universal and 'normal', or universal and 'abnormal'" (p. 60). Chesler (1989) analyses female mental distress as a " … continual state of mourning" that is a consequence of the power men have over women and the subsequent gender roles that are outlined as acceptable (p. 44).

The DSM-5 (2013) outlines the diagnosis of BPD as: "A pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts" (p. 663). Additional elements include " … 'chronic feelings of emptiness', 'suicidal behaviour, gestures, or threats', 'frantic efforts to avoid real or imagined abandonment', 'affective instability', and 'impulsivity' in areas such as 'sex', 'spending', and 'binge eating'" APA (as cited in Jannson, 2018, p. 139). To critically analyse the element of power in the biomedical understanding of distress, there must

be a nuanced analysis of the potential reasons why women are more likely than men to receive a diagnosis of BPD and how this affects this group of women. Bjorklund (2006) asserts that the name of the condition, 'Borderline Personality Disorder' is often perplexing for women who are diagnosed due to the complexity of offering a definition of these women's experiences " ... that were perplexing, paradoxical, inconsistent, contradictory, and dominated to some degree by psychological difficulties that confront us all" (p. 5). The name however, is somewhat vague, somewhere on the border even, particularly where treatment is concerned (Bjorklund, 2006, p. 5). Over the decades, various studies have been conducted to establish whether a diagnosing bias is present in the diagnosis of BPD in women. Widiger and Spitzer (1991), in their study concerning sexual bias in personality disorders, define bias as " ... a systematic deviation from an expected value. Sex bias is a systematic deviation that is associated with the sex of the subject" (p. 2). The types of bias occurring in the research regarding the diagnosis of BPD include assessment sex bias and criterion sex bias (Widiger & Spitzer 1991, p. 10). Of the multiple studies conducted there is the suggestion that sex does play a role in the assessment and criterion sex bias, however "determining which criteria set is more sex biased requires the determination of which criteria set obtains fewer true positives and true negatives" (Widiger & Spitzer 1991, p. 16). The academic research conducted on BPD has shown that women are more likely than men to receive a diagnosis of BPD, which is indicative of a gendered bias in diagnostic assessment and criteria (Bjorklund, 2006; Kaplan, 1983; Sansone & Sansone, 2011; Skodol & Bender, 2003). A lack of attention given to external factors, including a person's environment, that may have contributed to a person's mental distress as well as the stereotypical notions of gender can lead research to be biased (Widiger and Spitzer,1991).

Feminist theory is essential in analyzing the power structures that have constructed the BPD diagnosis of women. Becker (1997) determines that the ratio of women to men diagnosed with BPD is " … anywhere between 2:1 to 9:1, depending upon the sample under investigation" (p. 22). Chesler (1989) examines the ways the patriarchal, prevailing view of what it means to be a woman has played a pivotal and harsh role

in the pathologising of women's experiences. Chesler (1989) discusses that women are affected by " … a double standard of mental health" (p. 118). Evidence, historically and currently, informs society that women are conditioned into certain gender roles from a young age which as a result creates a real sense of distress resulting from oppression (Chesler, 1989, p. 118). The reality for women who seek help for mental distress, as Chesler (1989) discusses, is often met with " … comparatively great social and psychiatric pressure to adjust- or be judged as neurotic or psychotic" (p. 118). This experience is unique to women, and is an artefact of the real oppression women face daily. Horsfall's (2001) analysis of the DSM diagnostic criteria for BPD outlines that the symptoms that are experienced " … could be seen to be an exaggeration of socially promoted feminine characteristics embedded in beliefs and practices in many cultures" (p. 427). Therefore, women's experience is bound into medicalization and psychiatric understandings that leave social factors invisible. Eriksen and Kress (2008) suggest that rather than reducing the experience of women to medical symptoms, perhaps there is a real need to change our " … biased and unreasonable society" (p. 427). The social conditions that impact women from an early age require an analysis of power to adequately appreciate the impact of early childhood (Lester, 2013, p. 74). Lester (2013) discusses the importance of making a gendered distinction in the way children " … are treated by caregivers and culturally appropriate strategies available managing developmental challenges" (p. 74). Chesler (1989) discusses patriarchy as responsible for defining the accepted ways that women must exist and as a result, these ideas can often become embedded in a woman's psychology (p. 265). Lester (2013) acknowledges that we learn, early on, ways to cope in invalidating and threatening environments and explains that a little girl growing up in this " … context where her physical existence, psychological existence, or both felt constantly threatened might become fearful of being left alone and unprotected" (p. 74). Subsequent behaviours that are developed to promote survival in these situations are labelled out of context and highly stigmatised (Lester, 2013).

