

Chapter 7

DISORDERED BOUNDARIES? A CRITIQUE OF 'BORDERLINE PERSONALITY DISORDER'

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In this chapter, I discuss the diagnosis of 'Borderline Personality Disorder' (BPD) and how it has been used to diagnose predominantly young women who self-injure and often who have survived abuse. 'Women at the Margins' is an activist group that is concerned about how the diagnosis of BPD pathologises and stigmatises women who struggle to survive experiences of abuse and oppression. The group put together a special edition of *Asylum* magazine on this issue which I co-edited (Shaw & Proctor, 2004). This chapter draws on some of the stories that women contributed to this issue. I discuss the implications of this diagnosis for young women who self-harm. I further discuss the reaction of mental health services to women given this diagnosis with particular reference to the notion of 'boundaries' and suggest that services often work to further stigmatise and take power away from young women. Instead I will suggest how mental health services could more usefully work to support young women and help them regain power over their own lives.

DIAGNOSIS

Like all psychiatric labels, BPD depends upon the practice of diagnosis. This practice, which is fundamental to psychiatry, is based on the assumption that mental illnesses exist in the same way that physical illnesses can be said to exist. It assumes that these 'diseases' can be identified and categorised as such by the mental health professional. This process is assumed to be scientific in the strictest sense of the word—based upon 'the accurate naming of an objective disease process' (Bracken & Thomas, 2000). Yet there is no physical test which can establish the presence of mental illness or disorder. Therefore diagnosis in mental health relies on the professional making observations and judgements about how a patient behaves, and about the thoughts and opinions she/he expresses.

Many psychiatrists suggest that mental 'illnesses' (such as 'depression' or 'schizophrenia') are caused by physical conditions such as chemical imbalances

or faulty genes. Yet there is a large body of evidence and opinion which suggests that these ‘illnesses’ in fact result from experiences—the kind of lives we have had, the things that have happened to us, and the context of our lives now. Although people from both approaches produce evidence to support their beliefs—pointing to, for example, the prevalence of certain illnesses within one family; or to the large numbers of people in the mental health system who have had traumatic experiences—there is no absolute proof for either approach. Most of the evidence used to argue for biological causes could equally point to environmental causes, as nearly always, people who share genes also share environments (Joseph, 2003).

There is even more lack of clarity in psychiatry about the ‘causes’ of personality disorders. Mainstream organisations—such as Borderline UK (www.borderlineuk.co.uk)—suggest an amalgam of multiple approaches—that BPD may be the result of traumatic experiences and disordered thought processes, combined with a pre-existing genetic predisposition towards the disorder. This bio-psychosocial model is increasingly popular, yet often involves an emphasis on biological causes and treatments. With a body of confusingly competing ideas it is easy for authorities to pick on whatever suits whatever political aim they have at any given time. This is confirmed by a brief look at BPD-related sites on the Internet which overwhelmingly indicate that US-based research is focused on discovering physical causes for the disorder, and then finding medication to treat it.

WHAT DOES BPD MEAN AND WHERE DOES IT COME FROM?

The term ‘borderline’ was first used by analyst Adolf Stern in 1938 to describe patients who he believed were more disturbed than ‘neurotic’ patients but who, he believed, were not ‘psychotic’. However, it was not until 1980 that BPD was first introduced as a diagnosable personality disorder in America. Now BPD is by far the most common PD diagnosis: one of ten personality disorders currently classified by the psychiatric classification system (DSM-IV). Self-injury is one of the primary diagnostic criteria of BPD. For a diagnosis of borderline personality disorder, five of the following ‘symptoms’ must be present (American Psychiatric Association, 1994).

- Unstable and impulsive
- Intense interpersonal relationships verging between idealisation and devaluation
- Affective instability and reactivity of mood

- Inappropriate intense anger
- Frantic efforts to avoid abandonment
- Identity disturbance; unstable self-image
- Suicidal and self-mutilating behaviours
- Chronic feelings of emptiness
- Transient stress-related paranoid ideas

SELF-INJURY AND BPD

However, research and my experience of working within the mental health system suggest that self-injury plays a much larger role in the diagnosis of BPD than this list would suggest. Herpetz et al. (1995), for example, demonstrate the importance of self-injury as a diagnostic criteria for BPD; whilst Habib (2001: 35) argues that BPD is 'the most common diagnosis given to primarily female self-harmers'. Indeed, it may often seem the case that simply being a woman who self-injures is enough to attract a diagnosis of BPD. Walker (2004: 21) illustrates this process:

I was given the BPD label by a psychiatrist the first time I saw her. She started by asking me all the standard questions from her sheet until she had established there were times when I had harmed myself, at this point she only asked me questions which related to the diagnosis of BPD. I don't believe I would have been given this label if it weren't for my self-injury.

