How women diagnosed with Borderline Personality Disorder negotiate identity in relation to risk

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Abstract

This thesis examines how women with a diagnosis of borderline personality disorder (BPD) negotiate their identity in relation to risk, also referred to as their ‘risk identity’. This is defined as, ‘...the view people have of themselves and project to others in their talk and actions in relation to risk and risk taking’.

The theoretical perspective which underpins the study is informed by ontological realism, epistemological discursive/linguistic social constructionism, and an ideological critical liberatory position primarily derived from the work of Foucault (1978; 1991a; 1991b; 1998; 2002; 2008a; 2008b; 2009). This perspective informed the decision to adopt email interviews as a method for generating appropriate texts for analysis. Eight women diagnosed with BPD were interviewed over a period of ten months.

Adopting a critical emancipatory methodology which incorporated feminist principles of research, Lather’s (1991) adaptation of Van Maanen’s (1988 cited in Lather 1991) ‘four tales’ was employed to view and analyse the texts from four theoretical perspectives; a ‘Realist Tale’, a ‘Critical Tale’, a ‘Deconstructivist Tale’, and a ‘Reflexive Tale’.

By ‘layering’ these tales, the findings revealed sets of tensions discernable within the context of interactions with staff, the nature of services, and the wider material and discursive resources at play which inform how risk identities are negotiated. Converging Western discourses of the subject, binary gender discourse, neoliberal discourse, ‘psy’ discourses, and discourses around motherhood were found to be key discursive resources through which risk identity is produced, resisted and projected.

In addition to these broad discursive findings, the study also contributes to the existing empirical literature that focuses on the lived experience of those with a BPD diagnosis.

A conclusion is drawn that women with a BPD diagnosis not only receive a label which discursively excludes them from being able to be viewed as a ‘good subject of psychiatry’ (and hence leads to them being viewed as dangerous and risky), but that their difficulties and need for relational approaches to manage risk and promote recovery run counter to the way that mental health services are structured in the current neoliberal era.
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Declaration

I declare that the research contained in this thesis, unless otherwise formally indicated within the text, is the original work of the author. The thesis has not been previously submitted to this or any other university for a degree, and does not incorporate any material already submitted for a degree.

Signed

Dated 29th August 2017
Chapter 1 Introduction

My aim in this opening chapter is to introduce the reader to my study. To achieve this, orientation will be given as to my professional background, the risk-dominated culture of modern mental health services, the women subject to the diagnosis of BPD and the historical background and working definitions of the key concepts of BPD, identity and risk. Once these details are delineated, the chapter will conclude by formally stating the purpose, overall aims and objectives of the research.

Before undertaking this task, it is first necessary to introduce the reader to the style in which this thesis is written since, as will be seen, this is key to the overall rigor of the undertaking and is firmly rooted in my theoretical position.

Writing style
Throughout the thesis I will utilise the first person pronoun on the understanding that the implication of detached objectivity rooted in traditional positivistic research writing is not only an epistemological impossibility but also a means by which power, in the Foucauldian sense of ‘power/knowledge’ (Foucault 1991a), hides its operations within discourse. As an imperfect gesture towards an openness as to the necessary and unavoidable biases that frame my exploration of the research themes and the investments I have in producing knowledge, I deliberately insert myself into the text of the thesis following the principles of reflexivity embedded in reflective research. As Alvesson and Sköldberg (2000) characterise reflective research:

“Reflective research has two basic characteristics: careful interpretation and reflection. The first implies that all references – trivial and non-trivial – to empirical data are the results of interpretation. Thus the idea that measurements, observations, the statements of interview subjects, and the study of secondary data such as statistics or archival data have an unequivocal or unproblematic relationship to anything outside the empirical material is rejected on principle ... The second element, reflection, turns attention ‘inwards’ towards the person of the researcher, the relevant research community, society as a whole, intellectual and cultural traditions, and the central importance, as well as problematic nature, of language and narrative (the form of presentation) in the research context” (ibid pp5-6).
Mental health nursing as a profession

The professional role of a mental health nurse in the UK is defined by the Nursing and Midwifery Council (NMC), the statutory body established in 2002 by Parliament as the regulator for the nursing and midwifery professions. Whilst the NMC Code of Practice sets out general ‘standards of competence’ applicable to all nurses and midwives under the four areas of professional values, communication and interpersonal skills, nursing practice and decision making, and leadership, management and team working, it also provides specific standards for each branch of nursing under these headings. For mental health nurses, it gives the following guidance for each of the competences:

Professional Values
"Mental health nurses must work with people of all ages using values-based mental health frameworks. They must use different methods of engaging people, and work in a way that promotes positive relationships focused on social inclusion, human rights and recovery, that is, a person’s ability to live a self-directed life, with or without symptoms, that they believe is meaningful and satisfying”.

Communication and Interpersonal Skills
"Mental health nurses must practice in a way that focuses on the therapeutic use of self. They must draw on a range of methods of engaging with people of all ages experiencing mental health problems, and those important to them, to develop and maintain therapeutic relationships. They must work alongside people, using a range of interpersonal approaches and skills to help them explore and make sense of their experiences in a way that promotes recovery”.

Nursing Practice and Decision Making
"Mental health nurses must draw on a range of evidence-based psychological, psychosocial and other complex therapeutic skills and interventions to provide person-centred support and care across all ages, in a way that supports self-determination and aids recovery. They must also promote improvements in physical and mental health and wellbeing and provide direct care to meet both the essential and complex physical and mental health needs of people with mental health problems”.

Leadership, Management and Team Working
"Mental health nurses must contribute to the leadership, management and design of mental health services. They must work with service users, carers, other professionals and agencies to shape future services, aid recovery and challenge discrimination and inequality”

(Nursing and Midwifery Council 2015 pp18-19).
If the above competences define and construct the role of, and expectations for, mental health nurses in the UK, discernible amongst the various competencies is a duel valuing of the importance of building ‘person-centred’ therapeutic relationships (with this rooted in the humanistic psychology of Carl Rogers [1995; 1999]), and of the importance of ‘evidence based practice’ (which is rooted in positivistic notions that is possible to have objective evidence and an unproblematic measurement of outcomes for interventions).

While person-centred approaches and evidence-based practice are dominant strands defining the profession at the present time, historically this has not always been the case. Prior to the instigation of the asylum system after 1845 when the term ‘attendant’ was chosen to describe the role of those charged with the ‘care’ of people deemed mentally ill, individuals fulfilling such a role who owned or ran the private houses where the ‘mad’ were kept were known as ‘keepers’, the term, as Nolan (1998) points out, implying that:

“...those who looked after the mentally ill both restricted access to them and controlled the movements of patients in the same way that zoo-keepers and game-keepers controlled animals and game” (ibid p6).

During the years of the asylum, which spanned much of the twentieth century until the beginnings of ‘care in the community’ in the 1980s, attendants, whose role it was to attend to the day-to-day administrative needs of the institution, to undertake the ‘care’ of the patients, and to action the orders of the doctors, gradually took on the mantle of ‘nurse’, first applied to female attendants and later to males (ibid).

Formal psychiatric nursing education and admission to a professional nursing register began in the early 1900s. From the outset, psychiatric nursing knowledge was rooted in bio-medical approaches (ibid), however, over the course of the century following the rise of psychoanalysis and psychology, psychodynamic and, later, behavioural psychology theory and practice were also incorporated (ibid).

By the time I trained as a mental health nurse in 2001, the curriculum reflected this broad church of professional knowledge. Biological, psychodynamic, cognitive behavioural, and humanistic person-centred approaches, to name just four theoretical stances, contested amongst themselves and contributed to the professional culture into which I was inculcated.
Risk and the modern mental health services

The task of supporting people experiencing mental health problems in the UK through ‘compassionate therapeutic relationships’ and the utilisation of ‘evidence-based therapeutic interventions’ is presently conducted within a multidisciplinary framework known as the Care Programme Approach (CPA), a framework which, “…is a way that services are assessed, planned, coordinated and reviewed for someone with mental health problems or a range of related complex needs” (NHS.uk 2016 no pagination).

The CPA was developed in response to the Spokes Inquiry into the murder of social worker Isabel Schwarz in her office in Bexley psychiatric hospital by patient Sharon Campbell in 1984. Identifying that the murder could have been avoided had there not been a breakdown in the service delivery and communication around Sharon Campbell’s care, the Inquiry recommended that:

“…before discharge from in-patient treatment, a plan should be prepared for a psychiatric patient. The plan should set out the proposals for community care and the time when the plan will come up for review…” (Department of Health and Social Security 1988 p16).

Amid widespread and largely inaccurate media discourse and constructions of those deemed to be mentally ill as being dangerous and violent (Paterson and Stark 2001), to meet the Spokes Inquiry recommendations, the CPA was introduced in 1991 as a means of organising care but also of managing risk. Over the intervening years, risk assessment and management has come to dominate mental health service provision. As Langan and Lindow (2004) noted over a decade ago:

“What is striking, when looking back over the past decade of mental health policy, is the ever increasing focus on risk, and particularly risk to other people. There was no mention of risk at all in the circular introducing the Care Programme Approach (CPA) within England (DOH, 1990). Since then, mental health services users have become increasingly defined in terms of the risk that they are seen as presenting rather than in terms of their needs and rights, despite consistent research evidence (Steadman et al, 1998: Langan, 1999) that people defined as mentally ill make either no or minimal contributions to violence” (ibid p2).
In addition to this tendency to equate mental health difficulties with dangerousness and the ‘blame culture’ that exists within mental health services characterised by fear of litigation (Morgan 2000), Langan and Lindow also highlight the impact of constructing all risks as manageable and preventable, suggesting that this creates a climate that inhibits more positive and collaborative ways of working with service users in regard to risk and recovery, i.e. ‘positive risk taking’ approaches.

‘Positive risk taking’ has been defined as, “…making good quality clinical decisions to support and sustain a course of action that will lead to positive benefits and gains for the individual service user” (Morgan 2000 p49). Focusing on the service users’ strengths, the quality of relationship between service users and their carers, and being recovery focused (Department of Health 2007), positive risk taking represents a strand of risk management within mental health service provision that potentially stands in tension with the prevailing negative, risk averse culture.

While there is positive risk taking discourse within mental health services, the aforementioned negative climate continues to pull in the direction of risk averse practice and there is arguably a danger of the listing of the strengths of service users being, as Morgan (2008) warned, mere lip-service paid to actually working with said strengths and reducing overly restrictive risk management practices.

Over the course of the decade since Langan and Lindow’s (2004) characterisation of mental health services as a risk dominated culture, a period during which I practiced positive risk taking as a mental health nurse within a therapeutic community dedicated to meeting the recovery needs of women described as having ‘complex and challenging mental health needs’, my impression has been that the negative focus on risk which they describe has only intensified.
Women with ‘complex and challenging’ mental health needs and borderline personality disorder

The female residents I encountered within the therapeutic community had complex needs, stemming primarily from histories of childhood and adult abuse. Varied in social background but similar in terms of their histories of trauma, their distress and subsequent behaviours could be challenging to both themselves and to the staff team. Whilst the diagnoses ascribed to these women included psychotic illnesses such as schizophrenia and bipolar disorder, the vast majority of women that passed through the community had been diagnosed with BPD.

Suicidal and para-suicidal behaviour, high expressed emotional distress or self-directed hatred and rage in the form of self-harm, and interpersonal difficulties were common presenting problems but were generally successfully managed via the ward’s therapeutic milieu.

Whilst supporting the women in their distress characterised the work undertaken by staff and residents within the community, there is a need to balance this portrait of distress and conflict by acknowledging the fun times that were had by residents and staff alike. The residents had demonstrated their robustness though the sheer feat of surviving their pasts, and were often a joy to be around as they joked, shared their experiences, and supported one another with care and insights into their situations.

Borderline personality disorder

According to Linehan (1993), the term ‘borderline’ was first introduced by the psychoanalyst Adolf Stern in 1938 and was used to describe patients whose presentations posed challenges to traditional psychoanalytic methods and whose difficulties refused to fit neatly within the classic ‘neurotic/psychotic’ psychiatric classifications. These difficulties were thought to resemble the perceptual and cognitive presentations of psychotic disorders but not to the degree to which such categorisation would be appropriate.

Following Stern, ‘borderline’ was adopted and used colloquially by fellow psychoanalysts to describe a heterogeneous group of patients who didn’t respond well to traditional psychoanalytic treatment despite indications of positive prognoses and who, when engaging in therapy, provoked the deterioration of the emotional state of both themselves and the therapist (ibid).
BPD formally entered medical psychiatric discourse in 1980 with its inclusion as a specific psychiatric condition in the American Psychiatric Association’s Diagnostic and Statistical Manual 3rd edition (DSM-III). Having achieved ‘legitimacy’ through translation from psychoanalytic nomenclature into the terminology of the psychiatric medical establishment, the diagnostic label quickly became widely applied, and by 1984 became the most frequently diagnosed personality disorder (Gunderson and Zanarini 1987).

BPD is classed as a ‘personality disorder’, i.e. where the individual is thought to have:

“[an] enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment” (DSM-V 2013 p645).

The DSM-V identifies a number of characteristics (see Appendix 1) that enable clinicians to make a formal diagnosis of BPD. Represented within these characteristics are features pertaining to both risk and identity. For example, in relation to risk, the DSM-V identifies the following:

“Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating) ... Recurrent suicidal behavior, gestures, or treats, or self-mutilating behavior ... Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)” (DSM-V 2013 p663).

With regard to identity, the DSM-V identifies: “Identity disturbance: markedly and persistently unstable self-image or sense of self ... chronic feelings of emptiness ... severe dissociative symptoms” (ibid).
BPD has been one of the most studied personality diagnosis over the past thirty years (Zhong and Leung 2007) although little has been researched into the lived experiences of those so diagnosed (Fallon 2003). As will be explained in the upcoming Theoretical Perspective chapter, my ontological, epistemological, and ideological stance led me to focus on the critical literature. This broadly argues, by way of explaining why women make up around 75% of those diagnosed (DSM-V 2013 p666), that the diagnosis reflects moral and cultural assumptions about gender, i.e. social constructionist arguments, whilst obscuring the reality and nature of women’s oppression under patriarchy, i.e. social causation arguments (Wirth-Cauchon 2003). These two arguments are interwoven within the critical literature to show how women’s oppression both makes them more vulnerable to distress, and how this distress is then pathologised within the sociocultural and sociohistorical context of gender norms.


Within her critique, Wirth-Cauchon focusses on the notion of ‘unstable selfhood’ arguing that, rather than BPD being a real underlying pathology, attending to the discursive history of the concept reveals the diagnosis to be the product of shifts in psychiatric discourse, whereby, “…the borderline category [being] ambiguous and contradictory, [is] frequently applied to the patient who is socially deviant or marginal” (ibid p38).

She explores the role that relationships between conceptions of selfhood, madness, and femininity play in the construction of the fragmented and dysfunctional self that is produced within the discourse of BPD. In so doing, she delineates the ‘feminisation of the borderline’, i.e. the role that gender plays in the genealogy of the concept of borderline, incorporating the links between sexual abuse and diagnosis, and more broadly (given that histories of sexual abuse are not always present in those diagnosed with BPD), looks at the role of gender norms in the assignment and identification of pathology. In addition, she also examines the positioning of women within the wider cultural symbolic order in relation to the diagnosis.
With regard to the former, drawing on Herman’s (2001) work, Wirth-Cauchon acknowledges the high incidence of sexual abuse in the histories of those diagnosed, noting both how many of the ‘symptoms’ of BPD are comprehensible given the effects of such trauma, and how the pathologisation of such displays of distress as indicative of a personality disorder obscures the reality of male violence against women and children.

Later detailing how the predominantly male medical profession has consistently failed to hear the abuse stories of such women, rendering their distress as attributable to their unstable selves, Wirth-Cauchon illustrates the obscuring impact of BPD by quoting one of Herman’s (2001) patients:

“Having that diagnosis [BPD] resulted in my getting treated exactly the way I was treated at home. The minute I got that diagnosis people stopped treating me as though what I was doing had a reason” (ibid p69).

Herman, when examining the treatment by mental health services of women who have survived childhood sexual abuse, argues that the traumatic effects of such experiences are often constructed as either somatization disorder, multiple personality disorder, or BPD. As Herman writes:

“Patients, usually women, who receive these diagnoses evoke unusually intense reactions in caregivers. Their credibility is often suspect. They are frequently accused of manipulation or malingering. They are often the subject of furious and partisan controversy. Sometimes they are frankly hated. These three diagnoses are charged with pejorative meaning. The most notorious is the diagnosis of borderline personality disorder. This term is frequently used within mental health professions as little more than a sophisticated insult” (ibid p123).

Whilst the poor treatment of those subject to the BPD label will be further ‘fleshed out’ in the literature review, other writers have also contributed, from a critical social constructionist/feminist perspective, to uncovering the links between BPD and the now defunct diagnosis of hysteria.
Wirth-Cauchon delineates Becker’s (1997) argument that BPD effectively replaced hysteria as the quintessential female malady by pointing to the mutability of symptoms that both conditions exemplify through their historical development. Hysteria, Becker argues, initially focused on hysterical seizures/fits, but went on to become a ‘catch all’ diagnosis, backgrounding seizures/fits whilst expanding to incorporate and foreground a wide variety of stereotypically ‘female’ behaviours.

Similarly, BPD’s initial focus on transient psychotic symptoms and cognitive distortions shifted over the years to ‘downplay’ these symptoms whilst expanding to incorporate a wide variety of ‘feminised’ symptoms, with particular focus given to emotions such as rage, emotional dysregulation, depression etc.

In both cases, Becker notes how the diagnoses became heterogeneous in regard to symptoms, unable to describe a single unitary diagnostic entity: “As is true in the case of the “borderline” women, many of the women diagnosed “hysterical” looked very different from other women carrying the identical diagnosis “ (ibid p20).

This heterogeneity can be regarded as undermining the scientific validity of both diagnoses, in that valid scientific categories ought to delineate a specific phenomenon from which predictions can be made (Bentall 2004). The differences between BPD and hysteria in terms of symptoms, however, are also revealing.

Wirth-Cauchon draws on Jimenez’s (1997 cited in Wirth-Cauchon 2003) work to illustrate how the differences between hysteria and BPD reflect the changes in the cultural norms for feminine behaviour between the nineteenth century and mid to late twentieth century. Jimenez argues that the shifts in cultural gender norms during the 1960s and 1970s resulted in a revision of psychiatric norms for what constituted appropriate female behaviour. Increased vocalisation of female anger and increasing assertiveness became reflected in the borderline patient being constructed as a, “...demanding, aggressive, and angry woman” (ibid p73), with anger and assertiveness constructed as inappropriate and/or excessive.
More broadly, the diagnostic criteria employed for BPD have been critiqued as an expression of a ‘double-bind’ of feminine identity whereby, “...no matter what a person does... [she]... ‘can’t win.’” (Bateson 1972 p201), with women being positioned as disordered by either conforming too closely, or not closely enough to gender norms. For example, Shaw and Procter (2005) note in relation to anger that:

“In the case of BPD, the diagnosis can be applied to women who fail to live up to their gender role because they express anger and aggression, which is unacceptable for women in this society. Conversely, the diagnosis is also given to women who conform ‘too strongly’, by internalising anger, and expressing this through highly stigmatised, self-focussed behaviour and self-injury” (ibid p484).

Ultimately, Jimenez argues that the construction and application of the diagnoses of both hysteria and BPD are moral judgements rooted in gender norms and expectations of appropriate behaviour for women. Noting that psychiatric interest in hysteria diminished as BPD as a diagnosis took hold, she asserts that: “Borderline personality disorder replaced hysteria as the diagnosis that captured contemporary values about appropriate behaviour for women” (Jimenez 1997 cited in Wirth-Cauchon 2003 p72).

Wirth-Cauchon moves to look beyond gender roles and patriarchal violence in her analysis of the feminisation of the BPD label, examining the cultural symbolic order itself. She explores how women are positioned as unstable, detailing the links between the very positioning of feminine subjectivity to the construction and application of the label. She articulates feminist arguments which assert that the category of ‘woman’ is inherently an unstable construction given its relationship to the masculinised Western construction of what constitutes the universal subject, a subject position that necessarily ‘Others’ women.

Following other feminists in using Levi-Strauss’s theory of how the exchange of women by men in marriage ascribes to them the status of a commodity of exchange (i.e. women assume the subject position of a gift that is given, contrasted with the masculine subject position of being one who exchanges), Wirth-Cauchon notes that women are, “...located in the interstices of social exchange, off-centre from subjecthood, serving as the medium of exchange between subjects” (ibid p81).
She moves on to delineate the implications of such theorising through the work of de Beauvoir (2009), Butler (1997; 2004; 2007), Kristeva (1995), Irigaray (1985) etc., noting that the positioning of women as ‘Other’ within the symbolic order constructs them as inherently lacking the qualities of the ‘masculinised’ subject which has stood at the centre of Western epistemology, i.e. characteristics such as stability, self-definition, unification, and autonomy.

In terms of the implications that such considerations have for BPD, Wirth-Cauchon situates the diagnosis, with its attendant stresses on instability of self, against the complex relationship between selfhood and subjectivity and women within the symbolic order. The inherent marginality of women is glossed over within psychoanalytic and psychiatric contexts, as the unproblematised norm of the male subject is wielded as the yardstick by which women are measured and found pathologically wanting (henceforth, I shall follow Wirth-Cauchon in referring to such yardsticks as ‘regulatory ideals of the subject’). Disorder is again localised within the individual woman and the gendered nature of the normative subject by which she is judged is obscured, along with the sociohistorical context of the distress.

**Defining borderline personality disorder**

When defining BPD, it is first necessary to note that Europe has its own diagnostic manual for mental disorders, i.e., The World Health Organization’s ICD-10, and a broadly equivalent diagnosis of ‘Emotionally Unstable Personality Disorder (borderline type)’ (EUPD). My rationale for utilising BPD over EUPD within this research project reflects its dominance as a diagnostic term on both sides of the Atlantic, as evidenced by its use in the majority of research studies, popular self-help books, and by public bodies such as the UK’s National Institute for Clinical Excellence (2009), among other examples.

As to the reason why the term BPD has become dominant, I would suggest this reflects the influence and power of the DSM and the American Psychiatric Association. As an NHS Choices news article of the 15th August 2013 noted in relation to the importance of the DSM-V for the NHS (despite its formal use of the WHO ICD-10):
“It [the DSM] helps set research agendas, brings conditions into the public eye and influences clinical guidelines. Previous versions of the DSM were arguably responsible for making certain conditions better known in the UK, such as attention deficit hyperactivity disorder and borderline personality disorder” (NHS.uk 2013).

As it is the constructive effects of the diagnosis that interest me, I shall define BPD by employing the diagnostic criteria of the DSM-V (see Appendix 1). My employment of this definition, however, does not indicate a commitment to its validity. In accordance with the social constructionist/feminist critiques of this label presented above, I assert that it represents an interest-driven social categorisation rooted in moral and cultural assumptions, rather than an objective value-free classification of an underlying psychiatric condition.

Identity
Sass (1992) identifies that:

“One of the most fundamental presuppositions of contemporary Western society and thought is that each individual has some kind of inner being or personhood existing apart from or prior to his or her actions or social roles” (ibid p98).

He goes on to note, however, that these conceptions are, “...far from universal, being absent not only in traditional societies of the non-Westernized world but also in the West prior to the modern age” (ibid).

Whilst ‘identity’, and concepts closely associated with it such as ‘soul’ and ‘self’, have a long history, stretching at least as far back as Classical Greek civilization (Martin and Barresi 2006), the modern Western constructions characterised by Sass have identifiable roots in historical developments emerging from the Renaissance onwards (Benwell and Stokoe 2009). I shall briefly note these developments before stating my own position and rendering a definition.
The Enlightenment of the seventeenth century can in part be characterised by the emerging humanistic faith in the authority of human reason and the scientific method over the religious authority characteristic of the pre-modern. In terms of identity, the work of the rationalist philosopher Descartes (1968) and empirical philosopher Locke (2014) stand as significant conceptual turning points, with their assumptions and epistemological reasoning continuing to influence current renderings of identity both in academic and popular discourses. Through Descartes’ championing of the foundational role of disengaged reason in his ‘Cogito’, and Locke’s claim that, “...since consciousness always accompanies thinking, and it is that which makes every one [sic] to be what he calls self ... in this alone consists personal identity” (ibid pp316-317), a notion of identity founded on ‘inwardness’ (as opposed to that found in relation to an external God or metaphysical system) opened up a conception of the self as sovereign, reflexive, and instrumental, with identity construed as relating to rational self-determination and agency (Taylor 2000).

The Romantic Movement of the late eighteenth century contributed to our modern understanding of identity though its rejection of some elements of the Enlightenment rendering of the self. With the Romantics, emphasis was placed on feelings and sentiment rather than thought; identity was viewed as the expression of a true authentic self, discoverable within our ‘inner’ impulses and convictions, with one’s moral duty being to fulfil one’s own unique destiny. As Blake (1975) wrote by way of illustrating this emphasis: “Sooner murder an infant in its cradle than nurse unacted desires” (ibid plate 10).

Whilst this rendering of identity contributed to the modern construction of the self, albeit emphasising emotion and desire over thought and rationality in pursuing personal improvement through self-fulfilment, the impact of the romantic conception of self and identity can be seen to have influenced the existential philosophy of the mid twentieth century. Its influences can then be seen in humanistic psychology and current popular ‘self-help’ guides, in which the self is viewed as a project that the individual can ‘work upon’ though rational free choice and agency (Martin and Barresi 2006).
The rise of psychoanalysis in the late nineteenth century and later, throughout the twentieth century, and the growth and development of disciplines such as psychology, sociology, linguistics etc., heralded the beginning of a diversification and specialisation with regard to the meaning of identity (Benwell and Stokoe 2009). Whilst this progression was shaped by the Enlightenment and Romantic essentialist renderings of the self, the undermining and suspicion regarding the possibility of a ‘transparent’ subjectivity and the attendant need for expert interpretation/analysis arising out of psychoanalytic, psychological, and psychiatric disciplines, and the emerging focus on the impact of the social production of identity within the developing social sciences, all contributed to the diverse discourses of self and identity we encounter in the present era (ibid).

My own positioning on identity has been informed by the fragmented, anti-essentialist rendering of self and identity characteristic of the ‘linguistic turn’ in academia which emerged in the late twentieth century. Whilst arguably, philosophically, the roots of this conception of self can be traced back to Nietzsche in the late nineteenth century, who wrote, “...there is no ‘being’ behind the deed, its effect and what becomes of it; ‘the doer’ is invented as an afterthought, - the doing is everything” (Nietzsche 1994 p28), writers such as Foucault (2002), Derrida (1997) and Butler (1997; 2004; 2007), have critiqued the dominant renderings of the subject rooted in the theoretical shifts noted above, arguing that self and identity are produced by sociocultural and sociohistorical forces rather than having some essential interior ontological status, i.e. that identity is an, “...unfinished product of discourse” (Benwell and Stokoe 2009 p30).

Whilst these arguments will be detailed further in the upcoming Theoretical Perspective and Methodological Approach and Methods chapters, at this stage I should inform the reader that I adhere to the notion that identity is the product of an engagement and negotiation with discourse, i.e., that our sense of who we are is both produced and constructed out of the available discursive resources which our culture affords.
Defining identity

Benwell and Stokoe (2009) note that:


Identifying that some of the terms they discuss are linked to specific theoretical traditions, due to the interchangeability of said terms and lack of overall theoretical agreement across traditions, they employ the tactic within their own work of regarding identity in its broadest sense, adopting the particular term utilised by a specific theory when discussing that theory.

Confronted with the same multiplicity of terms, and being mindful of not wishing to confine myself to, or identify myself with, any particular scientific discipline, following Benwell and Stokoe’s example, I shall define identity in its broadest and least technical sense. In so doing, my aim is to avoid becoming ‘bogged down’ in the classificatory mire whilst still being able to employ the term meaningfully.

For the purpose of my research project, then, I define ‘identity’ as, ‘the view people have of themselves and project to others in their talk and actions’. Consistent with my theoretical standpoint, my understanding is that this does not represent some essential stable or unified rational agent but instead represents a discursive construct. Again following Benwell and Stokoe’s example, I will adopt the terminology of identity utilised by whichever specific theory I engage with ‘along the way’ as a pragmatic measure.

Risk

Lupton (2007) summarises the scholarly work on the genealogy of the term ‘risk’, tracing the shifting meaning from the medieval, through modernity and into the present. The origin of the term stems from medieval maritime usage, ‘risk’ denoting, “...the possibility of an objective danger, an act of God, a force majeure, a tempest or other peril of sea that could not be imputed to wrongful conduct” (Luhmann 1993 cited in Lupton 2007 p5).
In response to the increasing administrative needs of industrial capitalism heralded by the modern era, the term later took on predictive connotations as the mathematical sciences of statistics and probability developed in conjunction with the administrative and technological demands of the age (Lupton 2007). With the rise and expansion of the insurance industry during the eighteenth and nineteenth centuries, the meaning of risk expanded to include, not only consequences for individuals, but, as Beck (1992 cited in Lupton 2007) explains:

“...systematically caused, statistically describable and in that sense “predictable” types of events, which can therefore also be subjected to supra-individual and political rules of recognition, compensation and avoidance” (ibid p6).

The concept of risk, then, expanded from referring to consequences that can happen to someone or something, to consequences that fall within the remit of positivism. Towards the end to the nineteenth century, ‘risk’ began to be located within society itself, i.e., within individual subjects and their social relations, and not merely within the natural world (Lupton 2007). ‘Risk’, therefore, becomes ‘governable’ within technical predictive practices at this point. Lupton identifies this as the ‘technico-scientific’ understanding of risk, and it is this positivistic rendering of risk which underscores and dominates contemporary mental health services’ conceptualisations and operationalisations of psychiatric risk in relation to assessment and management.

Whilst I do not deny that statistical approaches to risk play an important role, as the reader will now be aware, in terms of psychiatric risk management, further critical social constructionist renderings are necessary for my analytical aims.

Alongside the dominant technico-scientific discourse on risk, there are a number of sociocultural perspectives deriving from social science and philosophy which expand the analysis of the concept of risk beyond the positivistic remit of mere prediction and management. In order to briefly describe them, I shall focus on the main exponents of each position and follow Lupton in organising them under the headings, ‘cultural/symbolic’ theories, ‘risk society’ theories, and ‘governmentality’ theories.
In presenting these further three theories of risk to the reader, whilst being mindful of the dominance of technico-scientific model, my intention is not to raise one theory above another as the definitive lens through which risk ought to be viewed, but rather to provide the reader with the various theoretical ‘takes’ on risk from which an exploration of risk including considerations of gender can draw. As Hannah-Moffat and O’Malley (2007) note:

“...by shifting the focus to questions of gender and risk ... the disputes between [the] various approaches to risk become of lesser concern, and the constructive possibilities of integrating them become apparent” (ibid p25).

The cultural/symbolic perspective on risk, first espoused and developed by Douglas (1970), posits risks as objective external realities, while focussing on how risks are perceived and judged, and how they are culturally and symbolically constructed via societal discourse. This discourse is aimed at managing anxieties stemming from defining differences at the margins between ‘self’ and ‘other’, i.e., between individuals, social groups and larger communities.

According to Douglas, these social anxieties can be understood as reflections of individual anxieties surrounding bodily boundary issues regarding purity and impurity, i.e., anxieties and fears surrounding the dangers associated with substances excreted from the body:

“...all margins are dangerous. If they are pulled this way or that the shape of fundamental experience is altered. Any structure of ideas is vulnerable at its margins. We should expect the orifices of the body to symbolize its specially vulnerable points. Matter issuing from them is marginal stuff of the most obvious kind. Spittle, blood, milk, urine, faeces or tears by simply issuing forth have traversed the boundary of the body. So also have bodily pairings, skin, nail, hair clippings and sweat. The mistake is to treat bodily margins in isolation from all other margins” (ibid p145)

Whilst Douglas’ work offers an early constructionist account of risk, her work has been criticised for valorising ‘expert’ risk knowledge over ‘lay’ risk knowledge, with her account deemed by said critics as therefore being unequipped to furnish a critical account of dominant risk discourses and open to accusations of presenting the powerful authorities who define risks, i.e., governments, scientific bodies etc., as neutral, objective and benign (Lupton 2007).
Whilst acknowledging these reservations, as a theory of risk, I would argue that despite its critical shortcomings, it still proves analytically useful when employed within the context of feminist thought. Kristeva (encountered in Wirth-Cauchon’s critical appraisal of BPD above), for example, adopts Douglas’s notion of the ‘abject’, i.e., that which has been, “…expelled from the body, discharged as excrement, literally rendered ‘Other’” (Butler 2007 p181) in her rendering of female subjecthood.

I would argue that Douglas’s rendering of risk as that which is marginal and her emphasis on the body resonates with the concept of the borderline and issues surrounding the body. The common practice of self-harming amongst those with a BPD diagnosis, for example, may raise risk related bodily boundary issues in terms of bloodletting through cutting and the insertion of foreign objects into the body.

Similar, in terms of incorporating both realist and social constructionist understandings of risk, but addressing and meeting the need for a critical analysis of expert risk knowledge, is the ‘risk society’ theory developed by Beck (1995; 2008).

Risk society theory describes the development of a new epoch within late modernity characterised by efforts to manage an increasing number of real, objective risks resulting from the technological processes of modernisation (e.g., climate change, disease, risks posed by nuclear technologies etc.). Due to the unforeseen negative consequences of modern technologies - which may take generations to become manifest - and their sheer number and complexity, Beck characterises the risk society as one defined by ever increasing uncertainty and unpredictability.

Governmental efforts to identify and minimise such risks, increasing public awareness of risk issues, and criticism of the governmental responses, thereby creates a society in which risk and uncertainty become dominant themes in both public and private discourse.
Examining why some risks are identified over others, i.e., why some issues are constructed as riskier than other dangers, whilst not denying the reality of these dangers in a realist sense, Beck argues that specific issues (for example, environmental causes, nuclear disarmament, genetically modified foods etc.) represent tangible symbolic expressions of illusory control, which provides some defence against the anxiety that accompanies a generalised, nebulous awareness of the background of increasing dangers. As he notes, such campaigning issues symbolically:

“...touch a cultural nerve and cause alarm, shattering and making comprehensible the unreality and hyperreality of hazards in everyday life, [they] gain a key significance precisely in the abstractness, imperceptibility and impalpability of the process of devastation kept alive by the advanced industrialism of hazards” (Beck 1995 p47).

Whilst this perspective may be useful in terms of contextualising the increasing centrality and emphasis of risk discourses in psychiatry within broader cultural historical trends, the abstract, ‘grand narrative’ nature of this theory does not lend much analytically concerning the local meanings of risk within mental health contexts for those subject to psychiatric discourse and risk management.

This conceptual need can arguably be addressed though Foucault’s (1978) concept of ‘governmentality’ (these theories will be explored further in the Theoretical Perspective chapter). By ‘governmentality’ Foucault means:

“The ensemble formed by institutions, procedures, analyses and reflections, the calculations and tactics that allow the exercise of this very specific complex form of power, which has as its target population, as its principle form of knowledge political economy, and as its essential technical means apparatuses of security” (ibid p102).

This perspective understands the identification and management of risk as one discourse amongst many, through which governing social institutions manage and control individual subjects. Risk governance therefore represents a form of social control and regulation. In addition, given Foucault’s (2008a; 2009) contention that subjects are produced through discourse, governmentality perspectives on risk also afford a perspective through which risk discourse can be viewed as potentially productive of the identities of those subject to it at a local, or ‘micro’ level.
Finally, and coming full circle to the technico-scientific underpinning of psychiatric risk management, from a governmentality perspective on risk, Castel (1991) has argued that ‘risk’ has eclipsed ‘dangerousness’ within psychiatric risk discourse. Whereas risk was once understood as a quality of dangerousness, i.e. the potential for a specific individual to act in an unpredictable aggressive way, this conception has been replaced by statistical probability renderings of patient populations, with the emphasis having changed from an identifiable danger located within an individual to the statistical probability seated at the conjunction of a number of abstract risk factors within patient populations. As Castel writes:

“*What the new preventive policies primarily address is no longer individuals but factors, statistical correlations of heterogeneous elements ... Their primary aim is not to confront a concrete dangerous situation, but to anticipate all the forms of irruption of danger*” (ibid p288).

For Castel, this shift heralds a new governmental expert technology of surveillance whereby the shift to the statistical calculations made of populations renders individuals as members of ‘risk groups’, the management of which is informed by standardised evidence based interventions developed from data/patterns derived from wider populations, as opposed to employing individualised approaches to risk management. The scope for intervention and governance thereby widens beyond the individual to the whole population. As Castel identifies:

“*...the shift from dangerousness to risk entails a potentially infinite multiplication of the possibilities for intervention. For what situation is there of which one can be certain that it harbours no risk, no uncontrollable or unpredictable chance feature?*” (ibid p289).

From this perspective, risk and risk management discourse represents another means by which liberal governments exercise control over populations utilising a complex web of power that involves technologies of surveillance, expert knowledges, disciplinary techniques, and processes of subjectification.
Defining risk and risk identity
Having acknowledged the fact that mental health services are increasingly preoccupied with risk, with the term itself coming to be associated in a negative sense with dangers rather than therapeutic opportunities (Petch 2001), it should also be noted that academics have identified a more generalised recent cultural shift in the term’s use, emphasising negative over positive meanings (Lupton 2007).

Whilst I define ‘risk’ as embodying the above meanings, positive connotations must also be acknowledged, as Parker and Stanworth (2005) note, “...risk-taking in everyday life can have positive meanings and occurs outside and alongside the risk-avoiding regimes typical of many formal organizations” (ibid p319).

In addition to the negative connotations associated with the term risk, my usage must also reflect the wider cultural meanings, including positive understandings, e.g., risk-taking as heroic, sexy, rebellious, etc., as these meanings also form cultural risk discourses.

When speaking about how those with a diagnosis of BPD negotiate their identity in relation to risk, in accordance with my earlier definition of ‘identity’, I shall speak of ‘risk identity’ as, ‘the view people have of themselves and project to others in their talk and actions specifically in relation to risk and risk taking’.

Research purpose and overall aims
The focus of my research and attendant research question and aims arose from my experiences working as a staff nurse supporting women with complex and challenging mental health needs during a period in which the established use of ‘relational security’, i.e., “...a way of relating [with patients] that increases feelings of safety rather than diminish them...” (Birch et al 2011 p295) and positive risk taking, was disrupted through the piecemeal imposition of more traditional forms of risk management, such as room searches, confiscation of ‘dangerous’ items, observations. The context of this change was the incorporation of the previously independent women’s service into a long established forensic service.
As I witnessed previously manageable risk situations become riskier due to what I began to suspect were the constructive effects of traditional psychiatric risk management on those subject to them, I identified the nexus of BPD, risk, and identity as a potentially fruitful area for study. The research question I formulated at that time and which drove my study was as follows: ‘How do women subject to the diagnosis of BPD negotiate their identities in relation to risk?’

The purpose and overall aims of the study were thus to explore how individuals subject to the diagnosis of BPD negotiated their identities in relation to risk, and how this impacted on their behaviours within the context of mental health services. My objectives were:

- To raise awareness amongst mental health professionals of the constructive effects of psychiatric discourse in the production of the identity of those subject to the diagnostic label of BPD in order to challenge dominant psychiatric discourse and problematise potentially oppressive practice.

- To offer recommendations for mental health professionals as to how risk management practice and, more broadly, mental health services might be improved, both in terms of reducing potentially oppressive practice and better managing risk.

- To raise awareness amongst those subject to the diagnostic label of BPD in order to contribute to their awareness of, and better equip them for, challenging oppressive practice and dominant psychiatric discourse.

- To contribute to the critical empirical literature around the diagnosis of BPD with a focus on the previously unstudied area of the risk identity construction of individuals subject to this diagnosis, thereby offering an original contribution to both to my profession’s knowledge base and to knowledge in general.
Chapter summary
Having orientated the reader to the project and given some historical and theoretical background to the key topics of BPD, identity, and risk, and furnished working definitions of each, I hope to have provided a grounding to the territory within which my research is situated. To further aid this orientation, the task now at hand is to detail the relevant research literature, in order to both explicitly detail what is already known about the area of BPD, risk, and identity, and to ‘make the case’ for the necessity of my specific project.
Chapter 2 Literature Review

Introduction
The purpose of this chapter is to introduce the reader to the existing empirical and theoretical research relevant to the project. This will take the form of specifying what is already understood and, through systematically reviewing this literature by way of a concluding summary, indicate the knowledge gap that justifies the research undertaking.

Search methodology
CINAHL (searching all databases), British Nursing Index, and PubMed databases were utilised to identify the relevant literature. Whilst a full list of the search terms used is provided in Appendix 2, a brief explanation needs to be given regarding the choice of ‘borderline personality disorder’ over ‘emotionally unstable personality disorder’ as a search term.

As one might anticipate given the dominance of BPD over EUPD (as discussed in the previous chapter), with particular reference to the role of the DSM in setting research agendas (NHS.uk 2013), employing the latter diagnostic term in the literature search only revealed a handful of studies, none of which were of relevance to my research area. As a consequence of this, ‘borderline personality disorder’ was used as my primary search term when seeking to identify relevant studies.

The research studies identified through searching the aforementioned databases were subject to the following selection criteria; studies which most closely resonated around the key themes of risk, BPD, and identity as they related to the ‘risk identity’ of those so diagnosed, and studies most in keeping with a broadly social constructionist methodology.

Whilst I believe the former criterion to be self-explanatory, the latter was used to assist in the exclusion of studies that explicitly and uncritically presented the objective existence of BPD as an ontological fact or framed ‘risk’ in relation to the more technico-scientific understandings (for example, studies that identified risk factors in developing BPD); both elements, as I discovered from my review of the literature, being more common, although not exclusive, to studies with positivist methodologies.
Potentially relevant research referenced within my group of initially identified studies was additionally used as a further indicator and the selection criteria delineated above were applied.

Whilst my literature review revealed no studies examining the specific topic of the construction of ‘risk identities’ by individuals diagnosed with BPD, the final section of studies relevant to my research area could be grouped under the following headings; BPD, self and identity; perspectives of those subject to the diagnosis of BPD; experiences of mental health services; staff attitudes and exclusionary practices in relation to BPD; governmentality research in relation to BPD; risk and identity and BPD risk and identity. These headings are used below to present the review of the literature.

**BPD, self and identity**

Qualitative studies into self and identity of those with a BPD diagnosis are relatively new and, like the majority of quantitative studies examining this topic, tend to focus on identity disturbance. Whilst the broadly non-critical assumption of the validity of this rendering of identity sits at odds with my theoretical position, setting aside the issue of the assumption of some normative notion of ‘self’ implicit in the designation of identity disturbance, these few studies are included insofar as they represent positive efforts to explore the topic of identity from the patients’ perspective.

Dammann et al (2011) conducted the first study specifically exploring the self-image of patients with a BPD diagnosis from a qualitative research approach. Utilising content analysis and grounded theory, the authors compared the responses to structured interview questions around self-perception and self-description (the Structured Interview of Personality Organization [STIPO]) of 12 patients with BPD to the responses of 12 patients with major depressive disorder (MDD) in remission (19 women and 5 men).
The results indicated that those with a BPD diagnosis tended to describe themselves as sensitive and helpful, and reported singularly negative emotions such as anger, anxiety, and sadness. This contrasted with the MDD group, who reported positive as well as negative emotions. The results also indicated that those in the BPD group were likely to describe others as ‘egoistic’ and ‘satisfied’ compared to the MDD group who described others as being ‘balanced and ‘secretive’. Noting that features of aggression were attributed to others by the BPD group whilst they presented themselves as, “…altruistic, superficial, and suffering” (ibid p517), the authors concluded that their findings support the notions of those with a BPD diagnosis having disturbances in relation to self and others.

Adler et al (2012) conducted the first qualitative study into BPD identity disturbance utilising the perspective of narrative identity. The authors conducted in-depth ‘life story’ interviews with a group of 40 middle-aged adults, half with features of BPD (9 men and 11 women) and half without (9 men and 11 women). The interviews were analysed for various narrative elements with themes of agency, and communion (i.e. intimacy and connection with others) highlighted, but not communion fulfilment (i.e. the ability to meet this motivational need), or narrative coherence (i.e., a “…multidimensional structural aspect of stories that captures both their overall flow as well as the narrator’s ability to contextualize the specific story being recounted” [ibid p506]).

Understanding identity as an, “…internalized personal narrative” (ibid p508), their findings suggested that the narrative identity of those with features of BPD was significantly lower in relation to the themes of agency, communion fulfilment (not communion) and total narrative coherence than the other participants. The authors therefore concluded that the identification and targeting of narrative deficits may represent a fruitful area for therapeutic intervention.

Whilst the aforementioned studies framed their qualitative investigations in line with assumptions around identity disturbance as described by the diagnosis, Agnew et al (2016) departed from this dominant research focus to examine identity from the patient’s perspective. Conducting ‘lightly structured’ in-depth interviews with 5 female patients with BPD diagnoses, thematic analysis identified three major themes, i.e., connecting with myself, distance between us and hurt and healing, each containing further subordinate themes.
With regard to the connecting with myself theme, this highlighted how the participants, “...described themselves in multiple connecting and disconnecting ways” (ibid p4). In terms of connection, descriptions focused on how the participants were able to hold on to a sense of self across situations including early life experiences, memories and recent behaviour. Descriptions were given of conflicting internal relationships, and the researchers noted the internal struggles revolving around, “...morality and wickedness, goodness and badness, and childishness and adulthood” (ibid). A subordinate theme focusing on patterns of self and behaviour, cyclical, contained descriptions of alternating moods and oscillations between, “...periods of inactivity, seclusion, and negativity to periods of complete positivity, activity, and involvement with others” (ibid). Finally, the theme of disconnected[ness] was identified as describing blocks to, disconnection from, and a ‘glazing over’ of traumatic life events, and a sense of disconnection between, “...aspects of childhood and adulthood. Some participants described thinking about some negative life experiences as if it happened to someone else” (ibid).

The major theme of distance between us revealed how participants held differing relational distances to others, highlighting issues of confusion around the separation of self from others and notions of intimacy. The subordinate theme of self/other blurring described confusion/difficulties that the participants experienced in distinguishing themselves from others both emotionally, and with regard to the impact that other people’s emotional state had on them. Hiding from others described a desire to seclude themselves from others to avoid negative judgements, hurt, or abuse. The theme of a different way described the identification of relationships that enabled a sense of connectedness, care, and intimacy, and also highlighted, “...growth with others and improving and changing connections over time” (ibid p5).
The author’s final major theme of *hurt and healing* identified the ways in which participants experienced relationships with others and the world. The subordinate theme of *harsh and violating* described the participants’ experience of relationships where they had been poorly treated, especially in relation to interruptions to their lives rooted in relationships and family dysfunction. *Critical and controlling* was identified as a theme which described a widespread sense of rejection and helplessness around others who were critical and controlling within their relationships with the participants. Finally, *a different way* acknowledged the reporting of recent changes in relationships that furnished a glimpse into, “…different ways to relate to others and acceptance of more positive ways in which others can relate to them” (ibid p6).

The authors argued that these results indicated that their participants’ identities were influenced by present-day and historical family and relationship dysfunction, but also noted the positive impact of ‘healing relationship experiences’ within their life stories, with the participants being able to form connections with others, varying from disconnection where necessary, to care and intimacy. More broadly, and resonating with my notion of ‘risk identity’ and broader anti-essentialist rendering of self (please see the previous chapter), they argued that the narratives supported notions of multiple/flexible renderings of identity, in contrast to more standard unitary conceptualisations, support, “…psychological theories that consider a multiple and relational self/identity and the empowerment of healthy aspects of the self in BPD recovery” (ibid p1).

**Perspectives of those subject to the diagnosis of BPD**

The studies focusing on the perspectives of those subject to a BPD diagnosis that was identified in the review were predominantly phenomenological in terms of their methodologies. Given my anti-essentialist understanding of identity, phenomenology is problematised for me by its focus on uncovering and representing the essence of experience. Nevertheless, and with the aforementioned caveats in mind, these studies do have the advantage of focusing on the micro/local level of the BPD diagnosis and include references to both identification/non-identification with it, in addition to references to risk behaviours.
As far as I am able to identify, Miller (1994) conducted the earliest study into BPD from the patient’s perspective. She obtained life history narratives from 10 patients with a BPD diagnosis (8 women and 2 men) using a ‘minimal structure’ interview style, simply asking participants to talk about themselves. The focus of the research was to address two questions, namely:

“...how individuals with a diagnosis of borderline personality disorder perceive being in the world, or how they [sic] experience and are involved in their social context, and, second, how they experience the disorder and its treatment” (ibid p1215).

Whilst the narrative produced revealed prominent similarities between the participants’ experiences, the author noted the marked divergence from clinical descriptions relating to a diagnosis of BPD. With regard to their self-definition, the participants gave consistent accounts of their likes and dislikes, and who they were and who they wanted to be, across the course of the interviews. Common to all were reports of times at which they felt able to be themselves, contrasted with times when, due to their need to please others or hide insecurities, feelings of estrangement from others and sense of inadequacy against the social standards was perceived. The author suggested that the participants’ presentations implied a core identity discernible behind their attempts to feel better about themselves through the adoption of strategies such as making changes to their outward appearance, or adopting different lifestyles, with these potentially appearing to the observer as evidence of identity diffusion.

The participants were noted not to employ the diagnosis as part of their self-definitions, identifying more with their struggles in life, and the task of ‘fending off’ despair. Themes of estrangement, inadequacy, and despair were found to be common in relation to their sense of being in the world, and the strategies of dissociation and avoidance of self-disclosure were identified.
In discussing dissociation, some participants identified a sense of estrangement commencing in childhood or adolescence. However most were unaware of the origins of this, with their perceived inadequacy being rendered as a ‘falling short’ in comparison to others, and a feeling of being overwhelmed by despair and emotional pain. With regard to avoidance of self-disclosure, blocking out feelings via dissociation and avoiding sharing their feelings with others was common among the participants, despite the large body of literature which emphasises the importance of self-disclosure for recovery.

In terms of the patient experiences in relation to treatment, participants noted disagreement in relation to their therapists’ opinions on the use/role of inpatient admissions and their emphasis on self-disclosure. Viewing hospital admission as respite from their daily struggles, participants noted their reluctance to reveal their distress for fear of involuntary admission. Once hospitalised, the participants revealed that they often utilised negative behaviour to communicate their distress and flagged up instances of ‘faking it’, i.e. pretending to feel better despite wanting to die, as a means of being discharged. The lack of control over discharge when involuntarily admitted was also noted by participants as a significant concern.

Miller concluded that the narratives obtained provide information that could lead to more effective treatment. Arguing that clinicians need to be more cognisant of the ways in which a patient’s developmental history can result in their sense of inadequacy and marginality, she highlighted the ways in which power dynamics within clinical relationships can inadvertently reinforce said feelings, and recommended collaborative approaches that acknowledge the patient’s expertise in relation to their distress.

Given my definition of ‘risk identity’ as ‘the view that people have of themselves and project to others in their talk and actions, specifically in relation to risk and risk taking’, Miller’s findings relating to participants noting their reluctance to reveal distress for fear of involuntary admission, of utilising negative behaviour to communicate their distress, and of pretending to feel better can be understood as examples of the performance of a risk identity as projected to others.
Horn et al (2007) explored the perspectives of 5 service users (4 women and 1 man) on their diagnosis of BPD via Interpretative Phenomenological Analysis (IPA) of interview data. The authors identified five superordinate themes namely, knowledge as power (i.e. how being diagnosed gave the individuals a sense of power and control though being able to name their distress, but also how professionals withheld said control by not providing adequate information about their diagnosis); uncertainty about what the diagnosis meant (i.e. the disjunction between what appeared as a simplistic diagnostic label and their lived experience and histories of distress); diagnosis as rejection (i.e. feeling that the diagnosis resulted in rejection by mental health services, motivating a rejection on the service users’ part of both services and their diagnosis); diagnosis is about not fitting (i.e. either feeling that one’s distress didn’t ‘fit’ the diagnostic categories or feeling that the diagnosis itself was a catchall ‘dustbin’ diagnosis); and hope and the possibility of change (i.e. either feeling that the diagnosis engendered hope in terms of identifiable treatment, or feeling that it engendered hopelessness, thereby leading to a potential questioning of the validity of the diagnosis) (ibid p260).

The authors identified both how the participants questioned the validity of the diagnosis, and how they found hope and recovery in the context of the interpersonal relationships. In terms of identity, they identified the participants’ talk of positive change in relational terms as being indicative of a social constructionist rendering of self, concluding that:

“...ways of understanding the self which are consistent with a social constructionist perspective were more helpful to the participants in this research than ways of understanding the self which were consistent with a realist, essentialist perspective” (ibid p267).

Nehls (1999) similarly conducted IPA on interview texts produced by 30 female patients with a BPD diagnosis in order to uncover the meaning, and lived experience of the diagnosis for those so diagnosed. It was found that participants were critical of the effects of being ‘labelled’ as opposed to being diagnosed, with their difficulty not so much relating to the descriptions of their distress, but to the negative impact that BPD as a label has in terms of prejudicing professionals and limiting access to care, with self-destructive behaviour being perceived as manipulation being a key theme.
Participants reported that their proclivity for self-mutilation and suicide attempts were rooted in their need to control emotional pain but that this was exacerbated by the negative interpretations of clinicians, who framed said risk behaviour as manipulation. The authors hypothesised how such interpretations maintained prejudice against those diagnosed with BPD, and prohibited the formation of positive therapeutic relationships.

The phenomenon of those diagnosed with BPD being generally accepting of the diagnostic descriptions of symptoms but rejecting of the diagnostic label has been given further support by Kalapatapu et al (2009). They conducted an Internet survey asking participants with a diagnosis of BPD to give opinions about the existing BPD diagnostic criteria within the DSM-IV-TR (2000), and to suggest modifications for the development of the DSM-V (2013).

Whilst the survey responses demonstrated a general acceptance of the validity of the diagnostic criteria, “[a] significant percentage also felt that BPD should be renamed in the DSM-V, most commonly with some combination of words “emotion(al)” and “(dys)-regulation”” (ibid p490), resulting in the authors suggesting that alternative names would perhaps be less stigmatising and value neutral.

Brook and Horn (2010) investigated the meaning of self-injury and overdosing by interviewing 4 women with a diagnosis of BPD and analysing their data using IPA. Identifying three interrelated themes of the context of distress (i.e. childhood abuse, interpersonal conflict, and negative thoughts about themselves); the progressive management of distress (i.e. overdosing as a ‘last resort’ once self-injury no longer adequately manages distress); and ambivalence in relation to death (i.e. overdoses appearing to represent attempts to manage unbearable emotional distress through an unarticulated ‘cry for help’, despite the participants’ insistence that the suicidal intentions were genuine), the authors concluded that:

“*The overall impression gained was of a group of women in a world of problematic relations (to both self and others) struggling to know how best to attract support and understanding*” (ibid p113).
They also noted the lack of qualitative and phenomenological research into the experiences of individuals engaged in risk behaviours construed as, “...complex, manipulative, or attention seeking” (ibid p126).

Addressing both identity and risk themes, Black et al (2014) interviewed 9 individuals with a BPD diagnosis, exploring phenomenologically the experience of living with the diagnosis. Noting that, “...all participants introduced the topics of self-harming and suicidality spontaneously, suggesting that these are predominant concerns” (ibid p81), the authors identified two superordinate themes, namely, internal dynamics (i.e. experiences located within the individuals’ bodily sensations), and external dynamics (i.e. experiences generated through interpersonal interactions).

With regard to the former, the themes of risk and identity converge, with participants voicing the interweaving of being in the ‘zone’ (the authors suggested such perceptual states have relevance to dissociative identity) when undertaking acts of self-harm, with engagement in said behaviours often taking place in a states of semi-consciousness, dissociated awareness of pain, amnesia, and hallucinations.

In relation to the latter, participants stated that the desire to protect family members, whether parents or children, led to hiding distress and self-destructive acts from them, but also explained that the existence of said relationships served to protect against self-destructive acts to a degree, through identification with their family roles, e.g. being a mother.

**Experiences of mental health services**

The studies identified which focus on how those with BPD diagnoses experience mental health services also contained references to risk behaviour, identity and identification/non-identification with the diagnosis that were relevant to my research topic. A focus on the experience of and interaction with services has pertinence to ‘risk identity’, both in terms of how experiences of treatment impact on the view those with a BPD diagnosis have of themselves, and the context within which they project their identity to others in talk and actions.
Fallon (2003) adopted a grounded theory approach in generating and analysing data obtained via interviews with a mixed gender group of 7 individuals with a BPD diagnosis (4 women and 3 men). The author identified a thematic category of *travelling through the system*, dividing this into two subcategories of *movement* and *navigation*:

> “Movement represented the positive and negative experiences of moving between settings of care and levels of independence. Navigation detailed the strategies utilized to facilitate positive movements” (ibid pp398-399).

Confirming that relationships were key to managing the participants’ emotional distress, whilst identifying the difficulties fostered by trust issues and encountering negative staff attitudes, positive outcomes for patients in their journey ‘though the system’ were understood through overcoming these relational paradoxes by:

> “…consistent long-term involvement with experienced staff, containing relationships, encouraging the participants to contribute to their care ... and improving staff understanding of their behaviour by key informants” (ibid p393).

