

**CROSSING THE BORDER:  
CONSTRUCTIONS OF BORDERLINE PERSONALITY  
DISORDER WITHIN THE SOUTH AFRICAN CONTEXT.  
A DISCOURSE ANALYTIC STUDY.**

A thesis submitted in partial fulfilment of the  
requirements for the degree of

MASTER OF ARTS IN CLINICAL PSYCHOLOGY

of

RHODES UNIVERSITY

by

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OCTOBER 2008

### Acknowledgements

The researcher would like to gratefully acknowledge all those who helped in the development and completion of this thesis, especially Henriette, Mark ('the wolf'), Anita, Phia, Shayne, Sam and Charlie.

### ABSTRACT

This research aims to open up for critical discussion the effects of the discourses employed by mental health professionals in relation to the diagnosis of BPD, with a view of questioning the discursive practices available within a South African context. This discussion will situate identified discourses in relation to the subjects and objects to which it refers in an attempt to identify and interrogate dominant discourses which circulate to oppress and discriminate against female 'others' within the mental health setting. This discussion will serve to challenge mainstream, traditional psychology by questioning the utility of deploying these concepts within a South African context as well as the effects this deployment may have. A discourse analytic methodology is employed to identify the constructions of BPD by five mental health professionals working within a government setting. The analysis aims at interrogating the broader role of the identified discourses in supporting institutions, preserving power relations and transmitting ideological practices. Ultimately the aim of the research is to open up for critical debate, through the example of psychology and psychiatry's treatment of BPD; constituted as 'other', the possibility that there may be deleterious consequences for the wholesale acceptance of traditional psychological understandings by mental health professionals working within a South African context.

**TABLE OF CONTENTS**

**CONTEXT OF RESEARCH** ..... 1

**LITERATURE REVIEW** ..... 6

2.1 The Social Construction of Madness .....7

2.2 The Historical Development of the Psy-Disciplines.....11

    2.2.1 The ‘text’ of the Psy-disciplines- An Overview of the DSM ..... 12

    2.2.2 The Development of the DSM and the concept of Personality Disorder ..... 13

2.3 Borderline Personality Disorder .....16

    2.3.1 The Genealogy of the Borderline concept ..... 16

    2.3.2 Historical Formulations 1800-1945 ..... 17

    2.3.3 Modern Formulations 1915-1945 ..... 18

    2.3.4 Contemporary Formulations 1945-Present ..... 19

2.4 The ‘chaos’ of the Borderline .....20

    2.4.1 The Problematic Nature of the BPD Label .....21

    2.4.2 Alternative ‘social’ understandings of BPD .....22

2.5 Women and Psychiatry .....24

2.7 The South African Context .....26

**METHODOLOGY** ..... 30

3.1 Research Aim.....30

3.2 Theoretical Perspective.....30

3.3 Participants.....32

    3.3.1 Ethical Considerations .....33

3.4 Data Collection .....34

3.5 Data Analysis .....34

3.6 Issues relating to Reliability and Validity.....35

**ANALYSIS AND DISCUSSION** ..... 37

    4.1 The Acknowledgement of Reflexivity.....37

    4.2 Analytical Processes .....38

    4.3 ‘Distanciation’ and Identification of Discourses .....41

    4.4 Discourses Operating within the Text.....42

        4.4.1 The Bio-Medical Discourse .....43

            4.4.1.1 The Appeal to Truth.....45

            4.4.1.2 Diagnosis as Part of Power Relations .....49

            4.4.1.3 Diagnosis as Treatment.....55

4.4.1.4 The Impact of the Biomedical discourse .....	56
4.4.2 Discourse of Science and Rationality .....	58
4.4.2.1 Expectations vs. Experience (Borderlines are Referred not Heard) ....	58
4.4.2.2 BPD as Genesis of “difficulty” .....	63
4.4.2.3 Discourse of indemnity .....	66
4.4.2.4 Implications of the Discourse of Science and Rationality .....	68
4.4.3 The Psy-discourse .....	69
4.4.3.1 The White Western discourse .....	70
4.4.3.2 The Implications of the Psy-Discourse .....	72
4.4.4 Discourse of Gender .....	73
4.4.4.1 Sexual Abuse and Suicide within the Patriarchal discourse .....	78
4.4.4.2 The implications of the Discourse of Gender .....	82
<b>CONCLUSION AND REFLECTIONS .....</b>	<b>84</b>
5.1 Reflections on Methodology and Paradigm.....	87
5.1.1 Data Collection .....	87
5.1.2 Sampling .....	87
5.1.3 Discourse Analysis.....	88
5.1.4 Social Constructionism .....	88
5.2 Further Research Initiatives .....	89
5.3 Implications of Current Research .....	90
<b>REFERENCE LIST .....</b>	<b>93</b>
<b>Appendix A- Interview Transcripts .....</b>	<b>99</b>
Participant 1 .....	99
Participant 2 .....	103
Participant 3 .....	106
Participant 4 .....	110
<b>Appendix B- Consent Form .....</b>	<b>120</b>

## SECTION 1:

### CONTEXT OF RESEARCH

Borderline personality disorder (BPD) is amongst the most researched of psychiatric disorders, as well as being the most researched personality disorder (Bjorklund, 2006). Its notoriety within mental health settings (Alarcon & Keetz, 2001; Bjorklund, 2006; Busfield, 1989; Cauwels, 1992; Flanagan & Blashfield, 2005; Herman, 1992; Hodges, 2003; Jimenez, 1997; Kerr, 2004; Markham, 2003; Nehls, 1998; Wirth-Cauchon, 2003), positions the diagnosis as a controversial entity within the mental health field. The historical development of the diagnosis is demonstrative of the contested nature with which BPD is viewed and understood. There are multiple theories concerned with the identification of borderline symptomology (Becker, 1997; Cauwels, 1992; Skodol & Bender, 2003; Trippany, Helm & Simpson, 2003; Wirth-Cauchon, 2003; Zanarini, 2000), however, this research will utilise the definition outlined in the American Psychiatric Association's (2000) *Diagnostic and statistical manual of mental disorders, fourth edition, text revision*. The employment of the DSM-IV-TR should however not be seen as coincidental, but rather as instrumental in the development of a critical understanding of how the diagnosis of BPD as well as the position of women is situated within the disciplines of psychology and psychiatry.

Research suggests that BPD has a higher prevalence rate amongst the female population as compared to the male population, with approximately 75% of those diagnosed with BPD being female (APA, 2000; Becker, 1997; Bjorklund, 2006 & Wirth-Cauchon, 2003). Due to the pejorative nature in which BPD is spoken about within psychiatric discourse (Wirth-Cauchon, 2003), concerns have been raised about the gendered nature of the diagnosis, as well as the consequences this diagnosis has for women within a mental health setting (Brown, 1995; Landrine, 1989; Markham, 2003 & Nehls, 1998). Aligned with this gendered approach is the identification of the high prevalence of childhood abuse, particularly sexual abuse, which is reported within the histories of those, diagnosed with BPD (Herman, 1992; Herman, Perry & Van der Kolk, 1989). Because the individual diagnosed with BPD presents with a history of trauma and abuse, the need for a sympathetic and sensitive reception by the mental health system becomes significant.

This research is informed by a feminist standpoint, which suggests a critical approach to dominant theories of knowledge production, which are conceived of as being derived from male populations (Durrheim, Terre Blanche & Painter, 2006; Brown, 1995; Bjorklund, 2006; Chesler, 1973; Ingelby, 1995 & Wirth-Cauchon, 2003). By taking this standpoint, the researcher aims to move away from positivist assumptions and locate the research as a political and action-oriented text (Durrheim *et al*, 2006). These aims are encompassed by post-modern, post-structuralist and social constructionist epistemologies that recognise the manner in which dominant perspectives serve to undermine and eradicate alternative 'voices' or subjectivities (Hook, 2001; Parker, 1992, 1993, 1994, 1999, 2008; Smith, 1990). According to discursive theories, subjectivities are positioned not only in relation to other subjectivities but also in relation to multiple discourses and ideological practices and furthermore, can be understood as being produced by these discursive practices (Parker, 1992, 1994). As such, discourses actively constitute the subjectivities to which they refer (Parker, 1992).

From this it can be seen that individuals with BPD are created within discourse and that BPD is constituted in different ways by different discourses and each way will have specific effects. For example, within the biomedical discourse, the individual with BPD is constructed as manipulative and treatment resistant with poor prognostic indicators, which results in mental health professionals being judgemental, pejorative and rejecting of the individual (Landrine, 1989; Nehls, 1998; Wirth-Cauchon, 2003). Research serves to confirm these effects. Nursing staff approach individuals with BPD in a more negative manner as compared to other psychiatric diagnoses (Markham 2003), clinical psychologists reported higher feelings of frustration and anger in response to a vignette outlining BPD than other diagnoses (Brody & Farber, 1996) and psychiatrists refer to BPD as 'psychological cancer' (Kernberg, 1984) and 'a death sentence' (Nehls, 1998). As such, the particular discourse employed to construct BPD will have lasting effects on the outcome of treatment for the individual. Thus, by constructing the individual with BPD in this way, the individual's ability to access treatment within the mental health care system becomes compromised (Nehls, 1998). Furthermore, treatment is characterised by rejection and frustration on the part of the mental health professional, which in the context of BPD, has been identified as re-traumatising (Herman, 1992; Linehan, 1993).

Alternative discursive frameworks have been developed within the biomedical discourse. The introduction of a discourse which constitutes the diagnosis of BPD within the realm of affective disorders would serve to contextualise the diagnosis in terms of the biological make-up of the individual as opposed to the personality structure, which is understood as pervasive (Landrine, 1996 & Wirth-Cauchon, 2003). However, this change of focus cannot only be viewed as an attempt by the biomedical fraternity to address the discrimination faced by those diagnosed with BPD, but also substantial financial gain. In light of the prevalence of BPD within the health care setting, some research suggesting up to 8% in the outpatient setting, and 27% of those diagnosed with personality disorder (Bjorklund, 2006, Widiger and Sanderson as cited in Bjorklund, 2006), the financial implications of placing the disorder as amenable to pharmaceutical treatment is vast. Thus, even this discourse, would not engage with the multiple aetiological factors identified by the literature and would serve to effectively reduce the experience of the individual to a 'chemical imbalance'.

A Foucauldian perspective assists in the critique of mainstream approaches to mental illness, as it focuses on the socio-cultural and historical aspects with an emphasis on power relations (Parker, 1992). Foucauldian (1961, 1977) concepts of discipline, surveillance and normalisation are all relevant in an attempt to conceptualise why and how certain subject positions have been constructed. Thus, individuals within society are subject to 'normalisation' through the emphasis of socially sanctioned norms. Furthermore, these norms are not coincidental, but rather are informed and endorsed by structures of power. As such, normalisation occurs when individuals submit to dominant normative expectations, which are prescribed by powerful structures, with particular agenda's (Foucault, 1977). Therefore, a professional making use of a biomedical understanding is not simply aligning him/herself with this discourse, they are also perpetuating a positivist conception of illness, which historically has patriarchal foundations and as such positions any individual who is not a western, white, middle class male as 'other'.

Following from this, the biomedical discourse may construct this 'other' as pathological, and appeal to a rationalist, scientific discourse to support the subjugation and discrimination of those who do not submit to the institution of medicine as the

manifestation of 'truth'. This has ramifications within the South African context, as there are multiple disease discourses which when deployed could be identified as opponents to this dominant discourse e.g. traditional conceptualisations. Furthermore, the utilisation of the biomedical discourse may operate to de-contextualise individuals' experience from historical and political influences (Hook, 2001, Seedat, 1997).

This thesis aims to open up for critical discussion the effects of the discourses employed by mental health professionals in relation to the BPD diagnosis, with a view to questioning the discursive practices available within a South African context. This discussion will situate identified discourses in relation to the subjects and objects to which it refers, in an attempt to identify and interrogate dominant discourses which circulate to oppress and discriminate female 'others' within the mental health setting (Parker, 1992). This discussion will serve to challenge mainstream, traditional psychology by questioning the utility of deploying these concepts within a South African context as well as the effects this deployment may have.

The review of literature, which follows, will outline the historical development of the diagnosis BPD, and how current understandings are formed around issues of power and ideological practice. It explores how the construction of the diagnosis of BPD has led to its problematic status within the mental health setting. Various aetiological factors are documented in an attempt to situate the diagnosis as a by-product of current societal practices. This review then, attempts to problematise the pejorative discourse utilised by mental health professionals in their 'talk' around BPD. It also attempts at situating this problem within a South African context.

A critical discourse analytical methodology is utilised in the analysis of interview transcripts with five mental health professionals working within a government setting. The analysis aims at interrogating the broader role of the identified discourses in supporting institutions, preserving power relations and transmitting ideological practices. Ultimately I aim to open up for critical debate, through the example of psychology and psychiatry's treatment of BPD, constituted as other, the possibility that there may be deleterious consequences for the wholesale acceptance of traditional

psychological understandings, as presented within the DSM-IV-TR, by mental health professionals working within a South African context.

The focus of this research is not the identification of particular discourses within psychology which disable oppressed and previously oppressed groups in South Africa. This thesis is, however, in support of the notion that psychology as an enterprise is derived from Euro-American research and as such cannot transcend its cultural and ideological foundations (Seedat, 1997). As such, the researcher aims to demonstrate the manner in which traditional psychology is able to subvert feminine understandings, even within a Euro-American context. From this tenet, the elitist, ethnocentric, sexist and decontextualised nature of traditional psychology within a South African setting supports the view that psychology is a cultural product. And following from this, the research situates itself in support of the call for culturally appropriate mental health services for the majority of South Africa's population (Seedat, 1997).

## **SECTION 2:**

### **LITERATURE REVIEW**

The following review of literature, concerning Borderline Personality Disorder (BPD), follows a social constructionist perspective. The historical development of the borderline personality construct is examined in order to produce a contextual account that locates the diagnosis both historically and within a particular socio-cultural milieu. The inclusion of complementary approaches will also be considered and applied; these include post-structuralism, post-colonialism and other cultural studies perspectives. These approaches aim to understand the borderline diagnosis as a socio-cultural and societal issue and attempt to locate it within patriarchal and other power structures (Wirth-Cauchon, 2003).

Firstly, a review of the development of the concept of 'madness' will draw on Foucauldian understandings of power relations, ideological practices and institutions in terms of the designation of normality vs. abnormality (reference madness and civilization). Furthermore, an explication of how the concept of 'madness' is not merely an evocation of reality but one which constructs a particular kind of reality (Foucault, 1961, Parker, Georgeca, Harper, McLaughlin, & Stowell-Smith, 1995). From this discussion, an overview of the development of the psy-disciplines (any discipline with the psy- prefix) will follow in order to demonstrate the subjective nature of psychiatric and psychological practice. An exposition of the DSM-IV-TR (2000) conceptualised as a tool of the psy-disciplines, will investigate the precept and authority of the biomedical model and demonstrate the pervasive positivist understandings of mental illness.

Secondly, there is a critical evaluation of the concept of personality disorder as an introduction to the focus of this research; BPD. A genealogical overview of BPD will serve to demonstrate how diagnostic categories are socially and historically located. A feminist evaluation of the disorder will serve as a platform for critically discussing the gendered nature of the BPD diagnosis, as well as outlining the non-biomedical

alternatives in understanding the disorder. These alternatives highlight the social and political influences on diagnostic practice.

Lastly, an attempt to identify the challenges faced by mental health professionals working within a South African context, serves to highlight the multiple sites of contention, (i.e. racism), by exploring the historical construction of mental illness within South Africa. This brief historical evaluation attempts to parallel the sexist deployment of the BPD diagnosis in the Euro-American setting (as expounded by the literature), with the deployment of traditional psychology within the South African setting.

## **2.1 The Social Construction of Madness**

### **2.1.1 Foucault and Madness**

According to Foucault (1977) all social institutions and ideological systems are actively structured, enforced and reinforced by contextually dominant discourses. Thus, even psychological knowledge's 'become time and culture bound and cannot be taken as once and for all descriptions of human nature' (Burman, 2003, p. 7). Foucault (1977) argued that the ways in which people think and talk, and the ways in which they are symbolically represented in society, have a direct relationship with the ways in which people are treated in society. Disciplines therefore act as the gatekeepers of what is socially acceptable and by implication what is socially unacceptable (Foucault, 1977). It is argued that concepts of health and illness are socially constructed and mediated through language, and furthermore, are maintained by social systems that serve the interests of dominant groups (Foucault, 1977). With reference to concepts of bodily and mental illnesses, knowledge is not simply something that professionals- as representatives of disciplines- possess but also something which they *do*. A social constructionist understanding would posit that contextual perceptions of psychological knowledge are embedded in a particular history, especially a western focused history (Burman, 2003).

Foucault (1961) has suggested that the development of 'madness' served to control and isolate individuals who were considered to be outside of the 'norm' thereby creating an 'other'. Throughout the development of madness (Foucault, 1961) the contrast between what was considered normal, as espoused by the white, western,

male, middle class, the 'other' became black, female and poor (Long & Zietkiewicz, 2002; Parker *et al*, 1995; Terre Blanche *et al*, 2006; Wirth-Cauchon, 2003). As such the 'other' gained a pathologised status within the development of psychiatric and psychological 'knowledge' (Rose, 1989). This 'knowledge' was based on dominant views at any given time during its development, therefore the current understandings of this knowledge has multiple sources (Parker *et al*, 1995). The shifting understandings of madness operate to constitute and construct people in certain ways, therefore the manner in which society absorbs and accepts behaviour will ultimately be defined through an academic (i.e. disciplinary) understandings and the two have an intractable link.

### 2.1.2 Critique of traditional psychology

Chesler (1972) has argued that 'madness' can be understood as a symptom of social distress, and cites the high rates of 'madness' in women as a consequence of social repression. As such, the appeal to patriarchal ideology has practical consequences, as can be seen in the mental health field, where what is female is constructed in opposition to what is male. As such, stereotypical understandings of males as rational, stable and controlled is contrasted with females as irrational, unstable and impulsive (Bjorklund, 2006; Wirth-Cauchon, 2003). This construction of the 'other' is pertinent in the development of the BPD diagnosis.

Long and Zietkiewicz (2002, p. 159) argue that, 'psychiatry, psychology and the study of the abnormal is one of the primary ways in which power relations are established in society' and as such 'when abnormality and its corresponding norms are defined, it is always the normal that defines the abnormal'. The notion of power relations (Foucault, 1977) then, is not situated with powerful individuals per se, but rather people who are in the possession of powerful knowledges. As such, mental health professionals become the arbiters of normality within society, and have the power to label what is undesirable in society and furthermore can utilise these labels as a justification for treating, removing and 'othering' individuals.

The biomedical psychiatric model's conception of madness has been criticised for being universalistic, ahistorical and rigid in its acceptance of demarcated diagnostic categories (Wetherell, 1996). Furthermore, the ability to identify pathology rests

solely in the hands of professionals and as such renders the labelling of pathology a powerful practice (Brown, 1990). Western discourses tend to situate the cause of mental illness within the individual (Parker, 1994), thereby focusing on the individual as the site of pathology, rather than taking into account broader socio-cultural influences. This is problematic within the South African context when socio-historical and political factors are neglected or ignored in deference to the western biomedical model.

Following Foucault, as well as many other theorists, it is argued that the practice of psychology is not a liberatory project but rather another form of social control (Foucault, 1977; Hook, 2002; Kristeva, 1995; Long & Zietkiewicz, 2002; Parker, 1994; Rose, 1985). This notion of social control is explicated through what has been termed the 'psy-complex' (Rose, 1985), which refers to the integral role the psy-disciplines play in the surveillance and regulation of people in contemporary society (Burr, 2003). Furthermore, the 'psy-complex' is defined as the discourses within the context of the institutional practices and power relations of psychiatry (Ingelby, 1985). Drawing on Foucauldian ideas it is posited that the information utilised by the psy-disciplines works towards establishing norms within society, against which any person can be assessed (by professionals) or assess themselves (through the integration of expected norms). This process of self monitoring is a result of what Foucault (1977) termed disciplinary power. However, in order to be effective, the psy-disciplines and psychology in particular, appeal to the lauded status of science, which gives the knowledge authority within society. Although, as we will see, the science employed is not always good science.

Therefore, as Hook (2001) argues, the supposed discovery of subtypes of madness becomes acknowledged in society through discursive systems of knowledge, and the operationalisation of these systems, by professionals. Together this provides justified admission into the professional domain. This is illustrated in that the first DSM in 1952, listed 60 types and subtypes of mental illness, in 1980, this number had increased to 200 (Hook, 2001; Long & Zietkiewicz, 2002). The development of diagnostic categories is not merely the identification of tangible diagnostic entities, but rather through rigorous debate and discussion. In the case of the Diagnostic and Statistical Manual, the American Psychiatric Association appoints task forces

compromised of experts within the various fields. Through discussion within these task forces, and when consensus is reached, a diagnostic entity or changes to existing entities can be included within the nomenclature. Therefore, through appeals to science, particular groups of people have the power to endorse certain disorders. This can currently be evidenced by the debate concerning the inclusion or call for further study of Premenstrual Dysphoric Disorder (APA, 2000). Once entities are entered to the nomenclature, professionals are able to utilise the diagnosis in return for financial gain.

Power does not belong to discrete members of society (Foucault, date); however prevailing discourses help to bolster certain groups above others. The study of ideology according to Thompson (in Burr, 2003) is therefore the study of the ways in which meaning is mobilised in the social world in the interests of powerful groups. Discourses can therefore be used ideologically, as can be seen in the deployment of notions of 'normality' and 'abnormality' within society.

The positions available within discourses bring with them a 'structure of rights', they provide the possibilities and the limitations on what we may or may not do and claim for ourselves within a particular discourse (Burr, 2003). Therefore, it is argued that the practice of psychology and psychiatry needs to be aware of the discursive practices it utilises in the diagnostic process. A person labelled as 'abnormal' is constructed within society in particular ways, their ability to access resources becomes compromised but most importantly their 'voice' is imbued with concepts of irrationality, thereby positioning them as unstable and untrustworthy and consequently in need of professional help. Thus once we take up a position, which may be done intentionally or unintentionally, in our discourse, we then inevitably come to experience the world and ourselves from this vantage point. Not only do our subject positions constrain and shape what we do Burr (2003) argues that they become part of our self identity, with our thoughts and words being filtered through the discourse. This type of reasoning is especially prominent in labelling theory, which has criticised the notion of reducing the diagnosed individual to their diagnosis i.e. "The borderline client" as compared to "The client who has been diagnosed with Borderline Personality Disorder". The former implying the self is disordered rather than understanding the self as having a disorder (APA, 2000). Sadler (2007) argues

that semantically this seems trite, and the ability to make the self distinct from a disorder of the self (especially in the case of personality disorders) becomes a difficult project, for both the individual and the professional. However, considering this aspect of labelling as well as the researchers' sensitivity to the possibility of reification, diagnostic categories within this research are referred to using the somewhat more cumbersome, however politically correct terminology, a terminology which is also employed by the DSM.

## **2.2 The Historical Development of the Psy-Disciplines**

Within western societies, prior to the development of the psy-disciplines, concepts of normality and abnormality were understood through a religious and moralistic lens. Thus deviance became aligned with demon possession or as a result of leading an immoral life (reference). Therefore, psychiatry needed to replace a predominantly moralistic perspective of insanity with a scientific model of mental illness (Foucault, 1994). This change in relationship assisted in the development of power differentials and as a consequence knowledge became ingrained into professional relations, as a consequence of the appeal to science and positivism (Parker, 2002).

Thus, as Harper (1994) highlights the fact that although labelling of disorders is based on categorised symptoms, it is still the clinician who has the power to choose which label to utilise. Following from this, the label attributed to an individual is subsequently utilised in service of the justification of challenges relating to certain diagnoses. As such, Parker *et al*, (1995) argues that diagnostic demarcation serves as a 'justificatory argument' rather than an objective assessment. Isaak and Hook (1996) go further in arguing that psychotherapists are able to make use of rhetorical devices through their access to technical language and as such have discursive and language based powers.

Chesler (1972) has argued that psychotherapeutic treatments convert socio-political factors into individual psychopathology, as demonstrated by conceptualising female distress as personal rather than as a result of social oppression. Psychotherapy can be seen as constructing social problems and furthermore serves to maintain these social ills through the maintenance of the notion of the 'ideal' self (Cushman, 1990, Hook, 2001). Rose (1995) suggests that psychology can never be value free or politically

neutral as the notion of the ideal self is constructed in relation to contemporary, and therefore socially influenced, concepts of 'normality'.

The history of psychiatry as a divergent field within medicine is integral in understanding how the current relationship or positioning may be inappropriate and have negative consequences for the individuals it is trying to serve. Foucault (1994) was instrumental in forging the understanding and comprehension of how the institution and furthermore the ideology of dominant socio-cultural beliefs serve to maintain structures of oppression. This convergence of understanding had the effect of objectifying human behaviour (Foucault, 1994).

Vogel and Rosenberg (1979, in Kerr, 2004) have argued that certain systems of belief were needed at the beginning of the nineteenth century to bring about the acceptance of therapeutic intervention. They argue that both professionals and society at large needed to accept a rationalistic view and explanation of disease. Furthermore this view necessitated that the professional have a position of authority, so that those they purported to treat had implicit trust in their particular understanding (Vogel & Rosenberg, 1979, in Kerr, 2004). With the creation of a good doctor, came the simultaneous creation of a good patient (Kerr, 2004). According to Kerr (2004, p.204), 'escaping suffering became correlated with accepting a diagnosis and treatment... Sickness thus replaced suffering, and with it, 'patienthood' replaced 'personhood'. From this it is also important to understand the discursive power involved in transforming someone who *has* suffered, into someone who *is* sick.

Therefore, discourses are informed by various socio-cultural and historical foundations and these 'knowledges' inform the professional relationship between the abnormal 'patient' and the mental health 'professional'. An understanding of the text of the psy-disciplines further emphasises the constructed nature of mental illness.