Often diagnoses are not made on the basis of long-term observations and relationships. Indeed 'research suggests that decisions made about patients are usually done so within thirty seconds to three minutes of the first contact' (Habib, 2001: 40). Suzi (2004: 12) recalls 'I saw doctors on the acute ward perhaps four times, so do not believe there is any way they had enough experience of me to draw any conclusions about the state of my personality'. When diagnosis is made so quickly, practitioners will rely on judgements based on what they perceive as obvious outward symptoms of mental illness or disorder. Self-injury may function as an easily, speedily identifiable symptom of BPD. Self-injury is not only visible and external, it is also a highly stigmatised act which challenges many of society's most deep-seated assumptions about how people ought to behave. It is a visible rejection of many of society's expectations of how women, in particular, should act and appear:

Women are stereotypically caring, passive and image conscious. If you injure yourself you are not being caring towards yourself, self-harm can be seen as an aggressive act (although directed at yourself) and self-harm also seems to be in conflict with the stereotype of women being really image conscious. (Walker, 2004: 21)

Diagnosing behaviour as ‘abnormal’ and ‘inappropriate’ involves comparison to social norms and ideals; ways of behaving that the majority of people in a given society view as normal and acceptable. Given that self-injury is subject to so many negative associations and assumptions, it is likely to attract both the attention and the judgements of mental health professionals seeking to make a diagnosis. Stigma and judgement associated with people who self-injure are similarly associated with people given a diagnosis of BPD. Both are often assumed to be manipulative, attention-seeking, treatment-resistant, hostile and bring about feelings of anger, dismay and powerlessness amongst staff. It may well be that the major role that self-injury plays in the diagnosing of BPD has less to do with the objective scientific observation of diagnostic criteria than with the subjective judgements and feelings of mental health professionals. These judgements are often based upon socially shaped expectations of what is normal and acceptable behaviour—norms which are frequently constructed around gender.

IMPLICATIONS OF BEING DIAGNOSED WITH BPD

To be diagnosed with BPD can be a deeply stigmatising experience. Although there is no precise agreement on the meaning of ‘personality’, the lay consensus is that it in some way refers to the deeply personal essence of who we are. To say that the essence of who we are is ‘disordered’ is the ultimate invalidation of our humanity. “To say that someone’s personality is disordered or faulty is to place a judgement on someone’s whole sense of “being”” (Walker, 2004: 21). This has particular resonance for people who have been abused: ‘I spent much of my childhood being told directly and indirectly that I was mad, bad and that being treated badly was in some way my fault’ (Suzi, 2004: 13). Women who, through experiences of abuse and trauma, were given the message that something is ‘wrong’ with them, are again marked out as disordered and blamed:

Children are often made to feel responsible for the abuse that happens to them and made to feel that their emotions and responses to this abuse are inappropriate. Many survivors already have strong

feelings of blame and guilt for things they were not responsible for and had no control over: to label them as having BPD only reinforces these negative feelings. (Walker, 2004: 22)

It can be argued that diagnosis at least has a purpose if it leads to useful treatment. So what help have people with BPD been offered in mental health services? BPD has long been a diagnosis of exclusion from mainstream mental health services. Women are marginalised and stigmatised within services by being described as 'manipulative', 'untreatable' and 'attention-seeking nuisances'. It can be argued that, in practice, 'Personality Disorder' (PD) in general, is little more than a catch-all label applied to 'difficult' and 'non-compliant' patients: 'Personality Disorder appears to be an enduring pejorative judgement, rather than a clinical diagnosis' (Lewis & Appleby, 1988: 8). Further, 'in British mental health services it is very common for PD to be anything that cannot be accounted for in a patient by mental illness. PD is a dustbin category of problematic 'behaviour' as judged by significant others or staff' (Pilgrim, 2001: 255).