Morris *et al* (2014) investigated whether contact with adult mental health services was helpful for individuals with a diagnosis of BPD. The authors conducted semi-structured interviews with 9 service users with a diagnosis of BPD, whom they recruited through voluntary sector services in England. Analysing the data through inductive thematic analysis, they generated three interconnected themes, i.e., *the diagnostic process influences how service users feel about BPD, non-caring care and it’s all about the relationship.*

In terms of the first theme, the participants identified that how they felt about the diagnosis was influenced by how they were informed about it. Those who reported being informed about the diagnosis in an insensitive way felt less positive about the diagnosis, compared to those who felt news of the diagnosis had been handled with sensitivity. They valued being given information about the diagnosis but suggested that, in many cases, services had failed to do this, resulting in confusion as to what the diagnosis meant. Participants were also found to be more optimistic with regard to the potential for recovery when they were given information as to potentially effective treatments, as opposed to those who were told that there was no cure.
The theme of not-caring care revealed descriptions of unreliable and disjointed services with significant gaps in care. Linking a perception of them by staff as complex, challenging and/or at high risk with poor communication, the participants noted feeling unsupported and not knowing what to expect in terms of service provision.

Mental health services were viewed as being reactive rather than proactive in responding to risk, with the suggestion that underlying risk issues were of less concern than managing the immediate risk situation. One participant spoke of services withdrawing whilst the appropriate care pathway was identified despite his distress, whilst another spoke of being discharged by his therapist whilst in crisis, as he had presented as too risky. Both examples indicated a withdrawal of services when they were most needed.

Participants generally spoke of feeling let down by services, which were seen to focus on risk reduction rather than prevention, and felt that they lacked the necessary skills and motivation to address this, leading them to deem said services as unhelpful and inaccessible. Most felt defined by the diagnosis, with all their difficulties being interpreted through the prism of BPD, with their psychotic experiences no longer deemed to be real. They also noted a general sense of being viewed as difficult rather than unwell.

The final theme, it’s all about relationships, reflected the participants’ emphasis of the importance of good quality therapeutic relationships with staff who treated them as individuals rather than case numbers. Positive and highly valued experiences/encounters with staff were noted to increase both hope and self-esteem. However these were contrasted with staff who took little interest in listening to them, and led them to feel criticised and blameworthy. Said interactions increased distress by fuelling feelings of alienation and emptiness.

Whilst the importance of care coordinating roles was acknowledged, participants felt that service provision was disproportionate and superficial given the degree of their distress, and recommended greater emotional and psychological support. The participants spoke of feeling that staff were unable or unwilling to spend the necessary time in establishing trusting therapeutic relationships, which could result in patients finding it difficult to be open and honest with them, due to fears of rejection and abandonment.
Mental health services were presented as unable to effectively meet the needs of service users, particularly during times of crisis, with the need for positive relationships with knowledgeable staff stressed as being necessary to managing risk.

The authors concluded that their study highlights the need to prioritise therapeutic relationships as a primary component of treatment when working with those with a BPD diagnosis but noted that, “...the willingness of staff to develop and maintain a truly helpful relationship, particularly in the face of crisis, is likely to remain a major hurdle for services” (ibid p255).

Lovell and Hardy (2014) conducted a qualitative investigation into the lived experience of those with a BPD diagnosis within a forensic setting. Using IPA, the authors undertook semi-structured interviews with 8 women with a BPD diagnosis in three private secure units. Their findings revealed four overarching themes of identity, power, protection and containment and confusion.

The theme of identity revealed polarised positions in relation to the diagnosis, with the participants either feeling that BPD had taken their identity from them, or accepting that BPD was their identity. With regard to the former, participants questioned their identity, leading to the sub-theme of who am I? The women identified the diagnosis as shameful, having destroyed their lives, taken the essence of them away, and having been imposed on them against their will. They identified that the secure environment had contributed to this sense of lost identity.

For the latter position of identifying with the diagnosis, participants viewed the diagnosis as explaining their behaviour and experiences, with BPD providing an explanation of themselves; elements of gratitude at being diagnosed were evident among these participants.

Confusion around their identity, the diagnosis, and their place in life was evident, with some of the women noting a sense of loss in relation to a previous sense of who they were, whilst others questioned whether to identify with the diagnosis or not.
In terms of power, participants acknowledged the power of others over their lives, with the degree of power and control held by the service being one source of disturbance. Of relevance again to my definition of ‘risk identity’ (in relation to how a ‘risk identity’ is projected to others), the participants also identified their own attempts to gain a sense of power within this context, for example, by controlling how they presented themselves to others through remaining distant or ‘putting up a front’, or by making attempts to gain power over their situation by refraining from behaviours that would impact on discharge (e.g., self-harm).

The authors also speculated that the widespread desire to die may be linked to a desperate attempt to gain power, suggesting that forensic settings may inadvertently fuel suicidal thoughts due to the power and control structure.

The theme of protection and containment revealed a conflict between the participants’ need for others to contain and protect them and the need for them to rely on themselves due to the failure of others to do this for them, with this conflict also leading to confusion. The women spoke of strategies of self-protection including detachment from their own emotions and those of others in order to avoid emotional overwhelm, and self-harm as a safety-valve to prevent worse harm to themselves.

The secure environment was generally perceived to function as an external means of protecting against self-harm and suicide, with one participant noting that it provided her with safety though routine. The failure of the services to protect and contain the women in the past was also identified, however.

Finally, in relation to the theme of confusion, the authors noted that the dynamics of the previous three themes contributed to a general state of confusion. The women spoke of their confusion in relation to acknowledging their unpredictability, difficulty in making sense of or communicating their experiences, of being unsure about the future due to being unsure of themselves and how they might feel, and of confusion as to how both BPD and self-harm had become part of their lives to begin with.
Staff attitudes and exclusionary practices in relation to BPD

Research into staff attitudes and exclusionary practices was included in the literature review given the importance of good quality relationships and the impact of stigmatising staff attitudes, and inadequate service provision in relation to risk and identity (as discussed above).

Studies into staff attitudes towards those with a BPD diagnosis generally support the view that professionals perceive such patients in an unfavourable light. As Sansone and Sansone (2013) note following their literature review of such studies, “…with few exceptions, most researchers have found that the majority of participants in various studies harbor negative feelings about and attitudes towards patients with BPD” (ibid p41-42).

Specifically focusing on mental health nurses in order to establish whether their responses to people with BPD are problematic and, if so, inform solutions to support change, Dickens et al (2016) conducted a literature review of 40 studies selected from the existing research into the attitudes of nurses, and their behaviour, experience, and knowledge in relation to this clinical group. They concluded their meta-analysis by identifying that:

“Mental health nurses’ responses to people with borderline personality disorder are sometimes counter-therapeutic. As interventions to change them have had limited success there is a need for fresh thinking” (ibid p1).

Significantly, given the importance of how others view those with a diagnosis of BPD for their perceptions of identity, and the negative impact of poor relationships stemming from attributions of manipulation to self-harm and suicidal acts, several studies within this research area indicate attributions of ‘dangerousness’ by staff are a key source of negative feelings for those in receipt of a diagnosis of BPD.

Markham and Towner (2003) conducted a study investigating how the diagnosis of BPD affected staff attributions and perceptions. The researchers distributed a qualitative questionnaire to 50 Registered Mental Health Nurses (RMNs) and received 48 completed responses. The study revealed that staff were more likely to view those with a BPD diagnosis as being more in control of their negative actions, compared to patients with diagnoses of depression or schizophrenia.
Markham (2003) specifically investigated the attitudes of nursing staff towards those with a BPD diagnosis, focusing on the issues of social rejection and dangerousness. Having conducted questionnaires with 50 RMNs and 21 Health Care Assistants (HCAs) in relation to said attitudes regarding the diagnoses of BPD, schizophrenia, and depression, the study revealed that the RMNs expressed more social rejection and attributions of dangerousness to those with a BPD diagnosis than to those diagnosed with the other conditions, whilst HCAs made no such distinctions.

Woollaston and Hixenbaugh (2008) conducted interviews with 6 nurses working in both inpatient and community settings in relation to their perceptions of those with a BPD diagnosis. Analysing the interview data through thematic analysis, the core theme rendered was of nurses perceiving individuals with BPD as being destructive whirlwinds, viewing them as a, “…powerful, dangerous, unrelenting force that leaves a trail of destruction in its wake” (ibid p703). The authors identified that nurses believed that said patients had a tendency to idealise or demonise staff, and would engage in threats and manipulation.

Forsyth (2007) conducted a study into the effects of diagnosis and non-compliance attributions on therapeutic alliance processes in adult acute psychiatric settings. Focusing on identifying whether the cognitive processes of mental health workers varied across clinical diagnoses for patients with either a BPD or a major depressive disorder (MDD) diagnosis and, if so, whether this impacted on their emotional reactions and ‘helping behaviours’, the author surveyed 26 mental health nurses across four adult acute inpatient wards and one psychiatric intensive care unit.

Using a $2 \times 2 \times 2$ factorial design, participants completed a 15-item rating scale for helping, empathy and anger reactions, having read eight clinical vignettes which contained a combination of controllable/uncontrollable and stable/unstable attributional dimensions for service users who had failed to complete a therapeutic task. The diagnoses of MDD and BPD were then added to the vignettes in order to identify whether these diagnoses impacted on alliance factors.
Analysis of the findings indicated that anger reactions were more common for clinicians working with those with a BPD diagnosis, and that attributions of controllability were related to this, with the mental health workers questioned being, “...less likely to help service users with a diagnosis of BPD compared with that of MDD” (ibid p37).

Identifying the diagnosis of BPD as signifying the quintessential ‘difficult patient’ for professionals, Sulzer (2015) conducted a grounded theory-based study of 22 mental health clinicians in the US, in which she evaluated how said clinicians described patients with BPD, how the diagnosis affected the treatments provided, and what this implied for the patients in question.

Drawing a distinction between de jure and de facto medicalisation, i.e. to be classed as ‘sick’ by definition as per, for example, the DSM, as contrasted with being treated as ‘sick’ in practice, her findings suggested that those with a BPD diagnosis were routinely labelled as ‘difficult patients’, leading to exclusion from treatment. She argued that, functionally, this represents a de facto demedicalisation of BPD, despite the diagnosis’ de jure medical status.

Sulzer identified that the clinicians in her study justified their treatment and exclusionary practice though the oft-cited moral judgements of manipulation and attention seeking, which hold that those with a BPD diagnosis were, “…manipulative people who feigned sickness to gain access to attention” (ibid p86).

To explain the de facto demedicalisation of BPD, Sulzer suggested that those given this diagnosis often passively or actively refuse care, and that their behaviours were frequently viewed as a means of dominating the clinician. With regard to the former, she suggests that, “...refusal of care denies one of the most fundamental sick role rights: access to treatment” (ibid p85). In relation to the latter, she suggests that such behaviours represent, “…an inversion of the traditional hierarchy in the clinical encounter” (ibid p86).
In contrast to the above studies, which note the stigmatising and exclusionary attitudes and behaviours of staff, an awareness of the stigmatising effects of a BPD diagnosis and of its contested nature was found amongst staff by Koehne and Hamilton’s (2012) study into how staff ‘work around’ the diagnosis of BPD as it relates to adolescent service users. Employing discourse analysis, the authors undertook interviews with 23 Child and Adolescent Mental Health Services (CAMHS) clinicians in two publicly funded services in Melbourne, focusing on their use of BPD in relation to the young people in their care. The authors identifying that, within this setting, “...clinicians face a quandary regarding the application of adult diagnostic criteria to an adolescent population, aged less than 18 years” (ibid p37).

Through their analysis, the authors identified social and discursive strategies employed by clinicians including ‘team rules’ by which diagnostic disclosure was discouraged (i.e. encouraging psychiatrists not to disclose that a diagnosis has been made to patients due to fears around misdiagnosis and over diagnosing, and a resistance to the truth claims of the DSM); *hedging* (i.e., a linguistic device whereby clinicians used words such as ‘traits’ or ‘emerging’ rather than ‘BPD’ as a means of ‘softening’ the permanency associated with the formal diagnosis); a prohibition against informal *borderline talk* (i.e., staff using talk of the diagnosis, although not uncritically, between themselves but not directly to their patients); and *reframing the diagnosis with young people* (i.e., avoiding and reframing talk about BPD with patients due to the clinicians’ dissatisfaction with the label, and in order to remain hopeful/meet the perceived needs of the patient).

Noting how the psychopathological diagnosis of BPD is situated within complex social and power relations, the authors concluded that, “...doctors, nurses and allied health clinicians resisted and subverted a diagnosis of BPD in their work with adolescents” (ibid p37). They concluded that concern amongst clinicians over the potentially damaging effects of the diagnosis with this vulnerable group led to the various strategies employed to deflect patients away from a BPD identity ‘trajectory’.
Whereas the impact of stigma and inadequate services in relation to risk and identity has been identified within the studies that examine the perspectives of those subject to the diagnosis of BPD and their experiences of mental health services, the staff attitudes and exclusionary practices studies presented above confirm that such negative attitudes are common amongst mental health workers, and contribute to the level and quality of service provision.

Whilst Koehne and Hamilton’s study indicates that some staff have an awareness of these issues and may try to resist and subvert the impact of the diagnosis, from a ‘risk identity’ perspective, it is clear that how a woman with BPD negotiates her identity in relation to risk is likely to be impacted by staff attitudes and exclusionary practices.

**Governmentality research in relation to BPD, risk and identity**

The governmentality studies located within the literature review were included as they provide theoretical analysis as to how subjectivities are produced by psychiatric discourse; this resonates with my focus on the productive features of the diagnosis of BPD. Although these studies are theoretically ‘in tune’ with my own anti-essentialist stance on identity, in contrast to the empirical studies presented above, they approach the issue from a macro theoretical perspective which arguably loses sight of what takes place at the level of the individual within their specific micro/local contexts.

Whilst no studies examining the specific role played by psychiatric risk discourse in the construction of identity for those with a BPD diagnosis have been located, a study conducted by Futtaga and Gattuso (2002) was identified which examined the construction of risk subjectivities in a group of Australian women diagnosed with depression.

Focusing on the constructive role played by dominant psychiatric discourses embedded in public health policy and the wider culture, and on the understanding, taken from governmentality risk theory, that said discourses are, “…‘productive of self’” (ibid p3), the authors concluded that, “…contemporary experience of depression cannot be separated from culture knowledges that now proliferate about it” (ibid p10). They also called for broader research and analysis into the productive effects of public health policies on modern experiences of the self, and were highly critical of the ‘gender blindness’ that they identified within mental health policies.
With regard to how psychiatric risk discourse is formative of identity, Crowe (2003) performed a deconstructive analysis of risk assessment and management in mental health nursing, exploring the historical, clinical, cultural, political, and economic context of such practice. Identifying that the concept of risk and its assessment and management have been, and are, employed as a form of governmentality, she argued that said concerns have been raised above clinical judgement, as the, “...codification, commodification and aggregation” (ibid p19) of this practice, stemming from the fiscal needs of the organisation, and leading to increased attempts to control the behaviour of patients and nurses alike.

Crowe observed that the transition from asylums, where disciplinary power was embedded within the institution, to ‘care in the community’ where patients are expected to comply with medication, self-assess their mental health, and keep booked appointments, has created a distinction between the, “...good subjects of psychiatry” (Rose 1996 p14), i.e. those who align themselves with professional assessment, and the ‘bad’, risky subjects who fail to conform to said expectations, thereby constituting a marginalised ‘risky’ patient group.

Within governmentality nursing research on risk assessment and management, the practice of ‘observation’ has been a particular focus. Holmes (2001) examined the modern use of mechanical surveillance devices (i.e., cameras and microphones) from a Foucauldian perspective, noting that the use of such technologies contributed to the arsenal of disciplinary methods though which individual patients are tamed, guided, and moulded; the psychiatric gaze in such cases resulting in a situation whereby: “Individuals that are observed or believe that they are being observed end up internalizing such surveillance” (ibid p9). The authors stress the contradictions and negative impact that this ‘iron gaze’ may have on the therapeutic relationship between nurse and patient whereby, ideally, both parties, “…co-construct their reality, their potential, and the intervention” (ibid p13).

Stevenson and Cutcliffe (2006) studied ‘special observation’, i.e. the practice of allocating a nurse to a patient deemed to be at risk of self-harm or suicide to remain within touching distance and in clear view of them at all times, from a Foucauldian perspective.
Recognising ‘special observation’ as a productive form of power, the authors proposed that when individuals are constantly monitored, there ensues a production of, “…a state of awareness [which] ensures the patient regulates her or his conduct in accord with the mores of mental health nursing” (ibid p719). The authors also noted, however, that, concordant with a Foucauldian perspective where there are, “…no relations of power without resistances” (Foucault 1980 cited in Stevenson and Cutcliffe 2006 p719), patients may resist these techniques of power by, for example, constantly moving about the unit to frustrate the efforts of the allocated nurse.

**BPD, risk and identity**

Whilst no specific studies examining ‘risk identity’ in relation to BPD were identified, the final study that I will present was found to have resonance in relation to how the identity of those with a BPD diagnosis can be influenced by the reactions of others to scars which can result from the risk behaviour of self-harm.

Drawing on her doctoral thesis of 2006, Walker (2009) wrote a paper which explored the subjective experiences of women with a BPD diagnosis who engaged in self-harm, shedding light on how their identity and sense of agency was impacted by the reactions of others to their scars in social and healthcare settings. Drawing on interviews with two of her participants for the research paper, the author’s analysis highlighted several processes by which identity and agency may be influenced by the reactions of others.

Firstly, self-harm scars may ‘take over’ one’s sense identity through the attention that they are given by others encountering these external signs, and thereby failing to see, “…beyond the battled body” (the title of the paper). Whether the reactions evoked are expressions of sympathy or horror, identity is suggested as being partly dependent on the reaction of others to the physical scars of self-harm.
A second process suggested, in the context of a participant changing the method and site of her self-harm in order to hide it from her Community Psychiatric Nurse (CPN) for fear of being reported to social services as an unfit mother, is that of falling foul of discursive constructions of femininity and motherhood. The author suggests that failure to comply with gender normative assumptions of feminine passivity by expressing anger in the form of self-harm results in being pathologised as not, “…fit and well enough” (ibid p125) to fulfil the role of a mother. The author further posits the development of ‘situation consciousness’ whereby a woman’s sense of self, “…must assess in advance the impression her scars will make in various contexts and situations” (ibid p125).

A third process identified was that being known as someone who self-harms can lead to negative encounters with health professionals, including having one’s agency practically nullified. Based on a participant’s experience of seeking medical help for an infection and her battle to have this legitimate health need met, an analysis was given as to how professionals position individuals known to self-harm as being unworthy of treatment, through processes of stigmatisation and ‘Othering’ practices employed to ‘shore up’ and define normality.

The participant’s disempowering experience of being talked about as though she wasn’t in the room and being given medical intervention without consultation points towards her being positioned as not ‘active’, and rendered speechless. The participant in question is, “…known and seen by her scars as a self-harer” (ibid p126) with the result that the professionals involved fail to see the woman behind this ascribed identity.

Whilst limited to the risk behaviour, and signs of, self-harm, the paper offered insight into the ways in which stigma around self-harm impacts identity and agency though interactions with others.
Chapter summary
The review of the available literature in this area has revealed a dearth of studies focusing on the ways in which the identity of those diagnosed with BPD may be impacted by risk on a local/micro level. While a handful of studies attending to the voice of those with a BPD diagnosis from a phenomenological methodological perspective/design have revealed some insights into the meanings of self-harm, suicidal behaviours and identity as part of wider projects focusing on the lived experience of those so diagnosed, wider notions of risky behaviour indicated by the diagnosis, e.g., impulsivity, dangerous driving, etc., and an examination of identity beyond dissociative phenomenon and relationships have not been addressed. The studies by Miller (1994) and Lovell and Hardy (2014), however, indicate that managing one’s ‘risk identity’ in the sense of strategically using one’s risk presentation in order to achieve certain aims has resonance with my research topic, given my definition of ‘risk identity’.

Specific qualitative enquiry into identity in relation to those with a BPD diagnosis is a relatively recent avenue for research and, with the exception of a study conducted by Agnew et al (2016), these few efforts arguably have broadly and uncritically interpreted their results as evidence of identity disturbance against an unacknowledged regulatory norm of what constitutes a non-pathological identity. Although the Agnew et al (2016) study recommends multiple/flexible renderings of identity in contrast to unitary conceptualisations (echoing the recommendation of Horn et al [2007]), and this is more in tune with my theoretical position, their study does not specifically address risk in relation to this topic.

Futtaga and Gattuso’s (2002) examination of the construction of risk subjectivities for women diagnosed with depression is more sympathetic to my theoretical position and research aims, pointing the way towards an examination which incorporates the productive roles that psychiatric and wider cultural discourses may play for women subject to a BPD diagnosis.
Theoretically, my investigation can also draw insight from the identified studies examining psychiatric risk governmentality by revealing the discursive forces that produce subjects through disciplinary power, and exploring the resistance that such power invites. Whilst Crowe’s (2003) utilisation of Rose (1996) in her deconstructive analysis of nursing risk assessment and management opens up interesting avenues to explore how the correct or incorrect performance of the ideal, self-reflexive ‘consumer’ of mental health services may render one a ‘good’ or ‘bad/risky’ subject of psychiatry, the focus on ‘observation’ by Holmes (2001) and Stevenson and Cutcliffe (2006) indicates the role that specific risk technologies may play in these subject productions.

Although instructive of how risk identities in regard to BPD may be produced by discourse, the focus of all of the governmentality studies is, however, limited to the macro rather than micro/local level.

Whilst Walker’s (2009) study has greater resonance to my research aims, particularly with regard to raising normative gender constructions and the process of ‘Othering’, the focus is limited to self-harm, and the interpersonal effects of the attendant scars on identity.

In conclusion, I believe there is a ‘gap in the literature’ into which my study fits, focussing on the micro/local production of ‘risk identity’ for those with a diagnosis of BPD, with consideration given to the macro discursive processes at work. This will further meet the need for more qualitative research addressing the risk behaviours commonly understood as being complex, manipulative, or attention seeking as identified by Nehls (1999), Brook and Horn (2010), Woollaston and Hixenbaugh (2008) and Sulzer (2015) from the vantage point of identity. Additionally, this focus would avoid the well-trodden paths of obscuring the individual through positivistic abstraction, or reifying the individual through phenomenological essentialism.

In terms of the specific focus of my research project, Lupton (2007) identifies that: “The question of how risk-related discourses and strategies operate, how they may be taken up, negotiated or resisted by those who are subject of them, remains under-examined” (ibid pp102-103). Given this general under-examination, and from the studies identified above, my specific research focus on the negotiation of ‘risk identity’ by women with a BPD diagnosis represents an inquiry into an underexplored area of psychiatric risk research.
Chapter 3 Theoretical Perspective

Introduction
The purpose of this chapter is to ‘stake out’ my theoretical perspective in relation to the study undertaken. In order to do so, an account will be given of my ontological, epistemological, and ideological standpoints, as these three commitments structure my theoretical position and inform both the nature of the research questions and the chosen methodology and methods. Having defined what I mean by ‘ontology’, ‘epistemology’ and ‘ideology’, the chapter will proceed by first giving an account of the development of my current theoretical perspective through an exposition of the key theorists I encountered and whose work developed my position, namely Foucault (1978; 1991a; 1991b; 1998; 2002; 2008a; 2008b; 2009), Rose (1996; 1998; 1999) and Butler (1997; 2004; 2007).

The inclusion of relevant biographical details feature as part of this exposition in recognition of my commitment to reflexivity and the notion that, following Foucault’s (1991a) rendering of ‘power/knowledge’ (see below) the researcher is unavoidably present in constructing that which is being investigated. A brief statement as to my theoretical position upon commencing this doctorate will introduce this account in acknowledgement of the fact that both my research question and methodology grew out of a pre-existing theoretical position, rather than it being the case that the methodology chosen simply reflected the theoretical position that best met my research question. The chapter will conclude with a formal statement of my theoretical perspective in terms of ontological, epistemological and ideological positioning.

Defining terms
In my engagement with reading social scientific research, like Crotty (2007), I have found the terms ‘ontology’ and ‘epistemology’ to be frequently entangled; this, Crotty suggests, results from the fact that ontological and epistemological issues have a tendency to emerge together in discussions of methodology: “To talk of the construction of meaning is to talk of the construction of meaningful reality” (ibid p10).
Following Crotty’s example, I shall reserve the use of the terms ‘epistemology’ and ‘ontology’ in their strict philosophical sense and employ his term ‘theoretical perspective’ (reflected in this chapter’s title) when referring to the general philosophical standpoint from which epistemological and ontological positions emerge. Accordingly, I have employed a philosophical dictionary to provide standard philosophical definitions.

‘Epistemology’ will henceforward be taken to refer to, “[t]he branch of philosophy concerned with the theory of knowledge” (Flew 1984 p109). To hold an epistemological position, then, is to have a belief in what knowledge is and how one can obtain it.

‘Ontology’ will be understood as meaning, “[t]he branch of metaphysical enquiry concerned with the study of existence itself (considered apart from the nature of any existent object)” (ibid p255). To hold an ontological position is thus to have a belief in what constitutes the world as such.

Turning to ‘ideology’, and in keeping with the critical position found within Althusser (2008) and Gramsci (2007), I assert that an ideological position is an unavoidable feature of any researcher’s theoretical perspective and all claims to knowledge. In accordance with this understanding, but by way of furnishing a reasonably straightforward definition, I will again employ the use of a standard philosophical dictionary, with ‘ideology’ defined as, “...any system of ideas and norms directing political and social action” (Flew 1984 p162).
Development of my theoretical perspective - my theoretical position upon commencing this doctorate

Upon commencing the doctorate, having undertaken a Bachelor of Arts degree in Philosophy at the University of Hertfordshire and a Master of Arts degree in the Philosophy of Religion at the University of London, my theoretical perspective was initially informed by the Western analytic philosophical canon, and was heavily influenced by the late work of Wittgenstein. Two key threads within his ‘Philosophical Investigations’ (1996) made a deep and long-lasting impression on me. The first was his identification of the role of language in constructing and delineating our world, and the foreclosure of being able to speak meaningfully about the world as it is in itself (i.e., anti-realism), and the second was his anti-essentialism, particularly in relation to the self (with this informing my research questions’ focus on how identity is constructed).

Despite being influenced by Wittgenstein’s language-based social constructionism and anti-essentialism, I was also mindful of the apolitical nature of his work. This was a tendency that stood at odds with my broadly Marxist ideological position, which had its roots in my undergraduate extracurricular participation in ‘Living Marxism’, a political discussion group based around the British Revolutionary Communist Party (RCP) journal of the same name. Wanting to speak meaningfully about social injustice, particularly in relation to mental health, as a realist but being epistemologically bound by the totalising horizon of language reflected a theoretical tension I battled with when commencing the doctorate. Whilst language appeared to construct and limit all that I could know, I struggled with my desire to ground my epistemology within a form of philosophical realism through my fear of slipping into some form of toothless relativism without such a theoretical bulwark.

Development of my theoretical perspective - Foucault

Commencing my doctorate in 2008, I engaged with the task of formulating my research question and attempting to establish my theoretical and methodological position. Pursuing both my commitment to language and critical thought, I continued to struggle with wanting to acknowledge the constructive effects of language in the spirit of Wittgenstein, combining this with a critical, realist commitment to the world in the spirit of Marx.
Being aware of Foucault since reading ‘Madness and Civilization’ (2002) during my nurse training and having read references to his works in a number of the papers that I was reading around BPD and risk management, I read further around his ideas for inspiration and was rewarded by discovering his rendering of discourse and its constructive effects, an emphasis which chimed with my focus on language and anti-essentialist rendering of the self, but also promised a critical political dimension lacking in Wittgenstein’s work.

Foucault delineated his notion of discourse in ‘The Archaeology of Knowledge’ (2009) and ‘The Order of Things’ (2008a). His use of the term can be broadly understood to refer to anything that is communicated, be it written, spoken, signed etc., i.e., that which is communicated via language, ‘discourses’ consisting of groups of regulated and systematically organised statements. As Foucault defines it: “...discourse is constituted by a group of sequences of signs, in so far as they are statements, that is, in so far as they can be assigned particular modalities of existence” (ibid 2009 p121).

Foucault understood discourses as having constructive effects, i.e., that discourses construct our reality by directing how we think about, act upon, and experience our world. Through developing an archaeological method for uncovering the rules that enable discourses to form, specify, and produce features of knowledge, Foucault espoused an anti-essentialist view of the self, arguing that the ‘subject’ was discursively produced through dominant discourses embedded in non-discursive social and material practices and institutions and embodied power relationships within our society.

Through his analysis, Foucault furnished a historicised account of the modern self, detailing how this emerged with the rise of liberal democracies during the eighteenth and nineteenth centuries, which required a diverse set of institutions and administrative regulatory practices for the purpose of governing.

In terms of how modern human subjectivity was produced and rendered amenable to governance, Foucault specified ‘dividing practices’, ‘classification’, and, ‘subjectification’ as three related, yet analytically distinguishable, processes. By ‘dividing practices’, Foucault refers to the initially crude practices of domination over marginal populations, for example, the confinement of lepers during the Middle Ages and, later, the insane, as described in ‘Madness and Civilization’ (2002).
He described how said individuals are ascribed a personal and social identity though the techniques of physical exclusion (i.e. prisons, asylums etc.) and social exclusion and noted how the emerging ‘scientific’ classificatory systems of the nineteenth and twentieth centuries created discourses that constructed knowledge of said individuals under the guise of humanitarian and progressive liberalism, whilst exercising power and control over them to produce ‘docile bodies’, i.e. manageable subjects. The scientific ‘classification’ of those that deviate from the simultaneously produced notions of what is normal, i.e., ‘normalisation’, essentially represents an oppressive limiting of what the ‘human’ could potentially be under the guise of the objective scientific ‘discovery’ of ‘human nature’. The practical governmental origins of these practices of domination, he argued, is obscured within the discourses of science, humanism, and liberal democracy. Both dividing practices and classification represent examples of ‘objectification’, i.e., to be subject to another via their control.

Foucault’s ‘subjectification’, i.e. “...[the] way a human being turns him- or herself into a subject” (Foucault cited in Rabinow 1984 p11), represents an active process through which the individual is constituted as amenable to, and responsible for, their own subjection to power and control through various techniques of self-surveillance, self-monitoring, self-modification etc.

As to how these changes in the exercise of power came about, Foucault articulated and developed these ideas in his works ‘Discipline and Punish’ (1991a) and ‘The Will to Knowledge: The History of Sexuality: I’ (1998). Using the grisly example of the public execution of Robert-Francois Damiens, for his attempt to assassinate King Louis XV of France in 1757, Foucault introduces a shift/fracture which took place within an eighty year period in the nature of punishment, from public infliction of pain and death on the accused’s body, to a system of regimented control of the body within prisons, whereby the focus was redirected to the regulation and reform of the soul though timetables of educational reform.
This shift represented a historical movement from the exercise of the *Sovereign Power* of the classical age, i.e., “...a right of seizure: of things, time, bodies, and ultimately life itself” (Foucault 1998 p136), to that of the *Disciplinary Power* of the modern age, whereby, “[t]he old power of death that symbolized sovereign power was now carefully supplanted by the administration of bodies and the calculated management of life” (ibid pp129-130). Foucault goes on to chart the diversification of these techniques of discipline within societal institutions, both governmental and civic, such as schools, hospitals, the army, and the family, etc.

The transformation of power from the exclusive administration of pain and death to the management of life required, “...a whole army of technicians [to take over] from the executioner, the immediate anatomist of pain: ward doctors, chaplains, psychiatrists, psychologists, educationalists...” (ibid 1991a p11).

Complementary to his account of disciplinary power and practices, through his history of sexuality, Foucault details the practices and discourses through which the modern subject is made responsible for their own lives and therefore becomes more amenable to governing. Tracing how Christian confessional practices became modulated through modern psychoanalysis, with its exclusive focus on uncovering the truth of the subject though bringing to light repressed sexuality, Foucault inverts the dominant discourse that one’s true nature is discoverable through self-interrogation, with professional expert assistance, of one’s inner nature. Instead, he proposes that, rather than such expert knowledge uncovering deep truths of the self, such truths are inscribed by power with the notion of a true self being a discursive production, and an effect of governmental power:

“Causality in the subject in the other who knows, the knowledge he holds unbeknown to him, all this found an opportunity to deploy itself in the discourse of sex. Not, however, by reason of some natural property inherent in sex itself, but by virtue of the tactics of power immanent in this discourse” (ibid 1998 p70).
The shift from sovereign to disciplinary power represents the dawning of a new episteme identifiable through the rise of the social sciences and humanities, which simultaneously produce expert knowledge both of abstracted humanity through the quantitative statistical methods of fields such as economics and sociology, and knowledge of the individual though medicine, psychiatry, psychoanalysis, and psychology. Through rendering both power and knowledge as being inextricably bound together within discourse, Foucault articulated his concept of ‘power/knowledge’:

“We should admit ... that power produces knowledge ... that power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations” (ibid 1991a p27).

Although not implying that power and knowledge are identical, Foucault was interested in the relations between them within discourse showing how forms of power had produced forms of knowledge and vice versa, the exercise of power having attending apparatuses of knowledge and the production of knowledge reflecting matrices of power and force.

Whilst sceptical of the benevolent and objective/value free claims of scientific knowledge, Foucault also rendered a notion of power broader than that which is traditionally posited (for example, by Marxism). Rather than power being conceived of as a quality or force held by an individual or particular group (in the case of Marxist theory, by a ruling class exercising this capacity in a ‘downward’ direction to those subordinate to it), Foucault argues that power is relational. The effects of power are therefore conceived of as coming into being through action over a broad and widely dispersed field rather than merely being a reified force expressed though a hierarchical power structure. The relational quality of power and its effects is therefore located both within and, significantly, beyond the institutions of the state, with this becoming evident in the ‘micro instances’ in which knowledge is used and produced in our daily lives.

Due to Foucault’s potentially fruitful rendering of ‘power/knowledge’ in relation to modern disciplinary power and the production of subjectivities, I continued to read Foucauldian inspired work. Most notably Rose (1996; 1998; 1999) who explored Foucault’s ideas further in relating them to the psychiatric context which was the focus of my research.
Development of my theoretical perspective - Rose

Rose expanded and built upon Foucault’s genealogy of the subject in relation to the ‘psy’ disciplines, i.e., “…all those disciplines which, since about the middle of the nineteenth century, have designated themselves with the prefix psy – psychology, psychiatry, psychotherapy, psychoanalysis” (Rose 1998 p10).

Following Foucault’s mode of analysis, Rose asserts that the history of the rise of ‘psy’ is inextricably fused to the history of government, and traces the discursive construction of subjectivity across the nineteenth and twentieth centuries by showing how the disparate schools and practices of ‘psy’ met the diverse needs for the administration of liberal democratic governments. He examines diverse areas such as the government of civilians and the military during war, strategies of intervention in family life and child development, and the regulation of labour within factories to show how ‘psy’ was developed through the invention of various technical assemblages, for example via the I.Q. test, personality tests, therapeutic interventions, etc. to govern within these different areas. Our modern sense of what it is to be human which draws upon psychological language and emphasises values such as self-actualisation and freedom, reflecting a formation of subjectivity amenable to the governmental requirements of modern liberal democracies.

In terms of our current historical period characterised by the rise of neoliberalism as an organising philosophy of government over the past thirty years, expanding on Foucault’s latter work focusing the productive effects of this historic turn on the subject, i.e., the ‘entrepreneurial self’ (Foucault 2008b p226), Rose described the ideological construction of the self within this phase of capitalism as follows:

“The self is to be a subjective being, it is to aspire to autonomy, it is to strive for personal fulfilment in its earthy life, it is to find meaning in existence by shaping its life through acts of choice” (ibid 1998 P151).

With regard to the role of the ‘psy’ disciplines in relation to this ideological construction of the subject, Rose provided the following account:
“It is here that the techniques of psychotherapeutics come into accordance with the new political rationales for the government of conduct. They are intrinsically bound to this injunction to selfhood and the space of choices that it operates within. They are themselves predominantly distributed to individuals though free choice in a market of expertise, rather than imposed by legal or religious obligation. They are characteristically sought when individuals feel unable to bear the obligations of selfhood, or when they are anguished by them. And the rationale of psychotherapists – and this applies equally to contemporary psychiatry – is to restore to individuals the capacity to function as autonomous beings in the contractual society of the self. Selves unable to operate the imperative of choice are to be restored though therapy to the statues of a choosing individual. Selves who find choice meaningless and their identity constantly fading under inner and outer fragmentation are to be restored, though therapy, to unity and personal purpose. Selves dissatisfied with who they are can engage in therapeutic projects to refurbish and reshape themselves in the directions they desire. The psychotherapies provide technologies of individuality for the production and regulation of the individual who is ‘free to choose’” (ibid 1999 p232).

Within this description I found my professional role, i.e., to restore to those in my charge the capacity to function as autonomous beings, and the obligation placed those given a BPD diagnosis, i.e., to bear the obligations of selfhood in the context of their anguish, to be lucidly and accurately encapsulated.

Returning to my research interest of understanding how women with a BPD diagnosis negotiate their identity in relation to risk, I felt that a more robust account of human agency was required than that which is found within the work of Foucault.

Foucault has been repeatedly criticised for presenting a form of discursive or linguistic determinism, with the subject of power being ‘trapped in the amber’ of discursive forces, unable to exercise agency or effectively resist oppression. Fairclough (2008), for example, critiqued what he describe as, “Foucault’s overstatement of the constructive effects of discourse” (ibid p60), suggesting that Foucault’s work, overall, gives the general impression of, “…people being helplessly subjected to immovable systems of power” (ibid p57). This criticism, despite Foucault’s attempts to address it in his late work, is a, “…well-worn critical path” (Adams 2007 p93) and therefore deserving of my attention.
Aware of the need to present a more effective means of conceptualising agency to theoretically underpin my notion that risk identity is not merely deterministically produced but negotiated, I explored the work of Butler (1997; 2004; 2007) and her concept of gender performativity.

Development of my theoretical perspective – Butler

Butler’s notion of gender performativity, and her attending account of the possibility for agency whilst affirming that subjects are constituted by discourse, developed out of her work to both critique versions of feminism reliant on an essentialist pre-discursive account of gender identity, and to offer an alternative critical feminist framework free of such assumptions. Butler argues against an essentialist rendering of gender identity by proposing that gender is a performance drawing on gendered discourses:

“Gender is the repeated stylization of the body, a set of repeated acts within a highly rigid regulatory frame that congeal over time to produce the appearance of substance, of a natural sort of being” (Butler 2007 p45).

Rather than present agency as an essential attribute rendered impossible or incoherent by a Foucauldian understanding of power and discourse, Butler essentially argues that agency is a potential which, “...exceeds the power by which it is enabled” (Butler 1997 p15). For her, discourses of identity, which are necessarily gendered, are inhabited and reproduced by subjects through the process of repetition, and it is this repetition that creates the possibility of their transformation. Whilst the discourses of identity that we inherit have an ideological historical underpinning, their continued existence is only guaranteed through their repetition via active performance by subjects:

“The subject is not determined by the rules through which it is generated because signification is not a founding act, but rather a regulated process of repetition that both conceals itself and enforces its rules precisely through the production of substantializing effects. In a sense, all signification takes place within the orbit of the compulsion to repeat; “agency,” then, is to be located within the possibility of a variation on that repetition” (ibid p198).
Agency is therefore reframed, not as an attribute to an essential pre-discursive subject, but as an effect constituted in the repetition of discourse enacted by the subject, said subject, “...never fully determined by power, but neither is it fully determining” (Benwell and Stokoe 2009 p32). The constituency of discourse through the very acts of performance necessarily opens up the potential for change by creating a ‘space’ within which ‘distortion’ or mutation of the discourse is possible though the failure to reproduce the constituent acts via omission, deformity, parody etc. (Lloyd 2005 p26). The, “…complexity of the discursive map” (Butler 2007 p44) which constructs gender itself being conducive to the possibility of said distortions and mutations.

Whilst Butler enables a rendering of agency which is missing from Foucault’s work, performative agency should not be misconstrued in the sense of subjects having the freedom to choose whichever identity they might wish to perform (with such a misreading representing a retreat back into traditional humanistic renderings of agency reliant on an essential subject). Butler clearly argues in her presentation of performative agency that there is no pre-existing humanist subject and the rules of the gender script are limited within a highly rigid regulatory frame, with constraint within this formulation of agency, “…built into what that language constitutes as the imaginable domain of gender” (Butler 2007 p12).

The ‘freedom’ to negotiate one’s identity is therefore understood to be a product of the forces of subjectification rather than a capacity of an agent on which such forces act. As Rose (1998) articulates in relation to Butler’s performative agency:

“The heterogeneity of these practices and techniques – their multiple interconnections, alliances, conflicts, and demands they make of human beings – can produce all the effects of resistance, appropriation, utilization, transformation, and transgression that theorists of the postmodern have highlighted, without the need to invoke a unifying conception of ‘human agency ... agency is itself an effect, a distributed outcome of particular technologies of subjectification that invoke human beings as subjects of a certain type of freedom and supply the norms and techniques by which that freedom is to be recognized, assembled, and played out in specific domains” (ibid p187).
With Butler’s notion of performative agency, I had a more effective means of conceptualising agency than Foucault provides, but one which remained in sympathy with his rendering of discourse and power. Rather than being left with a sense that those in receipt of a BPD diagnosis were simply prescribed by discourse or having to posit a subject behind actions to solve the question of agency, Butler’s work enabled an understanding that opened up the possibility of said individuals negotiating their identity via, “…resistance, appropriation, utilization, transformation, and transgression” (ibid), albeit against the constraints of the discursive resources available.

**Development of my theoretical perspective – embracing uncertainty**

Whilst the work of Foucault, Rose, and Butler appeared to offer a theoretical perspective that could underpin my research, throughout my reading I continued to struggle with my desire to ground my epistemology within a form of philosophical realism, due to my fear of slipping into relativism. Reflecting on my philosophical journey and my need for certainty, I began to realise that, whilst I had rejected an essentialist notion of the self grounded in humanism and the Enlightenment for an anti-essentialist rendering of the subject, perhaps my need for certainty and fear of relativism was a ‘hang up’ rooted in my enmeshment with the Western analytic philosophical canon.

My thoughts crystallised when I chanced upon the following quote in Lather’s (1991) ‘Getting Smart’, after which Foucault’s critique of totalising theories really began to sink in:

“…fears of relativism and it’s seeming attendant nihilism … seem to me an implosion of Western, white male, class-privileged arrogance-if we cannot know everything, then we can know nothing” (ibid p116).

Engaging with Lather’s work (see Methodological Approach and Methods chapter) made me reflect upon my motivations in craving certainty, reflections that would see me rejecting such efforts in favour of embracing the uncertainty I’d been running from. With this realisation, I was finally in a position to ‘stake out’ my theoretical perspective and choose my methodology.
My theoretical position
To formalise my theoretical position, currently I describe myself as a realist with regard to my ontological beliefs, i.e. believing that the world exists independent of the mind, and a social constructionist with regard to my epistemological beliefs, in the sense that I believe all knowledge is a social construct produced by discourse. In terms of my ideological beliefs, in accordance with Foucault’s rendering of ‘power/knowledge’, I believe that whilst one must remain committed to a critical emancipatory position, resistance to power must be understood as necessarily resisting both the formal structures of the state and the forms of individuation enmeshed with said institutions but also manifested in wider webs of power. As Foucault wrote:

“…the political, ethical, social, philosophical problem of our days is not to try to liberate the individual from the state, and from the state’s institutions, but to liberate us both from the state and from the type of individualization which is linked to the state” (Foucault cited in Rabinow 1991 p22).

Chapter summary
Having delineated my theoretical perspective through exposition of the key theories and theorists that were deployed, and formally stated my ontological, epistemological and ideological commitments, I am now in a position to present my chosen methodology and methods in the following chapter.
Chapter 4 Methodological Approach and Methods

Introduction
The aim of this chapter is to introduce the reader to the methodological approach that developed out of my theoretical perspective and the methods employed to achieve my research aims. ‘Methodology’, is defined by Crotty (2007), as being, “...the strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and use of particular methods to the desired outcomes” (ibid p3).

I will proceed by detailing the influence of the work of Lather (1991; 2007; 2010), introduced at the end of the previous chapter, and by explaining my methodological approach and general ‘plan of action’ in regard to how I approached my research field, before presenting the more prosaic, ‘nuts and bolts’ features of the chosen methods and research design. This will include; sampling; data collection; participant recruitment, selection and ‘drop out’ rates; a description of the online email interviews; ethics and governance; transcription; rigour; and textual analysis. The chapter will conclude with a summary of the above in preparation for the analysis chapters.

Methodological approach
My theoretical perspective led me to be highly influenced in this regard by the work of Lather (ibid), a feminist writer and researcher with a specific interest, amongst other areas, in both feminist emancipatory research in light of the deconstructivist critique of science, and the future of research methodologies and methods in light of this critique.

At the outset, given the influence of Lather’s work on my methodology and her position as a feminist scholar, it is necessary to position myself in regard to feminism and feminist methodology; the focus of this is given particular pertinence both due to my research interest in BPD, a diagnosis which I have presented as being deeply gendered, and my employment of Butler’s (1997; 2004; 2007) feminist presentation of performative agency.
As a theoretical perspective, feminism has employed a diverse range of critical paradigms and research methods in order to realise its aims of justice and liberation. Broadly speaking, a social constructionist epistemological stance is put forward in order to problematise notions of gender, science, knowledge, and experience etc., which are rendered simple and benign within dominant paradigms, but are viewed as oppressive and socially damaging from a feminist critical perspective.

Creswell (1998) has identified several procedures adopted by feminist research which stem from this critical social constructionist position:

“1. Conduct sequential interviews in an interactive, dialogic manner that entails self-disclosure on the part of the researcher and fosters a sense of collaboration.

2. Conduct group interviews that provide potential for deeper probing and reciprocally educative encounters.

3. Negotiate meanings of results with participants in the study.

4. Strive to address issues of false consciousness and conceptual determinism.

5. Be self-reflexive about what researchers experience as they conduct research”

(ibid pp83-84).

Whilst the social construction of gender is a significant theme of my research, it would be inaccurate to state that it was at the centre of my enquiry at the outset. Although my research project may be considered supportive of a feminist perspective, my commitment to exploring ‘risk identity’ precludes a thorough negotiation of meaning with participants as recommended by feminist researchers (including Lather). Whilst other features of a feminist emancipatory methodology, outlined by Creswell (1998) will be adopted (see below), I approached my research wanting to explore a specific feature of social reality, which implies a pre-existing interpretative agenda.
Although some feminist researchers would be supportive of selectively incorporating features of a feminist research approach (Harding; Seibold et al cited in Kralik 2005), I feel that, as a male researcher with a specific agenda in mind, it is more sensitive and honest to state that, whilst my research project is supportive of the feminist research agenda, my aims as a researcher were at no stage consciously feminist, nor do I exclude the possibility that my ‘maleness’ – not forgetting my commitment to this being a discursive construct – influenced my choice of research topic in some regard.

I therefore choose to describe myself a researcher engaged in emancipatory critical research who recognises the analytic need to incorporate feminist theory and methodology within my approach, my methodology being informed by feminism but not being of itself feminist.

‘Persistent interruptions’ of Marxism, feminism and poststructuralism

A central concern across Lather’s work has been her attempt to articulate the possibility of emancipatory research within the context of poststructural and postmodern critiques of science. Lather looks towards innovations in research practice itself as the way forward for emancipatory research in the wake of poststructuralist scepticism of the legitimacy of ‘naïve’ Marxist and feminist emancipatory paradigms: “...instead of hovering above, legitimacy descends to the level of practice and becomes immanent in it” (Fraser and Nicholson 1988 cited in Lather 1991 p117).

Acknowledging that she too shares an ambivalence in regard to the politics of postmodern practice and thought, Lather conducts a, “...critical appropriation of postmodernism” (Hutcheon 1988 cited in Lather 1991 p2) in order to, “...salvage [emancipatory] praxis in a way that denies both teleological Marxism and a postmodernism of cynicism” (ibid p12).

With regard to Marxism, Lather acknowledges the Foucauldian critique of this school as the central emancipatory paradigm positioned in some ideal space beyond discourse, however recognising that it has yielded results as one strand amongst a plurality of discourses of resistance. She decentres it from its privileged explanatory position whilst acknowledging its utility when held with the necessary degree of deconstructive suspicion amongst a polyphony of critical approaches.
Turning to feminism, a critical perspective which she follows Kipnis (1988 cited in Lather 1991) in describing as, “…the paradigmatic political discourse of postmodernism” (ibid p27), Lather supports this claim by noting three key features of feminism, namely, its emphasis on practice-based theorising, its anti-essentialist positioning of the subject as neither a unified static subject nor a thoroughly determined subject, and its long-standing reflexivity, which acknowledges the provisional and problematic nature of cherished theoretical assumptions, whilst still acting politically and pragmatically in the world.

Using Kroker and Cook’s (1986 cited in Lather 1991) metaphor of feminism as, “…the quantum physics of postmodernism” (ibid p27), Lather justifies this claim by arguing that:

“…feminism has pushed post structuralism in directions it might otherwise not have gone in terms of political engagement. … While both feminism and Marxist thought share aspirations to be theories in the service of a politics, my argument for foregrounding feminist thought and practice in the inscribing of postmodernism displaces both the concept of post-feminism and the hegemony of Marxism over left discourse/practice. This is not to conflate feminism and postmodernism, given the politics of the one and the irredeemable political ambivalence of the other. Nor is it a move to do away with Marxism. It is, rather, to position Marxism, feminism and poststructuralism as “persistent interruptions of each other” (Spivak, 1987:249) in the struggle to do cultural change work in a post-foundational context” (ibid p31).

Lather, then, whilst acknowledging the differences between these theoretical traditions and ‘holding them apart’ rather than attempting to reconcile them in yet another grand foundational synthesis, argues positively for their incommensurability and interruptions of one another within research practice, a ‘forward movement’ within emancipatory research practise which grounds research in praxis whilst avoiding both the spinning of grand totalising meta-narratives and the inertia of an apolitical idealism.

Whilst not denying the real world nor the importance of engaging in practical emancipatory research, epistemologically, rather than falling into the pit of relativistic despair or attempting to create a new foundation for knowledge, Lather embraces and valorises the uncertainty of pragmatic approaches that acknowledge the complexity of reality whilst refusing to reconcile the irreconcilable, with this epistemological ‘messiness’ reflecting the contingent and complex nature of the world.
In addition, given the oppressive totalising critique of foundationalist emancipatory research, this acceptance of ‘not knowing’ embodies an ethical dimension in that, “...embracing not knowing is a condition of a less dangerous doing” (Lather 2010 p15). The mobilisation of research that embraces this humble uncertainty, according to Lather, has the effect of, “...setting philosophy on a journey toward an indeterminacy that is no longer about relativism but about responsibility in not knowing” (ibid p17).

For Lather, given the poststructuralist critique of foundationalist emancipatory efforts with regard to excluding the ‘Other’ through processes of normalisation and exclusion, this scientific orientation towards messy imperfection and difference as a way of knowing enables an opening up to the ‘Other’, with the embracing of indeterminacy representing a political commitment to diversity and to the ‘Other’:

“...my interest is in scientificity that is about imperfect information where incompleteness and indeterminacy are assets, more or less, central elements of a scientific posture of getting lost as a way of knowing. Here the absence of foundations is enabling, opening us to the other” (ibid).

Responsibility regarding knowledge, and therefore, as we have seen, power in regard to the ‘Other’ requires self-reflexivity. Through self-reflexivity, the very critique of the ideological nature of knowledge is applied by the critical emancipatory researcher to themselves and their own production of knowledge. Their investment, accountability, and responsibility is brought to the fore within the research endeavour in accordance with a Foucauldian ‘power/knowledge’ perspective.

Ultimately, then, Lather calls for researchers to embrace, practically, ethically, and politically, uncertainty and to attend to the ways in which the social world, under the emancipatory investigations of the researcher, brings forth messy, contestable interpretations. Such an approach acknowledges the complexity of the world without committing the procrustean imperious sin of foundationalism or embodying the lamentable apolitical apathy of a ‘full blown’ postmodernist idealism. The complexity and ‘openness’ of such an approach enables attention to be given within research to the plethora of potential empirical material as one ‘takes the side of the messy’. As Lather writes:
“To “take the side of the messy” is to counter faith in a naïve and transparent social world, to work with empirical material in a way that pays attention, simultaneously, to language, bodies and material conditions, to present a mix of interpretations verses seeking consensus, both finding patterns and opening up closures, to show the problems with all efforts to represent reality” (ibid p10).

The ‘plan of action’

Taking these methodological issues on board when accounting for my ‘plan of action’ with regard to my choice of methods and choice of analysis, a commitment to self-reflexivity, anti-foundationalism, anti-essentialism, and the decentring of the humanistic subject had particular ramifications in terms of my research design and form of analysis chosen.

Following Lather’s example in the final chapter of her book ‘Getting Smart’ (1991), I chose to employ her appropriation and adaption of Van Maanen’s (1988 cited in Lather 1991) ‘Four Tales’ of how one might approach data whilst remaining true to the theoretical considerations noted above, namely a ‘Realist Tale’, a ‘Critical Tale’, a ‘Deconstructivist Tale’, and a ‘Reflexive Tale’. As Lather herself explains:

“By “realist,” I mean those stories that assume a found world, an empirical world knowable through adequate method and theory. By “critical,” I mean those stories which assume underlying determining structures for how power shapes the social world. Such structures are posited as largely invisible to common sense ways of making meaning but visible to those who probe below hegemonic meaning systems to produce counter-hegemonic knowledge, knowledge intended to challenge dominant meaning systems. By “deconstructivist,” I mean stories that foreground the unsaid in our saying, “elisions, blind-spots, loci of the unsayable within texts” (Grosz, 1989:184). Deconstruction moves against stories that appear to tell themselves. It creates stories that disclose their constructed nature. And, finally, by “reflexive,” I mean those stories which bring together the teller of the tale back into the narrative, embodied, desiring, invested in a variety of often contradictory privileges and struggles” (Lather 1991 pp128-129).

Like Lather, I wished to approach my research by acknowledging the complex nature of the world, and I sought to achieve this by emulating her example of ‘spinning’ four tales about the data from differing yet productive theoretical approaches, whilst noting how said tales interrupt and converge through layering them together. In addition, in the telling of the Reflexive Tale which foregrounds my investment in, and production of, knowledge, my aim was to be as transparent as possible regarding my role and power privileges in said production of knowledge, through the explicit reinsertion of myself into the narrative of the research.
Before specifying how I put this methodological position into practice, I first need to ‘set out’ and justify my choice of methods and research design.

**Methods**

In order to generate the texts required to meet the needs of my research question, I chose to conduct online open-ended interviews with participants diagnosed with BPD via email. My reasons for adopting this method were as follows.

The conducting of interviews, as a method, was selected due to being ideally suited to exploring highly specific research issues (Sofaer 1999), such as my own. It is worth highlighting however, in relation to my theoretical perspective, that this method has traditionally been used within studies that assume many of the humanist assumptions that I reject. As Zavarzadeh and Morton (1986 cited in Lather 1991) point out:

“As a mode of knowing, the interview technique is an exemplary strategy of traditional humanism since such a device inscribes fundamental humanist values (that is, liberal pluralism, unmediated knowledge, participatory democracy, consensus among free subjects) in the very practices it claims to be studying ... The focus of the interviews (unitary, sovereign subjects) reaffirmed the belief that people contain knowledge (they are self-present subjects) and all that one has to do to have access to that knowledge is to engage in “free” and “unconstrained” discussions” (ibid p113).

Rejecting the assumption that interviews are an unproblematic means of shedding light on the subjective truth of participants’ experiences and the attendant humanist assumptions entwined with this, as a method employed within post-foundationalist research, my choice in no way sets a precedent. Texts generated through interviews are regarded as a legitimate means of uncovering prevailing discourses and discursive practices within discourse orientated methodologies (Potter and Wetherell 2004).
In terms of the style of interviewing adopted, an entirely unstructured interview style was rejected due to this running the risk of my specific research interests being inadequately addressed. Closed-questioning was also rejected as this would have been equally inadequate, with a danger of failing to facilitate the identification of unanticipated issues/information which I assumed would be present, given the situated participant’s knowledge of the field. The choice of employing open-ended questions within the interviews was therefore made based on the need to facilitate and encourage detailed and meaningful exploration of the specific key themes within the field.

With regard to the decision to conduct the interviews online rather than the more traditional ‘face-to-face’ encounter, it must first be acknowledged that face-to-face interviews can, “...provide rich and in-depth stories of experience and help researchers to gain an understanding of how people construct their lives and the stories they tell about them” (James 2016 p152). In addition, acknowledgement must also be given to the fact that the trustworthiness and veracity of information elicited online has been criticised in terms of the quality of the information being compromised, through researchers not having access to verbal or paralinguistic information (Markham 2008).

To justify my choice of online email interviews given the above points, I need to show how this method better suited my research objectives. As Hine (2008) states, “...the decision whether to conduct research relationships online or offline is situated in the demands of a specific research goal” (ibid p109).