### 2.2.1 The 'text' of the psy-disciplines- An overview of the DSM

Foucault (1986) has argued that taxonomies of madness are not neutral documents, but rather actively delineate what is deemed socially acceptable through the exercise of power. As such, the taxonomy plays a role in productive and exclusionary practices in service of circulating power relations by setting up opposition between the 'sane'

and 'insane' (Foucault, 1986). This allows for certain practices which are then informed by discourses of expertise and appeals to truth (Foucault, 1986). Diagnostic practice within the field of psychology is radically informed by cultural and contextual understandings (Leahey, 2000). Therefore a nosological system such as the Diagnostic and Statistical Manual (DSM) in its various incarnations can be seen as a cultural document that problematises particular behaviours in relation to those that are normalised and thus socially accepted. These nosological systems are presented as a-historical and universalisable concepts by appealing to the status associated with scientific knowledges in the construction and presentation thereof, and result in diagnoses that therefore appear to be objective (Long & Zietkiewicz, 2002).

Diagnostic practices have been criticised by post-structuralist feminists (Gallop, 1990; Kristeva, 1991; Ussher, 1991; Ussher, 1992) for constructing female and 'other' experience as pathological in relation to the normalised experience of the predominantly white, middle class, heterosexual male in society which acts as a reference point for diagnostic tools, a practice which Brown (1990) has termed 'diagnostic sexism'.

Similar ideological stances have been identified with reference to race especially within the South African context (Msemi & Strebel, 1999). Although the DSM-IV-TR system identifies the need for culturally specific assessments for clients presenting from backgrounds which are different from that of dominant western cultural expectations (APA, 2000), Castillo (1997) suggests that it lends itself to the pathologisation of certain cultural groups. Therefore, multiple aetiological variables need to be taken into account when diagnosing individuals and their behaviour, more especially when utilised outside of a western context.

### 2.2.2 The Development of the DSM and the concept of Personality Disorder

It is argued that the development of the DSM serves to perpetuate the ideology of masculine supremacy and because diagnostics can be seen as 'the language of psychiatry, the 'social representation' of psychiatric knowledge, as well as the psychiatric professions' presentation of self' (Brown, 1990, p.389), this perpetuation becomes problematic. This can especially be seen with the occurrence of the multi-axial system which relegated disorders of the 'personality' to Axis II. This

progression in the understanding of personality has a demonstrative and practical consequence with clinicians drawing on different canons of knowledge in order to treat people who were considered treatment resistant when on Axis I (Landrine, 1989; Widiger, 1998). The proposed reason for the move to place personality disorders on Axis II was the fact that along with mental retardation, personality disorders were believed to have a lifelong duration (Millon, 1996).

The DSM's bid for accuracy and objectivity has not been consistent over time. The DSM was first published in 1952, however it was argued that neither the DSM I nor the DSM II were reliable, which was argued to be as a result of the vague nature of pathology presented (Hoeksema, 2001). It is noteworthy, that in subsequent editions not only were 'new' disorders introduced, but also components such as duration, and severity in terms of functioning. Thus the boundaries of 'disorder' became more specific. Issues of reliability continued to plague that manual, with Kirk and Kutchins (in Hoeksema, 2001) suggesting that experienced professionals agreed on diagnosis in only 70 percent of cases, with this percentage steadily decreasing for personality disorder. Furthermore, this was attributed to the fact that the criteria listed in the DSM III depended heavily on the client's self report, as such, it was argued that the professional's objective assessment would be more reliable than the subjective report of the client (Hoeksema, 2001). This move away from the client's appraisal positions individuals entering the mental health system as unreliable historians, which is in line with the construction of the 'abnormal' individual (e.g. unreliable, irrational and impulsive). Therefore, the goal of the DSM-IV-TR was ultimately to ensure an 'objective' and static tool which *professionals* could utilise in a bid to *accurately* diagnose patients. This goal was in accordance with positioning the professional as an expert in evaluating clients, and furthermore, what is considered significant to the client becomes eclipsed by the 'gaze' of the professional (Kerr, 2004).

The development of the multi-axial system has been critically evaluated (Becker, 1997; Kerr, 2004). The need to distinguish personality disorders from clinical disorders has been conceptualized as an attempt by the profession of psychiatry to actively demarcate their scope of practice by maintaining the authority of medicine over psychology (Becker, 1997). Kerr (2004, p. 12) posits that "psychiatry's own struggles with the borderline between science and non-science, medicine and social

welfare, disease and social ills, is embedded in the caste-like structure of the DSM and the attitudes it engenders towards patients". Thus, it can be argued that while disorders listed on Axis I become the domain of biomedicine, which attempts to explain health in terms of physical, chemical, and physiological influences on the body, the personality disorders listed on Axis II become the 'other', those not able to respond to medicine (Kerr, 2004). This has special significance for the diagnosis of BPD, which was conceptualized as being neither psychotic nor neurotic, both of which are amenable to medicine, but on the border between these two.

From this understanding, individuals with clinical disorders can be recognized as 'sick' by way of physical, chemical or physiological reasons. The positioning of individuals with personality disorders is in stark contrast to this. Whereas individuals with clinical disorders can be seen as suffering from a physical ailment, over which they have no control, individuals with personality disorders are constructed as agentic and while not necessarily being conscious of their disorder, the individual is seen as inherently flawed. Furthermore, a diagnosis on Axis II is framed as a permanent 'affliction', one that cannot be treated, *even* by the authority of the biomedical model.

In order to understand the aetiology of personality disorders, there has been much research, both from within the biomedical framework and beyond. For example, object relations theory has attempted to explain borderline pathology as related to ruptures in early relationships (Summers, 1999), cognitive-behavioural understandings of borderline pathology place emphasis on cognitive distortions (Linehan, 1993), and biomedicine has attempted to explain borderline pathology through an affective disorder model (Markham, 2003). These varying understandings assist in determining how an individual is treated within the therapeutic space, as Hodges (2003) argues, if disorder is accrued to circumstances as compared to being understood as a character flaw, the response and treatment model will vary. Therefore, the discursive tropes deployed by professionals can be understood as representative of the manner in which they approach not only the individual but also the treatment of that individual.

### **2.3 Borderline Personality Disorder**

BPD, as a distinct personality disorder, was entered into the DSM III in 1980. The inclusion of BPD was not a neutral result of unified discussions amongst professionals, but rather as a controversial, contested, and ultimately misunderstood entity (Millon, 1996; Wirth-Cauchon, 2003).

The diagnosis of BPD, according to the DSM-TR-IV (2000) is as follows:

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 as indicated by five (or more) of the following:

1. frantic efforts to avoid real or imagined abandonment
2. a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
3. identity disturbance: markedly and persistently unstable self image or sense of self
4. impulsivity in at least two areas that are potentially self damaging
5. recurrent suicidal behaviour, gestures, or threats, or self mutilating behaviour
6. affective instability due to a markedly reactivity of mood
7. chronic feelings of emptiness
8. inappropriate, intense anger or difficulty controlling anger
9. transient, stress related paranoid ideation or severe dissociative symptoms.

These criteria are filtered through a process of differential diagnosis, whereby the professional is required to ensure that the group of symptoms is not better accounted for by another diagnosis.

#### **2.3.1 The Genealogy of the Borderline concept**

The historical antecedents of the borderline category, as suggested by literature, span as far back as Hippocrates, Aristotle and Arastus, all of whom referred to a character they deemed 'labile' (Millon, 1996). The identification of the disorder through the ages depends heavily on the conceptualisation that one takes. This is because at varying points in its development the category has been conceptualised as 1) a level of personality organization (Kernberg, 1975), 2) a distinct personality disorder, distinct from other personality disorders (Gunderson, 1984), 3) as a schizophrenia spectrum disorder, with an emphasis on psychotic episodes (Zilboorg in Wirth-Cauchon, 2003),

4) as an affective disorder, with the emphasis on dysphoria and affective dysregulation (reference), 5) as an impulse control disorder, with an emphasis on impulsivity, especially in relation to self damaging behaviours (reference), 6) as a form of chronic PTSD, with an emphasis on trauma (Herman, 1992; Zanarini, 2000) and 7) as a result of socialization processes (Becker, 1996).

The development of BPD throughout the course of the last century, culminating in the inception of the disorder into the DSM III in 1980, can be divided into three stages, historical, modern and contemporary formulations. As Stone (in Cauwels, 1992, p.361) suggests, 'when we have portrayed the history of the usages of the term "borderline" in psychiatry, we will have simultaneously defined the term. Its history is its meaning'.

### 2.3.2 Historical Formulations 1800-1945

The development of madness in the late nineteenth century was constructed with the development of the concept of 'reason' (Wirth-Cauchon, 2003). With this development of reason, was the development of the insane, those individuals who did not have the capacity to reason. The distinction between those considered sane and insane was not an easily designated position, and as such the identification of individuals who were considered to be on the cusp grew out of the inability of developed understandings to account for these 'borderland' symptoms (Bjorklund, 2006). In 1884, Hughes (in Millon, 2001, p.648) commented that, 'the borderland of insanity is occupied by many persons who pass their whole life near that line, sometimes on one side and sometimes on the other'. Due to its ambiguous status, individuals who would today be diagnosed with BPD could then be understood as transgressing the social code (Wirth-Cauchon, 2003). As such, while they may have appeared 'normal' Wynter (in Showalter, 1985) argued that a psychiatrist would be able to identify the undercurrents of 'insanity'. This is exemplary of the powerful position of the psy-disciplines, as only a professional can identify when pathology is present, and as such the lay individuals' concept of self becomes overlooked. Showalter (1985) has argued convincingly that the identification of 'borderline' pathology grew out of psychiatry, as part of a discipline and institution, to deter females from defecting from their positions as wives and mothers. Thus, women who

were perceived as crossing the border became subject to 'mental derangement' (Showalter, 1985, p.106). At the time this mental derangement, was understood as hysteria, which many theorists have suggested is the antecedent of the modern day borderline diagnosis (Becker, 1996; Wirth-Cauchon, 2003).

### 2.3.3 Modern Formulations 1915-1945

With the development of psychoanalysis, American clinicians began to identify individuals who did not fit easily into the psychotic or neurotic groups. However, these individuals were still considered disordered (Wirth Cauchon, 2003). The theoretical understandings of the borderline category developed within the American context, and psychiatrists who were psychoanalytically trained (and therefore with biomedical backgrounds) began to conceptualise the borderline as well as narcissistic personality organisations. The first analyst to make use of the term 'borderline' was Adolph Stern in 1938 (Millon, 2001; Wirth-Cauchon, 2003), with his sentiment, 'it is well known that a large group of patients fit frankly neither in the psychotic nor the psychoneurotic group, and that this borderline group of patients is extremely difficult to handle effectively by any psychotherapeutic method' (in Wirth-Cauchon, p. 48).

During this stage of the development, the borderline patient was not only considered to be on the border between psychosis and neurosis, and therefore difficult to treat with medicine; the borderline patient, being absorbed into the therapeutic milieu, was now also conceived of as a group of patients, who were difficult to handle (Stern, in Wirth-Cauchon, 2003). Schmeideberg (in Wirth-Cauchon, 2003, p.51), an analyst, described these 'difficult' analysands as, 'unable to stand routine...they transgress every rule; naturally they do not attend treatment regularly, are late for their appointments...they do not associate freely...they refuse to lie on the couch...it is difficult to establish emotional contact' all aspects which could be argued to fall outside of the biomedical framework. Thus, the conflation of behaviour in treatment, understood as resisting the efforts of the analyst, as well as the analysts difficulty in 'establishing emotional contact' began to be incorporated into the professional discourse of borderline pathology.

In contrast to the emphasis on neurosis, Zilboorg (in Wirth-Cauchon, 2003), situated borderline pathology on the schizophrenia spectrum, where apparent 'normality' masks underlying psychotic tendencies.

#### 2.3.4 Contemporary Formulations 1945-Present

The conceptualisation of the descriptive term 'borderline' into a personality state or organisation occurred during the 1950s and 1960s. During this period there was an emphasis on instability and the self as fragmented, as opposed to the social maladjustment that characterized the previous conceptions of what constituted borderline pathology. The move away from schizophrenic understandings of the borderline was in part due to the conceptualisation of the borderline utilising ego psychology terminology, thus focusing not on the unconscious impulses but rather on the organisation of the ego and its ability to cope and adapt to 'reality' (Wirth-Cauchon, 2003).

Kernberg's (1975) introduction of the 'borderline personality organisation' outlined the disorder, by making it amenable to diagnosing professionals. As such, there were inclusion and exclusion criteria, delineating discernible characteristics of the borderline personality (Wirth-Cauchon, 2003).

However, the build up to the induction into the official taxonomy was fraught with disagreement (Nikelly, 1996). Theodore Millon who was in charge of the DSM III personality subcommittee, radically disagreed with the term 'borderline', citing its vague and ambiguous denotation (Millon, 2001). He argued that labelling a disorder based on what it is not, i.e. neither psychotic nor neurotic, allowed for the unreliable application of the syndrome, stating that the term 'borderline' could be understood as a level of severity but not a diagnostic entity (Millon, 2001). Despite these objections, Borderline Personality Disorder was officially entered into the DSM-III in 1980.

The inclusion of BPD within the taxonomy had an added benefit for the professional community, as through its codification, BPD became the object of professional intervention and as such through medical schemes, professionals could now be compensated for the treatment of the disorder (Flanagan & Blashfield, 2005). In fact, by 1984, BPD was the most commonly diagnosed disorder (Zanarini, 2000).

Furthermore, its inclusion in the DSM III represented a move away from psychoanalytic thinking back to medical conceptualisations (Wirth-Cauchon, 2003), by moving away from psychodynamic processes, to observable behaviours.

The remaining conceptualisations of BPD, namely as a result of trauma (Herman, 1992; Zanarini, 2000), and as a result of socialisation practices (Becker, 1996) will be explored in the social understandings of BPD at a later stage.

#### **2.4 The 'chaos' of the Borderline**

In order to understand and illustrate the importance and variability with which the term borderline is utilised within the psychiatric and psychological nomenclature an overview of the term is needed. The term borderline denotes the spurious and somewhat indistinct entity as embodied by the idea that the personality organisation is placed neither on the psychotic nor neurotic scale, however, borders on both (Bjorklund, 2006). This can be seen to be problematic, as the literature suggests, as it has been misused within the mental health community as encompassing a disorder which struggles to separate itself, and as such is employed as a last resort in terms of categorising (Wirth-Cauchon, 2003). Some research has suggested that it is a 'wastebasket' diagnosis, the main criterion of which is the fact that the pathology fits into no other category (Becker, 1997; Brown, 1990).

The use of the diagnosis to identify problematic personality structures, one with which the mental health professional struggles to interact with, has become an attempt to rationalise and neutralise levels of responsibility and indemnify professionals in terms of not only the success of treatment, but also in terms of the demonstration of failure. Following from this, is the idea that by utilising the diagnostic category of BPD, the clinician is either placed as an expert, when the outcome is positive, or alternatively as vindicated of responsibility, when the outcome is negative (Becker, 1997; Bjorklund, 2006; Markham, 2003; Nehls, 1998). Consequently, labelling an individual borderline personality disordered has dire ramifications as the weight of the label not only limits the care provided but also constructs the individual as diametrically opposed to treatment (Markham, 2003).

As a result of these many factors the diagnosis is frequently used as a derogatory label, with Becker (1997, p. 38) stating that, 'BPD has the distinction of being one of the few diagnoses for which a failure to thrive in treatment and the counter transference reactions of the counsellor serve as evidence of validity'. As such the term borderline carries along with it not only the understanding as provided by the DSM but furthermore the connotations of the subjective accounts of mental health professionals.

When traditionally predominantly female behaviour is imbued with negative connotations within the realm of psychological practice, it is particularly pertinent to focus critical reflection (Wirth-Cauchon, 2001). Because persons demonstrating behaviours commensurate with a diagnosis of BPD have a pathologised status, the professional treatment becomes iatrogenic in nature, especially within a hospital setting (Flanagan & Blashfield, 2005; Landrine, 1989; Markham, 2003 & Nehls, 1998).

#### 2.4.2 The Problematic Nature of the BPD Label

Ideological viewpoints that impact on the construction and diagnosis of BPD include a culture of patriarchy, where feminine experience is undermined and invalidated by perceived masculine superiority and social status (Wirth-Cauchon, 2003). The particular implications for the diagnosis of BPD, as suggested by relevant literature involve the high prevalence of sexual, physical and emotional abuse in the histories of diagnosed patients (Wirth-Cauchon, 2003), with several theorists indicating that a diagnosis of chronic Post Traumatic Stress Disorder may be more appropriate (Hodges, 2003, Herman, 1992, Herman, Perry & Van der Kolk, 1989). As such, the diagnosis of BPD may be seen as a re-traumatising act, one which induces withdrawal and a negative appraisal from treating clinicians (Trippany, Helm & Simpson, 2006).

Popular understandings of BPD have not escaped the vitriolic perceptions of the disorder by professionals. Popular literature (e.g. Kaysen, 1995; Kreissman & Strauss, 2002; Moskovitz, 2001; Reiland, 2004) has attempted to bring the BPD category into the public domain. An example of this negative view can be seen in the foreword of Rachel Reiland's (2004, p. x-xi) autobiographical account, by Kreissman:

“BPD is the monstrous, metastatic malignancy of psychiatry. Most professionals shun patients with this diagnosis, convinced they are exhausting, hopeless, and often terminal. The sickest, most severely psychotic schizophrenic patient is preferred over one with BPD...hospitalisation and medication can easily and quickly subdue the schizophrenic monster. But BPD symptoms can rage unpredictably, are difficult to control, require months or years to detect improvement, and can overwhelm the vulnerable therapist”

Even in a book he edited, *Sometime I Act Crazy* (Kreissman & Strauss, 2002, p.11), Kreissman states that, “among many professionals, borderline patients are the most dreaded. They bear a reputation for being overly demanding, with frequent phone calls and agitation for attention. They are the most litigious group of psychiatric patients”. Ironically, both these books purport to offer hope to individuals diagnosed with BPD, with both citing the importance of receiving professional help.

Iatrogenic in nature, the manner in which the literature portrays borderline patients has significant effects on the approach employed by the mental health professional in the diagnosing of the proposed disorder (Becker, 1997; Wirth-Cauchon, 2003). As such, the varying discourses which are deployed in the development and organisation of the borderline personality, e.g. gender and biomedical understandings, frame the understanding of the individual. Furthermore, these discourses are influenced by broader social forces such as patriarchy and institutional practices of social control, which are gradually filtered into knowledge systems which are absorbed under the umbrella of rational scientific ‘truth’.

#### 2.4.3 Alternative ‘social’ understandings of BPD

Trauma, as it is represented by modern psychiatry, has been rendered an individual's psychological response to the trauma and as such can be explained coherently as existing solely in the individual self. It is argued that the move to identify the notion of trauma as within the individual results in the loss of meaningful ties to what it means socially and politically to be a victim (Kerr, 2004).

A prominent theory which attempts to assist in this identification is that of childhood sexual abuse which has been shown to result in psychological difficulties later in life (Herman, 1992). The prevalence of sexual abuse is not known, however, the majority

of reported cases are brought forward by females. This has implications as; if sexual abuse can be identified as a factor in the development of BPD, then it can also be argued that this has detrimental effects for those patients who are further victimised through the diagnosis of the disorder (Trippany, Helm & Simpson, 2006). Within the caveat of prolonged abuse the presenting difficulties of a client can be understood in context with Herman (1992) suggesting that to ignore the original reason for this behaviour, it can become to be seen as perverse, incomprehensible and ultimately pathological. Herman (1992) posits that the symptoms commensurate with BPD may be reframed as adaptive mechanisms as a result of childhood abuse and goes further in suggesting that a diagnosis of chronic Post Traumatic Stress Disorder may be more appropriate.

While 60 to 80 percent of women diagnosed with BPD have a history of sexual abuse, there are 20 to 40 percent who have therefore not experienced sexual abuse (Becker, 1997). Moving from this, Becker argues that while sexual abuse is an important indicator in the development of BPD, it does not adequately address the gendered nature of the diagnosis (Becker, 1997). Becker (1997) argues that female socialisation has a discernible link to the development of female symptomology. Therefore, aspects valued in females which inform socialisation practices, are widely devalued within society (Wirth-Cauchon, 2003). As a response to this theoretical argument, Dialectical Behavioural Therapy was developed, which focuses on the development of a 'healthy sense of self' (Linehan, 1997, in Wirth Cauchon, 2003). It is argued that development of a healthy sense of self is to counteract the invalidating environment that individuals find themselves in (Linehan, 1997 in Wirth Cauchon, 2003).

Becker (1997) views the feminization of the borderline category as having developed in a similar way to that of hysteria, which was considered a heavily gender laden diagnosis of the early twentieth century and conceptually was linked to the 'wandering womb'. Becker (1997) also argues that since the development of BPD, there has been a shift away from cognitive symptoms towards more emotionally focused symptoms. Therefore, there has been a move away from the traditional 'masculine' reference point of cognition to the stereotypical 'feminine' emotionality. Furthermore, Becker (1997) states that BPD does not represent a unitary disorder but

rather a heterogeneous entity, and therefore the identification of BPD in an individual do not guide the professional in terms of treatment.

### **2.5 Women and psychiatry**

Considering the heavily laden meanings attached to the development of the borderline category, the prevalence of the disorder amongst females is brought into question. Chesler (1973) has argued that throughout its history, psychiatry has targeted and pathologised females. Some theories attempt to account for this focus by suggesting that, there is a sexist double standard (Brown, 1990) in mental health, there is a stress on the demanding, devalued female sex role (Becker, 1996; Chesler, 1973), women tend to seek help more often than men (Nikelly, 1996) and that diagnostic categories are misogynistic in that they mirror women's roles and stereotypes and therefore function to oppress and control woman (Wirth-Cauchon, 2003).

It is also interesting to note that there is much more research focused on female based disorders than male disorders (Becker, 1997; Landrine, 1989; Sperry & Mosak, 1993) and as such the focus on female disorders suggests how the psy-disciplines have situated the female as the object of scrutiny. BPD is among the most researched personality disorders (Landrine, 1989). The reasons for this may vary, however, considering the reported incidence of the disorder, especially amongst the female population who in general tend to seek treatment more readily than their male counterparts, this may have provided some incentive to understand and characterise the alleged 'pathology'. An understanding of why women seek out treatment more readily also has implications in terms of society's acceptance of women as 'other'.

Research on gender bias in diagnostic systems has taken place predominantly within the American context and in a broader context of the biomedical model (Wirth-Cauchon, 2003). It has been argued that psychodiagnostic systems tend to neglect the unique cultural, gendered and racial elements present in non-Western societies, although they are interpreted and utilised subjectively by clinicians making use of, and embedded within various cultures (Castillo, 1997). While the behaviours commensurate with BPD may be present in all societies, the varying ideological positions of the diagnosed and the 'diagnoser' take on context-specific meanings.

This research is aligned with Nikelly's (1996, p.17) sentiment that; 'to ignore or tolerate existing injustices to woman as 'normal' and then to label as pathological their self defeating behaviour is a contradiction'. Modern representations of female pathology in many ways reflect the Western feminine social reality (Nuckolls 1992; Ussher 1991). As Chesler (1972) indicates, the pathologising of female social experience can be seen as the penalty for being feminine.

The historically gendered approach to understanding predominantly female behaviour has been viewed through a male lens which has construed it in particular ways. The manner in which the prevailing understandings of what is considered normal is quantifiable in terms of the socialisation of men and women, and therefore the pathologisation of female behaviour has become the norm whilst concurrently predominantly male behaviour is considered 'normal'. Therefore woman are essentially compared to men as the golden standard from which to base their behaviour, however, should they take on masculine features they would be acting outside of their prescribed gender roles and consequently pathologised, thereby laying women on the border between normality and insanity effectively stagnating and contaminating any attempt by women to lead 'normal' lives. As Nikelly (1996, p. 20) suggests, 'the definitions of normality depends on who does the defining and in what context; however, clinicians have traditionally espoused different criteria of normality for men and woman'. Research has suggested that similar difficulties are faced with the diagnosis of Antisocial Personality Disorder which is considered a predominantly male diagnosis (APA, 2000). However, the difference in attitudes towards females and males differ. The antisocial personality is considered to be the extreme of masculinity; where as the borderline constellation takes the role of the devalued female position (Busfield, 1996). If gender can be understood as providing a context for diagnostic practice (Flanagan & Blashfield, 2005), the South African context offers multiple sites of contention as will be reflected upon in the next section.

## **2.7 The South African Context**

The relevance of the current research for the South African context requires an overview of the pertinent issues facing South African mental health professionals in relation to diagnostic practice, which makes use of the nosological tools derived from biomedical, Western concepts and categorical hierarchies.

South Africa's specific historical and cultural legacy may have unique implications for diagnostic practice including the diagnosis of BPD. Therefore, within the South African context there are unique characteristics which differ from the contexts within which diagnostic tools such as the DSM were developed.

The history of biomedicine in Africa is demonstrative of the manner in which institutions serve to maintain power relations. A social constructionist overview of the use of biomedicine in colonial Africa, suggests that by focusing on the 'natural' causes of pathology, biomedicine assisted in decontextualising the social and political influences of society in the development of pathology (Knowles, 1996; Swartz, 1991, 1995; Yen & Wilbraham, 2003). Furthermore, biomedicine within colonial Africa, is itself socially constructed, as can be seen by the emphasis on the difference between 'black' and 'white' and between different *ethnic* groups, as such, it served to perpetuate notions of difference, by utilising scientific reasoning to colonise the 'native' (Swartz, 1991). This emphasis simultaneously undermined and devalued traditional healing in South Africa, situating it in contrast to 'rational science', thus positioning it as 'irrational non-science' (Swartz, 1995).