Another area that requires an analysis of power, concerns women who are diagnosed with BPD and their experience of seeking treatment and accessing services. As a

stigmatized psychiatric diagnosis, women diagnosed with BPD face barriers to effective services and treatment (Ferguson, 2016). A critical theory analysis of the classification of BPD, outlines the oppressive nature of the diagnosis which has meant that treatment options have followed this trajectory. Nicol et al. (2013), discuss the association between early childhood trauma and a future diagnosis of BPD (p. 1). Lester (2013) outlines that the diagnosis of BPD predominately in women is controversial due to " … a mechanism of regulatory control that is historically and culturally predisposed to find women defective and sick" (p. 71). However, Lester (2013) acknowledges that for women the BPD diagnosis can " … often deeply resonant with clients' daily lived experiences" (p. 71). The dominant clinical discourse surrounding BPD has neglected to view or even consider " … the characteristics of BPD as survival strategies" (Lester, 2013, p. 72). The early childhood experience of many women diagnosed with BPD is characterised by negative early environments that often included child abuse and child sexual abuse (Lester, 2013, p. 72). Ferguson (2016) outlines that the " … "antisocial," "difficult," "manipulative" aspects of BPD" can often be taken out of context, meaning women diagnosed with BPD often face judgement and exclusion in a range of services (p. 207). Viewing women with BPD as survivors and placing their subsequent behaviours in context allows for a deeper understanding and therefore, better ways of working with women diagnosed with BPD (Ferguson, 2016; Lester, 2013). Power therefore, pervades some aspects of the services that women diagnosed with BPD will access for treatment. In terms of medication for the treatment of BPD, pharmacotherapy options work in some instances to address major depression or in some cases mood stabilisers are prescribed. However, the evidence on the effectiveness of medication to treat BPD in women is controversial and limited (Biskin & Paris, 2012, p. 4). Dialectical Behaviour Therapy (DBT) is a therapeutic treatment method developed by Marsha Linehan in the 1980s that was specifically designed for the treatment of young women with a diagnosis of BPD (Jansson, 2018, p. 132). Biskin and Paris (2012) outline that DBT has merged concepts from eastern traditions that individuals use to manage their distress (p. 3). There are four components of DBT including

“mindfulness (being aware of one's emotions), distress tolerance (tolerating and accepting difficult situations or emotions), emotion regulation (using various therapeutic techniques to modify thoughts and emotions) and interpersonal effectiveness” (Biskin & Paris, 2012, p. 3). DBT skills are often taught by trained therapists and the settings can range however, it is typical for sessions to be conducted in groups in a classroom like setting (Biskin & Paris, 2012, p. 3). There is an element of individual therapy that may or may not occur alongside group sessions (Biskin & Paris, 2012, p. 3). The central tenet of DBT concerns the ‘patient’ and their ability to use skills to manage their emotional distress (Jansson, 2018, p. 143). When DBT is critically analysed using a power lens, there are inherent flaws. Jansson (2018) outlines that DBT places the responsibility on a woman to transform her behaviours with the end goal being “ … an autonomous and responsible individual able to function in a society” (p. 143). This conceptualisation of DBT is at risk of putting a large emphasis on the individual women to manage and change their behaviour, that maintains the biomedical dominant discourse of mental distress, without paying attention to the oppressive power structures that have contributed to a person’s life experiences and context (Jansson, 2018). DBT also fails to mention the inherent survivorship of women diagnosed with BPD. There has been research that has debated the idea of changing or combining the BPD diagnosis to a Post-Traumatic Stress Disorder (PTSD) (Becker, 1997, p. 74). Becker (1997) outlines that PTSD and BPD have overlapping symptoms however, the labelling effect is extremely different (Becker, 1997, p. 74). Adding the concept of trauma can be seen as a concerted effort to move the emphasis away from the individual and onto their external environment. However, Tseris (2019) outlines that “ … trauma work performs a social control function, preventing women from critiquing the broader power relations that are affecting their lives” (p. 691).

There are many opportunities for social work to advocate for women diagnosed with BPD. Social work drawing on insights from social constructionism, is able to work at a micro level with women diagnosed with BPD, to understand social contexts and mental distress that challenge the dominant biomedical discourse. Becker (1997)

outlines that in clinical settings, women with BPD are overlooked in terms of treatment and are privy to dismissive responses from mental health professionals (p. 153). Social workers must play an advocacy role in these situations where biomedical discourses become dominant to the detriment of their clients. This would include challenging the BPD diagnosis and its oppressive nature while also acknowledging power structures that are oppressive. Eriksen and Kress (2008) outline that there are a number of psychotherapies including narrative therapy and feminist therapy that are effective in analysing gender issues and the position that women are often placed in society (p. 158). How this can be implemented in a more available way to women with a BPD diagnosis requires further exploration. Gender inequality pervades all aspects of women's life and there is a need for social workers to remain committed to advocating the continuing need for change. Krumer-Nevo and Komem (2013), two academic social workers from Israel, discuss their programme designed for adolescent girls to engage in discussions around gender, ethnicity, class, sexuality and employment from a critical feminist perspective and using intersectional theory (p. 1192). Engaging young women in feminist issues allows for attitudes and beliefs regarding the roles of women to be challenged early (Krumer-Nevo & Komem, 2013). Social workers must challenge dominant discourses around issues of gender inequality in their daily practice, to stay committed to social justice.

An analysis of women diagnosed with BPD cannot be done without a critical analysis of power. Patriarchy is still the predominant power structure in society which women encounter from birth (Chesler, 1989). The ideas and expectations that patriarchy promote regarding women is oppressive and simply unattainable. Patriarchal structures and biomedical understandings of mental distress have pervaded psychiatry and psychology and, in this case, created a diagnosis that holds individual's accountable rather than oppressive power structures. Social workers must endeavor to promote social justice and gender equality in practice areas and see individuals in their socio-political contexts.

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