Beginning this justification with the client group itself, Bjerke (2010) has noted that one advantage of email interviews is the potential to:

“...“give voice” to different groups of people who for various reasons—such as social isolation, shame, physical disability, or shyness—cannot or will not participate in [face-to-face or telephone] research” (ibid p1723).
Given the potential difficulties around relationships, shame, and anxiety as described by the diagnosis (see Appendix 1), I believed conducting the interviews via email would not only encourage those less likely to participate due to feeling intimidated by face-to-face or telephone communication, it would also prove potentially less anxiety provoking for those who agreed to take part. This strategy would therefore not only potentially give voice to individuals who may have been discouraged from participating otherwise, but was also ethically justifiable in terms of reducing possible harms (i.e., potential distress).

Whilst the former consideration resonates with the emancipatory dimension of the project, the rationale for minimising potential distress was arguably supported by comments made by one participant (Susan) who spoke of her high anxiety in the context of anticipating contact with people, even via the telephone:

“I can be on tenderhooks to the point of cannot function. I cant talk, or engage with another human being. I will do so with the children but the bare minimum ... like a lot of BPD fellows, I do not like making or receiving phone calls” (Susan).

Acknowledging the positive features of face-to-face interviewing noted above, a second reason that I chose to conduct my interviews via email was based on the empirical evidence which suggests that, specifically in terms of self-disclosure, participants in online research ‘disclose’ more about themselves than they do in conventional face-to-face interviews (Markham 2004; Joinson 2008). Whilst my theoretical commitments mean that I need to be wary when citing studies that speak of ‘self-disclosure’, as this language intimates the kind of essentialist notions of identity that I reject, what was clear was that online interviews were likely to generate richer and more detailed accounts of self-identity than those potentially produced through face-to-face or, by extension, telephone encounters (ibid).

Related to this issue of greater self-disclosure in terms of the quality of texts produced via email interviewing is the issue of the ‘chrono-malleable’ nature of this specific medium, i.e., that it permits asynchronous and synchronous forms of communication (Markham 2004).

Asynchronous communication opens a space within interaction that permits reflection and the honing of responses not possible within purely synchronous face-to-face or real time communication. As James (2016) notes:
“...the asynchronous nature of email [seems] to offer a solution to follow up on questions and fully complete interviews in ways that the more immediate and often one-shot nature of face-to-face and telephone interviews could not do” (ibid p152).

Whilst, as noted above, verbal and paralinguistic information is not accessible via email, I would argue that the benefits of email interviewing as a method outweigh the cost of such losses. The opportunity afforded by adopting emails in enabling both participants and myself to edit and reflect upon responses prior to sending enhanced the quality of the research interviews in terms of generating texts of high significance for my research aims and would arguably not have been possible using traditional interviewing strategies.

Whilst the spontaneous synchronous nature of face-to-face interviewing has been cited as a strength in terms of eliciting valuable information, with Opdenakker (2006), for example identifying that: “An advantage of this synchronous communication is that the answer of the interviewee is more spontaneous, without an extended reflection” (ibid no pagination), ethical qualms around unintentionally ‘catching out’ participants with regard to them revealing information they may later regret disclosing again pushed me towards email interviewing and the reflection and editing of response that this enabled them.

It has been argued that the power and control offered to participants in regard to editing their responses via the asynchronous nature of email interviewing is inherently empowering (James 2016) (a consideration which again resonates with the emancipatory dimensions of the project), and I propose additionally that, whilst some spontaneous information may be lost, it is also ethically preferable in terms of participants being able to confirm meanings rather than the researcher forming interpretations on potentially non-volitional verbal or visual cues.
Whilst, as previously stated, I believe the benefits of email interviewing outlined above outweigh the loss of verbal and paralinguistic information and justify my choice of method, I would also note that criticism of the disembodied nature of the email interviewing seems to posit essentialist notions of the self, in that it suggests ‘truths of a self’ that might be obscured, in one way or another, by not being in a face-to-face interview encounter. Here I would argue that my theoretical position more broadly sidesteps this criticism in that it is not the veracity of the account of identity elicited that is relevant, but how this identity is produced and negotiated. In other words, it is the discursive resources accessed and evident through the interview text that is of interest, not whether what is being related is a true or false in a humanist positivistic sense.

In addition to the reasons stated above, a further reason for adopting email interviews as a method was the geographically dispersed nature of the Internet itself, i.e., that it collapses distances by facilitating instant access to individuals located over a wide geographical area. This feature of the Internet supported my research goals in terms of considerations around accessing potential participants, contributing to the research rigour, and overcoming potential practical/logistical hurdles.

In terms of email interviewing lending itself to participant recruitment, since psychiatric discourse is not bound by the walls of psychiatric units but extends into the wider culture (Rose 1996; 1998; 1999), the implications of this was that participant recruitment needed not to restrict itself to any specific geographical location (for example, psychiatric units). The theoretical background that underpins my research topic therefore lends itself to legitimately accessing individuals not bound by geographical location, this being afforded, as stated, by the geographically dispersed nature of the Internet.

Whilst ethical considerations limited my study to the UK only (see below), mental health service provision is known to be variable and patchy within this region (British Medical Association 2015). On the assumption that encountering differing mental health services could impact on participant’s experiences in ways relevant to my research themes (i.e. access to services, and the quality of response of local mental health services), selecting participants from a wide geographical area also mitigated against any local bias rooted in the experiences of services from one single locale. This, I would argue, contributing to the overall rigour of the research design (see below).
Whilst this potential source of bias might have been overcome through physically travelling across the country to enable face-to-face interviewing or considering the option of telephone interviewing, the cost and inconvenience of such a solution may have impacted on participant recruitment and, therefore, email interviewing appeared ideal as a means of overcoming these financial and logistical obstacles.

In summary, the choice of adopting online open-ended interviews with participants was made based on a number of factors. The advantages of the method in regard to generating quality texts of high significance and necessary depth, was mixed with emancipatory, ethical, and research design (i.e., recruitment, rigour, logistics) considerations. What was lost in terms of verbal and visual information was balanced with and, I believe, outweighed by, the advantages to the specific method of email interviewing.

**Research design - inclusion and exclusion sampling criteria**

My inclusion criteria were as follows: individuals with a diagnosis of BPD with regular Internet access and an identified support network. My rationale for the first criterion was that it is the negotiation of identity with these individuals that is the focus of my research and that, in order conduct the interviews, regular use of an internet-enabled computer was a practical necessity. The requirement of a support network pertains to the ethical requirement to reduce risk of harm (see ‘ethical considerations’ section below).

In terms of my exclusion criteria, participants were required not to be currently receiving treatment by NHS or private mental health services. The rationale for this was twofold, firstly to eliminate the possibility of clients known to me and potentially under my care from taking part in the research, and secondly, to avoid broader ethical issues around the possibility of exploitation of individuals in vulnerable states without capacity to give informed consent (see ‘ethical considerations’ section below).

Finally, due to practical considerations around timing interviews with individuals potentially anywhere in the world within differing time zones, and ethical complications around differing data protection and research ethics legislation around the world (Ess et al. 2002), the geographical scope for participant recruitment was limited to the UK only.
Sample size
With regard to the number of participants required for my study, i.e., the sample size, two considerations were borne in mind; namely a methodological commitment to the notion that significant patterns can emerge from small samples (Phillips and Hardy 1998), and practical considerations around completing the research project within the designated timeframe. With regard to the former, the issue was approached in relation to what is required to address the specific research topic under investigation. The emphasis is thus on the quality and relevance of the texts employed rather than on the quantity (McCloskey 2008).

With regard to timeframe limitations, approaching the texts from four differing perspectives involves painstaking and time-consuming analysis. Attempting to analyse too many texts would have swamped me with data and rendered an analysis practically impossible to conduct, both in terms of allowing the analytic details to emerge and in terms of completing the study within the timeframe allotted by the doctoral programme.

As a consequence of the above considerations, the ‘ball park’ estimate at the commencement of the recruitment phase was to involve no fewer than 6 and no more than 12 participants.

Sampling procedure
In terms of justifying my sampling procedures, viewed as a method for producing texts, one can look at this approach as a ‘purposeful criteria’ based sampling procedure, in that it deliberately creates and selects texts that reflect the requirements of the research question. As McCloskey (2008) states, “…the research question or questions will drive the selection of texts and, initially, the researcher should focus on texts in a particular discourse plane” (ibid p31). Accordingly, the main consideration in selecting my sample was that of producing texts relevant to constructing the object of analysis (Phillips and Hardy 2002). As the object of my analysis is the constructed identities of individuals subject to the BPD label, the texts produced needed to reveal the discursive construction of said identities. To this end, I obtained texts generated through semi-structured interviews with individuals diagnosed with BPD. My aim was to generate discourse on the specific issues of relevance to my research topic, with the interview texts, i.e., the transcripts themselves, representing my textual source and ‘entry point’ into accessing the ‘discourse plane’ relevant to my research interest.
**Data collection methods - participant recruitment**

In order to recruit the required participants, a research website was commissioned (http://www.riskidentity.com/) which gave a brief synopsis of the research topic (see Appendix 3), full participant information, and contact details of the researcher should the reader of said information be interested in participating in the research.

To advertise the existence of this website, a news article/recruitment advertisement entitled ‘Borderline personality disorder: risk and identity’ (Maxwell 2011) was commissioned to be placed on the ‘Mental Healthy’ (2011) website, an UK Internet site which features, “...mental health information, guides, features, experts, news and community” (ibid no pagination) (see Appendix 4). The news article gave readers a brief exposition of the research study and provided a ‘link’ to the aforementioned research website’. Embedded within the advertisement was a web link that the interested potential participant could click on to be directed to my research website for further information.

Whilst 6 of the 8 participants recruited for the study were obtained in this way, prior to the news article/recruitment advertisement being placed, one participant (Ramona) discovered the research site having searched for BPD in an internet search engine. A second participant (Simone) was known to me as a fellow mental health professional and through her attendance at a therapeutic community conference, and was recruited following her having been informed of the research and expressing an interest in participating.

In terms of the impact of knowing Simone personally compared to the other participants, she herself noted when reflecting on my role as a nurse and as a researcher that knowing me already did make a difference. She identified that she could, “...assume some shared knowledge...”, and knew that I was, “...open to non-mainstream, different ways of seeing and doing things”. She also identified that her experience of being interviewed consequently did not feel like she was, “...writing to "the enemy" (Simone).

From Simone’s comments and from her interview text in general, I believe that knowing one another prior to the research resulted in her being more able to ‘speak her mind’ and, due to our shared knowledge, communicate more easily than those participants previously unknown to me. Additionally, knowing one another already meant that time was not needed to establish rapport.
Gaining informed consent

Individuals who made contact and expressed an interest were directed to the research website which contained a detailed account of what to expect as a participant in the research (the equivalent of an ‘information leaflet’). Said website detailed information on the study under the following headings; the purpose of the study; participation requirements; what you will be asked to do/expectations; risk of possible harms; confidentiality; expected outcomes; results; and ethics approval (see Appendix 3).

Those not wishing to take part at this stage or who did not meet the inclusion/exclusion criteria were thanked for their interest and offered to be included on an email list whereby they could be updated about the progress of the research (see Appendix 5 for an example of said emails). Potentially suitable participants were then engaged in an assessment/vetting email exchange through which I further explored and confirmed that they met the inclusion criteria and asked them to detail their support network and current mental health status (see ‘ethical considerations’ section below).

Once I was satisfied through this process that the potential participant both understood what would be required of them and was suitable for the study in terms of fitting the exclusion/exclusion criteria, they were sent a physical consent form with a stamped addressed return envelope for them to sign and return (see Appendix 6). Having received the signed consent form, it was only at this stage that they formally became participants, on the assumption that they now were fully informed of what was required of them to consent.

As the research design called for the interviews to be semi-structured, the possibility of an unanticipated significant theme emerging that was of relevance to my research question but unknown at the outset had potential repercussions in terms of informed consent, should it be the case that the participant did not wished to pursue this particular emergent theme. In order to meet the needs for informed consent given this unknown quantity, this potential risk, and the right to withdraw from the study was emphasised within the risk of possible harms section of the research website and also in the consent form. This identified risk, however, did not seem to arise during the process of interviewing the participants as established by frequent ‘check in’ questions by myself regarding their welfare.
Participant selection
Of the 24 potential participants who expressed an interest in participating in the research, 15 were excluded due to not fitting the inclusion/exclusion criteria and one participant ‘dropped out’, identified by her not responding to ‘follow up’ emails having returned the completed consent form. This left 8 participants who took part in the research project. Whilst 6 of the potential participants were male, the final participant group was all female and this was reflected in the title and focus of the study.

The participants
Due to the research interest being directed by the emerging themes drawn upon by those with a BPD diagnosis, participants were not selected on ethnicity, gender, or, other than having to be over the age of eighteen, age, since this would pre-frame important identity theme constructions.

Participants revealed details about themselves during both the recruitment and interview phases from which the following general information was gleaned; this information is provided in the spirit of introducing the participants to the reader, rather than constituting a definitive description of them or an exhaustive demographic account (please note that all the names given are pseudonyms).

- Ramona was a university student returning to her studies having had to take a break several years back due to her distress. She wasn’t acquainted with anyone else with the same diagnosis as her.
- Simone was a mental health nursing graduate working as a mental health advocate and involved in several groups and projects focused on progressive approaches to mental health. She had worked with and advocated for individuals with a BPD diagnosis.
- Emily was a researcher and writer for a mental health charity for whom she conducted presentations for professionals and relatives on the topic of BPD.
- Summer was a woman in her mid-twenties who worked full-time in the care sector and was completing a diploma in health and social care during the period of the interview.
• Susan was the mother of a teenage daughter living with her partner. Aside from her diagnosis of BPD, she also had a diagnosis of bipolar mood disorder.

• Dawn had once trained as a mental health nurse but did not complete her studies and worked for a mental health charity at the time of interview. She had an 11 year old son and lived with her partner.

• Sally was a middle aged mother of three grown up children and one young son and worked for a mental health charity. She’d spent several years living in Italy before her first marriage ended. She currently lived with new partner and their young son.

• Bell was an older woman who had an adult daughter no longer living at home and an ex-husband. She experienced a bout of pneumonia during the interviews resulting in her only being able to contribute a few email responses within the timeframe of the interview phase of the research.

‘Drop out’ rates
Aside from the one potential participant who did not respond to ‘follow up’ emails despite having returned her signed consent form, whilst ending the interview with the participant ‘Susan’ (pseudonym), she informed me that:

“I suppose this will be our last email as soon I will be under the community team again because I am struggling with my Ocd /anxiety and the bi-polars on it's regular visit, I have been sparodically forgetting my meds as I think I subconciously hate them, the Seroxat is a real bastard, it helps but the side effects - pfffft, especially the withdrawal, are hellish” (Susan).

Given the inclusion/exclusion criteria, the interview was ‘wound down’ however I had no more questions to ask of her and through replies to the ‘update emails sent’ and her reported positive experience of participating, I am left with no concerns about her welfare, nor do I believe that her participation was a factor in her mental health status .

Apart from Susan, all the other selected participants completed the interview process. Whilst I was mindful of the possibility of needing to conduct more than one phase of recruitment had ‘drop out’ rates been such that the participant number dropped below the lower threshold of 6, this turned out not to be necessary.
The online interviews
The online interviews were commenced at individually agreed dates and times with the participants for their convenience, and began by me inviting them to write about their broad thoughts as to their diagnosis, in order to set the scene of the engagement, asking the question, ‘what are your thoughts, feelings, or beliefs about the BPD diagnosis?’ being an example of one of the structured questions employed to ‘get the ball rolling’ or to direct focus onto topics specific to my research topic.

Other examples included: ‘I thought it might be a good time to ask you to think about whether there are any songs, poems, films, books etc. that you find resonate with your experience and sense of identity?’ The rationale for this question was to ‘open up’ potential discourses of identity construction as yet untapped within the ‘run’ of questioning around mental health. ‘Has my role as a mental health nurse as well as a researcher has impacted, positively or negatively, on the interview process?’ The rationale for this question was to recognise and be transparent about the power dynamic created by my professional identity and to gauge its potential impact on the interview process.

With each interview, I explored with the participant the arising themes in an open ended fashion, balancing my desire to focus on the key topics of the research with an awareness not to ‘close down’ prematurely or exclude potentially relevant lines of enquiry.

Following a response to a question that I had asked, in my follow up email response, I would proceed by summarising the participant’s answer, inviting them to correct any misunderstandings, distortions, or misrepresentations I may have made before asking my next question. My rationale for this was to highlight my fallibility in capturing and representing their responses, both in terms of attempting to address the power imbalance inherent within the construction of the researcher or clinician role as the ‘expert’, and in terms of ‘opening up’ and inviting dissent in an effort to empower them within the production of the interview text.
I would also seek clarification of comments made by the participants about which I was unsure, and invite them to explore further intriguing insights and observations relevant to the research topic. Occasionally, a participant would apologise for ‘going off at a tangent’, however I reassured them that tangents were potentially very fruitful in terms of ‘opening up’ unexpected themes, and that it was my responsibility to guide the interview ‘back on track’ if it seemed to meander too far from the research topic (I didn’t, however, find the need to employ any such guidance however).

As the interviews were conducted via the medium of email and were open ended, the timescale of each interview was determined by the following parameters. Firstly, each interview was allowed to run its ‘natural’ course within the limits of the planned period of data collection, i.e., three months. This was to ensure sufficient time for the participant and I to reflect on the questions and responses, whilst being time bound for the practical requirements of the research project.

Throughout each interviews, I ‘signposted’ the point at which it seemed that they were coming to a close, and that the topics of the research had been exhausted, and the participants were invited to reflect on whether they felt that there were any subjects or topics they believed were relevant to the research that hadn’t been covered. The rationale for this was threefold; firstly, to mitigate against any distress caused by any perception of a sudden termination of the interview process (see ‘ethical considerations’ section below), secondly, because I understood the participants to be the experts in terms of the subject matter and didn’t wish to assume I was the best place person to judge when the topics had been exhausted, and thirdly, as a means of compensating somewhat for the unequal power relationship necessarily bound up both within researcher/participant roles and clinician/client roles.

If no further topics were raised or, having explored any raised topics and again asked whether they felt the exploration was completed, the participant was asked to re-read the email exchange to ensure they were happy and satisfied with what had been produced, and to again see whether they felt anything extra needed to be said by them. The rationale for this again mirrored the rationale given above.
In terms of the texts produced, there was variance in terms of the amount that participants wrote in response to my questions, and the speed with which they replied. On three occasions with regard to different participants, following a period of over a week without a response to an email, I sent a polite reminder, enquiring whether they were ‘okay’ and confirming that they were happy to proceed. Replies to the reminder emails revealed that delays responding were either caused by busyness at work (Summer), physical sickness (Bell) or feeling vulnerable due to the Christmas holiday and needing to prioritise their mental health (Simone).

In the spirit of mutual disclosure and as a means of establishing rapport with the participants, I offered details about my life in an appropriate and boundaried way whilst remaining cognisant of my professional standards and code of conduct. Although some features of professional ethics in relation to boundaries are clear cut, for example, “...refuse all but the most trivial gifts, favours or hospitality as accepting them could be interpreted as an attempt to gain preferential treatment” (Nursing and Midwifery Council 2015 pp16), in less clear cut interactions between professionals and patients, it has been recognised that boundaries can be somewhat contested (Shevellar and Barringham 2015).

For the purposes of maintaining boundaries whilst interviewing the participants, I adopted an approach inspired by the ‘situated ethics’ of Banks (2011) who views ethical issues as, “...embedded in everyday practice and in people’s lives” (ibid p16). She goes on to propose the following:

“Ethics is not just about dilemmas and making difficult decisions about rights and resources by rational deduction from abstract principles. All facets of life have ethical dimensions. Ethical being and ethical action require sensitivity to the particularities of situations and human relationships, and encompass emotion (empathy, care and compassion) as well as reason” (ibid pp 16-17).
Employing this approach as my guide, when engaged in the practice of interviewing the participants, I sensitively answered any questions I felt were appropriate about myself or the research project as they arose (for example, where I was based in the UK, how much work I had ahead of me, etc.). Had any of the participants asked me for any details about myself that I would have felt uncomfortable disclosing or that would have clearly breached my professional code (for example, my home address, private/non-research contact details, detailed information about my personal life etc.), my plan was to not proffer such details but to politely remind the participant of my role both as a nurse and as researcher and acknowledge the asymmetry of researcher/participant relationship, whereby they were being invited to disclose more about their lives that I could disclose about my own. At no time, however, did I feel I was asked to disclose any details about my life that I felt uncomfortable disclosing, and my belief is that the details that were given enhanced the establishment of rapport.

Humour was also employed where appropriate to enhance rapport. This did not seem to be hampered by the online nature of the communication and I found myself looking forward to the participants’ emails, finding myself frequently moved and/or amused by their articulate and often witty replies.

In summation, and following Creswell (1998), the interviews were conducted sequentially in an interactive, dialogical manner and involved self-disclosure on the part of myself in order to establish rapport and a sense of collaboration with the participants. My experience of conducting the interviews confirmed my hope and assumption that the quality of information provided via online interviews ensured a high degree of relevance with regard to the research topic, and provided a rich source of data or analysis.

The period of time covered by the research interviews for all participant spanned 10 months, with the first email question sent to Ramona on the 21st October 2011 and the last email finalising the end of the last interview sent to Bell on the 11th July 2012.
Ethical considerations

Studying individuals with a mental health diagnosis represents research into vulnerable groups. Extrapolating from the clinical descriptors of individuals with a diagnosis of BPD, it is clear that these individuals in an ‘acute phase’ of their ‘condition’ are potentially vulnerable to exploitation by others, the re-experiencing of past traumatic episodes, and feelings of either rejection or interpersonal overwhelm. In states of dissociation brought about by extreme stress, such individuals could not be said to have capacity, or the ability to consent.

It is important to emphasise that the focus of the research was upon the participant’s sense of identity in relation to the concept of risk and not directed at asking them to recount past, and potentially traumatic, incidents of risky behaviour (this was made clear on the information page of the website and re-emphasised throughout the interview process).

Whilst those with a BPD label are more vulnerable to becoming distressed through interpersonal interactions, there is a great difference between individuals in an acute crisis phase and those in the ‘recovery phase’, living relatively settled lives in the community.

The inclusion criteria specifically excluded individuals in the ‘acute phase’ of their ‘condition’, focusing instead on individuals in the ‘recovery phase’ (this criterion also excluding participants under the age of 18). In order to establish that this was indeed the case, once a potential participant made initial email contact having accessed the research website, I engaged in the assessment/vetting process discussed earlier via email, whereby I confirmed with them that they met the inclusion criteria and asked them to detail their support network and current mental health status. Examples of questions asked were as follows:

- ‘Can I confirm that you are not currently receiving treatment under the NHS or are resident at a privately run mental health unit?’
- ‘How would you describe your mental health at this present time?’
- ‘Can you tell me the nature of your support network?’
In terms of addressing the potential for distress caused by perceptions of rejection or through interpersonal overwhelm during the interview process itself, i.e. potential attachment issues, as noted above, throughout the course of the interview, I ‘signposted’ when it seemed that they were coming to a close, to mitigate against any distress caused by any perception of a sudden termination of the interview process and also regularly ‘checked out’ with the participants whether they were ‘okay’ and whether they were happy to continue.

In addition, my clinical work has required a sensitivity and mindfulness with regard to how relationships are established, maintained and terminated in safe and mutually respectful ways, and by extending these skills into the research domain, I safely negotiated the required research relationships without causing participants undue distress.

Towards the termination of one interview with the participant Sally, she expressed a degree of difficulty in ending the interview process. However this was safely and respectfully managed though using the communication skills noted above and did not cause any significant distress: “In terms of the ending...yes it has jolted me but in an ok reflective I can cope way. It is part of life and I'm aware of it and again compared to other 'detachments' it is fine” (Sally).

Had a participant become significantly distressed by the interview process despite my best efforts, and mindful of the perceptions of rejection often experienced by individuals in receipt of the BPD diagnosis, my plan was to direct the individual to seek the support of their identified support network and to gently remind them that they did not have to continue to participate in the research (with re-engagement with the process potentially to have been negotiated with the participant if they wished to continue, and a ‘safe ending’ provided if they wished to drop out). This, however, proved unnecessary.

Whilst participants and potential participants were invited to be included on an emailing list for research updates due to respecting and appreciating their interest in the study, for those who were selected as participants, this served the additional function of enabling a further gradated ending for those who accepted the offer (Sally [see above], for example, appreciated this option and reflected that it would be beneficial).
Whilst the exploratory and emancipatory nature of the study design requires that the interview texts produced are a mutual undertaking by both participants and researcher, abiding by the principle of self-reflexivity, I acknowledge that I am in a more powerful position, having both the power to include and exclude participants but also, more significantly in terms of power/knowledge, the final say with regard to the conclusions drawn.

To go some way to counter this power imbalance, participants were encouraged to re-read the interview correspondence prior to interview termination to ensure that they were satisfied with what had been written, and that the power imbalance had been made explicit as a theme within the interview process (no participants chose to change any of their responses).

Whilst Creswell (2008) identifies conducting, “…group interviews that provide potential for deeper probing and reciprocally educative encounters” (ibid p83) as beneficial, due to the ethical need to maintain confidentiality between participants, such a group interview, be this in person or virtually, was unfortunately not an option.

**Research ethics and governance**

The University of Brighton Faculty of Health and Social Science Research Ethics Committee gave approval of the research proposal on the 19th April 2011 following submission of the ‘online’ FREGC application on the 29th March 2011 (see Appendix 7). As the ethical design planning excluded patients receiving treatment, including under the NHS, local research ethics approval was deemed unnecessary.
Transcription
The texts generated through the interview in the form of an email exchange were ‘cut and pasted’ into Microsoft Word documents with pseudonyms inserted and information potentially identifying the participant removed (i.e. references to specific institutions or work places, the participants email address etc.). These documents, with the necessary anonymity alterations undertaken, became the transcripts on which my analysis was conducted (see Appendix 8 for an extract of such a document). Whilst the original text paragraphs and typographical/spelling errors etc. were all maintained from the original email texts to keep them as close to the original texts as the ethical anonymity/confidentiality requirements permitted, the fonts were altered to ‘Times New Roman’ (i.e. the specified font for doctoral thesis presentation ). The rationale for this being that the type of font did not appear to lend specific meanings to the research area under investigation and the task of reading differing fonts was felt to be ‘jarring’ thereby interfering with the ‘flow’ of reading.

Rigour
“Where, after the metanarratives, can legitimacy reside?” (Lyotard 1997 p xxiv –xxv).

Attempts to establish what constitutes rigour within the social sciences, have been, and continue to be, contested (Rolfe 2006). Given my theoretical commitment to post-foundational discourse theory, traditional notions of validity and reliability are problematised, in that they spring conceptually from positivism and objectivism, both rendered as instances of discourse and disciplinary power rather than ‘innocent’ standpoints.

In terms of reliability, i.e., “...the degree to which the finding is independent of accidental circumstances of the research” (Kirk and Miller 1986 cited in Peräkylä 2009 p285), the reflexivity I bring to the research and the commitment to the notion that I am co-producing my results undermines the traditionally championed positivistic criterion of repeatability, this being an impossibility.

Similarly, ‘validity’, i.e., whether, “...the researcher is calling what is measured by the right name” (ibid p289) requires a ‘re-thinking’ given that this too posits a ‘found’ objective world where representation is possible, rather than a linguistically constructed one in which representation is deeply problematic and inevitably bound up with power relations.
To avoid the ‘trap’ of foundationalism and attendant methodological attempts to validate research premised on epistemological correspondence theories of truth, Lather (2007) argues for, “…counter-discourse/practices of legitimation” (ibid p119). Amongst other ‘formulations’ of what she terms ‘transgressive validity’, she identifies ‘paralogical validity’ as one potential means of addressing the issue of validity from a poststructuralist critical perspective. Acknowledging the irony of her task, she produced a checklist for paralogical validity which I found broadly dovetailed with my theoretical commitment and research design:

“Paralogical Validity
- Fosters differences and heterogeneity via the search for “fruitful interruptions”
- Implodes controlling codes, but still coherent within present forms of intelligibility
- Anticipatory of a politics that desires both justice and the unknown, but refuses any general grand transformation
- Concerned with undecidables, limits, paradoxes, discontinuities, complexities
- Searches for the oppositional in our daily practices, the territory we already occupy”

(ibid p128).

In detailing how I conducted my textual analysis, my aim is to show how paralogical validity was woven into the study design. Before moving on to this task however, I wish to make a few comments in relation to the broad use of reflexivity within the thesis since, according to Darawsheh (2014), this feature, “…significantly adds to the rigour of qualitative research” (ibid p561).

Having stated in the Introduction chapter that I have deliberately employed reflexivity in acknowledgement of my position that detached objectivity is an epistemological impossibility, whilst my own judgement is that, as a tool and as a strategy for transparency, this has enhanced the rigour of the project, ultimately the burden of judgement arguably rests with the reader.
In discussing the implications for judgements about the quality of research studies in the context of the lack of a unified qualitative research paradigm, Sandelowski (1993 cited in Rolfe 2006) has argued that in place of a focus on truth and value within positivistic quantitative research, ‘trustworthiness’ might be seen as the mark of quality, with the task of the social scientist being to persuade others of this, through rendering their practices both visible and auditable. It is my hope that in addition to applying paralogical validity as a guide, my employment of reflexivity by way of transparency and the presentation of the research processes, both within the main body of the thesis and the appendices, will persuade the reader of the rigour of the project.

**Textual analysis**

In a reproduction of an interview with Lather in her book ‘Getting Lost’ (2007), Lather makes the following suggestion as to how, as a research supervisor, she maintains the integrity of scholastic rigour while encouraging experimentation with alternative research genres with her students. She states that:

“I insist with my students that they learn the interpretive paradigm first. In order to deconstruct something you’ve got to have something to deconstruct ... I make them write what John van Mannen calls the “realist tale” in his Tales of the Field where he talks of 13 ways you can tell data stories. The big one, he says, and about 85% of all fieldwork, is what he calls realist tales. And then you have the confessional tale and the critical tale and the feminist tale, etc. Then if they want to tell another kind of tale or three other kinds of tales ... they can do all of that, anything they want after they’ve done the standard thing” (ibid p24).

As noted above, my plan was to tell four tales through four approaches to the texts, i.e. the Realist Tale, the Critical Tale, the Deconstructivist Tale, and the Reflexive Tale, my rationale being that these four tales address my theoretical position. In accordance with the recommendation made by Lather in the preceding quote, mastery of the interpretive paradigm was addressed though adopting the traditional coding practices of said paradigm with regard to analysing the texts.
Having produced the interview transcripts for analysis (see transcription section above), I read through each text, noting my initial impression of themes that appeared to be present. These themes were then recorded as a Microsoft Word document which brought together all of the themes within all of the women’s texts into the one place, a different colour code being employed for each women’s text to maintain order (see Appendix 9 for an example section of this document relating to Susan). Having completed this, the identified themes were organised into a table, with the broad themes being placed on the left column, ‘sub-themes’ placed in the central column, and the quotes from the participants that appeared to fit with/into said themes, placed in the third column (see Appendix 10 for an example section of the analytic table).

With this large table completed, I returned to the original interview texts to see whether other themes had emerged, or whether I felt that any themes identified in the table could be collapsed into one another without losing thematic subtleties. This analytic movement from examining the interview text as a whole, to the interview themes considered as parts of that whole, and then back again, was informed by the notion of the hermeneutic circle whereby, “...the part can only be understood from the whole, and the whole only from the parts” (Alvesson and Sköldberg 2000 p53).

My rationale for employing this practice of shifting my attention ‘back and forth’ between the texts as a whole and the themes identified therein was based on the understanding that the identification of themes would inform my reading of the interview texts which could in turn reveal more themes or clarify or collapse previously identified themes. This ‘hermeneutic circling’ movement is a, “…dialectic process that deepens one’s understanding of the whole through increased knowledge of the parts” (Heinonen 2015 p31). Editing the table accordingly, the process was repeated until I had achieved what felt like a saturation of themes.
The numerous groups of quotes were then divided up along the lines of which of the four tales they seemed to address, i.e. quotes that ‘revealed’ the participant’s thought, feelings, and experiences in relation to the organising thematic topics of BPD, risk, and identity were grouped together for the Realist Tale, quotes that ‘revealed’ critical thoughts and beliefs with regard to said topics were grouped together for the Critical Tale, and quotes that lent themselves to the Deconstructivist and Reflexive Tales were similarly grouped together accordingly. As one might anticipate, many quotes ‘ticked’ more than one or two of these category boxes, these were placed in either two or more of the four groupings.

With these groupings having been made, the writing of the four tales could be undertaken, on the understanding that the process of writing would act as the final stage of the analysis for each tale, with themes that appeared not to address the research topic being discarded.

In telling the Realist Tale, I assumed the perspective of a realist, backgrounding my ‘shaping influence’ on the selection of what was presented, and foregrounding the voice of the participants through telling the reader what the women had to say about the research topic, and noting the dominant themes identified in the email texts as they relate to the themes of BPD, identity, and, risk. An additional aim of representing the participant’s narratives through a realist lens was to honour the participants’ stories and embedded understanding of research from a humanist perspective.

In telling the Critical Tale, the interviews were analysed through the lens of critical theory (itself rooted in realist ontology) by emphasising the hidden underlying structures and political influences that root and perpetuate oppression. The aim of this was to produce emancipatory, counter-hegemonic meaning, for the purpose of ‘opening up’ the possibility of positive social change.

In telling the Deconstructivist Tale, the interview texts were approached through the deconstructivist lens to show how the ‘truths’ of identity were constructed, through focusing on the underlying discourses which produce them.
In telling the final Reflexive Tale, I re-introduce myself as the co-producer of the texts in a reflexive manner in order to foreground my investment in, and production of, knowledge. The aim was to be as transparent as possible in terms of my role and power privileges in said knowledge production through the explicit reinsertion of myself into the narrative of the research, noting my investments in knowledge production as an embodied researcher with unavoidable theoretical, political and ethical values. This tale addresses Creswell’s (2008) criteria for conducting feminist research relating to the need for self-reflexivity about the researcher’s experience of conducting research.

With regard to the issues of paralogical validity introduced above (Lather 2007), as noted, the rationale for analysing the texts and presenting results within the four tales was to embrace the differences and to show and contrast said differences as, “...fruitful interruptions...” (ibid p128), whilst embracing and deliberately seeking out the, “...undecidables, limits, paradoxes, discontinuities, [and] complexities...” (ibid) as one attempts to conduct research situated within a territory one cannot but help occupy.

Whilst the use of coding was employed in analysing the texts, thereby keeping to an intelligible form, the analysis ‘goes beyond’ controlling codes through problematising humanistic assumptions about the legitimacy of said codes as rooted in humanistic/positivistic research (as per the deconstructivist critique) and in terms of attending to the underlying constructive discourses, i.e. the ‘unsaid’. As I am committed to both emancipatory justice and the ethics and epistemology of the unknown in a complex world, no general ‘grand transformation’ of the data within a single unified totalising theory was accordingly attempted.

Chapter summary

In this chapter I hope to have shown how my theoretical position led to my embracing a methodology that was both critical and emancipatory without falling into the ‘traps’ of either foundationalist epistemology or relativism, these ‘traps’ being two sides of the same theoretical coin forged in the, “...implosion of Western, white male, class-privileged arrogance” (Lather 1991 p116).
Whilst not positioning my research as strictly feminist, I incorporated feminist principles of conducting emancipatory research (i.e., conducting the interviews in an interactive, dialogic, and self-disclosive manner, meanings within interviews being negotiated, the critical addressing of conceptual determinism, and, self-reflexivity by the researcher) and employed Lather’s embracing of the ‘messy’ and her method, inspired by Van Maanen’s (1988 cited in Lather 1991), of approaching data through research tales, namely, the Realist Tale, the Critical Tale, the Deconstructivist Tale, and the Reflexive Tale. The specific research method employed was that of online interviews with women with a diagnosis of BPD.

Whilst traditionally conceived concerns around reliability and validity were problematised by my theoretical stance, paralogical validity was employed to meet and critique these challenges in a counter-discourse of legitimacy, as embodied within my research design. We are now in a position to present the four tales over the next four analytic chapters.
Chapter 5 Analysis – The Realist Tale

Introduction
My aim in this chapter is to tell the Realist Tale, i.e. to tell the story of my data on the assumption of, “...a found world, an empirical world knowable through adequate method and theory” (Lather 1991 pp128-129), thereby assuming a realist perspective.

Borrowing Fallon’s (2003) thematic categories of movement and navigation, broadly speaking, the narratives of the women in the present study reflect both this movement, in descriptions of contact with psychiatric services, and navigation in relation to how risk presentations are utilised to navigate and negotiate psychiatric services and communicate needs. Thematically one can discern the following broad stages; life before diagnosis; being diagnosed and learning about the diagnosis; experience of mental health services; and recovery in the context of identifying with or moving beyond the diagnosis.

Life before the diagnosis
In terms of the women’s sense of identity prior to diagnosis, descriptions were given of feelings of incompleteness (for example, “...in some ways i dont feel i am a complete person either, this feeling i have had for as many years as i can recall from childhood” [Bell]), of distorted body image (for example, “…looking back I have always had a very warped sense of my size and body shape. Always thinking I was fat and naturally this led to eating too much or not enough” [Sally]), and of feelings of worthlessness (for example, “[e]ver since I was little (2-3 years old) I have very vivid memories and feelings of being more trouble than I was worth” [Dawn]).

With regard to their sense of identity in relation to risk, one can identify three overlapping features by which the women identified themselves as being ‘risky individuals’ prior to coming to the attention of psychiatric services, these being self-harm, dissociative states and impulsivity (all identified within the DSM-V diagnostic criteria [see Appendix 1]).

In relation to viewing their own self-harm as being risky in and of itself, Dawn identifies direct and indirect behaviours:
“These involved direct self-harming and other behaviours which I guess would be labelled more as in direct behaviours - so putting myself deliberately in vulnerable position, excessive alcohol (so getting so drunk I would have no recollection of what had happened) promiscuity (to the point that I wanted to get a STD or pregnant) Deliberately engaging in violent unstable relationships etc…. The list could go on and on and on....”

Whilst (as we shall see below) the meaning behind why they engaged in self-harm were by no means in total conformity with how mental health workers interpret such behaviour, the accounts of the participants all identified the self-harm as containing an element of risk. This risk was considered to be greater when self-harm took place whilst dissociating, i.e., when detached, “…from the immediate surroundings or emotional and physical experiences, including the feeling that one's body does not belong to oneself” (Bekrater-Bodmann et al 2016 p37).

The significance of dissociation in relation to identity and risk is emphasised by Simone who writes, “I don't believe that, for me (or for lots of people I know) it's really possible to understand fully issues around identity or about risk without having a good understanding of dissociative processes” (Simone).

With regard to the topic of self-harming whilst dissociating, Dawn identifies such times as:

“...my most difficult times and often when I most likely to act out life threatening behaviours... I do not feel anything at all and in the past for example, I have held my arm over our gas cooker “just to see if I'm alive” and not felt a thing. It just feels like everything is on automatic pilot – like I have very little control” (Dawn).

This account fits the ‘anti-dissociation’ model of self-injury developed by Gunderson (1984 cited in Klonsky 2006) who proposed that self-injury could be used as a means of physically shocking oneself out of a dissociative state into feeling alive again. Dawn’s description identifies the risky potential of this strategy whereby the distress caused by a dissociative lack of feeling instigates desperate measures to feel, accompanied by a diminished sense of agency.
Whilst self-harm has risks associated with it when engaged upon in ones ‘normal waking state’ the lack of control identified by the women when engaging in this behaviour whilst dissociating resonates with Black et al’s (2014) superordinate theme of internal dynamics where they identify a dissociative ‘zone’ characterised by states of semi-consciousness, dissociated awareness of pain, amnesia, and hallucinations during which acts of self-harm may be undertaken. Significantly, according to Gunderson (2011), around 40% of self-harming acts conducted by those with a BPD diagnosis take place during dissociative experiences.

Further insight into the link between dissociation and the risk of self-harm (and indeed suicide) can be found in research by Foot et al (2008). They undertook a comparative study examining suicidality in patients with and without dissociative disorders. Conducting structured interviews with 231 patients admitted to an inner-city psychiatric outpatient clinic, 82 participants were identified as having a dissociative disorder diagnosis including that of BPD. Comparing these 82 participants with the non-dissociative participants revealed that dissociative disorders were strongly associated with all measures of self-harm and suicidality.

In addition to the specific issue of the risks around self-harm when dissociating, dissociating in general was identified as being ‘risky’ in itself, due to the loss of the awareness generally associated with ‘normal’ consciousness, with the following example given: “I’ve known people who wander off in the middle of the night and find themselves in fairly dicey situations” (Sally). Simone highlights the dissociative experience of a service user known to her and describes this individual;

“...waking up to a flat painted a different colour from the colour it was when she went to bed, and not remembering doing it. She also reported often waking up in alleyways miles from home, having badly self-harmed, but with no memory of how she’d got there or of having harmed herself” (Simone).

Here then, aside from again linking the increased risks around self-harm to dissociation, diminished awareness and the potential for ending up in dangerous situations is seen as an associated risk of experiencing dissociative states, and therefore part of the risk presentation of those prone to said states.
In terms of impulsivity being identified by the women as contributing to acting in risky ways, the following examples were noted:

“Occasionally, like with the driving, the dangerous behaviours were very impulsive and, in some cases, compulsive. I couldn't stop myself, it was an urge I had to close my eyes and I couldn't fight it. One minute I could be driving, not even feeling that emotionally unstable or dissociated, and then the next second my hands are off the wheel or my eyes are shut. The same thing would happen with eating (although obviously it's harder to be impulsive); I never binged but I would sometimes purge, and that only ever happened in a very impulsive way” (Ramona).

“I sometimes act on impulse, without really thinking of the consequences, overspending, binge drinking and I've been very promiscuous in the past too” (Summer).

“Impulsivity – this for me is about money – I don’t actually receive any of my salary because I would spend it in a day – actually controlled by my partner who gives me a spending allowance a week” (Dawn).

From the above quotes, a variety of types of impulsivity is evident within the examples given, with dangerous driving (including a dissociative element), purging, binge-drinking, promiscuity, and impulsive spending all referenced. This reflects the lack of any agreed-upon operational definition of the concept (Coffey et al 2011). As Coffey et al identify:

“...impulsivity has been variously defined as the tendency to act with less forethought than most people of equal ability (dysfunctional impulsivity), unconscious risk taking, acting without thinking, inability to stop a behavior that has negative consequences, preference for immediate over delayed gratification, preference for easier routes to self gratification, an inability to persist at a task, heightened novelty-seeking, having a short attention span, and difficulty waiting (Perry & Carroll, 2008)” (ibid p129).

Acknowledging the conceptual imprecision, impulsivity is clearly linked by the women to risk and can be viewed as forming part of the individual’s risk identity prior to considerations of how interaction with mental health services might modulate said risk. The authors also note that this conflation of impulsivity and risk is reflected in the DSM-IV (2000) with the satisfaction of the criteria for impulsivity also met with behaviours, “...conceptually closer to risk-taking than impulsivity (e.g., gambling, reckless driving)...” (Coffey et al 2011 p129).
Being diagnosed and learning about the diagnosis -
Before being diagnosed with BPD, Ramona and Emily described a lack of knowledge about the diagnosis, particularly in relation to the stigma that they and other participants identify as being bound up with it:

“Before I was diagnosed with BPD I didn't know much about it. ... At the time I didn't really understand the controversy that seems to surround it, or the stigma that is attached to it” (Ramona).

“I'd never heard of BPD before I was diagnosed with it, so it's not like I had any preconceived ideas about stigma or other people's judgements” (Emily).

Simone notes how the act of being diagnosed reframed her difficulties as pathological as opposed to extreme manifestations of normal human problems: “Before that label [BPD], I had problems, extreme problems, yes, but human problems nonetheless, that was how I saw it” (Simone).

Having received a diagnosis of BPD, Ramona, Summer, and Susan described an initial sense of relief at being given the label, with all three pointing to how it made sense of their distressing feelings and chaotic lives and, in the case of Summer, gave hope of the possibility of treatment:

“When I was diagnosed I was probably in the worst place I've ever been, and I accepted the diagnosis as something I could cling to in order to make sense of what was going on inside me and around me” (Ramona).

“...after speaking to the psychiatrist about it, he showed me the DSM and all of the criteria seemed to 'fit.' After speaking about different treatments available, both medication and talking therapies, I felt relieved, it was as if I finally had an answer to why I was feeling the way I did” (Summer).

“I had always had such a deep self loathing and utter hopelessness about the way I thought, looked and felt, that being told 'you have a disorder, it is a real existing condition, it is not just you being YOU' was slightly comforting, in a slightly desperate way” (Susan).

This identification of a sense of relief and validation supports the findings of Fallon (2003), Horn, Johnstone and Brook (2007) and Lovell and Hardy (2014), with the initial acceptance of the psychiatric construction of their distress being inferable from their accession to the diagnosis.
Whilst she emphasises the negative effects that being diagnosed with BPD had on her abilities to develop healthier ways of being, Simone identifies that, at the time, the negative identity of being ‘the screwed up one’ was better than not knowing who one was, her comments chiming with Susan’s, “…comforting, in a slightly desperate way…” comment: “I am the screwed up one, that's who I am, it's messed up but at least I know who I am” (Simone).

This sense of relief and, in the case of Summer, the possibility of hope in terms of treatment is consistent with the findings of Horn et al’s (2007) study in relation to the two superordinate themes of knowledge as power and hope and the possibility of change, which describe similar experiences of being diagnosed.

Bell, on the other hand, speaks of the distress that receiving the diagnosis created, due to a lack of understanding of what such a diagnosis meant: “i remember feeling so broken hearted as i wasnt really sure what it meant, i thought i was being told i was mad” (Bell). This fear of being seen as ‘mad’ as a consequence of being formally diagnosed is consistent with Horn et al (2007) and Lovell and Hardy’s (2014) findings, who identified a sense of uncertainty as to what the diagnosis meant in the context of professionals either not informing them that a diagnosis had been made or not giving them adequate information as to its implications.

Whether the reaction to being diagnosed is one of relief or of questioning one’s own sanity, both arguably represent shifts in the sense of identity in response to diagnosis, the first being an identification with the diagnosis through the naming and legitimising of one’s distress, and the second being a compounding of one’s sense of being ‘disordered’. Identification with the diagnosis thus seems to either legitimise or render comprehensible one’s pre-diagnosis distress, or compounds a sense of being somehow defective by having one’s madness officially sanctified.

Following formal diagnosis, Susan and Summer describe a process of educating themselves about the diagnosis through their own research. With Susan, this took the form of reading books and speaking to her CPN, whilst Summer was able to use the internet:
“I briefly researched into it. I never had a pc or anything then so mostly went to the library or read books in bookshops, plus my CPN had sound knowledge of BPD and provided me with some good feedback, info and printouts” (Susan).

“I began to get restless and I was surfing the Internet for hours, sometimes days at a time, although the things I read seemed to be negative. Basically after exhausting myself from all the 'research' I felt there was no way out, no help available, no cure. My symptoms worsened and the self harm was increased” (Summer).

Whilst, as will be describe later, Susan would learn about the stigma of hopelessness associated with the diagnosis through her interactions with professionals, Summer identifies how her own independent research lead to a sense of hopelessness, due to the negative nature of what she read and, consequentially, a worsening of her symptoms and increase in her self-harm.

Through the process of learning about the diagnosis, the women describe comparing the diagnostic criteria of BPD with their own experiences. Summer, Susan, Sally, Ramona, and Dawn report how the diagnostic criteria seemed to fit at the time (Dawn went as far as to reference each specific DSM-IV (2000) criteria to facilitate an extensive analysis of how she identifies with BPD noting that, “...I do still identify with the symptoms” [Dawn]):

“The diagnosis I was given seemed fitting in a number of ways. I felt I could fit almost my entire life into those categories!” (Summer).

“Once I looked at it, I immediately identified with much that was said and the symptoms described, so much so that I did feel a slight relief at thinking that I was not the only person to feel the way I did” (Susan).

“...I don’t argue against the fact that at the time of receiving the diagnosis I did fit [the DSM –IV diagnostic criteria for BPD]. Out of the 9 traits of the BPD I probably covered 6 or 7 of them...So as a set of symptoms it is correct” (Sally).

“The first three criteria definitely do apply to me ... Thinking about it now, I suppose you only need 5 of the 9 for a diagnosis to be made, and I definitely have at least 5” (Ramona).

The general, although not unanimous, consensus of the validity of the DSM diagnostic criteria for BPD, at least at the time of diagnosis, is consistent with Nehls’ (1999) and Kalapatapu et al’s (2009) finding that the diagnostic criteria were generally accepted reflecting the experiences of those with a BPD diagnosis.
Alongside this general acceptance of the diagnostic criteria is a dissatisfaction with the naming of the condition due to the associated stigma, this again being consistent with Nehls’ (1999) and Kalapatapu et al’s (2009) findings. In the present research, this is evidenced through the contrast between the comments made by the women about the validity of the diagnostic criteria (above), with their unanimous dislike of the diagnostic label:

“I agree with Judith Herman, that BPD is "little more than a sofisticated insult ... "BPD" clings to the person so-labelled like a bad smell, like the "dustbin diagnosis" that it is” (Simone).

“...it is as if the diagnosis lets you and everyone else know that you are intrinsically flawed as a human being” (Ramona).

“I actually hate the wording itself. It feels as if someone is saying that there is something fundamentally flawed, disorded about me, my self, the core of me, i.e. my personality and character” (Sally).

“My first thought was that it was a very negative sounding syndrome. Personality disorder seems ..well.. to risk sounding ironic..so PERSONAL. I think I kind of took it as a slur against my being, if you catch my drift, like my personality/ who I was, was flawed... I also felt it seemed quite a dismissive diagnos, you know - this person has a personality problem, end of. I knew nothing about the condition and being such a 'sensitive' insecure, paranoid person at the time, it screamed FAILURE!!!! To me” (Susan).

As prefigured by her account of the negative impact that researching the diagnosis had for Summer, a gradual awareness of the stigma associated with the diagnosis developed as the women engaged with mental health services, particularly through contact with mental health professionals. For example, Susan writes:

“I had no idea at the time of the stigma and distain bestowed upon the disorder and it's sufferers by the medical profession / general public. That was something I was to find out for myself ... I can say however, that I was never, ever self conscious about my diagnosis until I started getting this odd vibe from professionals in the mental health field” (Susan).

Experience of mental health services - not being told about diagnosis
For Ramona, Bell, and Susan, the awareness of the stigma that surrounds the diagnosis begins though the professional’s reluctance to formally tell them what they have been diagnosed with:
“...the psychiatrist who diagnosed me was even hesitant to say what my diagnosis was ... [she] ... rambled for a while about ‘emotional instability’ until I actually said to her, "Just tell me what is wrong with me" (Ramona).

“...When i was first aware of my dx, i wasnt told by any dr i saw it written down on my medical notes, even many yrs after the dx i still have never been told by any dr, ...i saw it written in my notes, and no dr has ever verbally told me that i have this dx” (Bell).

“...Well, I never actually was even given the news to my face that I had BPD, I happened to read it on one of my very first care plans way back in around 1996” (Susan).

This reluctance to acknowledge the diagnosis appears not to be limited to psychiatrists and can continue once the individual has embarked upon their psychiatric ‘career’. Emily describes this reluctance to speak about BPD in relation to contact with her GP:

“...With my GP and all the GPs at the local surgery it [BPD] just doesn’t come up. I can go in and say I’m suicidal (well, actually I did this once and was so awful I never did it again) and they talk of Depression and feeling low – and I think ‘surely you’ve seen my notes? You must know by the meds I’m on, and the therapies I’ve attended that there is more’ but it’s never mentioned” (Emily).

Acknowledging that the phenomena of not disclosing a BPD diagnosis has been identified by Fallon (2003), Walker (2006), and Koehne and Hamilton (2012), it was first empirically verified by McDonald-Scott et al (1992) who assessed the attitudes of 112 US psychiatrists and 166 Japanese psychiatrists towards disclosure of a BPD diagnosis using case vignettes for schizophrenia, schizophreniform disorder, bipolar disorder, dysthymia, panic disorder and BPD.

The results revealed that 55% of the US psychiatrists studies would disclose the diagnosis of BPD without being asked to by the patient compared to 16% of Japanese psychiatrists. Additionally, 16% of US psychiatrists and 16% of Japanese psychiatrists would disclose the diagnosis if directly asked by a patient to do so. Other than Schizophreniform disorder rates which were similar rates of disclosure to that of BPD, the authors figures indicate that for both scenarios, BPD had the lowest inform rates amongst the disorders studied.
Building on this early study, Lequesne and Hersh (2003) identified in their discussion paper on the topic that clinicians may not disclose that a BPD diagnosis has been made due to uncertainty as to the validity of the diagnosis, fear of transmitting the stigma that surrounds the diagnosis, and transference/countertransference issues between patients and clinicians that can result in the fear of eliciting negative, self-destructive reactions (e.g., anger, self-harm, etc.) in response to disclosure. Howe (2013) has since echoed these arguments in his own discussion paper on the topic specifically focusing on psychiatrists.

Experience of mental health services - encountering stigma through engaging with mental health services

The sense of stigma transmitted by mental health workers becomes more pronounced as the women engage with services. Susan gives an account of an encounter with staff on an acute unit in which she overheard the views of staff in relation to a fellow inpatient with a BPD diagnosis:

“Staff 1- well, yes shes had a better night but you know the borderlines... What's the point. It will just carry on. They can't stay in hospital forever. Just until next time. We can only patch the wounds- they're their worst enemy ... Staff 2- god yeah.... They say every doc has to take on their fair share of the bpd's... It's just they're so DRAINING. I know it's difficult but you have to be careful of the manipulation, very sneaky, they're good t twisting it ... Staff 3- mmmm and you know every emotion is so exaggerated. Very over sensitive. I mean we have to be careful or they will be encouraging each other ..with the harming you know ... I thought " that's what they think underneath... That all borderlines are manipulative, sly, needy non treatable pain in the arses. Great"” (Susan).

Through summarising the literature, Nehls (1998) identifies the following non-exhaustive list of stigmatising beliefs held by professionals which chime with Susan’s account. She identifies beliefs that the patient with a BPD diagnosis are, ‘not sick’, are ‘manipulative’, ‘more difficult’, ‘angry, noncompliant’, and ‘hateful’ (ibid, p101).

Stigmatising beliefs – manipulation and attention seeking

Of the stigmatising beliefs identified, being ‘manipulative’ and ‘attention seeking’, usually spoken about together, received the greatest attention within the interview accounts: “There is a lot of preconceived ideas about personality disorders. i.e. the attention seeking and manipulative behaviour stereotypes and these can at times can make me quite cross!” (Dawn).
Whilst there were some examples of the participants agreeing that some behaviours might indeed be both manipulative and attention seeking, for example: “Perhaps that is genuinely what people with BPD are like (I’ve been accused of manipulating people before” (Ramona), misunderstandings in this area were a common explanation given as to why many mental health practitioners held such stigmatising notions:

“Borderlines get a bad rep because we know we feel different to others, but nobody believes that possible, they think you’re needy or putting it on, the whole point is you cannot control your emotions, so how is that manipulative??!!!!!” (Susan).

“If someone is feeling manipulated does it necessarily mean they are being manipulated by someone else? No. How hard must it be for people working in environments where they feel like this, daily on the edge of their seats wary of anyone and everyone and suspicious of behaviours. That is hard but does not mean that someone is actually ‘doing’ it to them. And I think often attention seeking is the worker feeling exhausted and drained by the demands of the job/the day/their roles. But does not mean that their patients/service users do not have very valid needs” (Sally).

Whilst acknowledging that self-harm and suicidal urges are, to a degree, about seeking attention from others, Simone argues an alternative perspective, proposing that the majority of such actions and urges are more related to intra-psychic, rather than interpersonal, communication. To support this claim, she draws on the secretive nature of some forms of self-harm as evidence that attention seeking from others is not the primary motivation behind the behaviours:

“I think that self harm and suicidal urges are partly about attention-seeking, but not necessarily or primarily about the person seeking attention from other people this is clear from the fact that many people who self harm don’t let anyone know and take great pains to hide their scars from others” (Simone).

Within the interviews, Emily and Sally also note the secretive and shameful nature of their self-harming:

“My self-harming is so secretive and shameful I had a full blown panic attack when a psychiatrist asked to look at it” (Emily).

“I self harmed, not in a major way but rather intermittingly. I would either cut or boiling water on part of me. I was secretive about it and deeply ashamed so often it would be in secret, told no one, just superficial lacerations” (Sally).
These accounts, as opposed to demonstrating a deliberate attempt to manipulate or seek attention, mirror Fallon’s (2003) findings in that:

“...participants were aware of the stigma attached to self-harm and of its common perception as attention seeking behaviour. They described concealing most episodes of self-harm from mental health professionals. This suggests its use was primarily as a coping strategy...” (ibid p399).

Clear from the accounts, however, is the notion that there is a severe disjunction between the stigmatising beliefs and attitudes of mental health professionals and the distress experienced by individuals with a BPD diagnosis.