Research carried out by Sally Swartz (1995) on asylums in the early 19<sup>th</sup> century, outlined the manner in which psychiatric knowledge became racialised. This is illustrated by the development of the conception of the 'African mind' as primitive and therefore not able to experience 'melancholia' but rather 'simpler forms of mania' (Swartz, 1995, p. 415). This distinction then became the basis for legitimating the difference in management of African psychopathology. As such, individuals who were white, female and insane were constructed as in need of care which abdicated them of domestic responsibility, while those who were black, female and insane were actively put to work, thereby mirroring the economic value placed on manual labour outside of the asylum (Swartz, 1995).

Butchart (in Yen & Wilbraham, 1998) has argued that the intersection between the psy-disciplines and politics is not a uniquely South African phenomenon. Contemporary research into the understandings of biomedicine, especially subsequent to South Africa's first democratic elections in 1994, acknowledge the role biomedicine had in subjugating any non 'white, male, middle class' groups within

South Africa (Swartz, 1995; Vogelman, 1990). Furthermore, the relevance of the practice of psychology, in particular, with its 'talking cure' derived from American and European populations, is conceived as limited in its ability to address the difficulties and pathologies presented by the African working class (Vogelman, 1990).

Appealing to a universalist understanding of mental illness further individualises pathology and does not provide a discursive space for alternative understandings within the South African mental health system, as evidenced by the devaluation of traditional healing (Yen & Wilbraham, 1998). Following a universalist view, BPD, being developed in a Euro-American setting, could be considered a culture bound syndrome by South African professionals, just as amafufunyana is considered culture bound to western professional understandings.

As identified in the literature, the impact of gender, culture and race on diagnostic practices indicates the need to view diagnostic tools as historically and culturally embedded, as well as being responsible for the reproduction and perpetuation of ideologies within which individuals are placed in relation to others (Parker *et al*, 1997). Historical, cultural and social factors need to be identified in diagnostic practice, and therefore the DSM cannot be seen as an independent objective tool.

Msemi & Strebel (1999) indicate that admissions as well as diagnostic practice have social implications, as evidenced by the prevalence and correlation of certain disorders with members of differing gendered, racial and cultural groups in South Africa. Their findings suggest that psychiatric diagnostic practice in many ways mirrors the country's ideological past, with more women, as well as more black males, being diagnosed and hospitalised with severe psychopathology than white males (Msemi & Strebel, 1999). They also found that more white women than black women were given the diagnosis of BPD (Msemi & Strebel, 1999). Furthermore, white patients were in general given a diagnosis on Axis II as compared to the prevalence of Axis I diagnoses among black patients (Msemi & Strebel, 1999).

Research based on the admissions to psychiatric hospitals in South Africa bears this out, in suggesting that white women are more likely to receive a diagnosis of personality disorder as opposed to women of colour who receive a diagnosis of

psychosis more readily (Msemi & Strebel, 1999). This distinction has peculiar but pertinent relevance to the current thesis. Firstly, a diagnosis of psychosis places an individual within the realm of medical care, as such the biomedical discourse is utilised more readily. As has been discussed, the deployment of the biomedical model can be viewed as the simultaneous acceptance of the notion of the body as the site of pathology. This is opposed to the diagnosis of BPD, which is traditionally treated with therapeutic intervention, thereby suggesting, in a somewhat ironic fashion, a prerequisite of psychological sophistication. In terms of treatment, the biomedical model draws on pharmacology to ameliorate symptoms, but therapeutic intervention necessitates the provision of professional expertise over extended periods of time, with a view to 'understanding' the individual and bringing about change through a collaborative relationship. The positions available to these two different 'patients' becomes infused with different rights and expectations from service providers. Essentially, the objective, rational account of the decontextualised black patient is contrasted with the psychodynamic, in depth account of the white patient. Furthermore, stereotypical ideas concerning race become contextual in the deployment of diagnostic categories, rather than objective assessment. Additionally, the difficulty posed by language may play a role in this uneven diagnostic practice. This may also suggest that psychological distress is aligned with the ability to communicate particular symptoms, which may be difficult to communicate when the professional and the patient do not speak the same language or share similar cultural backgrounds (Drennan, 1999; Swartz & Drennan, 2000).

Not only does the DSM-IV-TR (2000) suggest that there should be an incorporation of culture within the diagnostic practices of mental health professionals, it suggests that there may be difficulties or problems with diagnosing, especially personality disorders, across cultures (Castillo, date). This places the South African mental health professional in a particularly problematic position. The training offered in South Africa is Eurocentric in nature (Seedat, 1997), and may not provide a sound foundation for the identification and understanding of various disorders within contexts outside of a Westernised model. Furthermore, there are many groups in South Africa who have held disadvantaged positions within society, and therefore may not hold as much power within certain professions (Seedat, 1997).

As identified in the literature, the impact of gender, culture and race on diagnostic practices indicates the need to view diagnostic tools as historically and culturally embedded, as well as being responsible for the reproduction and perpetuation of ideologies within which individuals are placed in relation to others (Parker *et al*, 1995) Historical, cultural and social factors need to be identified in diagnostic practice, and therefore the DSM-IV-TR cannot be seen as an independent objective tool when utilised in non-western contexts.

## SECTION 3:

### METHODOLOGY

#### 3.1 Research Aim

The overall aim of this research is to open up for critical reflection and debate, the contested nature of the BPD diagnosis in the South African context. Through the investigation of a discursive text, provided by mental health professionals in a South African governmental psychiatric hospital, dominant discourses will be interrogated so as to identify the modes of power which they carry.

#### 3.2 Theoretical Perspective

The research was conducted from a feminist standpoint within a social constructionist paradigm and made use of a critical discourse analytic method to analyse five interview transcripts. According to the social constructionist paradigm, language mediates all experience and as such it can be said to construct reality as subjectively experienced (Burr, 2003; Parker, 1992; Parker & Burman, 1993; Terre Blanche, Durrheim & Painter, 2006). From this perspective knowledge is seen, not as something that people possess, but rather as something that is contextually co-constructed through discursive systems of meaning in which language plays a central and unquantifiable role (Burman, 2003). Language can therefore be said to have performative rather than simply descriptive functions, and as such symbolic communication between people serves to inform experience as well as to dictate appropriate social consequences to behaviours in particular contexts (Burr, 2003).

In this view the parameters of language actively delineate the sets of meanings attached to particular objects, events, subjects and experiences (Burr, 2003; Parker, 1992). These linguistic parameters are organised into discourses (Parker, 1992) which interact to form elaborate webs of shared meanings that inform and are informed by various cultural practices. From this standpoint, knowledge is again vested in individuals, and it can be gathered from their self disclosures.

The research methods used to obtain these insights are usually qualitative (Terre Blanche *et al*, 2006). Such methods are preferred because they avoid the pitfalls of traditional standardised measures that censor or deform the localised personal

knowledge of research participants and support the hierarchy of researcher over researched (Gergen, 2000). By deconstructing meaning claims, my aim is to look for the modes of power they carry and from this, open a discursive space for counter-meanings (Burr, 2003).

A discourse is a set of statements about an object which allows people to define and speak about things (Parker, 1992). Discourses always entail relations of power, and by way of example, within a social constructionist perspective, females within psychiatry hold little power, as their experience is assessed by comparison with the ideal male (Chesler, 1972). Therefore, it is posited that 'talk' around female experience, while already subjugated, may be further devalued through the use of diagnostic categories which evoke a pathologisation of female experience in society (Wirth-Cauchon, 2003).

This perspective was chosen to demonstrate how the discourses related to BPD, as reflected in the 'talk' of professionals, serve to construct both objects and subjects (Parker, 1992). Therefore, conceptualisations of BPD, including the theoretical underpinnings of the concept of BPD, can be said to be socially constructed (Burr, 2003). From the assumption that BPD is constructed through language, professionals will draw on various discursive practices in their descriptions of the BPD diagnosis. Therefore, the discourses of professionals will be used to explore the manner in which professionals construct BPD and these discourses will be interrogated for the discursive practices they engage in (Burr, 2003; Macleod, 2002; Parker, 1992; Terre Blanche *et al*, 2006). Interrogations of written and spoken language are therefore appropriate ways to study the complex, dynamic and radically contextual power relationships present within all societies (Parker, 1992).

Since the exact parameters of BPD diagnoses are unquantifiable and rely on subjective interpretations of language and behaviour it is appropriate that this research is situated within the qualitative paradigm, and conducted from a social constructionist perspective (Kvale, 1996). Discourse analysis was identified as a suitable method for this study as it focuses on the operation of language, rhetoric and ideology (Berg, 2001; Parker, 2005). The structure and interaction of power differentials will be the focal point for identifying the manner in which power

relations - which circulate in society rather than being owned by an individual or a group (Mills, 1997) - operate. The Foucauldian perspective was useful in this study as it helped to explicate how discourses are intrinsically bound up in and responsible for the legitimisation and reinforcement of institutional practices of “organizing, regulating and administering social life” (Willig, 2003, p.172).

Foucault (1977) argued that in order to understand the operation of power it is necessary to look not only at the macro or ideological levels of social interaction, but also to interrogate the micro everyday workings of power, which result in subjects being positioned, or positioning themselves in relation to others. The position of a particular subject regulates that subject’s behaviour in specific contexts, as well as governing expectations and interpretation of that behaviour by others (Willig, 2003). These ‘subject positions’ are characterised by a structure of rights and duties which can facilitate and limit not only what can be said by whom, when and where but can also constrain agency, experience and opportunity within society (Parker, 1994).

Discourse analysis is an appropriate method to address research conducted from the social constructionist paradigm, as the structure and function of particular discursive manoeuvres in which language does not reflect, but constructs reality are scrutinised and interpreted ideologically and positionally (Parker, 1992). The utility of discourse analysis is thus meaningful in this research as it attempts to uncover claims of ‘truth’ within psychological practice that have been normalised over time (Burman, 1991).

### **3.3 Participants**

Participants were selected by means of purposive sampling which was guided by the availability and suitability of the participants (Terre Blanche *et al*, 2006). Mental health professionals working in a state psychiatric hospital in the Eastern Cape were approached. Five participants were selected on the basis of their professional status; specifically for their ability to engage in diagnostic practice.

Because professionals can be seen as the representatives of disciplinary power, their position as expert serves as a focus for exploring and expanding upon power relations, ideological practices and institutional norms (Parker, 1992; Foucault, 1977). Therefore, in a somewhat antithetical move, those members in society, who are part of

powerful institutions, were deemed to be the most appropriate individuals to approach when identifying discursive practices. The overt power-relations present within professional and non-professional interaction was seen as a vital element in the exploration of the construction of the BPD diagnosis.

### 3.3.1 Ethical considerations

The role of professional mental health care workers can be seen to be socially mediated through the social construction of the expert/non-expert binary. As such, the sensitive nature of the data, in terms of professional identity and responsibility was discussed with the participants by way of explaining the tenet of social constructionism; that language is independent of the speaker, and rather is representative of particular discursive practices. The aim of the research was explained, and willing participants were assured of confidentiality and anonymity. While, an analysis including, especially the profession of the participant, may be considered relevant, identification of the participants through their professions was considered as compromising to their anonymity within the geographical context of the research. For this purpose, identifying features, such as names and professions, were removed from the transcripts subsequent to the analysis.

To ensure willing co-operation, the participants were required to read and sign consent forms, which outlined the aims and nature of the study (see appendix A). In the conception of the data collection method, the researcher became aware of the possible influence her questions may have on the responses given by the participants, especially considering the critical nature of the literature regarding professional treatment of individuals diagnosed with BPD. As such, she remained vigilant of her own perceptions and understandings, informed by the review of literature, and attempted to ensure that the responses given by the professionals were received and responded to in a neutral way, but also as part of a critical research focused dialogue. Therefore, the portrayal of the narratives was dealt with sensitively and consideration was given to the process in terms of not only eliciting relevant data by providing a confidential space, but also by protecting and upholding the rights and responsibilities of their roles as professionals.

### **3.4 Data Collection**

Discourses are realised in texts which form the basis of discourse analytic data (Parker, 1992). The texts for this research were generated through the tape-recorded and transcribed interviews which were conducted with mental health professionals working in a psychiatric hospital in South Africa. Participants were initially asked to describe 'typical' manifestations of BPD as they encounter in their practice, and questions were generated from their responses. Interviews in discourse analytic methodology are treated as pieces of social interaction and therefore, it is postulated that the interviewer is contributing just as much as the interviewee (Parker, 2008). As such, the interviewee can be seen to be enrolled as a co-researcher and the, 'use of reflection within the interview process, affectively enabled the co-researcher to respond and interact with the issues discussed' (Parker, 2008, p. 95). By opening up space for debate around certain pertinent issues related to BPD, the researcher was able to engage the participants in a dialogue about divergent contemporary theories concerning BPD. This 'introduction' of information is therefore not viewed as contaminating, but rather as part of the recognition of the researchers role in the development of the discourse (Parker, 1992).

### **3.5 Data Analysis**

The Foucauldian perspective adopted by Parker (1992 & 2005) asserts that language produces meaning and proposes that there is a profound relationship between language and subjectivity (Willig, 2003). In order to analyse the data, the seven steps set out in the procedure identified by Parker (1992) were systematically adhered to. This procedure enabled the researcher to delineate discourses by immersion in the data in order to establish familiarity with the discursive operation of dominant ideologies as supported by and resisted by discourses identified in the text, paying particular attention to the positioning of subjects. The operation of discourses deployed in the text, as well as the subject positions made available by these discourses, were interrogated using techniques such as identifying binary oppositions, recurrent themes, phrases and metaphors (Terre Blanche *et al*, 2006). The identification of ways in which particular discourses operate, and the positions offered to various subjects within these inter-connected webs of meaning were located in a feminist reading of the text which assisted in revealing the ideological positions.

The purpose of the analysis was to identify discrete discourses within the text, so as to demonstrate how these discourses function as part of broader social interactions and effects (Burr, 2003; Parker, 1992). With this in mind the researcher worked towards the deconstruction of the text, by breaking the text into pieces so as to provide a basis for the re-construction of the text, which ultimately opened a space for the discussion of the identified discourses (Parker, 1992). The aim of identifying the discourses was the explication of their relationship to each other, as well as their location within legitimating and reinforcing institutional practices (Willig, 2003), in order to interrogate the operation of power dynamics on the discursive and ideological levels and how these position individual subjects in relation to each other.

### **3.6 Issues relating to Reliability and Validity**

Research conducted within a constructionist framework struggles to accept notions of reliability and validity, as in line with the constructionist paradigm, there is a denunciation of positivist appeals to accuracy (Terre Blanche *et al*, 2006). However, the rejection of reliability and validity does not mean that research conducted within this paradigm is not rigorous or thorough. As such, the researcher attempted, through alternative means, to ensure the credibility and rigorous nature of the research (Terre Blanche *et al*, 2006).

As part of acknowledging her own agenda, as well as her subject position within the academic environment, the researcher has included a detailed systematic analysis in a bid to provide for the intended academic audience a means of evaluating the extent to which the researcher has followed the recognised research methodology, has explored alternative or contradictory findings within the body of her research as well as reflexivity in order to assess her own position within the research setting. A brief discussion of these various points will follow.

A systematic analysis, following a respected methodology was included within the research. This was done in order to provide the reader with an 'audit trail' (Miles & Huberman, 1984 in Terre Blanche *et al*, 2006). Thus, the researcher has attempted to provide a detailed 'map' of how the research 'findings' were reached. While the approach may be deemed dogmatic, the need to reflect upon and account for rigor within the research was given preference to semantic eloquence.

## SECTION 4

### **ANALYSIS AND DISCUSSION**

This discussion explores the operation of discourses in the text of five transcribed interviews with mental health professionals. Considering the scope of this research project, particular attention is paid to the manner in which BPD is constructed as both object and subject within the text, as well as the manner in which various subjects and objects are positioned in relation to one another (Parker, 1992). In particular the manner in which professionals are positioned in relation to the diagnosis of BPD is examined. This investigation explores the multiple ways in which the diagnosis of BPD is constructed within the text with a particular emphasis on the gendered nature of the diagnosis through the construction of the female *other*. Furthermore, the implications of this construction are juxtaposed with broader ideological practices, power relations and institutional concerns (Parker, 1992).

Multiple discourses emerged during the interrogation of the texts. These discourses will be discussed independently. However, as with all discourses the themes are interlinked and interwoven. As discussed in the methodology section, the discourses were realised in an integrated interview process, which enabled the interviewee to become part of the research, by asking the participants to reflect on the discourses they had alluded to. For this reason, the researcher played a role in developing and revealing the discourses during the interviews (Parker, 1992). These discourses were predominantly introduced based on the literature presented in the literature review.

#### **4.1 The Acknowledgement of Reflexivity**

It is understood that the text is independent of the speaker, but that the speaker, in the manner in which the sentences have been constructed are also emphasising certain aspects of their understandings and that these emphases will be picked up on by the researcher, the listener and the reader (Parker, 1999). These particular emphases can be seen as indicative of how knowledge is presented as being privileged. Therefore, the researcher can be seen to be playing a role not only in the co-construction of the dialogue but also in the analytic procedure of identifying the discourses.

The researcher is an inductee into the profession of psychology, and as such may have been viewed as naïve in terms of the experiential understanding of BPD as well as being viewed as having limited experience with individuals classified as having the diagnosis of BPD. This influence can be recognised in the emphasis within the text of the need for *experience* and *supervision*, which could be construed as a way of inculcating the researcher into the institution of clinical assessment and judgement, especially when dealing with individuals diagnosed with BPD. It is proposed that through the course of the texts the researcher becomes aligned with the institution of psychology (as is evidenced by her pursuit of becoming ‘part’ of the profession). Her lack of experience and naivety concerning the diagnosis provided a discursive space for participants to claim authority within the field.

Moving from this position it can be said that the researcher is positioned on the outskirts of the institution of psychology, which in the context of this research aided in the explicating of certain taken-for-granted understandings. This notion of positioning became clearer to the researcher through the identification of the *experience* discourse, which positioned the participants as experienced and the researcher as inexperienced. Due to this, the notion of reflexivity was taken into consideration at all stages of the research so as to acknowledge the influence that the researcher’s position may have had in the dialogue (Parker, 1992; Terre Blanche *et al*, 2006). From a methodological point of view, it is understood that, considering the nature of research, there is a relationship between the ‘author’ and the ‘listener’ as the ‘world’ that is created is through dialogue between the two (Terre Blanche *et al*, 2002). Therefore, the questions posed by the researcher during the interview process have an influence on the manner in which the discourse is constructed, and although her position as an inductee into psychology may be taken into account, it is also important to note her position in terms of the research endeavour. As such, within the interview process itself, through follow up questions and reflections the researcher acknowledges the powerful position held and the importance of reflecting on this position.

#### **4.2 Analytical Processes**

The initial stage of analysis required the text being transformed into written form (Parker 1992). This stage enabled the researcher to become familiar with the text.

With this in mind, it is also important to remember that while the interviews were transcribed verbatim, the meanings and inferences made within the text were beginning to be interpreted by the researcher (Parker in Banister, Burman, Parker, Taylor, Tindall, 1998). As such, the text does not stand alone, but rather comes under the scrutiny of the researcher and her assumptions. The connotations and inferences made within the course of the text would be clarified with the researchers 'lens' and therefore during the transcription phase the text was already transforming itself into a discursive space in which subjective meanings could be interrogated (Smith, 2003).

Through a process of free association the researcher was able to become familiar with the text (Parker, 1992). Subsequent to the transcription, the interview transcripts were broken down into individual statements, which were analysed independently and then in successively increasing relation to the text as a whole. Therefore, each sentence was filtered through multilayered contexts and these associations were noted and 'kept in mind' during the subsequent phases of the analysis (Parker in Banister *et al*, 1998). This process was helpful in identifying the various connotations and interpretations which could be made of the text (Parker in Banister *et al*, 1998). Furthermore, the associations yielded data that was useful in the discussion of the various discourses identified at a later stage (Parker, 1992).

In a bid to contextualise the text within a broader setting the researcher explored the text creatively as part of the process of immersion (Parker, in Banister *et al*, 1998). As it stands the text is presented in the form of an interview, a dialogue, between a researcher and a participant. This format already suggests that there is 'something' which is being discussed. Further investigation suggests that this same 'thing' is being discussed across five interviews. The interview has content which is profession specific, which can be identified by certain terms which are not in common every day use; therefore a professional lexicon can be identified. This situates the text as a discourse which is not readily available to individuals outside the field of psychology, psychiatry, medicine and mental health. This has implications for the manner in which it positions people in general and particularly those who receive a diagnosis of BPD, as the analysis will demonstrate.

The texts can be said to centre on specific aspects of psychological knowledge; however, everyday interpretations of some words may be understood by those outside of the profession. Pieces of text such as, 'personality', 'borderline', 'client', 'patient' and 'diagnosis' for example present a myriad of different interpretations through different usages of the words. For example, the conventional uses of words become absorbed into a professional discourse which serves to include professionals and exclude non-professionals. This kind of positioning is also present in professional contexts, where the professional has access to knowledge which the lay-person does not. An example of this positioning can be seen through the use of the word 'personality'. An everyday understanding of the word personality is defined as the 'way a person is' and is deemed to be fairly consistent over time, with people being able to refer generally to the 'way' a particular person is. Within a psychological framework, personality can be divided up into different aspects, and with reference to the current discourse can be referred to as disordered or not disordered. Thus, it can be seen that the psy-disciplines (disciplines related to the mind with the pre-fix 'psy' e.g. psychology and psychiatry) actively construct the 'object' of personality in different ways through power-knowledge systems (Foucault, 1977). As such, the psychological knowledge of the personality highlights the power differential between what is known colloquially and what is known within a professional context. This garnishes the professional with the power to distinguish between different personalities as well as delineate what is considered normal and abnormal (Rose, 1985).

Socially sanctioned understandings of professional terminology can be understood to have been translated and made more accessible because of the influence of the media (Parker, in Banister *et al*, 1998). As such, the function and roles of words such as 'psychology', 'therapy', 'diagnosis' etc. have rich descriptive meanings, which have been absorbed into (common) everyday language. It is crucial to investigate the intersection between lay understandings and those understandings which are employed by inducted professionals, who have the power and authority to deploy the linguistic 'truth' through recognised systems of authority.

Therefore, the use of professional psychological terminology within the lay community is seen as significant within this paradigm as language is not seen as

neutral but rather as constituting reality (Parker, 2008). As such shared meanings of concepts construct and constrain elements within discourse.

#### **4.3 'Distanciation'<sup>1</sup> and Identification of Discourses**

Parker (1992) identifies the need to remove oneself from the text in what he calls 'striking a critical distance from the text'. Understanding how not only other researchers would understand the text, but also how other professionals, feminists, individuals diagnosed with BPD etc would respond is an important element in realising how the various discourses operate. These stakeholders were identified in response to the dominant theory put forward within the literature review however there are multiple other parties which may respond in different ways to the concepts put forward by the text and consequently the participants and researcher. The audiences listed above were identified by the researcher but by no means represent an exhaustive list of all possible 'listeners'

To begin, individuals positioned outside of the profession would struggle to understand the concepts put forward in the text, as such it can be said that there are concepts within the text which are taken for granted. It can also be said that there is a particular jargon being employed which serves to exclude individuals who have not been inducted into the profession, which as it stands serves to maintain certain power relations.

Following on from this, subjects within the profession would be able to understand the text, and while they may not agree with the sentiments put across, they would at the very least be able to identify how the dominant discourses present have been constituted. As such, an audience of professionals would with varying degrees accept the text as legitimate. This also assumes that there is a shared and uncontested community of knowledge and as such reveals the positioning of expertise within the discourses which are deployed.

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<sup>1</sup> Distanciation is a concept which suggests the understanding of a context from outside of the context (Riceour, in Terre Blanche & Durrheim, 2002).

An individual, who has been diagnosed with BPD, may recognise some of the terms utilised within the text such as self mutilation for instance. It would be interesting to explore how the stance taken within the text is either familiar or unfamiliar to them in the context of their contact with mental health professionals (see Suggestions for Future Research in Section 5). It could therefore be argued, that considering the widely accepted notion of the dominance of the biomedical discourse, those individuals who fall within categories delineated by the practice of this discourse would ultimately position themselves as subject to the text or alternatively as objects constituted by the text.

An audience comprising of feminists, may recognise the patriarchal undertones present within the text and position themselves as diametrically opposed to the notion of pathology being attributed to females. A feminist reading can be understood to be critical of the gendered practice of diagnosis as well as the reproduction of particular relations of power, institutions and ideologies.

#### **4.4 Discourses Operating within the Text**

Through the interrogation of the text the researcher was able through a process of delineating, conceptualising and placing the text under scrutiny; to label the discourses which emerged from the analysis (Parker, 1992).

The following meta-discourses were identified within the text and will be expanded upon during the course of the discussion:

- The Biomedical discourse which is embedded within a scientific discourse which structures the 'world' through objective and rational facts. Furthermore, this is specifically situated within the medical discourse which operates through the acceptance of the ability with which the practice of medicine is able to identify signs and symptoms of disease.
- Discourse of Science and Rationality. This discourse operates within the text through the positioning of people either in agreement with or in opposition to science and rationality. Thus, aspects identified as opposed to this discourse come to be viewed as irrational and non-scientific.
- The Psy-discourse. This structures the world according to what is considered 'normal' and 'abnormal' in terms of mental health. Professionals within the

psy-disciplines utilise this discourse through the ability to ‘diagnose’ and ‘treat’ individuals who are considered ‘abnormal’ within a mental health context.

- Discourse of Gender. This structures the text through identifying and emphasising the distinction between men and women.

The implications and ‘practice’ of these discourses will be explored in further detail in conjunction with issues of ideology, power and institutions within the discussion that follows.