So what models of treatment are associated with this diagnosis? Historically, very few. In the minds of many who work within and use mental health services, the diagnosis of BPD carried an assumption of 'untreatability' the only hope being that you may 'grow out of it'; or that you may develop a 'more stable' personality disorder. Some people are offered dialectical behavioural therapy (DBT). The theory behind DBT suggests that women with BPD are unable to tolerate and 'regulate' their 'extreme' emotions. DBT focuses on teaching people diagnosed with BPD 'coping skills' to 'regulate their emotions'. The focus is on the present, as opposed to past experiences of trauma and on teaching people to think and behave in the 'right' ways, in particular to stop self-injury. Indeed, in DBT women are punished when they self-injure, inasmuch as they are denied contact with their therapist after self-injury (so as not to reinforce their behaviour). DBT is the therapy currently most publicised and seemingly popular with workers, being presented as the 'benign' response to BPD, as at least a service is offered. However, DBT carries an assumption that women with BPD are damaged creatures who need to be saved by the professional and taught how to be more 'appropriate'. It fails to address the personal legacies of abuse, and distracts attention from the endemic abuse of women and girls within this society. DBT has been renamed 'Diabolical Behavioural/Doing Bollocks Therapy' by survivor activist Louise Pembroke (who writes in Chapter 11 of this book).

BPD is a highly stigmatised diagnosis, with significant negative consequences both inside and outside of mental health services. Women already marginalised by society are further stigmatised by BPD, compounding

feelings of guilt and shame. Some are already institutionalised and abused by mental health and criminal ‘justice’ systems, or have experienced unemployment, poverty and homelessness. Women are often lesbians, lone mothers, and other women who, in different ways, are considered to have ‘failed’ to live up to cultural, moral and normative expectations of what it is to be a woman in this society. Then, as a result of the BPD diagnosis, women are marginalised in society, for example by having their children removed, and are often unable to claim disability benefits but are too distressed and stigmatised to work:

As they were dragged out, my eldest son was screaming for his comfort cushion. But I was already handcuffed and couldn’t do a thing about these people taking my lovely children. I was sectioned and once again silent without a voice—the label had followed me in every walk of life. (Hurt, 2004: 23)

Women given the diagnosis of BPD can be further punished and blamed for ‘needing too much’ or ‘resisting help’, or sutured without anaesthetic in A&E. Can this diagnosis possibly be the start of a helpful service response to women in distress? Lack of services for people diagnosed with BPD was acknowledged and addressed by the British Department of Health paper, ‘Personality Disorder: No longer a diagnosis of exclusion’ (NIMHE, 2003) which suggests that mental health services need to be created and extended to offer help to people who have a diagnosis of PD. In 2003–4, £6.4 million of government money was distributed to 11 non-forensic pilot projects nationally to create new services specifically for people given the diagnosis of PD. In 2006 this money will be redistributed to the National Health Service Primary Care Trusts for the purpose of establishing and continuing PD services nationwide. The 11 pilot projects vary in the services that they offer. However, all of the projects stipulate that people must have a diagnosis of PD in order to be able to access the service.

It seems, therefore, that the exclusion of people with a diagnosis of BPD is to be addressed by the creation of services which respond specifically to PD diagnoses. In order to access such support, distressed people will need to attract and accept a diagnosis of personality disorder. As PD-specific services become an increasing presence within mainstream mental health services, so we might expect personality disorder diagnoses—including BPD—to increase in prevalence. This may have some profoundly negative consequences for those subjected to the diagnosis. Furthermore, in detracting attention from the endemic abuse of women and girls, it has negative consequences for society as a whole.

GENDER AND BPD

That BPD is a gendered diagnosis is beyond question—at least 75 per cent of those given the diagnosis are female (APA, 1994). However, the gendering of the diagnosis extends beyond statistics. For decades, feminists have written about how society is constructed around financial, social, physical, legal and other inequalities between men and women, and how these inequalities are related to our understanding of madness in women (see for example, Chesler, 1972; Johnstone, 2000; Ussher, 1991). These relationships are reflected in the feminist argument that the diagnosis of BPD is located within gendered structures of power and processes of understanding. This can be understood simplistically in terms of a dual approach:

1. *Labelled mad:* Women are labelled ‘mad’ when they don’t conform to society’s norms. This approach argues that the concept of ‘madness’—rather than describing disease entities—is an idea which has been created by society to exclude and stigmatise people who refuse to behave as society expects they should.
2. *Driven mad:* Women are driven mad by their lot in this society. This approach looks at how women cope with life in a society in which they are less likely than men to have access to money, status, power and other resources, and are more likely to experience sexual abuse and violence.

WOMEN AND GIRLS LABELLED MAD

BPD is only one of the most recent diagnoses which apply particularly to women. Szasz (1972), for example, traces the history of the concept of madness all the way back to ‘witchcraft’. Women who threatened social norms in the Middle Ages weren’t called mad; instead they were called ‘witches,’ who could then be isolated and punished. Later, as science, medicine and psychiatry took over the social control function of the Church, the concept of ‘hysteria’ arrived in the nineteenth century.