**Stigmatising beliefs – anger/aggression**

The second most common stigmatising assumption identified by the women, directly pertinent to being constructed as ‘risky’ patients by mental health workers, is the idea that all individuals with a BPD diagnosis are angry, aggressive, or a danger to others (this supports the findings of Markham [2003] and Woollaston and Hixenbaugh [2008]):

“I think when people have an incorrect understanding of BPD it is very centred around their expectations that people will have anger problems, yes. It seems a lot of things online surrounding BPD talk a lot about the anger (as well as being manipulative in therapy)” (Ramona).

Whilst the women don’t deny that they experience anger or, in the case of Summer and Susan, identify that they can be aggressive in presentation, a general criticism of the assumptions believed to be held by mental health workers is made.

In terms of whether those with a BPD diagnosis are more likely to be a danger to others through violence and aggression, the burgeoning number of empirical studies present a complex picture, given that the focus so far has tended to be on identified violent populations rather than community samples (Allen and Links 2012).
In their literature review of studies examining elevated risk of aggression for those with a diagnosis of BPD, Allen and Links’ (2012) noted that a, “[h]istory of childhood maltreatment, history of violence or criminality and a comorbid psychopathy or antisocial personality disorder appear to be predictors of violence in patients with BPD” (ibid. p 62). They demonstrate, however, that when such comorbid conditions are taken into account, there does not appear to be a significant link between BPD and aggression and violence. The authors conclude that, “…the stigma these patients face about being more violent than members of the general population is not justified by the research to date” (ibid. p 68).

The critiques of this stigmatising view offered by the women either attack the stereotype as inaccurate in terms of their own presentation (for example the internalising of anger rather than the externalizing of it) or, echo the critique made of accusations of being ‘attention seeking’ and/or ‘manipulative’, as shallow and distorted in terms of the underlying distress.

In terms of the first critique, Emily notes how the weighting of descriptions of individuals with a BPD as displaying overtly aggressive behaviour can feel alien to her experience of anger: “When professionals come in and talk about Risk and how volatile we are (we being people with BPD) it makes me think that we have two separate diagnoses…” (Emily).

Giving a sense of how and why those who don’t express anger externally deal with the emotion, Dawn describes the internalisation of anger due to the terror of expressing this emotion:

“...it really scares me when I get angry so I automatically swallow it back down and fume from the inside (which isn’t helpful) I certainly can’t do other people getting angry – it really upsets me (even if their anger is justified)...” (Dawn).

Sally, whilst identifying that anger and BPD are correlated by professionals, “…to a certain extent fairly”, describes how her upbringing caused her to self-invalidate her anger and to direct the energies towards herself:

“My parents were not outwardly angry though it was definitely there so perhaps I meant that I didn’t display overtly angry out bursts, hitting, shouting inappropriately ... But there is no doubt that there was underlying anger which, yes, was directed at myself. Anger at my appearence, me needs, my other emotions” (Sally).
She goes on to identify the internalising of anger with her self-harm as a means of managing her distress, an association also made by Dawn (although she minimises this in comparison to other internal processes): “I have definitely self-harmed when I get ‘angry’ but I think for the that’s relatively superficial compared to some of the thought processes that go on inside my head” (Dawn).

Both examples appear to resonate with Brook and Horn’s (2010) theme of the progressive management of distress, with self-harm being utilised in these instances as a means of managing the distressing emotion of anger. As to why anger and aggression is identified with BPD over and above internalised forms of distress, Ramona theorises that it is just easier for observers to understand:

“I think anger and mood swings are just easier for other people to deal with and understand. If I ever do get inappropriately emotionally reactive then I’ve found that people are much less likely to look scared or back off, because even if it’s inappropriate, it is still something they understand. Whereas, there are times when I’ve been curled in a ball because the emptiness is so deep-rooted and consuming that it physical hurts, and people don’t know how to react to that” (Ramona).

For those that are able to externalise their anger, the sense of professionals ignoring the internal processes and distress around anger, aggression, and violence in favour of simplistic characterisations can also be found in the responses of Susan who, whilst acknowledging that she can appear angry and has physically injured her ex-husband in the past, describes how her aggression is really about internal distress rather than an active wish to harm others:

“...can you try to understand that SOMETIMES, the seemingly aggressive nature is actually aimed at ourselves, the pain we are in, the effort of being alive with all the hard work it entails, the aggression is about within and its born of frustration and despair and it surfaces as we are engaging with another human being because we are battling, but socialising, so obviously cannot hide it, so it shows its face ... I don't want to hurt anyone ... My anger, hatred, frustration and anguish consume me from within. My bark is worse than my bite towards others - leave me alone and you will be safe, although I might not be” (Susan).

She suggests further that professional assumptions and the expectation of aggression and anger leads to misattributions of other states, for example, in the case of agitation: “I would say that a lot of what appears to be aggression, is actually agitation - sometimes. Agitation which causes you to act in a manner that may be seen by others as aggressive” (Susan).
Experiences of mental health services – stigmatising beliefs, identity, shame, and risk

Given that those with a diagnosis of BPD often report difficulties with regard to their sense of self, and given also that the diagnosis itself is surrounded by negative stigma - including that of being inherently risky - the question that needs to be asked in light of the research topic is how the diagnosis and attending stigma impacts on the individual’s sense of identity and risk presentation.

With regard to the former, as will be made apparent, the women describe a process of initially attempting to ‘fit’ themselves to the diagnosis, with the negative associated stigma ‘feeding into’ their negative view of themselves.

Having established that a negative sense of self pre-exists being diagnosed and encountering psychiatric services, it is perhaps unsurprising that some of the women in the present study report how the negative, stigmatising beliefs around BPD can compound their negative sense of self both in the past (Simone) and in the present (Dawn), this resonating with Horn et al’s (2007) finding in relation to one of their participants who appeared to internalise the rejecting nature of BPDs stigma:

“I internalised all the prejudices and judgements and negativity and learnt to expect as little of myself as those who had "gifted" me this cloak expected” (Simone).

“I actually believe I deserve this condition and all the crap that comes with it” (Dawn).

This link between a negative sense of self and identifying with the stigma of the diagnosis resonates with a research project by Rüsch et al (2006). They conducted a study into ‘self-stigma’ (i.e. how patients may accept the common prejudices around mental health diagnoses and how this impacts on self-esteem) in order to test their hypothesis that, “...a high level of perceived discrimination, little sense of identification with the group of people with mental illness, and a high level of perceived legitimacy of discrimination lead to self-stigma” (ibid p399).
Recruiting 60 women with a BPD diagnosis and 30 women with social phobia, participants were asked to complete a stigma-related questionnaires. Their results revealed that, for both diagnostic groups, perceived discrimination and depression can lead those with mental illness to be vulnerable to self-stigma and that low perceived legitimacy of discrimination may be a protective factor in relation to this tendency.

In relation to my participant group, the authors’ findings may support the idea that the pre-diagnosis negative sense of self and burgeoning awareness of the stigma that surrounds the diagnosis potentially contribute to their negative identification with it. Given this pre-existing sense of shame held about themselves by the individuals in this study prior to being diagnosed, receiving the BPD diagnosis and becoming aware of the stigma that surrounds it appeared to add to this shame (with this resonating with Lovell and Hardy’s [2014] finding that their participants felt that the diagnosis was shameful and had a destructive effect on their lives):

“Just as a point of interest (maybe!?) I don’t tell anyone that I have this diagnosis, I am too ashamed. I can tell people I have depression and anxiety, and they get that, but not even my oldest friends know I have BPD” (Emily).

“I would happily and without care wear a sign upon my head displaying my varies mental illnesses when appropriate Le bi-polar.OCD anxiety disorder. PTSD ... But when it comes to the Bpd bit, I can only describe sort of mentioning it in an afterthought way... Like a coughed joke... Cough cough bpd ahem shhhhh....” (Susan).

“...its almost like its a dirty secret, i do not really see what telling others will do to help me really, so i guess its the secret and if any one really needs to know for any reason, then they would probably approach my gp, (the professionals i am thinking of here) as to casual friends knowing no i do not tell them at all...” (Bell).

“...When I think of myself as "someone who has had a BPD diagnosis", or "someone who's been ill", I very quickly slip into a dark and familiar, hopeless groove, and I feel deeply ashamed, like I can't be trusted, like there's nothing to live for” (Simone).

Having accepted the diagnosis as being ‘negative’ but also as providing an explanation for their suffering, some women speak of how they attempted to fit the diagnosis by either repressing the aspects of themselves that didn’t match the diagnosis, i.e., following the, “...sick script...” (Simone), or by wilfully allowing the diagnosis to validate and permit a sense of sickness and recklessness, both then and in the past (Ramona):
“As someone "with BPD", whenever I had those kinds of thoughts [suicidal and/or self-harming thoughts/urges], whatever followed was a "fait-accomplis", was what was expected of me, was who I thought I was. An urge would arise and it would remind me that I was ill/ disordered/ crazy/ broken, and to cut/ overdose/ try and hang myself was the only thing that made sense to do. If an urge arose and I didn't act on it, it would cause some painful and confusing cognitive dissonance - I'm supposed to be someone who hates herself, doesn't respect herself, needs to be punished, can't "ground" herself in the present, can't bear her own feelings etc etc, so how can I then not hurt myself, not follow through with the act itself? It would be like being given a script to read in a play but then casting it aside and improvising instead - unheard of, doesn't make sense – if, as a person with BPD, I don't harm myself, I must be somehow lying about the distress in the first place, it can't be that bad, but I know that it is that bad (I know because I'm experiencing it), so I have to complete the sequence, play my part, in order to know who I am - I am the screwed up one, that's who I am, it's messed up but at least I know who I am” (Simone).

“In terms of the diagnosis feeding into the recklessness. As I said, for me, it is more in terms of the diagnosis 'giving me permission' to be reckless, so I suppose in that sense it does feed into it. Although I was obviously reckless before the diagnosis too, I guess, until I was willing to begin to consider to recover from BPD, the diagnosis did act as some kind of security blanket, like a buffer, which almost allowed me to be reckless without consideration because it was 'allowed' due to being 'sick.' It also, in my mind, excused any behaviour which had gone before the diagnosis for the same reason - I couldn't help my behaviour because I was legitimately ill, and it meant that I was weak and couldn't stop myself from giving into these thoughts and feelings” (Ramona).

In both instances, it is clear that the attempt to identify with the diagnosis has the effect of increasing the likelihood of acting in ‘risky’ ways, be this by needing to fulfil the ‘risky script’ of the diagnosis by ‘locking’ ones identity to the ‘illness’ or through legitimising ‘risky’ or ‘reckless’ behaviour as an expectation of the diagnosis.

Yanos et al (2010), acknowledging that it has long been recognised that the experience of being diagnosed with a mental illness impacts on identity, develop an empirically supported model for the less explored impact of mental health diagnosis on recovery. With the intention of creating a model that begins to address how illness identity, including the internalisation of stigma, impacts on significant aspects of recovery (specifically; hope and self-esteem; coping and engagement in rehabilitation; vocational outcomes; suicide risk; social interaction and symptom severity), they propose that:
“...accepting a definition of oneself as mentally ill and assuming that mental illness means incompetence and inadequacy impact hope and self-esteem, which further impact suicide risk, coping, social interaction, vocational functioning, and symptom severity” (ibid p1).

Whilst their model was developed in relation to severe and enduring schizophrenia-spectrum disorders and is limited to suicide risk, without a more comprehensive account of risk behaviour, it arguably supports the links made by the participants between identifying with a stigmatising diagnosis and subsequent risk behaviour in relation to suicide.

Complementary to the self-conscious identification with and attempt to ‘fit’ the diagnosis is the converse phenomena of others judging behaviour in relation to the expectations of the diagnosis. For example, Ramona describes how not displaying anger externally as others expect can lead to them not believing you ‘fit’ the diagnosis:

"I do not always show outwardly how I feel, but that does not mean that it doesn't hurt just as much. I think that's sometimes why people 'don't believe' that I have BPD ... quite a few times the reactions I've had from people regarding my diagnosis are, "Well, you can't possibly have BPD because you are the least angry person I know” (Ramona).

Similarly, the women also note the phenomena of others judging, or pathologising’ their behaviour in light of the diagnosis. Again, in relation to anger and aggression, Susan notes, “...if you're a naturally aggressive woman, it's seen as a disorder and they lump it with BPD, when you just might be that way inclined regardless” (Susan).

Simone identifies this ‘pathologising’ phenomena in relation to both ‘relationships’ and ‘passion’:

“...once someone has a BPD diagnosis, it is difficult to view their relationships as normal ... but then I realise, through talking to pretty much everyone I've ever met, that it's really common for people to think they're rubbish at relationships, and that comparisons or pathologising of your own way of doing it are utterly utterly pointless and unhelpful ... since the diagnosis of BPD, my passion and enthusiasm have often been interpreted as proof "emotional intensity dis regulation”” (Simone).
It would seem then that when the women identify themselves with the diagnosis of BPD, the stigma that surrounds it may not only be internalised and contribute to the pre-existing sense of shame, but it may also tie them into a script that incorporates a sense of sickness and riskiness that they feel obliged to act out. This is compounded by the tendency of others familiar with the diagnosis to judge their behaviours by the implicit assumptions contained within them and interpret behaviours as pathological. In both instances, identification with a ‘sick’ identity (Yanos et al 2010) and the expectation of acting in ‘risky’ ways is made both by those subject to the diagnosis and by those conferring the identity on others.

Whilst Ramona speaks of ‘liking’ the diagnosis on occasion: “Sometimes I do like having the diagnosis. When I’m feeling ‘sick’, and I want to be unwell and be taken care of, and my emotions are crazy” (Ramona) and identification with the diagnosis as a means of legitimising ones distress and need for care is widely reported at the point of being diagnosed, a major focus for those in receipt of a BPD diagnosis is, however, on the negative effect that being so labelled causes with regard to the treatment that they receive.

**Experiences of mental health services – invalidation and risk**

Having already noted that interactions with staff is a major means by which those with a BPD diagnosis learn about the stigma surrounding the diagnosis, it is unsurprising that reported experiences of mental health services seem to be overwhelmingly negative.

The key theme that runs through these interactions, as noted above in relation to anger and aggression, is that of the invalidation of needs and impact that this has on their mental health and risk presentation. This invalidation appears focused around the instances where the women report feeling at risk, with the responses that ensue impacting on the women’s distress and their risk presentations:

“I have told people that I am suicidal or have self-harmed and they have completely ignored me...I once told a CPN that I had self-harmed rather badly but didn’t want to go to A&E and her response was “oh that’s so Borderline!” I had no idea how to react to that one, and still don’t – apart from complete confusion and invalidation! ... [I]t makes me so angry to think of all the times that I have sat in doctors or care team appointments and when asked how at risk I am, I would put myself at medium – but they say “no, no Emily” because I’ve not tried to kill myself for over 10 years or because they are unaware of self-harming” (Emily).
“I felt lower than before and every time I called my psychiatrist and spoke to his receptionist, I felt helpless. I felt that nobody really understood how I felt or wanted to offer assistance and now I was stuck with this label nobody ever would. It seemed to me that the BPD Caused me to be labelled an attention seeker. I wanted to die but nobody believed me … I remember having a very bad time, and I just wanted to die. I felt there was no way out of this downward spiral I was in. I was desperate for someone to ‘pull me back’ but I felt nobody understood how low I actually was. It was as though anybody I asked for help just wanted to pass me on to somebody else” (Summer).

Through the accounts of the women, we can see that invalidation increases their risk levels in several interrelated ways. Namely by making them feel more alienated, by invalidating their attempts to communicate distress and be taken seriously, and by making it more difficult for them to effectively access services.

Simone describes, in the context of risk assessment, how the disjunction between one’s own inner lived world and that of the professional mental health worker decreases the sense of safety, thereby increasing risk:

“I get the feeling I have caused a great deal of frustration in various mental health professionals who have been trying to "assess" me, and the feeling of having "been assessed" and knowing, beyond doubt, that the person who's just been in the room with you has no clue what it's really like in your world, is alienating enough in itself to make your level of risk soar” (Simone).

Identifying ‘kindness’, ‘compassion’, ‘empathy’, ‘warmth’ and ‘understanding’ as necessary characteristics to ‘bridge’ the interpersonal gap, and thereby reduce alienation and risk, she notes that, in her own experience, when there has been no one to turn to with such characteristics, “…the risk has been a lot higher” (Simone). Simone’s identification of the importance of these interpersonal characteristics clearly chimes with Fallon’s (2003) finding that relationships were key to managing emotional distress and Morris et al’s (2014) findings that, “…it [effective care] is all about relationship” (ibid p253), contrasting positive relationships with negative, critical encounters that fuelled alienation and emptiness.
Linked to the notion of attempting to bridge the divide between internal distress and the understanding of professionals charged with one’s care is the phenomenon of utilising risk as a means of communicating distress and being taken seriously, a strategy noted by a number of the women which resonates with Miller’s (1994) finding of how negative behaviour may be strategically employed to such ends. Emily relates the following account in relation to being discharged by a psychiatrist:

“When I was discharged from the psychiatrist, I felt I was not listened to. I said I was feeling unwell, but because of my sunny demeanour it was dismissed, and I was discharged. When I went to the reception to text my friend, I was already planning of ways to injure myself - Very badly. It was only when I got in the car to go home that I thought “who am I doing this for?” and it was plain to me that it was to show them (being my care team) how wrong they all were. I wanted them to listen to how much pain they had caused, and I wanted to show them how unwell I was. But that is just wrong, and not putting my point across very well, so I did not engage in any of those behaviours” (Emily).

Emily clearly articulates how she contemplated injuring herself in order to communicate how unwell she felt to her care team whom she believed had invalidated her though the act of clinical discharge. Ramona also describes how she would strategically utilise risk as a means of communicating her needs (in this example, the need for attention) and of how she would escalate her risk presentation if her needs weren’t met:

“I used to act in increasingly risky ways in order to get the attention that I felt I needed, or in order to communicate something to someone ... if I self-harmed in order to make someone stay with me or help me, but it didn't achieve what I wanted, then I would do something that was riskier, such as say that I wanted to commit suicide or take a small overdose” (Ramona).

This escalation in risk presentation was also identified by Sally who, having described how she smashed a window in order to be placed back on 1:1 observations, stated: “Had that event been dismissed and was not put on obs then it is possible I would have had to up the ante and do something which they couldn't ignore” (Sally).

Emily identifies that escalation could be avoided if professionals could see past the stigmatising beliefs that those with a BPD diagnosis were just behaving badly, and enable patients to feel listened to and validated:
“Often they just see the ‘bad behaviour’ and don’t realise that if the person with BPD was listened to and validated, sometimes the behaviour would not have to escalate to such a pitch - before they felt they were being listened to” (Emily).

Simone, in discussing the experience of a women known to her whose statements about feeling suicidal had been invalidated by staff, under instruction from the psychiatrist not to ‘fuel’ her illness identity, describes how her risk was increased through the need to prove to her care team that she was as unwell as she was reporting:

“…she said, telling them she felt suicidal was obviously not enough. This meant she was at far greater risk as a result of being seen through the "behavioural" lens than if what she had been saying to them had simply been taken at face value to begin with” (Simone).

Arguing in a similar vein, Susan notes how mental health services respond to overt expressions of distress and less so when one tries to engage help in a more reserved and controlled way. As she writes:

“...you get much more help if you're sobbing pale faced and red eyed, hands around your knees, pale and unkempt, wailing what's wrong with meeeeee??, then if you sat there and said, perfectly seriously and carefully "I do not feel right”’ (Susan).

Here then, it seems, the ‘gatekeepers’ to services appear to respond to outward displays of distress, with perceived risk becoming the key to services in some instances. This resonates with the findings of Morris et al (2014) who noted how their participants felt that mental health services were reactive rather than proactive in responding to risk and focused on crisis management rather than preventative strategies.

Emily identifies, again in relation to ‘acting out borderlines’, how some will utilise evidence of being at risk, i.e. ‘fresh wounds’ and threats of suicide, as a means of communicating distress and attempting to access services:

“If someone is acting out, by being blatant about their self-harming or taking overdoses; services will be called and engaged for these types of behaviours (and rightly so). But the acting in will not usually engage in these types of behaviours, or if they do, they will keep it secret” (Emily).
The women are, however, aware that this means of responding to invalidation can reinforce the very source of the invalidation, i.e. the underpinning stigmatising beliefs. Summer, for example, in relation to self-harm and the stigma of ‘attention seeking’, articulates this paradox:

“I think that where some people label risky behaviours (eg self injurious behaviour) as 'attention seeking', speaking from my own personal view, I find that I need to actually participate in riskier behaviour to begin to be taken seriously, which only reinforces the fact that I'm attention seeking” (Summer).

In challenging the researcher’s proposal that those with a BPD diagnosis are considered ‘risky’ by professionals, Simone describes how mental health workers actively ignore the reported risks, either due to attributions of attention seeking, or as a result of fear of instilling dependency, rooted in attachment issue concerns:

“I know you say that people with a BPD diagnosis are generally considered "risky", but I often work with people who are given that diagnosis, whose risks the staff seem to ignore, saying that they are unlikely to actually kill themselves, since they're "just attention-seeking". So people will say that they feel suicidal, or that they feel like they want to harm themselves but they are still refused admission to hospital, or discharged early, before they get "too dependent"’ (Simone).

Susan echoes this sense of complacency towards reported risk using the analogy of ‘the boy that cried wolf’, suggesting similar attributions of attention seeking (i.e. repeated reports of suicidal ideation) which further locate the failure to respond adequately within the individual with the BPD diagnosis:

“I can only describe the feeling I get is that BPD sufferers are the mental health equivalent of the boy that cried wolf. You know..we come in all I'm going to kill myself, but then we don't, repeat repeat until one day you actually kill yourself and someone says' oh, they did mean it after all..oh well, we might've taken it seriously but it's their own fault for having so many false alarms’” (Susan).
Despite the association between the diagnosis of BPD and high risk levels that is held by professionals, evident within the women’s accounts is a fundamental paradox underlying their experiences of being ‘treated’ by mental health services, namely that whilst those with a BPD diagnosis are seen as representing a high risk clinical group by professionals, the treatment/services received by those so diagnosed don’t reflect this. Echoing Simone’s comments on the issue of whether those with a BPD diagnosis are viewed as ‘risky’ by those charged with their care, Susan encapsulates the paradox when she states that, “I feel BPD sounds deadly serious, but on the other I don't think it is treated seriously enough” (Susan).

Interaction with mental health workers – problems with risk assessment

Turning to the specific encounter with mental health professionals engaged in the process of risk assessment, the women note other challenges that arise which complicate this task. In contrast to the situations described above, where risk presentations are raised in response to perceived invalidation, ‘covering up’ or ‘putting a mask’ over ones distress is also characteristic of the presentation of those with a BPD diagnosis both generally, and specifically when interacting with professionals engaged in risk assessment.

In terms of the general tendency to hide feelings of distress, Dawn, Susan and Sally articulate this tendency:

“I believe I am a very good actress and quite capable of putting on a show (many people would struggle to understand that the Dawn they see is not the Dawn in private) I feel incredibly lonely and empty” (Dawn).

“BPD’s can smile and laugh, have a conversation and do the mundane, when all the time your mind is fixated on the best way to end your life so the people that you love may have the blessed relief away from you and your burden, and you shall have the peace you have never felt but crave like some holy grail of normalness” (Susan).

“Intellectually I can see what they are saying insomuch as I know what a fantastic ‘front’ I put on, how I was able to mask the emotions from my myself often as well as others. But it still feels so so odd that I am who I am to them considering I feel so differnt. So emotionally it is odd but logically I understand” (Sally).

Sally goes on to explain this tendency within the context of her childhood experiences of learning to invalidate her own emotions:
“As a child I remember pretending to be unwell so I could get my mum to myself and get her care and attention. One time I remember a Monday am not wanting to go to school so said I was ill by Wednesday I was very ill for real with such high temp and delirium they suspected meningitis. It wasn't however just a nasty bug. My mind was very scared as I was convinced I had caused it, it felt scary that I had the ability to do that. If I wanted attention could get it. This amongst other things led to many many years of not believing myself, invalidating whatever I felt” (Sally).

In terms of how this ability to mask emotional distress from oneself and others impacts specifically on risk assessment, Emily identifies how a ‘sunny demeanour’ can result in discharge from services and an underestimation of risk by the professionals: “I have a hard time thinking about myself as a Risk. So many professionals have been ‘fooled’ or ‘sidelined’ by my smiling and cheery manner – which is 100% defence mechanism” (Emily).

As Susan identifies, however, not communicating distress can be strategically used to end contact with services when such services are making one feel worse:

“...if you know your stuff well enough you can pull a few fast ones like that. I'm not proud but I had 3 kids at home and I felt worse being in hospital. From being told I would be a few weeks in hospital and on heavy doses of lithium and seroquel etc I wangled it down to some anxiety meds and an anti depressant!” (Susan).

This strategy appears to parallel the finding of Miller (1994), Lovell and Hardy (2014) and Agnew (1016) who all identify similar strategies for attempting to navigate out of services or achieve more positive outcomes in the context of negative service experiences (i.e., pretending to feel better than one is, refraining from risk behaviour, and hiding from others).

Another factor at play in terms of the individual’s presentation within the risk assessment processes is that of trust, as Emily identifies:

“...all the professionals have to go on, is what I tell them. This is a trust game, and in the past if I have not trusted a doctor or psychiatrist, I do not tell them all that has happened for me. So I may see myself as a risk, because I know what’s really going on, but because of what I have told (or rather not told) the professionals, they see me as low risk. So it depends on how well I am whether I tell them what is going on or not” (Emily).
It can be seen, then, that there are significant difficulties and paradoxes with regard to both risk and identity which ironically spring from the interaction between those with a diagnosis of BPD and the mental health professionals tasked with their care. Given this failing of services aimed at the recovery of those in its charge, and in light of the pessimistic stigmatising beliefs held by mental health professionals, it is interesting to see what meaning ‘recovery’ has for those with a diagnosis of BPD within psychiatric services.

**Recovery in the context of identifying with or moving beyond the diagnosis - identifying with the diagnosis**

Noting that ‘recovery’ has become, “...the new mantra for reforming the mental health system” (Lal 2010 p82), Lal (ibid) identifies the variability and frequently contradictory nature of the competing definitions of the term in use. In relation to the use of this concept within mental health, she summarises the literature to highlight that:

“Mental health consumers or psychiatric survivors tend to refer to recovery as a personal journey and/or a transformative process (e.g., Deegan, 1996); clinicians refer to recovery in terms of measurable outcomes, such as the reduction of psychiatric symptoms and improvement of function” (ibid p84-85).

Resonant with the former characterisation of the meaning of recovery, Susan, Dawn and Sally express the view that one does not recover from BPD, but accepts one’s distress and learns ways of coping with it:

“‘You have BPD. It's you, being you and theres no amount of 'getting it, getting over it and getting on with it'. I ask you - how can you get 'better' if its your self? basically the new ' BPD gets better with age' bollocks is down to the sufferer learnign to put up and shut up and accept it as” (Susan).

“...I don't believe people ever recover from BPD – I just think that as you get older you learn more and more skills to manage the intense emotions” (Dawn).

“I think an issue for me ... is that of whether one ever 'recovers' from BPD. Opinions vary widely, most people I know think that it is coping with the 'symptoms' ... it isn't really recovery as that suggests an illness type thing and someone will and can get back to their [c]ore illness self” (Sally).
Simone takes issue with the latter clinician rendering of recovery, but expands her critique to encompass the popular ‘recovery model’ as endorsed by the National Institute of Mental Health in England (NIMHE 2005). Her argument is that this paradoxically impedes real recovery when cast as helping people recover from a mental illness or condition:

“Practitioners and services working within a "recovery model" are similarly impeding the process of real recovery (something that can only be meaningfully defined for each individual concerned by that individual themselves) If they imagine that they are helping people recover from some kind of disease or disorder, if they refuse to cast aside the label and all the projections it has led them to make” (Simone).

Rejecting an illness model of recovery and reconceiving it as learning to cope resonates with the findings of Larivière et al (2015) who conducted narrative research examining the perspectives on recovery of 12 women (ages ranging from 23 to 63) with a BPD diagnosis. In identifying dimensions of recovery, five participants associated recovery with healing from a physical disease but noted that this didn’t fit their experiences and understanding of BPD. As Larivière et al note, their participants said that:

“…it is unlikely or unrealistic to be fully healed from BPD because they will always have to face challenging life situations where they will always have to work on their emotional and interpersonal difficulties. These women preferred naming their personal experience with BPD as: ‘journey’, ‘progress/improvement’, ‘accomplishment’, ‘acceptance’, ‘being functional’, ‘confidence in oneself’ and ‘learning’” (ibid p560).

In terms of recovery understood as learning to cope, for Summer and Dawn, this appears to be related to gaining self-knowledge and insight into the origins of distress and finding more adaptive coping strategies than self-harm, suicidal behaviours, and compartmentalising experiences. As Summer notes:

“I do still identify with the symptoms, I have just learnt now to manage them better. I don't go straight into crisis mode, sometimes I end up in 'crisis' but able to recognise the signs which enables me to cope/deal with things better” (Summer).
Dawn, who also emphasises the development of less destructive and healthier ways of coping, also stresses the how this gradual learning process can feel like a constant battle: “Life feels like a constant battle – from the minute I open my eyes to the minute I go to bed!” (Dawn). Consistent with Lal’s (2010) characterisation of the ‘consumers/survivors’ conceptualisation of recovery and again echoing Larivière et al (2015) theme of recovery as a journey, Dawn goes on to write:

“Part of my own personal journey of recovery has been having to accept that I am never going to be miraculously cured or completely symptom free and that my recovery needs to focus upon healthier (and less destructive) ways of coping with stuff on a day to day basis – but some days that’s really difficult and truly mentally and physically hurts – but I keep trying to surf the wave (as such)!” (Dawn).

The difficulty of this battle/journey in relation to the temptation to slip back into long established negative ways of coping is spelt out by Sally:

“I seem to have slipped back into, old patterns of eating and blame holidays, time, ie not enough of it to reflect, relax, think about it etc. so it feels shit again. I know I can do something about it. But what is holding me back? It can seem like it a default setting at times and if I let my eye off the ball, ot be quite so self caring then these things can slip back into the (mildly) self destructive pattern which is BPD. Or is it merely a convenient excuse?” (Sally).

In Sally’s account, there is also uncertainty over whether her suffering is a result of BPD or simply the all too human trait of letting one’s resolve to change slip. Here, then, we have a question about identity in relation to both the diagnosis and issues pertaining to recovery. Latent within Sally’s account and detectable within the accounts of Ramona and Simone, there also appears to be indications of a movement ‘beyond the diagnosis’ as part of the journey of learning to manage their suffering.

Recovery in the context of identifying with or moving beyond the diagnosis - life beyond the diagnosis

As introduced above, the topic of how identifying with a mental health diagnosis can impact on recovery has been explored by Yanos et al (2010). In terms of the model they develop, they summarise that:
“...beginning with a definition of oneself as mentally ill and the assumption that mental illness means incompetence and inadequacy, a process may unfold in which persons become at risk of ceasing to try to work and fit into their communities. We have suggested that when stigma leads to an impoverished sense of self, low self-esteem and suicide risk follow. These then not only lead to avoidance and poorer psychosocial outcomes but also may be a factor that sustains symptom severity, leading a vicious cycle” (ibid p9).

Whilst the authors recommend cognitive-behavioural therapy (CBT) to address negative patient attitudes towards self-conceptions around illness identity, evident within the accounts of Sally, Ramona and Simone is a sense of how recovery might be linked to rejecting the diagnosis. This resonates with Horn et al’s (2007) findings in relation to one of their participants, whereby his questioning of the diagnostic label allowed for an increased in self-reported resilience and perseverance.

As we saw above, Sally clearly feels a sense of ‘being at the cross roads’ in terms of her identity and the BPD diagnosis, as the following quote articulates:

“So have I recovered? Have I gone back to the way I was/would have been had I not had such awful experiences? Was I born a certain way and I cope better now but have found better ways do coping yet still am fundamentally a BPD type? Not sure I have the answer at the moment, if ever, feels quite convoluted to me too if spend too much time debating it. ... Only now, in the last 2 years have I begun questioning the idea of who I am in relation to BPD. It has been due to the training I received, the training/ work I deliver and the open and fascinating organisation I work for” (Sally).

With Ramona, we find the same theme of needing to alter one’s ‘relationship to the diagnosis’ in order to recover or ‘move on’:

“...if I ever want to move on from this, I’m going to have to have a different relationship to the diagnosis, and if that means leaving it behind altogether, then I guess that’s what I’ll have to do. Though it does make working out ‘who I am’ an even harder struggle” (Ramona).

In her account, we can also see a sense of needing to ‘undo’ the sense of validation or relief that identification with the diagnosis initially yielded in order to recover, and a recognition that this will return her to the struggle of trying to ‘work out’ who she is. This ‘undoing’ of a BPD identity is also evident in a reversal of the process, identified earlier, of ‘trying to fit the diagnosis’. As Ramona writes:
“...in my head I've sort of made myself not fit the criteria anymore, especially as I'm so much better now than I was when I was first diagnosed ... if I'm ever going to work out who I am as a person, having a diagnosis like BPD is not going to make that process any easier when people react to it the way they do, either with ignorance or disapproval” (Ramona).

Ramona explicitly identifies the treatment from others as feeding into a need to ‘move on’ from the diagnosis and be ‘accepted and understood’:

“...when I learnt more about BPD (or more specifically, the way other people react to it) I began to realise that perhaps I shouldn't include the diagnosis as part of my identity if I ever wanted to be accepted and understood. And be able to accept myself in the process” (Ramona).

Simone articulates and develops the notion of recovery as involving a ‘moving on from’ the diagnosis the most fully of all the participants. Like Ramona, she emphasises the difficulty of ‘dropping the BPD script’ in terms of throwing oneself back into the uncertainty around identity:

“...it leaves you wondering who you are again and wondering how to act. It's like taking away the script and leaving you to improvise on that stage after all, and that takes guts ... It's a process of continually letting go of the "BPD story of me" and opening to new possibilities about "who I am", and in that, daring to believe that I might just be connected to the human race after all” (Simone).

The ‘dropping of the script’ however opens up, for Simone, the possibility of an identity rooted in her acceptance of those aspects of her that were previously pathologised, i.e. an new identity free of BPD established through an act of self-affirmation:

“When I think of myself as "someone who has had a BPD diagnosis", or "someone who's been ill", I very quickly slip into a dark and familiar, hopeless groove, and I feel deeply ashamed, like I can't be trusted, like there's nothing to live for – even now, post-"recovery". It takes a steady and consistent effort on my part to carve out new grooves and keep believing in myself – when I do, I feel so proud, like a warrior spirit, and I feel blessed, grateful to have touched life so deeply - I see all of the difficulties I go through - the sensitivity, the intensity, the numbness, the internal noise, the knots, the dissociation, the confusion, the urges to self harm or to suicide – I see all of these in a positive light - I don't mean just putting a positive spin on a bad situation, I mean I actually would not change a single thing about what I've been through or go through, because every single aspect of my experience has taught me so much and made me who I am” (Simone).
Finally, as part of this affirmation of self beyond the diagnosis, she describes how she would advise others to cast off this cloak also:

"I would advise them just to say, no thanks, and to brave the feeling of the wind on their skin and to keep walking, head high, exposed to the world, scars and all. And I would walk right there beside them" (Simone).

Summary of the Realist Tale
In summation, the women in this study identified themselves as having risky characteristics prior to encountering mental health services. Whilst some reported relief at receiving a diagnosis of BPD in that it validated their distress and many found that the diagnostic criteria accurately described their distress, they quickly became aware of the stigma that surrounds the diagnosis through learning about it via researching the topic, and through encounters with mental health workers. The ‘baggage’ inherent in the label both serves to create a negative view of the diagnosis and also ‘feeds into’ the pre-existing negative view of self, and into a general sense of shame stemming from their traumatic histories.

Some women adapt their behaviour, including risk presentations, to fit the diagnosis whilst others report that not demonstrating expectations of the diagnosis can lead to others questioning whether you fit it. Behaviours are also pathologised by professionals in light of the diagnosis.

In terms of their experience of services, this is primarily characterised by invalidation which increases risk behaviours due to the effects of alienation, attempts to communicate distress/be taken seriously, and as a means of accessing/negotiating services.

The difficulty of getting needs met by services is hampered by the tendency not to present to services/professionals with a ‘true’ picture, due to lack of trust, self-invalidation, covering up emptiness/distress, or as a means of strategically negotiating oneself out of services. A paradoxical picture also arises whereby those with BPD are viewed as being risky but yet do not feel that these risks are taken seriously enough.
Some women, accepting the diagnosis as applying to them whilst recognising the stigma, speak of recovery in terms of learning to live with, and find ways of coping with the distressing symptoms. Others view recovery as incompatible with the diagnosis and begin to negotiate identities that reject the diagnosis, in one case, seeking to move beyond the diagnosis.
Chapter 6 Analysis – The Critical Tale

Introduction

In telling the Critical Tale, the interviews are analysed through the lens of critical theory, itself rooted in realist ontology but emphasising the hidden underlying structures and political influences that root and perpetuate oppression, with an aim of producing emancipatory, counter-hegemonic meaning, thereby opening up the possibility of positive social change.

Evidence of critical perspectives and political activity were forthcoming in a number of the accounts and several broad, overlapping, critical themes were identified. Namely, gender and BPD; psychiatry obscuring the social context of distress; critique of bio-medical psychiatry in relation to BPD; the professionalisation and technological imperative within healthcare; stigma and BPD and engagement with change. The tale will proceed by presenting each of these areas in turn, evidencing and contextualising the critical comments made in relation to the themes of identity and risk where appropriate.

Once this task is complete, given the emancipatory drive evident within the research paradigm, the tale will conclude with comments made by the women in relation to the benefits of participating in the research process.

Gender and BPD

“As a society we do have certain expectations of the different gender roles. Of course this too is a generalisation but I have seen it, subtle though it may be in many instances, throughout my life. Having 4 children I have seen how parents see their children in a different light depending on their gender. Pregnant women are teased for example when their unborn baby is kicking hard saying, 'oh it must be a boy practising football'. In utero subtle stereotyping occurs all the time. When small, it is expected of boys that they are rough, outdoorsey types who find it hard to concentrate, girls though are quieter and more able to sit concentrating for longer. When roles are reversed it can 'throw' people's expectations” (Sally).

The most prominent hidden structure identified by the women was that of the effect of gender assumptions in regard to both receiving a diagnosis of BPD and in terms of how their behaviour is and was refracted and pathologised through the prism of a gendered diagnosis.
By way of introduction, I will quote a section of the interview with Susan followed by my own response within the interview, the inclusion of my own ‘voice’ being resonant with the notion that critical theorists are not ‘neutral’ and/or removed from the research but have an active agenda (i.e. emancipation):

“I often wonder if more women than men are diagnosed with BPD because of the attitudes in medical practice to women in general. The old school belief that women are overly emotional anyway - you know, because of their....cue serious sound effect,...HORMONES. Coupled with the childhood abuse link, I suppose years ago the belief was women suffered sexual abuse, not so much men and that it caused more damage. You have the link there with Post traumatic stress disorder, which I think is given to you if you display a more meek, 'damaged' traumatised personality. If, as a woman, you show any more masculine traits like aggression or hostility, they tend to say BPD. That is sexism right there, but is hard to define as even the diagnoser may not realise they are doing it. Women are stereotyped as the more gentle sex and that is a fact. So if you're a naturally aggressive woman, it's seen as a disorder and they lump it with BPD, when you just might be that way inclined regardless. Do you get what I mean?” (Susan).

“…I do follow what you mean. You’ve very succinctly summarised much of the critical literature that identifies the role of cultural and gender assumptions in the forming of the BPD diagnosis” (Michael).

Without, at this stage, teasing apart the themes within this text, taken as a whole, this passage, like other passages in the texts produced, demonstrates an established critical knowledge of how oppressive hidden assumptions around gender influences and constructs experiences of psychiatric services as outlined by authors such as Herman (2001), Chesler (2005), Becker (1997), Jimenez (1997), Shaw and Procter (2005), Showalter (2008), Ussher (1991), Wirth-Cauchon (2003) etc. In terms of the specific issues raised, the unacceptability of women displaying anger was a key theme within the women’s accounts, a diagnostic characteristic - i.e., “Inappropriate, intense anger or difficulty controlling anger” (DSM V 2013 p663) – associated with risk.

In tune with Susan’s introductory quote, in which the unacceptability of women expressing anger is suggested as an explanation for why more women than men are diagnosed with BPD, Ramona and Sally describe how displaying aggressive or hostile behaviours goes against the gender stereotype of women as passive and meek and is therefore pathologised with the application of the BPD label:
“Perhaps that is why more women are diagnosed than men, because I think displaying anger is a very natural reaction to certain situations, but perhaps it is viewed as 'deviant' behaviour if women engage in outward expressions of anger, whereas it is less likely to be viewed as pathological or unusual if men do. I'm not sure if this is the case, but it definitely sounds like a plausible notion as to why more women are diagnosed than me” (Ramona).

“Perhaps what I am saying is that I don't believe it is purely a genetic reason why in our culture women are the ones more often diagnosed with BPD yet more men have the ASPD label. Yes, women can be violent, and can be seen as a trait of BPD but still less so than men” (Sally).

Sally and Ramona also speak of how the cultural stereotype of women not displaying anger specifically impacts on the internalisation of anger in the form of self-harm:

“...outward bursts of anger are more 'tolerated' from men therefore women internalise it, i.e. DSH = BPD in it's extreme. (And men 'externalise their actions/anger = ASPD in it's extreme)” (Sally).

“I didn't feel that my anger was displayed in a way that warranted a diagnosis, as I was conforming to the stereotype of how women are 'required' to internalise their anger” (Ramona).

In the above quote from Ramona, her frustration in relation to receiving a diagnosis of BPD despite not externalising her anger but by conforming to the gender stereotype of internalising this emotion, in her case in the form of self-harm, points to the ‘double-bind’ position that women themselves in. This is identified by authors such as Chesler (2005) and Becker (1997) who argue that one is not only pathologised for not conforming to gender stereotypes, but also pathologised for conforming too strongly.

In terms of risk and identity, one can suggest that notions of riskiness associated with internalised anger, in the form of self-harm, and externalised anger, in the form of aggression or violence are both linked to identifying too strongly or not strongly enough with gendered expectations of femininity. BPD as a diagnostic label affixed to this pathologisation of gendered behavioural expectations can thus be seen as a ‘risky’ diagnosis rooted in said expectations. As highlighted by Becker (1997), behaviours positioned as deviant to gender expectations are also likely to be viewed as a sign of ‘identity problems’ which, when cast as a symptom of pathology, can contribute to a BPD diagnosis.
Aside from anger, other critical explanations as to why more women than men receive a BPD diagnosis are posited by the women. Ramona points to the fact that women are more likely to seek help for their difficulties than men as an explanation for why more women than men are diagnosed: “I think perhaps women are more likely to seek psychological or psychiatric help than males” (Ramona).

Having reviewed the literature on men’s help seeking behaviour, Addis and Mahalik (2003) affirm that:

“The studies reviewed ... consistently found that men of different ages, ethnicities, and social backgrounds are, on average, less likely than women to seek professional help for physical and mental health problems” (ibid p6).

Whilst Ramona doesn’t offer an explanation for why men don’t seek help from health professionals, Addis and Mahalik go on to note that, “...a variety of masculinity ideologies, norms, and gender roles play a part in discouraging men’s help seeking behavior” (ibid p12).

In light of the women’s descriptions of their own seeking behaviour and experiences of invalidation when interacting with mental health services, it is worth mentioning that, historically, one of the few ways by which women have been permitted to resist their gender prescribed roles and legitimately express their distress has been though the role of illness. As Showalter (2008) wrote in relation to the now defunct gendered diagnosis of hysteria:

“When the hysterical woman became sick, she no longer played the role of self-sacrificing daughter or wife, as did the anorexic. Instead, she demanded service and attention from others. The families of hysterics found themselves reorganised around the patient, who had to be constantly nursed, indulged with special delicacies, and excused from ordinary duties” (ibid p133).

Whilst, as Showalter points out, the ‘sick role’ identity liberated some women from the binds of their prescribed gender roles, it limited lives in other ways (for example, confinement to private dwellings or asylums) and could cause conflict between physicians, who suspected ‘malingering’, and the patient.
As part of her explanation as to why more women than men are diagnosed with BPD, Ramona goes on to suggest a ‘self-fulfilling prophecy’ explanation for the diagnosing bias of clinicians: “I also think that doctors are more likely to diagnose women with BPD, maybe because there is this notion that it is a more common amongst women - I'm not sure which came first” (Ramona).

Here then, we have a critical explanation that suggests that the expectation by doctors that more women than men suffer from BPD results in them being more likely to diagnose the condition in women rather than men. To quote the ‘Thomas theorem’ that inspired the development of the self-fulfilling prophecy concept: “If men [or doctors] define situations as real, they are real in their consequences” (Thomas 1928 cited by Merton 1948 p193). If psychiatrists expect women to be more likely suffering from BPD than men, they will diagnosis it in women more frequently than in men.

In her accounting for the difference in diagnostic rates for men and women in relation to BPD, Ramona also draws on an essentialist belief, although not uncritically, by suggesting that women are more emotional than men and are therefore more likely to display the symptoms listed in the diagnostic criteria:

“Perhaps women are also more likely to display symptoms listed in the criteria - I think women are more likely to have an unstable self-image and instability in mood. These are stereotypes, but there is evidence to suggest that women tend to be more sensitive and emotional than men, which could affect the number diagnosed with BPD” (Ramona).

Susan, however, as we saw in the introductory quote, questions the ‘old school belief’ that women are more emotional due to hormones, and suggests higher rates of female sexual abuse as a possible explanation for why more women receive a BPD diagnosis. Women are therefore not inherently more emotional than men, but are at greater risk of being traumatised and thus experience difficulties leading to a BPD diagnosis (the effects of trauma on emotional regulation being widely recognised [Linehan 1993]).
Ramona, whilst seeming to hold the belief that women are inherently more emotional, also echoes Susan’s point in identifying that, “...women are more likely to suffer sexual abuse, which is meant to be something that can make individuals vulnerable to developing BPD” (Ramona).

Acknowledging the difference of opinion as to whether women are inherently more emotional than men, both Ramona and Susan locate a major source of the distress they experience within a wider oppressive social context by identifying the phenomena of abuse against women and children (this is in keeping with the feminist social causation arguments introduced in the Introduction chapter). They also notably leave BPD as a mental health disorder intact and valid. Contrary to this stance on the diagnosis but also taking the phenomenon of child abuse as her starting point, Simone turns her critical attention towards the BPD diagnosis itself and the effect it has in obscuring social processes that cause distress. It is to the theme of psychiatry obscuring the social context of distress that we shall now turn.

**Psychiatry obscuring the social context of distress**

Simone argues that the move to locate disorder in the form of psychiatric conditions such as BPD obscures the social issue of child abuse, shifting the focus away from a societal ill towards a ‘problem’ within the individual:

“People who are given a BPD diagnosis hold up a mirror to everything in society that society would like to ignore. In labelling someone with BPD, society "puts" all it's ills into these people, and demands that they "take responsibility" for burdens that should not be theirs alone to bear: If a person has been abused as a child, why is every opportunity to hear the pain of that child (now an adult, attempting to tell their story) not taken up gladly, and used to motivate society to face up to the problem of child abuse, and to all the other problems that lead to it? Why, when a person has been abused as a child, does the survivor of that abuse grow up to be viewed as "the problem", the "disordered" one? " (Simone).
The diagnosis of BPD is therefore rendered as a construction which relocates social ills through the pathologisation of the ‘sick’ individual, with the violence against women and children identified by Ramona and Susan being obscured by a diagnosis which burdens the individual with sole responsibility for their suffering. Here, we might quote from Shaw and Proctor (2005) who, having noted the high incidence of childhood abuse in those later diagnosed with BPD and the historic failure of society to acknowledge the problem, argue that:

“...the history of societal responses to childhood sexual abuse is a history of denial and distortion, and this is reflected in psychiatry’s denial of the aetiological importance of abuse, trauma and oppression for psychological distress ... [The] individualization inherent in the diagnosis of BPD maintains the general failure to understand that for many women the ‘symptoms’ of BPD are a complex attempt to maintain personal survival and integrity in the face of past and current trauma” (ibid p486).

In relation to symptoms representing survival strategies, regarding her distress and self-harm, Simone recalled her positive experience of meeting an understanding mental health worker when accessing the Children and Adolescent Mental Health Service (CAMHS). Having beseechingly asked the worker, “I want to know what’s wrong with me” (Simone) she reported that the response she received was the following:

“... [that] they didn't think anything was "wrong" with me, that they thought I was a healthy girl dealing with a very unhealthy situation as best I could. She said they she thought I cried through my wounds, and I felt she saw my pain” (Simone). She adds that, “I always had the feeling that my "symptoms" were really "symptoms" of wider family problems, and she confirmed this” (Simone).

Simone’s account illustrates how the wounds of self-harm can be de-pathologised through contextualising the individual. One’s identity as a ‘sick’ ‘wrong’ individual who engages in risky self-harm is transformed into of a that of a healthy individual wronged by an abusive social situation, and one whose behaviour represents a meaningful, normative coping response.

In line with this de-pathologisation of self-harm through rendering it meaningful within a social context, Simone interestingly compares self-harm with similarly risky yet socially sanctioned forms of harm:
“I'm not saying it's a great idea to self harm if you're frustrated, but it's not a great idea to smoke cigarettes or eat fried food or drive too fast or stay in codependent relationships, it's not a good idea to stay working in an overly stressful unsupported role in the nhs, but everyone's taking these kinds of risks all the time, trying to get the right balance, doing what they can, what works well enough for now until they are able to make changes, one day” (Simone).

Following Becker (1997) one might suggest that Simone’s observation reflects notions of how perceptions of social utility impact on how human behaviour is cast as risky or pathological, i.e., “[w]hen certain behaviours have no institutionalized meaning, they and the person who engages in them are viewed as deviant – most likely mentally ill” (ibid p135).

Whilst it would be overly simplistic to suggest that the risk behaviours identified by Simone are not uncontested - for example, smoking and consuming fast-food are becoming ‘frowned upon’ in a culture that increasingly emphasises the individuals’ self-responsibility over their health - they do have institutional meaning in a way that self-harm does not.

For example, arguably, smoking, consuming fast food, and, overwork have economic meaning within our capitalist economy in terms of consumption and productivity, co-dependent relationships (albeit damaging and dysfunctional) is meaningful in the context of supporting the institution of the family and ensuring the reproduction of workers/consumers, and driving too fast is generally regarded as normative rather than an aberration against societal norms. Self-harm, however, as a risk behaviour that has no institutional utility and whose meaning is hidden through the obfuscation of unjust abusive social contexts, is rendered deviant and pathological.

Returning to the specific topic of childhood sexual abuse, whilst the study didn’t seek descriptions of the women’s traumatic upbringings, allusions to and details of such traumatic pasts were forthcoming. Sally, for example, wrote:

“I was abused between ages of 4 ish and 14 by 3 different men...I have some memories re certain sounds/music, bizarrely the Dr Who theme tune...it reminds me of the time when we spent at the cottage we had... I was abused by the father of neighbours there from about 4 or 5 until 14 ish” (Sally).
In terms of critically understanding the phenomenon of child abuse, the fact that ethnicity and class do not appear to be associated with risks of sexual abuse (Finkelhor 1993) and the fact that the majority of reported offences are abuses of males against females (The National Centre for Victims of Crimes 2016) lends itself to a feminist analysis. As Herman (2000) writes:

“...a feminist analysis remains the only one capable of explaining how such widespread abuses visited mainly by one sex upon the other could be so long denied or condoned. Only a feminist analysis explains why incest perpetrators look like the ordinary men they are – indeed, why so many are men of power and respect. Only a feminist analysis explains why women have always been the most committed advocates for abused children and adult survivors. And only a feminist analysis explains why such bitter conflict arises any time a survivors effort is made to hold incest perpetrators accountable for their crimes” (ibid p220).

The obscuring of child abuse and responsibilisation of the abused party identified by Simone as characteristic of psychiatry can be understood from a feminist perspective as furthering male privilege through assisting victim blaming, via the location of disorder at the individual level, and the denial of sexual abuse through obscuring the reality of widespread sexual offenses against children (ibid). Mindful that the tactics of victim blaming and denial are also frequently employed by abusers in silencing their victims and denying of responsibility (Craven et al 2006), whilst, historically, the ‘psy’ disciplines have actively and openly engaged in both the silencing the victims of abuse and the blaming the child or non-abusing mother for the abusers’ actions (Herman 2000), whether deliberate or not, the effect of obscuring the social context of distress in this regard can be understood through the lens of patriarchal oppression.

Widening Simone’s focus on child sexual abuse, BPD was also presented as reflecting broader social difficulties and processes. As Susan asks herself and the researcher, “...BPD or a crappy life?” (ibid). Scheff (2007) articulates this bias of bio-psychiatry clearly when he writes:
“One frequently noted deficiency in psychiatric formulations is the failure to incorporate social processes into the dynamics of mental disorder...[T]he conceptual models used in formulating research questions are basically concerned with individual rather than social systems ... In these investigations, social processes tend to be relegated to a subsidiary role, because the model focuses attention on individual differences rather than on the social system in which the individual is involved” (ibid p17).

Susan described experiences archetypical of home circumstances Linehan (1993) would defined as ‘invalidating environments’, or, “...one[s] in which communication of private experiences is met by erratic, inappropriate, and extreme responses” (ibid p49):

“I come from a critical home, my dad was a right bully and always taking the piss out of how we looked/ spoke, my mum was emotionally unavailable - downtrodden yet hostile, she had a very hard life and had too many kids and not enough money, we were never really spoken to unless we were playiong up, we were treated as an irritation, but I was loved I suppose, as much as they could have given their own damaged mental states, plus they were heavy drink and drug users” (Susan).

Susan’s account of her upbringing and her critical reflections on the aetiology of BPD reveal her awareness of the influence of the social environment of the family on her experience of distress. Whilst concluding that, in her own case, her difficulties was half caused by genetic predisposition and half the result of a traumatic childhood, Susan goes on to describe her sense of anger and resentment when recalling her own abuse and later experiences of being a mother with a diagnosis of BPD:

“I had a very chaotic dysfunctional childhood. So at the time of my first diagnosis, when I read up on BPD, I was brought to the belief that it was purely my upbringing and certain circumstances i.e childhood abuse that had made me 'weird'. That, coupled with being a fairly new mother myself and thinking how I could never hurt my own child, made me start to feel immense anger and some bitterness towards my parents. Although they were not the only ones to cause me pain during my childhood/formative years, I must say I did feel some strong resentment” (Susan).

She describes her realisation, through later comparing her life with others that her adverse childhood experiences had disadvantaged her:

“I suddenly felt that maybe I COULD have been someone 'normal' after all, that it wasn't just the way I was born. I had always accepted my upbringing because you think that is how everyone is or that is how life just is, you accept your fate. It is only when you mix with other people or families, or have your own children and you grow up that you question your upbringing more” (Susan).
Susan expands her analysis of her family background to include her experiences of growing up in a deprived borough of London making explicit reference to how this impacted on her sense of identity:

“*It's not just your home life, its where you grew up as well. I lacked a sense of identity, I was one of only 3 white children in my class at school and all my friends were west indian, I just was surrounded by things i wanted to be but could not. My mum and dad would be killing each other and smashing the house up and I would be sitting at the window looking at the family next door, cooking in their little garden, laughing and cuddling their kids*” (Susan).

In noting that, “…it’s where you grew up as well”, her account indicates an awareness of the impact of these wider social forces on her difficulties and identity. As Pilgrim and Rogers (2008) write:

“*With a poor family origin (a risk factor in mental health problems) comes a sense of particular cultural space to do with locality, schooling, and family expectations about social status and prospects. Personal identity and 'knowing one’s place' are set early in childhood*” (ibid p31).

Referencing the work of Bourdieu (1983), the authors identify that amidst the interweaving factors that contribute to human distress, financial capital (assets, money, property etc.), social capital (resources in the form of networks of relationships amongst people), and cultural capital (assets such as knowledge and skills [e.g. education]), “…*all impinge on mental health status and vice versa*” (ibid p30). Deficits in these areas are therefore linked to increased risk of developing mental health difficulties.
All three areas of capital are potentially open to government intervention, conceivably leading to improvements in the overall mental wellbeing of the population. Elliot (2016), for example, in her report ‘Poverty and Mental Health - A review to inform the Joseph Rowntree Foundation’s Anti-Poverty Strategy’, makes several recommendations that could inform the development of government mental health policies following her review of how mental health is shaped by the characteristics of their social economic and physical environments (including inequalities). Diagnoses which locate disorder at the individual level, however, undermine efforts to redress inequality and disadvantage enabling governments to sidestep their responsibilities. As Rosenthal (2016) identifies: “Separating the individual from the social in order to emphasise the individual is capitalist ideology, not science. Prioritising individual factors absolves the system of responsibility” (ibid no pagination).

Widening the analysis to tackle another feature of our capitalist economy, resonating with Simone’s “BPD or a crappy life?” (Simone) comment, Sally reflects in relation to an article she read about the use of opioids for the treatment of BPD that:

“...the drug companies are desperate to find a drug to 'help' or 'cure' to target the many thousands of people with the diagnosis. Perhaps they should invest in working with children and parents so the people do not have crap upbringings in the 1st place” (Sally).