#### **4.4.1 The Bio-Medical Discourse**

Within the text, there is an appeal to the objective and rational nature of the DSM-IV-TR and by virtue of this the biomedical model. This model implores the professional to act in a similar vein to the manner in which the model is constructed, as such; the professional should be objective and rational when utilising the concepts put forward by the model. However, the text suggests that the professional understanding of the diagnosis of BPD is not limited to the objective theoretical understanding of the diagnosis but has at the same time a subjective understanding. It is the conflation of these two alternative discourses which becomes the subject of scrutiny within this research, and this ‘overlap’ will be explored extensively.

The biomedical discourse can be seen to operating in the text through the deployment of particular terminology and through the manner in which diagnostic categories are understood. The biomedical model is based upon positivistic understandings which suggest that the ability to diagnose is based on scientific methods of observation and assessment (Flanagan & Davidson, 2007). Thus the professional has the ability to distinguish between what is healthy and unhealthy. Within the psy-disciplines this ability to distinguish is further illustrated with the ability to distinguish between normal and abnormal. Therefore, the deployment of the biomedical discourse places the ‘personality’ under assessment and thus makes it available to the psy-discourse (any discourse related to the disciplines involving the mind, namely psychiatry and psychology). The word diagnosis also enables a professional to label a disorder, in such a way that through identification, treatment can be sought. Therefore, the word diagnose is not just a term used within the profession, but is one that implies activity

or practice. Following this, the realm of treatment further enforces the concept of personality in this light as within the realm of psychology, medicine and psychiatry.

An individual becomes the object of the treatment once they enter into a setting which requires a professional to make use of knowledge to make sense of the presenting complaint, as identified by the individual. As such it is a social convention that an individual will seek assistance from someone who has been sanctioned to address the concerns they may have (Wirth-Cauchon, 2003). In response to this it is the responsibility and duty of the professional to respond to the individual with the knowledge he/she has in order to facilitate recovery from the complaint, which within the mental health context would be to no longer meet the criteria which identify 'disorder' within the individual.

The individual who comes to the attention of the professional has a certain responsibility to acknowledge the professional as having knowledge which may assist in alleviating current concerns. Conversely, the professional works from the stand point that they have knowledge which will be useful to the individual seeking assistance and as such both parties have a vested interest in engaging with one another. This relationship evokes a hierarchical notion of the all knowing healer and the helpless seeker (Parker, 1995). Because the professional has particular knowledge and access to particular understandings of what is considered 'normal' the help seeker has very little control over how the treatment may progress (Parker, 1995).

Appeals to the biomedical discourse are pervasive throughout the text, in the form of references to the DSM-IV-TR. There is an emphasis on highlighting the 'symptoms' which culminate in identifying and therefore diagnosing BPD. Thus, when the text attempts to describe the 'typical' borderline, narrative accounts by clients appear to become problematic for the clinician as they do not fit with a biomedical view of an individual requiring medical intervention. As such, symptoms which cannot be treated by the biomedical enterprise, such as the lasting effects of sexual abuse, become relegated to the 'waste basket' notion suggested in the literature (Markham, 2003). Thus, by bringing non-medical symptoms into the medical milieu the individual with a diagnosis of BPD becomes a 'difficult' patient to categorise, one which poses a threat to the stable and rational biomedical discourse. Considering the statistical

nature of the DSM, it is interesting to note that despite research suggesting a high prevalence of abuse, this aspect has not been incorporated into the criteria for the diagnosis.

The researcher attempted at identifying the discourses which are utilised when discussing and hence treating individuals diagnosed with BPD. It is because of this that the researcher structured questions in such a way as to provide the interviewee an opportunity to either identify their ambiguity or decisively defend alternative means of understanding. The discussion that follows will focus on discursive themes which utilise the biomedical model and critically analyse the implications this utilisation has.

#### 4.4.1.1 The Appeal to Truth

The appeal to the medical model, as espoused by the DSM-IV-TR, presents a difficulty to professionals who encounter the individual diagnosed with BPD. It is through the highlighting of the manner in which the text subverts the presenting complaints of the individual diagnosed with BPD, that the researcher was able to identify the deference to the bio-medical discourse. This becomes apparent through the understanding of the tenet of diagnosis, which is to bring into view multiple symptoms, so as to treat a unitary disorder. The DSM-IV-TR is portrayed within the text as a reference manual, which assists mental health professionals in the endeavour to diagnose. The taxonomy of the DSM-IV-TR therefore, carries power, and can be said to shape and organise the 'objects' of psychiatry and psychology. This reliance can be identified in the following extract:

I: Ok, so do you find that the DSM is not always helpful in terms of assisting people?  
Participant 1- "No, no look the DSM is my bible, the DSM is absolutely essential, you have to have a good understanding of that, I mean without that I don't think one could practice..."

As the text infers, the DSM is an essential tool to the professional standardisation of the clinician's comprehension of pathology. However, the word bible plays a significant role in this sentence as the comparison to the bible employs various alternative discourses which are in some cases in contrast to the underlying theoretical underpinnings of this text. The utilisation of the word bible implies a particular kind of understanding, which is described by Christians as the ultimate truth. Similar comparisons engage the text as greater than the sum of its parts, thereby carrying unquestioned authority as its appeals to the 'truth' of its contents undermine critique

due to its wide following. Therefore the DSM-IV-TR, in its entirety, functions as a 'brand' which is associated with scientific rigor. As such, considering the lauded status it has, the DSM-IV-TR becomes a doctrine which is necessary to follow and those not making use of it or in opposition to it may be referred to as heretics or anti-establishment. Furthermore, the bible is itself a socially constructed text, the authors of which are seen as followers and understood as translating the 'truth' into text. Similarly the authors of the DSM are chosen by particular people, with particular agenda's and this cannot be overlooked in terms of the message the DSM-IV-TR carries (Millon, 2000). Thus, the opening for critical thinking, in terms of diagnostic practice is limited, and members of the profession, it can be argued, follow the text of the DSM-IV-TR with the same sort of blind faith or dogmatism.

Considering that Christianity is broadly based on and employs the bible as the text as a foundation, the DSM-IV-TR too can be seen as marketed as an independent neutral tool utilised by those members of the privileged professional class. The concept that the message of the bible holds many secrets and is not easily accessed by the lay person furthermore has parallels with the academic text of the DSM-IV-TR which requires years of 'conversion' in order to interpret and comprehend. Thus it supports the notion of positioning as it comes to be viewed as privileged knowledge. This adds to the perceived authority and scientific validity of the DSM-IV-TR.

It must be noted that the interviewer has asked a closed question, suggesting that there is a clear answer. However, as this participant demonstrates, many clinicians acknowledge the ambiguity present and as such endeavour to work within the parameters they have identified for themselves. As such, the interviewer acknowledges that by asking particular kinds of questions, she herself is setting up a binary which offers little in terms of research results as it fails to recognise the meaningfulness of a pragmatic approach to individuals within a clinical setting.

The impact of the bio-medical model has multiple implications for the borderline client, women in psychiatric settings and the treating professionals. As has been suggested in the literature review, the modernist perspective employed by psychiatry is broadly based on traditional medicine and is espoused and spoken about within the literature as biomedicine. Because the biomedical model approaches health and

disease in terms of organic failure, there is little room for taking social factors into account (Swartz, 1991). Thus, as the following excerpt suggests diagnostic decisions can be presented as devoid of any consideration to the aetiological factors involved in the diagnosis of BPD:

I: It seems like there is quite a lot of interpersonal dynamics that go on..., even in the assessment interview?

Participant 3- "you pick it up quickly when you've been doing psychiatry for a while, you quickly realise, ok, this person is not clinically depressed, this person is not psychotic."

What is more alarming about this approach to diagnosis is the implied notion that the more experience possessed by the professional, the more appropriate it is to utilise such deductive reasoning. This also positions the more experienced clinician as more powerful, as it becomes even more difficult to object to the expert role which they play. As a result, this places the individual with BPD in a doubly difficult position, as not only is the expert able to identify pathology, their years of experience act as a legitimating force which is difficult to protest against.

The question which elicited this response also clearly makes reference to a model which does not ascribe to the biomedical model, and as such limits the participants options in terms of a response. The question also presupposes her/his agreement to the statement about interpersonal dynamics within the assessment process. To deny the presence of interpersonal dynamics, in an interaction between any individuals, but especially within a clinical setting is problematic. However, the interviewer aimed the question to the possibility of the identification of particular dynamics that emerge within an assessment with an individual who is subsequently diagnosed as BPD.

The use of the biomedical discourse is also apparent in the manner in which the text constructs the individual diagnosed with BPD. Within the text, the introduction of the individual is usually through the listing of symptomology. The 'symptoms' identified within the text are not all present within the canon of the DSM-IV- TR. As such, professional discourse concerning what constitutes a diagnosis of BPD is not standard. The employment of non-standardised symptoms alongside standardised

symptoms suggests a struggle between a strict adherence to objective scientific 'facts' and the utility and validity of experience. There could be multiple reasons for this struggle, however, it is posited within this thesis, that language is not a neutral practice (Parker, 1992), but one which structures the world in a particular way and following from this, the 'extra' symptoms listed by the text become important artefacts in understanding the manner in which professionals deal with the borderline diagnosis. The following extract is exemplary of this 'slip-up':

Participant 5- "...mostly young females, who normally enter a psychiatric setting following a suicide attempt. At the time of admission there is generally quite a lot of dramatics, in the sense that there is confusion and the reason for the attempt is unclear. I mean obviously this is a generalisation, but there is a history which seems to be concomitant of borderlines, so claims of sexual abuse, instability in their relationships and occupations. Most clearly I suppose is the kind of affective disturbances, there is a huge hopelessness, which is pervasive. I have also noticed eh that there is a loss of self, in terms of lack of identity and an inability to accurately and cohesively give an overview of their own histories, so basically a lack of insight."

Within this excerpt, the professional draws on various sources to explain his/her understanding of the borderline diagnosis. The excerpt includes references to the age of the individual, the idea that there is 'dramatics', 'hopelessness' and lack of insight, all of which are not included in the DSM-IV-TR criteria for the diagnosis of BPD.

Despite clear support for the biomedical model, there are numerous instances within the text which work to critically engage with the concepts proposed by the biomedical model, such as diagnosis and medication. Some of these objections may be seen as tentative; however, they do demonstrate openness to an increased awareness of how the biomedical model may function to maintain certain power relations. The following extract serves as an example of a critical approach being taken:

Participant 4- 'Because obviously if we say this is the diagnosis, this is the label we use, then that implies a certain approach to that.'

This excerpt demonstrates an understanding of how the practice of diagnosis is not a neutral practice, but one which entails ideological consequences. As such, it would be difficult to utilise biomedical concepts, such as diagnosis, in isolation of the surrounding theoretical and institutional practices.

Within an institutional setting, biomedical understandings of disorder are given priority over psycho-social explanations (Swartz, 1991). As such an acknowledgment and identification of the hierarchy operating within mental health institutions is necessary in order to comprehend the deference of opinion to those who are medically trained. Furthermore, this hierarchical structure can be seen to have ideological consequences, especially when medical understandings are revered and emphasised to the exclusion of other explanations of borderline symptomology. The positioning within the field of mental health serves to maintain this understanding.

Again, it would be unrealistic to assume that there would be definitive approaches to individuals within a clinical setting. All clinicians enter the assessment process with varying levels of knowledge, awareness and insight and as such this too can be said to influence the manner in which particular behaviours, histories and affective states may be defined and interpreted. To disavow and discourage the human aspect of a clinician presupposes a notion of scientific rationality and narrowly demarcates the variability present within the individuals in various positions and could be accused of generalising and undermining the clinician cohort, in much the same way as this thesis is aimed at identifying the discriminatory practices in relation to the diagnosis of BPD.

#### 4.4.1.2 Diagnosis as Part of Power Relations

The utilisation of the practice of diagnosis serves a function within the professional/patient relationship. It can be said to instigate the power/knowledge dynamic as suggested by Foucault (1961). The DSM-IV-TR serves as the representation of professional mental health and is utilised as an aide to communication between professionals (APA, 2000). As Brown (1990, p.389) suggests, "Diagnosis is the language of psychiatry, the 'social representation' of psychiatric knowledge, as well as the psychiatric professions' presentation of self". It can be inferred that diagnosis also becomes the language of psychology and as such of the psy-disciplines. The manner in which this language is deployed becomes relevant within the context of the current research.

Just as the texts being discussed serve to exclude certain readers, the text of diagnosis functions as a privileged text for use by professionals. Within the psychiatric setting, women are encouraged to speak about themselves, as part of an assessment for

instance, however, they make use of a very different lexicon as compared to the professionals treating them (Parker, 1995). As such, the diagnosed female is positioned in such a way that they are unable to make use of the lexicon of reason and understanding, and as such the female becomes fixed within the setting and is unable to challenge or oppose the way in which they are spoken about (Burr, 2003). Specifically, within this text, the individual diagnosed with BPD is constructed as being outside the realm of the psy-disciplines, which positions the individual as helpless. The following excerpt demonstrates how the individual with BPD is constructed when an attempt at utilising the language of psychology:

Participant 1- "...she understood this (self mutilation) was self destructive behaviour, it was abnormal, umm, but refused to see the use of taking that symptom seriously and getting the help she needed so she was sort of like very happy to brazenly say, 'look I use this behaviour for my own benefit'. You know in a way showing the manipulative side and not necessarily being aware of it herself."

Within this excerpt, the individual's acknowledgment of what society may categorise as "abnormal" is eclipsed by framing the dialogue as manipulative and "not being aware of herself". Thus, despite the suggestion within the DSM-IV-TR that a person should experience distress with the symptom, the text denies this understanding and rather configures the 'talk' as irrational and resistant to the treating professional.

Within the context of psychiatry, the diagnosis of BPD becomes difficult and frustrating and subsequently relegated to psychology, which is itself unable to accurately articulate the diagnosis in a way that incorporates the experience of an individual diagnosed with BPD. This sense of frustration in the face of BPD symptomology is explicated by the following excerpt:

Participant 3- "I think in a way they are very much written off, and delegated to the psychologists (laughs), which is very often the correct way of doing things as well..."

The excerpt demonstrates the manner in which the individual diagnosed with BPD is reduced to their label, as such it appears as though in some cases the imparting of a diagnosis of BPD serves as an end goal, thus labelling becomes viewed as sufficient when dealing with individuals diagnosed with BPD. This sense of frustration is further emphasised by the associated reasoning associated with the perceived lack of skills, thereby suggesting that the medical training received is inadequate:

Participant 3- "...that it is a useful sort of a way to see a certain group of people that are difficult to manage with the skills that we have...or the lack of skills a lot of the time. When referring to BPD"

The excerpt portrays the clinician as initially appealing to a rational and scientific understanding of the diagnosis, and then subsequently commenting on the inadequacy of the approach. And furthermore, the lack of progress within treatment is framed as resistant, which suggests that it is the individual diagnosed with BPD that is held responsible.

This understanding of the diagnosis places the individual with BPD outside the scope of psychiatric treatment. Therefore, women are absorbed into a psychiatric setting and are effectively imprisoned by their diagnosis as the profession of psychiatry does not have the skills to effectively treat the disorder. Furthermore, this lack of resolution is placed on the female, as they become positioned as treatment resistant. Therefore, as the literature has suggested, once an individual has been diagnosed with BPD, or any psychiatric disorder, it becomes a label which constructs them in certain ways and it is the pejorative nature of the discourse which has brought the diagnosis, especially that of BPD, to the attention of feminist researchers.

An appeal from outside of this understanding, as has been mentioned would position an individual as irrational. However, moving on from this aspect is the understanding that such a construction also implies that what is identified as disordered is seen as inherent to the individual. Therefore, the diagnostic entity is realised within the structure of the personality, as understood by western conceptualisations. Therefore, through this understanding there is an emphasis on the individual. Thus an alternative understanding which may posit that societal dysfunction may play a role in the development of the pathology identified becomes redundant. As such, Herman's (1992) conceptualisation that BPD could be better understood as chronic post traumatic stress disorder would be placed in opposition to the notion of disorder present within a bounded individual.

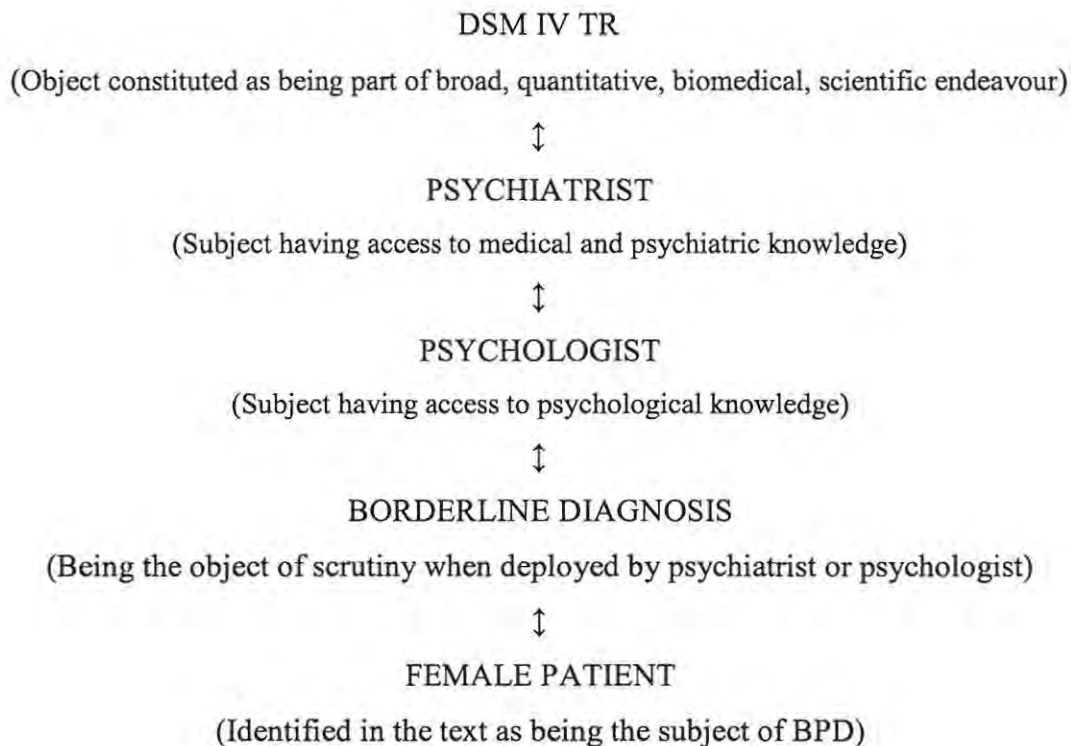
As such, even the term 'borderline' in its every day use becomes infused with meaning within the professional milieu. Firstly, the *borderline* is constructed as



neither the object of psychology nor psychiatry, as suggested by the text, which situates the diagnosis as the responsibility of the individual diagnosed with BPD rather than that of the professional who diagnosed the disorder. Therefore, the diagnosis remains outside of both domains within this text. As a result of this, the individual diagnosed with BPD is unable to 'cross the border' and remains 'nowhere'. Added to this, the construct of agency within traditional psychology is employed, as can be seen with the utterances 'manipulative' and 'treatment resistant' and become explanations for why the individuals are not able to 'regain lost ground' in the treatment setting.

Considering that the relationship constituted between psychology and the biomedical model, it follows on from this that the relationship between socially sanctioned understandings of the therapist/patient dyad will mimic that of the doctor/patient dyad. As such, the deployment of the recognised relationship between professional and their subject of treatment places the role of the psychologist in line with a curative, all-knowing doctor who is able to accurately identify disorder and alleviate distress. As such, the text can be seen to be accepting a bio-medical stance by constructing psychiatry and psychology as dependable and reliable disciplines, through the expression of a rational discourse which suggests that; 'the facts don't lie'. Furthermore it is taking for granted the biomedical discourse, which states that reality is definable, and therefore the 'fact' that more women are diagnosed with BPD than men simply suggests that more women meet the criteria, which ignores the socio-historical constructions of sexed and gendered identities.

The text also suggests that mental health professionals are in positions of power and have the knowledge and expertise to deal with the disorder. The text suggests that individuals diagnosed with this disorder, having less knowledge and expertise, would inadvertently trust the treating professional. Over and above the subjects in the text, the object of the DSM-IV-TR (2000) is given an enormous amount of power, in the sense that concept of BPD is understood as being explicated within this 'object'. The following flow diagram illustrates the hierarchy present within the text as evidenced by the diagram below:



By articulating alternatives at each stage of this hierarchy we may come to a closer understanding of how the text has constructed one particular understanding of the world. The alternatives to the DSM-IV-TR(2000) could be a broader more inclusive understanding of what constitutes a mental disorder; as such an anti-psychiatry and feminist perspective would radically oppose the tenets of the DSM-IV-TR(2000) and would simultaneously be positioned by the biomedical model as irrational and unfounded. Furthermore, the DSM-IV-TR(2000) can be said to be based on a broader ideological standpoint, that of the biomedical model which could have multiple objections, such as a critique of its patriarchal nature, the reducing of complex mental functions to one particular label etc (Flanagan & Davidson, 2007).

A consideration of the alternatives to psychiatrists and psychologists would appeal to a different understanding of the necessary treatment needed to alleviate the identified disorder. So alternative subjects with knowledge, such as traditional healers, religious institutions and familial or community intervention could be identified as subjects within different social settings. It could be said that appealing to any of these alternatives would be viewed as irrational by the subjects present within this hierarchy, as constituted by the text.

Considering the nature of the object of diagnosis, namely BPD, it can be said that the ability to impart the label holds power within the social world. It can be said to hold a particularly authoritative control over those subjects who receive the diagnosis. Alternatives or objections to this diagnosis, while still being constituted within the biomedical framework have been suggested within the text, namely chronic post traumatic stress disorder (see Herman, 1992). However, a feminist objection may suggest that the conglomeration of the identifiable 'criteria' may be explained through an understanding of the manner in which society has targeted the female experience as pathological and as being part of the 'other' (Wirth-Cauchon, 2003).

The access to professional knowledge, such as the DSM-IV-TR (objective) and professional experience (subjective) provide a stark contrast with the silenced experiences of the diagnosed and labelled. Indeed even the interview process does not allow for alternative voices within the context of this research. This could also be because the diagnosis of BPD is rarely conveyed to the client, for multiple reasons. This further complicates the power relationship between the mental health professional and the individuals they purport to treat. This also speaks of the researcher's acceptance of the sensitive nature of the diagnosis of BPD as there is a discrepancy between the phenomenological experiences of the client, and that of the professional. As such, rejection felt by the client would be attributed to the manifestation of pathology rather than an attempt at understanding how the client has felt marginalised. If BPD is trying to be medicalised by the mental health field (Wirth-Cauchon, 2003), the question about releasing a diagnosis to a client is symbolic in terms of the professionals' inability to accurately relinquish the complexity of the diagnosis. The withholding of a diagnosis calls to question the medical enterprise, which encourages transparency in the divulging of *findings*. The

hesitancy to release a diagnosis of BPD, or any personality disorder, may intersect with the self-conscious nature the profession may feel about the controversial nature, the lack of funding for the diagnosis and the denial of equality in the therapeutic relationship.

#### 4.4.1.3 Diagnosis as Treatment

The utility of the DSM-IV-TR was also interrogated within the text, with questions about its ability to delineate, construct and enforce treatment protocols. However, the view of the DSM-IV-TR as anything other than a guide to the identification of symptoms and clusters of symptoms is misguided. Within the text of the DSM-IV-TR itself, no reference is made to the utility of the text as a guide to treatment, but rather it is constructed as a neutral diagnostic tool which must be used in conjunction with accepted treatment protocols, which are not explored within the text of the DSM-IV-TR (APA, 2000). It is the aim of the DSM-IV-TR to assist in the identification rather than treatment of symptoms and symptom clusters (APA, 2000). Thus, clinicians appear to defer to the DSM-IV-TR in some talk, especially in relation to diagnosis but also rebel against it in other talk, especially in relation to treatment. This sentiment is articulated in the following excerpt:

“Participant 2- ‘I just find that the diagnosis alone does not help you, in terms of treatment, ja so it doesn’t tell you anything about the client or how you can work with them or, so its not useful.’”

Treatment, within the text, is understood as being contingent upon the identification of a disorder. Therefore pathology requires naming in order to be treated and supports the dissemination of the concepts of ‘normality’ and ‘abnormality’ as dictated by dominant powers within society (Foucault, 1961). This dissemination serves to support and maintain the institution of psychology. Because the DSM-IV-TR categorises what is within the scope of practice of professionals within the field of mental health, what is ‘treatable’ comes under the auspices of professionals who have been inducted into the institution of the psy-disciplines. This serves to exclude subjective understandings of professionals, which while effectively placing the professional as the arbiter of normality within society, also positions them as the ‘figure-heads’ of the institution of psychology and psychiatry.

The intersection between diagnostic practice and treatment may be due to the necessity of diagnosing, as with diagnosis comes power. This is exemplary of Parker's (1992) suggestion that discourse entails action. The technology of this power is operationalised in psychotherapeutic intervention (Foucault, 1977; Rose, 1985, 1989). That is, a technology in the sense of a set of applied skills, techniques, strategies, and specialized forms of knowledge and language used simultaneously as part of a systematic goal of control (Rose, 1995). Thus the role of the professional is not a neutral attempt at addressing distress, but rather therapy, when viewed as a technology becomes a tool of institutional control and influence (Rose, 1995). This also has specific ramifications within the South African context, which will be discussed later.

It must be acknowledged that the deployment of diagnostic categories within the current managed care milieu has a particular purpose and is not an end in itself within mental health settings. The researcher has taken a particular stand within the text which positions the professional as a 'labeller' and as such in opposition to the deleterious aspects of labelling. In practice the utility of identifying a diagnostic entity is not an end in and of itself but rather marks the start of a treatment process which to a greater or lesser extent is influenced by the actual diagnosis. Therefore, it could be argued that suggesting a subscription to the DSM precludes an acknowledgement of the difficulties involved and therefore negates the clinician's ability to work within the field of mental health.