Hysteria occupies a central position in the history of women’s madness. It was used to indicate behaviours which are disapproved of, and these days is still used as a put-down when women express emotions: indeed, it is often applied to women who self-injure and/or have a BPD diagnosis. Feminists suggest that the behaviours which were diagnosed as ‘hysteria’ were in fact women’s responses to their powerlessness in Victorian society; a reaction to the expectation that women should be passive, and an attempt to establish

an identity for themselves instead of living by someone else's rules all the time (Showalter, 1985). Instead, they were subjected to a diagnosis which positioned them as sick and disordered; and which paid no attention to the powerless and often abusive situations that they were trying to cope with. I argue that the diagnosis of BPD is the latest example of this historical tendency to explain away the strategies which some women use to survive oppression and abuse, by describing these strategies as symptoms of 'madness'.

Chesler (1972) talks about how women are in a 'double bind'—that we can be labelled 'mad' both for conforming to, and for failing to conform to, mainstream expectations of feminine passivity. 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 behaviour focused on self, such as self-injury. In addition, the diagnosis of BPD is focused on the idea of irrationality which has long been associated with the feminine stereotype. Women are associated with emotionality, feelings and subjectivity, whereas men are associated with rationality, order and objectivity (Showalter, 1985). Emotions—already defined as 'mad'—are located within the individual woman, rather than understood as a reaction to the social context of women in distress. The act of diagnosing BPD depends upon a psychiatrist judging whether emotions are appropriate and healthy, with reference to the norm of 'rationality'. This means that both anger and fear of abandonment can be—and frequently are—judged to be inappropriate, as opposed to being understandable in the context of a person's history of being violated or abandoned.

One of the suggested 'symptoms' of BPD is inappropriate anger. I believe that fighting back is an appropriate response. (Suzi, 2004: 11)

DRIVEN MAD: THE SEXUAL ABUSE OF WOMEN AND GIRLS

It is not hard to imagine how the contexts of women's lives—the pressures and oppressions that women have to cope with—can actually cause the feelings and behaviours which lead to a diagnosis of BPD. To say that we live in a male-dominated society usually provokes a lot of reactions. People like to point out how much things have changed in the past few decades for women. Yet many things remain the same. Women still earn much less than men; are overwhelmingly found in low-paid, low-status work, are massively under-represented in structures of power; are still largely responsible for childcare and housework; are sexually objectified in the media; told how our lifestyles,

bodies and appearances should match up to a feminine norm, and stigmatised and excluded if we ‘fail’. Without a doubt, this has a huge impact on women’s mental health.

One important feature of women’s experience of society is the sexual abuse of women and girls. Research has shown that between one in ten and one in three women will have experienced sexual violence or abuse at some point in their lives (e.g. Women’s Support Project, 1990). Research indicates that the figure for women with a diagnosis of BPD is even higher. The ‘Women’s Mental Health: Into the mainstream’ document acknowledges that many women with a diagnosis of BPD have a history of trauma (Department of Health, 2002). Castillo (2000) found that 88 per cent of the people she talked to who had a diagnosis of BPD had experienced abuse. For 70 per cent of women diagnosed with BPD this was early sexual abuse—the highest prevalence of association between gender and diagnostic categories (*ibid.*). This is reflected in other research, as well as in my experience.

Much research supports the belief that self-injury often functions as a means of coping with the effects of sexual abuse (see, for example, Bass & Davis, 1988; Arnold, 1995; Walker, 2004). Fifty per cent of the women who took part in Lois Arnold’s 1995 research ‘Women and Self-Harm’ disclosed sexual abuse as one of the causes of their self-injury, as well as physical and emotional abuse, neglect and other factors. Self-injury can function as a powerful coping strategy for surviving the sometimes overwhelming feelings and situations associated with abuse. Yet frequently the prevalence of child sexual abuse is misrecognised and underestimated.