Through this reflection, Sally raises the issue of the complicity of the pharmaceutical industry with bio-medical psychiatry in shifting the location of disorder from the societal to the individual context by developing drugs to target individualised symptoms of psychopathology. Although neither Sally nor the other participants explore this issue in great detail (it should be noted that Susan did partake in legal action against GlaxoSmithKline in relation to paroxetine [see below]), it is worth highlighting from a critical perspective the overlapping interests of psychiatry with the pharmaceutical industry.

Criticism of the links between psychiatry and the pharmaceutical industry have been made for some time. Breggin (1993), for example, in relation to the American Psychiatric Association (APA), identified that:
“...drug companies provide the backbone of financial support for the APA and most of organized psychiatry. The psychiatric newspapers and journals, including those published by APA, are largely paid for by drug company advertising” (ibid p426).

Resonating with Sally’s critique and Breggin’s remarks above, the well-publicised resignation letter from the APA by the late American psychiatrist Loren Mosher's in 1998 also encapsulates the concern that the pharmaceutical industry effectively ‘owns’, or at least has an unhealthy level of control over, the profession of psychiatry:

“Psychiatry has been almost completely bought out by the drug companies. The APA could not continue without the pharmaceutical company support of meetings, journal advertising, luncheons, unrestricted educational grants etc. Psychiatrists have become the minions of drug company promotions ... No longer do we seek to understand whole persons in their social contexts - rather we are there to realign our patients’ neurotransmitters” (Moher 1998 cites in Read 2005 no pagination).

Even the then president of the APA, Steven Sharfstein MD, wrote an article for Psychiatric News in 2005 in which he acknowledged, in relation to an overemphasis on drug treatments compared to psychotherapeutic and psychosocial treatments, the detrimental influence of the pharmaceutical industry over his profession in this regard (Sharfstein 2005).

This intertwining of psychiatry’s and the pharmaceutical industry’s drive to locate the cause of human distress at the individual biological level arguably deflect critique of the social and political causes of human distress. As Fisher (2009) writes:

“‘The current ruling ontology denies any possibility of a social causation of mental illness. The chemico-biologization of mental illness is of course strictly commensurate with its depoliticization. Considering mental illness an individual chemico-biological problem has enormous benefits for capitalism. First, it reinforces Capital’s drive towards atomistic individualization (you are sick because of your brain chemistry). Second, it provides an enormously lucrative market in which multinational pharmaceutical companies can peddle their pharmaceuticals’” (ibid p37).

In terms of the profitability of this market, the global profits of the pharmaceutical industry for 2014 reached over one trillion US dollars (Statista 2016). We shall explore the consequences of such financial incentives on the corporate practices of ‘big pharma’ below.
Bringing these themes together, the accounts of the women articulate a rejection of the location and treatment of distress at the level of the individual, and a call for understanding, and investing in ‘treatment’ at the level of the social. In terms of risk and identity, situating distress within its social context has the potential to liberate otherwise pathologised individuals from a ‘sick’, and in the case of BPD, risky identity. If ‘personal identity’ and ‘knowing one’s place’ are set early in childhood as Pilgrim and Rogers (2008) identify, and the impact of childhood sexual abuse and deficiencies in financial, social and cultural capital are known to be risk factors in poor mental health difficulties, a critical light thrown upon the context of one’s childhood experiences arguably has the potential to challenge and transform one’s identity, and opens up the possibility of social change through political action.

Through identifying how the status quo serves both the interests of the patriarchal order in the context of sexual abuse and the capitalist order by absolving governments of responsibility over the wellbeing of the citizenship, whilst filling the coffers of a pharmaceutical industry that bankrolls the psychiatric medical profession, efforts to direct a critical focus onto the social and political causes of human distress can be viewed as essentially counter-hegemonic in nature. We will now turn to the critique made by the participants of the knowledge claims of bio-medical psychiatry in relation to BPD.

**Critique of bio-medical psychiatry in relation to BPD**

Aside from the obscuring effect that psychiatry has in relation to the social context of distress, the women level a specific criticism against bio-medical psychiatry in relation to their diagnosis. Resonating with Horn et al’s (2007) finding in relation to their theme of hope and the possibility of change, the main focus of their analysis is on the validity of BPD as a diagnosis. Whilst we have seen criticisms of the validity of BPD rooted in it being a value-laden social construct which oppressively mobilises gender norms and moral judgements for women (e.g., Jimenez 1997), Sally critiques the validity of BPD as a scientific concept by focussing on the compulsion of psychiatric power to categorise human distress:
“I believe that it was a diagnosis made up, fabricated by doctors who were baffled by people presenting with certain symptoms and problems but didn't fit neatly into the boxes of the axis I disorders, the depressives, manic depressives etc. We didn't fit. It confused those 'scientists' who felt more comfortable with known labels. So PD was born. And I think to a certain extent it is still like that” (Sally).

Sally’s criticism appears to suggest that the heterogeneity of symptoms/problems that could not be explained by traditional psychiatric classification resulted in the invention of a new category in a movement designed to create a ‘thing in itself’ out of a disparate set of presenting difficulties. Resonant with Horn et al’s (2007) theme that the diagnosis is about not fitting (specifically that the diagnosis itself was a catchall ‘dustbin’ diagnosis), Sally identifies the traditional ‘scientific’ classificatory assumptions that underlie the psychiatric scientific project from which the profession of psychiatry draws its legitimation and power (Price 2008). As Milton et al (2010) note: “The classification systems assume that each disorder can be classified as a distinct entity, that psychopathology is a ‘thing in itself’” (ibid p6).

Critiquing this assumption, Bentall (2004) traces the origins of this classificatory drive to Emile Kraepelin, one of the key founding fathers of psychiatry. He identifies Kraepelin’s contribution, proposed within the second edition of his 1887 ‘Compendium’ textbook (later renamed the ‘Textbook of Psychiatry’), was to assert that, “...there was a discrete and discoverable number of psychiatric disorders” (ibid p13). He goes on to note:

“Although he [Kraepelin] recognized that some symptoms could occur in more than one disorder, he argued that each disorder has a typical symptom-picture. He also believed that the different disorders were associated with different types of brain pathology and with different aetiologies. On this view, the first step towards discovering the causes of mental illness was to identify the different disorders on the basis of their symptoms” (ibid).

Bentall (2004), however, questions the validity of such classificatory systems noting that, “…a diagnostic system cannot be valid without first being reliable” (ibid p68). Making several arguments against the reliability of our existing diagnostic categorisations, he proposes that psychiatric diagnoses fail to adequately identify, or make accurate prognostic predictions from, distinct disease entities; symptoms such as hearing voices or delusional thoughts that are supposedly indicative of underlying pathology are also found within the general population as a whole.
In terms of Sally’s critique, we might view this as highlighting the reifying power of psychiatry in producing the diagnosis of BPD on the assumption that the collection of symptoms identified represent a distinct underlying pathology. The accusation here is that Kraepelinian inspired psychiatry is not only inadequate but is also pseudo-scientific.

In agreement with this position, Simone expands the critique by noting how the ‘fixed view’ held of the individual diagnosed with BPD prohibits therapeutic encounters:

“...the pseudo-scientific practise of psychiatric diagnosis ... gets in the way of genuine therapeutic engagement by creating this fixed view of a person through the psychiatric lens’ (Simone).

She theorises further that the invention and application of the label of BPD is rooted in the desire by professionals to defensively project the aspects of themselves they cannot face onto the other:

“I think that when a practitioner applies this diagnosis to a person, they are basically saying, "I don't understand how you, I don't dare try to understand you fully. I can't bear to contemplate the things that have happened to you, I can't bear the feelings that being around you or that thinking about what it actually be like to be you brings up in me. The intensity with which you experience your feelings and the ways in which you deal with them are so far removed from my own experience that it must mean you are inherently different from me (otherwise it would mean we are the same, which is unthinkable). I'm afraid to see all the ways in which I myself sometimes lie, cheat, manipulate, seek attention, self harm, harm others, go numb or feel overwhelmed, and I'm afraid to see feel the depths of my own despair and emptiness, or to acknowledge that I too have been wounded in my life, and am broken ... And so I will instead hang a big flashing neon sign around your neck to point these things out in you, because in you they are extreme, they are obvious, inescapable, and like this I will attempt to escape them in myself” (Simone).

In discussing this issue, whilst it was clear she was drawing on psychoanalytic ideas of ego defences in her talk of projection, i.e., projecting one’s own uncomfortable thoughts, feelings, motivations etc. onto others (Freud 2014), within the interview I suggested that she might also be describing a process of ‘Othering’. Not having come across this term before, Simone looked it up and agreed that this term described the phenomenon:
“I googled "othering" and found this article: Health Commun. 2004;16(2):255-71. Othering and being othered in the context of health care services. Johnson JL, Bottorff JL, Browne AJ, Grewal S, Hilton BA, Clarke H. If this is what you mean by othering, then yes, I'll excuse the term, and might even start using it myself!” (Simone).

Within the paper cited by Simone, ‘Othering” is defined as, “…a process that identifies those that are thought to be different from oneself or the mainstream, and it can reinforce and reproduce positions of domination and subordination” (Johnson et al 2004 p253). Linking processes of projection with processes of ‘Othering’, her account suggests then that the frightening patient is rendered different and wholly ‘Other’ with the practitioner’s painful awareness of their own despair projected onto them and safely distanced through application of the BPD diagnosis. The process, following ‘s Johnson et al’s rendering (above), has implications around reproducing power differentials of practitioner as dominant and patient as subordinate within services.

Aside from projecting negative aspects of the self onto the troubled individual via the application of the diagnosis, Simone also suggests the powerlessness and sense of therapeutic inadequacy felt by professionals attempting to help those with these difficulties are also projected onto the patient, thereby rendering the labelled individual incapable of recovery:

“I think the other thing that a practitioner applying this label is saying is, "I've tried to help you, and you're still suffering, so that must mean you can't be helped. I am trained to make people well, and I can't fix you. So I will put my sense of inadequacy and helplessness inside you alongside everything else I have loaded you with. I'll now see you as incapable of recovery, incapable of leading a purposeful life or of contributing to society in any meaningful way, because I'm tired, I'm burnt out, and I just don't have the staying power to support you in the way you need supporting." (Simone).

Simone’s comments mirror those of Preston (2006) who, in speaking to clinicians of the feelings of impotence that can arise from working with clients with a BPD diagnosis (stemming both from the complexities of their traumatic histories and time limitations) notes that:

“One response ... can be to blame the victim and feel critical towards our client. Another possible response is to develop a pervasive sense of therapeutic nihilism (which often leads to an increasing sense of bitterness or burnout)” (ibid p3).
Relating this to risk identity, it would seem obvious that a critical questioning of the validity of both the diagnosis of BPD and psychiatric categorisations more broadly will have implications in terms of identifying with a risk identity enmeshed with one’s diagnosis.

**The professionalisation and technological imperative within healthcare:**
Linked to the problematisation of bio-medical psychiatric knowledge is an awareness and rejection of both the professionalisation and the technological imperative of modern mental health care. This mirrors Kemp’s (2008) observation that:

“It is notable that surveys of what service users find most helpful to them frequently illuminate the importance of wider, informal social support over ‘technical’ professional interventions (for example, Faulkner and Layzell, 2000)” (ibid p30).

Resonating with her comments above as to how genuine therapeutic encounters are hindered by the ‘psychiatric lens’, Simone discusses the experience of a client for whom she advocated. Within this account she illustrates the tension that can exist between the self-identified needs, desires and wishes of the diagnosed individual and the assumed superior professional judgement and application of a technical therapy (in this case, Dialectical Behavioural Therapy [DBT]):

“...an advocacy client of mine currently in a medium secure unit has been incident-free for over 3 months, has had lots of successful unescorted leave, is feeling better in herself, has been "asymptomatic" for some time, and wishes to be discharged home. However, the team around her are adamant that she must now undergo a year of DBT in the medium secure setting (for "containment" of all that they expect the therapy will bring up) before they feel she is sufficiently "recovered" - this, she is told, is the "treatment of choice" for "people with "BPD". Their prognosis for her is that she will soon relapse in the community, and this is based on her diagnosis, rather than on her own past experience (this has been her first ever admission to hospital, her "psychiatric career" is only 2 years old, but rather than encouraging her to get on with her life, the team tell her, "people with BPD continue to have severe problems and need to have therapy"). So there is an insistence on her "facing up to her problems" in therapy, which is the only thing they believe that they can "do" for her, regardless of whether or not it's what she feels she needs” (Simone).

Specifically, in regard to the professionalisation of healthcare, Susan expresses her antipathy towards her experience of being treated by professional therapists, i.e. practitioners with a professional academic body of knowledge which they apply to advising their clients:
“...I quickly got despondant and gave up all that talk therapy and couselling - I don't want to contantly repeat myself and get that condesending mmmm mmmm yes but did you suck your thumb when you were 5, I really dont need someone with a load of academic but no real life experience telling me what to do or state the obvious. I may be mentally ill but I'm no idiot” (Susan).

Closely related to this criticism and resonating with Fallon’s (2003) finding whereby their participants claimed that they didn’t want therapy but, “...just to be listened to and given time and emotional support” (ibid p397), Susan reported there being a sense of mismatch between her existential awareness of needing someone or something to, “…help me cope with being me” (Susan) and the technical, and seemingly facile, advice offered by said professionals. The implication here is that what is sought is not some technico-scientific solutions designed to make her ‘better’, but a containing ‘bearing witness’ to her attempts to ‘come to terms’ with herself; not change but acceptance:

“When I'm feeling like I'm being crushed by the weight of my thoughts and a 21 year old perky newbie comes in giving it the old ‘well! Lets all do some deep breathing and then discuss the importance of a regular sleep pattern and a 5 a day diet, folks!’ I am aghast - I just only despair and think what planet are these people on - and WE are classed as not normal??!!!!” (Susan).

In both Simone’s and Susan’s accounts, one detects a frustration at the mismatch between the firsthand experiential knowledge of the service user in terms of their needs, and the dominant professional knowledge that dictates the ‘actual’ nature of their difficulties, and prescribes the ‘correct’ intervention, as directed by the scientific evidence base.

Whilst listening to and involving the voice of service users and regarding them as holding expert experiential knowledge of their own distress and needs has been increasingly officially recognised and promoted within health polices since the 1970s (Barnes and Cotterell 2012), the accounts given above appear to reflect a tension between the status of this knowledge and the practice decisions made by professionals derived from their own body of knowledge.
Identifying the modern values of objectivity, rationalism, empiricism, universalism and individualism that underpin the scientific foundations of the healthcare professions, Price (2008) explained that this resulted in, “...the objectification of disease in which this is seen as an entity separate from the subjective experience of the sufferer...” (ibid p52-53). He goes on to observe that this process,” ...creates professional experts and expertise which stand apart from and above the lay person...” (ibid p53).

Arguably, the knowledge that underpins professional status and power, in so far as this derives from the objectification of disease, inhibits more egalitarian power relations and, as identified by Simone and Susan, may trump the experiential knowledge of service users when the two come into conflict. We shall return to these themes when examining how the women engage with trying to change mental health services (see below).

**Stigma and BPD**

Concordant with the emphasis on stigma in relation to the diagnosis of BPD, the women have much to say in terms of their critical reflections on the underlying causes of this oppressive phenomenon. Again, reflecting the critique of psychiatric classification, their arguments rest on the difference between how personality disorders and psychotic and mood disorders are conceived of and treated, both in terms of clinical responses to them and interactions with professionals.

As the literature search revealed, these perceptions of being treated worse due to a diagnosis of BPD are borne out by the research examining the attitude of staff towards those with a BPD diagnosis (Markham and Towner [2003]; Woollaston and Hixenbaugh [2008]; Sansone and Sansone [2013]) and looking at exclusionary practices by mental health professionals rooted in this (Markham [2003]; Forsyth [2007]; Sulzer [2015]).

Evident from the interviews is the women’s sense of being judged as behaving badly or thinking wrongly rather than perceived as being ill. Supportive of the findings of Markham and Towner (2003) and Forsyth (2007) in relation to depression and schizophrenia diagnoses, a number of the women noted that they felt that they had received poorer treatment by professionals compared to patients with disorders such as schizophrenia, bipolar disorder, depression etc. Ramona noted, for example, that:
“At times, I have wished to have a different type of mental illness, whether that be bipolar or schizophrenia because although there is still major issues with having this condition I believe it is actually more accepted, particularly by biomedical type professions” (Ramona).

Simone goes on to relate this difference in treatment to the dominant psychiatric notions that those with schizophrenia, bipolar disorder, depression etc. have a biological disease whilst those with a personality disorder diagnosis merely behave badly:

“I think people who are viewed through the "disease" lens ("bipolar", "schizophrenic", "depressed") tend to be treated with more softness (as they're "ill" they need to be "looked after" and often end up "wrapped up in cotton wool") than those seen as "behavioural" (as in BPD), who are often thought just to need to "learn to take responsibility for themselves" ... [those with a BPD diagnosis are] generally shown less concern and less kindness than someone whose similar behaviour is being put down to "mental illness" rather than "behaviour" (Simone).

This sense of those with mental health diagnoses of schizophrenia, bipolar disorder, depression etc. being treated better by medical professionals was also noted by Susan who, having a bipolar disorder diagnosis in addition to her BPD diagnosis, noted that the quality of her treatment would depend on which diagnosis was seen as the underlying cause of her presenting distress:

“I'm treated better when I am suffering from despair and confusion, lethargy and flat behaviour with my bi-polar than when I am having a slightly aggresive BPD paranoid induced flip out temper tantrum rage when everythings got too much and my brain is overloaded” (Susan).

In order to understand this tendency for staff to assume that those with a BPD diagnosis are “...‘not sick’...”’ (Crow 2004 p328) and are morally at fault, Sulzer’s (2015) study identifying how BPD signifies the quintessential ‘difficult patient’ is instructive. The reader will recall how she identified that the clinicians in her study justified their treatment and exclusionary practice though the moral judgements of manipulation and ‘attention seeking’, as also identified by the women in my own study:
“‘Manipulation” is not a sign of sickness, or of needing help from a clinician, but rather an indication of immoral behavior. In this way, the word manipulation functions as a shaming device, framing patient behavior as moral badness rather than sickness and making the patient personally responsible for symptomatic behavior. This is in contrast to a perceived-biological sickness such as Schizophrenia, wherein the patient might manifest similar behaviors, but would be viewed as legitimately in need of medical help” (ibid p86).

In order to explain the de facto demedicalisation and responsibilisation of BPD, Sulzer identified how those so diagnosed often passively or actively refuse care, and that their behaviours were frequently viewed as a means of dominating the clinician, and of challenging professional hierarchy and psychiatric power.

By not correctly ‘playing the part’ of the sick patient according to the norms of the clinical encounter, the actions of those with a BPD diagnosis are given a moral/behavioural interpretation, which in turn suggests that they are responsible, due to not being ‘sick’. This failure to properly submit to psychiatric power arguably fuels the stigmatising negative attributions identified within the empirical literature, and also by the participants in the present study. The identification of difference (i.e., not fulfilling the ‘sick role’) and subsequent shaming through the ascribing of negative attributions within the context of this challenge to psychiatric power might be viewed also as a means of reinforcing the threatened professional position of dominance; if the BPD patient is deemed not ‘sick’, but ‘morally wanting’, then the power represented by psychiatric expertise in treating the mentally sick remains unchallenged. As Susan suggests in regard to the mismatch between the expectations and expertise of the professionals and the presenting difficulties of the BPD patient:

“Basically, with BPD, you're boring to your average Psych. Youre not going have an epiphany under their guidance, feast on what they, the all knowing have help open your eyes to - you're not going to talk and talk and finally 'get it'” (Susan).

Writing in a similar vein, Emily notes that:

“Professionals that we come into contact with often just want to do their job, and feel like people with BPD get in the way of that – we’re the awkward ones who don’t turn up for appointments, and kick off, and take 2 steps forward, and 3 steps back!” (Emily).
In terms of identity and the ‘sick role’, we can recall how Showalter (2008) identified the adoption of this role as a means by which women have historically found a legitimate outlet for expressing distress and escaping some aspects of life prescribed by their gender role, although the potential to be regarded as a malingerer by one’s physician is a risk. From the participants’ comments about the stigma surrounding the BPD diagnosis, we can see that the ‘hysterical’ woman’s contemporary counterpart may equally draw moral condemnation when adopting this role. A woman with a BPD diagnosis is therefore pathologised within the ‘double-bind’ of the female gender role and then condemned for her failure to fulfil the sick role despite the de jure medicalization of her experiences and behaviour.

The responsibilisation bound up with such moral judgements might also be viewed as an extension of the tendency for psychiatry to obscure the social context of distress. The adoption of a ‘sick role’, as a woman with BPD, might be seen as a quasi-legitimate means of expressing distress that simultaneously locates disorder in her, whilst obscuring the social context of her trauma. ‘Quasi-legitimate’ in that, whilst she takes on an identity that defines her as ill, in practice she is demedicalised and held responsible for her distress (with BPD itself seeming to represent a site for a further ‘double-bind’ between ‘sick’ and ‘not sick’ identities). The responsibilisation that takes place not only serves the interests of psychiatric services (for example, by obviating their responsibility towards, and excluding ‘difficult’ patients from, treatment provision) but more broadly, as argued above, serves patriarchal and capitalist agendas.

**Engagement with change**

“Sometimes I’m more on the ball than other times and I’m a bit of a woflie smith, power to the people, baby!” (Susan).

In addition to a critical awareness of the hidden structures that root and perpetuate oppression, the majority of the women were also actively engaged in changing social reality for themselves and others, and in gaining a sense of identity and meaning from the struggle. As Susan jokes:

“I had to laugh just reading back what I had sent - I was a bit ..er..edgy when I wrote to you last time, lol. I suppose I have come across as a bitter person, but I honestly am, HAHAHAHAHA - no, seriously, all jokes aside, I am more of a ‘struggler against the unjust!’” (Susan).
Social change and the psychological benefits of gaining meaning and identity through activism have been identified within the literature on ‘empowerment’ (for example, Rogers et al 1997, Tones and Green 2002, MacDonnell et al 2017). Encapsulating these two dimensions and, as we shall see, resonating with the remarks on the topic by the women, Barnes and Bowl (2001 cited in Byrt and Dooher 2002) write:

“Self-efficacy-self-esteem, power-powerlessness, community activism, righteous anger, and optimism – control over the future. These criteria reflect both psychological and political dimensions of the concept [of empowerment]” (ibid p26).

The women’s activism takes place within the context of the rise of the ‘service user movement’ that has been emerging over the past few decades (Barnes and Cotterell 2012). This movement has its origins in the birth of psychiatric survivors groups (Rogers and Pilgrim 2008) and represents examples of broader emerging ‘new social movements’, i.e., “…loose networks of people that actively resist established dominant forms of power or pursue cultural or social change” (ibid p226).

The range of the women’s remarks around their engagement with social change appear to reflect the forms of activism which Crossley (1999 cited in Kemp 2008) identifies as having characterised three phases of the development of the service user movement. These are the ‘reformist’ phase (between the end of the Second World War up to the early 1960s) where those advocating for the rights and treatment of patients functioned as pressure groups to inform and reform policies.

The subsequent ‘radical’ phase (between the mid-1960s to 1980) characterised by the rise of more patient led campaigning organisations and activities, reflected the emergence of radical social movements and influence of ‘anti-psychiatry’. Finally, the ‘pluralistic’ phase (from the mid-1980s to the present) was characterised by the rapid growth and expansion of activities within the field of mental health, including a focus on and engagement with local mental health service issues and service development, a focus on self-advocacy, and the greater securing of formal approval of the service user movement within the health services (ibid).
Reflecting the plurality of the contemporary service user movement, both reformist and radical positions were evident in the women’s responses. By way of illustration, when referencing an article in ‘The Guardian’ newspaper by Barber (2012), Susan writes:

“I read a thing in the guardian the other day that said ‘Is mental the new gay?’, claiming that the derogative term for the mentally ill is bounded about in schools and needs addressing etc. I do agree mental health needs covering in schools to end the ignorance, but I fully claim back the term nutter, mental etc and I own it, I am a bit mad and I'm not ashamed to say it because sometimes, life can be funny” (Susan).

Here one can detect both sympathy for the reformist tradition in her support for anti-stigma campaigns in schools but also the adoption of a position sympathetic to the no longer active radical ‘Mad Pride’ movement which, among other objectives, reclaimed terms such as ‘mad’ in a move to combat stigma and undermine the term’s prejudicial use (Abraham 2016).

In terms of other expressions of this radical positioning, when speaking about the harmful effects of bio-medical psychiatric power, Simone argues that anti-stigma campaigns fail to address and ultimately compound the issue of stigma within mental health through constructing mental distress within an ‘illness’ paradigm which, she argues, is intrinsically prejudiced:

“The notion of "stigma" in mental health is intimately tied in with the medicalisation of mental health; any attempt to "stamp out stigma" via campaigns like "Time to Change" are inadvertently compounding the problem of public perception of mental/ emotional differences/ distress by intrinsically supporting the assumptions and prejudices of the medical model” (Simone).

This position, resonant with the anti-psychiatry movement, focusses its ire on the institution of medical psychiatry itself, with the attendant belief being that this institution must be abolished or radically transformed in order to tackle the oppressive effects of an inherently stigmatising medical paradigm (Sedgwick 1987).
Again, reflecting the ‘pluralistic’ phase of the service user movement, for Sally, Summer, Simone, and Emily, their activism took the form of working within the field of mental health as advocates and trainers. Emily describes how her presentation work about BPD to professionals and carers enables her to derive something positive out of having the condition, describing how her experiential knowledge of the difficulties she experiences are validated through this forum and how she has gained a sense of empowerment though helping others (including myself as the researcher):

“I did a presentation yesterday, and I was explaining to the delegates what it was like to have BPD and to self-harm, and to ‘feel’ suicidal every day. And the questions and interest shown validated my own experiences – and made a positive, out of having BPD ... As I have said earlier, the only good thing about having BPD is the ability to help people like yourself & the people who come on the courses” (Emily).

In response to the researcher informing Simone that the process of interviewing participants has informed his practice, she makes a similar observation in regard to how the empowerment that she derives from helping:

“I liked it in one of your emails where you said that reading my emails was informative for your own practice. That makes it worthwhile writing to you, even if you never finished your paper, that I've had an opportunity to put down some of these ideas in writing and get them across to someone who it might help in their work” (Simone).

Having identified the knowledge that she has gained, and the enhancement of her ability to challenge how the BPD label applies to herself through working for an organisation that delivers training to health care professionals, Sally identifies the problem of potentially furthering an oppressive discourse by legitimising its terms when attempting to challenge it.

Noting her hatred of the BPD diagnostic label itself, she describes having to carefully explain her position to those she trains, “...otherwise it feels as if by delivering PD training I am somehow condoning the use of the label” (Sally).
Reporting how, historically, the state has responded to the growth of both user groups and the establishment of services outside of mainstream provision through incorporation, or users becoming ‘partners’ in designing and delivering services, Rogers and Pilgrim (2008) highlight the tensions that exist between the user roles of advising, providing services, and campaigning within a context where, ultimately, power still resides with provider managers who, “...retain control over decision making and may expect users to address the organization-set agendas and conform to their management practices” (ibid p233).

Sally’s noted concern over legitimising the use of BPD might be conceived as reflecting one such tension as an ex-service user working within mainstream service provision in an advising/training role. ‘BPD’, as a term within dominant psychiatric discourse, has here to be practically adopted to communicate with health care professionals within state and private services in the full knowledge that the term itself is problematic and damaging. Her discomfort of having to adopt the language of a professional system of knowledge that one has experienced as oppressive is evident and, again, arguably reflects the tension between expert service user experiential knowledge and expert professional knowledge.

Remaining on the outside of mainstream mental health services, Susan jokes that she, “...would have liked to worked in Mental health, but at the end of the day I'm just too..well, mental” (Susan). Her activism, aside from the reappropriation of the stigmatising terms like ‘nutter’, ‘mental’, and ‘mad’, takes that form of advocating on behalf of her daughter who also experiences mental health difficulties, and (as noted above) by having taken part in a legal action against the pharmaceutical company GlaxoSmithKline:

“I was part of the original complaintants who were taking action against Glaxo, due to when I was placed on Paroxetine it was being pushed as the wonder drug, I had refused all meds due to my parents illegal and perscription drug addiction, is but there was little choice for me on this one as I was in Hospital for the first time and had little confidence” (Susan).
Susan’s efforts against GlaxoSmithKline represent part of a broader challenge to the pharmaceutical giant’s business practices. In 2004 GlaxoSmithKline agreed to $2.5 million in charges for consumer fraud and suppressing the negative findings of their Paroxetine research (Angell 2009). In 2012 the company announced it was set to pay £3 billion (£1.9 billion) in a criminal settlement following charges that, among other allegations, it had unlawfully (i.e., without FDA approval) promoted Paroxetine use for children (Neville 2012). In 2016, the company was fined £37.6 million by Britain’s competition authority in relation to illegally blocking generic versions of the drug, thereby costing the NHS, and the tax payer, greater expense (Kollewe 2016).

Whilst GlaxoSmithKline have also been accused of criminal actions in relation to the safety and marketing of other drugs, most notably the anti-diabetic drug Avandia (Mattera 2015), they are not alone among the pharmaceutical giants in garnering accusations of criminal activity. An analysis of the court judgements and criminal settlements of the pharmaceutical industry over the past 25 years conducted by the consumer watchdog group ‘Public Citizen’, aside from finding that a decline (by one third) in recovered penalties from 2014 to 2015 compared to 2012 to 2013, found that Pfizer had the most settlements, followed by Merck, with GlaxoSmithKline, Novartis and Bristol-Myers Squibb jointly coming in third. Arguing for greater penalties and potential prison sentences for CEOs, the report notes that without such sanctions, these kinds of corporate criminal activities will continue to be, "...part of the companies' business model" (cited in Fortune 2016).

It appears clear that profit for shareholders currently trumps legal and ethical considerations when it comes to the pharmaceutical corporations who produce the medications targeted at those labelled as mentally ill. As Constable (2012) writes:

“Pharmaceutical companies bend or withhold scientific data and lie about their drugs, in ways which endanger, harm or kill sick people, to make a profit ... This is a prime example of the way the profit motive rewarded by Capitalism stands in front of human progress” (ibid no pagination).

Susan’s challenge to the power of pharmaceutical corporations through taking part in collective legal action represents a bid to curb their power and injurious practices through our legal institutions.
Taking part in the research project
The women made a number of comments in relation to having taken part in the project, both spontaneously in the form of unsolicited comments made during the course of the interviews, and in response to being specifically asked towards the end of each interview. These positive responses can be grouped into three categories, *positively contributing to knowledge and practice*, *feeling validated and listened to*, and, *finding the interview therapeutic*. Each will be illustrated in turn.

Resonating with the above comments made in relation to the benefits of activism and the valuing of experiential knowledge, Simone and Dawn note how contributing to knowledge through their participation in the research project has given them a welcome outlet for their expertise, as those with the experience of having a BPD diagnosis:

“*Nice to have an opportunity to write about it all. And nice to be asked for my thoughts about this! [BPD]’*” (Simone).

“*I am so delighted that your research project is focusing on BPD – very rarely is it a condition that people give any influence to and I am incredibly grateful for being given the opportunity to contribute … the only way I can cope with my past and unbearable feelings in the present is to believe that my experiences can and will make a difference for future generations to come …. ”* (Dawn).

Dawn and Ramona also speak about how they experienced a sense of validation in participating in the research process through being listened to. This potentially reflects my epistemological position which valued their experiential knowledge, thereby validating their experiences:

“*I guess my reflection on my participation in these interviews has been favourably good! I have actually felt very supported and validated in what I have said”* (Dawn).

“*…you made me feel as though you were interested in what I had to say … you definitely made me feel like my comments were valid and of interest”* (Ramona).

Simone, harking back to her descriptions of the invalidation that she feels characterises her experience of mental health professionals and the mental health system in general, identifies her experience of the ‘open-minded’ approach of the researcher as characteristic of the attitude she would like mental health workers to adopt:
“...your willingness to try to understand me better and your warm invitation to share my inner world are precisely the kinds of qualities I would like to see more of in clinical settings. I think clinicians should approach their patients with the kind of open-minded curiosity of a "researcher", interested in finding out more about "what it's like to be you", instead of the more common closed-minded "I know what's wrong with you and it's called BPD” mind-set” (Simone).

Aside from, but perhaps related to, the feelings of validation reported by the participants, a final unanticipated effect of taking part in the study was a sense of the interview process as therapeutic. As Dawn states:

“I have been so used to (for pretty much all of my life) feeling unable to disclose a lot of the stuff that goes on in my head for fear of consequence and disgust that I will quite often keep a lot of my thoughts and emotions ‘inside’ giving me opportunity for self-combustion and angst yet I have felt able to be open and supported to just say it how it is without judgment ... your non-judgemental stance of the stuff I have disclosed has been incredibly therapeutic...” (Dawn).

Simone too emphasises the ‘therapeutic’ character of taking part in the interviews and projects the therapeutic benefits beyond the participants to the researcher and the reader of the final report: "I can't help but see the process as "therapeutic" too, for your interviewees, for you, and for anyone who reads your finished work” (Simone).

Whilst not using the team ‘therapeutic’, Sally speaks of the positive benefit she derived from having a reflective space to look back at past difficulties:

“I will leave it there I think although I can think of other stuff...enjoyed thinking about it too. These emailings are fab reflection for me but I am sorry if I go off on a tangent at times...it is just me, I am verbose in real life as well!!...” “...When I look back along my journey, to all of it not necessarily just the mental illhealth, I can learn a great deal. As I have said these emails have formed a reflective space which I have found interesting” (Sally).
Summary of the Critical Tale

In summation of the Critical Tale, several critical themes were identified by the women, namely, gender and BPD; psychiatry obscuring the social context of distress; critique of biomedical psychiatry in relation to BPD; the professionalisation and technological imperative within healthcare; stigma and BPD and engagement with change. Through exploration and analysis of these themes, the interweaving influence of patriarchy, capitalism (including the power of the pharmaceutical industry), and the power of the ‘psy’ professions (particularly psychiatry) were identified as underlying, rooting and perpetuating the oppression of women with a BPD diagnosis.

Within and through these spheres of power, invalidation of the women’s experiences, identified by them in the Realist Tale as being linked to distress and risk behaviours, appear to be structurally ‘written in’ to mental health service provision. The women are positioned as deviant, their trauma is decontextualised, their knowledge of their needs delegitimised and, when they do submit to a ‘sick role’ identity by taking on the BPD mantle, their character is questioned and shaming attributions are made.

Other than the women expressing a critical awareness of said underlying structures and how they impact on the construction, application, and oppressive effects of the BPD diagnosis, the majority (5) of the women have translated their awareness into engagement with social change, a commitment which saw them engaging in the research project.

A number of comments made by the women in relation to the benefits of participating in the research process point towards broadly positive effects stemming from their engagement with it. Such positive effects included the sense of empowerment through positively contributing to knowledge, feeling validated by the research process, and finding the efforts to ‘tell their stories’ therapeutic. It is my hope that these effects reflect the incorporation of feminist principles of research within the overall critical emancipatory methodology, as presented in the Methodological Approach and Methods chapter.
Chapter 7 Analysis – The Deconstructivist Tale

Introduction
When analysing the women’s interview texts through the deconstructivist lens in order to tell the Deconstructivist Tale, the focus is on looking at how the ‘truths’ of identity are constructed by examining the underlying discourses which produce them. The convergence of said discourses forms discursive frameworks which mediate these truth statements and reflect power relations that may be either repressive or liberatory (Pennington 2011).

Accordingly, attention will be paid to how the women’s identities are both produced through discourse and how they incorporate, resist, and, restructure elements of discourse within the texts; with ‘risk identity’, as a feature within this broader construction of identity, being delineated through the telling of this tale.

The tale will proceed by first making a general analytical observation about how identity is negotiated in relation to BPD before analysing how the women identified with or resisted specific features of the diagnosis raised within their interview texts in relation to ‘risk identity’. Identifying the underlying discourses as we progress, the tale will then examine broader ‘non BPD’ discourses before culminating with an analysis of the most influential non-psychiatric discourse that was found to be productive of identity. The chapter will conclude with a summary of the main discourses identified that appear to be productive of identity more broadly, and ‘risk identity’ specifically.

Alongside new extracts of text taken from the interviews, some previously encountered quotes from the earlier tales will be reintroduced; in this tale, however, they will be subjected to a deconstructivist interpretation. This analysis will ‘look beyond’ the explicit meanings to the discourses from which they spring. It should be noted that whilst the focus will be on how identities are produced through discourse, the reality of the women’s suffering should not itself be viewed as invalidated or diminished as the mere product of language. Following Ussher (2003), the position that I have taken is that the suffering is real, but how it is experienced and related is through a nexus of discourse.
Negotiation of identity and ‘risk identity’ in relation to BPD

When discussing BPD as a discursive resource in relation to the negotiation of identity and ‘risk identity’, I present the diagnosis as a discursive feature situated within broader psychiatric discourse. Psychiatric discourse itself is set within the various discourses produced by, “…the human sciences, in particular psychology and its affiliates – the endeavors which can be generally termed ‘psy’” (Rose 1999 pvi).

The participants in this study inhabited differing subject positions in relation to identifying with the diagnosis. At the outset it is therefore necessary to acknowledge the obvious analytic observation that the degree to which the diagnosis itself, and the specific diagnostic features that are constructive of it, are identified with within the interview texts reflects BPD as a discursive resource productive of identity in general and, more specifically, ‘risk identity’.

In terms of BPD being broadly productive of identity, the following extracts are illustrative:

“My BPD affects relationships; it utterly guts and destroys them. It affects how I view myself in this world, it affects my work, my thinking, my appearance … with BPD it’s part of me, it’s in my pores and oozes out and corrupts everything I try to do” (Emily).

“I feel like this diagnosis has taken away my life – I lost my childhood and as a result of that I have lost my adulthood – I don’t want to appear pessimistic or negative but actually from the minute I open my eyes to the minute I go to sleep its there – living it, breathing it, but never being able to grasp it! … BPD is incessant – its there, all the time, its affects my judgement” (Dawn).

“You have BPD. It's you, being you and there's no amount of 'getting it, getting over it and getting on with it'. I ask you - how can you get 'better' if its your self?” (Susan).

BPD here is constructed as a mental health condition that dominates how one views oneself and one’s world. Emily and Dawn identify how BPD adversely impacts on central features of their lives, whilst Susan constructs BPD as being indistinguishable from who she is. In all three examples, identification is made with the diagnosis in relation to identity, mirroring the empirical finding of Lovell and Hardy (2014), whose participants adopted either the position that their diagnosis had taken over their identity, or that it was their identity. The following examples reveal how identification with the diagnosis is explicitly productive of a ‘risk identity’:
“It is almost as if the 'non-bpd' part of me is very cautious and scared to take risks, but the BPD part of me will throw itself into risky situations only if they are self-damaging” (Ramona).

“In my twenties, after I had been through overdoses, hospitalisations, being diagnosed and treated, I found it a lot harder to stop self harming than I had when I was younger. I believe this was largely to do with my identity being wrapped around having a mental disorder as a result of the internalising of all that my label told me I was and of the institutionalisation that occurred through being "in the system”” (Simone).

In Ramona’s quote, we see the ‘cautious’, non-risk-taking construction of self-identity being ‘separated out’ from the BPD-produced identity, with the diagnosis being cast as an aspect of the self that causes risky acts. With Simone, difficulties in ceasing self-harming (constructed as a risky behaviour within this portion of her interview text) are linked to an illness identity produced by the diagnosis. In both examples, identities in relation to risk and risk taking are presented as ‘bound up’ with the application of a BPD diagnosis.

Whilst the passages reproduced above allow us to pinpoint that BPD as a discursive feature of broader psychiatric discourse can be productive of identity and ‘risk identity’, the interview texts reveal more nuance in regard to the identification with, and resistance to, the specific diagnostic features of the diagnosis. It is to these nuances that analysis will now turn.

**Negotiation of identity and ‘risk identity’ in relation to BPD – identity disturbance and the essential core self**

When analysing ‘risk identity’ within the women’s texts, a logical place to start is the articulation of their difficulty with their sense of self, given that identity disturbance is understood to be symptomatic of BPD, and that this feature speaks directly to the topic of their identity. The following extracts illustrate identification with this diagnostic feature:

“…in some ways i dont feel i am a complete person either; this feeling i have had for as many years as i can recall from childhood, (approx 6-7 yrs when first felt that i was not complete)” (Bell).

“My identity is something that I struggle a lot with, for me it's been a big part of my treatment” (Ramona).

“Looking at the traits I think the feeling of emptiness was clearly there all the time” (Sally).
In terms of ‘risk identity’, the notion of a ‘pervasive instability of self-image’ as described by the diagnosis contributes to psychiatric discourses’ positioning of those subject to the diagnosis as being risky individuals. As Wirth-Cauchon (2003) notes in relation to this instability, “...this unstable and incoherent abjection [is] depicted as a space of chaos, inhumaneness, or danger” (ibid p87). Accordingly, where there is identification with the diagnostic criteria of identity disturbance, this can be viewed as formative of a ‘risk identity’.

The theme of identity disturbance, whilst manifest within psychiatric discourse's construction of BPD, may also be understood as having been produced through convergence with binary gender discourses on the subject. Following feminist theorists such as de Beauvoir (2009), Kristeva (1995), and Irigaray (1985), gender binary discourse necessarily positions women as 'Other', thereby constructing the feminine as inherently lacking the qualities of the ‘masculinised’ regulatory ideal produced by Western discourses of the subject. As Oksala (2011) identifies:

“...feminine subjects are constructed through patriarchal, disciplinary practices as very different kinds of subjects than the autonomous, liberal model suggests [i.e. the Western regulatory ideal of the subject]: they are constructed as subjects who are dependent on others, who must suppress their aggression, egotistical interests and ambitions and demonstrate caring and nurturing qualities” (ibid pp104-105).

By positioning women as ‘Other’ to the aforementioned masculine Western regulatory ideal of the subject, an ideal which includes valorised characteristics such as self-definition, unification, and autonomy, such patriarchal disciplinary practices also position women as inherently unstable (Wirth-Cauchon 2003). The following extracts taken from Summer’s and Sally’s texts lend weight to the identification of binary gender discourses of the subject being ‘at play’. The particular focus on self-image is mediated through the reflective gaze of mirrors, photographs and imagined others, resonating with the construction of women as dependent and defined by others rather than autonomous and self-defining:

“I also have unstable self image, at times I will think I'm so ugly that i refuse to leave the house and other times I will think I look amazing and take endless photographs of myself (finding fault with them at a later date.)” (Summer).

“...in the 'bad' days I was utterly confused and basically hated myself. Couldn't look in mirrors, was scared of how people saw me” (Sally).
Having presented how binary gender discourse of the subject and the construct of BPD are productive of risk identity in relation to identity disturbance, the interview texts also provide examples of resistance to this positioning through the construction of the notion of an essential core self.

As discussed in the Introduction chapter, the notion of an essential core self has existed in the Western culture since at least the Classical Greeks (Martin and Barresi 2006). From a Foucauldian perspective, knowledge of, and belief in, the ontological reality of an essential core self can be understood as reflecting Western discourses of the subject historically embedded in discursive and non-discursive social and material practices, institutions and power relationships (Foucault 2008a; 2009).

Miller (1994) identified that her participants’ responses implied a core identity discernible behind their attempts to feel better about themselves, and the interview texts produced by Simone and Sally similarly appear to imply, and therefore construct, such an identity. Simone, in writing about the pathologisation of her ‘passion’, notes that this was all part of, “…me being me" and it is one of the aspects of "me" “(Simone).

Sally’s text also represents her strong emotions as being part of who she is rather than describing them as necessarily pathological, through the evocation of a core identity:

“My strong emotions I know are part of me. I may always have them, it is part of who i am and would not change them as they are big on both ends of the happiness scale now. Actually not true, they are by far up in the top quarter now, but they are intense albeit fab emotions” (Sally).

Resonant with a construction of an essential core self, she also writes in relation to the topic of recovery that, “Sal, my core character was always there but circumstances meant that my way of coping and surviving was to adopt certain behaviours and actions… “ (Sally).
In terms of Simone’s ‘passion’ and Sally’s ‘strong emotions’, the notion of an essential core self appears to discursively resist the pathologising constructions of psychiatric discourse around BPD which renders strong affect (i.e., ‘affective instability’ and ‘marked reactivity of mood’) as evidence of disorder, and may position one with a potential abject risky identity (Wirth-Cauchon 2003). Discernible within Sally’s ‘core character’ comments, the essential core self seems to affirm an identity distinct from, and more fundamental to, her coping behaviours/actions. In both cases, the ‘truth’ of oneself is established as being one’s true core self.

If emotional features such as ‘affective instability’, ‘reactivity of mood’, ‘intense anger’ etc. and behavioural features such as ‘impulsivity’ and ‘self-damaging/self-mutilating’ behaviours are constructed within the diagnosis as reflecting an unstable ‘risky’ self (ibid), the positive re-inscription of passionate/strong emotions as being part of one’s ‘true self’ and the construction of a ‘core character’ which exists in spite of distressed behaviours/actions, suggests an identity that, in the former encompasses and naturalises such features and in the latter endures in spite of them. If Western discourses of the subject appear to be constructive of the notion of an essential core self, this is perhaps unsurprising given Rose’s (1996; 1998; 1999) analysis of the dominance of ‘psy’ discourse in shaping contemporary constructions of the self, and the prevalence of the construct of authenticity within ‘psy’ discourse.

**Negotiation of identity and ‘risk identity’ in relation to BPD – inappropriate, intense anger and self-harm**

Within the DSM-V (2013) classification for BPD, following the symptom descriptor of ‘inappropriate, intense anger or difficulty controlling anger’, the examples of ‘frequent displays of temper’, ‘constant anger’ and ‘recurrent physical fights’ are given to instruct professionals in the ways in which this symptom may manifest. Taken together, one can see how the notion that those with a BPD diagnosis are characteristically outwardly angry, aggressive and potentially a risk to others is constructed within this diagnostic identity. In terms of evidence of identification with this construction of being a risk to others, only Summer and Susan relate this to their own behaviours:

“*I also remember times when my (now ex) partner would want to go out with friends I would cause arguments, cry, become aggressive, anything I could do to stop him from going out I would try*” (Summer).
“...I do get very angry, Im 0-60 quick at switching and my temper can be called a rage at times, i can rant and i will tell you, somewhat ashamedly, that at the height of my BPD days I have injured my ex husband many times” (Susan).

Although Summer’s reporting of becoming aggressive is made in the context of her identifying with the diagnostic descriptor of ‘attempting to avoid real or imagined abandonment’, both her text and Susan’s construct their externalised anger/aggression in the context of positively identifying with the diagnosis indicating that, to some degree, their ‘risk identity’ in relation to this feature is in part produced by the BPD diagnostic construct.

In terms of other textual examples where BPD and externalised anger/aggression are positively linked, Susan makes reference to, “...females with bpd...” (Susan) in general, suggesting that they are, “...more agressive, maybe due to their background, the hand life has dealt them, nerves, worries, agaitation” (Susan). Sally also notes in relation to others so diagnosed that, “... I think it is fair to say that anger is associated with BPD by professionals and to a certain extent fairly” (Sally). Whilst Susan provides an explanation for why women with a BPD diagnosis may present as angry/aggressive in terms of hypothesised difficult backgrounds (see below), both she and Sally again link anger/aggression to the diagnosis within their texts.

In writing about whether she identifies with features of the diagnosis, Emily brings out a distinction between BPD and anger/aggression through contrasting, in relation to the story of their discharge from services, how she and her best friend – who was also in receipt of a BPD diagnosis - differ:

“When I was discharged from my psychiatrist it was simply awful. He discharged me without any prior warning, and said it was because of how well I was - rather than budget cuts (a blatant lie). Anyway, when he did so, my head exploded and yet on the outside I was calm and didn’t say a word. I nodded my agreement, and even shook his hand as I left. I went out to the reception area and texted my friend to warn her he was discharging patients. When she saw him she demanded that she had a about how dangerous the budget cuts were! Now, I don’t condone her behaviour, but I could never do that. I might feel like it, but could never do it. I would see her behaviour as acting out – she felt pain and let others (in a maladaptive way) of seeing it. Whereas I, felt the pain, and kept it locked so deep” (Emily).
Like Sally and Susan, Emily’s text constructs anger as a true feature of BPD, with a distinction made between, “...acting out... [and keeping the pain] ...locked so deep” (Emily), introducing a broader resistive theme discernible within the women’s interview texts in relation to constructions of being outwardly angry and potentially a risk to others. As Emily complains, “I’ve never shouted, screamed or hit/slapped another person in my life – and yet this is what professionals associate with BPD” (Emily). Broadly, the women’s texts resist this rendering, emphasising instead both their internalisation of anger and the risk they pose to themselves through self-harm:

“...after a lot of therapy I've sort of come to realise that I am actually quite an angry person [it's] internalised... I take it out on myself [through self-harm]” (Ramona).

“Self harming/life threatening behaviours and most definitely risk taking behaviours” (Dawn).

Interestingly, ‘self-harm’ is currently classified within the DSM-VI (2013) under the symptom description of ‘recurrent suicidal behavior, gestures, or threats, or self-mutilating behaviour’. It is therefore discursively distinguished from the symptom description of, ‘inappropriate, intense anger or difficulty controlling anger’. Whilst I would argue that this construction of self-harm within the diagnostic formula supports the moral attributions of manipulation and attention seeking by linking it with intentional communication terms (i.e., ‘gestures’ and ‘threats’), it is clear that the women’s texts construct this risk behaviour as a means of coping with difficult emotions, including anger:

“...the self-harming, that has to be anger ... it is a momentary comfort and release though of course then leads to anger at my lack of self control, my appearence etc, fabulous vicious circle stuff” (Sally).

“I have definitely self-harmed when I get ‘angry’ but I think for the that’s relatively superficial compared to some of the thought processes that go on inside my head” (Dawn).

“...the majority of the time though, i use cutting to 'scream' without making noise” (Summer).
With this tension between how the diagnostic descriptors construct self-harm and how the women render this behaviour within their texts acknowledged, one might understand the emphasis on ‘harm to self’ in relation to anger/aggression as reflecting an identification with one aspect of the ‘risk identity’ produced by the diagnostic construct of BPD, whilst resisting the ‘harm to others’ representation. Examples of such resistance can be found within Emily’s and Summer’s interview texts:

“I definitely think borderlines are a risk to themselves, but not so much others, except I suppose if the risks they take infringe /impact on another persons safety, but rarely would I be afraid of a fellow bpd” (Emily).

“I don’t believe I am a risk to others around me however I do sometimes feel a risk to myself which is when I call for help” (Summer).

The construction of the meaning and function of self-harm in relation to anger/aggression within the women’s texts mirror their explanations as to why mental health workers seem to overemphasise externalised anger/aggression whilst minimising internal distress. Ramona, for example, proposes that outward emotion is easier for others to identify:

“Yes, I do think the BPD is weighted towards expressed anger. Perhaps because it is an outward emotion that people understand and can latch onto. I think a lot of the BPD criteria, such as chronic feelings of emptiness, identity disturbance, dissociation, are a lot harder for people to understand and relate to” (Ramona).

Susan’s explanation that inner agitation can be misattributed as outward aggression similarly reproduces the notion of others struggling to appreciate or understand inner turmoil: “I would say that a lot of what appears to be aggression, is actually agitation - sometimes. Agitation which causes you to act in a manner that may be seen by others as aggressive” (Susan).

Combined with the women’s remarks on self-harm as a means of internalising anger/aggression, such explanations reflect Western discourses of the subject which construct a private inner subjective realm. As Rose (1998) writes in relation to this Western conception of the self:
“...the person is constructed as a self, a naturally unique and discrete entity, the boundaries of the body enclosing, as if by definition, an inner life of the psyche, in which are inscribed the experiences of an individual biography ... [I]t is only at this historical moment, and in a limited and localized geographical space, that human being is understood in terms of individuals who are selves, each equipped with an inner domain...” (ibid p22-23).

Western discourses of the subject’s distinguishing of an inner subjective realm from an observable objective realm has been significantly informed by Cartesian dualism (Taylor 2000), which is a philosophical rendering of the subject that has also been highly influential within psychiatry and the wider ‘psy’ disciplines (Kendler 2005). Given the profound influence of ‘psy’ discourses in shaping contemporary constructions of the self (Rose 1998), the subject/object dualism evident in Ramona and Susan’s texts is again perhaps unsurprising.

In terms of how this constructs ‘risk identity’ in relation to anger/aggression, by evoking the construct of subject/object dualism, the ‘truth’ of this is framed within these extracts as residing in their subjective world of ‘inner’ distress and not in the ‘objective’ signs of distress localised in one’s body or behaviours. It may therefore be understood as resisting the view that others can understand or have access to the nature and level of one’s risk based on their observations, with the ‘risk identity’ assigned to you as a patient not necessarily equating with the reality to which you only have access.

For those women that positively identify as having difficulties with anger/aggression and offer explanations for this within their interview texts, acknowledging that dualistic renderings of the self are again evident, a further discourse is discernible that has implications for identity. Susan’s and Sally’s texts offer examples whereby the context of childhood experience is mobilised to explain their difficulties with anger/aggression.

Susan’s text represents her difficulties with anger/aggression as stemming from the impact of growing up in an aggressive family environment in a socially-deprived borough of London:
“I come from [CONFIDENTIAL] in [CONFIDENTIAL] London and my mum and dad were very loud aggressive people. I had many siblings and we had to make ourselves heard. I do have a defensive way of talking because I have had to protect myself from home life and the society/environment in which I grew up in. If you didn’t look tough you were easy pickings. But inside I was scared to death, nerves abounded and anxiety ruled” (Susan).

Sally’s text constructs her difficulties in externalising anger as resulting from never having learnt to do so in her childhood: “My parents were not outwardly angry though it was definitely there so perhaps I meant that I didn’t display overtly angry outbursts, hitting, shouting inappropriately…” (Sally).

In both extracts, whilst identification is made with a pathologising construction of anger/aggression as produced by the diagnosis, the renderings of this difficulty appear to resist bio-psychiatry’s tendency to fail to account for social processes when conceptualising symptoms (Scheff 2007). As a profession and as a body of knowledge, however, it would be inaccurate to portray psychiatry as wholly reducible to the bio-psychiatric paradigm, despite its dominance. As Rogers and Pilgrim (2008) identify:

“As with other branches of medicine, psychiatrists vary in their assumptions about diagnosis, prognosis, aetiology and treatment ... modern Western psychiatry is an eclectic enterprise. It does, however, have dominant features” (ibid p2).

They also identify that:

“Those psychiatrists who have rejected this illness framework, in the whole or in part, tend to have been exposed to, and have accepted, an alternative view derived from another discourse (psychology, philosophy or sociology)” (ibid).

Psychiatric discourse therefore incorporates psychiatric perspectives alternate to the dominant bio-psychiatric view. In the case of the extracts produced by Susan and Sally, the explanations presented resonate with sociological and social-psychological concepts such as socialisation and social-learning theory. Since, as noted above, they also appear to identify with the diagnostic descriptor of ‘difficulty controlling anger’ thereby affirming the ‘truth’ of anger/aggression as a psychiatric symptom, I would argue that this suggests the influence of social psychiatric discourse as being constructive of ‘risk identity’ in relation to this feature of the diagnosis, with social psychiatry defined here as:
“...a branch of psychiatry that deals in collaboration with related specialties (as sociology and anthropology) with the influence of social and cultural factors on the causation, course, and outcome of mental illness” (Medical Dictionary 2017).

Before detailing the implications that framing distress within a social context has in terms of risk identity constructions, we might recall that feminist social causation arguments were presented in the Introduction chapter in relation to feminist critiques of BPD. Feminist discourses not only converge with social psychiatric discourse but also historically contributed to its development as they emerged as social movements during the 1960’s (Leff 2010).

Resonating with the social causation arguments for anger presented above, but introducing the specific social experiences of women in society, Sally speculates over whether the social suppression of women’s anger causes internalised and externalised anger difficulties: “Is it though the societal suppression of women's anger which causes the implosion and explosions seen with BPD?” (Sally).

Also linking the ‘symptoms’ of BPD (including difficulties with anger) to women’s societal experiences, Ramona and Susan argue that that such difficulties are caused by women being at greater risk of sexual abuse:

“...women are more likely to suffer sexual abuse, which is meant to be something that can make individuals vulnerable to developing BPD” (Ramona).

“...I suppose years ago the belief was women suffered sexual abuse, not so much men and that it caused more damage” (Susan).

I would therefore suggest that feminist discourse in the form of feminist social causation arguments that construct women’s madness as result of their oppression under patriarchy (Wirth-Cauchon 2003) is evident within the women’s interview texts. In terms of ‘risk identity’, when framed by feminist social causation arguments, anger/aggression is arguably constructed as potentially risky and pathological, but set within the social, historical and political context of trauma. Anger and aggression form part of a ‘risk identity’ but one which is resistant to individualising constructions that locate risk or pathology solely within the being of the woman.
In relation to feminist discourse, there are also extracts within the women’s interview texts that construct anger/aggression by employing feminist social constructivist arguments (also presented within the Introduction chapter in relation to feminist critiques of BPD) which posit that the diagnosis reflects moral and cultural assumptions about gender and anger/aggression [Wirth-Cauchon 2003]). For example, when discussing why more women than men are diagnosed with BPD, Susan writes, “...if you're a naturally aggressive woman, it's seen as a disorder and they lump it with BPD, when you just might be that way inclined regardless” (Susan).