#### 4.4.1.4 The Impact of the Biomedical discourse

It is argued that the adjectives in the text employed in relation to the diagnosis of BPD are pejorative in nature. The words identified by the researcher suggest an undermining of the character of the prototypical individual diagnosed with BPD. The discourse draws upon the highlighted areas addressed within the literature review concerning the female within dominant male discourses as 'other'. The strength of the discourse is realised in the subjugation of the female 'other' as inherently pathological and draws upon the scientific framework to legitimate this. As such the text utilises words such as, "dramatic", "manipulative", "explodes", "exaggerating" and "malicious" along side words such as "affective", "mood instability" and "parasuicide". As such the interweaving of the two distinct discourses function as one

independent discourse which together are conveyed as representing familiar scientific understandings. Because these subjective understandings and opinions are difficult to distinguish from the statistically based literature, the conflation of the discourses that maintains the subjective pejorative reflections of females within the biomedical framework becomes the focus of attention within this research.

Contextualising the DSM-IV-TR within a social understanding of mental illness situates it within a publicly contested arena, where the social interpretation of what is considered normal and abnormal is documented. As such, when professionals align themselves with this nosological document, they are advertently or inadvertently aligning themselves with a biomedical understanding.

There may be multiple reasons for why the biomedical model is utilised within this text. The authoring of the text took place within a psychiatric setting, which as alluded to, defers to the biomedical model. Following from this, the professional within an institutional setting, is required to subscribe to the dominant biomedical discourses that circulate. Therefore, the professional also has to submit to the prescriptive nature of these dominant discourses. As such, the professional is not only informed by institutional practice, but is also constrained by it. The disciplinary power present within the institution of psychology and psychiatry not only informs professionals, but also has the power to limit what can and can't be said, and what can and can't be 'done'. As such, it is not only society who is subject to surveillance but the professional too (Foucault, 1970).

The notion and allure of scientific validity has plagued the practice of the psy-disciplines. The explication of the psy-complex (Ingelby, 1985) within the literature review has demonstrated the manner in which the psy-disciplines have attempted to align with the scientific enterprise. The following discourse suggests that science and rationality are utilised within the text as means of appealing to this scientific enterprise. As will be discussed, this appeal to science has ramifications for the South African context.

#### **4.4.2 Discourse of Science and Rationality**

The broad discourse of science and rationality was identified by the prominence of talk around professionalism and practice in the text. This talk was understood to be built on empirical and positivistic understandings related to the belief that the psychodisciplines are affiliated with the scientific enterprise. Therefore, the discussion that follows centres on issues surrounding the positioning of the object of BPD as well as the subject evoked through the talk of BPD i.e. the individual diagnosed with BPD. The researcher identified a shift between the general relationship between the professional subjects and their work with individuals, drawing upon objective tools of investigation such as the DSM-IV-TR and the relationship between the professional subjects drawing upon subjective accounts of their experiences with individuals diagnosed with BPD. As such this dual notion of treatment, shifts within the text and will be explored further, especially in relation to the notions of responsibility, indemnity and professional status.

A number of discursive themes were identified as constitutive of this broader discursive category. These will be discussed separately in detail below.

##### **4.4.2.1 Expectations vs. Experience (Borderlines are Referred not Heard)**

The text suggests that there is a discourse about BPD which is not based in the text of the DSM-IV-TR. This aspect of the discourse was highlighted in the identification of symptoms or details of the disorder which are not present in the categorisation of the disorder within the sanctioned nomenclature, namely the DSM-IV-TR. Therefore the researcher identified a discourse which comes into operation with reference to the diagnosis of BPD, which in turn propagates the development of expectations which are identified by the literature as pejorative.

Through the analysis of the text the object of BPD as well as the subject of BPD (the individual identified by the professional to be diagnosed with BPD) are both conceptualised as being constituted through a discourse of experience (Parker, 1992). Within this text the object of BPD has multiple definitions and it is within these varying definitions that the researcher was able to identify contradictions. The BPD diagnosis is identified as being contained within the nosological system of the DSM-IV-TR. Diagnoses identified within the DSM-IV-TR are deemed to be treatable by

particular professionals, namely psychiatrists and psychologists. Therefore, one definition of the diagnosis BPD is that it is a disorder which is identified by professionals and can be treated by these professionals. Another definition of BPD is that it is a diagnosis which is resistant to treatment and one which is identified as being difficult to treat. Therefore, the notion of what constitutes 'treatment' becomes contested within the two definitions of BPD. Furthermore, the contrasting definitions constitute the subjects in different ways, which overlap. As such, the individual diagnosed with a disorder becomes part of the help seeking process which places them as requiring the attention and hence treatment by a professional, as is seen by the initial understanding of the construct of the diagnosis, BPD. The alternative is that the individual diagnosed with BPD is constituted as a treatment resistant individual. This reasoning can be observed in the following excerpt:

Participant 1- "She did not think she needed any help, ok, and she was very against therapy and she believed that she could get ehm the help that she needed from her friends."

Within this excerpt a binary opposition operates to position therapy as a rational approach to treatment, whereas finding assistance outside of this rational approach is undermined and positioned as irrational. This is further entrenched by the suggestion that the individual "was very against therapy" which suggests a conscious decision, one which places the individual outside of the realm of rationality. This understanding of the excerpt, within the context of the interview suggests a particular view of what constitutes psychological intervention. It would be short sighted not to acknowledge that the individual being discussed is a teenager and may have been referred by a parent or teacher and as such to use the utterance as significant in terms of the interviewees' understanding of the concept of psychotherapy and BPD would limit alternative explanations.

Furthermore, what is considered to be rational is mandated by the professional subjects of the text and more broadly the psy-disciplines. As such, within this text, treatment has been identified as either requiring medication (via psychiatry) or psychotherapy (via psychology) thus placing any treatment plans or coping strategies outside of these two approaches as irrational. For the individual diagnosed with BPD, or any psychiatric disorder, there is little power or control over what would constitute

treatment. The power to decide on the most rational course of action lies with the professionals who have been inducted into the disciplines of psychiatry and psychology. Thus, it can be said that the psy-disciplines actively constitute the objects (and subjects) which they purport to treat (Parker, 1992).

This discourse can also be identified in reference to the process of referral and reception of individuals diagnosed with BPD. This intersection between expectation and reality is further explored in the comparison between preconceived ideas about the diagnosis of BPD and that of narratives about particular individuals. The manifestation of this discourse is present with references in the texts to, “a trail of chaos” and “they’ve burnt all their bridges”. This suggests a preconceived notion of the individual as well as predetermined understanding of the individual as a “difficult client”. The texts also serve to align the term “difficult” with the diagnosis BPD. This conflation of the terms emerges in light of a suggestion that, “it (BPD) makes them vulnerable to referral”. With this reference, is the added difficulty of attributing, “multiple relationships with mental health professionals” as the responsibility of the individual diagnosed with BPD rather than that of the treating clinicians. This is also seen as problematic and indicative of a so called “borderline constellation”. The following excerpts serve to illustrate this point:

Participant 3- ‘But be very cautious because they tend to get problematic’

Participant 2- ‘The relationship is going to be very difficult and stormy’

The first excerpt demonstrates how individuals diagnosed with BPD are spoken of in terms of their diagnosis, as well as being considered to be part of a homogeneous group. The second excerpt suggests that there is a preconceived notion of what the relationship between the individual and mental health professional will be like. This preconception undermines the position of an individual diagnosed with BPD, as their specific phenomenological experience is minimised through the expectation that the relationship *is* going to be difficult and stormy, thus it is possible that new information is subverted.

Reflection on both excerpts can be understood as prospective statements for the inexperienced clinician. Thus, the presence of the researcher as a novice practitioner

appeared to allow suggestions regarding future experiences in relation to the prospective therapeutic relationship with an individual diagnosed with BPD. Furthermore, the excerpts can be understood as warning the inexperienced clinician as it suggests the necessity to be “cautious” as “they get problematic”. The suggestion that the professional should be wary and suspicious of individuals diagnosed with BPD has dire consequences for the individuals. Firstly, if the inexperienced clinician were to follow this *advice* it could be argued that either there would be a hesitancy to make use of the diagnosis of BPD (as will be discussed later through the evocation of traits as an alternative), or that a relationship which ideally should consist of implicit trust will become imbued with mistrust and suspiciousness. Secondly, by accepting this *advice* the inexperienced clinician is covertly being given permission to utilise the “difficult and stormy” relationship as leverage should the relationship fail.

The construction of the BPD diagnosis within a professional lexicon is employed when identifying the discourses of other mental health professionals, as pejorative and disparaging. As such, identifying the discourse of other professionals signifies an underlying understanding of what it means to treat an individual diagnosed with BPD. Thus difficulties encountered are understood in terms of a mutual acceptance of the individual diagnosed with BPD as a difficult and resistant individual. This is highlighted in the reference to the experience of the individual diagnosed with BPD as something to be alarmed by. This is depicted in the texts in following excerpts:

Participant 1- “Yes, no look they are difficult”,

Participant 1- “There is often, even before you see them, you’re already hearing about all the chaos around them.”

This is further contextualised with hesitancy to diagnose BPD as there is an acknowledgment of the generalised treatment of an individual with this diagnosis. Furthermore, the theoretical understanding of the diagnosis is eclipsed by the notions of critical connotations associated with this population and it is this negative understanding that serves as a platform for this caution. The following text serves to illustrate this point:

Participant 3- “I think very often it’s, ehm, difficult people that the clinical...the doctors and people struggle to manage. And, and, ehm, it’s almost like they get written off and put in that box and said ‘Well, it’s their responsibility anyway, nothing can be done for

them', ehm, (laughs) so in a way I think it's ehm, I'm very, very reluctant to make that diagnosis at all. I'd rather possibly say that the person has traits. But be very cautious because they tend to get problematic."

The excerpt demonstrates the conflation of a discourse of science and that of *a priori* assumptions about individuals diagnosed with BPD. Firstly, the participant acknowledges that the diagnostic category is utilised for "difficult people...that...the doctors...struggle to manage". As such, the participant identifies the spurious nature of the diagnosis, as has been illustrated in the literature (Wirth-Cauchon, 2003). Secondly, the participant identifies the stigmatised position held by the individual diagnosed with BPD through the comment, "it's almost like they get written off..." This suggests that there is a professional discourse which endorses the notion that "it is their responsibility...nothing can be done for them". This sentiment provides a discursive space within which professionals discuss subjective understandings of diagnostic categories, which are divorced from the professional discourse which outlines and identifies the diagnosis of BPD (e.g. DSM-IV-TR). Thirdly, the participant reflects on these discourses and introduces the concept of "traits" to neutralise with the stigmatising effects a label of BPD would have. The evocation of the concept of traits does not neutralise or disregard the appeal to science. The concept of traits still infers an essentialist conceptualisation of personality organisation, which constructs the personality as static. However, lastly, the participant yet again enters a discourse which reifies the diagnosis of BPD by saying, "but be very cautious because they tend to get problematic". As such, the participant can be seen to be reflecting on the usage of discourses, but simultaneously is still entrenched in the discourse of professional legitimacy.

The induction of professionals into the fields of psychology and psychiatry plays a pivotal role in the dissemination of information. The prominent theories and ideologies concerning the practice of mental health is outlined and presented within an academic institution, where it is expected for the inductee to implicitly accept the knowledge being offered. The function of power/knowledge is evident in these institutions as experienced professionals relay dominant trends in the milieu of recognised documented practice, as has been suggested with the previous excerpts. The regulation of acceptable practice is generated through the disciplinary power which governs what is considered acceptable and unacceptable professional practice.

Participant two alluded to the nature of the professional discourse presented within the literature, as well as reflecting on an experience of an individual diagnosed with BPD which was vastly different. This can be seen in the following excerpt where the participant discusses a client who was referred with the label of BPD:

Participant 2- "I didn't ever find her to be manipulative or dishonest, which is kind of what the literature sets borderline people up to be, that they sort of play games with you and I never found that with her at all. She's very honest, it's just that the world she finds herself in is very hard to live in and it's hard to be there with her."

A professional discourse becomes apparent in this excerpt, especially with reference to how the "literature sets borderline people up to be". It could be argued that it is this literature that allows for the subsequent pejorative treatment of individuals diagnosed with BPD. As such, the discourse of professionalism is providing a discursive space within which the professional's discourse is privileged and imbued with academic (read: scientific) prominence. As such, this allows for the reification of particular kinds of knowledge within the professional community. Furthermore, the participant appears to have presented a coherent argument concerning how she *found* the individual to not match what she expected, which suggests that prior to her engagement with the client she had certain expectations based on the diagnosis of BPD.

#### 4.4.2.2 BPD as Genesis of "difficulty"

The description of an individual diagnosed with BPD included the words, "manipulative", "dramatic", "liars" and "brazen" all of which served to classify and delineate what a diagnosis of BPD signifies in terms of the character of this individual. These words are operationalised as a consequence of the symptoms, and therefore are viewed as agentic and intentional. This positions the individual diagnosed with BPD in opposition to the clinician and suggests an ability to control their actions, as well as actively utilising their symptoms in fulfilment of their own needs. This is relevant in terms of the words not being used in the context of other symptoms but as a description of the individual.

The description of the pathologised individual is characterised as self inflicted. The utterance:

Participant 4: "you have a feeling you're not hearing the whole truth"

This excerpt suggests an intentional withholding on the part of the client. The text also refers to a lack of skills associated with an inability to effectively regulate the needs of the individual within an interpersonal realm. This is articulated in the data through the following excerpt from the data:

Participant 2: "inability to articulate one's needs...they get pleasure out of that"

These suggestions juxtaposed with one another serve to undermine the supposed severity of the disorder in terms of the discourse of the unconscious. Therefore, the individual diagnosed with BPD is articulated as not being able to rationally discern what it is they need, implying that a professional would have the ability to do so. The further claim that the individual would "get pleasure" from this lack of satisfaction, suggests a detachment from the phenomenological experience of the individuals diagnosed with BPD. As the literature suggests, including the nosological tool of the DSM-IV-TR, the experience of the symptomology associated with the diagnosis of BPD, is both distressing and debilitating (Becker, 1996; Wirth-Cauchon, 2003). Therefore, the text can be seen to be undermining the experience which it simultaneously constructs as a distressing and debilitating disorder.

The use of the word "inability" serves to construct the individual as passive, while discussing and describing the individual as manipulative and "difficult to manage" (as contained in an excerpt by Participant 1 below). The issue of contention is not whether or not the symptoms do operate within an intentional framework, but rather the text indicates that there is operation of will employed by the individual diagnosed with BPD. It is this construction that appears to be problematic for clinicians, as the text also frames treatment in terms of co-operation and compliance, and there is an implication that the failure of treatment may in some cases be attributable to the individual. This is reflected in the data through the following quote:

Participant 5- "I think treatment resistance with a borderline is a more intellectual cognitive process, whereas with schizophrenia it is the medication that fails."

This text implies a self inflicted aspect to the failure of treatment and operates to nullify responsibility in relation to the treating clinician. Furthermore, the suggestion by participant one that, "they are creating their lived experience" does not adequately

demonstrate an understanding of the manner in which the disorder creates distress in the individuals lived experience and undermines the function that the symptoms have in the individuals life. The contextualisation of symptoms within a specific framework, (e.g. trauma based) would serve to situate the individual from within a pathological environment rather than constructing it as part of the character of the individual (Herman, 1992). This is suggested by theorists who have proposed a diagnosis of chronic post traumatic stress disorder when an individual presents with a history of abuse (Herman, 1992). This identified juxtaposition between passivity and active involvement is highlighted through the varying understandings of the aetiology of the disorder. On numerous occasions the text identifies the influence of the media, and overtly associates with particular symptoms such as self mutilation. The notions of BPD as, “idealised” and “popularised by the media” suggest a causal relationship, outside of endorsed understandings of the aetiology of this disorder. It also suggests a choice on the part of the individual, or an undertaking to *become borderline* which further implies a willingness to make their lived experience disordered. Therefore, the contextual understandings of the diagnosis are identified as falling outside the realm of academic rigour. The following excerpts demonstrate this agency:

Participant 1(A) - “the person with the borderline personality is attracted to similar, eh, their friends also have this borderline personality component, and it’s sort of in a way idealised”

Participant 1(B)- “Ok, and that eh, yes she understood this was self destructive behaviour, it was abnormal, umm, but refused to see the use of taking that symptom seriously and getting the help she needed so she was sort of like very happy to brazenly say, ‘look I use this behaviour for my own benefit’. You know in a way showing the manipulative side and not necessarily being aware of it herself. Ok, ja.”

The first excerpt (A), constructs the object of BPD as an entity which, when idealised, can constitute a diagnosis within interpersonal relationships. As such, the proposal that a diagnostic category may be idealised removes it from a psychiatric context, which would endorse the notion that disorder is realised within an individual not within a social context. The second excerpt (B) constructs the behaviour of the individual as irrational, especially in terms of the individual using asocial behaviour for personal benefit. Thus, the notion of rationalism is again invoked in order to position the individual as irrational as suggested by the idea that the individual was “brazen” to dismiss the option of therapeutic intervention.

It can be argued that the relationship the professional has with an individual diagnosed with BPD is veiled in various *a priori* assumptions. This argument was articulated within the text through the acknowledgment that a receiving a referral of an individual diagnosed with BPD initiates a discourse related specifically to the diagnosis of BPD, one which the research has identified as pejorative (Brown, 1995; Landrine, 1989; Markham, 2003; Nehls, 1998). There is a noticeable juxtaposition between understanding an individual diagnosed with BPD as an agentic, aware individual, who intentionally resists treatment, and an individual who is unaware of their emotional, behavioural and cognitive ‘problems’ and as such is treatment resistant as a result of their diagnosis. This conceptualisation has implications for the manner in which the client is recognised within the treatment setting and can have consequences for how the client’s behaviour is perceived. This juxtaposition is closely aligned with the appeal to the scientific bio-medical model and will be referred to later in the discussion.

#### 4.4.2.3 Discourse of indemnity

Throughout the text, a discourse of indemnity was evident, which was articulated in reference to the acknowledgement of the pejorative tone identified by the researcher. This discourse was closely aligned with the identification of the role and responsibility professionals have when treating individuals diagnosed with BPD. The following excerpts demonstrate this appeal to indemnity:

Participant 5- “There are times when it becomes difficult, especially as I try and help patients as much as I can, but there does seem to be a general feeling of dis-ease, it’s mostly discomfort, with kind of having the feeling that you’re not hearing the whole truth.”

Participant 2- “I think there are expectations and its sort of easier to refer maybe because you have this idea that its going be really bad and having that diagnosis means it’s a poor prognosis, I think that it’s a lot less likely that people will stick with that client because well I think there is a belief out there that, well it’s a poor prognosis and once you have borderline personality you always have BPD and there’s not that much effort.”

The first excerpt invokes the notion of responsibility as well as personal involvement with an individual diagnosed with BPD. By stating that “I try to help as much as I can” suggests that the individual diagnosed with BPD is in some way responsible for the inability of the clinician to help effectively. As such, the idea that the clinician is ‘not hearing the whole truth’ implies that it is the patient (term utilised by participant)

who is responsible for creating a “feeling of dis-ease” and furthermore it positions the professional as actively working against the foregone conclusion that the patient is withholding the truth. The second and third excerpts both demonstrate the manner in which the participants position themselves in relation to the pejorative nature of the diagnosis of BPD. Firstly, the discourse of referral and prognosis are closely linked with a professional lexicon which can be understood as granting the professional disciplinary authority and power which imbues the professional as legitimate and trustworthy. Thus the professional has the knowledge and power to determine if an individual should be referred as well as determining the probability of the outcome of treatment.

Closely aligned with identification of pathology is the recognition of consequential understandings of the course of diagnostic categories. The text suggests that the concept of prognosis is closely linked to the notion of responsibility and accountability. Demonstrates how the power linked to assessing an individuals prognosis, and in relation to the diagnosis of BPD, there is an assumption that there are limited prognostic features as suggested by the following excerpt:

Participant 4- “I’m already exempting myself from responsibility in terms of prognosis.’ So if she has a very poor prognosis, and she don’t make it you can say, “Oh, but it’s a borderline”

This reference to prognosis in relation to responsibility infers a relationship between the initial diagnosis and the manner in which the treatment is viewed. This positioning of client and clinician serves to further enforce the propensity to malign the borderline diagnosis by removing accountability from the professional.

Within the body of the text an articulation of the assignment of the borderline client as a part of the realm of other mental health professionals is apparent. The suggestion of the passing on of responsibility restricts and confines the outlets that are available to individuals diagnosed with BPD. As such, there appears to be a problematic relationship between various professionals, which alienates the client as much as dividing the mental health services. As the flow diagram above suggests there is a hierarchical structure in place within the psy-disciplines, with psychiatry holding

more power in terms of its ability to medically treat diagnostic entities. However, the following excerpt demonstrates a lack of consciousness regarding the holistic understanding of an individual with a personality disorder:

Participant 5- “medical treatment while in some cases is necessary doesn’t address the actual interpersonal flaws present”

The acknowledgement that psycho-pharmacological intervention does not assist in the alleviation of symptoms is closely followed by the suggestion that “interpersonal flaws” are the focus of intervention. While this may be so, there is a lack of acknowledgement regarding how the diagnosis is distressing to the individual. This constructs the diagnosis as interpersonally distressing rather than psychically distressing. However, the researcher has identified discursive themes which have been reflected in the literature review. Alternative understandings of this particular discourse may be excluded in order to demonstrate a particular agenda. Acknowledgement of this does not exempt the researcher from her identified focus, in terms of the manner in which it precludes certain alternatives but rather has been noted by the researcher and demonstrates an openness to the possibility of alternative discourses within the current text.

#### 4.4.2.4 Implications of the Discourse of Science and Rationality

The evocation of a discourse of science and rationality can be seen to be deployed in service of discursive themes relating to professional conduct. The construction of the subject of BPD as manipulative and difficult- alongside a biomedical discourse which constructs the individual as resistant to treatment- conjointly depicts an individual as transgressing the stipulated criteria for not only an ideal patient, but also an ideal person. This construction then places the mental health professional in a powerful position in that any transgression or failure in treatment can be accrued to the diagnosed individual.

It can also be argued that the focus on science and rationality in the realm of a construct so closely aligned with emotions devalues the experience of the diagnosed individual. As such statements regarding their psychic distress are theoretically neglected in order to maintain the institution of the psy-disciplines as scientific and rational. The construction of this discourse entails the denigration of the individual through a transformation into “they”. The presence of the researcher, as a novice

within the psy-disciplines, may have added to this generalised talk as representative of the benefit of experience.

The ideological practice involved with a discourse concerning science and rationality has practical consequences within the institution of the psy-disciplines. As such, individuals in society come up against a pre-ordained standard with which they are expected to meet in order to be considered *normal*. The professional can be seen to become further entrenched in this ideological practice within the psy-discourse which follows.

#### **4.4.3 The Psy-discourse**

The following discussion serves to identify and explicate the presence of the psy-discourse within the text and is situated as part of the framework within which the professional works.

Disciplinary power serves to identify individuals through a continual observation, recording and calibrating by institutions such as psychology and psychiatry, in similar ways to how the judicial system operates within society (Foucault, 1961). Furthermore, the prevalence and pervasive nature of the psy-disciplines means that individuals within society monitor themselves as well as those around them. This is particularly interesting as personality disorders are constructed as being ego-syntonic, in the sense that the individual is unaware of the manner in which sets of behaviours may be labelled as problematic (APA, 2000). Therefore, these behaviours can only be grouped together by a professional in order to 'assist' the individual, which requires labelling. As such, by exploiting the dependence society has on the biomedical model, the psy-disciplines have the power to name certain clusters of 'symptoms' pathological. This colonisation of the mind has enabled the psy-disciplines to dictate normal and abnormal personality functioning. In the case of the diagnosis of BPD it can be seen that women are positioned as 'other' to the dominant 'ideal' male subject and women's behaviour, emotions and cognitions are excluded from or defined in negative opposition to this 'ideal' male subject, as demonstrated in the pathologisation of women diagnosed with BPD (Wirth-Cauchon, 2003).

The text also carries with it the appeal to the scientific notion of quantifiable and hence diagnosable entities of human behaviour. Therefore, the significance that the text carries constructs what is considered normal and acceptable within a particular professional milieu (Parker, 1992). This discourse does not stand independently but can be seen to be articulated in opposition to alternative discursive explanations, e.g. traditional healing, religious practice and community intervention. (Terre Blanche *et al*, 2006). As such, from an analytical perspective it is the omission of acknowledging alternative explanations that is the focus of this research. By examining the alternative 'voices' in the social world that are constructed in the text the researcher was able to open for debate the notion that while what is considered pathological in a particular grouping of individuals, may also have marginal explanations which can be explored through understanding the social structures that have been repressed by dominant ideological standpoints. As such an exploration of the manner in which the psy-disciplines interact with various discourses assists in 'mapping' the social world created (Parker, 1992).

The relationship between the psy-disciplines and the biomedical model within the context of this discourse suggests that the ideology of the biomedical model is consistent with the prevailing ideas in the psy-disciplines. Therefore, the professionals responsible for the upholding of the psy-disciplines become aligned with the ideas and concepts associated with the biomedical model. As such, the practice of psychological knowledge becomes synonymous with a scientific enterprise.

#### 4.4.3.1 The White Western discourse

The silence or absence of acknowledgement of possible cultural influences in the diagnosis of BPD suggests an undermining of the outlines of the theoretical orientation of the DSM-IV-TR (APA, 2000) which supports the inclusion of sensitivity to the importance of culture in diagnosis, especially in the expression of personality dysfunction (APA, 2000).