THE FALSE MEMORY SYNDROME AGENDA

The history of societal responses to childhood sexual abuse is a history of denial and distortion (Shaw & Proctor, 2005). Freud presented women’s stories of sexual abuse as memories of fantasies rather than actual experiences and as a result the extent and impact of childhood sexual abuse was hidden for nearly a century (see Masson, 1985). In the 1970s and 1980s, childhood sexual abuse began to regain some limited recognition as an important issue. Yet very quickly, it met with a similar response in the form of ‘false memory syndrome’: a term which was invented by the founders of the False Memory Syndrome Foundation in the USA in 1992 to refer to ‘memories of sexual abuse they believe are not real and which have been planted by a therapist or which have been “borrowed” by the person hearing accounts of sexual abuse’ (Follini, 1995: 12). This ‘syndrome’ rapidly gained a lot of media attention. This illustrates how, wherever there is any recognition of the extent and the

impact of the sexual abuse of women and children, there then follows a backlash: an attempt to deny sexual abuse and to invalidate those who expose its prevalence and its impact (e.g. Hill, 2004).

BPD reinforces this 'false memory syndrome' agenda by distracting attention from how psychological distress is often rooted in the experience of childhood sexual abuse. The mental health implications of sexual abuse are well-substantiated, both in research and theory (e.g. Finkelhor, 1986) and in direct accounts. 'I had flashbacks, terrifying anxiety symptoms and felt so dirty that I could barely walk down the street' (Suzi, 2004: 11). The 'symptoms' defining BPD can often be better understood as attempts to cope with experiences of sexual abuse and other kinds of trauma.

Instead, when people are given a diagnosis of BPD, this context of abuse and trauma is obscured as an important factor in a women's distress. The focus is placed on her as an individual: defining her as defective and disordered, and failing to recognise her 'symptoms' as appropriate expressions of feeling, and as ways of coping and surviving. As a nurse consultant describes in Warner and Wilkins (2003: 173): 'it's then that this person is like this for some reason that we don't know'. The only explanation that is offered is the diagnosis. Why is this woman distressed and self-injuring? Because she has BPD. Why does she have BPD? Because she is distressed and self-injuring:

Instead of recognising the devastation caused by rape and child sexual abuse, honouring and supporting a women's survival, she is described as in need of treatment or perhaps 'untreatable'. (Hill, 2004: 16)

POWERLESSNESS

I have argued previously that the experience of powerlessness is a significant causal factor in the experience of psychological distress and the causes of distress (Proctor, 2002a). Within the psychiatric system, a survivor of sexual abuse is subject to a profound loss of control over her own life, as power is assumed by the psychiatric professional, who, through diagnoses such as BPD, has the power to define a woman's distress, to make statements about her 'prognosis' and to determine what 'treatment' is available to her (Johnstone, 2000; Proctor, 2002a; Shaw, 2004). In short, psychiatric responses and even psychological therapies (see Proctor, 2002a) can actually worsen the impact of abuse by 'denying to victims the healing experience of informed consent. They reinforce her status as victim, ignore her capacity for survival, and undermine her recovery' (Koss & Harvey, 1991: 133). It is not surprising then that these systems often fail to help survivors and people labelled with

BPD, but then this can be further used to blame people for 'resisting' help. One of the key concepts arising from these systems of power and control is the concept of 'boundaries'.

DISORDERED BOUNDARIES?

One of the concepts most frequently mentioned in the philosophy and rationale for new PD services is the importance of boundaries. 'Boundaries' are usually explained as the importance for clients of the therapist or worker setting limits which are predictable and consistent. The idea originates in psychodynamic therapy, based on Freud and other psychoanalytic theorists. Clearly the notion that workers need to be aware of the vulnerability of clients and take care to not abuse or exploit clients in their relationship is paramount. But this focus on boundaries has other effects not as benign as avoiding exploitation. This model is of an expert therapist, who can interpret and predict a client's needs. Boundaries usually refer to the timing of sessions and to rules limiting contact between therapist and client outside the session time. Often a picture is painted of a client diagnosed with BPD 'pushing' the boundaries of a therapist or 'resisting' the therapist's boundaries, and the usual advice given to therapists is of the danger of 'giving in' to the client. Already we can see the links between this approach and the common stereotype of women diagnosed with BPD as 'manipulative'. Indeed, the 'symptoms' of BPD include reference to no boundaries in relationships. It seems that women with this diagnosis are seen as deficient in their ability to have 'boundaries' in relationships and so it is the worker's job to help them by setting boundaries for them.