Ramona also argues in regard to anger/aggression that:

“I think displaying anger is a very natural reaction to certain situations, but perhaps it is viewed as 'deviant' behaviour if women engage in outward expressions of anger, whereas it is less likely to be viewed as pathological or unusual if men do” (Ramona).

Relating this to risk identity, when framed by feminist social constructionist arguments, the framing of anger/aggression is resisted as either pathological or risky, and is reframed as understandable, justifiable or natural. Anger and aggression are thereby not viewed as being constructive of a ‘risk identity’ but of a liberated female identity.

**Negotiation of identity and ‘risk identity’ in relation to BPD – Severe dissociative symptoms, impulsivity, responsibilisation and risk**

With the exception of Ramona who wrote, “...I don't think dissociation was a significant factor where my risk taking was concerned” (Ramona) - thereby resisting this diagnostic feature as productive of a ‘risk identity’ - dissociation was a significant thread within the texts in relation to the theme of risk. As Dawn writes in relation to her experience of dissociation:
“These are my most difficult times and often when I most likely to act out life threatening behaviours. I believe I dissociate all the time – although that’s probably not true but it feels that way. If it’s only for a brief few moments then that’s not too bad but it’s when it goes on for hours or days it becomes really dangerous” (Dawn).

The consensus within the interview texts discussing dissociation was that capacity to be responsible for one’s risk behaviours is significantly diminished, if not fully vitiated, when undergoing the experience. Significantly, within the text produced by the women, they relate that the message they receive from professionals contradicts this, i.e., that they are always held responsible (i.e. responsibilised), for their risk behaviours (with this impression seemingly supported by the empirical studies by Markham and Towner [2003], Forsyth [2007] and Sulzer [2016]).

Illustrative of this tension, the following extract from Simone’s text describes experiences of working with a patient who would buy and store craft material in her bedroom to the point that this presented a fire hazard:

“When she went on shopping binges to buy this stuff, she'd often come back and report not being able to remember buying half of it. The staff would usually not believe her and play the "she needs to take responsibility" card on her - I remember wanting to help her carry her heavy shopping bags upstairs to her room and being reprimanded, because she had "made her choice" to buy it all and now she needed to "feel the consequences of her actions". I believed her when she said she had no memory of buying half the stuff she'd bought, and I really, really felt for her” (Simone).

Having also written that, “[y]ou can't expect someone who is literally not there a lot of the time to "take responsibility" for themselves, just like that” (Simone), these comments chime with those found in Ramona’s and Dawn’s texts in relation to risk and responsibility:

“... sometimes the risky behaviours would be engaged in when I was in a dissociative state, and it didn’t feel that I had a lot of control over them” (Ramona).

“I would personally argue that during those times when I am dissociated I lack the insight to fully understand the implications of my actions. If when I have self-harmed during these times I do not feel any pain; at times I have not realised that I have seriously hurt myself. ... [H]ow can I take responsibility for my actions if I am not aware that I have done them” (Dawn).
Whilst the texts produced by Simone, Ramona, and Dawn resist representations of always being responsible, this resistance also drew upon questioning the notion found within areas of psychiatric discourse which construct dissociation as ‘not proper’, i.e. not a schizophrenic or psychotic feature (Bray 2003). This resonates with Morris et al.’s (2014) findings that their participants felt their psychotic experiences were not deemed to be real due to being seen via the interpretive prism of their BPD diagnosis.

Within psychiatric discourse, disagreement exists as to whether certain types of dissociative experiences are truly psychotic. As Bray (2003) notes:

“There is controversy about the nature of psychosis in BPD (whether it is the same kind of phenomenon as the psychosis of schizophrenia, or whether it represents dissociative pathology or regression to primitive thinking)” (Bray 2003 p274).

In tackling this controversy in relation to the issue of responsibility she goes onto argue that:

“As one enters the philosophical tiger country of severe dissociative states, such as fugue states, if there should prove to be true loss of cognitive functions and information then it would appear that responsibility is indeed diminished ... It is most likely that only in the most severe cases is reality testing sufficiently impaired to vitiate responsibility” (ibid).

Mindful, given Bray’s comments, that within the DSM-V (2013), ‘severe dissociative symptoms’ is one of the diagnostic descriptors for BPD, through the lens of the deconstructionist perspective there is evidently a tension within psychiatric discourse around both the nature of dissociation in relation to psychosis and the implications that this has in relation to attributions of responsibility. This tension is reflected within the text produced by Dawn, in which she directly questions the distinctions drawn between psychotic states and dissociative states, with the former being deemed as undermining capacity, but the latter not:

“...if someone is having a psychotic episode most would argue they have lost insight and therefore cannot be accountable or responsible for their safety. Is this different [to dissociation]? ... A social worker once said to me that people with BPD don’t have a ‘proper’ psychosis and therefore he would avoid detaining someone under the MHA but I don’t personally agree with that” (Dawn).
In terms of ‘risk identity’ in relation to dissociation as a feature of the diagnosis, the women’s texts position themselves as risky in relation to this due to a lack of capacity at such times, and resist those tendencies within psychiatric discourse and practice to construct them as responsible and therefore less risky.

As was the case when discussing anger and aggression, Western discourses of the subject appear to be ‘at play’ in relation to ‘risk identity’ and are discernible within the women’s explanations as to why professionals fail to adequately address dissociation. The texts produced by Ramona and Simone construct this difficulty as stemming from an inability to understand and grasp the more ‘subjective’, ‘interior’ forms of distress:

“I think a lot of the BPD criteria, such as chronic feelings of emptiness, identity disturbance, dissociation, are a lot harder for people to understand and relate to” (Ramona).

“...most of the professionals who worked with her missed this "inside" understanding of her [a patient’s] experience entirely, in favour of terms like "acting out"” (Simone).

In terms of the implications of this for constructions of ‘risk identity’ relating to dissociation, the ‘truth’ of identity in relation to the risks associated with dissociation is constructed as residing in their subjective world of private ‘inner’ distress, with the risk of the women being constructed as potentially greater than would be attributed by others who lack access to their inner realm and may either miss, or misconstrue, this risk.

Returning to the theme of responsibility and risk, aside from dissociation, ‘impulsivity’, as a symptom descriptive of the diagnosis was also identified by the women:

“Occasionally, like with the driving, the dangerous behaviours were very impulsive and, in some cases, compulsive. I couldn't stop myself, it was an urge I had to close my eyes and I couldn't fight it. One minute I could be driving, not even feeling that emotionally unstable or dissociated, and then the next second my hands are off the wheel or my eyes are shut. The same thing would happen with eating (although obviously it's harder to be impulsive); I never binged but I would sometimes purge, and that only ever happened in a very impulsive way” (Ramona).

“I sometimes act on impulse, without really thinking of the consequences, over spending, binge drinking and I've been very promiscuous in the past too” (Summer).
Impulsivity – this for me is about money – I don't actually receive any of my salary because I would spend it in a day – actually controlled by my partner who gives me a spending allowance a week” (Dawn).

In all three of the extracts cited above, impulsivity is positively identified with as a feature of the diagnosis and is linked to risk behaviour, i.e. dangerous driving, purging, binge drinking, promiscuity, and reckless spending. The areas identified closely match the description of impulsivity within the DSM-V (2013) rendering of BPD, which clearly constructs it as being risky characteristic:

“Individuals with borderline personality disorder display impulsivity in at least two areas that are potentially self-damaging (Criterion 4). They may gamble, spend money irresponsibly, binge eat, abuse substances, engage in unsafe sex, or drive recklessly” (ibid p664).

One might therefore argue that, in these instances, BPD as a discursive feature of psychiatric discourse is productive of a ‘risk identity’. In relation to this, it should be noted that there were no instances within the women’s interview texts where behaviours constructed as impulsive were framed as non-risky, i.e., where the BPD construct of impulsivity as risky was resisted.

Whilst not so prominent within the interview texts as during the discussion of dissociation, a similar construction of diminished responsibility as a consequence of impulsivity can be detected. Ramona’s text constructs impulsive behaviours as actions she couldn't stop herself from engaging in, Summer identifies having difficulties thinking about the consequences of her actions, and Dawn places another in the position of being responsible for her money, framing this as an area that she has little control over.

Although it is necessary to acknowledge that the severity of the impact of impulsivity on one’s capacity appears to be variable among these constructions (i.e., there is considerable difference between not being able to stop oneself, not really thinking about consequences, and consciously handing over responsibility in an area of one’s life to someone else), there appears to be some evidence for impulsivity being constructed as potentially resistive to a responsibilised identity in relation to BPD.
Acknowledging that dissociation and, albeit less pronouncedly, impulsivity are constructed within the women’s texts as resistant to a responsibilised identity, resistance was also found in this regard in relation to broader, non-specifically risk focused, discussions. For example:

“Your way of thinking is the problem, not physical illness or even a mental illness - it's a thought pattern that needs adjusting and you're causing your harm as you think 'wrongly' ... But personality disorder? Eyuww, you've got Problems and they're All self induced in your mind so you need to be taught to think "proper" and to get a grip on your out of control rampaging emotions. Calm down. Chill out. Do some yoga’” (Susan).

Within this extract, identification is made with being positioned as responsible for one’s difficulties, with such difficulties being localised within the individual’s thinking by professionals who encourage self-responsibility in modifying behaviour and, as evidenced by the sarcastic tone, recommend facile treatments. The theme of responsibilisation found within Susan’s characterisation of BPD, and also arguably within the analysis of dissociation and impulsivity, may be seen to point towards a further discourse that converges with psychiatric discourse, i.e., the neoliberal discourse of the subject.

Addressing the influence of neoliberalism within our lives, Rose (1999) identifies in relation to responsibilisation that:

“...cultural developments over the closing decade of the twentieth century have been characterised by an acute ‘ethicalization of existence’ which has intensified the demands that citizens do not devolve responsibilities for health, welfare, security and mutual care upon ‘the state’, but take responsibility for their own conduct and its consequences in the name of their own self-realization” (ibid p263-264).

In terms of how these developments have impacted on psychiatry, writing in relation to the gendering of depression within neoliberal healthcare, Gardner (2007) echoes and expands upon the themes identified above in relation to Susan’s text:
“Active democratic practices of questioning, dialogue, debate, and dissent are absent from the diagnostic economy, which instead restrains comprehensive information and positions female citizens, particularly, as consumers. Within this economy, women are granted choice only among biotechnical products, while power resides primarily with experts, doctors, and husbands, who control the discourse. In glossing, re-framing, and invisibilizing social problems and highlighting their negative impact on women’s functioning, these discourses create an imperative for women to act upon themselves—a practice reinforced by the peculiar character of advanced liberal democracies: “a complex of marketization, autonomization and responsibilization” (Rose, 2006, p. 4)” (Gardner 2007 pp551-552).

Translating the above into the context of women with a BPD diagnosis, through medical psychiatric discourse wielded by ‘experts, doctors, and husbands’, the burden of governance for one’s distress is placed on the responsibilised woman who is expected to act as a rational consumer of healthcare services. Distress is located within the individualised construction of personality dysfunction, with the political and social causes for this distress omitted, which disempowers those subject to the diagnosis by inhibiting criticism and debate.

As neoliberal discourses converge with psychiatric discourse, a particular regulatory ideal of the psychiatric subject is produced, which Rose (1996) identifies as follows:

“These [the subjects of psychiatry] are divided between those ‘good subjects of psychiatry’ who are ‘medicine compliant’, keep appointments, are able to assess their coping performance in a way that aligns with the assessment of professionals, and those who do not ‘play the game’ of community care” (ibid p14).

The responsibilised element of this regulatory ideal can be seen to be resisted within the women’s texts, and I would suggest that a generalised resistance to the regulatory ideal of the ‘good subjects of psychiatry’ can also be detected. In Susan’s text, this is evident in her sarcastic rendering of the responsibilising and individualising standards against which she is positioned and judged, with the expectation being that she should abide by the expert advice of the professionals who have the power to define her difficulties and offer inadequate - in the sense of not truly representing or adequately addressing said difficulties - and ‘trite’ treatment choices.

We will return to the convergence of neoliberal discourses with ‘psy’ discourse below, once an analysis of wider psychiatric and ‘psy’ discourse has been presented in relation the women’s negotiation of identity and ‘risk identity’.
Negotiation of identity and ‘risk identity’ - wider psychiatric discourse and ‘psy’ discourse

Whilst we have seen that BPD is a major discursive feature with regard to the women’s negotiation of their identity and ‘risk identity’, within the interview texts it was evident that wider psychiatric, and broader ‘psy’, discourses were also important.

Examining the texts produced by the women, other, non-BPD diagnoses were seen to be constructive of identity. Susan identifies as having, and therefore gives legitimacy to, ‘bipolar disorder’, ‘obsessive compulsive disorder’ and ‘post-traumatic stress disorder’; “I would happily and without care wear a sign upon my head displaying my varies mental illnesses when appropriate. Le bi-polar. OCD anxiety disorder. PTSD” (Susan). Similarly, Sally and Emily note the following in relation to ‘depression’:

“For many years my ‘identity’ in terms of what influenced me was depression more than the BPD label” (Sally).

“Because I also suffer from bouts of Severe Depression I can tell the difference between when I am becoming unwell for Depression – it’s that clichéd black cloud that slows everything down and turns everything to grey – and it’s horrendous, of course it is” (Emily).

In terms of establishing the ‘truth’ of one’s identity in relation to these bio-psychiatric conditions, of note is that they are constructed as illnesses that one can have as opposed to disorders, such as BPD, which as we have seen are constructed as fundamental disorders of one’s personality (Crowe 2004). For example, in the following extracts, Emily describes depression as an illness that happens to her, whilst Ramona presents it as an illness one can recover from. Their texts thereby construct ‘depression’ as an illness separate from oneself, but from which one can suffer:

“With my Depression I manage to see it as an illness – something that happens to me. But with BPD it’s part of me...” (Emily).

“I just think by labelling someone with depression or an anxiety disorder, people are much more optimistic in that it can be something that can be ‘overcome’ and you can ‘recover.’ As soon as you start labelling people with personality disorders, it becomes much harder to shake” (Ramona).
In terms of ‘risk identity’, I would nevertheless suggest that there is a discursive distinction between how ‘risk identity’ might be constructed in relation to BPD, as compared to the other diagnoses identified above. When identifying with a diagnosis that is constructed and understood as an illness from which one suffers, risk to self (for example, risk of suicide due to depression or risk of dissociation due to PTSD etc.), and risk to others (for example, risk of violence when suffering from paranoid delusions) are constructed as risks which stem from the effects of a disease acting upon the individual. When identifying with BPD, a diagnosis constructed as representing a disorder of one’s very personality, risk to self and others is arguably constructed as emanating from one’s self. ‘Risk identity’ in relation to BPD therefore represents a location of disorder and risk in or as one’s very being.

When discussing the women’s treatment of the topic of anger and aggression, social psychiatric discourses are again identifiable through analysis of instances whereby either BPD or bio-psychiatric knowledge itself are rejected as invalid. Sally, for example, constructs BPD as, “…made up, fabricated by doctors…” (Sally). Simone similarly rejects the validity of BPD, “…there is no point to discussions about "what to call it [BPD] then?", since there is no "it" that needs a label…” (Simone), but also psychiatric diagnostic knowledge altogether referring to, “…the pseudo-scientific practise of psychiatric diagnosis…” (Simone).

Given that social psychiatric discourse also reflects the thinking and practice of psychiatrists influenced by alternate psychology, philosophy or sociology discourses (Rogers and Pilgrim 2008), support for broader social scientific discourses being significant is identifiable within the texts where alternate and radical practitioners and practices are referenced. In Simone’s text, for example, we find recommendations for drawing upon psychological approaches to case formulation that stem from the clinical psychologist Lucy Johnson: “I heard the psychologist Lucy Johnson at a conference talk about formulation instead on diagnosis, and I thought, that makes so much more sense to me!” (Simone).
She also references psychiatrist Judith Herman’s (2001) book ‘Trauma and Recovery – From Domestic Abuse to Political Terror’ when writing about her thoughts on the diagnosis: “I agree with Judith Herman, that BPD is "little more than a sophisticated insult" (Simone). Within Susan’s interview text, based on the broad themes of the research, she recommended that I acquaint myself with the work of a consultant psychiatrist who specialised in, “...more radicalized” (Susan) approaches to treatment in relation to women’s mental health.

In terms of ‘risk identity’, social psychiatric discourse as a means of framing one’s distress and difficulties may produce alternate risk identities to those produced by the bio-psychiatric discourse. This is because rejecting the validity of BPD (or psychiatric diagnoses in general) opens up potential for a reconfiguring of ‘risk identity’ away from constructions rooted in pathology towards constructions with a differing, and potentially liberating, meaning.

As an example of this, in Simone’s critiquing of self-harm as being singled out as risky compared to other socially sanctioned coping strategies, i.e., “…to smoke cigarettes or eat fried food or drive too fast or stay in codependent relationships … [or] … stay working in an overly stressful unsupported role in the nhs,” (Simone), the discursive potential is opened up for the behaviour to be de-pathologised. Similarly, when she and Sally present strong emotions as life-enhancing and normative, this also opens up new meanings in relation to previously pathologised emotions.

In instances where diagnosed ‘features’ of BPD are both given validity and constructed as risky within the women’s texts, but where alternative social psychiatric discourses are mobilised to provide a social or biographical context, as identified above in relation to feminist social causation arguments, I would argue that ‘risk identity’ may be produced differently from how it might be produced through bio-psychiatric discourse. This similarly resisting individualising constructions that locate risk solely within the individual.

By way of illustration of this, Simone writes in relation to a CAMHS worker telling her that she ‘cried through her wounds’ that, “I always had the feeling that my "symptoms" were really "symptoms" of wider family problems, and she confirmed this” (Simone). Whilst self-harm is not constructed as being risk free, positioning the symptom as a function of wider family problems may produce a ‘risk identity’ where the individual isn’t positioned as being solely to blame for their difficulties, with risk being constructed at the level of the social.
Navigating identity and ‘risk identity’ – neoliberal discourse

Within the texts produced by Emily and Dawn can be found broader discussions of identity that hinge around comparing oneself to perceived standards of ‘normality’. In their texts, they either report a sense of shame or failure in relation to said standards (in line with Miller’s [1994] identification of a sense of inadequacy in relation to social standards evident amongst her participants) or resisted said standards.

With regard to the former response, Emily’s text identifies that she does not feel ‘normal’, and feels a sense of shame when comparing herself to others. She notes how this increases her vulnerability and risk:

“I do not feel ‘normal’ – and yes, I know, who is normal? But to me, there are milestones in a person’s life that make it normal: learning to drive, going to Uni, having a relationship/s, moving out of home. And I’ve not done those because they are too overwhelming to me. I cannot cope when I have tried. They lead me to being too vulnerable, and not in a safe way… I am ashamed when people ask me where I live, who I’m going out with, what car I drive. Really practical things, but for me are massive hurdles. I hope this doesn’t make me sound too shallow!” (Emily).

Dawn’s text also identifies a sense of shame for not living to perfection the normative standards set by society. Whilst her text constructs the realisation of a perfect life as unattainable, she nevertheless writes of feeling like a failure:

“I am so desperate for a perfect life, a perfect home, a perfect relationship with the people I love and who are close to me that I believe I end up pushing them away … I do understand that nobody is perfect and the perfection I am trying to achieve is unattainable but in a way, I think I use the fact that I know I can’t achieve it as a reason to beat myself up even more” (Dawn).

Arguably, this construction of one’s self as a failure for not living up to the normative societal standard reflects the operation of an entrepreneurial regulatory ideal of the subject, rooted in neoliberal discourses. As Brown (2003) delineates this subject position:
“...neoliberalism normatively constructs and interpellates individuals as entrepreneurial actors in every sphere of life. It figures individuals as rational, calculating creatures whose moral autonomy is measured by their capacity for “self-care”—the ability to provide for their own needs and service their own ambitions. In making the individual fully responsible for her- or himself, neoliberalism equates moral responsibility with rational action; it erases the discrepancy between economic and moral behaviour by configuring morality entirely as a matter of rational deliberation about costs, benefits, and consequences.” (Brown 2003 pp42-43).

As with dissociation and impulsivity, the responsibilisation discourse once more comes into play here; within Emily and Dawn’s texts, constructions of being responsible and morally at fault are evident in relation to not having achieved certain goals, despite experiencing difficulties and distress that act as a constraints upon such ambitions. As Brown goes on to note, “…the rationally calculating individual bears full responsibility for the consequences of his or her action no matter how severe the constraints on this action…” (ibid).

Ambitions such as learning to drive, going to university, and leaving home might additionally be construed as reflecting neoliberal ideals of the subject being economically independent (leaving home) and engaged in projects to further their own self-interest (learning to drive, going to university etc.) (ibid). The goals of being in, and attaining, perfect relationships and the perfect home, however, suggest converging binary gender discourses on identity and arguably reveal a tension between the autonomous entrepreneurial subject of neoliberalism and a feminised identity rooted in patriarchal gender discourse. The female subject in the latter is constructed as one who doesn’t pursue individualistic interests but is nurturing, caring and dependent on others (Oksala 2011). Caught between being produced as a female subject but also as an entrepreneurial subject, a feminine ‘double-bind’ is again evident, whereby women are compelled to attempt to embody these contradictory regulatory expectations.

In terms of resisting such an individualised entrepreneurial identity, this is evident in Emily’s interview text during an explanation of the significance to her of the lyrics to the song ‘Helplessness Blues’ by ‘The Fleet Foxes’, specifically the line, “...a functioning cog in some great machinery serving something beyond me” (Pecknold 2011):

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“I think society is told it’s ok to be different – but different in a way that society suggests, and if you’re the wrong kind of different you’ll never fit in. I don’t think I fit into what society deems to be normal and I’m not ok with it. It might sound ridiculous but those programmes where they do the makeover (clothes and fashion etc) and they say ‘oh you need to stand out in a crowd’. I’ve never felt that it was important to do so – I like being a sheep in a flock of sheep! ... Most of the time I feel society’s idea of normal to be disabling in the fact that it’s not seen as ok to be part of the crowd. You have to stand out and be who you want to be but I do believe that to be quite selfish and self-centred. I think having BPD I’m worried about coming across (to others) as being selfish as I tend to need a lot of attention and care – and I don’t like being that way, so perhaps it’s not something I admire in others in society” (Emily).

In keeping with the renderings of the neoliberal entrepreneurial subject (as discussed above), Emily identifies the neoliberal subject as one that is compelled to pursue individuality but only through narrow choices over such things as clothing and fashion commodities (essentially the freedom to express oneself as a consumer of goods and services). This reflects Rose’s (1999) observation that:

“The political subject is now less a social citizen with powers and obligations deriving from membership of a collective body, than an individual whose citizenship is to be manifested through the free exercise of personal choice among a variety of marketed options” (ibid p230).

Evident in the comments, “I like being a sheep in a flock of sheep!” and, “...it’s not seen as ok to be part of the crowd” and within Emily’s identification with wanting to be a, “…functioning cog in some great machinery serving something beyond me” (Pecknold 2011) appears to be a desire for some collectivist identity, with this desire standing in tension with unsatisfying entrepreneurial identity. It is a tension recognised by Harvey (2007) who identifies that, within neoliberalism:

“A contradiction arises between a seductive but alienating possessive individualism on the one hand and the desire for a meaningful collective life on the other. While individuals are supposedly free to choose, they are not supposed to choose to construct strong collective institutions... ” (ibid p69).

In resisting entrepreneurial individualistic identities through mobilising discourses of the collectivist identity, Emily’s identity is positioned within political discourses and traditions that predate and resist the neoliberal ideological and socioeconomic shift (ibid).
Despite Emily’s resistance, however, she also speaks of being worried about, “...coming across (to others) as being selfish as I tend to need a lot of attention and care”. Here, I suggest one can detect the action of the entrepreneurial injunction that individuals should enhance their self-caring capacity and service their own needs without recourse to others (Brown 2003). Her concern for needing attention and care might be seen to mirror the devaluing of relatedness within binary gender discourse, given that as Oksala (2011) observes, women are constructed as dependent, caring and nurturing but are also rendered ‘Other’ and potentially pathologised in relation to the Western regulatory ideal of the subject. As Becker (1997) notes regarding the devaluation of this cultural value:

“...the glorification of autonomous functioning has been achieved by excluding a sense of relatedness from the pantheon of cultural values. By extension, since a woman is more influenced in her sense of self by her relational experience, she is consistently “defined out” of the world of effective beings when an equation is made between dependency and pathology” (ibid p98).

**Negotiation of identity - essential motherhood**

Of the participants who took part in this study, half (4) were mothers. A significant identity orientation within three of these accounts (Susan, Dawn and Sally) was that of motherhood, this being understood as a non-psychiatric regulatory ideal ‘at play’ within the texts and, itself, rooted in the discursive construction of the gender identity of women.

Adopting the term 'essential motherhood' to represent the regulatory ideal bound up with Western cultures construction of mothering, DiQuinzio (1999) describes it as follows:

“...mothering is [constructed as] a function of women's essentially female nature, women's biological reproductive capacities, and/or human evolutionary development. Essential motherhood construes women's motherhood as natural and inevitable. It requires women's exclusive and selfless attention to and care of children based on women's psychological and emotional capacities for empathy, awareness of the needs of others, and self-sacrifice” (ibid pxiii).
Whilst not embodying the ideals of essential motherhood can lead to assumptions of deviance and constructions of being a ‘bad mother’, fulfilling the role too closely has also been constructed as damaging. This construction takes the form of the all-powerful ‘demonic’ mother causing harm to her children though being smothering, intrusive, and, overprotective contrasting with the romanticised idealisations of self-sacrifice and life-giving (Kaplan 1992 cited in Glenn, Chang and Forcey 1994 p11). Within essential motherhood, again the ‘double-bind’ of femininity is evident whereby one is pathologised for either not conforming enough, or for conforming too closely to feminine ideals (Chesler 2005; Becker 1997).

Sally describes how her own mother’s experience of depression and alcoholism prevented her from fulfilling her role as a mother and that, in a reversal of roles, she took on the task of caring for her mother’s needs, thereby embodying the nurturing and self-sacrificing elements of the mothering ideal she would later transfer to her own children:

“I had a mother who was depressed and had a very bad back so I spent my childhood feeling the need, and therefore caring to her needs. I was always doing that and later when I went on to have children I obviously felt the need to continue ... I didn't want them seeing me [depressed], not wanting them to care for me, shop for me, cook for Meir be witness to my moods when I could not control them. ... I was adept at keeping secrets, and fundamentally knew that my children were never, never going to have to look after, whatever the cost to me” (Sally).

Within her text, the experience of being the daughter of a mother who failed to embody normative mothering expectations is presented as informing how she would go on to better embody an essential mothering identity. Evident within the descriptions of her mother, the description of her own mothering, and discernible also within the interview texts produced by Susan and Dawn, is a tension that exists in attempting to construct one’s identity as a mother in the context of one’s own mental distress. Susan’s text describes, for example, how she believed her children would be better off without her as she didn’t want them to be adversely affected by her distress:

“...the way I saw it is that my kids are better off without me because I dont want them to see my behaviour/ emulate it/ be affected by it, I dont want to hurt the most innocent and precious things I have, taint them with my darkness” (Susan).
In order to prevent their distress from negatively impacting on their children, descriptions are given of strategies employed by the women to manage this. Sally’s text describes separating distress from one’s children through compartmentalising one’s life and by invalidating one’s own suffering:

“So I was a mum and I certainly didn't go around with the idea that I was a depressed mum. The influence it had however, was almost an innate knowledge that so as not to fuck up my kids I had to compartmentalise my life. Mood, depression and the past were in one place. My marriage and children were in another… I also was an expert at invalidating what I was going through” (Sally).

It appears that though identifying with the role of being a mother, Sally was forced to resolve the tension between this and her own distress by embodying the self-sacrificing ideal, invalidating her own distress and not identifying herself, as she later would do, as suffering from depression.

Dawn’s text also presents the desire to prevent her distress impacting on her child whilst noting the sense of failure in this regard in terms of her belief that she overcompensates and is overprotective of him: “I try not to let it affect my relationship with my son but actually I know it does – if anything it has made me over protective of him, wanting to give him everything that I did not have in my own childhood –” (Dawn).

Echoing the account found within Sally’s text of how one’s own negative childhood experiences motivate those subject to them to become a ‘better mother’, Dawn writes of her fear of, and identification with, being an overprotective mother. This fear of causing harm though being ‘overly mothering’ arguably orientating her identity against the backdrop of the demonic discursive construction of the essential motherhood, i.e. that mothers can be destructive and damaging though being intrusive and smothering.

Implicit within the texts of Susan, Sally and Dawn in regard their fears, anguish, and the strategies employed to prevent their own distress from damaging their children’s development additional mothering discourses can be discerned. The expectation that ‘good mothers’ must be mindful of how their children’s development might be impacted by their own action or inaction suggests the adoption of moral, responsibilised, and psychological discursive constructions around motherhood.
By way of illustrating this point, I will quote Lupton (1999) who notes, in relation to pregnant women, that:

“Many of the discourses of risk that surround the pregnant woman suggest that it is her responsibility to ensure the health of her foetus, and that if she were to ignore expert advice, she is culpable should her baby miscarry or be born with a defect. The pregnant woman, therefore, is positioned in a web of surveillance, monitoring, measurement and expert advice that requires constant work on her part: seeking knowledge about risks to her foetus, acting according to that knowledge” (ibid pp89-90).

Following the birth of one’s children, and arguably before, ‘good mothers’ are expected not only to sacrifice their own needs to those of their children (as identified above), but are also positioned as morally responsible for drawing on expert psychological knowledge to ensure their child/children’s development is not compromised. Through this, we can again identify broader neoliberal risk discourses that responsibilise individuals in regard to managing their own risk. As this translates into mothering identities, disciplinary power in the form of disseminated expert knowledges over one’s child’s development may be seen as producing responsibilised mothering identities.

Returning to Sally’s text, she details how the strategy of compartmentalisation and invalidation failed, in that her suicidal depression began to ‘spill over’ into the areas of her life cordoned off for motherhood, “…depression, which would kill me, that was the thing which eventually spilled into the other compartments” (Sally).

The identified solution, having separated from her husband, was to not live with her children but to remain involved as much as possible by living close to her children, her ex-husband, and his new partner. The rationale given was that she wasn’t able to give them the stability they needed when she was unwell but that, in periods when her distress receded, she could resume a more direct mothering role:
“I separated from their dad a year or so after the first of many hospitalisations and got a flat 6 doors away from their dad. It was an agreed arrangement that he would have the kids and I would see them, have them to stay when i was well ... One reason i took the decision to live without them on a full time basis was because I knew I couldn't offer them that sense of stable, calm, home life they needed. Warped though it appears now I may have been hell bent at times on killing myself or inflicting serious damage to myself, they were not to be a party to it, see it, know anything about it and not have their everyday lives affected directly affected by it ... So it spilled over into their lives, bless them, when I could no longer keep them [the ‘compartments of her life’] apart but it was done in a way which would cause the least damage” (Sally).

Evident within Sally’s text is guilt over experiencing suicidal depression, given the tension between her desire to annihilate herself and the idealised notion of the mother as being the self-sacrificing homemaker who furnishes her children with the stability and calm they require to develop; it is instructive to hold in mind the popular construction of suicide as the ‘ultimate selfish act’ when contrasting suicide with motherhood. Within her text, a conversation with her daughter is represented where this tension is clearly revealed:

“"My daughter asked many years ago if I had ever felt suicidal. I responded with an outright lie. No. She seems relieved. I felt I could to, and still feel in some odd way whatever their ages, that they went through enough without trying to comprehend, an impossibility I believe unless you have been there, how their mum, who doers and loves them, would want to die, actively take her life away from them. God knows if the subject, conversation will ever come up again. What would I say to them when they are fantastic, seemingly happy sane adults?" (Sally).

By prioritising her children’s need for stability and for her to remain alive for them, aside from living separately, Sally also writes about her acceptance of, and need for, hospitalisations. The acceptance of this intervention, whilst expressing that the situation wasn’t ideal, is represented by her as the best course of action she could have taken, given the needs of her children. From a self-sacrificing position of invalidating her distress, through crisis, she moved to a position of accepting hospital admissions and a psychiatric identity as a depressed woman, finding resolution from the aforementioned conflict between her mothering identity and her psychiatric identity by accepting the need for help for the sake of her children: “I said I was suicidal, they put me in hospital. Of course at the time I was relieved as felt that I HAD to keep safe for my children” (Sally).
In contrast, Susan writes how hospitalisation prevented her from fulfilling her mothering role reporting how she deliberately misled the hospital staff to reduce her medication and hospital stay in order to get back to her children:

“...if you know your stuff well enough you can pull a few fast ones like that. I'm not proud but I had 3 kids at home and I felt worse being in hospital. From being told I would be a few weeks in hospital and on heavy doses of lithium and seroquel etc I wangled it down to some anxiety meds and an anti depressant!” (Susan).

In both examples, however, self-sacrifice for the sake of one’s children is evident as linking Sally’s and Susan’s identities to the regulatory ideal of essential motherhood.

Aside from accepting hospitalisation as an intervention problematised by the normalising ideal of essential motherhood, Susan’s text also notes how her prescribed medication impacted on her ability to function as a mother:

“...as a mother you cannot function if you take these meds, how can I get up with a baby when I'm drowsy etc...ehhh, maybe people like me shouldn't have children to be honest. I know I am a good mother, but being a bit of a nutter causes problems for the whole family” (Susan).

Whilst the above indicates being at a remove from one’s children in terms of one’s level of conscious awareness is a problem in relation to fulfilling one’s role as a mother, the notion of having to be present and attuned to one’s children in this sense resonates with the notion of being present for them in terms of proximity and availability, as identified in relation to Susan’s termination of her hospital admission and Sally’s compromise of moving a few doors down from her children. Again, in both instances, the notion of always being present for one’s children is arguably part of the self-sacrificing ideal of motherhood which is productive of the women’s identity and has practical repercussions with regard to accepting or rejecting certain forms of psychiatric intervention.

In terms of their children, both Sally’s and Susan’s texts reveal their concerns for their daughters’ mental health, Sally in terms of how she feels that, given different circumstances, her daughter could have also ended up with a BPD diagnosis, and Susan in terms of her daughter’s negative experience of mental health services:
"…from an early age it seemed my daughter was pretty sensitive, felt things pretty deeply and at times could have 'catastrophic' thoughts ... We would chat sometimes about it and she thought, wisely and in some ways possibly correctly, that it was also at a point when I was around more, not in and out of hospital as I had been for so many years on and off. Perhaps, she thought, she just wanted to be with me, spend more time with me with perhaps the anxiety I might disappear again at any point. Luckily I didn't. She was also worried if I wasn't at home when I said I would be and again she voiced her reasons as being scared whether I was back in hospital again. But I suppose my point is that had she led a different life, not had a mum who she could to, a dad who, although less psychologically minded was and is a fantastic stable dad who adores his kids, and a step mum who, though odd herself was very much a stable and caring influence on the household when I was off being anything but stable! ... But she could have turned BPD with her sensitive nature, could have turned the angst against herself" (Sally).

Sally’s text again raises the theme of her proximity/availability, on this occasion, as a potential explanation for her daughter’s anxious presentation noting that, without the stable and caring influences of her ex-husband and his partner during her absences, potentially her daughter could have followed her route into significant distress and a BPD diagnosis.

Whilst she appeared to regard her solution to mothering her children in the context of suicidal depression as a compromise, her identification of the stable and caring influences of her ex-husband arguably points towards the notion that the task of mothering can be performed and supported by individuals other than the biological mother, thereby resisting the responsibilising construction within essential motherhood that only the biological mother can and should fulfil this task.

In terms of Susan’s text, having revealed that her daughter has been diagnosed with a psychiatric condition, she noted her frustration with mental health services, but also her frustrated desire to protect her daughter from an inadequate mental health care system:

"Take this week - the whole system stinks, my Daughters CPN AKA SUPPORT WORKER is passing her back over to CAMHS and I just love the way they give you just enough support to keep you alive, then pass the buck to some lame series of meaningless sessions where nothing gets solved and they state the obvious. Thats all it is. 'Management' of the condition. My poor Daughter who hasnt the experience I have and is so sweet and naive to the world of mental illness and so called treatment. They know nothing of her struggle and our struggle to help her. As long as they've filled a few forms in and got the paperwoprk together for handover and shes alive at that moment, then wahey, its all good" (Susan).
Within Susan’s text, one can read how enacting the protective role of motherhood translates into her concern for her daughter’s vulnerability within mental health services, and also how her identity as a mother with mental health difficulties better enables her to advocate and be protective for her daughter within the conjunction of these of these two identities.

**Summary of the Deconstructivist Tale**

To summarise the Deconstructivist Tale, then, and to draw the various discursive findings of the analysis together, the ‘truths’ of the women’s identity and ‘risk identity’ were seen to be negotiated at the site of a number of converging discourses, predominantly ‘psy’ discourses, binary gender discourse of the subject, Western discourses of the subject, neoliberal discourses and essentialist mothering discourses.

Having identified that BPD, as a discursive feature situated within broader psychiatric and ‘psy’ discourse, was productive of identity and ‘risk identity’, specific diagnostic elements were pinpointed that were found to be either incorporated, resisted, or restructured within the women’s interview texts. Highlighting the regulatory and productive power of Western discourses of the subject as these converge with psychiatric and ‘psy’ discourse, these diagnostic elements can be understood as being constructed as pathological against the masculine Western regulatory ideal of the subject.

The role of binary gender discourse was identified in relation to the positioning of women with a BPD diagnosis as ‘Other’. Tensions were identified between fulfilling a female subject identity and the expectation to act in accordance with the masculine regulatory ideal of the subject. It was further observed that being produced as a subject by psychiatric and ‘psy’ discourse, the women are judged against the regulatory ideal of the ‘good subject of psychiatry’ which appears to be constructed at the confluence of said discourses.

Although the psychiatric identity of being a woman with a BPD diagnosis was found to be significant in terms of producing identity and ‘risk identity’, for those women who had children, the role of essential motherhood as a regulatory ideal was also presented as significant in terms of identity construction.
Chapter 8 Analysis – The Reflexive Tale

Introduction

In telling the Reflexive Tale, my aim is to once again bring myself back into the research narrative in order to acknowledge and foreground my investment in, and production of, knowledge within the project. I hope to be as transparent as possible in terms of my role and power privileges in said knowledge production, noting my position of advantage and unavoidable values as an embodied researcher enmeshed within a socio-cultural context. Having detailed my privileged position and restated the theoretical values that underpinned my research, the tale will proceed by furnishing examples of how my privileged position and voice was present within the interviews with participants and how this impacted on the process of conducting the research.

The privileged position of the researcher

At the time of conducting the interviews with participants, I was employed as a Band 5 mental health nurse working on a specialist unit catering for the needs of women described as having complex and challenging mental health needs. I therefore occupied the privileged positions of being both a professional clinician and also a health researcher engaged in doctoral level study. More broadly, and in addition, I occupy the privileged position of being a straight, cis-gender, white, middle-class man with all the attendant advantages that this identity affords within our world.

The theoretical and ideological values of the researcher

As articulated in the Theoretical Perspective and Methodological Approach and Methods chapters, I approached the research with specific theoretical assumptions in place, being a realist with regard to my ontological beliefs, a social constructionist with regard to my epistemological beliefs, and holding an emancipatory position based on my assumption of the oppressive nature of the social world in relation to my ideological beliefs. Whist my ontological and epistemological positions have been adequately explored within the preceding chapters, further comment on my political position is required in order to elucidate the ethical tensions I experience within my professional clinical role as a mental health nurse, since these tensions revealed themselves also within the process of interviewing the participants.
Whilst the dominant critical paradigm though which I viewed the issue at hand was initially rooted in the Marxist notion of class inequality under capitalism, my critical perspective was widened though reading critical feminist literature around BPD whilst a student nurse and a staff nurse and, ultimately, widened further through reading Foucault (1978; 1991a; 1991b; 1998; 2002; 2008a; 2008b; 2009), Rose (1996; 1998; 1999), Butler (1997; 2004; 2007), Lather (1991; 2007; 2010) etc., whilst studying for this doctorate. Essentially, although I still believe it is necessary to fight against institutional oppression operating directly though the state, I also believe in the need for, and meaningfulness of, resisting the processes of individualisation which extend beyond the formal structures of the state. This resistance encompasses class, gender, sexuality, and race perspectives amongst others.

Practicing as a mental health nurse during an era characterised by both bio-medical psychiatric dominance and the ascendance of neoliberalism as an organising economic model within health services presented significant challenges to me given my aforementioned political position. Broadly, my difficulties related to how one tries to support clients in distress (whose lives one understands as enmeshed within oppressive social structures and discursive formations) within the context of institutional and community settings dominated by a psychiatric paradigm that obscures the socio-cultural and economic context of human suffering. Within this context, ‘disorder’ is localised within an individual’s biology or their cognition, with treatment primarily focussing on psychopharmacological and/or cognitive behavioural interventions.

Arguably, the very act of practicing within such a culture lends tacit legitimation to it, both in terms of not adopting an ‘out and out’ oppositional stance against said culture, and with regard to necessarily, for practical communication within multidisciplinary contexts, having to adopt the language of psychiatry with all its attending problematic processes of individualisation and obfuscation. In addition to the power wielded though the use of psychiatric discourse, psychiatric nurses also hold formal powers of detention and enforced treatment under the Mental Health Act (1983), and this capacity being bound up within the role and identity of clinicians working within the profession.
I have found strategies for working with clients that ease the dissonance I experience, for example, by avoiding working in ‘mainstream’ psychiatric services, by referring to clients’ presentations as being describable by diagnoses, as opposed to clients being labelled as ‘schizophrenic’, ‘personality disordered’, ‘bipolar’ etc., and by focussing on clients’ difficulties rather than employing medical notions of symptoms or disease etc. However I recognise that despite these efforts, my professional role and expertise drawn from my professional knowledge base ultimately mean that I am complicit in maintaining and disseminating ‘regimes of truth’ with their attendant oppressive effects.

**Researcher identity (as nurse) – wanting to defend other nurses**

Despite positioning of myself as mental health nurse who is both critical of psychiatry in terms of the concepts it employs and the quality of services provided, during the interview process, I nevertheless experienced a defensiveness on behalf of fellow nurses when my profession was criticised by participants. Having asked Simone my standard question regarding the impact of my role as a nurse may have had in regard to the interview, she offered the following comment:

“…there have been times when I’ve imagined that some of my criticisms of "the system" may be difficult for you to hear as someone working in it. And I'm aware as well that you may have different views from my own on a lot of stuff” (Simone).

I reflected the accuracy of her comment in my response to her:

“You are correct that there has been times where I’ve felt a little uncomfortable at some of you criticisms however this has been more to do with my desire, not appropriate within the context of our research interview, to acknowledge the stresses that nursing/mental health staff are under (not to excuse bad practice but to render it a little more intelligible). Generally I’m in sympathy with your criticism of ‘the system’ which, as you probably have guessed, is the main motivation for me engaging in this research project” (Michael).

Whilst I attempted to keep my desire to defend my colleagues out of the interview process, arguably, this bias may have ‘seeped through’ in my responses, perhaps accepting too easily the positive assumptions about my profession expressed by the participants and not pursuing more critical avenues that raised the issues of power identified above.
Researcher identity as nurse – knowledge and position of power/expertise

My professional identity in terms of being viewed as someone with professional expertise clearly had an impact in terms of how the participants felt during the interview process and would have coloured the responses given. Ramona, for example, noted that:

“I have definitely been aware of your professional identity throughout the interview, and in a few cases I have been worried in case I was saying something ‘wrong’ about BPD, as you obviously have a greater professional knowledge about the diagnosis. I am only one person with one personal perspective on the diagnosis, whereas in your line of work you see many women with the diagnosis, and occasionally I did feel a bit self conscious about discussing certain things” (Ramona).

From a Foucauldian ‘power/knowledge’ perspective (Foucault 1991a), the framing of my identity as someone with ‘greater professional knowledge’ reflects an imbalance of power between myself as ‘expert’ with professional knowledge over the participant’s lay knowledge. In Ramona’s case, this impacted negatively on the interview through the experience of self-consciousness she described. Conversely, although I would argue that this effect is also rooted in the imbalance of power stemming from my professional identity, being seen as an individual with specialist professional knowledge also had a positive effect in terms of feeling able to talk about the diagnosis with someone who understands it. As Ramona went on to point out:

“...it is good to know that you understand the diagnosis and everything it entails, as I so rarely talk to people (professional or otherwise) who have actually had direct experience with BPD” (Ramona).

This sentiment was also expressed by Susan who, having forgotten that I had indicated my professional role at the outset, wrote:

“Well I never - theres you a mental health nurse and theres me explaining stuff when you know all about it! Actually that's good because I feel you will identify with some of the issues raised and will understand certain scenarios” (Susan).

Whilst I emphasised during the interviews that I regarded the participants as the experts in knowing what it is like to experience the kind of suffering they endure and the experience of being labelled with BPD, authority and trust were also bound up within my identity and would have impacted on how the participants wrote about their lives.
Having worked with this patient group for the majority of my professional career, my motivation for doing so is rooted in the sense of injustice that I feel on their behalf, in terms both of their treatment under mainstream mental health services, and more widely as women living/or coping with the diagnosis within a patriarchal culture and subject to male violence. I hope that being sympathetic to their suffering and critical of the context of said suffering impacted on the quality of the texts produced and that these qualities outweighed the potentially negative power effects which spring from my professional role. Some evidence of this can be gleaned though the following quotes by Dawn and Sally:

“P.s – you are also not bad for a ‘medical model approach RMN’ – you have restored my faith in the profession! Lol” (Dawn).

“With regards to you and your role as a nurse...no, I can honestly say that I don't get a sense of you in that role. I was even thinking that I have forgotten the theme/reason for this research which merely requires a look back at the emails from the beginning. ... I don't spend much time thinking about your role outside of this contact we have. ... Just to add that although your role as a nurse hasn't seemed to influence I do feel that your experiences lends you to be far more empathic than someone who didn't have empathy and knowledge of PD. you appear to be very aware of the sensitivities. Although I also know not all nurses have this awareness, understanding and compassion hence the need for my role!” (Sally).

**Researcher Identity as nurse and a researcher - professional language**

Although it was not my intention to do so, my use of professional and academic language within the interviews reflected, enhanced, and, secured my professional authority and power position, thereby impacting on the interviews and texts produced. Emily explicitly noted how my use of language spoke of my identity as a mental health professional: “I think I think by the language you used you can tell that you’re a MH professional, but it has had no sway over my answers, or bothered me in any way” (Emily).

Whilst Emily denied that this impacted on the answers she gave to my questions, given, as noted above, that there was evidence elsewhere that my professional role had the potential to have both a negative effect in terms of participants feeling in a less powerful position (i.e. Ramona’s self-consciousness) and a positive effect in terms of feeling understood, heard, and, empathised with, the use of such language arguably impacted on the interviews through constructing my identity as an individual with authority.
Another impact of my use of this language was identified by Simone who made the point that she feels there is a positive dimension to my ability to wield authoritative language:

“I have struggled with getting my thoughts down in "rational" academic language that is not too emotionally loaded to be taken seriously, so I really like the idea of you taking my thoughts and somehow translating them into the kind of writing that professionals and academics will be able to take on board” (Simone).

Here there is a sense that by translating the participant’s comments into academic language, said language can be employed strategically on behalf of those without such a voice, on the understanding that ‘everyday’ language is denigrated whilst academic and professional language is valorised and ascribed value within our culture.

To sum up, my use of academic and professional language appears to have cemented my privileged power position in terms of conveying my status as a mental health nurse and as a researcher and, it is argued, impacted on the interview process. Mindful that such language is both privileged and powerful within our culture, my hope is that any negative effects caused by my employment of it during the interviews will somehow be offset in terms of giving ‘Othered’ voices a means of being heard, albeit on the assumption that much will be lost in translation.

**Researcher identity as nurse – overtly bringing my nursing identity into the texts**

Aside from the general impact that my role as a mental health nurse researcher is understood to have had in terms of the interviews, on two occasions during my interview with Dawn, my nursing identity was explicitly inserted within the text, firstly due to having been asked a specific question regarding dissociation and psychosis by her (i.e. at her own instigation) and secondly, due to my wanting to address a comment she had made as to her worthlessness (i.e. at my own instigation).
With regard to the former example, I responded in the following way:

“In regard to your question about how services distinguish between psychosis and dissociation, generally speaking, dissociation is viewed as stemming from trauma whilst psychotic episodes are usually viewed (at least as far as the dominant medical model within psychiatry) as stemming from some kind of biochemical imbalance and incorporating delusions as well as alterations in perception (I’ve my own thoughts on this but am conscious of putting my clinicians hat to one side and sticking with my research role ;-)). I think it’s fair to say that it’s a complex and tricky issue since, to name just a few complicating factors, we know that many individuals with a diagnosis of BPD have previous diagnoses of schizophrenia or bi-polar disorder (i.e. it’s appears that the task of assigning diagnoses to individuals is problematic in practice), that trauma can trigger psychotic episodes, and that dissociation was incorporated into the early formulations of schizophrenia. Practically, as far as the issue of access to services you mention, I think your comments about the transient nature of dissociation are very valid and, as far as ‘capacity’ goes, dissociation would ideally be factored in to any risk or capacity assessment. The comment about ‘proper psychosis’ and opposed to dissociative phenomena is an interesting one, perhaps more revealing of the attitudes and classificatory models of mental health professionals than clinical needs?

Perhaps part of the problem stems from the ‘black and white’ character of the psychosis/neurosis, psychotic vs. behavioural (in terms of explanations for behaviour) that crops up (borderline processes within psychiatric services perhaps?). I feel you’ve raised a really interesting issue here and would welcome any other thought you may have” (Michael).

With regard to the latter occasion, I once again explicitly ‘donned my professional nursing hat’ and offered the following response:

“You also note that you adamantly believe you don’t have anything to offer people other than your faults and imperfections and describe the visceral sense of sickness you experience when seeing your reflection (I don’t doubt that you feel this way and, whilst I realise that my comments won’t alter this perception, however I wanted to note that, given what you’ve contributed to my research project, I would have to disagree with this perceived worthlessness. Perhaps I’m in danger of slipping briefly into my professional nurses role but I felt I needed to note this, perhaps more for my own sake, given my gratitude for the hard work you’ve put in *takes nurse hat off and puts researchers hat back on*)” (Michael).
On these occasions, I felt compelled to formally bring my identity as a mental health nurse into the interview encounter, due to being directly asked to provide information rooted in professional knowledge, and due to an ethical imperative to acknowledge my disagreement of Dawn’s lack of self-worth (one might argue that this could have been achieved without speaking from the position of a mental health professional however, as my awareness of the distress that she experienced was rooted in my clinical practice and experience, it felt more honest and also more boundaried to do so).

On both occasions I was conscious of this shift from the researcher role to my role as a mental health nurse and, whilst I generally tried not to focus on my professional role too much within the interviews given the power imbalances that I had anticipated this constructing, reflexively aware at the time of the impossibility of entirely ‘bracketing off’ this aspect of my identity within the interviews (Alvesson and Sköldberg 2000), I consciously ‘gave into’ the shift in role while being aware that this would inevitably colour the texts produced.

**Researcher identity as a straight, cis-gender, white, middle-class man**

My privileged position as a straight, cis-gender, white, middle-class man significantly colours and limits the nature of the knowledge produced within the study. Whilst I am sympathetic to those who don’t share my privileged position, without knowing ‘first hand’ what it is like to occupy oppressed positions due to gender, class, race, sexuality etc., it is impossible to fully gauge the subtleties of said subject positions, nor necessarily to ‘pick up’ potentially significant nuances within the texts produced due to this bias.

As noted in the Theoretical Perspective chapter, my privileged position no doubt impacted on my commitment to Western philosophical thought and consequent struggle with the epistemological binary set up within said tradition between certainty and relativism. My subject position would have impacted on my research question in that this sprang from my experience of working with women with a diagnosis of BPD rather than originating in the experience of those occupying said subject position.
Following on from this, my privileged position impacted on my choice of methodology and research design, in that I conspicuously didn’t fully follow feminist research methodology due to wanting to explore a specific feature of social reality that I had identified thereby holding a pre-existing interpretative agenda rooted in my experience rather than that of the participants.

Finally, my selective use of the texts and my analysis would been influenced by the aforementioned bias, given the attending blind spots to potentially significant nuances within the texts.

**Summary of the Reflexive Tale**

“The road to hell is paved with good intentions” (Proverb).

In summary, my initial clinical disturbance, formulation of research question, experience of ‘staking out’ my theoretical position, selection of methodology and methods, interviewing, textual selection and analysis, and, ultimately, my conclusions, all reflect my privileged position of a mental health nurse and health researcher who is also straight, cis-gender, white, male and middle-class. Such a position, despite my efforts, will have necessarily structured my investment in the knowledge produced, and will have contained oppressive features.

My final reflection is that, had I known at the commencement of the project what I subsequently learned through engaging with the numerous dilemmas and struggles faced in engaging with the research, I would have probably undertaken the task differently. The consolation that I take from this is that I can bring what I have learned to future research endeavours, with an awareness that these too will shift my thinking in new ways.
Chapter 9 Discussion and Conclusion

Introduction

In this discussion chapter, I will critically examine key features of my results through ‘bringing together’ the analytic tales, layering them on top of each other to provide a rendering of how these approaches to the data revealed perspectives that resonate with and address my research question and aims.

Through layering the tales, the aim is not to produce a synthesized coherent model of the field under study but, in accordance with a commitment to the world as complex and transcending any attempt to render it within one theoretical model, to produce a refracted image of the field. In place of a single model representing reality, the reader is invited to imagine looking at the area of study through multiple prisms, with the refracted images telling us something about the world, on the understanding that this cannot be reduced to any one image.

Prior to this project, critical feminist literature had critiqued the diagnosis of BPD from a theoretical position (i.e., Wirth-Cauchon [2003]; Herman [2001]; Becker [1997]; Jimenez [1997]; Showalter [2008]; Ussher [1991]), and Foucauldian inspired governmentality studies into psychiatric risk management/discourse had argued that subjectivities are produced by risk practices/discourses (for example, Holmes [2001]; Futtaga and Gattuso [2002]; Crowe [2003]; Stevenson and Cutcliffe [2006]).

Given my definition of ‘risk identity’, to recap, ‘the view people have of themselves and project to others in their talk and actions in relation to risk and risk taking’, empirical studies and literature reviews were additionally identified that shed light on this topic in terms of BPD, self and identity (Dammann et al [2011]; Adler et al [2012]; Agnew et al [2016]); perspectives of those subject to the diagnosis of BPD (Miller [1994]; Nehls [1999]; Horn et al [2007]; Kalapatapu et al [2009]; Brook and Horn [2010]); Black et al [2014]); experiences of mental health services (Fallon [2003]; Morris et al [2014]; Lovell and Hardy [2014]); staff attitudes and exclusionary practices in relation to BPD (Markham and Towner [2003]; Markham [2003]; Forsyth [2007]; Woollaston and Hixenbaugh [2008]; Forsyth [2007]; Sulzer [2015]; Koehne and Hamilton’s [2012]; Sansone and Sansone [2013]; Dickens et al [2016]).
In relation to the specific topic of BPD, risk and identity, whilst Walker (2009) has suggested that the identity of those with a BPD diagnosis may partly depend on the reaction of others to the physical scars of self-harm, little more was known about how those subject to the specific diagnosis of BPD negotiated their ‘risk identity’ through taking on and resisting subject positions at the micro/local level.

The specific focus on ‘risk identity’ in relation to those in receipt of a BPD diagnosis therefore represents a new terrain of research and a broad original contribution to knowledge; analysis through the lenses of the four tales revealing numerous topographical features. These features reveal ‘sets’ of tensions discernible within the tales which require particular forms of negotiation in relation to how differing embodied ‘risk identities’ are constructed, and how mental health services are negotiated.

Whilst my approach has the advantage of sketching out a preliminary map of the field, practical considerations necessitate that the discussion is limited to those features that represent an original contribution to knowledge, these to be delineated along the way. Having made some preliminary remarks to situate the discussion, I will proceed by presenting some of the key tensions that emerged within the analytic tales. These were, adopting a BPD identity vs. moving beyond the diagnosis; trusting therapeutic relationships vs. professionalisation and technical interventions; lacking agency vs. being responsibilised; compulsion to self-assess one’s risk vs. barriers to self-assessing one’s risk; and essential motherhood identity vs. psychiatric identity. Finally, the topic of negotiating mental health services by strategically managing one’s risk presentation will conclude the discussion.

Once completed, the chapter will end with my final remarks before formally stating the limitations of the project, making recommendations for practice and future research, and presenting the dissemination plan.
Preliminary remarks
Whilst the use of the concept of ‘borderline’ to describe patients originated in 1938 within psychoanalytic literature, BPD formally entered medical psychiatric discourse in 1980 with its inclusion as a specific psychiatric condition in the American Psychiatric Association’s Diagnostic and Statistical Manual 3rd edition (DSM-III). This introduction of BPD into the bio-medical psychiatric canon took place the year after Margret Thatcher became the Prime Minister of the UK and a year prior to Ronald Regan becoming President of the US; BPD’s existence in the form that we understand it today can therefore be seen as coinciding with the ascendance of neoliberalism on both sides of the Atlantic.