While language may pose difficulties, the understanding of how personality is expressed and what aspect of personality is accepted within non-western cultures appears to be lost within the discourses made available. As such, there is either a judgement of the equivalence of personality assessment across cultural lines in an

attempt for equality or there is a naivety which portrays the clinician as technician rather than integrative interpreters of diagnostic guidance. Whatever the reason may be, and there may be many causal factors in this concept, the call for a more inclusive understanding is needed in order to align mental health recommendations with outcomes in treatment (Seedat, 1997). This is especially the case when diagnosis is understood as informing treatment. The following excerpt demonstrates the acknowledgment of these difficulties:

Participant 3- "I think, possibly the fact that we work more cross-culturally we might end up with some patients who, ehm, is exhibiting their distress by their behaviour being identified as psychotic or something rather than, ehm,... so that would be like example an English speaking doctor and a Xhosa speaking patient, and not understanding exactly what the patient is saying and interpreting their behaviour as, as.... So I think there is sometimes when one misses the personality aspect and ehm..."

Within this excerpt the participant identifies the notion that language may act as a barrier to the understanding of the cultural nuances present. There is also the assumption that when the clinician is linguistically able to understand the patient, they there would be no confusion. This was the only participant who acknowledged that there may be difficulties in diagnosing, especially personality disorders, across cultures. Individuals who do not speak the same language as the clinician are therefore placed in a vulnerable position. The issue of language also becomes constructed in opposition to the predominantly English based lexicon available to treating clinicians. As such, the inability of the mental health professional to clearly understand the patient becomes alarmingly associated with clinical syndromes such as psychosis. As the literature suggested the identification of clinical syndromes, such as psychosis, become associated with certain cultural groupings (Msemi & Strebel, 1999). This association has dire consequences for individuals who are misdiagnosed, especially when pharmacological treatment is instituted. As Seedat (1997) noted, the preponderance of white, English-speaking and middle class mental health professionals are unable to adequately address the mental health needs of the South African context. Thus it is not only language which is identified as a barrier, but cultural understandings too.

The understanding of the *individual* rests on western concepts of the development of the 'self' and as such the treatment that it entails will focus on the internal structure of the individual. This exclusive focus on the individual constrains alternative

understandings of the individual in society and furthermore excludes individuals who may ascribe to these alternative understandings. As such, it can be postulated at this point that the focus on the individual is radically different to societies in which the individual is comprised of the community to which they belong. Therefore, the inclusion of concepts of psychotherapy which focus on this westernised position of how the disordered individual can be treated, would for example include individual therapy with a psychotherapist, who would be seen as the expert and a 'broker' who is positioned as an authority on what is considered normal within society (Parker, 2002).

Another implication of this focus on the individual reiterates the binary between what is understood as the ideal of the rational, self aware individual as contrasted with an irrational individual who values the needs of the community within which they reside. Thus, it could be argued that there is a cultural bias within the DSM-IV-TR (2000), as the biomedical model implies that the locus of pathology is exclusively within the individual, which therefore places the locus of control within the grasp of the individual.

The alternative to this may evoke notions of including the social grouping from within which the individual is immersed, it could also posit that the help seeker is the expert on their lived experience, and as such the therapist acts as a moderator in order to understand and assist in possible resolutions in a collaborative relationship with the individual. This stance would not negate that the psychotherapist has access to knowledge, but rather would suggest that the individual along with their social grouping can alleviate the distress collaboratively. This notion of alternative understandings of the utility of psychotherapy is encompassed in the post-modern approach of narrative therapy which will be explicated within the conclusion of the research (White & Epston, 1990).

#### 4.4.3.2 The Implications of the Psy-Discourse

While the biomedical discourse can be seen as essentially a medical discourse, the psy-discourse can be seen as essentially a discourse utilised to denote mental health or disease. As such the psy-discourse becomes exclusive in its attempt to differentiate and separate from the discipline of medicine so as to gain authority with regards to mental functioning. Thus, the development of the technology of therapy (Foucault,

1961; Rose, 1995) provided a means of claiming the ethereal mind as the dominion of the psy-disciplines.

It can be argued that clinical practice takes place within a broad political, social and historical context and as the DSM-IV-TR has clearly stated, the deployment of diagnoses within contexts outside of western societies must be done with caution. However, in light of Brown's (1995) statement, that the DSM is the representation of psychiatry (and consequently psychology), then its usage within the South African context becomes problematic. From the text it appears as though the preliminary cautionary suggestions have been overlooked in a bid to adhere to the institution of the psy-disciplines. This oversight can be understood through the appreciation of the power with which these disciplines hold. Consequently, the deployment of the DSM-IV-TR as a valid guide to psychopathology within the South African context allows for the maintenance of unequal power relations. It also becomes exemplary of the way in which discourses, while conceptualised as independent of the speaker, are able to maintain power, institutional authority and ideological practice, which within the South African context could be understood as discriminatory and exploitative of marginalised and vulnerable groups. The discourse of gender will aim to demonstrate this exploitation.

#### **4.4.4 Discourse of Gender**

A gendered discourse was identified as operating within the text. Initially the researcher will elucidate the presence of the discourse and finally will demonstrate how this gendered discourse operates within two specific constructs which have come to be associated with the diagnosis of BPD, namely sexual abuse histories and suicidal behaviour.

The diagnosis of BPD has come to be associated with females, with statistical evidence supporting this notion (APA, 2000). This association was apparent within the text of all the participants, with all the participants referring to individuals with BPD with a feminine pronoun. The following excerpt demonstrates how multiple discourses are utilised in the normalisation of the feminine manifestation of distress:

Participant 2: "I mean statistically more females are diagnosed with borderline personality disorder, as I think generally the expression of female distress is expressed in the symptoms encompassed by borderline personality."

The object of the text can be identified as female, female distress and borderline personality. These objects are all framed as being part of the focus of the psy-disciplines, as can be understood by the use of psy-jargon, *personality disorder*, *symptoms and borderline personality disorder*. The operation of the term borderline personality disorder is reified in the sense that it is identified and utilised as if it were a real thing, something which the professional is able to identify and treat. Females become the subject of this text, although there is an allowance for male subjects, with the implication that while more females may be diagnosed, there are still male subjects involved in diagnostic practice. As such, the concept of BPD becomes part of a broader scientific enterprise associated with medicine and the psy-disciplines. By equating female distress with symptoms and disorder suggests an assumption about the particular ways in which females express their distress, which consequently becomes pathologised, with symptoms being treatable by professionals. This gives the text coherence, as there is an appeal to a scientific basis, through statistics, as well as the employment of the professionals' use of "I" within the text. Therefore within this text it is understood that the majority of individuals diagnosed with borderline personality disorder are female, this is supported by statistical evidence and as such when female distress becomes the object of professional scrutiny it is understood and *encompassed* by the diagnosis BPD.

The possibility that there may be social influences on the manifestation of this 'disorder' could account for the higher prevalence in women (Becker, 1997; Wirth-Cauchon, 2003). A feminist perspective may argue, that the dominant patriarchal system, which is embedded within a bio-medical approach is unable to take into account alternative understandings of what is considered 'female distress' and that the pathologisation of this 'distress' is in itself contributing to the ongoing legacy of discrimination against women within society (Wirth-Cauchon, 2003). Foucault (1977) and Rose (1995) suggest that psychotherapy is itself a technology of control and this further problematises the manner in which this 'rational' approach to understanding pathology is 'treated' within the profession of psychology. The role of the psy-disciplines is then to identify pathology and patrol the borders between normality and

abnormality. Thus the ideological practice of psychology is the identification of pathology in an iterative manner; a practice which is able to legitimately identify what is considered socially unacceptable manifestations of female distress.

The relationships at work suggest an appeal to the following kinds of understandings, e.g. the acceptance of the bio-medical model, the patient-doctor relationship, psychology as a rational, scientific profession and the acceptance of a gendered mental disorder. These understandings expose the types of relationships available to the subjects identified in the text as well as the relationship between these subjects and the objects which constitute the understandings.

The deployment of a discourse of gender was understood as a means of explanation, not only in the way it acted as a filter for the diagnosis of BPD, but also in relation to the gender of treating professionals. The practice of the psy-disciplines is the identification of abnormality, and as such any subject being brought under the scrutiny of the psy-gaze is assessed and compared to what is considered normal as espoused by the white, male and middle class subject. Therefore, within the bio-medical model, it is logical that behaviours commensurate with those outlined in the diagnosis of borderline, would become the focus of examination and judgement. The argument against this logical representation of females becomes difficult to critique as the scientific enterprise makes truth claims, and as such it is understood that it is not merely the 'talk' of science, but is the reality of the world, thereby placing the diagnosis of BPD as something which was always present but not labelled.

The identification of the 'female' individual with BPD was introduced by the text. This can be seen in that every participant described their 'general' experience of an individual with BPD as female. The feminisation of the diagnosis present within the text is supported by literature which suggests that up to 75% of individuals diagnosed with BPD are female (Widiger, 1998).

Above and beyond the descriptive purpose, the identification of gender within the text served to represent broad understandings of what constitutes the diagnosis of BPD. These broad understandings are associated with the designation of socially acceptable traits for females, and function to situate females in opposition to males. The

identification of this binary opposition served as a foundation from which the gendered approach to diagnosing can be understood.

The text identified the diagnosis of BPD as an equivalent to that of anti-social personality disorder (ASPD). Furthermore, the text described the diagnosis for 'female distress' as being encompassed by the diagnosis of BPD. Added to this, the expression of anger in females was pathologised and translated into the diagnosis of BPD, which was equated with ASPD. Thus, females expressing anger are seen to be acting outside of their sex role. The discourses present in the text also promote or suggest an association between anger and this particular diagnosis. Furthermore, the implication is that anger becomes an emotion with pathological associations. This suggestion is entrenched in the appeal to the ideal female as mild mannered and genteel. As such the emotion of anger does not fit into the idealised portrayal of females. The emotion of anger is undermined and instrumental in the pathologising of female experience. This identification of anger as a pathological symptom advocates a subjective lens from which to interpret what is considered normal and abnormal in females. Gender as a defining feature of the BPD diagnosis is represented in the following excerpts:

Participant 2- "in general terms, men and women express anger and emotion in different stereotypical ways",

Participant 5- "I mean statistically more females are diagnosed with borderline personality disorder, as I think generally the expression of female distress is expressed in the symptoms encompassed by borderline personality",

Participant 2- "(the DSM has) categorised what is acceptable behaviour for males and females" and

Participant 5- "BPD is a limited category that doesn't encompass male experience"

These excerpts demonstrate the identification of two key areas of discussion. It aligns anger as pathological when expressed by women and secondly, it suggests that the diagnosis of BPD encompasses female experience. These two areas of discussion articulate the feminisation of the diagnosis. Furthermore, it refers to the manner in which the text of psychology and psychiatry, the DSM, has incorporated gender stereotypes into diagnostic categories. This incorporation serves the interests of dominant groups within society. As has been suggested, the establishment of

biomedicine, positioned women as the site of pathology, the object of pathology and the representation of the 'other'. This stigmatisation and the consequences which follow are dealt with in the text as having to be dealt with exclusively by females. As such not only is the burden of the diagnosis placed on females, but the stigma related with it too, as is suggested by the excerpt:

Participant 1- "I think a lot of it has got to do with the stigmatisation of females, you know when there are problems then there's that angle, the gender issue, it's a sensitive thing for women, in that they get, tend to get diagnosed with this..."

The identification of gender as a factor in the diagnosis of BPD is also installed as problematic in terms of the gender of the treating professional. Due to the propensity of females diagnosed with BPD, as well as the prevalence of sexual abuse, the intersection between a female client and a male clinician has multiple consequences. This is due to the generalised idea that sexual abuse takes place with a male perpetrator and a female victim. As such not only does the female client enter into a relationship where she is positioned as powerless, she is also expected to implicitly trust the 'goodwill' of this powerful male. Furthermore, the text suggests that this trust may be misplaced as is evident in the excerpt:

Participant 3- "In general my experience working with male psychiatrists and, and, ehm, they're always the ones who are in charge. And they tend to be very disparaging of young women with emotional and social problems. And, and women who reporting that they've been raped or sexually abused by their fathers or things like that."

As such, the dynamic which exists prior to their entry into a psychiatric setting serves as a mitigating factor in the prognosis of treatment. Along with this, any discomfort felt by the female client in relation to the male clinician is framed as irrational and unfounded, especially as the clinician has an affiliation with the biomedical discourse, which structures the relationship between doctor and patient as one necessitating implicit trust.

Identifying the impact and lingering effects of labelling becomes more apparent in the case of BPD as research (Flanagan & Davidson, 2007; Wirth-Cauchon, 2003) has demonstrated an exacerbated critical stance on the side of mental health professionals who hold particularly pejorative views on individuals diagnosed with this disorder. In order to explicate and understand the genesis of these views an understanding of the

historical antecedents, as well as the definitional usages of the term 'borderline' becomes important. Despite the modernisation of the medical field, there appears to be a stagnant and persistent approach to females within the mental health profession, which is closely aligned to the societal and cultural overlays from the origin of psychology and psychiatry as a medium of effective intervention for individuals in society dealing with distress. Not to acknowledge the impact of society on the diagnosis, in the way that societal beliefs and practices infiltrate into professional practice, highlights the problematic and stigmatising effect of stereotypical understandings of particular groups of people. The enduring legacy of a label of BPD is one of the principle critiques levelled against the diagnosis, as it becomes a lens through which professionals view individuals, thus the diagnosis of BPD becomes the focus rather than the individual with a diagnosis (Alarcon & Keetz, 2001; Bjorklund, 2006; Busfield, 1989; Cauwels, 1992; Flanagan & Blashfield, 2005; Herman, 1992; Hodges, 2003; Jimenez, 1997; Kerr, 2004; Markham, 2003; Nehls, 1998; Wirth-Cauchon, 2003).

#### 4.4.4.1 Sexual Abuse and Suicide within the Patriarchal discourse

The identification of particular symptoms within the text were identified as carrying certain judgements which serves to inform the manner in which mental health professionals filter the reporting of certain symptoms. The assumptions highlighted within the text frame the subjective account given by the assessed individual in a negative light. Emanating from these negative attributions is the suggestion that aspects such as dishonesty become embroiled in the conveying of personal information as suggested by the following excerpt:

Participant 2: "...there is a history which seems to be concomitant of borderlines, so claims of sexual abuse..."

The text identifies this concept through the notion that 'claims of sexual abuse' do not get taken seriously. The use of the word 'claim' implies a manipulative slant which has negative connotations and serves to undermine the experience the individual is reporting. Furthermore, the issue of sexual abuse induces the notion of an environmental factor in the development of the current presentation. By not taking a history of sexual abuse seriously, the individual is at risk of being further disempowered by a system to which they are encouraged to entrust themselves. The following excerpts demonstrates this

Participant 3 (A) - "women who reporting that they've been raped or sexually abused by their fathers and things like that"

Participant 3 (B) - "Another thing which doesn't often come out in the first interview is, is, sexual abuse when young and, some will immediately report that as part of the problem why they there. Ehm and that is often also clearly in that direction."

The first excerpt (A) acknowledges the presence of sexual abuse histories but also minimises these histories when saying "things like that". The content of the history becomes divorced from the negative impact sexual abuse may have on the individual. The second excerpt (B) suggests that reporting of sexual abuse becomes a signifier for the diagnosis of BPD. The insinuation then that sexual abuse histories are concomitant with a diagnosis of BPD, positions the narrator of these histories as disordered. Therefore, there is little reflection on the societal influence on the distress being presented. As such, the revealing of a history of sexual abuse simultaneously becomes understood as resulting in a disordered individual.

Discourse around childhood abuse, specifically childhood sexual abuse, within this context is constructed as a means of manipulation. Within the context of a child's account of sexual abuse discourses of normality, morality, cultural and religious discourses would all be mobilised as a means to understanding the abuse. Questions about how and why these discourses change over the life span are opened up for critical discussion. The sexual abuse survivor/victim is transformed within the context of psychiatric discourse. As such during childhood, sexual abuse is seen as abhorrent and morally repugnant, and is constructed as damaging. However, reports of sexual abuse later in life are treated with suspicion and at times denied as being false 'claims'. Children would be positioned as 'victims' and would need professional amelioration. However, adult survivors of childhood abuse are not granted the same benefit, as such there is an emphasis on the 'claim' of sexual abuse, which undermines the possibility that this may be at the heart of the problem. While the text may not be attempting to deny that sexual abuse has taken place, the discourse utilised suggests a scepticism of this, and positions sexual abuse in the context of the diagnosis rather than the person.

Sexual abuse implies a victim and a perpetrator; furthermore, within a childhood context it implies innocence and guilt. So an innocent female child is sexually abused

by a guilty male perpetrator. This implicates men, in general. Just as a discourse can be used to bolster and preserve power relations, a discourse around blame and culpability may injure the dominant forces. As a child, the girl was unable to talk back, and was voiceless by virtue of her age, however when she grows up she gains a voice and when she enters into the psychiatric setting as a result of this abuse, the report of sexual abuse needs to be neutralised and undermined to preserve the notion of a respectable, protective, law abiding, rational man. Thus, the particular ideological practices employed serve to maintain patriarchal dominance by silencing its detractors. The way in which this ideological position is put into practice within this text is to undermine female recollections of abuse, by positioning them as unreliable history tellers.

In order to challenge the operation of this discourse the researcher introduced the construct of chronic post traumatic stress disorder (PTSD), as suggested by Herman (1992). The introduction of this suggestion was not aimed as a means to evaluate the scientific validity of the construct, but rather as a researched alternative to the established pejorative tone with which borderline personality disordered individuals are dealt with (Herman, 1992). The text dealt with this 'objection' by appealing to the scientific basis of diagnostic categories in general, thus highlighting the entrenched acceptance of the bio-medical model. In response to the objection discourses of responsibility, accountability and indemnity were employed in order to defend against alternative concepts of understanding BPD.

Aspects of the aetiology of BPD are discussed in conjunction with the understanding, awareness and impact these causal factors may have in the presentation of the client. As such, the statistical evidence of the incidence of sexual abuse histories is acknowledged by the text. However, the text simultaneously constructs the BPD subject as an unreliable custodian of their past. Furthermore, there is little objection to the identification of the vulnerable position the borderline diagnosis holds within the mental health system, however there is little in the way of attempting to ameliorate this situation and as such the discourses employed serve to support and perpetuate this 'vulnerable' position.

An identified aspect within the criteria of the diagnosis BPD is suicidal behaviour (APA, 2000). Within the criterion this aspect is stated as follows: “recurrent suicidal behaviour, gestures, or threats, or self mutilating behaviour” (APA, 2000, p. 710). As such, suicidal intent is absent within the criteria or at the very least can be understood as a manipulative manoeuvre on the part of the diagnosed individual rather than a legitimate expression of hopelessness. It can be argued that suicidality within the context of another ‘diagnosis’ such as depression, would be transformed. As such, an attempt at suicide within that context would be constructed as a reasonable response to the effect of depression. Within the criteria of a major depressive episode suicidality is explained as follows, “recurrent thoughts of death...recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide” (APA, 2000, p.356). Within this description, suicide attempts are understood as being a serious, life threatening symptom. Therefore, within the taxonomy the mortality rate of 15% (APA, 2000) within a major depressive episode is given more weight than the estimated 8-10% of completed suicides described within the borderline category. The text exemplified this ambiguity with regard to suicidality amongst individuals diagnosed with BPD.

Within this text the object of suicide is undermined and constructed in relation to the constructs of impulsivity and manipulation. The following excerpt demonstrates this undermining:

Participant 3- “And suicidality I found as well is not taken seriously, you know, in a sense that it is said that it’s a parasuicide and they’re just looking for attention, they’re being manipulative...Ehm, like they’re liars and manipulators and they, I mean one statement I heard the professor said ‘Don’t worry. Borderlines never die.’ So they threaten suicide and all that, but don’t worry, they never die”

The participant addresses the notion of suicidality as it is dealt with in an institutional context. A discourse of irrationality and impulsivity is evoked in the excerpt, whereby suicidal behaviour becomes aligned with attention seeking and manipulation, which positions the individual in an unfavourable light. Furthermore, the sentiment that “borderlines never die” is indicative of the insensitive approach to the behaviour. Not only does it conflict with the tenets of good practice it is pejorative and demeaning for the individuals being spoken about.

A social understanding of the rates of completed suicides suggest that while more men successfully commit suicide, more women attempt suicide (Sadock & Sadock, 2003). This difference could be attributed to the varying methods used by the two groups, with more men making use of firearms and more women attempting suicide through overdose. There is therefore an intersection between suicide and gender and as such due to the propensity with which the diagnosis of BPD is given to women there may be a theoretical argument as to why suicidal behaviour is not taken seriously within the diagnostic category of BPD. However, a theoretical argument cannot assess whether or not a suicide attempt will be successful and the apathetic approach to suicidal intent within the text is suggestive of a subjective rather than objective appreciation of the possibility that suicide is a very real risk for individuals diagnosed with BPD. It could also be instigating a discourse which positions women as weak while paradoxically suggesting that rational men are able to follow through with suicidal intent.

#### 4.4.4.2 The implications of the Discourse of Gender

It has been argued in this discussion that gender may act as a context for diagnostic practice. Through the identification of this discourse the researcher was able to demonstrate the manner in which the mental health system situates females as *other* and the focus of scrutiny. Thus, stereotypical and generalised conceptions of what it means to be female and male have become imbibed into the objective scientific nomenclature. This is problematic in that generalised female distress has become pathologised and positions females in opposition to the ideal self, which is constructed as male, rational and stable. This binary is also present within the discourse of science and rationality, where the *other* can be understood as being in opposition to male, white, rational, western, stable and independent which as a consequence situates those in opposition as female, black (as representative of marginalised racial groups), irrational, non-western, unstable and dependent on a collective. Considering South Africa's history, this *othering* becomes dangerously discriminatory and exploitative. As such this discourse assists in the maintenance of the imbalanced power relations present within society at large, and can be seen to be mirrored within the mental health setting.

The presence of a discourse of gender can be seen to be offering females a circumscribed identity, one with which they are positioned as vulnerable within the mental health setting. The links with both the biomedical discourse and discourse of science and rationality entrench this vulnerability under the auspices of objective scientific fact. Therefore, through the inclusion of the category of BPD within the text of DSM the psy-disciplines actively produced knowledge with which they could pathologise female experience through the guise of attempting to assist (Rose, 1985, 1989). The power and authority associated with science has led to the ascension of the psy-disciplines within society and it is through this association that ideological practices, such as patriarchy, become normalised.

The marginalisation of sexual abuse histories as well as suicidal behaviour amongst individuals diagnosed with BPD highlights the manner in which the mechanisms of disciplinary power become invisible (Foucault, 1977). Through the sceptical reflection on sexual abuse histories the participants do not overtly align themselves with a patriarchal discourse; rather their reflections take on subjective biases which become infused with a discourse of science and rationality. Because science and rationality are considered objective and therefore socially acceptable, the participants' talk becomes objective and socially acceptable.

It would also be important to take into account the role of the researcher as a female, as well the particular agenda held during the course of the interviews. Moving from a distinctively feminist perspective may have limited the opportunities afforded the participants to answer questions from a neutral position. By situating the questions from a feminist perspective, it could be argued that the discourses realised within the text may be restricted in their ability to represent dominant discursive tropes operating within the professional psychological and psychiatric milieu.

## SECTION 5

### CONCLUSION AND REFLECTIONS

The *borderline* between psychosis and neurosis has constantly been redefined, within a categorisation system which is discursive rather than one which is determined by a 'real' entity. The effect of this demarcation has political consequences, as has been suggested by the literature, that females are more often than males diagnosed with this disorder and that this disorder has a particularly negative effect on the outcome of treatment and consequently for the individual diagnosed. As such, this thesis has aimed to analyse some of the discourses available in relation to this discrimination within the field of mental health.

The tenet of this thesis was to explore and distinguish between the varying discourses made available by mental health professionals in their talk around the diagnosis BPD. By examining the discourses made available an investigation and interrogation of the talk allowed for an analysis of the manner in which a feminist perspective may be placed in contrast to the dominant biomedical discourse, which as argued serves to perpetuate the prejudiced interaction with females and the mental health system.

The findings of the analysis suggest that the participants broadly make use of a biomedical discourse to inform their assessment and diagnostic practice. This discourse was seen to be deployed in the reification of the BPD diagnosis. The discourse was also shown to operate in support of a dominant patriarchal ideological practice. This was particularly the case when deployed in conjunction with talk around BPD as demonstrated through the deployment of feminine pronouns. The prognosis of an individual diagnosed with BPD is presented as limited within the text, primarily due to the resistance of the individual therefore indemnifying the professional.

The conflation between morality and the individuals identified as disordered became apparent in the text. This suggestion positions individual's diagnosed with BPD as agentic and consciously transgressing the boundary of normality and therefore deservedly receiving a label.

The notion of labelling as a means to an end was presented within the text through the identification of the frustration of the participants with regards to the lack of utility the identification of the diagnosis of BPD has for treatment. As such the understanding of diagnosis as treatment was identified and demonstrated the power associated with labelling. The reflection of the effects of labelling was discussed in the review of literature, and was shown to reduce individuals to their diagnosis, without taking into account their specific contexts (Sadler, 2007). Within a South African context, a neglect of context within any assessment would limit the ability of both the professional and the individual identified as disordered. As such, the biomedical discourse has political ramifications within the South African context.

The deployment of a discourse of Science and Rationality was identified within the texts. This discourse served to position individuals outside of the professional community as irrational and non-scientific, thus constructing alternative discourses inadequate and powerless. It was argued that the participants conflated a discourse of subjectivity with one of objectivity normally associated with positivistic understandings, thus aiding in the credibility of the arguments they put forward. It was argued that this discourse also served to indemnify professionals in response to a diagnosis of BPD. This was established through the deployment of a professional discourse which serves to shield professionals from criticism in terms of the interventions strategies they may use in relation to the diagnosis of BPD. This renders the individual diagnosed with BPD as responsible for any difficulties that may arise during the course of treatment. Thus the ideological consequences of deploying this discourse become evident in their ability to discriminate against females.