This seems to be a response to the history of mental health services failing to offer a service that works for people who are often diagnosed as 'personality disordered'. When clients ask for help outside their allocated appointment times, or complain about the help they have been given, or communicate in other ways that the services offered are not enough, the result has historically been for services to blame the clients for this response and constrain their services even further. The discourse of 'boundaries' serves to blame the clients for the service not working. Often appointments are offered at specified times in advance, which will not serve a need for a client in crisis. When clients turn up to such services, because no crisis provision has been arranged, the clients are blamed, rather than a lack of care planning being identified. When clients do not 'get better' in a specified timescale, rather than blame the lack of long-term services, the client is blamed for being 'unable to use a focused intervention'. This then justifies women with

the diagnosis being blamed when the boundaries set by the services mean that services are not offering enough to help when a woman is distressed. Consequently, the woman herself is labelled as being 'too needy' (e.g. see Proctor, 2002b). This message can reinforce how women may see themselves, as being unworthy of care, and can increase distress at times when women are most in crisis.

The standard 'professional' model of care can ignore the subjectivity or personhood of the therapist or worker. The danger here is that these ignored needs are projected onto the client and then used to justify the therapist's own limitations as being 'boundaries for the good of the client'. For example, a worker with many responsibilities becomes increasingly frustrated with a client who regularly turns up in distress wanting to speak only to this worker. The worker decides the client is 'overstepping boundaries' and introduces a rule that the client can only turn up once a week, explaining to the client that these boundaries are for her benefit. The worker does not explain that she is unable to keep up with all her responsibilities and has reached a limit. Instead, the ethics of mutuality lead to more equitable relationships based on mutuality, where each has needs and limitations and these are discussed openly and honestly (see Proctor, 2004: 24–5). This is preferable to relationships based on dominance and submission: the more usual model for relationships in our society (Benjamin, 1988).

A major difficulty in discussions of 'boundaries' is the danger of workers constraining themselves to avoid potential abuse, but totally missing the danger of neglect. Taylor (1990) suggests that most women have already experienced too much emotional remoteness and that relating to a real person in a helping relationship is an essential part of empowering women. This is even more likely to be the case when working with women who have histories of abuse and abandonment. A refusal to be authentic and present in relationships can be experienced as abusive, and can result in harm. Heyward (1993: 137) notes:

It was becoming increasingly clear to me that abuse—damage, harm, violence—can result from a professional's refusal to be authentically present with those who seek help; and that such abuse can be triggered as surely by the drawing of boundaries too tightly as by a failure to draw them at all.

As mental health services are currently struggling with how to respond to recent government legislation suggesting that BPD should not be a diagnosis of exclusion from services, surely the bottom line of any service aims should be to avoid making women's and girls' distress worse. We, as service providers,

should not constrain ourselves by arbitrary or theoretical boundaries that restrict our human capacity to respond to people and care. Why should our boundaries be constrained by anything more than our own limitations of comfort within which we can look after ourselves and be able to honestly and openly respond to the needs of women and girls in distress?

DEFENSIVE OR HEALING PRACTICE?

A far better way to deal with the inevitable limits to what services can offer would be for mental health workers to be honest about their own limits and express them as such without trying to pretend that these limits are good for the client. If workers could be more honest about their limitations, then clients' need for other support and services could be identified and filled elsewhere. With this honest and mutual exchange, there could then be real attempts to fill the gaps in services and try to provide what women say they need.

To take the ethics of mutuality seriously is a big commitment, emotionally and politically. It requires clear commitment to our own self-awareness and a willingness to discuss the ethics of our decisions and ways of being with clients. If we want to take seriously the healing potential in mutuality, this will not be an easy or safe process. It has the potential to transform mental health services and indeed all our relationships. However, we cannot work this way without strong relational networks of support and solidarity.

CONCLUSION

In this chapter, I have taken a critical look at the growing prevalence of labelling women with BPD. BPD was presented as a particularly controversial diagnosis, which is highly stigmatised, with no agreed cause and few associated treatments—in practice, a catch-all label applied to 'difficult patients'. Many girls who self-injure are likely to end up being diagnosed with BPD, as self-injury is a highly stigmatised form of behaviour, which challenges many of society's norms and expectations. Women's and girls' distress can be understood as a response to our experiences in a society where power is shared unequally between men and women. Referring to a large body of feminist work, BPD is situated in a long history of responses to women's distress, denying the impact and extent of childhood sexual abuse. The diagnosis of BPD is criticised for focusing attention on the individual woman, rather than on the context of her life.

Women and girls who have been sexually abused or traumatised must have their needs and experiences taken seriously and feel a sense of control over treatment within services. Women and girls need people who respect the strengths and qualities that have helped them survive. Workers are needed who see women and girls as equals and as the experts on their own lives. Women and girls need to be understood in the context of our lives and relationships. We need mental health services to see sexual abuse as an issue that affects the whole of society, and which needs a political and societal response. Diagnosing women with borderline personality disorder achieves none of this.

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