As presented in the Introduction chapter, Wirth-Cauchon (2003), acknowledging that women are positioned as ‘Other’, situates the diagnostic features of BPD within the symbolic order’s complex representations of self-hood, subjectivity and women. Psychoanalytic and psychiatric thinking and practice, she argues, having ‘glossed over’ this marginality and rendered pathological those features which diverge from the yardstick of the masculinised Western regulatory ideal of the subject. Through this action, disorder is localised within the individual woman, rather than in the sociohistorical context of the distress, and the moral and cultural assumptions around gender by which such women are judged, obscured and mystified (ibid).

Supporting her analysis, it will be my contention that the neoliberal contribution to the regulatory ideal of the subject evident in Western discourses further disadvantages women with a BPD diagnosis via the psychiatric regulatory ideal of the ‘good subject of psychiatry’. The difficulties faced by the women in terms of their pathologised ‘Othered’ identity, the nature of their distress, and the stigmatising assumptions held by mental health workers set them up to be positioned as ‘the bad subjects of psychiatry’ within contemporary mental health services. This contributes, as Crowe (2003) contended, to their further positioning as being dangerous and risky.
With regard to the material and economic impact of neoliberalism, its introduction marked a profound shift in the organisation of capitalism in relation to how public services such as healthcare are provided. Whilst I would foreground the role of patriarchal oppression in rendering women more vulnerable to trauma and distress (both generally in terms of the wider societal context of trauma, and specifically in instances of individual abuse), it will be my further contention that neoliberal transformations in how mental health care is conceived of and delivered represents a further significant oppressive factor when understanding the difficulties faced by women living with a diagnosis of BPD.

**Adopting a BPD identity vs. moving beyond the diagnosis**

The Realist Tale identified that the women viewed themselves as being ‘risky individuals’ in relation to dissociation, self-harm, and impulsivity prior to being subject to a BPD diagnosis. In addition, they also spoke of their early sense of lacking identity, feelings of worthlessness, shame, guilt, and difficulties in their relationships with others.

Whilst the Realist Tale also confirmed a sense of initial relief and validation for several of the women following the act of diagnosis (in support of the findings of Fallon [2003]; Horn et al [2007] and Lovell and Hardy [2014]), absent from these studies is a recognition of the potentially negative effects of identifying with the stigma of the BPD diagnosis, in terms of how this relates specifically to risk.

Acknowledging that Horn et al’s (2007) participants stated that the diagnosis engendered hopelessness which could lead to a potential questioning of its validity (with one of their participants seeming to internalise the rejecting, stigmatising connotations), my research suggests a mechanism whereby the hopelessness bound to the stigma of BPD ‘feeds into’ the poor pre-diagnosis self-image through an identification with, and a sense of deserving, the negative diagnostic branding. The consequence here is that behaviour becomes ‘locked into’ pessimistic expectations, leading to a spiralling negative sense of self and a corresponding exacerbation of risk behaviours.
Whilst it has long been recognised that the experience of being diagnosed with a mental illness impacts on identity (Yanos et al 2010) and Rüscher et al (2006) identified that acceptance of the common prejudices and subsequent loss of self-esteem (‘self-stigma’) is more likely to occur when perceived discrimination (i.e. an awareness of stigma) and perceived legitimacy of discrimination (i.e., a belief that the stigma is legitimate) were high in relation to mental health diagnoses, the apparent specific link between identifying with the stigma around BPD and subsequent risk behaviour has not, as far as I am aware, been previously recognised.

Mindful that the present study also supports the findings of Fallon (2003), Walker (2006), and Koehne and Hamilton (2012) in identifying the negative impact of clinicians not adequately informing patients about their BPD diagnosis, it should be noted that typical recommendations made in light of this phenomenon usually stress the benefits of disclosure in relation to the positive effects of psycho-education (for example Hersh 2008). This is reflected in The National Institute for Clinical Excellence (NICE) guidelines for BPD recommending that clinicians, “...explore treatment options in an atmosphere of hope and optimism, explaining that recovery is possible and attainable” (National Institute for Clinical Excellence 2009 CG78).

Whilst such recommendations harbour the implicit assumption that the diagnosis is valid, and suggest that psycho-education enables patients and their families to have ‘insight’ into the ‘condition’ thereby improving concordance with the recommended treatments, this stands in tension with my findings (identified within the Realist Tale and Deconstructivist Tale) that questioning and outright rejection of BPD in relation to one’s identity may be necessary to ‘recovery’ in some instances.

Although Yanos et al (2010) identified that accepting a definition of oneself as being mentally ill and internalising the stigmatising assumptions of being incompetent and inadequate can have a negative impact on one’s recovery (for example by reducing hope and self-esteem and increasing suicide risk), as far as I am aware, the benefits of questioning and rejecting a specific BPD diagnosis represents another original finding in relation to the recovery literature.
Having acknowledged the wider context of female trauma in the Critical Tale in relation to the societal backdrop of the women’s devaluation, sexualisation and abuse (Becker [1997]), I wish to extend the discussion around the negative impact of identifying with a BPD diagnosis in relation to one’s self-esteem, and a sense of deserving the negative ‘branding’, in relation to the oft-cited histories of child sexual abuse among those so diagnosed.

It is known that childhood sexual abuse is linked to a propensity on the part of the abused child to blame themselves. As Babcock and DePrince (2012) note: “Child [sexual] abuse perpetrated by a close other, such as a parent, is linked to a wide range of detrimental effects, including an increased risk of self-blame” (ibid p526). Whilst self-blame can be seen as a means of minimising the abusive caregiver’s responsibility by the abused (ibid), it is also known that the responsibilisation of the child for the abuse underpins the ‘grooming’ process, with this being a recognised tactic employed by sexual offenders to overcome the child’s resistance (Murray and Gough 1991).

In instances where the individual diagnosed with BPD has a history of childhood abuse, arguably, the diagnosis may act in a particularly toxic way in terms of confirming and reinforcing negative appraisals of self and distorted beliefs around responsibility. I would suggest that the diagnosis may serve to legitimise and reinforce the abuser’s narrative and that, by locating disorder away from its sociohistorical context, the application of a BPD diagnosis may be seen as unintentionally collusive with such narratives.

In summation, there is a tension within the findings of this present research between the benefits and harms of identifying with the diagnosis of BPD. Contrary to the dominant narrative, I suggest that accepting a diagnosis of BPD may negatively act on one’s risk behaviour, self-esteem and recovery. Questioning and rejecting the diagnosis in relation to identity may conversely free one from stigmatising and pathologising assumptions and aid ‘recovery’.
Trusting therapeutic relationships vs. professionalisation and the technological imperative within healthcare

As identified in the Realist Tale, and consistent with the findings of Adler et al (2012) Fallon 2003, Horn et al (2007), Morris et al (2014), Agnew et al (2016), was an emphasis placed by the women on the importance of positive trusting therapeutic relationships for effectively managing their distress, risk and recovery. These were characterised by kindness, compassion, empathy, warmth, understanding, and consistency of approach, characteristics which are reflected in the NICE guidelines in relation to engaging therapeutically with those with a BPD diagnosis; clinicians are instructed to, “...build a trusting relationship, work in an open, engaging and non-judgemental manner, and be consistent and reliable” (National Institute for Clinical Excellence 2009 CG78).

Acknowledging within the symbolic order, that ‘relationality’ as a traditionally feminine value is devalued within our culture against valorised notions of independence, autonomy, and individualism (Becker 1997), and focusing on the centrality of relationality for the women in relation to risk management and treatment, I will argue that there are tensions between valuing relationality and the technico-scientific values found within contemporary mental health services.

Attending to the topic of risk management first, it is necessary to identify the shift that has taken place towards more calculative and predictive methods of risk assessment and management with a greater reliance on formalised risk procedures and actuarial tools. This emphasis on risk management within contemporary mental health services can be interpreted within the context of Beck’s (2008) ‘risk society’ as an institutional response to late modernity’s preoccupation with future risks.

In terms of how this shift leads to the devaluing of relationality within mental health services, Castel (2001) notes that, as a form of governmentality, contemporary risk assessment and management:

“...no longer takes the form of the direct face-to-face relationship between the carer and the cared, the helper and the helped, the professional and the client. It comes instead to reside in the establishing of flows of population based on the collation of a range of abstract factors deemed liable to produce risk in general” (ibid p281).
Orientated to the technico-scientific management of risks, Castel proposes that this promotes a new surveillance modality of systematised ‘predetection’:

“...in the sense that the intended objective is that of anticipating and preventing the emergence of some undesirable event: illness, abnormality, deviant behaviour, etc. But this surveillance dispenses with actual presence, contract, the reciprocal relationship of watcher and watched, guardian and ward, carer and cared” (ibid p288).

On the assumption that Castel’s analysis is correct, this shift would arguably lead to risk management strategies de-emphasising the importance of relationality in regard to individualised risk assessment and management, and to an increase in statistical assessment and a future-orientated surveillance risk management practice. Weight to this theory might be added by referencing the increasing use of both predictive actuarial risk assessment tools such as the ‘Historical, Clinical, Risk Management-20’ (HCR-20; Webster et al 1997) and the extension of impersonal surveillance technologies in monitoring and managing potential risks on mental health units (e.g., cameras and microphones). This has been identified by Holmes (2001) as likely to have a negative impact on the therapeutic relationship between nurse and patient, as well as contributing to the arsenal of disciplinary methods that tame, guide, and mould patients into docile subjects.

Turning our attention to relationality in regard to treatment, in accordance with Kemp’s (2008) summary of service user surveys that identify what patients find most helpful, the Critical Tale revealed instances whereby the positive effects of such relational support were contrasted against less helpful technological treatment interventions, and the unwanted professionalisation of those charged with their care. Focusing on healthcare provision in the UK to make my case, I will argue that the structuring of mental health services under neoliberalism jars with the relational needs emphasised by the women through promoting technological over relational interventions, and promoting an authoritarian professionalisation of healthcare.
With the neoliberal positioning of the free market as the ideal model for organising and delivering healthcare, we see a change in the values that underpinned public service institutions whereby the foundational social democratic and moral values supporting the right of citizens to access services became relegated to market logic and market mechanisms that emphasise regulatory efficiency and profitability (Lynch 2014). The term ‘new managerialism’ was coined to refer to the institutional framework that has developed. Lynch (ibid) defines new managerialism as:

“…the mode of governance designed to realise the neoliberal project through the institutionalising of market principles in the governance of organisations. In the public sector (and increasingly in civil society bodies) it involves the prioritisation of private (for-profit) sector values of efficiency and productivity in the regulation of public bodies, on the assumption that the former is superior to the latter” (ibid no pagination).

In their 1997 White Paper, ‘The New NHS’, Tony Blair’s ‘New Labour’ government placed clinical evidence-based practice (EBP) and cost-effectiveness at the heart of their health care reforms (Department of Health 1997). Noting that the emphasis on ‘cost-effectiveness’ essentially indicated New Labour’s acquiescence to the neoliberal ideological position that public health services are too expensive and need to be rendered more efficient, EBP becomes problematic if, as Davies (2003) writes, “...we understand evidence-based practice as a product of new managerialism and as no more than a means of implementing managerialist agendas” (ibid p98).

I would argue that relationality, understood as therapeutic in itself, is de-emphasised though the valorising of EBP interventions which lend themselves to new managerial agendas (i.e., interventions that are time-bound, teachable as techniques, priceable, easily amenable to randomised control trial [RCT] testing etc.). The promotion of such interventions helps to underpin the technological imperative within healthcare. As Lines (1997) identifies: “...evidence-based practice is more appropriate for the range of nursing activities that could be described as ‘technical’ ... rather than the more complex ‘participative nurse-person processes’ (Mitchell 1997; p154)” (Lines 2001 p170). Further implications in relation to relationality and the neoliberal shift can be derived from a paper by Ferraro (2016) entitled ‘Psychology in the Age of Austerity’.
Arguing that neoliberal political economy and policies of austerity are embodied within contemporary mental health practice, Ferraro details the implications of this for treatment. He does so by juxtaposing Cognitive Behavioural Therapy (CBT), the exemplar, he argues, of a neoliberal therapy, with psychoanalysis, the paradigmatic talking therapy of the era between the end of World War Two and the rise of neoliberalism:

“Psychoanalysis is oriented to unconscious desire and enjoyment (jouisance) as opposed to CBT’s emphasis on correct thought and self-mastery. Analysis posits its material as discourse, by definition, intersubjective and involving an exchange between individuals (see, for example, Benveniste, 1971) as opposed to the contemporary “cognition”, a private and intrasubjective phenomenon. The old method was strictly non-directive and participants were encouraged to say whatever they wished (free association). The new method is highly directive and the speech of participants is conditioned by homework tasks designed to inculcate correct thinking, behaviour, and self-observation. The old method, along with the common factors approach, emphasized the transferential basis for therapeutic effects, whereas the new method places the stress on isolable “techniques”, applicable to anybody and amenable to administration by a computer programme. The old subject presupposed by psychology was woven from the introjected elements of others, and, therefore, intrinsically relational; the new is monadic, assumed to be unified, and is addressed by procedures designed to manage or militarize this supposed unity. The old treatment explored forms of desire and enjoyment in relation to moral prohibitions, while the new itself indoctrinates subjects with its own moral regimen, as a system of protocols for thought (whether in the form of “acceptance”, “critical positivity ratios”, correction of “distorted cognitions”, etc.)” (ibid pp18-19).

NICE guidelines for BPD recommend DBT when there is a need to prioritise recurrent self-harm (National Institute for Clinical Excellence 2009 CG78) and this form of therapy was derived from CBT (Linehan 1993), Ferraro’s characterisation therefore appears highly pertinent to the women’s resistance to both the technological imperative and the professionalisation of mental health services. Translating his characterisation to specifically address BPD, this might be seen to be constructed as a disorder located within the individual’s thinking and behaviour, treatable not through relationality but through learning self-mastery techniques to correct said disorder, as directed by professional experts.

In relation to the technological treatment techniques, Ferraro goes on to critically characterise them as:
“...those of distraction, forced positivity and rationality (these amount to the same thing here), promotion of narcissism (“self-esteem”), enforcement of various “biopolitical” regimes (of sleep, medication, diet, exercise), and short-lived manipulations of affect. (ibid pp19-20).

I would suggest that these treatments indeed have a facile air about them when considering the profound and socially embedded nature of the trauma experienced and the inability of these techniques to address this injustice.

Turning finally to relationality as a form of treatment, whilst it would be inaccurate and disingenuous to suggest that relationships are not an important therapeutic factor cultivated by mental health practitioners, following Ferraro, I would however identify that their value is a, “...purely instrumental one rather than an end in itself; of value only insofar as it engenders compliance with the techniques” (ibid pp19-20).

Turning to professionalisation, the power imbalances resisted by the women within the Critical Tale can also be interpreted as having been informed by the neoliberal shift. Recalling the work of Foucault (1991a) and Rose (1996; 1998; 1999) whereby the historic rise of professional experts was identified as being inextricably bound to the diverse administrative needs of liberal democratic governments, the neoliberal shift has arguably resulted in an increased authoritarianism within the roles of mental health professionals, wrought by the regulatory demands of market forces.

The neoliberal project can broadly be understood as having authoritarian tendencies in that the transformation of civil society to the demands of a market society necessitates that democratic rights are curbed, to enable the transference of communal public wealth to private elites. As Azar (2015) notes:

“If the people were free to make decisions about their lives democratically, surely the first thing they would do is interfere with the property rights of the elite, posing an existential threat to the neoliberal experiment” (ibid no pagination).
Harvey (2007) observes that one of the contradictions of neoliberalism is that the ideal of a market remaining unmolested by the state paradoxically requires a state structure to ensure that democratic values and rights do not hinder its functioning (for example, through legislating against unions [ibid] or using austerity to defund and then privatise formally public services [Chomsky 2011]), in line with Foucault’s (1991a) and Rose’s (1996; 1998; 1999) analysis. Ferraro (2016) further identifies that this administrative need for neoliberal governments to promote an unfettered market is accompanied by authoritarian disciplinary forms of power that, among other areas, find expression in the ‘psy’ professions and in the forms of disciplinary techniques presented above. As he suggests:

“This general trend involves an emphasis on promoting the circulation of capital at precisely the same time as it is accompanied by an increase in government coercion, surveillance, and discipline. These oppressive functions are represented by, among other things, contemporary psychotherapeutic practice ... “cost-effectiveness” and authoritarianism ... [being] ... the hallmarks of biopolitical technologies in the age of austerity” (ibid p18).

Complementary to the state’s hindering of democratic power, professionalisation confers the status of expert to the mental health worker. Their professional knowledge, from a Foucauldian ‘power/knowledge’ perspective, represents a disciplinary form of power whereby docile psychiatric subjects are produced, whose acquiescence to psychiatric power dovetails with neoliberal government agendas.

Here we begin to see the mental health professional as a, “...enforcer/expert...” (ibid) in the mode, I would argue, that is seemingly resisted by the women. The professional expert in this scenario is not ‘standing alongside’, exploring and validating their experience and knowledge in a mutual, relational fashion but ‘standing above’ within a power hierarchy. The expectation here is that the woman with a BPD diagnosis submits to this power and embodies the subject position of the ‘good subject of psychiatry’.

In summary, I argue that there is a tension between the relational, non-technical and non-professionalised approaches identified as best meeting the needs of those with a BPD diagnosis and neoliberal agendas that structure service provision and risk management. Whilst the ‘good subjects of psychiatry’ are expected to ‘fit’ these agendas, those with a BPD diagnosis are arguably disadvantaged given that their relational needs in order to effectively manage their distress, risk and recovery are devalued by these agendas.
Lacking agency vs. being responsibilised

Whilst the women acknowledge that risk presentation can be used strategically on occasion (with these exceptions examined below in regard to negotiating services), overall, the Realist Tale confirmed the findings of the existing empirical literature that those with a BPD diagnosis feel stigmatised as manipulative attention seekers (Fallon [2003]; Nehls [1999]; Brook and Horn [2010]; Morris et al [2014]) and a danger to others (Markham [2003]; Woollaston and Hixenbaugh [2008]). In addition, support was found within the texts which resonated with the findings of Nehls (1999) and Morris et al (2014) that such stigmatising attributions contribute to the women’s emotional pain and therefore their risk to self.

Whilst the empirical literature tends to frame the problem of mental health staff stigmatising patients with a BPD diagnosis as reflecting a need for suitable staff education and training (for example, Fallon [2003]), I wish to offer an explanation that, whilst acknowledging the role of binary gender discourse in producing such stigmatising beliefs, also emphasises neoliberal responsibilisation discourse as this influences mental health service provision.

Dealing with attributions of dangerousness first, from a gender-binary perspective looking at why women with a BPD diagnosis are often perceived as dangerous, we might follow Wirth-Cauchon’s (2003) employment of Douglas’ (1970) concept of the ‘abject’ in relation to the diagnosis. If women are ‘Othered’ within the symbolic order as per the feminist critique of the subject (for example, de Beauvoir [2009], Butler [1997; 2004; 2007], Kristeva [1995], Irigaray [1985] etc.), with the regulatory masculine ideal positioned against the excluded feminine, "the concept of the “abject” is helpful in understanding exclusion of difference and the threat posed by that difference” (Wirth-Cauchon 2003 p85).

Noting the permeability of boundaries that demarcate the regulatory ideal of the subject and the ‘Other’, Wirth-Cauchon goes on to identify that the existence of those who appear to embody such ‘Othered’ abject identities (such as those with a BPD diagnosis) may come to represent a threat, a danger, and a risk.
In terms of the stigmatising attributions of dangerousness made by mental health workers, I would argue that it is plausible that the positioning of those subject to the diagnosis as different, pathological, and ‘Other’ fuels attributions of dangerousness rooted in BPD being an abject identity. As Wirth-Cauchon identifies: “...borderline as a signifier comes to refer not simply to the location between neurosis and psychosis, but to this indeterminate, and therefore threatening, position of abjection…” (ibid p86).

In relation to attributions of manipulation and attention seeking, these terms connote notions of unreasonable dependency; ‘manipulation’ here is construed as being rooted in the notion that those with a BPD diagnosis will cynically seek to meet such unreasonable dependency needs through controlled self-harming or ‘acting out’ behaviours, whilst ‘attention seeking’ attributions assume that such behaviours stem from the overly ‘needy’, i.e. overly dependent, desire for attention from others.

Arguably, the ‘double-bind’ of femininity can be seen as ‘playing out’ within such pathological attributions, in that gender discourse both normalises dependency and relatedness in its construction of femininity, whilst devaluing these feminised traits when held up against the masculinised regulatory ideal of the subject. As identified by Becker (1997), if women conform too strongly to these devalued feminised traits, they are liable to be pathologised as being overly dependent, whereas if they act against such stereotypes they may be viewed as deviant.

Re-evaluating the stigmatising portrait of being manipulative and attention seeking, the adversity that women face in the context of patriarchal oppression in this regard becomes clear. If dependent behaviours are understood as a means by which women attempt to get their needs met, the perceived ‘over-dependence’ as manifest in manipulative and attention seeking attributions can be understood as both an undervaluation and over-pathologisation of their needs. As Becker writes:

“If dependent behaviours were differently defined as the means for getting others to meet one’s needs, then the question would not be whether or how women in this society become overdependent, but whether women are dependent enough” (ibid p120).
Whilst the stigmatising attribution made against those women with a BPD diagnosis can be seen to reflect binary gender discourse, an argument can be made that the neoliberal responsibilisation discourse additionally contribute to such a subject positioning, as they both structure and intersect mental health provision.

It is clear that, as identified within the Realist Tale and Deconstructivist Tale, there was broad agreement that dissociation, and to a lesser extent, impulsivity, represent objective risks to the women’s wellbeing due to their lack of capacity to be responsible for their safety at such times. Whilst this finding resonates with the identification by Black et al (2014) of the coexistence of dissociative states with self-harm, although not specifically focusing on dissociation, Adler et al (2012) found that the narrative identity of their participants with features of BPD was significantly lower in relation to the theme of agency, compared to those with a major depressive disorder diagnosis.

Standing in tension with this, in detailing how neoliberalism responsibilises individuals within current health services, Brown and Baker (2012) note that personal responsibility is currently, “…urged upon clients of the mental health services as never before” (ibid p69). Acknowledging that the construct of the responsible patient sits problematically with biological and neurological determinist explanations for mental illness yet has become widespread (even deemed therapeutic), the authors argue that the experience of ‘personality disordered’ patients:

“…illustrate the imputation of moral responsibility particularly well in that it is accompanied by inferences that the person is wasting the time of practitioners, is being manipulative or is attention seeking” (ibid p77).

Returning to Sulzer’s (2015) study which identified the diagnosis of BPD as signifying the quintessential ‘difficult patient’, the reader will recall how, relating to responsibilisation, she too identified how clinicians justified their treatment and exclusionary practice though the moral judgements of manipulation and attention seeking. She additionally identified that those with a BPD diagnosis may passively or actively refuse care, and that such behaviours are frequently viewed as a means of dominating the clinician.
Failure to appropriately adopt the ‘sick role’ and conform to the norms of the clinical encounter leads to the behaviours of those with a BPD diagnosis who act in such a way being given a moral/behavioural interpretation, which in turn suggests agency and malicious intent. The irony here is that those who feel the least powerful in terms of lacking agency are constructed as powerful agents. As Becker (1997) writes:

“On an institutional level, the self-marking of women by cutting or burning may be responded to as manipulative primarily because it is presumed to be a challenge to the control of others ... The perception of manipulation itself is the ascription of power to individuals who themselves feel least powerful” (ibid p141).

Adding a further twist in terms of agency and responsibility and the challenge to professional power presented through self-harm, Walker (2009) identified a process whereby being known as someone who self-harms can lead to having one’s agency practically nullified by health care professionals when being treated at A&E. The challenge to the professional role is raised by having to attend to wounds that appear to have been deliberately inflicted (but, as identified above, may have occurred during a severe dissociative episode), and may result in the patient being treated as a subject without free choice.

Expanding on the notion of those with a BPD diagnosis representing a challenge to professional hierarchy, having noted above Foucault (1991a) and Rose’s (1996; 1998; 1999) identification of the historic rise of professional experts being bound to the administrative needs of liberal democratic governments, through Beck’s (2008) ‘risk society’ thesis we can view mental health professionals as also being constructed as ‘experts’ on future risks. These professional identities incorporate expertise in risk assessment and management within their particular ‘psy’ discipline. As Rose (1996) writes:

“Psychiatric experts ... they are caught up within a culture of blame, in which almost any unfortunate event becomes a ‘tragedy’ which could have been avoided and for which some authority is to be held culpable. This places new political expectations upon the professionals of ‘mental health’. It also places new responsibilities upon those who are actual or potential subjects of psychiatry and creates new divisions between good and bad patients, clients and users in terms of a calculus of risk” (ibid p4).
Digesting the above, I would suggest that professionals charged with their risk management, in the context of being held culpable should something go wrong whilst being positioned as experts in risk, may feel threatened by the perceived moral failure of ‘bad’ clients to engage appropriately with the systems of risk management and care. This fear can lead to an increased tendency to attribute ‘dangerousness’ when faced with behaviours that challenge their professional expert role, and expose their vulnerability to being held accountable. If the ‘good subjects of psychiatry’ are expected to align themselves with such power, women described as having BPD again tend to fail to fit these constructions.

Walker (2006) has also made similar arguments with regard to the construction by professionals of those with a BPD diagnosis as risky and dangerous to others, noting in relation to her own study that discourses of risk, “…not only involved a transformation of the women as psychiatric subjects but also a transformation of the professionals themselves” (ibid p253).

Before moving on, responsibilisation discourse within neoliberal mental health care also sheds light on the paradox identified within the Realist Tale whereby several of the women reported that the risk they posed to themselves was frequently invalidated and minimised within their interactions with mental health services, despite ‘risk to self’ being a significant construction within the diagnosis.

Recognising that the women’s claim that they are a risk to themselves is supported by suicide completion statistics which indicate that, alongside recurrent depression, BPD significantly increases suicide risk for both men and women compared to other diagnoses (Qin 2011), the paradox becomes comprehensible when one takes into account responsibilisation as a moral emphasis within neoliberal and modern psychiatric discourse. If women with a BPD diagnosis are simultaneously constructed as both having a risky identity and a responsibilised identity, whilst they may present as distressed and at risk, they are also held to be responsible for their actions, even, as we have seen, when experiencing severe dissociative states.
In summation, evident within the above discussion are tensions not only within gender binary discourse that simultaneously positions and pathologises women with BPD diagnoses, but also between the responsibilising tendencies of mental health services under neoliberalism and the difficulties experienced by the women which call into question their capacity to be responsible at all times. The problems this creates in fulfilling the ideal of the ‘good subject of psychiatry’ contribute to the stigmatising assumptions that such women are manipulative, attention seeking and dangerous. I will further ‘flesh out’ these difficulties below.

Compulsion to self-assess one’s risk vs. barriers to self-assessing risk

In describing his ‘good subjects of psychiatry, Rose (1996) identifies the expectation that these ideal patients are responsibilised to be, “...able to assess their coping performance in a way that aligns with the assessment of professionals” (ibid p14). From the women’s accounts in the Realist Tale and Deconstructivist Tale, however, there appear to be three factors that present as barriers to this which relate to the nature of their own personal distress, namely, trust difficulties, self-invalidation and dissociation.

Whilst the women’s trust difficulties can be viewed as stemming from invalidating early experiences, including sexual abuse (Linehan 1993), the impact of staff not embodying the positive characteristics of kindness, compassion, empathy, warmth, understanding and consistency of approach, would understandably exacerbate such issues. As noted in the Realist Tale, lack of trust can lead on occasion to those patients engaged in being risk-assessed defensively presenting as being ‘okay’ when in reality, they are distressed and potentially at higher risk. Their false ‘sunny demeanours’ can potentially result in premature discharge from services.

If trust difficulties rooted in early invalidating traumatic experiences can lead to a defensive ‘covering up’ of one’s distress, with this risk being greater when encountering mental health workers displaying counter-therapeutic characteristics, the disjunction between one’s presentation and actual distress also appears to stem from self-invalidation. This itself, also has its roots in early invalidating home environments. As Linehan (1993) notes:
“...by failing to validate emotional expression, an invalidating environment does not teach the child to label private experiences, including emotions, in a manner normative in her larger social community for the same or similar experiences” (ibid p51).

When a woman diagnosed with BPD is asked to comply with the expectation to self-assess and honestly report as one of the ‘good subjects of psychiatry’, an inability to name her experiences would clearly present as an obstacle to both effective risk assessment and to fulfilling her obligation to accurately self-report as the idealised responsibilised patient.

With regard to dissociation, having noted above that the duty to be responsible at all times is not always possible to fulfil when in a severe dissociative state, it is also worth noting that less severe dissociation impacting on accessing one’s thoughts, feelings, memories etc. would also impact on one’s ability to give an accurate impression of distress.

In all three cases, the disjunctions between self-reports of distress and actual distress all stem from early invalidation and trauma, with such experiences rendering the patient unable to accurately self-report to the assessing mental health worker. Whilst the assessing professional relies, in part, on patients’ verbal reports of their difficulties and distress, the expectation that patients with a BPD diagnosis will act as ‘good subjects of psychiatry’ through self-assessing their mental health in alignment with the assessing practitioner appears misplaced at times, given the aforementioned difficulties.

Whilst risk assessment relating to suicide appears to dominate the literature, with high suicide completion rates often cited as the need for greater understanding and skills in the area (for example Black et al [2004] and Gregory [2012]), I have found no references made to the impact of trust difficulties, self-invalidation or dissociation on a patient’s capacity to engage in being risk assessed. The identification of such non-deliberate blocks to risk assessment therefore do not appear to have been identified in the BPD risk literature to date.
In summary, a tension is identified between the expectation to act as a responsibilised ‘good subject of psychiatry’, accurately self-assessing one’s risk in alignment with the needs of the assessing mental health worker and the difficulties, stemming from early invalidation and trauma, which throw up blocks to this expectation. Those with a BPD diagnosis are therefore likely to experience difficulties which position them at a disadvantage in embodying the ideal psychiatric subject identity in this regard.

**Essential motherhood identity vs. psychiatric identity**

Having identified in the Deconstructive Tale how essential motherhood was a significant discursive resource that those women with children drew upon in regard to their identity, arguably, motherhood might represent a ‘normalising role’ that stands in contrast to one’s identity as a patient (Rutherford and Keely 2009).

Whilst this normalising role may facilitate an alternative identity to that of being a patient, it is by no means an unproblematic one, given that Western norms around motherhood idealise arguably impossible expectations in regard to this role. ‘Mothering’ is constructed as a natural ability of women, who should be constantly attuned and responsive to the needs of their children whilst sacrificing their own needs to them (Malacrida 2009). Naturalised as exclusively a female capability, the mothering role places the burden of care for children squarely on women, with responsibility being deflected away from both men and from the state. Whilst tokenistically regarded as the most important job any woman can undertake, such claims are clearly not recognised by significant material reward or financial support.

This material disadvantaging of mothers, combined with the impossible idealised expectations, contribute to the stresses and pressures which, from a feminist social causation argument, increase women’s vulnerability to developing mental health problems. The pressures of mothering, including stressors such as lack of emotional confidence, lack of functional social support for parenting, too much time spent with one’s child, and difficulty paying for child care have been seen to increase the risk of poor maternal mental health (Mistry et al 2007).
In addition, the masculinised regulatory ideal of the subject necessarily places women in a ‘double-bind’ with regard to mothering in that, whilst essential motherhood positions women who are not, or do not want to be, mothers as deviant, the feminised characteristics of motherhood are excluded from the masculine construction of the regulatory ideal of the subject (DiQuinzio’ 1999).

If the idealised expectations of motherhood render all mothers vulnerable to negative moral judgements when they are perceived as failing to ‘live up to’ said impossible standards, and binary gender discourse necessarily places women as the ‘Other’, I would argue that mothers with a diagnosis of BPD are even more vulnerable within this context.

For women with a BPD diagnosis, attributions of being a danger to others and being manipulative and attention seeking clearly conflict with the qualities constructive of being a ‘good mother’, with being a danger to others placed as antithetical to being caring/nurturing of others, and being manipulative and attention seeking viewed as antithetical to self-sacrifice. If BPD also renders an unstable intermediary subject position, arguably, the diagnosis functions as a fracture through which the devalued ‘Othered’ identity of the female subject position is rendered clear and explicit, and those given the diagnosis would be at greater vulnerability to be regarded as ‘bad mothers’.

In relation to their negotiating of services, for mothers accessing services due to their fear that, without support or intervention, they may deprive their children of themselves through suicide, arguably, the identity of being a patient and being a mother are broadly aligned. Seeking support to stay alive for the sake of one’s children meets the obligations both of a mother and a suicidally distressed patient.

In relation to a situation in which a woman may hide her distress in order to extricate herself from services to resume her mothering role (I will discuss other examples of strategically negotiating mental health services below), arguably, patient identity and essential mothering identity are in tension. Whilst one might imagine a scenario whereby a distressed patient needs to orchestrate her discharge due to a breakdown of child care arrangements, with the woman recognising she needs more time as a patient but being forced to prematurely terminate her stay, managing presentation to hasten discharge in order to resume the mothering role might be seen as the prioritising of mothering identity over patient identity.
Self-sacrifice and the sublimation of one’s needs for the sake of one’s children embodies the essential motherhood value of selflessness, and the requirement to be always and immediately present for one’s children. The latter value also underlies the reducing or stopping of prescribed medication in order to not be overly sedated or emotionally numb. Whether in relation to pretending to feel better than one does to be discharged home or reducing medication levels in order to be more attuned to the children’s needs, the identification of this motivation to return to caring for one’s children prior to fully recovering from a crisis appears also to be an original contribution to the literature.

Whilst not a situation described by the women in the findings of this research, hiding one’s distress may also be employed as a strategy in the community to avoid distressing others, and as a means of not attracting the attention of mental health or social services. From the Literature Review chapter, we noted that Black et al’s (2014) participants stated that the desire to protect family members, whether parents or children, led to hiding distress and self-destructive acts from them. Walker (2009) also described how one of her participants changed the method and site of her self-harm in order to hide it from her CPN for fear of being reported to social services as an unfit mother; as the NICE guidelines instruct clinicians assessing those with a BPD diagnosis, they should, “…identify the risks posed to self and others, including the welfare of any dependent children” (National Institute for Clinical Excellence 2009 CG78).

Although hiding one’s distress and scars is understandable given the self-sacrificing element of an essential mothering identity and the sense of shame that can accompany self-harm, strategically hiding these issues can also be understood in relation to the fear that children’s social services may instigate child protection procedures which might ultimately lead to the removal of children. If a mother has little in the way of family or friends to take care of their children during a hospital admission, social services would be called upon to organise temporary foster care. An awareness of both being viewed as a bad mother and the probability of social services involvement due to a lack of social support should they be admitted would likely motivate such a distressed and isolated individual to strategically hide and minimise their distress and scars from professionals.
From the discussion above, I conclude that, whilst fulfilling the role of the ‘good subject of psychiatry’ and the role of the essential ‘good’ mother can be in alignment, when treatment within services hinders the efforts to embody the role of the ‘good mother’, or if childcare arrangements break down, constructs around self-sacrifice and unwavering availability (both physically and emotionally) for one’s children can lead to strategically using risk presentation as a means of extricating oneself from services and treatment in order to fulfil this alternate significant identity. In addition, fear over the potential consequences of being open about one’s distress and thereby being judged as a bad mother and, potentially, having one’s children removed is also likely to be a factor in the strategic use of risk presentations.

If the characteristics of mothering, bound up with constructions of femininity, are devalued both within binary gender discourse and psychiatric discourse against the masculinised regulatory ideal of the subject, and the ‘good subject of psychiatry’ within new managerialist neoliberal discourse is rooted in said regulatory ideals (for example, devaluing relationality in favour of self-interest), I would suggest that there is a risk that the desire and need of the women to negotiate services for the sake of their children is potentially obscured.

To sum up, if the ‘good subject of psychiatry’ is a patient who rationally engages with services in order to ‘get better’ for themselves and to align themselves to the need of services for patients to be open, honest, self-assessors of their distress and adhere to the prescribed interventions, this stands in tension with essentialist mothering identities which place the needs of one’s children above one’s own, and may understandably result in hiding one’s true distress and risk where alternate child care is lacking or inadequate.

**Negotiating mental health services by strategically managing one’s risk presentation**

Within the Realist Tale we saw how the women may manage their risk presentation strategically in order to either communicate distress (in light of being invalidated), to access services, to increase observation levels within inpatient services, or to be discharged from hospital.
With regard to communicating distress, accessing services, and increasing observation levels, these are arguably rooted in needing to have their distress responded to by staff in order to feel safe. In terms of wanting to be discharged, this generally stemmed from either negative experiences on the unit or, as noted above, commitments connected to being a mother.

In terms of communicating distress or attempting to increase support from mental health services, Brook and Horn (2010) concluded, through analysing their theme of *ambivalence in relation to death*, that overdoses represent attempts to manage unbearable emotional distress through an unarticulated ‘cry for help’ (despite the participants’ insistence that the suicidal intentions were genuine). As to the success of such strategies, whether fully or partially consciously employed, Brown and Baker (2012) noted the following in relation to their own research: “[we] heard staff describing patients as ‘manipulative’ when patients were said to be ‘pulling out all the stops’ in a desperate attempt to access care” (ibid p82).

Whilst I have discussed attributions by staff of manipulation above, the need to strategically use one’s risk presentation in order to access support no doubt ‘feeds into’ these stigmatising attributions. As Fallon (2003) notes in relation to self-harm being potentially used strategically:

“As a strategy for eliciting attention, self-harm is singularly unsuccessful as it is strongly associated with difficult patients (Gallop et al. 1993) and is likely to elicit negative staff responses (Dunleavey 1992, Burrow 1994)” (ibid p399).

Given the self-defeating nature of this strategy, understanding is required as to why such desperate measures are taken. In order to make sense of this, the current crisis in mental health services and a return to the topic of responsibilisation of patients is revealing.

It is first necessary to note that the current era of austerity and subsequent cuts to mental health services in the UK can be understood as stemming from neoliberal governmental agendas. Whilst austerity measures have been presented by those on the political ‘right’ as a necessary means of cutting public spending to reduce the ‘deficit’ (Howard 2016), from a critical ‘left wing’ perspective, as Varoufakis (2015 cited by Howard 2016) argues in relation to the UK:
“...when you have the lowest percentage of public spending as a proportion of national income for the last 70 years, to be talking about reducing the state further when effectively you are reducing taxes like inheritance tax and at the same time you are cutting benefits, austerity is being used as a narrative to conduct a class war” (ibid p62).

In presenting the current state of crisis in mental health services, one can identify that they are both overstretched and underfunded (Winstanley cited in O’Hara 2015) within this climate of austerity. Mental health beds in 2015 have been reduced by 8% since 2010, and mental health services receive only 13% of NHS funding, despite mental health representing 23% of the disease burden (ibid). Following a Care Quality Commission (CQC) report in June 2015 into experiences of care during mental health crises, the CQC’s deputy chief inspectors of hospitals concluded that widespread inadequate responses to said patients, “...result in the most vulnerable people in society being abandoned at a time of crisis” (Lelliott 2015 cited Campbell 2015).

With many clients in crisis resorting to accessing A&E services for help and support, in relation to self-harm, despite NICE guidance advising that those presenting with self-harm should not be discriminated against (National Institute for Clinical Excellence 2004 CG16), “...many services are still failing to provide a caring, empathetic response when presented with a person who may have harmed themselves” (Lelliott, cited in Campbell 2015).

Whilst the current overburdened state of mental health services and the prevailing negative attitudes towards those that self-harm and present in crisis at A&E represent significant obstacles to accessing services at times of crisis for those with a BPD diagnosis, the continued underfunding of mental health services is further deepening the crisis, with dwindling resources rendering the accessing of support even more difficult.

When examining the relevance of responsibilisation discourse as it relates to accessing services, Brown and Baker (2012) identify that the increasing responsibilisation of mental health clients itself represents an obstacle for accessing services, with the, “…responsibility discourse [having] coincided with a retraction in services in many nations” (ibid p73). Resonating with the findings of Sulzer (2015) presented in the previous discussion, they go on to state their fear that:
“...the ground is shifting and the net of ‘individual responsibility’ is being spread so as to enfold increasing numbers of people and deflect them away from services which might otherwise have benefitted them but which are ... increasingly difficult to access” (ibid p76).

The authors point out that: “The responsible client, almost by definition, is less in need of care” (ibid p92). Those with a personality disorder diagnosis, they argue, are being deemed within psychiatric discourse as able to take responsibility. The ascendant responsibilisation discourse within new managerialism therefore appear to have supplanted clinical need as the arbiter of service provision.

To understand the need for those with a BPD diagnosis to strategically utilise risk as a means of accessing support given the above considerations, I argue that not only does the dwindling availability of services present a significant obstacle, but that the diagnosis itself within the generalised discursive shift towards responsibilisation, constructs those subject to it as being responsible for their actions, and therefore undeserving of services.

If one cannot access services and support by simply making one’s case - one’s ability to do so arguably strengthening the belief that one is capable of acting in a responsible and reasonable way and, therefore, not deserving of services - it is difficult to see what other options are available to the distressed individual other than strategically raising their risk presentation. As the Australian mental health activist Merinda Epstein noted in relation to the stigma of the diagnosis and the increasing difficulties in accessing services: “I heard a consumer telling people not long ago, it’s no use talking about suicide anymore, you should be talking about homicide if you want a service’ (Allan 2013).
Comparing the above findings to the existing empirical literature, from the studies by Miller (1994) and Lovelle and Hardy (2014), we already knew that those with a diagnosis of BPD may strategically present themselves in certain ways to achieve particular goals in their interactions with mental health services. Using negative behaviour to communicate distress (Miller [1994]), pretending to feel better than one is, or deliberately refraining from risk behaviour (Miller [1994] and Lovelle and Hardy [2014]), and remaining distant from staff (Lovelle and Hardy [2014]) have all been identified as such strategies. With regard to remaining distant from staff, Agnew et al (2016) discussed the subordinate theme of hiding from others describing a desire to hide from others to avoid negative judgements, which may also be seen as relevant in the context of the well documented stigmatising attitudes of health and mental health workers.

Our understanding of the motivation to communicate one’s distress is enhanced through the additional strategies identified in my research, i.e., increasing the severity of one’s risk presentation in order to access services or to increase observation levels on inpatient units. It is my view that the identification of the use of these strategies, in this particular context, within this current research adds nuance to existing knowledge. The need to access services when suicidally depressed for the sake of one’s children (i.e. not to deprive them of a mother, despite wanting to be dead) or to present as better than one feels to return to one’s mothering duties has not, to my knowledge, been identified elsewhere. This latter finding adds nuance to the existing knowledge of what motivates women with a BPD diagnosis to extricate themselves from services in relation to involuntary admissions as identified by Miller (1994) and Lovell and Hardy (2014).

**Conclusion**

By way of concluding and as an attempt to answer the perennial “so what?” question directed at doctoral projects, as a mental health nurse, the broad and specific contributions to knowledge identified above make clear the need for a critical stance towards the diagnosis of BPD, both in relation to my professional knowledge, and the structure of services in which I practice, in order to minimise, as far as this is possible, the oppressive effects identified.
Ultimately, the key finding of this analysis, and what represents my broad contribution to knowledge in this field, is the notion that those women given the diagnosis of BPD are subject to, resist and are produced by oppressive material and discursive structures that position them as risky individuals, unable to embody the constructions of ‘the good subjects of psychiatry’, which leads to their experiences of being stigmatised and excluded within mental health services. The ‘sets’ of tension discernible within this wider context require particular forms of negotiation in relation to how differing embodied ‘risk identities’ are constructed.

In 2003, National Institute for Mental Health in England released a policy implementation guide for the development of services for people with personality disorder entitled, ‘Personality disorder: No longer a diagnosis of exclusion’ (NIMH 2003). Within the discursive, material and economic conditions identified, and limiting my concluding remark to BPD, I would argue that it is the epitome of an exclusionary diagnosis.

**Limitations of the study**

With regard to the participants who took part in the study, ethical requirements necessitated that only those identifying as being in the ‘recovery phases’ from their earlier more profound distress and no longer in receipt of services under the Care Programme Approach (CPA) were recruited.

This represents a limitation in terms of generalising the results to the wider population of those women with a BPD diagnosis currently receiving treatment within mental health services. It might be the case that those experiencing greater distress and currently engaging in mental health services may negotiate their risk identities in ways not identified within this research, and have additional insights into navigating services in the current climate of crisis within the NHS.

The restriction of participants to UK residents only, similarly due to ethical considerations, may also limit the study in regards to its applicability outside of the UK. Cultural differences and the nature of mental health service provision in the wider world would likely impact on both constructions of identity and access to treatment, and this remains unexplored within the present research.
Whilst men were not excluded from participating in the project and many did respond to the recruitment drive for participants, those that did express an interest unfortunately didn’t fit the inclusion criteria. Given that gender discourses have been identified as significant in relation to how those with a BPD diagnosis are produced by, and may resist the diagnosis, this study’s findings are limited to women.

Similarly, whilst the design of the research and method of interviewing participants deliberately did not require participants to specify their race, sexuality, or gender identification (i.e. cis or trans), this decision was based on the desire to see what identities were important for the participants rather than to prescriptively presume that such categories were significant. It is presently unknown how such identities may interact with identity orientations around BPD and risk from an intersectional perspective.

Regarding the use of email interviews as the chosen method of generating texts, access to internet enabled technology may have skewed the selection of participants in relation to the ‘digital divide’, i.e., “...the gap between demographics and regions that have access to modern information and communications technology, and those that don't or have restricted access” (Rouse 2014). Arguably, within the UK, those of lower socioeconomic statuses may have effectively been excluded from participation. Whilst the growth of internet enabled mobile communication technologies is reported to be closing the divide (The Economist Intelligence Unit 2013), it remains uncertain whether the results of this present study may have been significantly limited in this way.

**Recommendations**

In making my recommendations, I am aware of the tension that exists between the deconstructive radical critique of both BPD and mental health services and the need to offer practical suggestions for improvement within said services in response to the very real distress and suffering encountered in the women’s tales. As Ussher (1991) notes in relation to the radical critics:

> “Their pronouncements may be spellbinding on the conference platform but they can have a hollow ring in the hospital ward or in the doctor’s surgery; in the lonely, desperate isolation of the world of many who feel mad, and who want this to be recognised so that the fear can abate” (ibid p221).
Accordingly, I hope to present my recommendations in a way that reflects both the need to push for radical change, whilst offering practical suggestions as to how to make the best of a less than ideal situation. As a consequence of this balancing act, caveats usually follow each recommendation noting reasons for caution. This caution reflects both the difficulties of implementing my suggested recommendations within institutions largely antithetical to my position but also my theoretical caution, which identifies that unanticipated oppressive effects can lead from the best liberatory intentions.

The diagnosis

Given the critique presented of the diagnosis both in terms of its validity and the impact of stigmatising constructions, whilst it might be suggested that there is a need to relabel the ‘condition’ to address the stigma that surrounds it, arguably, such a renaming in the context of the wider stigma around mental illness runs the risk of merely producing new labels which soak up the same negative constructions (Ussher 1991).

Accordingly, I believe a more substantial move is required, namely that of a shift of emphasis from the diagnostic label supportive of the knowledge claims of bio-medical psychiatry to an approach that gives greater emphasis to the individual’s distress, difficulties, and strengths, within their proper social context.

Calls for such an approach have peppered the professional disputes between psychology and psychiatry for seventy years (Skull 2011). However the balance has yet to shift away from the dominance of bio-medical psychiatry and the statistical diagnostic manuals which underpin its knowledge claims and, therefore, power. With this in mind, tentative support might be given to the recent (since 2009) move by the US National Institute of Mental Health’s (NIMH) to develop the Research Domain Criteria Initiative (RDoC).

RDoC attempts to address the reliability, validity, prognostic, and co-morbiditity difficulties that surround psychiatry’s historic emphasis on diagnosis by developing a new research framework, the agenda being to devise:

“...new ways of studying mental disorders [which] integrates many levels of information (from genomics to self-report) to better understand basic dimensions of functioning underlying the full range of human behaviour from normal to abnormal” (National Institute of Mental Health 2016a no pagination).
RDoC explicitly attempts to move beyond the explanatory limitations of diagnostic accounts through synthesizing a three-dimensional research matrix integrating multiple methodologies or ‘units of analysis’ including self-report questionnaires, data from electroencephalograms, genetics, behaviour etc. It proposes five tentative - in that they may change as the model develops - research domains, namely, negative valence systems, positive valence systems, cognitive systems, social processes, and arousal and regulatory systems (ibid).

Whilst it is too early to tell whether this approach, if successful, will appreciably improve the treatment of those currently given a BPD diagnosis through a shift away from such labels, and I am unable to give my unqualified support for the project given that my own theoretical perspective problematises grand totalising projects and attempts to synthesise multiple methodologies, as the strongest challenge yet to the power of the DSM and ICD, I would strategically recommend RDoC as the ‘best bet’ for challenging the power of diagnostic nomenclature, including ‘BPD’. This is not to say that such a reformulation might not itself have unforeseen oppressive effects.

The need for critical, as opposed to polemical, practitioners

Crowe (2000) identifies that:

“The norms of the professional culture are internalized by the clinician during their acculturation into the profession and the clinical culture and these act to shape the individual’s behaviour and attitudes” (ibid p72).

To borrow a phrase employed by Stevenson and Cutcliffe (2006) who drew upon Foucault’s work, acculturated professions might be viewed as ‘polemical practitioners’, Foucault (1991b) describes the ‘polemicist’ as proceeding:

“…encased in privileges that he possesses in advance and will never agree to question. On principle, he possesses rights authorizing him to wage war and making that struggle a just undertaking; the person he confronts is not a partner in the search for the truth, but an adversary, an enemy who is wrong, who is harmful and whose very existence constitutes a threat” (ibid p382).
Given the identified stigmatising attitudes towards those with a BPD diagnosis commonly held by staff and the widespread sense of invalidation experienced by the women, noting how Foucault’s description resonates with this in light of the preceding discussion, I would argue that there is a need for mental health nurses to be more critical, both of the validity of the diagnosis, and of the role they play in transmitting stigma via their interactions and assumptions.

To go some way to address this, I would recommend that the curriculums for trainee mental health nurses include an emphasis on critical approaches to both the diagnosis and the dominant psychiatric paradigm, through an emphasis on the critical feminist and social constructionist literature relating to the diagnosis of BPD.

By including this emphasis, my hope would be that professionals would be more able to recognise the wider patriarchal violence to which women with a BPD diagnosis are exposed, to understand how the diagnosis reflects and pathologises comprehensible responses to said violence and, arguably, through contextualising the difficulties experienced, to reduce the tendency to attribute disorder to the woman alone, through stigmatising attitudes rooted in an acceptance of the validity of the diagnosis.

Ideally, mental health nurses would question their confidence in the benevolent nature of their professional identity and embrace a more critical stance with regard to their professional knowledge. My hope would be for them to adopt a more Foucauldian approach to both their professional knowledge and the distressed individuals who present to them. Specifically in relation to the distressed women who present before them, the ideal would be for mental health nurses to adopt an anti-essentialist attitude to their identity whereby, as Holmes (2001) identifies, nurses and patients could, “…co-construct their reality, their potential, and the intervention” (ibid p13).

Such a shift is unlikely to be an easy one given that nurses predominantly practice within multidisciplinary contexts still dominated by diagnostic models and that many nurses may resist efforts to problematise the knowledge base from which their professional identity is, in part, derived.
Aware that, even if such educational recommendations could be implemented, professional acculturation takes place beyond formal professional training via the experience of working as practitioners in clinical settings, given the mismatch between the agendas of new managerialism and the relational needs of those with a BPD diagnosis, again, a more substantial move is required. Accordingly, I turn to co-production as a means of moving beyond new managerialism.

**Co-production**

Given that the women have identified relational approaches as best meeting their needs with regard to risk and recovery, and have made repeated calls to be listened to and collaborated with over their treatment, ‘co-production’ as a way of guiding public service reform, points towards a more inclusive strategy for developing the delivery of less oppressive mental health services.

Rooted in the US civil rights social action work in the 1970s (Clark 2015), as a developing alternative to either welfarist or new managerial approaches to health care provision, the goal of ‘co-production’ can be described as:

“...delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change” (Boyle and Harris 2009 p11).

Co-production works on the principle of equal partnership, whereby those who receive services are sought to assist in the design and development of said services as experts both in their needs and how services might best address them. It therefore represents a significant shift from the notion of service user as a mere passive consumer of health care to one of active partnership with professionals.

Should co-production be ‘rolled out’ in relation to the design and delivery of services for those with a BPD diagnosis, their need to be listened to and worked with in regard to risk and recovery could be structurally and procedurally embedded within the fabric of service design and delivery. One might reasonably hope that such co-working could lead to services that embody the relational dimension inhibited within current mental health services, and facilitate productive and containing relationships between patients, their families, and professionals.
In addition, in light of my recommendation that practitioners need to become more critical of their expert knowledge in regard to BPD, co-production’s shift from professional expertise to a mutual sharing of expertise and power resonates with this. As Dunston et al. (2009) note:

“All forms of co-production challenge existing forms of health care – in particular, expert based practice. They also profoundly disturb many fundamental constructs that have long informed professional identity, defined and differentiated expert knowledge from lay knowledge and shaped the roles and rules that typically govern the ways in which health professionals and health consumers interact” (ibid p42).

Whilst I am sympathetic to, and hopeful of, the aims and potential of co-production in regard to those with a BPD diagnosis, caution must be exercised due to the fact that, despite its origins, ‘co-production’ as a concept is seemingly rather elastic in regard being employed by those positioned at both ends of the political spectrum. As Clark (2015) warns:

“...we ought not to expect that the language of co-production could never be coupled with market and/or managerial ideologies. As co-production is also about the assets that people contribute to the process it is not inconceivable that it could be linked with a “rights and responsibilities” discourse, emphasising that people receiving public services have a responsibility to contribute something” (ibid p215).

Given the current climate of austerity and cuts to services, I fear that the laudable aims of co-production could be subverted within the neoliberal project as a means of further shifting the responsibility and cost of service provision onto ‘clients’. I would therefore argue that for co-production to be both truly meaningful and effective, it needs to replace new managerialism within health services rather than augment it. Arguably, this could only occur in the context of wider social changes that saw an end to the neoliberal project and a renewed commitment by future governments to social spending.

**Informing patients that the diagnosis that they have been given is contested**

If the stigma that surrounds the diagnosis is in part transmitted by professional reluctance to disclose a diagnosis at the outset, this also potentially undermines efforts to establish a therapeutic relationship; there is clearly a need, both ethically and practically, to fully inform patients that a diagnosis has been made.
Aside from the ethical need to inform patients of their diagnosis, studies have framed the benefits of disclosure in regard to the positive effects of psycho-education. i.e., providing a validating name for difficulties/distress, and guiding patients and families toward effective treatments (Hersh 2008).

Whilst psycho-education by polemical practitioners arguably reinforces the validity/truth of the diagnosis, the stigma that surrounds the diagnosis in this context is presented as rooted in outdated assumptions around BPD’s un-treatability (ibid). As my position critiques the validity of the diagnosis and articulates a wider analysis for stigma and invalidation, such psycho-educative practices are problematised.

To address the need for patients to be informed whilst not polemically asserting a questionable and potentially destructive ‘risk identity’, I would recommend that those diagnosed are informed both that a diagnosis has been made, including the difficulties the label describes, since this appears to positively validate their distress, but also, that the diagnosis is contested. This, I would argue, being necessary to fulfil one’s ethical duty to fully inform patients about their diagnosis whilst ‘opening a space’ for discussions/dialogue through which co-construction of the patient’s reality, their potential, and the intervention that might be of help, could occur.

By empowering the patient with a critical knowledge of their diagnosis and placing an emphasis on the difficulties that led them to present for help, the patient might be better placed to resist the negative individualised constructions that can exacerbate risk and feed into pre-existing low self-worth and shame. It would be up to the fully-informed diagnosed woman to either take the diagnosis on as potentially useful means of understanding her difficulties, or to reject it as unhelpful if this was found to be the case.
Whilst models of recovery exist that resonate with elements of the approach described above, for example, Barker and Barker’s (2007) ‘Tidal Model’, which emphasises the need for nurses to assume that they know nothing of the presenting patient or their experiences, and to eschew focus on diagnosis in favour of a solution-focussed approach to difficulties, as indicated in relation to the discussion of the need for more critical professionals above, I am fully aware of the intra- and inter-professional conflict that adoption of this Foucauldian inspired approach might well cause, given the investment of professionals in their professional identity and expertise.

**Relational security**

As the women identified relationships are key to managing risk and promoting recovery, the notion of safety located therein arguably resonates with ‘relational security’, a concept of psychological safety derived from attachment theory that describes:

“...a way of relating [with patients] that increases feelings of safety rather than diminish them ... The goal of developing this type of security [to] provide psychological safety, within which it might be possible to begin to put into words, and to understand, memories and feelings that have so far proved elliptical and elusive” (Birch et al 2011 p295).