The presence of a psy-discourse operated in service of the advancement of the alignment of the psy-disciplines with the scientific enterprise. The conceptualisation of the white western discourse enabled the researcher to demonstrate the manner in which the psy-disciplines effectively operate to maintain unequal power relationships. The discourse demonstrated the lack of consideration given to the *other* in terms of positioning this other as not only diametrically opposed to the notion of the ideal self but also as resistant to this notion. This resistance positions the *other* as irrational and operates to undermine alternative understandings of mental health.

The literature review outlined the problematic nature of applying western concepts within a South African context. The texts were limited in their reflection on the need for a culturally relevant practice. Thus, it is the absence of a discourse concerning the particular complexities presented in the South African context which was discussed. From this absence, the researcher suggested that the pervasive nature of the biomedical model, as a universal guide to mental illness was at the heart of the neglect. One participant reflected on the possibility of difficulties within South Africa through the explicit suggestion that language may serve as a barrier to understanding and respecting the cultural background of the clients treated. However, this understanding still does not address the socio-historical and political background with regards to mental illness within the South African context.

The feminisation of the diagnosis as identified in the literature was explored through the identification of a discourse of gender. This discourse operates in service of a patriarchal discourse, especially in relation to narratives of sexual abuse and understandings of suicidality within the texts. The reflection on a disclosure of sexual abuse was minimised in the text through the construction of the discloser as untrustworthy within the context of the BPD diagnosis. Through this construction the position of the professional is emphasised as the authority with the lesser position of the help seeker as “dramatic” and as a “liar”. Suicidality within the text is seen as a manipulative manoeuvre on the part of the individual diagnosed with BPD, with little to no reflection on the meaning the individual attaches to these “gestures”. The literature has suggested that the mortality rate of individuals diagnosed with BPD is up to 15% (APA, 2000), and as such the neglect of this aspect within the text is notable.

Throughout the texts, participants were identified as moving between multiple discursive tropes which is perhaps suggestive of the identification of the difficulty with which the psy-disciplines have when dealing with a socially constructed entity. As such, the introduction of Herman’s (1992) notion of chronic post traumatic stress disorder provided an opportunity for the participants to reflect on the possibility of alternative understandings of the diagnosis of BPD. Furthermore, the interview and discussion style assumed by the researcher engaged the participants in a critical analytical approach to diagnostic practice. By analysing the discourses the conflicting

narratives suggest a discomfort with the status quo; however this was accompanied by a seemingly passive acceptance of lingering patriarchal ideological practices.

## **5.1 Reflections on Methodology and Paradigm**

### **5.1.1 Data Collection**

Alternative data collection methods could have been utilised. A focus group with the aim of assessing how professionals talk amongst themselves would have reduced the input of the researcher and allowed for debate amongst professionals. However, with the acknowledgement of the presence of a powerful hierarchical system within and between professions dissuaded the researcher from utilising this collection method for the current research. However, future research may engage in this technique, so as to address how the various psy-disciplines defend and protect their own scopes of practice, and the consequences these positions have for the individuals they treat.

Furthermore, members of the professional community who engage with the diagnosis of Borderline Personality disorder, but do not have the power to confer the diagnosis, e.g. social workers, nurses and occupational therapists, may provide rich data in terms of the amount of contact time these professions have with this particular population.

### **5.1.2 Sampling**

The participants of the current research are all members of the professional community and as has been alluded to in the data collection section above, the inclusion of professionals not able to diagnose may have provided a more comprehensive portrayal of the discourses deployed in conjunction with the BPD diagnosis.

Furthermore, the current sample only includes professionals working within a governmental psychiatric setting and as such deference to medical knowledge is expected and may account for the emphasis on biomedical understandings. Identifying the discourses deployed within the private sector would be another avenue of research. It could be argued that financial gain is far greater within the private sector and as such the deployment of the biomedical model would have multiple benefits for the clinician. Alternatively, in the absence of a clear hierarchy,

professionals may have more freedom to understand and construct individuals in terms of what would be beneficial for intervention.

### 5.1.3 Discourse Analysis

The tenet of discourse analysis is the notion that a text provides the analytical reader the basis from which to draw meaning. However, by not situating this meaning within broader social and material contexts, e.g. acknowledging the status and hierarchy of those involved in the development of the text, the research may assist in the maintenance of power relations that circulate in society (Burr, 2003). Conversely, by analysing these broader social structures one may overlook what the participant is trying to do with the text (Burr, 2003). Thus, it could be argued that the current research has focused on the latter, through the suggestion that the text is merely a manifestation of particular discourses. It is argued that by emphasising the deployment of a sexist discourse the research suggests that it is women who should invariably have control and power. However, this suggestion implies that the researcher has a particular agenda, one which suggests that she can act as an arbiter of who has power within society.

The researcher has identified particular discourses, and within the context of research argued that through a process of analysis and deconstruction she has *revealed* or *uncovered* these discourses. This assumption suggests that the researcher has recourse in terms of what is available culturally as a topic, and transformed this into a discourse (Burr, 2003). By identifying discourses through common, socially shared understandings, the researcher has taken for granted that they are a valid means of naming and discussing the discourses the analysis has purported to identify.

### 5.1.4 Social Constructionism

Social constructionism has been criticised for being idealistic in its tendency to reduce to language the tangible experiences of those it studies (Terre Blanche *et al*, 2006). Therefore, by focusing purely on the manner in which the participants deploy language, there is a neglect of the actual practices involved, thereby neglecting the very real distress the professional may experience when dealing with the contested diagnosis. Furthermore, social constructionist research is sometimes viewed as a relativistic endeavour, as in its pure form it argues that there are many truths and as such descriptions are merely accounts and constructions (Terre Blanche *et al*, 2006).

However, it is argued that all texts are *doing* something and that by not critically evaluating their content, the paradigm may be accused of condoning certain practices (Burr, 2003). For example, without taking a feminist standpoint within this research, it may have become merely a description of the kinds of discourses utilised within a psychiatric setting. However, through the use of a feminist standpoint, the research becomes positioned within a critical framework. Therefore, the current research is not a neutral text, but rather one which argues against the wholesale acceptance of the biomedical model, through the evaluation of its deployment.

A Marxist critique would argue that there has been a gross neglect of the economic interests present within the widespread acceptance of the biomedical model, which consequently enforces diagnostic practice (Terre Blanche *et al*, 2006). Therefore, from a Marxist standpoint, it would be argued that the focus of the current research does not emphasise the economic factors involved in the deployment of the biomedical model.

## **5.2 Further Research Initiatives**

This thesis has aimed to serve as an example of how particular discursive practices operate within a supposedly neutral, scientific context. It is from this example that further research concerning the manner in which elitist, racist, ethnocentric biases and classist ideologies may be operating within psychology in South Africa (Seedat, 1997). Further research, conducted in service of liberatory psychology will assist in building a comprehensive critique of traditional psychology, so as to build relevant psychological practice within South Africa. It is suggested that clinicians may be unaware of the ideological practices they are inadvertently supporting.

It is exemplary in the manner in which it identifies purportedly innocuous discourses, and is able to articulate the way in which sexist ideological practices operate within the institutions of psychiatry and psychology. It raises questions about the possibility of the deployment of discourses which discriminate against particular vulnerable groups within a South African context.

Through the usage of the diagnostic entity described as Borderline Personality Disorder, the researcher has already engaged in the promotion of a biomedical

discourse. A more neutral avenue to discuss the treatment of vulnerable groups within the mental health setting could have been a more general understanding of women within the South African context. However, for the purposes of creating a forum within which discussion could be generated the researcher reflected on the diagnosis of BPD, as a contested diagnosis, and aimed to utilise this as a platform for the elucidation of discourses, which according to literature are pejorative in nature. By making use of a standpoint, the researcher has endeavoured to contextualise her research within a feminist perspective, thus taking an overtly critical and political stance on the data. Thus the research was an explicitly political endeavour.

### **5.3 Implications of Current Research**

This research has attempted to critically analyse the biomedical model and the role that it has in the ideological practice of professionals. Considering the pervasive nature of the biomedical model, a complete rejection of its usage would curtail any real attempts at resistance. However, it is argued that there may be a number of ways in which the professional may become more sensitised to the negative effects of the discourse deployed in support of the model and more aware of post-modern movements towards a more co-constructive relationship between experts and lay individuals within applied psychological and psychiatric settings.

The critique of diagnostic practice within this research has focused upon the diagnostic entity of Borderline Personality Disorder. However, considering the pervasive nature of the DSM-IV-TR (2000) and by implication the biomedical model, a consideration of how the deployment of discourses relating to this model can become less pejorative is one aspect of understanding how to address the concerns raised.

Firstly, it is understood that diagnostic entities allow for ease of communication between professionals, as well as providing a 'universal' language in which researchers can confer. However, it must be understood that this so called universal language, is actually foreign in some contexts, and serves to promote and maintain the hegemonic practices of powerful groups in society. Despite this, the current research, which itself has utilised terminology derived from biomedical nomenclature, argues against certain types of language deployment. As suggested in the literature the use of

diagnostic entities as labels is stigmatising and amounts to reductionism. Thus, it is suggested that when professionals engage in professional practice, there should be an emphasis on the individual, rather than utilising a discourse which reifies the pejorative notion of a diagnostic category. Furthermore, a move away from viewing mental illness as an individual bounded entity but rather as a result of multiple intersections with not only biology but with society e.g. socialisation practices (Becker, 1997). This is particularly pertinent in the South African context, where there are multiple *disease* understandings. As such, a closer engagement with the individual in distress, with an emphasis on the narrative which they bring to a biomedical setting, should not only be respected but valued in terms of conceptualising an appropriate intervention strategy.

Secondly, consideration with regard to the diagnosis of Borderline Personality Disorder as contextually constructed could assist in reframing the diagnosis more appropriately as women's reaction to their devalued position within society. However, not all women respond to this devalued position, and as with all pathology women's responses will fall on a continuum (Wirth-Cauchon, 2003).

This holds particular value for the practice of psychotherapy, which as mentioned above, would address not simply the pathology identified, but also more broadly the societal overlays with which clients may have to contend with (Flax, 1996). Therefore, psychotherapy becomes more about the construction of a narrative than an exercise in overt transformation, where the clinician highlights problematic areas. This narrative approach has incorporated post-modern and social constructionist paradigms, positioning the therapist as a co-constructor thus providing a more equal therapeutic relationship (McNamee & Gergen, 1993).

It is posited that through the acknowledgement of the effects of discursive tropes the suggestions outlined above can be employed to alleviate the heavily loaded, pejorative nature of the discourse surrounding a diagnosis of BPD as well as the stigmatising effects of labelling in general. From this acknowledgement, it is hoped that there will be a greater appreciation by professionals of the manner in which they construct individuals as well as an understanding of how a blind subservience to the identified

discourses serves to maintain the unequal and discriminatory power relations present within the broader South African context.

## SECTION 5

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## Appendix A- Interview Transcripts

### **Participant 1**

I: Have you ever made use of the diagnostic category borderline personality disorder?

P1: Yes, I most certainly have! Um I tend to; you know, um, focus more on the traits more. Making the diagnosis, in and of its pure form is quite rare, you know, so it's normally there as a predominant trait in a personality disorder along with other traits, ja.

I: Seems as though you have made the diagnosis, I was wondering if you could possibly give me a vignette of one of the people that you have diagnosed.

P1: Yes... a vignette of what?

I: Of someone, an individual diagnosed with borderline personality disorder.

P1: Just in terms of the presenting problem, or what?

I: Hmm, just briefly, race, age...

P1: Ja, teenage girl, grade 10 or 9, I'm just thinking of her ja, her presenting problem was self mutilation, ok that was why she was referred. She did not think she needed any help, ok, and she was very against therapy and she believed that she could get um the help that she needed from her friends. Ok, and that eh, yes she understood this was self destructive behaviour, it was abnormal, umm, but refused to see the use of taking that symptom seriously and getting the help she needed so she was sort of like very happy to brazenly say, 'look I use this behaviour for my own benefit'. You know in a way showing the manipulative side and not necessarily being aware of it herself. Ok, ja.

I: Ok, if I was to ask you for a generalised demographic, in your experience, so coming up with a prototype of everyone you have seen with this diagnosis, what would they 'look' like?

P1: I have seen mixed races, ok, the race things hasn't been a feature at all, I have seen people of colour and white people with borderline personality problems. Mostly I see them in the adolescent, early adult age range, and eh, mostly female.

I: Ok and their general kind of background and their history?

P1: Umm, background is educated, umm, very well educated, umm socially sophisticated, umm, very narcissistic, ja and umm ja very narcissistic. That's always a concomitant with the borderline problem.

I: Ok, can you explain that a bit more?

P1: Ja, its like you know eh eh, you know an inability to articulate ones needs appropriately and to see to it that you put in the work that you could in order to get those needs met, its like a shortcut to it, you know, but it's like a, like a, they stuck in this place where its got be gotten destructively. That seems to be where, they eh, they get pleasure out of that. And the thought of doing it any other way is unappealing.

I: The DSM has identified that there is a gender bias in borderline personality disorder, with female predominating more than males, what is your understanding of this?

P1: I think there is a bit social construction eh angle to it, and what I see often is that the person with the borderline personality is attracted to similar, eh, their friends also have this borderline personality component, and it's sort of in a way idealised. Jag, so it is something that I have noticed.

I: The literature has also noted that it is a problematic diagnostic category, being seen as quite a difficult client to have. Has that been your experience of it? And what is your understanding of those difficulties?

P1: You know the diagnosis part to me isn't that important to me, its like the object relations diagnosis, that's what helps in treating, diagnosing and treating people with this kind of problem, this personality problem is that when you, you know if you understand the umm object relations around borderline personality disorder it seems to stare you in the face when you are presented with that problem. If I didn't have that theoretical background I think it might be totally different, but so you know, my mind is immediately when I encounter people with these problems, is a way of thinking, so its not so much that they *meet all* these specific criteria and this is what the person is, like cast in stone, its just a way of helping me understand the person and then help me go about relating to them.

I: Ok, so do you find that the DSM is not always helpful in terms of assisting people?

P1: No, no look the DSM is my bible, the DSM is absolutely essential, you have to have a good understanding of that, I mean without that I don't think one could practice, but you know it's also like before that you need that understanding of object relations and to me that's more useful.

I: Ok so, do you think they can complement each other?

P1: Oh yes, you can't have one without the other.

I: Ok. As far as the controversial nature of borderline personality disorder, what is your understanding, what is problematic about the diagnosis?

P1: I think a lot of it has got to do with the stigmatisation of females, you know when there are problems then there's that angle, the gender issue, it's a sensitive thing for woman, in that they get, tend to get diagnosed with this, and then you know its also popularised, like you get it in movies, music, the press, artwork, and there's you know a whole lot of satire around people with borderline personality disorder. Ja, and I think there is a bit of an angle of defensiveness I suppose, and the controversy, ja it's a pity, you know, but that happens with a lot of disorders and problems around sensitive, and factors in the disorder, and ja.

I: Ok, well do think there is stigmatisation of borderline personality disorder and if so you think that plays a part in the treatment of borderline personality disorder? Or do you think it's kept quiet, or kept behind closed doors, in academic publications?

P1: No, yes I don't think it plays out in the treatment, I think that one big thing I have noticed is that the patient doesn't like to know that he/she has got a personality disorder, so this is the tension of treating a person with this problem is that, addressing it specifically will tend to make them freak, they don't like to hear that. So it's almost like they do and they don't want to have that kind of problem.

I: From the clients' perspective, I'm wondering if the therapists' ideas, or the medical idea, do you think their kind of idea, or the conception that it has comes into their role in the therapy?

P1: Hmm, no I don't find that, eh with me, it doesn't sort of put me off or think 'oh geez' or anything like that because you know each patient is a person you know, in their own right you know, so its very difficult o impose all those theoretical and conceptual problems, you know the person is there anyway so you know, so one empathises with the person like one would with anybody else. Ja, that doesn't play a role.

I: Did you ever find that it did play a role, perhaps earlier in your career or has there been a time when the client has been more difficult than others?

P1: Yes no look they are difficult, but yes they are just so different, they are just needing a totally different kind of relationship. And you know with the knowledge and training, its fine, you accept it, you know about it, it sort of happens as you know it will and you not taken by surprise it just goes with the territory. You know with this person it is likely to happen, and yes it does and it doesn't have any serious counter transference issues or anything. Because I'm still meeting the person, who is the unique person there and that makes it easy. Or makes it easier shall I say.

I: So it seems as if your understanding of borderline personality disorder, especially with object relations has helped you to...

P1: Ja, no definitely

I: Is there anything you would like to say that perhaps I haven't asked?

P1: Ja, let me just think, ja. You know often, borderline personality problem people get referred and they not ready yet for therapy, so you know one mustn't be afraid to address the ehm issue at hand and tell the person what you think is the problem. And so you like may say for instance, it seems like you have actually got a personality problem and you point out the things to the person and then if they say, 'I don't like you, I'm not coming to therapy' then you should be able to say or you mustn't take that personally because this person is sort of the journey with their disorder and you know, your encounter with that person might bring the one step closer to you know actually addressing it, so you know, you know its very complicated, you know it's a disorder you only become familiar with, only with experience and then supervision is very helpful.

I: Thank you very much for discussing this today, I appreciate your openness.

## **Participant 2**

I: Thank you for participating in this interview. Perhaps we could begin with a broad question, have you ever made use of the diagnosis borderline personality disorder?

P2: Yes, I have made use of the diagnosis, especially when I was abroad, eh, I mean if I were to compare the incidence in the UK to here, I would have to say that it was higher over there.

I: Ok, so it sounds as though you have come into contact with individuals who met the criteria for borderline personality disorder. Would you be able to give an overview of the individuals you have come into contact with?

P2: Sure, ehm, if you mean in terms of there general presentation...?

I: Yes, that would be great.

P2: Ok, well mostly young females, who normally enter a psychiatric setting following a suicide attempt. At the time of admission there is generally quite a lot of dramatics, in the sense that there is confusion and the reason for the attempt is unclear. I mean obviously this is a generalisation, but there is a history which seems to be concomitant of borderlines, so claims of sexual abuse, instability in their relationships and occupations. Most clearly I suppose is the kind of affective disturbances, there is a huge hopelessness, which is pervasive. I have also noticed eh that there is a loss of self, in terms of lack of identity and an inability to accurately and cohesively give an overview of their own histories, so basically a lack of insight.

I: It seems as though there is some frustration, I mean in terms of the confusion and lack of consistency, how do you deal with this?

P2: There are times when it becomes difficult, especially as I try and help patients as much as I can, but there does seem to be a general feeling of dis-ease, it's mostly discomfort, with kind of having the feeling that you're not hearing the whole truth. I don't think it's about dishonesty, or malicious, or anything of that nature but if I were to compare my experience with other axis two's, there seems to be a marked difference in interpersonal relations. I mean obviously the situation deteriorates when there is a co-morbid diagnosis, especially if they meet criteria for other personality disorders, which is quite often.

I: Ok, well you have touched on the kind of female aspect, noting that most of your clients who met the criteria for this diagnosis were female, in terms of your understanding, why do you think this is the case?

P2: Well there are many factors, perhaps I've just had females (laughs), no eh, I think it's mostly to do with kind of, well I mean statistically more females are diagnosed with borderline personality disorder, as I think generally the expression of female distress is expressed in the symptoms encompassed by borderline personality. I mean it's difficult to discuss because there are so many variables, not all aligned with gender, perhaps that's one of the difficulties of the concept borderline. There are obviously cases which were male, or who differ from what I have outlined above. There is also literature which supports this, and similarly in the other direction with narcissistic personality disorder, or maybe more congruently, antisocial personality disorder.

I: Could you say more about that?

P2: The antisocial?

I: Yes

P2: Well, I suppose comparing the two diagnoses, I would say that the diagnosis for an angry male is antisocial, whereas for a female, it's borderline. Not to say that there aren't variations, but I think that in general terms, as I've said, that ehm, men and women express anger and emotion in different stereotypical ways.

I: You've mentioned quite a number of difficulties you experience, as well as mentioning the statistical evidence in support of the slanted incidence in females, do you think there this needs to be addressed?

P2: Well I think there are problems with the propensity for a particular diagnosis in a particular population, questions about the bias become prominent, in terms of understanding why the situation is the way it is. However, having said that, I don't think there is a theoretical problem with the diagnosis borderline personality disorder, as for the most part the diagnosis serves as the basis for trying to understand the client, so the secondary problem of gender, does not warrant an overhaul, if you know what I mean?

I: Ok, what I hear you saying is that borderline personality disorder as an entity is a useful category, and that it in many ways represents a feminine expression of distress, which while it should be questioned does not mean it should be changed?

P2: Yes, I have read some literature which suggested a diagnosis of chronic PTSD, as an alternative, but this doesn't change anything in my opinion, in fact it's theoretically flawed. The two disorders are very different animals, so to say, in that their aetiologies are diverse and do not mirror one another as suggested by the literature...

I: Ok, in terms of the stigma attached to borderline personality disorder, and in light of the literature you have read, do you think that recognition of the pejorative tone in

the literature, regarding borderline personality disorder is warranted by mental health professionals?

P2: Well if in terms of pejorative you mean that they're criticised or that some clinicians are derogatory, I don't think that, that speaks of theoretical problems, its more of an expression of helplessness, on the part of the clinicians or that they feel that they cant help, which may also say more about the client than the clinician, as I've mentioned already. But saying that, it is also important to remember that those views that are portrayed in literature is a limited scope of the generalised views...but I do hear what you are saying. I think that in spite of some misgivings, the category, or at least those meeting criteria for borderline personality disorder is...well I think the semantics surrounding the 'concept' may be problematic, but not the category itself.

I: How do experience people diagnosed with borderline personality disorder?

P2: Well, each patient is an individual, but you know the kind of stereotypical patient? Well ja, I mean I experience them as quite passionate, very intriguing in a sense, mostly because of their lack of insight, its sometimes difficult to put across to them that they are creating their lived experience. I think that's where psychology comes in; I think long term psychotherapy is essential in dealing with this population. Medical treatment, while in some cases is necessary doesn't address the actual interpersonal flaws present. I think the general view of psychiatry is to contain and prevent further self harm, in terms of it being a character disorder, there is very little that medication can do to help.

I: ok, when you say there is very little that medication can do to help, I am wondering about the helplessness you mentioned earlier, in terms of clinicians feeling as though they can do very little to help. How do you think this helplessness is expressed to the patient?

P2: Well, I'm not sure that it is expressed, I mean that a lot of the patients we do see we cant help, its not an interpersonal difficulty, well not always, but even with schizophrenia, there are times when medication fails to assist or ease symptoms, and at times that can be disappointing.

I: Ok, I've heard you speaking about a comparison now, between borderline personality disorder and schizophrenia, both which have very different aetiologies, but that in terms of the manner in which they are treated is similar to an extent, with treatment resistance?

P2: Well, all patients are a blank slate when you meet them for the first time, and in that way it's not necessarily about a similarity between those two in specific. Ehm, I think treatment resistance with a borderline is a more intellectual cognitive process, where as with schizophrenia it is the medication that fails. I feel like you're putting me in a corner, I'm not sure if I'm expressing myself well?

I: Is there anything that you would like to say, perhaps something that you feel I haven't covered?

P2: No, I think that you've covered things pretty well, your questions were more difficult than I expected (laughs) I feel like I should have prepared myself a bit better.

I: Your participation is greatly appreciated, thank you for your time.

P2: No problem.

### **Participant 3**

I: Ok, maybe we can start out with just a basic question, have you ever made use of the diagnostic category, borderline personality disorder?

P3: I have, I got a client that was transferred to me with that diagnosis already and I had to review whether she still met that diagnosis and according to the DSM she did, so I still have it as a diagnosis for her.

I: I suppose, if we can go into one of the cases that you have had, could you give a brief vignette? Just with the basic demographics and brief history.

P3: Ok, umm, obviously I'm not going to mention her name, she is at the moment 43 years old, she was sexually abused by her father from the time she was 11 up to her early thirties, um in terms of her, I'm not even sure of what the criteria is for borderline, but eh she would probably qualify on the basis of her self harming, and she has mood instability, very much no stable sense of self, has very much, ehm unstable interpersonal relationships, finds it very hard to be with people, umm, constantly feels rejected, alienated, and longs for closeness but ehm feels empty and doesn't feel fulfilled in those relationships.

I: Ok, you've mentioned quite a few things now that obviously do meet the criteria in the DSM, I'm wondering interpersonally in your experience of her and your other clients, with literature suggesting that they are difficult clients, do you find that, that is commensurate with your experience?

P3: I found the therapy very challenging because of, of the nature of her... Firstly my own engagement with her, I found her very, she touched my heart a lot, so I found it difficult myself to ehm, leave that at the office, but in terms of her being a difficult client, I didn't ever find her to be manipulative or dishonest, which is kind of what the literature sets borderline people up to be, that they sort of play games with you and I never found that with her at all. She's very honest, it's just that the world she finds herself in is very hard to live in and it's hard to be there with her.

I: It sounds as though, you weren't surprised, but that you weren't expecting it to go as smoothly as it did go in terms of interpersonal kind of stuff. Maybe we could go back to when you got the actual referral letter, when you saw the diagnosis borderline

personality disorder, what were the kinds of things that were going through your mind, and how were you kind of perceiving it.

P3: Well, umm just generally from training you get the idea that, that if you get a client with borderline personality disorder that the interpersonal relationship between you and the client is going to be very difficult and stormy and angry and I guess I expected a lot of anger, based on what I had read, you know this stormy kind of anger, and push pull kind of stuff, and the manipulateness and I never, and so I was surprised that, that hasn't been the case. I was also expecting her not to attach very easily and in fact I found the opposite, there was a strong attachment right from the beginning and the fact that, that has maintained, I find that surprising in light of the literature that I have read. That the sort of therapeutic relationship sort of explodes, you know and that its something that you have to keep working on, not that it's something that I haven't kept working on, but it's never been that fragile.