As a means of therapeutically increasing a patient’s sense of safety, relational security emphasises relatedness as key to working positively with clients over instrumental or technological interventions that are ‘done to’ the patient with regard to care, risk management, and recovery. The ‘safe space’ provided, as indicated by the above quote, enables the naming of elusive memories and feelings which, if left unnamed, can cause problems in the self-assessment of risk.

In terms of the obstacles impeding the implementation of this form of risk management within existing mental health settings, the Department of Health’s 2010 guidance for secure services, writing about ‘relational security’, serves as an instructive warning. In their booklet titled ‘Your Guide to Relational Security – See, Think Act’, ‘relational security’ is defined as: “...the knowledge and understanding staff have of a patient and of the environment, and the translation of that information into appropriate responses and care” (Department of Health 2010 p4).
The contrast between ‘relational security’ understood as a way of establishing safety with a patient compared to ‘relational security’ understood as knowledge of a patient and their environment for instrumental risk management ends is stark, and should alert us to the risk of progressive concepts being appropriated and their meaning diluted. Arguably, the difference in emphasis noted reflects the influence of new managerialism’s valuing of regulation over relationality.

Whilst I would recommend relational security as a necessary component to managing risk with those given the label of BPD, this is with the caveat that greater structural changes in service planning and delivery would be required in order to undertake this meaningfully.

**Staff training in dissociation and self-invalidation**

Returning to the topic of staff training but from a less radical and more practical angle, given the women’s identified difficulties in communicating their feelings in relation to risk resulting from dissociative states and self-invalidation, training clearly needs to address these issues.

Understanding that both phenomena can be viewed within the context of past trauma and that this context can be obscured by an emphasis on the individualising and responsibilising tendencies accompanying the diagnosis, emphasis needs to be given to the impact of childhood trauma within professional training. Such training would need to stress both the nature of dissociation in relation to how it may impact on an individual’s capacity to maintain both their safety, and the ways in which both dissociation and self-invalidation can impact on ability to communicate and identify distress.

Whilst training relating to dissociation might include an emphasis on the signs to ‘look out for’ that a patient might be dissociating, and offer practical ‘grounding techniques’ to impart to those with such difficulties, working with patients locked into patterns of self invalidation arguably requires an approach that enables exploration of such issues in the context of psychological safety, i.e., relational security (as discussed above).
Practitioner awareness of how and why patients may navigate mental health services

In light of the preceding discussions over how those with a BPD diagnosis may use their risk presentation as a means of accessing, prolonging, or extricating themselves from services, it is clearly necessary for staff to be aware of the factors that may influence a patient’s need to use their risk presentation strategically, in order to allow them to better assess and manage actual risk and work therapeutically with patients.

In relation to accessing services, I have highlighted how the need to use one’s risk presentation as a means of accessing services is linked to responsibilisation discourses that render those with a BPD diagnosis as undeserving of therapeutic intervention in the context of the dwindling resources that currently characterise mental health services.

Whilst I have advocated for both a change in how services are structured and, more broadly, a move away from neoliberal economics, on the assumption that changes of this kind will not happen in the near future, staff need to be aware of the challenges such women face, to avoid making naïve stigmatising assumptions. For women in receipt of services attempting to use their risk presentation to delay discharge, again, the above clearly needs to be held in mind to avoid making oppressive assumptions.

If, as I argue, the women have little choice but to employ these strategies in attempting to meet their needs, it is wrong to apportion blame to them whilst ignoring the current crisis; staff anger and energy would be better directed towards the Government rather than distressed and disenfranchised patients.

For those women who either use their risk presentation to extricate themselves from services due to their experience being distressing/counter therapeutic or as a means of increasing the institutional risk management response, both might be better managed by improving the quality of relationships and communication between patient and staff. This, I have argued, could be achieved through the adoption of a critical Foucauldian approach and a restructuring of services through co-production.
An awareness of the destructive impact that stigmatising attitudes and invalidating responses have on patient-staff relationships would ideally improve staff responses to said individuals and reduce the likelihood that patients who pose a risk to themselves are discharged prematurely. In addition, listening, and appropriately responding to women who state they are in distress and require a continuation of, or increase in, the institutional risk management response would also reduce the need for said women to ‘up the ante’.

With regard to the latter point, mirroring my qualification around access to services above, clearly the availability of material and staffing resources plays a significant role in the ability to continue or increase the risk management response. Again, I would suggest that anger directed at patients for being manipulative or attention seeking would be better directed towards those ultimately responsible for resource allocation/funding, and that professionals should be politically engaged in advocating for increased spending on mental health services.

Finally, in terms of those women who use their risk presentation in order to meet the demands and commitments of their mothering role, staff need to take into account said needs, and the barriers to engagement that lack of child care support can cause.

Whilst it should be acknowledged that psychiatric mother and baby units do exist to support new mothers with mental health difficulties such as postnatal depression or psychosis, community mental health teams take over the care for mothers with children older than twelve months, should they face mental health difficulties.

Given that there may be a lack of child care support for women in the community, with this potentially contributing to the mental health difficulties with which women present, I would recommend that initial mental health assessments include questions around said needs. Close working with families and, if involved, children’s social services, would also be recommended, given that the presenting woman may have had difficulties problem-solving around implementing necessary child care at the time of crisis due to their distress.
For those women either receiving support in the community or about to be discharged from inpatient services, discussion around prescribed medication, and how this might impact on the ability to be present for one’s children would be advised. Less sedating medication alternatives or lower dosages should be considered if the mother has expressed concern around this in relation to her ability to be present for her child/children.

**Recommendations for future research**

This research project can be viewed as an early exploration into the terrain of risk identity and BPD, and raises many potential opportunities for further research both in terms of the specific topic of risk identity and BPD, as well as unexpected points of departure identified within the discussion that represent potentially fruitful and fertile areas for further study and exploration.

In terms of the former, having identified the limitations of my research above, I would welcome further research to explore and test out the findings in relation to the following:

- How women currently in receipt of treatment within mental health services diagnosed with BPD negotiate identity in relation to risk
- International studies exploring ‘risk identity’ in relation to women with a BPD diagnosis.
- How men diagnosed with BPD negotiate identity in relation to risk.
- How women diagnosed with BPD negotiate their ‘risk identity’ from intersectionality perspective that incorporates multiple social identities, e.g., class, race, age, sexual orientation etc.

In terms of the research beyond the specific focus of my research, three points of departure seem to stand out to me as being worthy of further examination.

- Specific focus might be given to exploring the hypothesised toxic overlap between the responsibilising diagnosis of BPD and the reinforcement of negative appraisals of self and distorted beliefs around responsibility that often ensue in cases of childhood sexual abuse.
• A more detailed examination of the interplay between mothering and psychiatric BPD identities would be of value, given the impact that trying to fulfil the role of a mother has upon ability to engage with and navigate mental health services and interventions.

• The paradox of feeling that the risk they posed to themselves was frequently invalidated despite ‘risk to self’ being a significant construction within the diagnosis, represents a fascinating fracture within psychiatric discourse in relation to responsibilisation and risk narratives. I would be interested in pursuing this particular unexpected finding within my own future research endeavours in relation to neoliberal/new managerial discourses.

**Plan to share the learning from the research**

In terms of my aim to raise awareness amongst mental health professionals of the constructive effects of psychiatric discourse in the production of the identity of those subject to the diagnostic label of BPD in order to challenge dominant psychiatric discourse and problematise potentially oppressive practice, the following plan has been devised:

• At a local level, to continue to engage with work colleagues as to the nature of my research project, critical reflections and conclusions, both formally within ‘practice development’ educational presentations and ‘peer supervision’ and informally, though case discussions where clients have been identified as having received a BPD diagnosis.

• To present a copy of my thesis to my employer as an educational resource for nurses, social workers, probation workers, family support workers, psychologists, and psychiatrists within my current service.

• At a national and international level, I plan to write several papers drawing on the research project for submission to nursing journals such as the ‘Journal of Psychiatric and Mental Health Nursing’ and ‘British Journal of Mental Health Nursing’.

• Having completed the thesis, I plan to attend relevant and sympathetic conferences where my work can be shared through liaising with fellow professionals.
• To make contact with the recently established (April 2015) ‘Critical Mental Health Nurses’ Network’ (CMHNN) in order to share my research and contribute to their project of directing critical thought to the, “…practice, culture and environment of mental health nursing” (Critical Mental Health Nurses’ Network 2016 no pagination).

In term of my aim to raise awareness amongst those subject to the diagnostic label of BPD in order to contribute to their awareness of, and better equip them for, challenging oppressive practice and dominant psychiatric discourse, the following plan has been devised:

• To notify the participants of the completion of the project through my ‘update email list’ making them aware that an electronic copy of the thesis, and any subsequently produced research papers, will be made available via my research website (with said website to be maintained for a two year period after completion of the project).

• To contact the ‘Mentally Healthy’ website, who carried the recruitment advertisement for my study, to offer a ‘follow up’ piece which summarises the results and directs interested readers to the research website, where the full thesis and any subsequently produced research papers will be made available.
References

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Appendices

Appendix 1 - DSM-V diagnostic criteria for BPD

Diagnostic Criteria 301.83

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 (Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.)
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 (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

(DSM-V 2013 p663).
Appendix 2 – Literature Review Searches

- ‘Emotionally Unstable Personality Disorder’
- ‘Borderline Personality Disorder’ ‘risk identity’
- ‘Borderline Personality Disorder’ ‘risk’
- ‘Borderline Personality Disorder’ ‘identity’
- ‘Borderline Personality Disorder’ ‘governmentality’
- ‘Borderline Personality Disorder’ ‘Foucault’
- ‘Borderline Personality Disorder’ ‘gender’
- ‘Borderline personality disorder’ patients’ perspectives’
- ‘Borderline personality disorder’ staff’s perspectives’
- ‘Borderline personality disorder’ ‘attitudes’
- ‘Borderline personality disorder’ ‘social constructionism’
- ‘Borderline personality disorder’ ‘social constructionist’
- ‘Borderline personality disorder’ ‘discourse analysis’
- ‘Borderline personality disorder’ ‘feminist’
- ‘Borderline personality disorder’ ‘feminism’
- ‘Borderline personality disorder’ ‘dangerousness’
- ‘Borderline personality disorder’ violence’
- ‘Borderline personality disorder’ ‘self harm’
- ‘Borderline personality disorder’ ‘impulsive’
- ‘Borderline personality disorder’ ‘crime’
- ‘Risk’ ‘governmentality’
• ‘Mental health’ ‘Foucault’

• ‘Psychiatry Foucault’

• ‘Risk identity’
Appendix 3 – Research Website

Borderline Personality Disorder, Identity & Risk
Research participant recruitment website

Please note that recruitment for this study has now ended.

RiskIdentity.com

Welcome to the research website of Michael Huggett, a professional doctorate student at the University of Brighton. If you are a potential participant in the project, please have a look around the site before getting in touch with any questions that you might have.

Those expressing an interest and selected to take part will be on a first come, first served basis. If you are not selected at first, however, there may be opportunities to join the study at a later date in the event that other participants drop out.

Many thanks for showing an interest.

The Study
The purpose of the study is to gain understanding of how people with a diagnosis of Borderline Personality Disorder (BPD) come to view themselves in relation to the topic of risk. What mental health services tend to view those given this diagnosis as risky individuals who may engage in activities such as self-harm, substance misuse, reckless spending etc, how those given this label view themselves and their behavior is little understood.

Participation Information
- Purpose of study
- Participation requirements
- What you will be asked to do
- Risk of possible harms
- Confidentiality
- Support and outcomes
- The results
- Ethics approval
- Contact the researcher

Links
- Brighton University
- University professional doctorate

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Privacy & Cookies
Website services by PYTIMES2
Borderline Personality Disorder, Identity & Risk

Research participant recruitment website

HOME  |  PARTICIPATION INFORMATION  |  CONTACT

What you will be asked to do/expectations

If you decide to participate you will need to follow the link to my email address and let me know that you wish to take part. Before being confirmed as a participant, I will ask you a few questions via email to make sure you understand what will be required of you and to confirm you meet the above criteria. If it is decided that you are a suitable participant, a consent form will be sent to your address with a stamped addressed envelope to be returned, assuming that you are happy to sign it.

Once accepted, you will be expected to take part in an interview conducted through emails with myself as the researcher. You can take as long as you like to answer the questions; however, whilst there is no minimum time limit to the interview, practical considerations mean that the ‘back and forth’ of emails cannot extend beyond three months.

Whilst you will be asked a few pre-prepared questions to ‘get the ball rolling’, for example, “What are your thoughts, feelings, or beliefs about the BPD diagnosis?”, because the aim of the study is to explore your view of yourself in relation to risk, the kind of answers you give may suggest themes that it would be interesting to explore with further questions from me. In turn, you will be encouraged to ask me questions so that together we can explore the themes of the project.

During the interview, you will also be asked to suggest a particular piece of music, poem, song, movie, book etc that you have found “speaks to you” about your experience (it is not necessary that you are able to do so in order to participate). The reason that this question will be asked is to gain a broader sense of what is important to you beyond the diagnostic label.

Once the interview is completed you will be asked to re-read the email exchange to make sure you are happy with your comments and to give you the opportunity to clarify or change anything you are dissatisfied with.

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Risk of possible harms

Whilst the risks of harm coming to you are judged to be low, the exploratory nature of the interview may reveal themes that you find difficult or distressing.

Although it is not the intention of the interview for you to reveal any traumatic or upsetting information, merely how you view yourself in relation to the subject of risk, if you become distressed due to anything brought up by the interview, I will encourage you to access your support network.

If I believe the interview is causing any undue distress, I may suggest that it would be better for you to cease participation. This does not reflect any failure on your part, only that perhaps it is not the right time for you to be taking part.

Participation is entirely voluntary and you are free to 'drop out' of the study at any point. Whilst you don’t need to provide a reason for dropping out, to prevent any unwanted emails from me it would be a good idea to inform me of your intention beforehand.

Please also note that whilst each email service employs their own security measures, no email service is 100% secure if an unauthorised individual is determined to hack into your account. The risk of hacking occurring is judged to be remote due to the research project not eliciting information that would be of use for criminal ends. If you have concerns over email security, please look up security information in relation to your personal email service. The researcher's email service is ‘1&1 Webmailer 2.0’.

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Confidentiality

Once the interview has been completed and you are happy with your answers, I will cut and paste the text into a word document and replace any names with pseudonyms to ensure confidentiality. Having used the word documents in my analysis, they will be stored for five years in a locked cabinet at my home address and then destroyed. All emails will be deleted by me once the word document is finished.

Other than myself, access to the word documents will also be available to my two doctoral advisors, Dr Graham Stew and Dr Kay Aranda.

Whilst any information about you will be kept secure and confidential, in the event that during the course of the interview information is revealed that represents a serious threat to anyone’s safety, confidential information may be given to the relevant authorities to prevent serious harm occurring.

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Expected outcomes

By revealing how those given the label of BPD view themselves in relation to the topic of risk, it is hoped that mental health professionals will be able to change their risk management practice in order to be more sensitive and less restrictive than tends to be the case at present.

It is also hoped that people with a diagnosis of BPD that either take part or read the results will be in a better position to argue against insensitive and overly restrictive risk management practice.

There is no reward for taking part in this study other than the knowledge that you will be assisting in a project that aims to improve the quality of care for individuals who share your diagnosis.

The results

The results of the study will take the form of a report by me exploring the findings from the interviews and my conclusions as to what they mean. This will be presented in full in my thesis and summarised in a ‘research report paper’ that will be available to you electronically on request and may be published in a mental health journal. The findings may also be presented at mental health conferences.

Ethics approval

The research proposal has been approved by the University of Brighton’s ethics committee. If during the course of participating you wish to make a complaint you can make this to Prof Julie Scholes, chair of FREGC (CNMR, Mayfield House 263, University of Brighton, Falmer, Brighton BN1 9PH, Tel: 01273 644078 (j.scholes@brighton.ac.uk).

Contact the researcher

Thank you for showing an interest in the research project. If, having read the outline of the project you wish to be considered as a participant, please complete the contact form below.
Appendix 4 – Mental Healthy Recruitment Article

Borderline personality disorder risk and identity

By Corinne Dyer

The media psychosis diagnosis of BPD has led to some work on the emotional responses to BPD. However, it is also important to consider ‘personality disorder’ risk and the identification of the disorder. The risk factors for BPD are typically associated with the following characteristics:

- Intense and unstable emotions
- Impulsive and self-destructive behavior
- Difficulty with relationships
- Chronic feelings of emptiness
- Preoccupation with abandonment
- Self-harm and suicidal behavior

These characteristics are often associated with BPD, and the diagnosis is made when these features are severe enough to cause significant distress or impairment in functioning. However, it is important to note that these characteristics are also common in other mental health conditions, and a diagnosis of BPD should only be made after thorough assessment and consideration of other potential diagnoses.

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- Intense and unstable emotions
- Impulsive and self-destructive behavior
- Difficulty with relationships
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For more information on the diagnosis and visual aid to assist in the study, further information and resources are available through the research website: [http://www.borderline.com](http://www.borderline.com)
Appendix 5 – Update email examples

Hi All and belated Happy New Year!,
This is the first of my updates on the risk identity research project for those that expressed an interest (if you’ve accidently been added to the list or simply no longer want updates, just drop me a quick email and I’ll delete you off of the mail out list).
It’s my intention to keep those interested posted of the general progress of the research project at key stages. At the moment I’m in the process of recruiting participants and conducting the email interviews which all appears to be going well (this phase should continue into the summer). Many thanks again for those of you that have either expressed an interest in the research or have contributed through your emails.
I anticipate the frequency of these updates will increase after the interviews are completed and I get stuck into the analysis and write up of the project.
That’s about it for the present time.
I hope everyone is doing well and keeping warm during this cold snap.
Best wishes
Michael

Hi All,
This is the second of my updates on the risk identity project (if you’ve accidently been added to the list or simply no longer want updates, just drop me a quick email and I’ll delete you off of the mail out list).
The interview phase has now drawn to a close and I’ll be presenting my experiences of using email interviews as a research method at the Brighton University MPhil/PhD and Professional Doctorate conference later this week.
The next phase will be the analysis of the interviews and will probably take around six months unless I run into any difficulties (fingers crossed!).
I’d like to thank everyone who participated and those that expressed an interest. I’ve been blown away by the efforts everyone has made and feel a deep sense of gratitude to you all.
Best wishes and stay dry!
Michael

Hi All,
I just wanted to let those that have participated in the study and those who have expressed an interest know that, due to my mother-in-law having a life threatening illness, I’ve had to take a six month break in my studies in order to prioritise supporting both her and my wife. I’d just started the analysis phase of the project and would like to again send out my thanks for those that participated (going over the material I’ve been reminded of the efforts you made and the quality of your responses). I’ll let you all know when I’m back in the research saddle (probably early Spring 2013).
Many thanks again and I wish you all a peaceful Christmas.
Best wishes
Michael

Hi All,
Apologies if anyone has tried to contact me on my 1&1 email account. For some reason the program keeps crashing whenever I attempt to check my inbox hence why I’m using my Gmail account (the joys of technology...).
I’ve not sent out an update of late due to being preoccupied with work. Sadly, following review by NHS commissioners, the unit I work on is in the process of being decommissioned, a process that’s caused a great deal of distress to both residents and staff. I’ve secured a new job and will be using my experiences of the process to inform my thesis so things could be worse for me personally.
Just to let folk know that the analysis of the interviews is going well and I’m on track to complete the research project by October 2014 (I’ve a lot of writing to get on with in the new year as you might imagine!).
I hope this email finds you all well and thank you all again for your interest and participation.
Best wishes
Michael

Hi All,
Apologies for the length of time it’s taken to get around to writing this update...
I’m afraid to say that my mother-in-law died a couple of months ago having been diagnosed with terminal liver in May. This necessitated me taking a second period of leave from studies to support the family both practically and emotionally.
I’m due to restart and complete the final 8 months of study in March 2015 but wanted to update you all.
Many thanks for your continued interest and I wish you all a peaceful Christmas and New Year.
Many thanks
Michael
Appendix 6 – Consent Form

The Negotiation of Risk Identity by Individuals Diagnosed with Borderline Personality Disorder (BPD).

CONSENT TO PARTICIPATE IN RESEARCH

You are invited to participate in a research study conducted by Michael Huggett, who is a doctoral student from the Health and Social Care Department at Brighton University. Michael is conducting this study for his doctoral thesis. Dr. Graham Stew and Dr Kay Aranda are the supervisors for this project.

Your participation in this study is entirely voluntary. Please read the information below and ask questions via email about anything you do not understand before deciding whether or not to participate. You are being asked to participate in this study because you have been diagnosed with BPD. In order to protect your well-being, you need not to be currently receiving treatment under the U.K.’s National Health Service (NHS) or as an inpatient in a mental health hospital. In addition, you should be in the ‘recovery phase’ (i.e. not acutely distressed) and have a support network in place. Due to the use of email for the interview process, access to an Internet enabled computer is also necessary.

PURPOSE OF THE STUDY

The purpose of this study is to gain a sense of how you view yourself in relation to the topic of risk, this topic frequently being associated with the diagnosis of BPD amongst mental health professionals.

PROCEDURES

If you volunteer to participate in this study, you will be asked to do the following:

1. You will be asked to take part in a semi-structured informal interview via email on the subject of risk and how you see yourself in relation to this topic. As the interview will take place via email, you can take as long as you wish in replying to the questions asked and are free to ask questions in return. An upper limit for the interview period, however, has been set as three months due to practical considerations.

2. In the course of the interview, you will be asked to suggest a particular piece of music, poem, song, movie, book etc that you have found “speaks to you” about your experience (although this is not a requirement for participation). The reason for asking
this question is to gain a broader sense of what is important to you beyond the diagnostic label.

3. Once the interview is completed you will be asked to reread the email exchange to make sure you are happy with your comments and to give you the opportunity to clarify or change anything you are dissatisfied with.

**POTENTIAL RISKS AND DISCOMFORTS**

It is not the intention of this research to uncover or trigger any painful or traumatic memories. Whilst the utmost care will be taken during the interview, and disclosing information that leads you to feel unsafe or distressed is not what the study aims to do, having a support network in place is essential in the event that distress is caused inadvertently as a result of taking part.

You are free to end your participation at any point and are under no obligation to answer any question if you are unhappy to do so. Having stated the above, it is anticipated that risks, discomforts, or inconveniences arising as a result of participation will be minor. To reiterate though, if discomforts become a problem, you may discontinue your participation at any time.

Please also note that whilst each email service employs their own security measures, no email service is 100% secure if an unauthorised individual is determined to hack into your account. The risk of hacking occurring is judged to be remote due to the research project not eliciting information that would be of use for criminal ends. If you have concerns over email security, please look up security information in relation to your personal email service. The researcher’s email service is ‘1&1 Webmailer 2.0’.

**POTENTIAL BENEFITS OF THE RESEARCH**

The research aims to improve the quality and sensitivity of services catering for individuals with a diagnosis of BPD in relation to risk management. It is hoped that by participating, you will be interested in the topic and become aware of some of the difficulties and negative effects relating to the ways in which psychiatric services think about risk.

**PAYMENT FOR PARTICIPATION**

You will not receive any payment or other compensation for participation in this study. Aside from your time, there is no cost to you for your participation.

**CONFIDENTIALITY**
Any information that is obtained in connection with this study and that can be identified with you will remain confidential. Disclosures of confidential information would only occur in the event of a significant risk to public safety being disclosed, as required by law. Confidentiality will be maintained by means of pseudonyms in the analysis and final report. Having printed the interviews with pseudonyms in place of your name, the emails will be deleted (with the ‘hard copies’ being stored for 5 years in a locked cabinet after which time they will be destroyed).

Information that can identify you individually will not be released to anyone outside the study although Dr. Graham Stew and Dr Kay Aranda will have access to the anonymised interviews as required by their supervisory role. Michael will use the anonymised information collected during the interviews in his thesis and other publications. Any information used for publication will not identify you individually.

Not all information gathered during the interview will be used in the final thesis report as some will not be of relevance to the aim of the research. The report will identify general themes across all the interviews and use anonymised quotes to illustrate them.

PARTICIPATION AND WITHDRAWAL

You can choose whether or not to take part in this study. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions that you do not want to answer. There is no penalty if you withdraw from the study and you will not lose any benefits to which you are otherwise entitled. The researcher may withdraw you from this research he deems it to be causing you undue distress.

IDENTIFICATION OF INVESTIGATOR

If you have any questions or concerns about the research, please feel free to contact Michael Huggett (Faculty for Health and Social Care, University of Brighton)

EMAIL: michaeljhuggett@riskidentity.com

RIGHTS OF RESEARCH SUBJECTS

The University of Brighton’s research ethics committee has reviewed my request to conduct this project. If you have any concerns about your rights in relation to this study, please contact Prof Julie Scholes, chair of FREGC (CNMR, Mayfield House 263, University of Brighton, Falmer, Brighton BN1 9PH, tel 01273 644078 (j.scholes@brighton.ac.uk).
I understand the procedures described above. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

________________________________________  _________________________
Printed Name of Participant      Date

________________________________________  _________________________
Signature of Participant      Date
Appendix 7 – ETHICS APPROVAL

Dear Mr. Huggett:

I am pleased to inform you that your application entitled "The negotiation of risk identity by individuals diagnosed with Borderline Personality Disorder (BPD)." has been approved by the Faculty of Health and Social Science Research Ethics and Governance Committee. The comments of the reviewer(s) who reviewed your manuscript are included at the foot of this letter.

Please notify The Chair of FREGC immediately if you experience an adverse incident whilst undertaking the research or if you need to make amendments to the original application.

We shall shortly issue letters of sponsorship and insurance for appropriate external agencies as necessary.

We wish you well with your research. Please remember to send annual updates on the progress of your research or an end of study summary of your research.

Sincerely,

Prof. Julie Scholes
CHAir, Faculty of Health and Social Science Research Ethics and Governance Committee
J.Scholes@brighton.ac.uk

Reviewer(s)' Comments to Author:
Reviewer: 1
Comments to the Applicant
This is an extremely well thought through and well-written proposal. Well done and good luck.

Reviewer: 2
Comments to the Applicant
Overall this is a strong ethics submission for an interesting and worthwhile piece of research. Great care has been taken as regards issues of ethics and risk. Although I don't share the researcher's sense of certainty that the procedure in place will be able to discern acute from non-acute BPD participants, I think that the procedure is as robust as possible with regard to attempting to ensure the use of participants in the recovery phase.
There also needs to be a separate information sheet and consent form.
Appendix 8 – Example of interview text (Susan extract)

From: "Michael Huggett" <michaeljhuggett@riskidentity.com>
To: Susan
Sent: 15/03/2012 14:41

Hi Susan,

Thanks for sending your consent form back (it arrived this morning). If it's okay with you, I'd like to start the interview today as I'm currently on annual leave at the moment so have a little extra time (I realise you probably busier than me so reply when you get some spare time).

As I indicated on the website, I'd like to get the ball rolling by asking for your general thoughts, feelings, beliefs etc, around the BPD diagnosis itself. Feel free to take as much time as you need and don't feel pressured to give a complete exhaustive account (we can explore themes that arise down the line).

All the best and look forward to hearing from you.

Michael

From: Susan
To: "Michael Huggett" <michaeljhuggett@riskidentity.com>
Received: 15/03/2012 20:39

Hi Michael,

That's fine. I will probably email at evening / later at night times as the kids are (sort of) out the way by then.

Well, I never actually was even given the news to my face that I had BPD, I happened to read it on one of my very first care plans way back in around 1996. The list had a few of my problems, such as major depressive disorder, generalised anxiety disorder, social phobia, OCD...which was no surprise to me and I knew plenty about, (Not to sound crude, but basically 'no shit, Sherlock') but then right at the bottom in bold letters they had added what we know as BPD.

You can only imagine the feeling seeing the word 'personality disorder' without being fully briefed on it's true meaning. As it does now, sometimes BPD is referred to by it's alternative name Emotionally unstable personality disorder. So that was what I saw in black and white. My first thought was that it was a very negative sounding syndrome. Personality disorder seems..well..to risk sounding ironic..so PERSONAL. I think I kind of took it as a slur against my being, if you catch my drift, like my personality/ who I was , was flawed. I also felt it seemed quite a dismissive diagois, you know - this person has a personality problem, end of. I knew nothing about the condition and being such a 'sensitive' insecure , paranoid person at the time, it screamed FAILURE!!!! To me.
I can't remember if I asked about it in detail to my CPN (community psychiatrist nurse, now known as 'care providers' or 'care support workers') but as she was lovely I may have discussed it at the time. All I know is that for a basically unshockable person who has seen plenty in life, I was genuinely a bit shocked and perturbed.

Being a person who likes to read a lot, it's the best way to lose yourself, separate from your surroundings etc, as well as there's nothing like a bit of knowledge and self empowerment, I briefly researched into it. I never had a PC or anything then so mostly went to the library or read books in bookshops, plus my CPN had sound knowledge of BPD and provided me with some good feedback, info and printouts. I did this more so to see why I had been given this diagnosis, what made the practitioners decide that I had BPD, what BPD actually was...that kind of thing.

Once I looked at it, I immediately identified with much that was said and the symptoms described, so much so that I did feel a slight relief at thinking that I was not the only person to feel the way I did. I had always had such a deep self loathing and utter hopelessness about the way I thought, looked and felt, that being told 'you have a disorder, it is a real existing condition, it is not just you being YOU' was slightly comforting, in a slightly desperate way. I knew about manic depression and OCD due to my family history, but to the untrained eye, the word personality disorder brings you straight to the thought of schizophrenic type illnesses or people with 'multiple' personality syndrome. It is actually difficult to describe because on one hand, I feel BPD sounds deadly serious, but on the other I don't think it is treated seriously enough.

I had a very chaotic dysfunctional childhood. So at the time of my first diagnosis, when I read up on BPD, I was brought to the belief that it was purely my upbringing and certain circumstances i.e. childhood abuse that had made me 'weird'. That, coupled with being a fairly new mother myself and thinking how I could never hurt my own child, made me start to feel immense anger and some bitterness towards my parents. Although they were not the only ones to cause me pain during my childhood/formative years, I must say I did feel some strong resentment. I suddenly felt that maybe I COULD have been someone 'normal' after all, that it wasn't just the way I was born. I had always accepted my upbringing because you think that is how everyone is or that is how life just is, you accept your fate. It is only when you mix with other people or families, or have your own children and you grow up that you question your upbringing more.

At no point during my initial diagnosis did I feel any hope of recovery, or was given any hope of recovery. The general consensus was you had it for life and could only learn to manage your condition. I had no idea at the time of the stigma and disdain bestowed upon the disorder and its sufferers by the medical
profession / general public. That was something I was to find out for myself. I also was not aware of the genetic disposition of BPD, if I was to have know I think it would have destroyed me with worry that my children could end up as sufferers.

Hope this starts you off ok. Anything else just ask. Honestly it's not a bother, if I felt unwell or stressed out I would let you know, I'm old hat at talking about mental illness and if I was on one you would soon know.

All the best, Susan

PS I hope you're not a grammar, spelling or punctuation nazi as I may talk the talk but the fine tuning just escapes me

From: Susan
To: "Michael Huggett" <michaeljhuggett@riskidentity.com>
Received: 16/03/2012 13:26

hi michael, just realised i only sent you my thoughts on my own bpd diagnosis, not what i thought of the diagnosis itself, Durrerrr. I'll elaborate on that later / whenever, sorry! Susan

From: "Michael Huggett" <michaeljhuggett@riskidentity.com>
To: Susan
Sent: 16/03/2012 14:53

Hi Susan,

No worries, either topic is a good place to start. What you've sent is a great and provides several areas we can explore (as for grammar and spelling, I'm hopeless in both these areas so please don't feel self-conscious as you're in good company :-().

As a way forward, what I've found useful in the past is for me to summarise the responses to my questions to ensure I've got the gist and to add comments/ask questions etc in brackets as I go (please feel free to correct any errors I may make along the way). It may sound a little repetitive to start with but it's important to me that I get a sense of where you sit in regard to the diagnosis and that you have a chance to correcting me if I go 'off beam'.

You begin by telling me how you came across the diagnosis in one of your care plans rather than being told upfront by a mental health professional (this appears to be rather a common occurrence sadly) and go on to write about the feelings that the term 'personality disorder' raised having not been properly briefed beforehand (you make the point that the diagnosis was of 'emotionally unstable personality disorder' rather than BPD however we understand that they are pretty much refer to the same thing).

You state that your first thought was of how negative and personal it sounded, like a "...slur against my being" (that's a great phrase btw); like it was your very being that was flawed. You also speak of how dismissive it sounded and how it seemed to scream failure to you. You go on to explain that it left you feeling shocked and
perturbed and describe a period of researching into the diagnosis using libraries, bookshops and your then CPN in order to understand why such a label had been given to you and what it actually was.

You describe how this research resulted in a sense of identification of the symptoms described and note a "slight relief" at discovering that you were not alone in feeling as you did. You clarify this 'slightly desperate' comfort by describing how your deep self loathing and sense of hopelessness about yourself was eased somewhat by the notion that this wasn't particular to simply 'you being you' but that it was a real existing condition.

You explain how you had a good knowledge of conditions such as manic depression and OCD due to your family history however note that the term ‘personality disorder’, to the layman' leads to thoughts of schizophrenic of multiple personality disorder. You make the interesting observations that the term 'BPD' evokes a deadly serious condition which, ironically, isn't treated seriously enough (I hope to hear more about this later).

You go on to expand on the initial sense of relief stemming from your research into the diagnosis by noting that it placed the cause of your distress as the abusive circumstances of your childhood and describe how your own experiences of being a mother resulted in immense anger and some bitterness towards your parents. You move on to mention feelings of resentfulness over the sense that you could have been 'normal' had your circumstances been different and link this realisation to learning about how things might have been though having your own family and mixing/talking to others.

Returning to the time of your initial diagnosis, you make the point that you were given no sense of hope or recovery, the general impression given being that you had this condition for life and could only make the best of things by learning to manage the distress it brought. It sounds like your awareness of the stigma and distain the diagnosis can evoke in professionals and the public around the BPD diagnosis was learnt after the diagnosis through your own experience and also mention that you have become aware of the genetic component to BPD since your initial period of research, stating that, had you been aware of this at the time, this knowledge would have destroyed you as a new mother.

Thank you for giving such a honest and detailed account of your experiences being diagnosed with BPD. I get the impression that, after the initial brief sense of 'slightly desperate' relief you experienced having researched into the area, you then experienced a number of difficulties living with the diagnosis (I’m thinking here of you comments about BPD not being taken seriously enough and about your developing awareness of the stigma and distain by professionals and the general public). Perhaps you could tell me a little about this experience and about how you feel about the diagnosis today?

I look forward to your next email.

Best wishes

Michael

From: Susan
To: "Michael Huggett" <michaeljhuggett@riskidentity.com>
Received: 18/03/2012 02:15

Hiya Michael.

That's all good. You got my gist and I agree with your relayed feedback.
Well, about my stigma comment...

Put it this way - I would happily and without care wear a sign upon my head displaying my varies mental illnesses when appropriate i.e bi-polar. OCD anxiety disorder. PTSD. I’m a blunt and down to earth east Londoner with a passionate belief in bringing mental illness out into the open. But when it comes to the Bpd bit, I can only describe sort of mentioning it in an afterthought way... Like a coughed joke... Cough cough bpd ahem shhhhh....

I can say however, that I was never, ever self conscious about my diagnosis until I started getting this odd vibe from professionals in the mental health field, around 4 years ago... then when I did some digging (i.e. joined a few online support forums etc) I found out that even some mental health forums look down on bpd - the belief being it’s not a physical, mental illness such as bi-polar, but purely from ones personality and sense of self. So it becomes a grey area, shunned by the mentally ill and doctors alike!

Here is an example- it may seem long winded at first but I have to set the scene for you to understand the scenario.

During my last hospital stay in a mental health unit, I was used to getting up around 6am because that’s when the bathroom is clean and nobody has used it yet. To use the bath you have to ask a member of staff to unlock the door and provide you with a plug, for safety reasons. They will then knock on the door every 10 minutes and call out to see if you are okay. I.e not drowned yourself in 2 inches of regulation bath water or suffocated on a paper towel.

So one morning I crept up the hallway to the work station of the support staff. It was an office with a glass front. The door was open as the night staff were ready to start change over with the day staff. There were 3 members of staff tapping away on the pc's doing the night observation reports. Now being quite a shy anxiousy person, especially when I’m Ill, it takes me ages to pluck up the courage to knock on the door or bother anyone - I hate confrontation and I hate attention. I don't like to put people out. So I hesitated before I knocked and sort of shuffled from one foot to the other getting the guts to tap in the glass window. As I approached I heard them discussing the woman in my ward who had come in after a massive wrist slashing episode. This is what I heard -

Staff 1- well, yes shes had a better night but you know the borderlines... What's the point. It will just carry on. They can't stay in hospital forever. Just until next time. We can only patch the wounds- they're their worst enemy

Staff 2- god yeah.... They say every doc has to take on their fair share of the bpd's... It's just they're so DRAINING. I know it's difficult but you have to be careful of the manipulation, very sneaky, they're good t twisting it.
Staff 3- mmmm and you know every emotion is so exaggerated. Very over sensitive. I mean we have to be careful or they will be encouraging each other ..with the harming you know.

I felt so embarrassed as I knocked on the window - the staff were like oh Susan why do you get up so early lol, we are trying to do our paperwork... Sigh... No rest here! Can't get anything done. Blah blah while all the time I felt my face burning.

I sat in that bath feeling really quite gutted. I thought " that's what they think underneath... That all borderlines are manipulative, sly, needy non treatable pain in the arses. Great."

This was confirmed with the list of support in place for bpd's in the hospital - talk therapy and mindfulness-the belief being borderlines love to air their over emotional thoughts and need that audience too.

I thought - they think im putting it on...they really have a shitty look on bpd....I'm getting out of here and this is simply how I got released early -

I blamed my suicidal thoughts and hospitalisation on my Bpd.

Please note that when they thought ( quite rightly I might add, but I wanted to go home as felt so self conscious so I convinced myself that i wasnt as ill as i thought) that I was having a bi polar low and reaction to new meds.( I was). The solution was longer in hospital and heavier anti - psychotics / mood stabilisers. Basically, If you don't take the meds offered you are down as refusing treatment. this can lead to you being sectioned or kept longer and forced to take meds. You have meetings and you can cajole beg plead moan shout cry all you like but what doc and team says goes. UNLESS you blame it on a bpd mood swing. Then they're all like ohhhhh I see. Any suicidal thoughts? You say no, they see what meds to stop or tweak, you pretend you're all better and it was a typical glitch and that's where I suppose manipulation comes in handy - if you know your stuff well enough you can pull a few fast ones like that. I'm not proud but I had 3 kids at home and I felt worse being in hospital. From being told I would be a few weeks in hospital and on heavy doses of lithium and seroquel etc I wangled it down to some anxiety meds and an anti depressant ! I'm ashamed of the bpd diagnosis now as this is what is assumed by most people -

You love attention, thriving on it even if negative.

You self harm

You have half hearted attention seeking suicide attempts. Or just loads of
unsuccessful cry for help suicide attempts.

You lie. A lot.

You are needy

You blame everyone else for your problems and have imaginary unfounded fears of rejection. Which causes you to be clingy and suffocating.

You are so fearful of abandonment that you practically hang onto peoples trouser legs saying dont leave meee please Or stalk your docs and workers and get too close and reliant on them.

Your way of thinking is the problem , not physical illness or even a mental illness - it's a thought pattern that needs adjusting and you're causing your harm as you think 'wrongly"

Whilst ive been guilty of a few over the years, I do none of the above - And I've met other bpd's who don't fit the whole stereotypical criteria.

The bi-Polars a doddle to explain as your average Joe public will say awww it's not your fault, you're ill And as well lots of famous people have it don't they .

But personality disorder?

Eyuww, you've got Problems and they're All self induced in your mind so you need to be taught to think " proper " and to get a grip on your out of control rampaging emotions. Calm down. Chill out. Do some yoga.

That's my first explanation , hope it's clear enough, I do ramble a bit but I have to get the whole picture in. Will do some more another time.

All the best

Susan

Sent from my iPad

From: "Michael Huggett" <michaeljhuggett@riskidentity.com>
To: Susan
Sent: 18/03/2012 14:36

Hi Susan,

Many thanks for your email around the issue of stigma and BPD (I didn't feel you were rambling one bit).

You very clearly state that it was your experiences interacting with professionals that led you to feel self-conscious about BPD, a self-consciousness that is specific to this diagnosis as you are more than happy to
acknowledge other diagnoses such as bi-polar, OCD, anxiety etc in the spirit of frank talking about mental illness. You also note that this negative attitude towards BPD is also evident in some BPD forums which suggests that it’s shunned by other professionals and service users alike and suggest that part of the problem lies in BPD not being viewed as a physical mental illness like others but as a problem with ones self/personality (I realise not everyone is happy with the term ‘service user’ and I’m happy to substitute any term you would prefer here).

You provide a great example drawn from your last hospital stay of the kinds of attitudes and beliefs found amongst some, possibly the majority (?) mental health professionals in regard to BPD and note your embarrassment and recollection of thinking "that's what they think underneath... That all borderlines are manipulative, sly, needy non treatable pain in the arses..." (In the spirit of mutual disclosure, if I’ve not already informed you, I’m a mental health nurse by profession that specialises in women’s mental health and well aware of the kinds of attitudes/beliefs that some professionals and service users hold around the BPD diagnosis. I mention this in order to be upfront and hope it doesn’t curb your sense of being free to speak you mind).

You move on to note how the types of therapy on offer in hospitals contributes to the perception of those with a diagnosis of BPD as being needing of an audience to air their over emotional thoughts, i.e., talk therapy, mindfulness etc (this is a really interesting point for me!)and note how you thought that the professionals around you perceived you, and others with the diagnosis, as ‘putting it on’ and that this resulted in your successful efforts to get released early by downplaying (both to yourself and to the professionals) the bi-polar low/new medication issue and instead painting the picture that your difficulties were down to a BPD mood swing. Within this description, you also point out that immense power held by psychiatric professionals and the tendency for them to view choosing not to take the medication on offer as refusing medication (I'm assuming that you view this last observation as contributing to the image of those with a BPD diagnosis as ‘difficult patients’). You also reflect that manipulation in this sense, i.e. of the system, can come in handy given the situations you describe on the wards and that, whilst you weren’t proud of your actions, hospital was making you feel worse and you had three children to get back to (I hope I’ve captured your main points here). You successfully reduced the planned three week admission on high doses of lithium and quetiapine down to an anxiolytic and an antidepressant by blaming BPD for your suicidal feelings and hospital admission.

You note feeling ashamed of the BPD diagnosis due to the negative assumptions you list, i.e. attention seeking, self-harming, ‘cry for help’, suicide attempts, dishonesty, needy, blaming others for difficulties, fear of abandonment, disordered thinking. You note how this stereotypical image fails to fit either you or others with a BPD diagnosis you have met and contrast this image of BPD/personality disorder with diagnoses such as bi-polar which is attributed to an underlying physical condition rather than a problem with the self/personality, i.e. "...you've got Problems and they're All self induced in your mind so you need to be taught to think " proper " and to get a grip on your out of control rampaging emotions. Calm down. Chill out. Do some yoga”.

Great stuff!

There are lots of interesting points we can pursue however you mention at the end of the email that you may have some more to add so please feel free to do so when you have time (I feel I’m building a good picture of how you stand on the diagnosis and of the negative consequences you’ve experienced, much of which was due to the professionals charged with your care). In terms of your sense of identity, unlike your other diagnoses, it sounds like you try to distance yourself as much as possible from BPD due to all the negative features you highlight, many of which stem from your experience of mental health professionals. Whilst I’m
sure you will have more to say on this, I thought I might raise the notion of risk and risk management given your experiences of being in hospital with all that that entails (i.e. 2 inches of bath water, observations etc). I’d like to ask for your thoughts on the common belief held by professionals that people with a diagnosis of BPD are ‘risky’ patients.

Please let me know if you find my questions a little too vague. I don’t want to ‘close down’ any potential avenues of exploration by asking anything too specific at this stage (at least that’s my excuse ;)).

Many thanks again and I look forward to your next email.

I hope you’re having a lovely mothering Sunday.

Best wishes

Michael
Appendix 9 – Example section of Microsoft Word document identifying initial themes within the texts (Susan).

Susan

BPD

BPD (PD) – Negative - Personality Disorder as so ‘personal’/ ‘slur against my being’/ ‘fundamentally flawed’
BPD – Negative - as dismissive diagnosis/screamed FAILURE
BPD - Paradox sounding deadly serious but not treated seriously enough
BPD - As the result of trauma (dysfunctional/child sexual abuse)
BPD – stigma and shame
BPD – Nature vs. nurture - genetic disposition and trauma
BPD - Nature vs. nurture - BPD or crappy life?
BPD – others assumptions
BPD - Blaming suicidal thoughts and hospitalisation on BPD
BPD - Ashamed of diagnosis due to other’s assumptions
BPD - Ashamed of BPD diagnosis due to other’s assumptions – attention seeking
BPD - Ashamed of BPD diagnosis due to other’s assumptions – self harm
BPD - Ashamed of BPD diagnosis due to other’s assumptions – attention seeking suicide attempts/cry for help
BPD - Ashamed of BPD diagnosis due to other’s assumptions – lying
BPD - Ashamed of BPD diagnosis due to other’s assumptions – neediness
BPD - Ashamed of BPD diagnosis due to other’s assumptions – blaming others & imaginary fears of rejection = clingy & suffocating
BPD - Ashamed of BPD diagnosis due to other’s assumptions – fearful of abandonment/dependent/stalking professionals
BPD - Ashamed of BPD diagnosis due to other’s assumptions – not mental illness but how you think/you think wrongly
BPD - Not fitting stereotype of BPD
BPD – feeling a burden/failure
BPD – Living with... suffering/pain/exhaustion
BPD - Not self-obsessed/saw kids as better off without her as don’t want negatively affect
them
BPD – BPD patients viewed by Drs as challenging/repeated use of services/lost
cause/waste of resources/boring
BPD – therapeutic nihilism
BPD - as post-traumatic stress disorder
BPD - being downgraded as something you can manage/grow out of
BPD - suffers as slipper wearing/confused poor souls
BPD - Manipulative
BPD – Manipulative - BPD sufferers as very self-aware > viewed as manipulative
BPD – Invalidation - Borderlines knowing they feel differently to other but nobody
believing this is possible
BPD – cannot control emotions
BPD – ‘it’s the way we are’/no one can help/looked down on
BPD - flight – screaming thoughts/emotions run amok/need to shut up, withdraw, run
BPD – presenting as good when planning your death
BPD – Neediness - Ironic experience of those with BPD disliking others with BPD due to
neediness/same reasons other dislike BPD sufferers ;)

Risk
Risk - Professionals belief that BPD sufferer is long term risk to self
Risk – greatest risk stemming from being unwell/paranoia and projection of feelings onto
others

BPD & Risk
BPD & Risk – positive identification/due to mood swings
BPD & Risk – Risk to selves/not so much others (risks that infringe on others)
BPD & Risk – Risk to others

Identity
Identity – down to earth East Londoner/wants to bring mental illness out in the
open/being ‘mental’ ;)/struggler against the unjust
Identity - Ambitions - Would have liked to be a mental health nurse
Identity - Apologies for tangent/Wolfie Smith at times ;)

303
Identity - Reclaiming the term ‘mental’/mental the new gay/addressing pejorative use in schools/I fully claim back the term ‘nutter’

BPD & Identity
BPD & Identity - Past identification
BPD & Identity - Present Identification
BPD & Identity - Present non-identification

Story of...
Story of being diagnosed - reading of diagnosis via seeing it on a care plan
Story of being diagnosed - BPD in contrast to known diagnoses
Story of getting to know about diagnosis - researching diagnosis/self-empowerment
Story of being diagnosed – relief at having an answer - a real existing condition
Story of childhood
Story of sexual abuse
Story of motherhood
Story of family
Story of parents/upbringing - Resenting ones parents/upbringing
Story of becoming conscious about negative diagnosis of BPD - via treatment from professionals and the mentally ill (via forums)/anecdote/treatments
Story of admission - Cause of admission being low mood/observations (monitored until deemed less risky or they can’t be arsed)
Story of being an inpatient
Story of being an inpatient - Medication - Having to comply with Dr and MH team, i.e. take the meds and blame on BPD mood swing or kept on section/increased admission time
Story of being an inpatient - Pretending to be better to end stay
Story of identity – lack of in relation to growing up amongst West Indian families/wanting what they had
Story of never feeling loved
Story of never being really happy/afraid to enjoy
Story of past fear of rejection and ridicule
Story of school - academically gifted but refused to participate

Professionals
Professionals - think service users don’t help themselves/don’t want to be helped
Professionals - Disjunction between weight of suffering and facile advice from professionals
Professionals - Therapists want light bulb moment

**Services**

Services - Failure/inadequacy of services
Services - The system stinks/passing daughter about/filling out paperwork

**Self-loathing**

Self-loathing - Feeling of loathing/ hating self

**Feeling pressured by others**

Feeling pressured by others -Telephone calls/too disconcerting/pressure
Feeling pressured by others -Negative experiences of counsellors/receptionists (arseholes)

**Mental illness and awareness of/insight**

Mental illness and awareness of/insight - Old adage/mental ill > no insight
Feeling pressured by others -Confrontation/bills etc. putting things off even when urgent and torturous/avoidance

**Groups**

Groups - BPD groups stressing drain on others/doesn’t help

**Normality**

Normality - Learning to question the ‘normality’ of ones childhood through comparing to others

**BPD & Gender**

BPD & Gender – diagnosed in women more than men/attitudes to women in general medical practice/sexism

**Recovery**

Recovery - Hope and recovery (lack of)
Recovery – Professionals - BPD as boring to professionals/no epiphany or finally getting it

**Coping**

Coping - Getting on with life/just managing
Coping - BPD better with age as bollocks/just learning to put up with it
Coping - No solution or help, just survival
Suicide
Suicide – BPD - Boy that cried wolf re suicide/false alarms
Suicide – often attributed to unnoticed cry for help
Suicide – often attributed to DSH accident
Suicide – often attributed to BPD sufferer hell bent on self-destruction

DSH
DSH – suicide/not about anger but attempt to silence thoughts

On being pathologised
On being pathologised - aggressive way of being/speaking

Aggression
Aggression – In context of upbringing/environment -Having to show tough exterior to survive environment/anxious on inside
Aggression - Agitation mistaken for aggression/extreme sensitivity to stimuli/examples
Aggression - aimed at selves/born of frustration and despair

Anger
Anger – gets very angry (0-60) ashamed to have injured ex-husband

Mental health sufferers
Mental health sufferers -Many mental health sufferers know why they are the way they are

On therapies
On therapies - Talking therapy (despondent about)/condescension

Confirms meaning for researcher
Confirms meaning for researcher - Confirms meaning of ‘?’/not stereotyped stalker after free advice

Public perceptions of mental health/PD
Public perceptions of mental health/PD - personality disorder and aggression /suicide

Communicating distress
Communicating distress – Accessing services - getting more help by presenting as distressed than if stating seriously ‘I do not feel right’

Accessing services
Medication
Medication - resenting use of
**Researcher Identity (as nurse)**

Researcher Identity (as nurse) - able to understand issues/scenarios

**Taking part in project**

Taking part in project - Needing to end participation as becoming unwell due to use of medication

**Recommendations**

Recommendations – need something to help cope with being me/too much for myself/real life experience of helper not academic qualifications

Recommendations - Recommends QE2 unit

**Music/songs**

Music/songs - can trigger intense feelings and get her thinking/bi-polar
<table>
<thead>
<tr>
<th>RISK &amp; IDENTITY</th>
<th>Risk &amp; Identity</th>
<th>Risk &amp; Identity - Past identification</th>
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<td></td>
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<td>I suppose the behaviours I engaged in that would come under that would be reckless driving (I would shut my eyes/take my hands off the wheel etc.) and starvation (not sure if that counts). Occasionally, like with the driving, the dangerous behaviours were very impulsive and, in some cases, compulsive. I couldn't stop myself, it was an urge I had to close my eyes and I couldn't fight it. One minute I could be driving, not even feeling that emotionally unstable or dissociated, and then the next second my hands are off the wheel or my eyes are shut. The same thing would happen with eating (although obviously it's harder to be impulsive); I never binged but I would sometimes purge, and that only ever happened in a very impulsive way. and I used it to give me permission in order to act in certain ways. It made me feel as if I were allowed to act like that because I had been given this diagnosis which told me I was risky and extreme and unstable, so I didn't fight it as much because I was 'legitimately crazy.' Although I was obviously reckless before the diagnosis too, until I was willing to begin to consider to recover from BPD, the diagnosis did act as some kind of security blanket, like a buffer, which almost allowed me to be reckless without</td>
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consideration because it was 'allowed' due to being 'sick.'

It… excused any behaviour which had gone before the diagnosis for the same reason - I couldn't help my behaviour because I was legitimately ill, and it meant that I was weak and couldn't stop myself from giving into these thoughts and feelings.

I just think that I had trouble seeing the danger myself in the behaviours I was engaging in. Like when I would shut my eyes while driving, or I would starve myself and almost pass out, I never saw those as dangerous behaviours in the way that other people did. The worry they expressed seemed greater than necessary.

Looking at it now I can view it more objectively and see that they were extremely risky behaviours in some cases,

But things like that would happen before I was diagnosed with BPD, so it wasn't the diagnosis that made me act like that. But once I had been diagnosed I did use it to give me 'permission' to act in increasingly riskier ways, if that makes sense.

As someone "with BPD", whenever I had those kinds of thoughts, whatever followed was a "fait-accomplis", was what was expected of me, was who I thought I was. An urge would arise and it would remind me that I was ill/disordered/crazy/broken, and to cut/overdose/try and hang myself was the only thing that made sense to do.
If an urge arose and I didn't act on it, it would cause some painful and confusing cognitive dissonance - I'm supposed to be someone who hates herself, doesn't respect herself, needs to be punished, can't "ground" herself in the present, can't bear her own feelings etc etc, so how can I then not hurt myself, not follow through with the act itself? It would be like being given a script to read in a play but then casting it aside and improvising instead - unheard of, doesn't add up, doesn't make sense –

Risk & Identity - Past non-identification

I never really believed that my behaviour was that 'risky.'

I just think that I had trouble seeing the danger myself in the behaviours I was engaging in. Like when I would shut my eyes while driving, or I would starve myself and almost pass out, I never saw those as dangerous behaviours in the way that other people did. The worry they expressed seemed greater than necessary.

They never seemed bad enough to me for them to be counted towards a BPD diagnosis.

but yes, I did sometimes feel that when I read things online about BPD, how people would be promiscuous and gamble and drink heavily, I did feel that my 'risky' behaviours weren't all that bad compared to other people,

I didn't feel that my anger was displayed in a way that warranted a diagnosis, as I was conforming to the stereotype of how women are 'required' to internalise their anger.
after a lot of therapy I've sort of come to realise that I am actually quite an angry person [it’s] internalised… I take it out on myself. So I'm not sure if that counts

In terms of the diagnosis feeding into the recklessness… for me, it is more in terms of the diagnosis 'giving me permission' to be reckless, so I suppose in that sense it does feed into it.

It is almost as if the 'non-bpd' part of me is very cautious and scared to take risks, but the BPD part of me will throw itself into risky situations only if they are self-damaging.

it might just be that any time I take a risk I view it as negative, even if it is in fact positive, because of my relationship with risk when I'm feeling like I'm in a bad place.

I suppose because of our mood swings we ARE a constant risk? But you cannot live in a hospital forever so

I definitely think borderlines are a risk to themselves, but not so much others, except I suppose if the risks they take infringe /impact on another persons safety, but rarely would I be afraid of a fellow bpd.

- I don't want to hurt anyone... My anger, hatred, frustration and anguish consume me from within. My bark is worse than my bite towards others - leave me alone and you will be safe, although I might not be.

I think the greatest risks I have shown to others would be when I am very unwell and I may project my own paranoia and feelings onto the
other person i.e. "You think I'm mad...you think I'm sick...I know what you think - that I'm a burden and blah blah blah blah.....I'm ugly......"
I don't believe I am a risk to others around me however I do sometimes feel a risk to myself which is when I call for help. I don't feel my life is in danger currently although it has been in the past.

Risk & Identity - Present non-identification
I never lose my temper, I hate conflict [anger criteria].
I am much too scared [of taking risks when ‘rational’] and the cost seems too high, it almost makes me feel more out of control than when I engage in the negative risks associated with my BPD.

To be honest, this might sound a little strange, but when it comes to things like positive risky activities I am quite a risk-averse person.

it might just be that any time I take a risk I view it as negative, even if it is in fact positive, because of my relationship with risk when I'm feeling like I'm in a bad place.

Risk to me equals being out of control, and so when I am feeling rational and I'm not engaging in BPD behaviours, taking risks, whether positive or negative, seems to be counter-productive.

But when I am feeling more rational I hate taking risks, even if they are positive ones.
<table>
<thead>
<tr>
<th><strong>Risk &amp; Identity - Having been known to engage in risky behaviour</strong></th>
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<tr>
<td>But I think they were scared. I had attempted suicide, I was known to them, i.e. I had known risky behaviour,</td>
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