I: Ok, so it seems like from your experience that there is kind of a disparity between what the DSM sets out, and what perhaps some of the other literature sets out and your experience, in that they are not all necessarily aligned with what the presentation is likely to be, within an understanding of a case by case kind of evaluation.

P3: For sure, and I think the DSM is one way that people have tried to make sense of, or generalise a range of clients that they've seen, you know, like to put it into one understanding, but I think it's a very narrow understanding, and I don't think it even touches, even slightly on the actual experience of that client, ja and I think they can meet the criteria and it still tells you nothing about that client and the way that they have experienced their pain, ehm ja, they might meet the criteria but, but I just find that the diagnosis alone does not help you, in terms of treatment, ja so it doesn't tell you anything about the client or how you can work with them or, so its not useful.

I: You have mentioned now that the client you spoke about was female, I'm wondering within your experience if you could, describe a generalised demographic of a client you expect to see or have seen with a diagnosis of borderline personality disorder. What are the things that kind of stand out for you in terms of your experience?

P3: Childhood sexual abuse, I'd expect that to be there, I'd expect them to be female, early twenties to early thirties, I would expect their presentation to be dramatic and I'd expect them to have very explosive sort of interpersonal relationships, umm a lot of acting out, eh, whatever that's supposed to mean, eh, a history of self harm, parasuicide, and eh many therapeutic relationships that haven't worked out, relationships with mental health professionals, ja you kind of expect a trail of chaos to have come before.

I: You've touched on two things there that I would like to follow up on. One of things was the gender, that you expect them to be female, I am aware that the DSM does identify that there is a gender bias, what is your understanding of this?

P3: Well I think it's a social, I think it's the way we've categorised what's acceptable behaviour for males and what's acceptable behaviour for females, and in the way people express their pain, like males express their pain differently, but maybe more

aggressively but will get a diagnosis of antisocial personality disorder, and women who tend to express their pain tend to be diagnosed with borderline personality disorder. I think that it's a very arbitrary thing and that it's a reflection of the way that our society is created and how our society creates gender and how people behave. I don't think you know I think if you had to focus on a more aetiological kind of diagnostic criteria for borderline personality disorder and antisocial personality disorder you might get a more even mix. I just think that its very limited category that doesn't encompass a male experience.

I: you also mentioned something now about society, obviously the DSM is formulated and created in America, and that they do make allowances for culture, but have you found in you experience that it can be translated into different cultures, I mean especially within the south African context, has it been as applicable as you think you would have liked it to have been?

P3: Its difficult to say because, ja even thinking about it would, would, I mean I have only dealt with a white client who fits the criteria and I haven't really had the experience of whether that would fit cross culturally or how would someone in a different culture express sexual abuse? I don't know, I mean I don't think it would. I think the DSM notoriously doesn't fit cross culturally, I mean even in terms of depression so I think it would be a stretch.

I: To follow up on what I was going to before, I think your words were, 'there's a trail of chaos', especially with other mental health professionals, I wonder what is your understanding of that, I mean if its someone who has been diagnosed with borderline personality disorder, why is this trend of having a trail of chaos following them?

P3: I think having the diagnosis itself plays into that a lot because I think there are expectations and its sort of easier to refer maybe because you have this idea that its going be really bad and having that diagnosis means it's a poor prognosis, I think that it's a lot less likely that people will stick with that client because well I think there is a belief out there that, well it's a poor prognosis and once you have borderline personality you always have borderline personality disorder and there's not that much effort and I also think that dealing with people who have been sexually abused as children, as most borderline people have, is very difficult, its not easy work and I think that and it takes a lot to stick with a client like that long term, and just in terms of my own experience of that I didn't have any idea how hard it would be, and if I had more than one client like that or more than two I don't know how much I could have been with them and I think it would have been impossible to be with them so intensely so that makes them vulnerable to being referred because it is difficult to deal with them and it requires a lot of yourself. Ja I think if you hadn't had experience and you have a client load that is more than one client that's going to take a lot from you then I think you are going to struggle and I think it does make them vulnerable to being referred.

I: it seems like it is difficult, especially between therapist and the client, and as you've alluded to the doctor and the client, even the nursing staff and the client, what are some of those difficulties, I mean if you were able to identify in your experience, what are the kinds of things that make it difficult to relate, and make it difficult to interact with someone with borderline personality disorder?

P3: There sensitivity to rejection, and I hate 'their' because I really don't like the category, in my own experience with my client, how easily hurt they are and how easily they shut down, and being with her pain is incredibly difficult, far more difficult than I imagined when I first started, in terms of interpersonal relationships I only really have experience with one so, in terms of her sexual abuse she is automatically on the defensive with a male doctor or psychiatrist and that makes it very difficult, she is very self protective and she gets angry so I think in terms of me being female, that's helped a lot. But she does get extremely angry and she is very protective, and in terms of her relationships with other doctors, boundary crossing has happened, where doctors have got more involved with her than they should have.

I: It also seems like, I mean you have obviously had the opportunity to interact with her and understand more about what's going on for her, I wonder if in this kind of situation where especially the male doctors are not kind of aware of what's going on and where her anger is coming from, I wonder if you feel that might have played a role in the kind of pejorative kind of way that she has experienced other medical health professionals or mental health professionals?

P3: I think there is an insensitivity to her history of sexual abuse and when this particular psychiatrist has asked her about her sexual behaviour and her sexual identity, you know I don't know if that would be an all round male insensitivity or if its just this particular male doctor but I do know that if its any male doctor she's automatically on her guard. So just an insensitivity about asking questions about that you know her sexuality and her current sexual practices and her body and her has been awful for her, it feels like being violated. The power relationship is also very difficult for her, because again she is in a situation where again a male has power over her and is insensitive to that dynamic.

I: Ok, what you've spoken about, the sexual abuse, that does seem to be a kind of common thread that runs through people with borderline personality disorder, that's one of the controversies around the diagnosis, um, one of the suggestions has been to move towards a more, PTSD, or chronic PTSD diagnosis, understanding in the context of their history, do you think that would help or assist in destigmatising people who are diagnosed with borderline personality disorder?

P3: I really think it does because calling someone borderline personality disorder, its almost like a character disorder and it doesn't name what the actual problem is and for me and my understanding of borderline personality disorder is that its very much trauma related and the kind of work that you do is trauma work so it would be more appropriate to diagnose it, I mean to me a diagnosis informs treatment and talking about a personality disorder doesn't give any indication at all about what the work, you know and its definitely trauma work, I mean its continual chronic trauma that then establishes into personality patterns perhaps that are defensive in nature and that are protective and you know even the approach to personality disorder is trying to undermine most things in a way and to rub out those characterological traits that are being named undesirable by society doesn't give those traits the recognition that they deserve as being protective and as being trauma related and that they have got that person to where they are now and its kept them alive and I think when you are dealing with someone who has been chronically traumatised those protective behaviours are

paramount to keep in place until the client has found a more comfortable way, and I think the whole psychodynamic way of labelling them as resistance can be very damaging and if you don't see it in the perspective of trauma.

I: Ok, so it's very much to contextualise and to

P3: Exactly, to identify what are those behaviour are serving and what are they there for, they there because of trauma, they not there to manipulate or I mean they might have all those consequences but I mean people might find them manipulative but if you don't get to the core of why they are there its very easy to judge them and not to get to the root of what's going on and can be very damaging you know.

#### **Participant 4**

I: Thank you for your participation. Let's get started with me asking, in the course of your professional career have you ever made use of the diagnosis, borderline personality disorder?

P4: Ja, ehm.

I: Ok, could you please describe one of your cases? Like in a vignette form: like personal details and demographics?

P4: That's very difficult...

I: Ok...

P4: Ehm, maybe I can't really think of anyone in specific at the moment, and maybe because I'm working mainly with the state patients and so see a lot of antisocials and very few... I mean with the borderline patients it would probably be an admission. And then they would go to A and be looked after by other people...So...

I: And in these admissions, can you think of a specific case? If you can, I know that you see so many people.

P4: Ehm...

I: Is there one case that stood out for you?

P4: Ehm, that's really difficult. Not really... I think one gets a general impression but it is very difficult in a cross-sectional once off interview to be really sure.

I: Ok...

P4:Ehm ...but I think, ehm, I mean, ja..... the biggest part with taking the history, what would guide one in that direction would be generally unstable, instability, ehm.. I mean from the basic demographics already, asking about the marital history and employment, and, ehm....., that kind of thing.

I: Can you just touch on the demographics, I mean if I have to ask you about your idea of a person with borderline personality disorder would look like, would you be able to give a generalisation of what they would look like?

P4: Ehm, sjoe, ja. I would say someone who's who's very manipulative and who is, ehm, has a very unstable life in a sense of being unsure about, ehm, sexual orientation and having unstable relationships. Often by the time they get here they burned all their bridges and and, ehm, you know... there is often even before you see them you're already hearing about all the chaos around them, and, and, ehm,... And then, ja, usually they presenting after suicide attempts. So suicidality is a big clue in that direction and then ehm, I think also substance abuse, eh, and, and, ehm. Which often, another thing which doesn't often come out in the first interview is, is, sexual abuse when young and, some will immediately report that as part of the problem why they there. Ehm, and that is often also clearly in that direction. Ehm...

I: It seems like there is quite a lot of interpersonal dynamics that go on..., even in the assessment interview?

P4: Ja, it's usually with that kind of problem, you pick it up quickly when you've been doing psychiatry for a while, you quickly realise, ok, this person is not clinically depressed, this person is not psychotic, ehm and that it's a lot of social problems going on, a lot of relationship problems, ehm, and there often very, ehm, ja, uncontained, ehm. Crying one moment and they will often exaggerate a lot of things and history of suicide attempts and they're often referred after that. But just, ehm, in general I don't, ehm, always agree with the whole concept of borderline personality at all.

I: Can you say more about that?

P4: It's, it's, I think very often it's, ehm, difficult people that the clinical... the doctors and people struggle to manage. And, and, ehm, it's almost like they get written off and put in that box and said 'Well, it's their responsibility anyway, nothing can be done for them', ehm, (laughs) so in a way I think it's ehm, I'm very, very reluctant to make that diagnosis at all. I'd rather possibly say that the person has traits. But be very cautious because they tend to get problematic.

I: When you say problematic, what are the problems that come with that, in your experience? It is obvious that it's something you're reluctant to do...

P4: Ehm, look my my, I mean in general my experience working with male psychiatrists and, and, ehm, they're always the ones who are in charge. And they tend to be very disparaging of young women with emotional and social problems. And, and women who reporting that they've been raped or sexually abused by their fathers or things like that. And suicidality I found as well is not taken seriously, you know, in a sense that it is said that it's a parasuicide and they're just looking for attention, they're being manipulative and, and...

I: so it's almost like....

P4: So on the one hands side it is a description for a group of people that are very difficult to manage, as a doctor. Because we are not really taught the skills to deal with a lot of those issues. But, ja, ehm, I can't remember where I was exactly, ehm.

I: You were saying earlier that you're mostly in contact with male psychiatrists and male doctors and things like that. Do you think that there is anything about that?

P4: Ja, I think that it is mostly, I mean it is mostly women who gets diagnosed with that problem, and, and, I think in a way it's a..., ja, it's hard to explain but what I said, ehm, that it is a useful sort of a way to see a certain group of people that are difficult to manage with the skills that we have, but, ehm, or the lack of skills a lot of the time. But, ehm, I do think that one needs to be careful in that a lot of the male people I've worked with are very disparaging of borderlines and quick in ....

I: If you say 'disparaging' what is it that you mean?

P4: Ehm, like they're liars and manipulators and they, I mean one statement I heard the professor said 'Don't worry. Borderlines never die.' So they threaten suicide and all that, but don't worry, they never die'. And, and, that kind of attitude which I find sometimes hard to....

I: Do you think that plays into your kind of reluctance and hesitancy to give that diagnosis?

P4: Ja! Ja... I think people get; I think they quickly become hopeless. But then they put that blame with the diagnosis on that patient, for their inability to help.

I: It seems like it gets taken away from the individual. So it's not an individual diagnosis any more, it's a kind of blanket for anyone with any kind of difficulties

P4: Hmm, and I've even seen it here attached to female doctors that I worked, that dr. S would say: 'Oh, she's actually just borderline' and things like that and, and, so it's used in a derogatory way quite often for women, and I think in a way it is used more by men in that sense.

I: Well, the DSM obviously identified that there is a gender bias and that a lot of the literature has discredited a lot of the diagnostic category because of that. But what is your understanding? Is it a female type of diagnosis?

P4: Ehm, ... most of the time, ja. I mean I have seen a few men in the Forensic system who would qualify on certain points like suicidality and, and, ehm, the manner of interacting. But very few, ehm...

I: Do you think that the South African context has anything different in terms of the type of patients that you do see that may not be accounted for or might distract clinicians from identifying borderline tendencies because of the predominance of females, with the DMS being American?

P4... I think, possibly the fact that we work more cross-culturally we might end up with some patients who, ehm, is exhibiting their distress by their behaviour being

identified as psychotic or something rather than, ehm,... so that would be like example an English speaking doctor and a Xhosa speaking patient, and not understanding exactly what the patient is saying and interpreting their behaviour as, as.... So I think there is sometimes when one misses the personality aspect and ehm...

I: Ok...

P4: ...so possibly in that way, but otherwise...

I: We had identified that there seems to be a general idea that it is a young, white, female...ehm, do you think that, because of that kind of stereotype, it may influence the clinicians to use the diagnosis on other groups of people. Or...

P4: Ja, I think if you were a Xhosa speaking clinician you would probably pick it up much faster. And I'm sure that it is very present as well, they just maybe don't always end up here.

I: Ok, so it's maybe some kind of communication barrier, that needs more time to...

P4: ... and I do think that the Western influence is much more than we think. Things like eating disorder are so often, we have had Xhosa speaking patients admitted who clearly had eating disorders, and everybody said 'No they don't, it's not that'. In one case in particular, I remember they decided that she had a psychotic disorder, ehm. And she was anorexic (laughs) and I think that that's not... that there is so much westernisation that it's more than we're think in many ways. It depends, I think, in many rural areas not so much. But, ehm, things like cutting and all those things, I think it's become so, ehm, it's in the media, it's, ehm...

I: It's quite mainstream now in a sense. Ehm, you have touched on quite a lot of it now, but in the literature it also identifies that it's quite a controversial kind of diagnosis, to give borderline personality disorder. What do you think, I mean, do you have any thoughts of why it's so controversial, what is the problems with diagnosing borderline personality disorder? I mean you have spoken about the pejorative tone that it takes on with certain professionals. But apart from that, do you feel like there is any other problem with it?

P4: Ehm, s'joe that's difficult, I'm sure there are but at this stage I think I need to read more to understand what is difficult.

I: Can you describe from your experience the way that professionals do, or the way they have treated or spoken about individuals diagnosed with borderline personality disorder. The way they follow up or the way they are treated once they are given the diagnosis borderline personality disorder?

P4: Ja, I think in a way they are very much written off, and delegated to the psychologists (laughs), which is very often the correct way of doing things as well, but umm ja.

I: You have mentioned childhood sexual abuse, and there have been suggestions that an appropriate diagnosis would be something like PTSD, which would give a fair

reflection of what's going on. How would you feel about that, in terms of the cases you have seen, especially when you taking a history and recording the things that the patient is reporting, does it sound like something that is more appropriate or obviously it's a kind of case by case?

P4: Ja, possibly, but you see there you also come in with the PTSD which is also a problematic diagnosis, but I think more should be looked at that because its almost a pervasive thing and also what I've often seen is that 'she's lying or she's making it up', and I think that attitude also is part of what they have to deal with all the time, so I I think more needs to be looked at and I think another aspect is societies obsession with female physical attractiveness and that also somehow tends to, I mean what I've seen is a lot of women are very angry that they don't fit the beautiful stereotype idea and somehow that seems to be linked into it a bit as well. What I have seen is a lot of woman who have been sexually abused when they are young is that they become obese, and its almost like the react by making themselves totally unattractive, (laughs), but then subconsciously also being angry about it in a way. So I think that societies huge pressure on women, valuing them for their attractiveness and appearance so much I think some how is involved in the whole thing.

I: So what I'm hearing you say is that there are a lot of influences from all over the place, that its not really justified in writing them off or perhaps that its not about the individual but about the pressures that they dealing with the pressures.

P4: I know with anti-social personality disorder I have read a very interesting article by a man who discounts that as a disorder basically saying that poor people growing up in a slum kind of environment learn a certain way of dealing with life and they have few options and so that would be seen as an antisocial person in the end but it's the way that they have adjusted to society and as compared to your white collar worker, who if they were really good at it be called a psychopath but generally get away with a lot so I think similarly in a way with borderline that's also done in that there's more a social, society issue than really a diagnosis that's in the person. I'm not sure if I'm making much sense...

I: Well do you think that perhaps that's why it's perceived to be so difficult to treat borderline personality disorder?

P4: Hmm, that makes sense to me in some ways.

I: Is there anything you would like to say that I haven't asked you?

P4: No, but thank you for listening to me drone on...

I: Thank you for participating.



## Participant 5

I: Umh, have you ever made use of the diagnostic category of borderline personality disorder?

P5: Hmm

I: Can you briefly describe one of your cases in a vignette form?

P5: Well, I saw a woman as an inpatient and then as an outpatient. Eh, and she was referred initially for, I think an eating disorder and self-mutilation. Ehm, after a brief assessment I saw her, therapeutically.

I: can you give me an idea of the age and ...

P5: She was in her early thirties, early to mid thirties and had two children and was separated from her husband at that stage. Uhm, ja...what do you want to know? If there is anything more just ask.

I: Ok, according to your experience, what would you say would be a generalised demographic for, for the people that you have diagnosed with borderline personality disorder?

P5: well, that is difficult, uhm, well I don't think I could give you anything that is reliable, I would just see who was referred to me. Uhm,

I: ...ok...

P5: ... and that would mostly be, sort of white and coloured women, in the range of probably 19 to about 35, maybe 40. Ok, that didn't say much but said more or less who it was.

I: Well, the DSM has identified that there is a gender bias with regards to borderline personality disorder. What is your understanding of that? I mean, obviously there is other personality disorders like narcissists that are more associated with males.

P5: actually my answer to the previous question could be generalised to everyone who was referred to me, they would fall into that category. Most people who were referred to me, probably about 60, 65 percent fall in that category. Uhm, say again the other personality disorder?

I: Well, there is a tendency to assume that narcissistic personality disorder and anti-social personality disorder are mostly associated with males while borderline and histrionic is mostly associated with females. I'm wondering what is your understanding of that. Is there something intrinsically female behaviour, is it (registered) that way or do you think that there could be other factors?

P5: well, I think a lot depends on how you define symptoms and, ehm; ultimately we're going to guess how people will really feel inside and what moves them to do what they do. And, ehm, I think different people express themselves differently, to a

certain extent, and you shouldn't quote me but I think Freud said- 'Anger is depression turned inwards'. 'Depression is anger turned inwards' sorry. So, you might find that one person expresses whatever discomfort they have in the form of anger at the world. Or another person who might have the same impulses, the same feeling states might express it as withdrawal, beating themselves up or drinking and that sort of thing. So, I think these things are, I don't know, we wouldn't know exactly what they thinking, or what they're feeling. But I suspect that it's possible that people might have similar discomfort, if you want to call it that, it drives them to express themselves in certain modes. And it's not impossible to say that anti-social and Narcissistic behaviour is another way of doing that. But I mean, ja obviously everyone says that women are borderline and men are antisocial. It's also weird, in the forensic unit, way back, a man, who was no doubt in my mind borderline, absolutely. And I saw a woman in therapy once who was definitely antisocial. And it was quite clear in terms of the diagnostic criteria, and in those days I was quite rigid in terms of categories and so on.

I: But even you saying that points out that you were taken aback or that it was out of the ordinary for you to diagnose that across the gender...

P5: Hmm, I knew for a fact, because I was an intern then, and I knew for a fact that I'm going to be questioned purely because I would say that. And I knew that I had to be able to justify, and I was expecting that and it obviously happened. Because the man was a case conference and... And some people still thought that he was antisocial and, but most agreed that he was borderline.

I: there seems to be a tendency to understand borderlines as difficult kind of clients, difficult patients by most mental health professionals, certainly about the difficulties they do experience. What do you understand around that, what do you think is the kind of difficulty. Obviously there is a case by case approach, but the category borderline personality disorder is spoken in a kind of pejorative way. Where do you think that emanates from?

P5: well, I think we have diagnosis for different reasons. One, I would like to believe, which is sort of central to it, is to guide management. Uhm, so, ehm ... Ideally, if it doesn't make it understandable, if it doesn't guide our management of certain patients and certain pathology, then ideally we shouldn't diagnose. But I think there's other reasons as well, and some of them are to protect us. And, ehm, it's a bit like stereotyped, a bit like discrimination. There's probably, and it sounds like a cliché but there's something probably to it otherwise people wouldn't use it, and use it and use it until it loses its meaning. I think we often, well I think it happens, we should guard against that in our profession. We keep using these words which could be a racial slur or something. But it becomes a bit of a cliché and we then stereotype and we do that not because we have sinister intentions necessarily but to have short-cuts to make things easier for us to understand. Perhaps it is just easier to believe that all taxi drivers are chaotic drivers or women drivers are worse drivers. Obviously we feel that this is not right and we can question that and all this. But why do we have these things? Where does it come from? Why do people believe that? It seems very nice for us to sit in an academic environment and say 'ooh, it's bad. People shouldn't speak like that.' But the tail is wagging the dog there. It is not for us to impose what we feel is right or wrong. Our job is to go into the world with certain humility and report what

we encounter there. We can form our own opinion of that but regardless of whether we believe its right or wrong, this is what is out there. And we have to deal with it as therapists. So, obviously we talk about personality disorder, borderline personality disorder. It's something we impose. People don't come with their own label. If they come with a label it means somebody else already gave it to them. And different people have different reasons for doing so. Some to inform their management and others because it protects them in a way. Because if you do that you can approach it either by saying 'well, I'm going to prove to the world that I can do something for borderlines' – which says something about my intentions. Or it says 'Well, I know that I'm going to have my defences up because obviously this person is going to try and abuse me in some way or the system. Or I'm already exempting myself from responsibility in terms of prognosis.' So if she has a very poor prognosis, and she don't make it you can say, "Oh, but it's a borderline"

I: You used the word label now and the idea of labels. But borderline personality disorder carries quite a pejorative tone to it. And it comes across as a controversial diagnosis in the literature with many authors suggesting, turning towards a more type of chronic PTSD kind of understanding because of the propensity of sexual abuse that has been identified. What would your understanding or what would you think the impetus behind that would be to change the diagnosis.

P5: I think again that is to inform the management. If you feel more comfortable working with a kind of PTSD type of model and if you feel that this type of lens would help with diagnosis in achieving that, then you would tend to lean more towards towards that. For myself, since anonymity is assured, I don't particularly go for diagnosis any more. I'll say this in this context as it is a different context than where I work. And there in terms of management, I sometimes have to do it. Obviously if I supervise I will make sure that. If I see people therapeutically, I see helpless or difficult or full of shit people. And I deal with it accordingly. To me it's a little bit easier to understand the individual in that way. And nothing to do with a particular diagnosis. Because obviously if we say this is the diagnosis, this is the label we use, then that implies a certain approach to that. and I'm quite comfortable to work with a very loose definition. And to, ehm, for the management to be informed by what develops during the therapeutic process, rather than to be guided by a more structured approach. Which I think is very useful. I just cannot work like that.

I: It is, was it problematic or was it just something you chose to do differently?

P5: Ja, it's just something that for me works better. Personally the way that I would approach things is from a sort of phenomenological perspective. And the way that I understand it and the way that I try to work with that is to let people define their own difficulty. So let's say this is what brings them to us, some difficulty, something that's not working for them, and I feel more comfortable with them defining that than me defining on their behalf. There's a very subtle, condescending attitude that I don't feel comfortable with. With that I'm not saying that all structural approaches don't work. It just doesn't work for me.

I: Is there any thing else that you would like to say that I didn't ask you?

P5: Well, just in terms of that, I think it also lends to a different prognosis. If I let a person allow to define their discomfort, for lack of a different word, then I'm not expecting to get it right or to fail or to give up.

I: So it opens it up, makes it more flexible.

P5: It makes it more flexible, but I also makes it more difficult because there is heaps of uncertainty that goes with that and ambiguity. And not everyone responds well to that. and I really try to always structure my practice so that I have enough of a referral network to therapist very different than me. And if I believe that it's not going to be a good match or this patient might not have much of a prognosis with me, then I refer them on. And I inform them of that in the first session, and will review that from time to time.

### Appendix B- Consent Form

I (participant's name) \_\_\_\_\_ agree to participate in the research project of Clair Elphick on the exploration of discourses deployed when reflecting of the Borderline Personality Disorder diagnosis.

I understand that:

- The researcher is a student conducting research as part of the requirements for a Masters degree at Rhodes University.
- The researcher is interested in the discourses employed by mental health professionals in relation to the diagnosis of Borderline Personality Disorder.
- My participation will involve a 30 minute interview with the researcher.
- I will be asked to answer some questions concerning the nature and understanding of Borderline Personality Disorder.
- I am invited to voice to the researcher any concerns I have about my participation in the study and to have these addressed to my satisfaction.
- I am free to withdraw from the study at anytime however I commit myself to full participation unless some unusual circumstances occur or I have concerns about my participation which I did not originally anticipate.
- The report on the project may contain information about my personal experiences, and attitudes but the report will be designed in such a way that it will not be possible to be identified by the general reader.

Signed on:

Participant:

Researcher:

Witness:

