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‘Borderline Personality Disorder’ a ‘Catch-22’ diagnosis:

A Foucauldian Discourse Analysis of women’s experiences of ‘Borderline Personality Disorder’

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Portfolio submitted in fulfilment of the requirements for:

Professional Doctorate in Counselling Psychology (DPsych)

City University, London Department of Psychology

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COVID-19 Impact Statement

This statement is provided for the aid and benefit of future readers to summarize the impact of the COVID-19 pandemic on the scope, methodology, and research activity associated with this thesis. The academic standards for a research degree awarded by City, University of London and for which this thesis is submitted remain the same regardless of this context.

Title of the research project: ‘Borderline Personality Disorder’ a ‘Catch 22’ diagnosis: ‘A Foucauldian Discourse Analysis of women’s experiences of ‘Borderline Personality Disorder’

1. Summary of how the research project, scope or methodology has been revised because of COVID-19 restrictions

I was contemplating an IPA and FDA dual focus study, however due to pressures around the pandemic, I chose to focus the study on solely the FDA element, which was the original focus and main objective of the study.

2. Summary of how research activity and/or data collection was impacted because of COVID-19 restrictions, and how any initially planned activity would have fitted within the thesis narrative

Due to the pandemic, I could only recruit 5 participants rather than the planned 6.

3. Summary of actions or decisions taken to mitigate for the impact of data collection or research activity that was prevented by COVID-19

I tried to recruit and offered online interviews but it became increasing difficult. I therefore chose to complete the data analysis from 5 participants.

4. Summary of how any planned work might have changed the thesis narrative, including new research questions that have arisen from adjusting the scope of the research project

If I recruited more participants it may have influenced the data analysis process, for example some may have identified with alternative discourses and some may have taken the position to reject a diagnosis.
Date of statement: 09/02/2022

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Firstly, I would like to begin with a special thanks to all the women who participated in this study for their invaluable contribution to this project, thank you all for your time and openness, which made this thesis possible.

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Declaration

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Section A: Doctoral Research

‘Borderline Personality Disorder’ a ‘catch-22’ diagnosis: A Foucauldian Discourse Analysis of women’s experiences of ‘Borderline Personality Disorder’

Abstract

There is much research looking into ‘Borderline Personality Disorder’ (‘BPD’) from a positivist ontological perspective and more recently, a variety of qualitative studies focusing on the subjective experiences of people with ‘BPD’ (Crawford et al., 2007; Rogers & Dunne, 2011; Stalker et al., 2005, Horn et al., 2007). However, research adopting a critical perspective to the construction of ‘BPD’ is limited, providing a rationale for undertaking a Foucauldian Discourse Analysis (FDA), enabling a macro focus exploring the construction of ‘BPD’ and the subject positions afforded within dominant discourses.

This study found the psychiatric discourses placed women with ‘BPD’ in stigmatizing, pathological, ‘othering’ subject positions, shaping how these women constructed their sense of self. In particular the analysis showed women with ‘BPD’ were located across competing discourses within ‘double-bind’ subject positions; for example, penalising some women for being ‘too ill’ (those who engaged in self-harm), or for presenting as too ‘functioning’ (through their appearance or ability to work), thereby declaring them as ineligible for therapeutic treatment. Women were also seen to be positioned as ‘bad mothers’ and ‘promiscuous’ drawing on gendered discourses. Psychological discourses were drawn upon to offer empathic understandings to these women’s feelings of anger and pain, through trauma explanations and the subject position of the client. This study found women with ‘BPD’ demonstrated resistance through the take up of positive self-representations, destigmatising and normalising talk of mental health. Charity settings enabled women to escape the diagnostic category and be seen as something more than the diagnosis.

Summary outline to the thesis:

This thesis is made up of four chapters. The first chapter will introduce the research topic ‘Borderline Personality Disorder’ (BPD), as well a critique of ‘BPD’, drawing on psychological, feminist and trauma informed understandings of ‘BPD’. The literature review will also briefly explore social, media, contextual factors and policy shifts that influence our understanding of the discursive world people with ‘BPD’ live in.

The methodology chapter will outline the theoretical framework that underpins this study, including the epistemological and ontological perspective and rationale for adopting a Foucaudlian Discourse Analysis (FDA). This chapter will offer a detailed account of the methodological processes that were undertaken, adopting a reflexive stance. This chapter will also address data quality, validity and ethical considerations. The analysis chapter will outline the findings of the analysis, with some reflexivity comments detailing the processes that shaped my findings. This chapter will be presented in five sub headings and will conclude with a reflective summary.

The final chapter, discussion, will draw on the key findings, bringing the study together. It will also further explore key implications for Counselling Psychology, as well as the limitations and thoughts for future research. This chapter will also include a section on personal and epistemological reflexivity, before ending with concluding remarks for the thesis.

1. Chapter One: Literature Review

This chapter begins with a brief discussion of my personal motivations for conducting this study. The chapter will then introduce ‘BPD’ as it is currently understood, followed by a genealogical inspired discussion, considering the various ways in which ‘BPD’ has been understood in history. This literature review also explore a critique of psychiatry and a feminist perspective of ‘BPD’ including the trauma perspective. Matters relating to the discursive world such as media, representations in government policy, stigmatisation are considered, as well as recent qualitative research in ‘BPD’

1.1 Background

A key motivation for this study came from my long standing experience of working in the NHS. I have come to learn that services and those who access services typically orient towards the taken for granted psychiatric discourse and practice of offering diagnoses to explain emotional difficulties. Psychiatric discourse also overshadowed my understanding of how best to help people. Whilst working in a substance misuse service, a ‘BPD’ diagnosis was often given to young women, many of whom had complex histories of abuse. Some of these women were discharged from services whilst others were placed in inpatient units for their ‘safety’ and the ‘safety’ of others. Specifically, I remember a young girl, with a history of complex adversities, battling with her identity, gender and ethnicity. Her expression of suicidality resulted in her entering the psychiatric institution and receiving a diagnosis of ‘BPD’. At this point, not only was she still experiencing the pain which brought her to the attention of psychiatric services, but she now had to manage a new identity as a ‘borderline’. It was from this moment, that I began to question the talk of a ‘borderline’ diagnosis and thus chose to research it further.

1.2 Introduction

‘BPD’ is a heavily debated diagnosis, currently used in psychiatric practice. Although the diagnosis is given to both men and women, the Diagnostic and Statistical Manual of Mental Disorders (DSM) has shown ‘BPD’ is a diagnosis that is frequently given to women, suggesting a 3:1 female to male gender difference (American Psychiatric Association, (APA), 2000). ‘BPD’ is considered a serious mental health disorder, categorised by symptoms including unstable sense of self, emotional liability, affective instability, impulsive behaviour and hypersensitivity to interpersonal dismissal (APA, 2013, Conway et al., 2015, Bortolla et al., 2019; Houben, et al., 2018; Miano et al., 2017).

‘BPD’ is considered the most prevalent of personality disorders in psychiatric settings (Zimmerman et al., 2005) and has been found to extend to 1-3% of the general population in Western cultures (Trull et al., 2010; Lenzenweger et al., 2007; Zimmerman et al., 2005). Research has suggested up to 10% of people with ‘BPD’ die by suicide, which is 50 times higher than the general population (Yen et al., 2021; APA, 2001; Leichsenring et al., 2011; Skodel et al., 2002). Thus, ‘BPD’ is talked about as a serious illness with detrimental consequences. The DSM-5 offers professionals with a common platform to describe ‘BPD’ as a medical illness that derives from the individuals diagnosed. However, the historical backdrop suggests ‘BPD’ has shifted in time through a variety of discourses including psychoanalytical, biomedical, social, trauma and feminist perspectives, influencing our current understandings of ‘BPD’.

1.3 Genealogical inspired discussion

The ‘linguistic turn’ is a significant movement in Western thinking (Rorty, 1967), concerned with the study of ‘discourse’. Foucault (1988) refers to discourses as systems of knowledge and power, which create particular ways of seeing and being in the world (Willig, 2013). According to Foucault, discourses are taken-for-granted knowledge, which dictate social norms. Foucault suggests shifting notions of ‘madness’ and ‘sanity’ are constructed through institutions such as the church, science and the legal system (Foucault, 2003), which co-exist alongside one another. He wrote ‘we leave it to medical archaeology to determine whether or not a man was sick, criminal or insane’ (Foucault, 1967, p.61). Foucault’s writings on discipline suggests power operates within dominant discourses and institutional practices, such as psychiatry with the aim to socially regulate the body via regulation of space, time and people’s actions (Foucault, 1995, 1991).

Pertinent to Foucauldian discourse analysis (FDA) studies, this literature review provides a small genealogical inspired review informed by Carabine (2001). A full Foucauldian genealogy was not possible due to the limitations of the word count requirement for the Professional Doctorate. The aim of this review is to consider the historical development of the construction of ‘BPD’ and how it fits with dominant, systemic, government processes and practice (Arribas-Ayllon & Walkderdine, 2008); it is not an attempt to provide a linear trajectory of the construction ‘BPD’, instead maps out shifting historical meanings of ‘BPD’ and how these have shaped current understandings of ‘BPD’.

1.3.1 Psychoanalytical understandings

The construction of a ‘Borderline personality’ was introduced into the field of Psychoanalytical therapy by Adolph Stern (1938) as a theoretical concept. The term ‘borderline’ was used to understand the ego function of patients, in particular women, who presented outside the typical expectations of therapy, deemed well in society but considered to be wearing a ‘mask of sanity’ (Bradley et al., 2005, p. 928). The attachment model has been a key discourse understanding individuals with ‘borderline’ presentation, ‘BPD’ is said to occur as a result of an insecure or disorganised attachment (Hengartner et al., 2015). Ruptures in early attachment are considered to significantly impact a child’s sense of security and development (Bowlby, 2005). Earlier psychodynamic theories focused on the process of separation – individuation, suggesting people with ‘borderline pathology’ experienced difficulties during the rapprochement phase, where children were being praised for behaviour promoting dependency on their care giver and reprimanded for pursuits of individuality (Mahler, 1971). Masterson’s (1976) suggested the mother of a ‘BPD’ individual, was in fact ‘borderline’ herself.

Kernberg (1975) offered a developmental model for borderline personality organisation rooted in object relations and ego psychological theories focusing on instinctual drives and defences. Personality organisation was considered as a continuum, including neurotic, borderline, and psychotic individuals. Those with ‘borderline’ pathology often experienced difficulties in their attachments and failed to integrate the good and bad representations of self and others (Kernberg, 1975). His theory talks about loneliness as a need for the return of a ‘lost object’ and specifies that feelings of emptiness are linked to the state of unreserved loss.

The term ‘borderline’ was used to improve therapeutic interventions and client’s ego functioning, advocating a transference focused therapy with the aim to increase affect regulation and integrate representations of self (Cammell, 2014). The psychodynamic framework emphasises the relational aspect of ‘BPD’ concerned with intersubjectivity; maladaptive defences associated with interpersonal difficulties. Recent psychoanalytical approaches continue to emphasise the therapeutic relationship between the therapist and client, attending to possible ruptures that may occur (Oud et al., 2018).

Critics of attachment theories object to the theoretical absence of the father and their contribution to children’s development (Birns, 1985; Lewis, 1986) and the overemphasis on ‘blameworthy’ mothers (Allan, 2004; Rose, 1999; Ussher, 1991). Furthermore, attachment theories are considered to neglect experiences of abuse and trauma, especially during the developmental phase (Asnes & Leventhal, 2011; de Aquino Ferreira et al., 2018; Stepp et al., 2016). However, psychodynamic approaches continue to focus on attachment, suggesting insecure attachments play a role in the understanding of borderline presentations, (Fonagy et al., 2013; Holmes, 2003; Fonagy, Target & Gergely, 2000). In 1989, ‘BPD’ was conceptualised as a ‘disorder’ of mentalising (Bateman, 1998; Fonagy; 1989), yet in 2004, psychodynamic approaches considered both the importance of mentalisation, as well as contextual and external influences in understanding ‘BPD’ (Bateman & Fonagy, 2004). Psychodynamic object relations theories consider the internalization of bad objects, recognizing the significance of the behaviour of other people in an individual’s life, locating the ‘problem’ in the context of their interpersonal and social context.

1.3.2 Psychiatric understanding

Individuals seeking help for their mental wellbeing are generally referred by their General Practitioner (GP) to psychiatrists for expert opinions and diagnosis. The existence of a diagnosis is made possible by the role of a psychiatrist and the legitimacy of symptomatic presentation. Unless diagnosed by a psychiatrist, an individual has no disordered personality (Burstow, 2005). Psychiatry is considered a medical speciality (Ahmed, Ramy, Abdel & Youssef, 2021; Bourgeois & Sharpe, 2020), some say a powerful discipline that can use a range of approaches to control patients' behaviour, compartmentalising and pathologizing difference, managing 'dangerous' behaviours, in the form of medication, therapies and inpatient stays (Showalter, 1985; Goffman, 1961; Foucault, 1971).

Earlier references to psychiatry viewed mental health through a bio-psychological lens, in which mental health difficulties arose as a response to an individual's life experiences and stress levels (Myer, 1906). Knight (1953) conducted observational studies and suggested 'borderline states' were evident in those who presented as both, 'neurotic' and 'psychotic'. He described individuals in 'borderline states' as having good functioning memory but experiencing severe difficulties with adjusting to change and upholding long-lasting and meaningful relationships (Bradley et al., 2005). Knight (1953) identified the need to focus on interpersonal relationships and contextual factors in therapeutic practice with individuals presenting as 'borderline'.

In contrast, modern-day psychiatry draws strongly from Kraepelin's observational studies in Germany. Kraepelin was a pathologist who believed mental health disorder originated from a brain pathology, studying signs, now deemed 'symptoms' in his patients. The DSM-III (APA, 1980) was critiqued as resembling a

Kraepelinian perspective due to its concerns with the classification of mental health issues linked to underlying pathological causes (Spitzer & Wilson, 1968). The DSM III's emphasis moved from a biopsychological approach to 'atheoretical' (Bayer & Spitzer, 1985), focusing on biological drives, dismissing the value and importance of social and inter-relational influences (Gaines, 1992). A study conducted by Rosenthal & Kety (1968), found links between Knight's 'borderline state' and 'schizophrenia', contributing to the location of 'BPD' within psychiatric literature as a 'borderline schizophrenia'. 'BPD' was first seen as a psychiatric diagnosis located in the DSM-II (APA, 1968) as an antecedent diagnosis of latent schizophrenia (Crowe, 2004). The phenomenon of 'BPD' entered the field of psychiatry and was primarily referred to as a 'mild version of schizophrenia' (Zilboorg, 1941). This understanding of 'BPD' is considered in contemporary revisions of the DSM as a 'schizotypal personality disorder' (Crowe, 2004).

The DSM III (APA, 1980) dramatically expanded its diagnostic categories in comparison to the first two revisions of the DSM (APA, 1968). Moving away from psychoanalytical theories, it developed an increasing concern with 'empirical research' demonstrating objective, scientific evidence for each diagnosis (Houts, 2000). The nature of inquiry into biological origins of mental health disorders is informed by funding, which favors 'evidence-based practice', and the field of psychiatry has been seen to be supported by 'billions of dollars' agencies (Moncrief & Steingard, 2019). Spitzer, Endicott and Gibbon, (1979) became the first to join a DSM committee for 'personality disorders' and created the criteria introduced in the DSM-III (APA, 1980). In 1975, there were 50 publications relating to 'BPD' and by 1985 there were 1000 (Gunderson, 1994). A diagnostic interview for 'borderline' patients was formulated by Gunderson & Kolb (1978) and Gunderson, Kolb, & Austin (1981) to provide validity and ‘empirical evidence’ for the diagnosis.

By 1980, ‘BPD’ was added to the DSM III as a ‘personality disorder’ (APA, 1980). ‘Personality disorders’ were placed on Axis II and all other mental health disorders on Axis I, emphasizing the specificity of ‘personality disorders’ (Krueger & Hubbs, 2020). The rationale for this change was that ‘personality disorders’ were deemed empirically distinguishable from other mental health illnesses (Paris, 2003), yet researchers found this rationale unconvincing (Livesley, 2003). The DSM III (APA, 1980) and DSM IV (APA, 1994) include ten categories of ‘personality disorders’, separated in three clusters. Cluster A personality includes paranoid personality disorder, schizoid personality disorder, schizotypal personality disorder; Cluster B includes ‘BPD’, anti-social, histrionic and narcissistic personality disorder; and Cluster C includes dependent personality disorder, avoidant personality disorder and obsessive-compulsive personality disorder (APA, 1994). The DSM III and DSM IV are mainly based on the work of Gunderson & Singer (1975), with the development of DSM IV including a ninth symptom, transient stress states (Biskin & Paris, 2012).

DSM-5 (APA, 2013) moved from the multi axial approach introduced in DSM III, towards a dimensional approach to ‘personality disorders’. ‘BPD’ is currently defined as a serious, complex mental health disorder, characterised by impulsivity, difficulty managing emotions, an unstable sense of self and others, and recurrent self-destructive thoughts and behaviours (APA, 2013). To receive a diagnosis of ‘BPD’ from the DSM-5, a person must present with at least 5 out of 9 symptoms, including fear of abandonment, unstable and intense interpersonal relationships, identity disturbance, impulsivity, recurrent suicidal behaviours or threats, affective instability due to a marked reactivity of mood, chronic feelings of emptiness, inappropriate anger, transient stress related paranoid ideation or severe dissociated symptoms (APA, 2013). Both, the psychoanalytical and psychiatric understanding of 'BPD' demonstrate significant cross over between two discourses of 'BPD'. 'Borderline personality' was considered solely a psychoanalytical construct for fifty years (Bradley et al., 2005) before the psychiatric introduction of the term 'BPD'. What Kernberg (1975) described as atheoretical 'features' of 'borderline organisation' such as impulsivity are understood in the field of psychiatry as 'symptoms' of a biological illness inherent to the person diagnosed.

1.3.3 Feminist understanding

Feminists offer a different understanding of the construction of 'BPD', critiquing the psychiatric and psychoanalytical discourses. Tracing historical roots of 'BPD', feminists suggest that women have been positioned in restricted and malevolent ways, from religious discourses depicting women as demonic and 'evil' (Becker, 1997) to the Middle Ages, labelling women as 'witches', placing them as outcasts in society (Ussher, 1992). Language such as 'devils' and 'witches' were used to describe women deemed as a threat to societal gendered norms (Larner, 2000; Ussher, 1992; Szasz, 1970). Eighty percent of those convicted as 'witches' were women, subjected to torture and killed for crimes associated to 'witchcraft' (Larner, 2000, p.100). Modern forms of torture against women can be considered to continue through the discourse of psychiatry, legitimised through forms of treatment including hospitalisation and pharmacology (Szasz, 1971). Shaw and Proctor

(2005) consider a social constructionist perspective to the construction of ‘BPD’ conceptualising ‘BPD’ as the new ‘witchcraft’.

By the 16th century, scientific discourse emerged as a new way of ordering the world, and ‘problematic’ women were constructed in terms of ‘madness’. The process of labelling women as ‘mad’ was seen as a scientific method of finding fault with women’s bodies, which feminists suggest, in turn, silenced women’s voices (Ussher, 1991, p.7). Changes in our understanding of psychopathology have been influenced through time, for example, through medical and religious institutions and discourses (Foucault, 2003; Lemma, 1996). Foucault (2006) identifies the concept of ‘madness’ was produced and reproduced throughout history via dominant institutions, such as medicine. ‘Madness’ and femininity seem to have close ties (Ussher, 2011). By the 19th century, artwork in England depicted madness as a ‘female malady’ (Kromm, 1994; Ripa, 1990) often portrayed in sexualized depictions (Kromm, 1994), promoting the visual perception of madness as primarily feminine (Braun, 2020).

Hysteria was initially coined in Greek mythology, as a fault with a woman’s womb, which could be cured through marriage (Tasca et al., 2012; Gilman et al., 1993; Ussher, 2011). By the Middle ages, women with hysteria were considered demonic and subjected to exorcism, and by the 18th century hysteria was considered a problem with the brain (North, 2015; Tasca et al., 2012). The origins of psychoanalysis lie within a biomedical discourse, in which many early theories and concepts were framed in terms of instincts and drives. For example, Freud postulated hysteria was a woman’s ‘disease’ resulting in failures of conception, (Freud & Breuer, 1895) or failure with sexual drive associated to the Oedipal conflict (Janet, Freud & Charcot, 2011). In the 18th and 19th century, hysteria was commonly diagnosed and treated using the DSM (APA, 2000), thus feminists consider hysteria as psychiatry's earliest attempts to pathologize women's distress (Ussher, 2013).

Critical evaluations of hysteria and 'BPD' have shown that through the psychiatric lens, the characteristics of femininity could put women at risk of being deemed 'mentally ill' (Braun, 2020; Ussher, 2013). Eventually, the medical diagnosis of hysteria seen in the DSM II was removed from the DSM-III in the 1980's (Tasca et al., 2012), arguably replaced with 'BPD' (Becker, 1997). Both hysteria (Bronfen, 1998) and 'BPD' (Kroll, 1993) are considered medical 'waste basket' diagnoses associated with women. Women with hysteria were described as 'difficult', 'narcissistic', (Smith-Rosenberg, 1982), 'manipulative' and 'attention seeking' (Showalter, 1987), coinciding with how women with 'BPD' are referred to (Markham & Trower, 2003; Ross & Goldner, 2009; Lester, 2013). Jimenez (1997) proposed that 'BPD' replaced hysteria, as a way of encompassing modern cultural values and characteristics of women, suggesting 'BPD' calls out women that encompass some masculine defined traits such as anger. Jimenez (1997) emphasizes hysterical women were talked about as 'damaged', and 'borderline' women are talked about as 'dangerous'. Thus, indicating that as the cultural climate changes, so do revisions within the DSM, moving from the gendered diagnosis of 'hysteria' to one of 'BPD'.

1.3.4 Media representations

The media as a social institution holds significant power to incite political and social views that are easily accessible to the general population. Media depicts women with ‘BPD’ in stereotypical, gendered roles, often as scary, promiscuous, possessive women. Within film, women with ‘BPD’ are depicted as ‘bunny boilers’ (Fatal Attraction), ‘promiscuous’ and ‘attention-seeking’ (Girl Interrupted) ‘dangerous’, ‘serial murderers’ (Monster) and, more recently, associated with ‘perfectionism’ and ‘darkness’ (Betty Cooper, Riverdale), without giving any attention to their traumatic past histories or social, contextual background. Men are rarely represented in the media with ‘BPD’, thus what we can see through cultural representations of ‘BPD’ is that women are often placed in a variety of sexualised, demonic positions, associated with crime and darkness.

The media plays an important role in how the public understands people with mental health problems (Rose, 1998), so much so that media illustrations can overrule people’s actual experiences with regards to mental health (Philo, 1996; The Department of Health, 1996). In the eyes of the law, one is considered either ‘mad’ or ‘bad’, yet the media portray images of people with ‘BPD’ as both ‘mad’ and ‘bad’, perhaps as a means to captivate the general public (Cross, 2014). In 1999, there was significant media coverage over the murder of Lin and Megan Russell by Michael Stone. Stone was depicted as a mentally unwell individual, diagnosed with a ‘personality disorder’, which fuelled the concept that people with a ‘personality disorder’ are ‘dangerous’ and ‘bad’, prompting the government to address the public concerns with new policies (Freestone, 2005; Pickersgill, 2013).

1.3.5 Representations in policy

In 1999, The Department of Health (DOH) introduced the ‘Dangerous and Severe Personality Disorder’ (DSPD) initiative as a reaction to the murder of Lin and Megan Russell (Pickersgill, 2013). The government (2001) invested £126 million into the ‘DSPD’ programme linking mental health with the control of criminal behaviour (Pickersgill, 2013). The Mental Health Act (1983; revised in 2007) shifted the notion that people with ‘personality disorders’ were ‘untreatable’ to ‘treatable’ (Pickersgill, 2013). However, the DOH (2003) later published guidance, ‘Personality disorders: No longer a diagnosis of exclusion’, citing no mention of the term ‘DSPD’. Instead, the emphasis in the guidance was on discriminatory practices and stigmatization, shifting views that that people with a ‘personality disorder’ are a risk to society, to people with a ‘personality disorder’ are vulnerable, at risk of stigmatization and harm to themselves through self-harm and suicide (National Institute for Mental Health in England, 2003). Thus, began a cohesive argument from psychiatry, the media and government that treatment for individuals identified with a ‘personality disorder’ was needed and possible, ignoring the ambivalence and contention surrounding ‘personality disorders’ (Pilgrim, 2007). The DOH guidance was also criticized for its attempts to acknowledge the impact of stigma yet falling to make any suggestions to remove the label of ‘personality disorders’ (Horn et al., 2007).

In 2003, ‘Breaking the Cycle of Rejection: The Personality Disorder Capabilities Framework’ (DOH, 2003), was published with the aim of raising awareness around ‘personality disorders’ and the stigmatizing impact of professionals, such as mental health workers, social workers, and criminal justice workers.

In 2011, ‘Meeting the Challenge- making a difference’ was published alongside ‘Working with Personality Disordered Offenders’ (DOH, 2011) to support front line staff with up-to-date training. The publications supported service improvement and management of ‘complex’ presentation of service users by retraining professionals’ thinking and attitudes towards people with ‘personality disorders’, with the aim of increasing awareness of concerns around stigmatization. Professionals were recommended to seek supervision to increase awareness and reflexivity regarding personal biases to reduce stigmatization, yet little to no change has occurred to the biomedical framework that introduced ‘personality disorders’ in the 1980’s. Therefore, underlying issues around ‘BPD’ in relation to stigma, marginalization, trauma, culture, and validity are likely to be overshadowed by government publications, maintaining the ‘truth’ that there are people that hold ‘disordered personalities’.

1.4 Critique of the psychiatric model

1.4.1 Aetiology and Prevalence

Despite 40 years of research since its entrance into the DSM III (APA, 1980), the aetiology of ‘BPD’ is still unclear (Biskin & Paris, 2012). Biological factors linked to the origin and development of psychopathology have been poorly evidenced (Dolan, 2010). There is limited research investigating the genetic predisposition of ‘BPD’. However, some twin studies have shown a heritability of 40-50% (Distel et al., 2008; Torgersen et al., 2000). Some studies have suggested a link between ‘BPD’, brain injuries and genetic abnormalities (Cornelius et al., 1989; Hollander et al., 1994). Studies have also looked into the neurotransmitter function of people with ‘BPD’ and found associations to low serotonin levels (Korzekwa et al., 1993;

Gurvits et al., 2000). Two epidemiological studies into the prevalence of ‘BPD’ in European studies were 0.7% (Coid et al., 2006; Torgersen, Kringlen, & Cramer, 2001) and studies in America found a range between 9-11% (National Institute of Mental Health (NIMH), 2017; Chanen et al., 2008). In America, Chanen et al. (2008) found a prevalence of 49% in an inpatient setting. However, no research has demonstrated biological markers for ‘BPD (Biskin & Paris, 2012), and no research has shown links to a precise ‘BPD’ gene (Fonagy et al., 2015).

Technological advances such as genetic imaging are being conducted with hopes to demonstrate validity and a biological origin for ‘BPD’, yet research into genetic links has been considered difficult, as it is not possible for a single gene to produce a ‘disordered’ personality, (Caspi et al., 2005). Thus, critics suggest psychiatry upholds the status quo by placing the difficulties within the individual as an internal deficit, depreciating the importance of social, cultural factors that impede an individual’s experience (Ussher, 2006; Becker, 1997).

Prior to the release of DSM-5, the NIMH, and the APA, both expressed reservations. The NIMH indicated it would be re-orienting research away from diagnostic classifications due to the lack of poor scientific validity, while the APA acknowledged that the field of psychiatry had failed on their quest to find biomarkers (Harper et al., 2020). Thus, the validity of the DSM has been receiving significant scrutiny for the lack of evidence to support the claims that mental health illnesses are inherently biological. Despite this, the language of diagnosis still continues and solidifies the notion that ‘psychiatry is a legitimate branch of medicine’ (Cromby, Harper, Reavey, 2013, p.103).

1.4.2 Culture and sociological critique

Research exploring sociocultural influences such as race and culture are limited to the field of ‘BPD’ (Chavira et al., 2003). Research in ‘BPD’ conducted in Asia is limited to a few studies and small scale sample (Choudhary & Gupta, 2020; Ono & Okonogi, 1988; Pinto et al., 2000). The prevalence of ‘BPD’ is considered higher in Native American men (13.2%) and lower in Asian women (2.5%) indicating cultural associations to the construction of ‘BPD’ (Grant et al., 2009). Research also found that ‘BPD’ is more prevalent amongst White Americans than African Americans (Akhtar, 1995). In Western society, ‘personality disorder’ services are heavily occupied by White people, often from lower social economic status (Manning, 2011), whereas black and ‘minority’ ethnic communities receive a disproportionately greater number of diagnoses of ‘schizophrenia’ (Minsky et al., 2003; Schwartz & Blankenship, 2014).

Manning’s (2011) critique of ‘BPD’ identified people are diagnosed with a ‘personality disorder’ through their behaviour and interpersonal relations, as opposed to a robust measurement of an individual’s mental processes. Manning (2011) suggested the emergence of ‘personality disorders’ was seen to occur often at the age of 18, linking ‘BPD’ to sociological processes such as transitioning into adulthood, which he considered is a turbulent time, especially for young girls who are also at a higher risk of childhood sexual abuse and complex interpersonal struggles.

In the United Kingdom, the International Statistical Classification of Diseases and Related Health Problems (ICD)-10 is a medical diagnostic tool maintained by the World Health Organisation (WHO), an alternative to the DSM. The ICD-10 uses the term ‘Emotionally Unstable Personality Disorder’ (EUPD), which can fall into two categories ‘borderline’ or ‘impulsive’ type. The two terms ‘EUPD’ and ’BPD’ are known to be used interchangeably depending on whether you live in America or the UK/Europe, and whether the ‘expert’ uses the DSM/ICD. Despite similarities in language, the ICD and DSM are two separate diagnostic manuals used to measure mental health and offer different terms to diagnose people. The ICD and DSM are deemed legitimate, evidence-based, scientific, manuals for psychiatrists to use to diagnose people with illnesses including ‘BPD’, ‘EUPD’, ‘PTSD’, ‘Complex PTSD’. Each diagnosis offered is subjective to the psychiatrist providing the diagnosis, offering different implications for the identity of the person that is diagnosed. Thus, factors such as geography and professional preference play a role in the distribution of a diagnosis.

1.4.3 Psychiatric treatment

Psychiatric ‘truth’ is maintained and legitimised through the multibillion-pound pharmaceutical industry (Lafrance & McKenzie-Mohr, 2013). Prescriptions for medications are seen to rise with little evidence of improving outcomes (Ilyas & Moncrieff, 2012). Furthermore, there are no recommendations in expert publications for specific pharmacological interventions and no clear evidence to suggest pharmaceutical treatment offers people with ‘BPD’ overall symptom relief (Pickersgill, 2013; Bridler et al., 2015).

Yet, according to the European drug safety report, people with ‘BPD’ in an inpatient setting were 80% likely to be on a poly pharmaceutical treatment plan, and 70% of all patients were medicated with anti-psychotics and/or anti-depressants, 30% with benzodiazepines, 4% lithium and 33% with anticonvulsants (Bridler et al., 2015).

Studies have found the use of an anti-psychotic such as Quetiapine, improved participant’s psychotic symptoms, impulsivity and feelings of anger (Gruettert & Friege, 2005). Pascual et al.’s review (2021) of the pharmacological treatment of ‘BPD’ outpatients found significant changes in the use of medications, with the use of benzodiazepines reduced, and anti-psychotics increased. Long term use of anti-psychotic drugs to treat people with ‘BPD’ does not demonstrate a reduction in the severity of symptoms, thus is considered controversial practice (Ingenhoven et al., 2011; Barnow et al., 2010).

1.4.4 Validity & Comorbidity

This review raises many questions about the validity of the construction ‘BPD’ as a diagnosable, medical condition. The conceptualisation of ‘borderline’ changed from a theoretical concept of personality organisation (Stern, 1938) into a diagnosable medical and psychiatric illness; initially as a ‘schizophrenic illness’ (DSM II, APA, 1968) then a ‘personality disorder’ illness (DSM III, APA, 1980). Consequently, the practice of assigning ‘BPD’ to an individuals’ personality as a diagnosis was legitimized and very quickly considered the ‘most common’ of ‘personality disorders’ (Gunderson & Zanarini, 1987). Since its arrival in the DSM, ‘BPD’ has received a lot of critical attention from clinicians (Kutchins & Kirk, 1997).

Historical enquiry into the construction of ‘BPD’ suggests ‘BPD’ entered the DSM during a period of psychiatric crisis, enabling a diagnosis that spans across diagnostic categories (Wirth-Cauchon, 2001). Consequently, the process of offering a diagnosis of ‘BPD’ is considered to occur due to the ‘uncertainty and indecision of the psychiatrist’ as opposed to the presentation of the client (Knight, 1953, p. 203). Thus, those critical of the psychiatric framework question not only the validity of the construction 'BPD', but the level of power that psychiatry has gained. The concept of 'personality disorders' continues to be a contested concept within the field of psychiatry (Pilgrim, 2007), yet it is still widely used as a legitimate, medical diagnosis. The conceptual validity of 'BPD' has been critiqued by psychiatrists (Tyrer, 2009) clinical psychologists (Bourne, 2011; Shaw & Proctor, 2005) and sociologists (Manning, 2011). The diagnostic criteria of 'BPD' is regarded as 'vague' (Miller et al., 2008), 'contradictory' and 'changeable' (Becker, 2000), offering little diagnostic validity (Bondurant et al., 2004; Lewis & Appleby, 1988), with chastising treatment options (Shaw & Proctor, 2005).

The psychiatric discourse stipulates that the diagnosis of 'BPD' is acquired through evidence demonstrating an enduring pattern of personality dysfunction. This is support through research that found 76% of young people post inpatient stay, met the criteria for 'BPD' in a four-year follow up (Greenfield et al., 2015). However, other longitudinal studies have questioned the diagnostic viability. For example, a two year, longitudinal follow up study found only 23% of young people still met the criteria for 'BPD' (Mattanah et al., 1995), suggesting the symptoms of 'BPD' may not be 'enduring' but transient (Barnicot & Ramchandani, 2015). This study also suggests social contextual factors may contribute to symptom recession. Low diagnostic stability was also found in studies with adults, in which only 14% met the criteria for 'BPD' after a 3 year follow up (Meijer et al., 1998), 30-40% of people had no symptoms after a 2 year follow up (Zanarini et al., 2003) and 75% had no symptoms after a 6 year follow up (Zanarini et al., 2003). These studies suggest that a person's personality can change over time, challenging psychiatric discourses that stipulate 'personality disorders' are fixed.

Due to the arguable heterogeneity of symptoms (Tyrer, 2009), the term ‘BPD’ has been criticized as a ‘catch-all’ diagnosis (Pauwels, 1992; Tyrer, 2009), a ‘waste basket’ diagnosis (Kroll, 1993). Bateman & Fonagy, (2004) suggest there are 256 ways in which a patient can meet the criteria of ‘BPD’, as the DSM stipulates you only need to meet five out of the nine criteria (APA, 2000). ‘BPD’ is diagnostically comorbid with PTSD (Shea et al., 2000; Pagura, Stein, Bolton, Cox, Grant, Sareen, 2010), eating disorders (Maranon, Echeburia & Griialvo, 2007), depression and anxiety (Mulder, 2004; Stalker et al., 2005; Shea et al., 2000) substance use disorder (Trull et al., 2000), alcohol dependency (Trull et al., 2000; Verheul et al., 2000; Sher et al., 1999) and other ‘personality disorders’ (Fryer et al., 1988; Widiger & Rogers, 1989). High levels of comorbidity between ‘BPD’ with other mental health conditions strengthens the psychiatric critique of ‘BPD’.

1.4.5 Critical psychiatry

The anti-psychiatry movement challenged the legitimacy of psychiatry and stipulated there was ‘no such thing as mental illness’ (Szasz, 1974, p.ix). Szasz (1974) suggested ‘mental health is a myth’ (p. xv), reconceptualising it as problems in living. Szasz (1974) emphasised the term ‘illness’ was first introduced in the field of medicine to identify a visible issue with the body, exploring physical irregularities discovering bodily diseases such as paresis; yet mental illnesses, he writes, was a ‘moral and political, enterprise’ (Szasz, 1974, p. xii) without any medical validity, creating diseases such as hysteria. The etiology in mental health illness have indicated no medical nosology (Di Nicola & Stovanov, 2021).

The critical psychiatry movement is not ‘anti-psychiatry’ but suggests psychiatry is not the only, nor most effective way to help people (Middleton & Moncrieff, 2019). The critical psychiatry movement developed as a way to encourage practitioners to consider different perspectives as a way of enhancing services and increase the quality of support available for individuals seeking help (Hopton, 2006), promoting hope, equality, and inclusivity. The medical model is criticised as a form of practice that disempowers and blames individuals for their suffering. The DSM creates mental disorders in terms of a shortfall, deficit or impairment, using language such as ‘disability, dysfunction, disease, disadvantage, distress’ (Davies, 2014, p.16). Critical psychiatry advocates propose a reformation of medicine, rejecting the practice of psychiatry that is concerned with pathologizing pain (Sen, 2019).

Throughout history, critical activists challenge the field of psychiatry that dismisses matters such as racism, sexism, homophobia etc. For example, what could be considered as typical and ‘normal’ responses to crimes such as slavery, where slaves were seen to try escape their owners, were talked about in the field of psychiatry as ‘mad’ and ‘disordered’ (Opara et al., 2021; Willoughby, 2018). History has demonstrated that illnesses that were once ‘pathologized’ have become ‘depathologised’, normative states (Drescher, 2015). For instance, ‘homosexuality’ was talked about as a ‘real’ disease, in DSM II, *removed* in the second edition of the DSM II (Burr, 2003; Stoller et al., 1973) and is currently talked about as a normative sexuality preference. ‘Hysteria’ was also talked about as a ‘real’, empirically evidenced ‘mental disorder’, *removed* in the DSM-III in the 1980’s (Tasca et al., 2012). The removal of what was once talked about as a ‘fact’, based on scientific evidence, raises questions not only about the validity of psychiatry, but also a matter of ethics and power.

A macro social constructionist perspective considers ‘discourse’ as a linguistic framework (Willig, 1999). Talk produces discourses and discourses function as conceptual repertoires available to a linguistic society (Burr, 2003). ‘Discourses provide us with conceptual repertoires with which we can represent ourselves and others. They provide us with ways of describing a person... Each discourse provides a limited number of ‘slots’ for people. These are the subject positions that are available for people to occupy when they draw on this discourse. Every discourse has within it a number of subject positions...’ (Burr, 1995, p.141), which can be taken up or rejected. Diagnostic classifications can thus be considered as social constructions, that govern people’s behaviour and defines their identity. Psychiatry is arguably considered as a system based not on scientific evidence but rather on ‘social judgements’ (Johnstone, 2019), in which diagnostic labels are produced within cultural, social, and historical frameworks used as a basis of reality and are talked into being.

Critics have shown how psychiatry has developed as a means of managing ‘defiant’ behaviour (Middleton & Moncrieff, 2019). Beresford (2002) queried the philosophical foundations of mental health with the regulation of behaviour deemed ‘dangerous’ or ‘bad.’ The field of psychiatry becomes focused on treating the ‘abnormal’, maintaining the status quo of the ‘norm’ population that never needs to be scrutinized nor problematised. Medical illnesses exist to function on the basis of having social ‘norms, values and expectations that make sense of illness for people in a specific culture and sets the criteria for what, locally can count as illness' (Burr, 2003, p.39). Hence, the use of psychiatric diagnoses is seen as a means of managing socially and politically difficult presentations (Middleton, 2015). The methodological approach to diagnosis within psychiatry has also been criticized as subjective, based on value judgements of what behaviours constitute as normality (Middleton & Moncrieff, 2019; Faust & Miner, 1986). The clinical assessment of internal processes and thoughts are often anecdotal from observations of behaviour or through self-reports (Crowe, 2004). The APA (2000) writes symptoms of 'personality disorders' must be considered as a transgression of cultural norms, suggesting how one thinks, feels and behaves must align to dominant cultures, and that failure to respond to cultural norms could result in a psychiatric diagnosis (Crowe, 2004). The psychiatric approach, which relies on a biomedical, disease framework, has been heavily criticized demonstrating poor validity, reliability, and treatment outcomes (Pilgrim, 2001).

As mental health illnesses are to be understood as a complex human phenomenon, relying on physical ailments or the biological framework is limiting. A positivist approach is thus inadequate (Middleton & Moncrieff, 2019). Instead, a hermeneutic approach, which considers an individual's life histories and social, cultural contextual factors, is more appropriate (Bracken & Thomas, 2007). Kinderman, a critical psychiatrist, urges practitioners to refrain from the use of terms such as 'disorders', stating 'labels are for products, not people' (Kinderman, 2019, p.184). Kinderman suggests the current psychiatric framework is causing harm by implying distress is 'treatable' through a biomedical framework, instead proposes suffering in the forms of self-harm, hearing voices, occur for reasons, not *because of* a diagnosis (2014). The psychiatric construction of ‘BPD’ has been considered to yield negative connotation, shame, and further social and economic discrimination (Gergen, 1994). Critics of this approach to distress and emotional suffering request a paradigm shift. For example, Crowe (2004) proposed that ‘BPD’ is in fact an individual’s response to the experience of ‘chronic shame’; ‘symptoms’ such as self-harm are seen as an expression of shame and the body may represent a site of shame.

Trauma focused advocates stipulate ‘the question shouldn’t be ‘what’s wrong with you?’, rather ‘what’s happened to you?’ (Longden, 2010, p.258), advocating the importance of social and contextual life events that impact an individual’s suffering as opposed to something inherently wrong with one’s identity and agency. Dillon (2011) stresses the need for a non-biomedical model to explore individual suffering, recognizing the significant impact of trauma and abuse. Websites such as ‘pd in the bin’ and ‘a disorder for everyone,’ (Watson, 2019) challenge dominant discourses around mental health, including ‘BPD’. In a current push to ‘drop the disorder’, professionals and experts by experience focus on learnings from the subjective experiences of people who are positioned as a ‘patient’ within the psychiatric discourse (Watson, 2019), thus moving away from pathologizing language embedded in psychiatric discourse, and towards a psycho-social understanding of an individual’s presentation of distress.

Power Threat Meaning Framework (PTMF)

The PTMF is a five-year piece of work created by psychologists and survivor campaigners, funded by the British Psychological Society (BPS) (Harper, et al. 2020; Johnstone & Boyle, 2018). Th framework adopting a bio-psych-social lens, recognises the influence of social and cultural factors as an alternative to the diagnostic framework (Johnstone et al., 2018). The model offers a person seeking help to understand their difficulties through a multi-dimensional lens (Boyle, 2020), considering their access to power, sense of threat and how they make sense of it. This approach acknowledges people's distress through experiences of adversities and social inequality (Harper et al., 2020) and aims to empower people by listening to their narrative about how they make sense of their distress, without pathologizing them for sharing their suffering. However, as a new model there is limited research on its use within services and service users' experiences of it.

1.4.6 Foucault's critique of psychiatry

According to Foucault, discourses are considered as taken-for-granted knowledge that create social norms and govern behaviour (Foucault, 1980). Foucault's concept of 'regimes of truth' (Foucault, 1973, 1979) refers to the way people take knowledge produced within these discourses as taken-for-granted 'truth'. People draw upon available discourses to understand themselves and their identity. This is particularly true for scientific, medical discourse, which is seen to dominate people's understandings of themselves, including the experience of distress. Practices, such as psychiatry use knowledge, 'truth'' as a means to legitimise the technologies of power over people (Proctor, 2017). Foucault challenges the notion of madness as a mental illness, suggesting it has emerged through history, dependent on changing socio-cultural-political influences. He suggested, shifting notions of ‘madness’ and ‘sanity’ are constructed through institutions such as the church, science and the legal system (Foucault, 2003), which co-exist alongside one another. Thus, madness was considered as a facade for controlling behaviours deemed unconventional to the social norms of morality, as opposed to a scientific breakthrough. Foucault stipulated that psychiatry is a moral practice, overlaid by the myths of positivism (Foucault, 1965, p.276). Diagnoses are defined as a way to classify individuals as a form of deficit (Foucault, 1982). Issues and deficits in the social environment are transferred to the person through the medicalisation of suffering, and are talked about as a dysfunction, deficit or risk (Gergen, 1997). Thus, power lies in a reciprocal relationship with knowledge (Foucault, 1979).

Foucault’s writing considers how ‘mad’ people were treated in history, exploring the various methods and practices, which subjected people to different forms of discipline. Foucault suggests, these methods were used to treat and reform both ‘mad’ people and criminals (Proctor, 2017). Foucault’s concept of the panopticon prison (Bentham, 1995) is a useful concept when thinking about how power works within everyday discourses (Foucault, 1991). Foucault proposed surveillance is a key factor within institutions, stating modern society is ‘one not of spectacle, but of surveillance’ (Foucault, 1979, p. 217). The public health sector enforces the concept of surveillance through the collection of data around weight, illnesses, pregnancies and so forth, determining societal norms by categorising people in ‘normative’ or ‘deviant’ states, (Couch et al., 2015). Mathiesen (1997) defined the term ‘synoptican’, recognising the increased level of surveillance in modern society carried out by the public to monitor one another, increasing self-discipline. Couch et al. (2015) proposed that the terms ‘panopticon’ (Foucault, 1979) and ‘synoptican’ reside in a dyadic relationship, in which mental health disorders are considered ‘deviant’ from societal norms that need to be controlled and endorsed through practices within health, criminal law and media.

The notion of assumed, constant supervision links surveillance with self-regulation (Foucault, 1979, 1991). Foucault’s (1991) concept of governmentality suggests that people self-regulate and monitor their own behaviours as if they were being monitored and observed by another. The nature of government relates to ‘the conduct of conduct’, referring to ‘programmes, strategies, techniques for acting upon the action of others towards certain ends’ (Rose, 1999). Nikolas Rose (1999) devised the concept of responsibilisation, inspired by Foucault’s theory of governmentality. Governmentality extends power through discourses and the distribution of ‘truth’ and ‘knowledge’ (Rose, 1999). Such ‘knowledge’ is taken up by the ‘governing self’ to self-regulate and in the practice of ‘governing others’, (Lemke, 2002), through surveillance and control of conduct. Both theories, suggest the development of the ‘self-responsible’, independent individual, one who is responsible for themselves. Thus, people and their bodies become ‘objects’, as a source of ‘practice of control’ (Eckermann, 1997, p.157).

Rose’s Foucauldian position (1999) indicates the notion of otherness lies within institutions and is achieved through existing regimes of truth. For example, within psychiatry, a person can be considered ‘normal’ or ‘abnormal’ and normality is decided by ‘experts’ via moral judgements, a ‘valuation’, (Rose, 1999, p.133). The ‘psy complex’ is a term coined by Rose (1985) suggesting professionals with a ‘psy’ prefix are predominantly focused on locating the ‘abnormal’, which sits outside the norm, and aims to treat it. Rose (1985) suggests that psychology became a scientific speciality once it began to produce norms of social control (Proctor, 2017). The surveillance and social regulation of individuals (Burr, 2003) through ‘psy’ disciplines can be seen as covert and subtle, where ‘individuals come to construe, decipher and act upon themselves’ (Rose, 1992, p.144) in accordance with what is deemed normal and desirable. The effect of technologies of power is social control, ‘normalisation of subjects’ (Proctor, 2017). Therefore, ‘expert’ knowledge through the ‘psy’ disciplines determines ‘technologies of the self’, shaping how an individual understands themselves.

1.5 Feminist Critique

1.5.1 Gendered diagnosis

Gender variation in relation to ‘BPD’ diagnoses is noticeable, from studies that find no gender differences in community settings (Trull et al., 2010) to those that suggest that both men and women are equally likely to receive a diagnosis of ‘BPD’ (Grant, Chou, Goldstein et al., 2008). Yet, most research indicates that ‘BPD’ is a diagnosis frequently given to women (Johnson et al., 2003; Kaess et al., 2014; BPS 2006; APA, 2000). Statistics suggest up 75% of people diagnosed with ‘BPD’ are women (Kaess et al., 2014; APA, 2000; Swartz et al., 1990). The disproportionate number of women diagnosed with ‘BPD’ as opposed to men is concerning given there are no scientific or genetic markers to account for this statistic. Thus, ‘BPD’ can be considered a gendered diagnosis (Shaw and Proctor, 2005).

Gender is a system, that both produces and is produced within social discourses and practices and determines how people understand themselves as men and women (Wirth-Cauchon, 2011). Gendered understandings are significant to the discourses and practices around ‘BPD’. For example, failure to maintain the role of idealized mother, who selflessly hands her life over to her children and their emotional, physical, social needs, (Hays, 1996; Mesman et al., 2016) is considered as a contributing factor to borderline presentations in psychiatric and psychoanalytical discourses. Ussher (1991) suggests the psychiatric and psychoanalytical disciplines blame mothers for a variety of different presentations under the legitimacy of science. Contemporary ideology also expects ‘progressive’ women to balance motherhood with a career (Rottenberg, 2018, p.73). Chesler (2005) writes that not all women that have a mental illness are actually mentally unwell, but rather they are victims of a patriarchal society, placed in unsatisfying feminine roles, thus emphasising the importance of gender inequalities and how they disadvantage women. Constructions of femininity can be understood as removing the focus on the social and economic structures and systems in place, challenging gender inequality (Yoong, 2020).

Gender ‘non-conformity’ is evident in mental health diagnoses (Boysen et al., 2014). Studies found that women diagnosed with ‘BPD’ displayed amplified levels of demanding and dependency behaviours, however men who displayed the same behaviours did not receive the diagnosis (Gunderson & Zanarini, 1987), demonstrating that men too can present with ‘BPD’ symptoms but are less likely to receive a diagnosis. Lazar (2007) argues women are positioned in a socially dichotomous category to men, attributing specific behaviours and attitudes to each gender. Women are deemed more likely to take up psychotherapeutic and psychiatric treatment than men (Sansone & Sansone, 2011; Kessler et al., 1994), which can further increase the likelihood of them receiving a diagnosis of ‘BPD’.

Men’s presentation of distress and anger is rationalized within the context of a ‘bad day’, yet women’s distress and anger are pathologized and considered ‘emotional’ (Barrett & Bliss-Moreau, 2009). Research indicates men are socialised into masculine norms such as ‘boys don’t cry’ (Vogel, 2011) and are more likely to be diagnosed with substance misuse disorders (Kessler et al., 2005) and paraphilias (Langstrom, 2010). Men are held to account in very different ways from women, resulting in different psychiatric diagnoses. Research suggests men are more likely to die from suicide than women (Payne et al., 2008), positioned as more likely to ‘take action’ and complete suicide (Jaworski, 2014), whereas women are considered more likely to engage in passive self-harm and suicidal tendencies (Jaworski, 2014; Vogel, 2011). Yet, people with ‘BPD’ are considered at high risk of suicide as 73% of people with ‘BPD’ are considered to make three attempts in their lifetime and up to 10% will die by suicide (Yen et al., 2021). Thus, women with ‘BPD’ can be caught between different discourses in which they are considered ‘passive’ as well as ‘serious’ in their presentation of distress.

1.5.2 Trauma

A feminist perspective strives to address social injustices, including those placed on women diagnosed with ‘BPD’. One of the current understandings is the ‘trauma’ discourse. The Department of Health (2002) recognises that a significant number of women with ‘BPD’ have suffered a prior history of trauma and abuse. Research has shown that women diagnosed with ‘BPD’ are often survivors of childhood trauma and abuse (de Aquino Ferreira, Pereira, Benevides & Melo, 2018; Wirth-Cauchon, 2001; Stepp, Lazarus, & Byrd, 2016; Herman, Perry & Van der Kolk, 1989). ‘Hysteria’ and ‘BPD’ have been criticised as psychiatric constructions imposed on women that are survivors of abuse, by placing a focus on women and their personality structure as a deficit, requiring treatment or changes (Becker, 2000). For example, in the field of psychoanalysis, Freud (1896), suggested that women who reported histories of sexual abuse were in fact suffering with ‘hysteria’ and experiencing sexualised fantasies (Tasca et al., 2012). Critiques suggest that Freud neglected women’s narrative of sexual abuse (Rush, 1996; Mason, 1984).

People with ‘BPD’ are considered to have histories of complex trauma, experiencing prolonged abuse, often from a primary caregiver (Asnes & Leventhal, 2011; de Aquino Ferreira et al., 2018; Stepp et al., 2016). Research from both community settings (Castillo, 2000) and inpatient settings (Van de Kolk, 1989) found that seventy percent of women diagnosed with ‘BPD’ experienced sexual abuse in childhood. Kessler (2000) suggests that people who report a history of trauma have often experienced multiple experiences of trauma rather than an isolated incident. Abram et al., (2003) found that 84% of detained females had experienced significant trauma, averaging a number of 14 traumatic incidences. These findings suggest women’s experiences of trauma are typically managed through the criminal and psychiatric systems.

Most women who have reported childhood sexual abuse meet the criteria for both ‘PTSD’ and ‘BPD’ (Crowe, 2004). Thus, feminists such as Herman (1997) argue that ‘BPD’ is rather a response to trauma as opposed to a deficit to one’s personality, whilst others such as Becker (1997; 2000) suggest ‘BPD’ is as an oppressive act preventing women from talking about their experiences of gendered violence, and inequality.

Post-Traumatic Stress Disorder (PTSD) and Complex PTSD

Feminist, trauma expert, Dr Judith Herman, offers an alternative understanding to ‘BPD’, suggesting ‘BPD’ is ‘a little more than a sophisticated insult’ (Herman, 1992, p. 123). In 1997, Herman (1997) described a state of existential crisis for victims who have experienced trauma. As such, psychiatry’s attempt to acknowledge trauma was to place PTSD into a new chapter headed ‘trauma and stress related disorders’ in the DSM 5 as opposed to anxiety ‘disorders’ (Taylor, 2017). Symptoms include disturbed memories, flashbacks, nightmares, increased physiological anxiety bodily response, and emotional distress when remembering the trauma (Taylor, 2017). Cognitive Behavioural Therapy (CBT) is recognised as a useful treatment to alleviate such ‘symptoms’ (Taylor, 2017; Ahrens & Rexford, 2002; Cohen et al., 2009; Smith et al., 2010). A new category of Complex PTSD was recently created within the DSM-5 as a helpful way to acknowledge individuals who have experienced prolonged, repeated abuse and trauma and acknowledge their experiences of disempowerment (Herman 1992; Briere et al., 2010). The ICD-11 (2019) also added Complex PTSD, but with the same criteria for PTSD, plus additional symptoms including emotion regulation difficulties, dissociation, somatization and adverse effect of life systems (Cloitre et al., 2011).

A key critique of the psychiatric classification systems lies around comorbidity, in which it is possible for a person to receive a diagnosis of ‘BPD’, ‘PTSD’ or ‘Complex PTSD’ depending on the social judgement of the psychiatrist. ‘PTSD’ evokes a ‘non blaming' attitude from professionals with their clients (Becker, 2000). The court systems and juror decisions are seen to be heavily influenced by psychiatric information (Berryessa et al., 2015) with damaging ramifications for people with 'BPD'. Stefan (1998) found that courts of law discredited women who had a diagnosis of 'BPD' and their outcomes in court often entailed losing their child, being placed involuntarily into institutions, or coerced into medication, whereas individuals with a diagnosis of 'PTSD' were advantaged, securing benefits and support.

1.5.3 'Othering'

The categorization of social 'norms' creates the conditions for the 'other' to be produced (Graham, 2006), creating the categories of 'us' and 'them' (Adler-Nissen, 2014; Weis, 1995), reinforcing 'norms' as the status quo, whilst positioning the 'others' as those who deviate. The 'other' encompasses anyone that differs from the 'norm', and who has limited access to power as opposed to the norm population (Proctor, 2017). The process of 'othering' has been researched in the context of gender (Archer and Francis 2005; Francis 2006), race and identity (Phillips 2008; Preston 2010; Ahmad, 1993; Fine, 1994), sexuality (Brewis and Gavin 2010) and unequal social relations (Johnson, 2004). Those who identify as the 'other' have referred to feelings of powerlessness and social exclusion (Johnson, 2004).

The concept of 'othering' was theorized in the 1950's by feminist Simone de Beauvoir (1952) in relation to how women are unfavorably positioned in society based on their sex. Taking a historical viewpoint, de Beauvoir (1952) suggests that women have been positioned as inferior to men in all societies, from the ancient Greeks; Pythagoras wrote 'there is a good principle that created order, light and man and a bad principle that created chaos, darkness and woman' (Beauvoir, 2015, p.112), and within religious discourses such as Christianity, in which Eve, the 'other', is created from the rib of Adam. Current psychiatric discourse continues to 'other' women, positioning them as 'mad' in psychiatric discourses, 'bad' in social discourses or 'sad' in psychological discourses (Appignanesi, 2009). As previously mentioned, Rose (1985) writes about the 'psy' complex in which disciplines such as psychiatry and psychology assign a deficit to a person, thus 'othering' them in society.

Women with 'BPD' are also considered to be located in a 'double bind' diagnosis, reprimanded for expressing anger as well as internalising anger, communicated through self-harm (Shaw & Proctor, 2005). Chesler coined the term 'double-bind', linking social, cultural and psychiatric language through the position of womanhood, in which women face repercussions when they display normative expectations of femininity such as concerns with their weight, could place them at risk of a mental diagnosis such as an eating disorder; yet those who rejected the stereotypical societal female roles are at risk of shame and social judgement. Historically, women who present to services with high levels of dependency are likely to receive a diagnosis of 'BPD' (Gunderson & Zanarini, 1987). Conversely, more recent studies found that women who defy the social construction of femininity, showing signs of anger and hostility, are highly likely to be labelled with 'BPD' (Wirth-Cauchon, 2000; Shaw and Proctor, 2005). Thus, gender stereotypes lie at the heart of the construction and development of 'BPD' as a psychiatric diagnosis (Boysen et al., 2014; Becker & Lamb, 1994).

1.6 Stigmatisation

The term stigma is traditionally understood through the work of Goffman who referred to stigma as ‘an attribute that is deeply discrediting’ (Goffman, 1963, p.3), setting people apart from one another. Goffman (1963) theorised people in society depend on stereotypes to categorise people and enable effective communication. He termed these stereotypical expectations ‘a virtual social identity’ and argued that the ‘actual social identity’ of a person is the true identity of the person. Thus, the term stigma derived from the incongruity between individuals’ virtual and actual social identities (Goffman, 1963). Stigma is understood as a social process, in which people are subjected to stereotyping, separation and discrimination (Link & Phelan, 2001; Thornicroft, 2006), including towards those who access mental health services (Mackenzie et al., 2014; Arboleda-Florez & Sartorius, 2008; Corrigan et al., 2003; Sartorius & Schulze, 2005).

‘BPD’ is a highly stigmatising psychiatric diagnosis (Rivera-Segarra et al., 2014; Sansone & Sansone, 2013; Nehls, 1998; Aviram et al., 2006; Lauber et al, 2006; Catthoor et al., 2015). Qualitative research found ‘BPD’ to be a ‘problematic’, ‘stigmatizing’ and ‘hopeless’ label (Stalker et al., 2005), associated with shame (Rusch et al., 2006). People with ‘BPD’ have reported the experience of marginalization and oppression, as a result of receiving the diagnosis of ‘BPD’ (Bonnington and Rose, 2014). Unsurprisingly, stigmatisation increases difficulties in an individual’s life including inducing low self-esteem (Wright et al., 2000). People with ‘BPD’ describe ‘BPD’ as a ‘horrible term’ and request a rename (Stalker et al., 2005).

People with ‘BPD’ have been consistently subjected to stigmatization and unethical treatment from health professionals (Black et al., 2011; Bodner et al., 2011). For example, in the 1980’s a medical world news article used language such as ‘pains in the ass’ to describe people with ‘BPD’ (The Borderline Personality, 1983, p.51). Negative attitudes towards people with ‘BPD’ can be seen in the language used by mental health professionals using terms such as ‘manipulative’ (Markham, 2003; Markham & Trower, 2003; Fraser & Gallop, 1993; Cauwels, 1992) ‘angry’, ‘difficult’ and ‘bad’ (Ross & Goldner, 2009; Woollaston & Hixenbaugh, 2008; Everett & Nelson, 1992), ‘less deserving of care’ (Markham, 2003), ‘deliberately not improving’ (Fraser & Gallop, 1993, p. 340), ‘attention seeking’ (Hazelton et al., 2006), ‘the most difficult’ (Luhrmann, 2001), ‘impossible to work with’ (Cleary et al., 2002), ‘untreatable’ (Hazelton et al., 2006), ‘not sick’ (Crowe, 2004) and ‘dangerous’ (Wilstran et al., 2007; Woolaston & Hixenbaugh, 2008; Markham, 2003). Counter transference reactions have led to early discharge and ruptures in therapeutic relationships (Aviram et al., 2006; Forsyth, 2007; Cleary et al., 2002).

Research found practitioners struggling to work with self-harm and suicidality, left them feeling inadequate and helpless, and creating tensions in the therapeutic relationship (Cleary et al., 2002). Aviram et al., (2006) suggests people with ‘BPD’ are often left feeling invalidated; their strengths and survival coping strategies judged and quashed. People with ‘BPD’ are placed at risk of oppression through the common practice of psychiatrists withholding a diagnosis from their patients, or neglecting to inform them (Lester et al., 2020; Castillo, 2003; Crawford et al., 2007; Rogers & Dunne, 2011; Koehne, Hamilton, Sands & Humphreys, 2013), thus leaving people with ‘BPD’ often with little support available in society (Adshead et al., 2012; Barnicot & Ramchandani, 2015). Alarmingly, Bonington and Rose (2014) found people diagnosed with ‘BPD’ have experienced physical and psychological violence from public health professionals and the police. These studies demonstrate the significance of power held within dominant discourses and institutions (Foucault, 1979) and systemic risk of oppression to individuals with an ‘othering’ identity, conferred by a diagnosis such as ‘BPD’.

Limited qualitative research has focused on how people with ‘BPD’ talk about their self-image, yet one study by Dammann, Hugli, Selinger et al., (2011), found some people with ‘BPD’ depicted themselves principally as altruistic in nature, ‘sensitive, caring, helpful or friendly, (p. 521); one participant described themselves as a person with ‘a big heart’, another said, ‘I’m good at helping people’ and another ‘a peace-loving person’. These findings demonstrate a stark difference between self-reported perceptions of people with ‘BPD’ and the stigmatising language reported by mental health professionals.

1.7 Qualitative Research

Feminists support the use of qualitative research advocating the rights of participants as opposed to positioning them as research objects (Griffin, 1986; Mies, 1983). Qualitative research offers a richer and more comprehensive understanding of an individual’s experience than quantitative research does (Tracy, 2013) and is concerned with how individuals make sense of their world (Willig, 2013). It values social contextual factors (Willig, 2001). Reviews suggest that matters such as gender and agency are accounted for within qualitative research (Eagly, Eaton, Rose, Riger & McHugh, 2012). However, research in ‘BPD’ is mainly underpinned by a positivist, epistemological standpoint more commonly adopted in quantitative research (Dyson, 2014), legitimising the construction of ‘BPD’ as a medical illness. Research in Counselling psychology has many benefits including a drive for social action. Rafalin (2010) stipulates that good quality qualitative research offers further thought on the various social, cultural, political processes and discourses available to individuals.

Qualitative research investigating ‘BPD’ has focused on service user experiences alongside the efficacy of therapeutic approaches such as Dialectical Behavioural Therapy (Cunningham et al., 2004; Russell & Siesmaa, 2017; Blennerhassett & O’Raghallaigh, 2005) and Mentalisation Based Therapy (Bateman & Fonagy, 2008; 2010; Dyson & Brown 2016). Critical qualitative research has also explored the lived experiences of controversial practices within the field of psychiatry, including the practice of withholding the diagnosis of ‘BPD’ from individuals (Castillo, 2003; Crawford et al., 2007; Rogers and Dunne, 2011) and the practice of being informed of the diagnosis in discharge letters (Stalker et al., 2005). Fallon (2003) conducted research with a grounded theory approach and found four themes, including living with ‘BPD’, the service response, relationships, and their experiences travelling through the system.

Walker (2009) completed a narrative study into the experiences of women who have a diagnosis of ‘BPD’ and found that self-harm was considered an important part of their selfhood and sense of agency, as opposed to dominant ideas that construct self-harm as risky and harmful behaviour. Sagan, (2017) also conducted a narrative phenomenological study emphasising the importance of the experience of loneliness with individuals diagnosed with ‘BPD’. This study found that participants described a perpetual sense of loneliness and emptiness from childhood and learnt to manage this pain through the use of coping strategies, some of which were defined as detrimental and harmful. Spodenkiewicz et al., (2013) completed an interpretative phenomenological analysis (IPA) study with an adolescent population, indicating how difficult it can be for young people with ‘BPD’ to navigate through societal pressures during adolescence. Evans (2016) also conducted an IPA study to account for the subjective experiences of men who were given the diagnosis ‘BPD’, all of whom reported a history of complex trauma.

Although limited, there is a growing body of qualitative research which focuses on the lived experiences of people with ‘BPD’ in forensic settings (Lovell and Hardy, 2014) and those in inpatient settings (Rogers and Dunne, 2011). These studies identified themes relating to power and stigma, supporting the need for future qualitative research with a social constructionist viewpoint. Horn et al’s (2007) research of five service users, took a critical perspective of the construct ‘BPD’ using IPA. The study identified five key themes, ‘knowledge as power; uncertainty about what the diagnosis meant; diagnosis as rejection; diagnosis is about not fitting; hope and the possibility of change’ (Horn et al., 2007, p.1) and identified a gap in research for a social constructionist perspective using a discourse analysis methodology. Little research has taken a critical stance challenging the construction of ‘BPD’ (Dyson & Gorvin, 2017).

1.8 Chapter summary

To summarise, this literature review has considered the different ways in which 'BPD' has been constructed in various discourses. Understandings have included a theoretical concept of personality organisation in the field of attachment and mentalising (Stern, 1938; Bateman & Fonagy, 2013; Fonagy, Target & Gergely, 2000; Oud et al., 2018) as well as the appearance of 'BPD' as a diagnosable medical illness in the DSM-III (APA, 1980). This review indicates 'BPD' is a highly controversial diagnosis, with severe implications for those diagnosed, including experiences of stigmatisation and oppression (Rivera-Segarra et al., 2014; Sansone & Sansone, 2013; Nehls, 1998; Bonnington & Rose 2014).

This review highlights the positivist, medicalised discourse that constructs 'BPD' as a biological, diagnostic classification of mental illness is under scrutiny due to the lack of scientific validity and failure to identity biomarkers (Harper et al., 2020). Furthermore, this review found research into 'BPD' is grounded with a realist lens (Dyson, 2014), with little research challenging the construction of 'BPD' (Dyson & Gorvin, 2017) and how dominant discourses position those diagnosed with 'BPD'.

1.9 Research aims

In light of the literature review, which found majority of research into 'BPD' is grounded with a realist lens (Dyson, 2014), a qualitative study, adopting a social constructionist epistemology and Foucauldian discourse analysis (FDA) was chosen to destabilise the universality and dominant framing of 'BPD'. This study is concerned with how people diagnosed with 'BPD' use language to talk of their experiences of 'BPD' and how they navigate their identity accordingly. Discourse analytical studies offer a methodological advantage to explore the significance of language in its construction of one's identity and can help people that are socially oppressed as an instrument for empowerment (Willig, 2013; 1999). The aim of this study is to conduct a meaningful, purposeful study that promotes social change, on both a micro level, enhancing practitioners' empathy to those diagnosed with 'BPD', and a macro level, for services and commissioners to tackle social injustices people with 'BPD' face in mental health services. This study does not ignore or deny the experience of suffering, but rather has been conducted with the purpose of illuminating the current structures and systems in place that situate people with 'BPD' in limiting subject positions, impacting their subjectivity and sense of self.

1.10 Relevance to Counselling Psychology

Adopting a Foucauldian perspective, this study allows Trainee Counselling Psychologists (CP) to consider the variety of discourses, that interweave to produce the identity of people with 'BPD', offering a premise to challenge the taken for granted assumptions of 'BPD'. CPs are encouraged to reflect on their understanding of 'BPD' and how their personal values could influence and shape the therapeutic relationship. For example, by adopting the position of the 'expert' in therapy such as Cognitive Behavioural Therapy, CPs are in turn dictating social norms (Proctor, 2017), instructing how people with 'BPD' should think, behave and feel. Thus, the role as a CP becomes concerned with the social regulation of their client's behaviour (Rose, 1999). This study requests CPs to engage in reflexivity and self-examine practice linked to the role of power (Parker, 1992), including the role of power as relational, for e.g. between a CP and a client.

CPs concerned with a social constructionist perspective would benefit to consider the role of discourse, practice, subjectivity and experience (Willig, 2000). This study allows CP to consider how people with ‘BPD’ are positioned in society, and how these positions affect their sense of self. This review found women are more often diagnosed with ‘BPD’ than men (Shaw & Proctor, 2005), many of whom have histories of abuse and violence (de Aquino Ferreira et al., 2018). Thus, this study encourages CPs to consider the role of institutional power, social and gendered inequalities that people with ‘BPD’ face, which contribute to their presentation of distress. This may, in turn increase the uptake of working with people with ‘BPD’, who are typically marginalised in mental health services. Thus, this study aims to enhance professional practice, reflexivity and promote social inclusion, which is of great benefit to the field of Counselling Psychology.

2. Chapter Two: Methodology

2.1 Introduction

The aim of this chapter is to document the research process of this study. To begin, the research questions are reviewed, followed by the epistemological and ontological perspectives of this study and a rationale for choosing a Foucauldian Discourse Analysis (FDA). The methodological procedure including sampling and recruitment will then be addressed, followed by the data analysis procedure, detailing Willig's (2013) 6 stages of FDA. Reflexivity, both epistemological and personal will be explored, followed by the ethical considerations and quality criteria of this study.

The research questions drawn from Willig (2013) include:

- *How do individuals with 'BPD' construct their understanding of 'BPD'?*
- *What is the action orientation of the available discourses?*
- *What subject positions are made available to individuals in these discourses?*
- *How may an individual's subjective experience appear enabled, or restricted by the available discourses?*

This study aims to explore the discourses that people with 'BPD' draw on when talking about their experiences of 'BPD'. This study takes a keen interest to the different subject positions available to people with 'BPD' and the implications of these positions. Thus, the research questions that inform this study are: 'how do the discursive constructions of 'BPD' situate people with 'BPD', and what are the implications for their ways of being?'.

2.2 Theoretical framework

2.2.1 Social Constructionism

The reductionist approaches to human suffering (pathologizing) are visible in services and worldviews (Fee, 2000). Psychiatric classifications are accepted as objective, universal ‘truths’ in which non-desirable social traits are described as ‘symptoms’ (Burt, 1997). These psychiatric ‘truths’ are created and maintained through social practices (Burr, 2003). The theoretical underpinning of this research is social constructionism (Burr, 2003; Gergen, 1985), which adopts a critical position regarding ‘taken-for-granted’ ways of observing the world and our existence (Burr, 2003). Social constructionists refute traditional positivist approaches, rejecting the concept of rules and configurations as an underpinning of the real world (Burr, 2003). Instead, social constructionism offers a critical perspective about the world as an outcome of historical processes between people (McLeod, 1997).

Elder-Vass (2012) describes social constructionism as the most dominant component to come through the movement of post modernism. Post modernism rejects the notion of binary positions and considers historical, social and cultural influences of underlying structures. The postmodernism perspective challenges the concept of ‘truth’ and positivist approaches to how the world is observed and experienced (Hoffman, 1991). Postmodernism suggests that power exists within language (Burr, 2003), which can have positive and productive influences in shaping an individual’s identity (Gorji & Mortazavi, 2018).

2.2.2 Epistemological and Ontological Perspective

Ontology refers to reality and what it means to be human (Willig, 2019). The ontological perspective of social constructionism implies that language constitutes social and material reality and refrains from making specific claims about reality. Wetherell et al., (2001) propose the ontological nature of the world is that there is 'no single truth… reality is neither single nor regular, there are multiple realities and therefore multiple truths' (p.12). A constructionist perspective allows space for 'alternative ways of thinking about (or constructing) the world and the people in it' (Holt, 2011, p.67). Social constructionism does not aim to disapprove or prove a 'truth' and makes no assumptions; instead, it is concerned with *how* 'facts' are constructed and their implications (Wetherell and Potter, 1992). Thus, this study aims to deconstruct 'BPD' exploring the various ways it is constructed through talk.

Epistemology is concerned with the different ways of obtaining knowledge (Willig, 2019). The epistemological stance in this study is grounded in social constructionism, interested in how meaning is constructed through language (Burr, 2003). Language precedes thought and constitutes experience. Social constructionism considers multiple realities, which are constructed on different levels; a micro level considers conversations, narratives, and interpersonal communications, whereas a macro level considers the wider context, such as historical, cultural, and societal attitudes. Social constructionism aims to challenge the dominant discourses that position those who are oppressed due to factors such as their race, gender, disability, sexuality and so forth (Parker, 1999). This study aims to explore how individuals use various discourses to position themselves and considers how this shapes their experiences.

Traditional social and psychological theories construct personality as something that is fixed and essential, whereas social constructionist perspectives argue that personality and identity change, depending on the available discourses. Social constructionism takes an anti-essentialism position, in which ‘there are no essences inside things or people that make them what they are’ (Burr, 2003, p.5). Discourses around personality characteristics can change based on ‘who we are with, what we are doing and why’ (Burr, 2003, p.31).

Over the years, the concept of personality has changed, the 20th century is dominated by the medical constructions of mental disorders including ‘personality disorders’. Burr’s (1995) social constructionist perspective rejects the concept of personality as an internal true representation of the self, instead she proposed the existence of the ‘self’ between people in a social context. Gergen (1985) also rejected the idea of the ‘self’ as a stable structure, proposing the concept of identity as a social construction. Social constructionism proposes that ‘a great deal of human life exists as it does due to social and interpersonal influences’ (Gergen, 1985, p.265). Bruner (1990) proposed the term ‘distributed self’ where the self is distributed specifically in social and cultural contexts. FDA stipulates that both reality and identity are created and maintained through social exchanges through language (Burr, 2003).

The foundation of social constructionism is often considered as a relativist approach. The focus on language has been criticised for reducing the existence of reality in its entirety to discourses (Cromby and Nightingale, 1999). Others have criticised the approach for stating there is a ‘lack of a person’ (Langdridge, 2004, p.345) and dismissal of agency (Parker, 1992; Burr, 2003). Danzinger (1997) criticises constructionism's paradoxical limitation, as the approach requires the dominant discourses to 'exist' in order to challenge them. It has also been criticised for the rejection of essentialism (Burr, 2003). One could also question if 'anything' can in fact be considered 'real' including language. Social constructionism's key criticism lies within the fact that it reduces people to being 'empty' (Burr, 2003, p.119), raising the importance of acknowledging people's embodied experiences. Social constructionism cannot justify why some individuals choose or reject certain positions (Frosh, Phoenix and Pattman, 2003).

2.2.3 Critical Realist perspective

Bhaskar (1989) proposed an epistemological position inclusive of individual personal agency, whilst recognising the impact of the social material world challenging the epistemological limitations of discursive studies rooted in relativism. The critical realist position combines the social constructionist and realist position, considering non-discursive factors (Sims-Schouten, Riley & Willig, 2007), and acknowledging a place for 'biochemical, economic or social' structures (Willig, 1999). A critical realist epistemology challenges the premise that reality exists simply through discourse (Parker, 1992; Willig 1999) and acknowledges the existence of 'underlying enduring structures' (Potter, 2002). Critical realists do not anticipate that the participants within their study are necessarily aware of the underlying conditions that inform their presenting behaviours and experiences (Willig, 2012). A critical realist position considers individual differences in people, recognising why some choose to take up specific constructions and not others (Burr, 2003; Willig, 2000).

Direct realism believes that raw research data constitutes as reality, whereas the critical realist stipulates that research data offers information about the origins and foundations behind the subjective experience (Willig, 2019). Researchers vary in accordance with their understanding and presentation of findings, with regards to the existence of underlying structures in relation to their research (Willig, 2012), in which some are cautious of their findings as a possibility of truth (Frosh & Saville-Young, 2008), whereas others suggest more certainty in relation to the underlying structures (Hollway & Jefferson, 2000). A critical realist perspective helps to offer accountability for subjectivity, a key limitation in discourse analyses. A critical realist perspective acknowledges personal agency, the non-discursive influences and various ways of being in the world (Willig, 1999), including the embodied, material reality (Cromby & Nightingale, 1999).

Holding a critical realistic epistemological stance, offers an ethical standpoint to this study, in the field of Counselling Psychology (Ponterotto and Grieger, 2007; Willig 2019). Furthermore, a critical realist perspective, allows the opportunity for this study to analyse and understand ‘BPD’ as a construction, whilst proposing that participants have personal agency, which is why they may choose specific discourses over others (Burr, 2003).

2.3 Methodological rationale: Foucauldian Discourse Analysis (FDA)

A phenomenological approach was initially considered using Interpretative Phenomenological Analysis (IPA) as the methodological approach for this study. IPA is one of the most established methods, concerned with investigating areas of the human experience in the field of Counselling Psychology (Eatough & Smith, 2017). After doing some research, recent studies had already been conducted looking at participants' subjective experiences of 'BPD' (Horn et al., 2007; Lovell and Hardy, 2014). However, there was little research challenging the construction of what 'BPD' is (Dyson & Gorvin, 2017). Furthermore, discussions with the academic staff including, course tutor and research supervisor, prompted the decision to use of a FDA framework, to challenge the taken-for-granted knowledge about 'BPD'. Without researching what 'BPD' is, it is difficult to offer a standpoint, nor challenge the various subject positions and individual's subjective experiences (Willig, 2000). Studies using critical methodological approaches such as FDA, are increasingly more common (Willig, 2011; Willig, 2013), permitting exploration in which 'health' and 'illnesses' are talked about and understood through language (Willig, 2000, p.549).

Foucault referred to organised classifications of language as discourses that are constructions of meanings (Foucault, 1991; 2006). Foucault (1978) stipulated that power was linked to institutions through the different classifications of knowledge that function via guidelines, rules and practices. Institutional practices limit and support dominant discourses, legitimising the available talk to an individual (Willig, 2017). The institution of medicine affords the subject positions of the 'patient' and 'doctor' in which the doctor is able to objectify people into patients (Eckerman, 1997) through processes and practices such as diagnosing, treating with medicine, and sectioning. Foucault described power as a relational process employed between people as opposed to something that is owned by individuals (Boyle, 2020).

FDA favours the macro approach, interested in institutional practices, historical, social systems and consider discourses as ‘a system of representation’ (Hall, 2001). A macro approach to language helps to gain an understanding of ‘what is being done’ through language (Willig, 2013). This study acknowledges ‘BPD’ as a discursive object located within historical, social, political, cultural discourses. FDA focuses on how objects (things) and subjects (people) are constructed through discourses (Willig, 2013) and the wielding of power, within processes and practices, promoting social control (Foucault, 1979; Fairclough; 1993). Foucault’s ideas about the relationship between discourse and how people make sense of the world and themselves (Foucault, 1990; Willig, 2000), are used in this study to focus on the links between language, power, subject positions and agency.

FDA conceptualises language as ‘constructive’, ‘functional’ (Willig, 2001), and a form of ‘social action,’ (Potter and Wetherell, 1987), aimed at challenging dominant discourses (Parker, 1992). ‘BPD’ is considered a challenging construction; hence the key interest of this study is to explore what ‘BPD’ is and what it affords individuals who identify as having ‘BPD,’ including implications to their sense of self (Willig, 2013). Power is located within the various systems of knowledge, or discourses, and linked to the available subject positions within discourse. FDA is interested in what subject positions are made available by particular discourses and what they enable and restrict in the subject’s way of being (Holt, 2011). Subject positions limit individuals to what can be written, spoken, and thought about within a given historical context (Willig, 2017). With a focus on discourse, this study analyzes how people with ‘BPD’ challenge power through resistance (Foucault, 1990), subject positions and action orientation.

2.4 Procedure

2.4.1 Sampling and Recruitment

A total of 5 participants were recruited for this study. All participants were aged over 18 and self-identified as having a diagnosis of ‘BPD’. Participants were recruited through a flyer advertisement (Appendix 2) that was posted in a range of sites, including the university building and counselling services. A number of agencies were contacted, some of which distributed the flyer via email and posted the flyer on their social media accounts to increase recruitment. A number of challenges occurred during the recruitment stage, which prompted the decision to complete an amendment ethics form (Appendix 9) to request to carry out interviews online via Skype, yet this did not improve the recruitment process. One woman shared her reluctancy to participate, expressing the opinion that only a person who identified as having ‘BPD’ could represent her voice; efforts to convey my motivations for this study, were not convincing enough at the time.

Those who shared an interest in the study corresponded with me via email asking questions about the study, eligibility and travel. A copy of the flyer and information sheet (Appendix 3) were emailed to all interested. Participants who remained interested, were given a consent form (Appendix 4), to ensure they were fully aware of the study, including their right to withdraw from the study. Once they agreed to take part in the study, a convenient location was mutually agreed at which to meet and conduct the interview.

A purposive sampling was used as this study was specifically focused on adults with a diagnosis of ‘BPD’. Smith and Osborn (2008) suggest that purposive sampling is designed for individuals who will find the research question significant. Snowballing sampling also took place, where an existing participant recommended the study to a friend who also had a diagnosis of ‘BPD’. With the exception of age, to ensure participants were adults, there were no other requests for any demographic information. This corresponds to discourse analysis principles that stipulate defining individuals into categories shape and change the object of the research, discourse analysts hesitate to place individuals into classifications as ‘such information out of context suggests particular social categories capture the essence of people placed within them’ (Willig, 2013, p121). Inclusion criteria included the age of the participants (aged 18 and above) with a diagnosis of ‘BPD’. The exclusion criteria included children and anyone who was unable to give consent (e.g. under the influence of drugs and alcohol).

2.4.2 Pilot Interview

A pilot interview was completed with a colleague, prior to commencing this study. The pilot interview was not completed with an individual with ‘BPD’ so as not to lose valuable, analysable data for the study. The aim of the pilot interview was to enable reflection on the process of conducting an interview, including the wording of questions, approach to asking questions and time management. Positive feedback from the pilot interview was received, in terms of the set-up of the interview, the structure of questions and the pitch and tone of the questions asked. Constructive criticism regarding the questions was also offered, it was clear that the question ‘what is BPD’ posed some difficulty. Thus, changes were made to include some useful prompts, to help when interviewing participants, such as ‘what is ‘BPD’ to you?’, ‘I would like to hear what you have to say about ‘BPD’ and ‘tell me about yourself in relation to ‘BPD’. The overall experience of the pilot was valuable, aiding to some changes to the interview process, whilst increasing self-confidence to deliver the interviews for this study.

After the pilot interview, notes were made in a reflective journal regarding the experience, including the difficulty to stay with the role as the researcher and not Trainee Counselling Psychologist (CP). This tension was managed through the use of an ongoing reflective diary and supervision, mindfully moving between roles, focusing on the role and responsibilities as a researcher, the research aims of this study and the role of participants, as opposed to the role and responsibilities of a Trainee CP offering therapy to clients. The colleague who volunteered in the pilot interview shared the set-up of the room and available resources made her feel comfortable and relaxed. Thus, further reflections regarding the room set up was considered including the amount of furniture, access to a toilet, refreshments, a clock and comfortable seating.

2.4.3 Semi-structured interviews versus focus groups

Focus groups were considered as the method to gather data as they engage a few participants invested in a specific subject matter (Wilkinson, 2008). They can also offer a ‘relaxed and spontaneous’ atmosphere (Billig, 1997), useful for discussing ‘sensitive topics’ that enable personal explorations and disclosures (Wilkinson 1998). However, a limitation of a focus group is that some individuals may feel unable to express themselves and some may dominate the flow and talk within the setting (Willig, 2013). Speer (2007) scrutinised interviews as a method of data collection, suggesting they compromise the ability for free talk.

There were thoughts to conduct both one-to-one interviews and a focus group, however participants were recruited from various locations, making it difficult to source an accessible location for all. Consequently, one-to-one interviews were the main data collection method. This study was informed by the work of Holstein and Gubrium (2004), who propose that all methods are considered to impact the production of discourses and thus natural occurring talk is just as reliable and authentic in an interview as other methods. A semi structured one to one interview method is considered a useful data collection method (Willig, 2013) as it allow the opportunity to ask specific questions about 'BPD'. For example, questions explicitly asking how people in mental health services talk about 'BPD'. Interview questions were open, non-directive (Robson, 2002) aimed to facilitate discussion with a curious, attentive stance and capture the client's language. These questions were delivered meeting the proficiencies of a Trainee CP, offering an empathic, non-judgemental atmosphere.

2.4.4 Interview process:

A total of five one-to-one semi-structured interviews took place in person, lasting between 60-90minutes. Online interviews were offered but all participants chose to conduct the interview in person. Initially, all interviews were going to be held specifically at charity settings, however after discussions with my supervisor it was agreed to offer up more locations, which were convenient for the participants (Smith and Bowers-Brown, 2015; Krueger and Casey, 2014). Locations included a room in the university, a charity setting and a public setting. Depending on the location, participants were reimbursed for train fare and offered refreshments. One participant lived quite far away from London, and it was difficult to source a charity setting that was open over the weekend. Together, we agreed on location, which was a public setting. A risk assessment took place, with careful consideration to source a quiet place to sit, and the opportunity given to the participant to end the interview short at any point.

Prior to the start of each interview, participants were informed of the study aims and given a copy of information sheet. Each point was carefully discussed, to ensure the participants were clear of expectations of their involvement and their rights as a research participant (Appendix 3). Once the participants had agreed to participate, two copies of the consent form (Appendix 4) were discussed and signed, one for the participants and one for my records. Participants were informed they could ask questions, take breaks and stop if they wished. Post-interview, debrief information sheets (Appendix 8) were given to participants detailing services should they require some support. Participants were kept updated and informed of any delays via email for e.g. maternity leave/ COVID-19 Pandemic. All participants will also receive a copy of the final thesis via email with the opportunity to contact me to discuss it, as a small token of appreciation for their contribution to this study.

2.4.5 Data Handling and transcription

The interviews were audio recorded using a digital voice recorder with participants' consent. The use of audio recording is an established method for data collection (Speer and Hutchby, 2003). Note taking was not chosen as it has been demonstrated to reduce rapport due to the lack of eye contact (Willig, 2013). Video recording was deemed unnecessary for a macro focus on the wider social context of discourse that does not account for detailed emphasis on talk (O Reilly, Parker and Hutchby, 2011). All audio recordings were stored on a device following City, University of London, policies and guidelines. All data, including transcripts and de-identifiers were stored in a secure locked filing cabinet in a secure location. All digital documents were password-protected and not shared with anyone other than the research supervisor. City University's Information Governance, confidentiality and safeguarding policies were followed.

As the study had a macro focus, the transcribing process did not entail micro details of talk (Willig, 2013). The process of transcribing involved some elements of Jefferson Lite (Parker, 2005) including (.) denoting a micro pause, (…) when pauses were greater and (sighs), (whispers), (laughter) and (stutters) as they were seen to be valuable forms of discursive communication. Italics were used for highlighting words that reflected longer emphasis, capitals for words used loudly and notes of non-verbal sounds such as 'mm' and 'hmm'. The process of transcribing offered another layer of reflection and connection to the data.

2.5 Reflexivity

2.5.1 Methodological reflexivity:

Qualitative research requires the importance of reflexivity to recognise the role researchers play within the research process (Willig, 2013). I engaged in reflexivity by maintaining a reflective journal, documenting my thoughts, feelings, and changes within this study (Lincoln and Guba, 1985). I also engaged in regular supervision, which provided me with a place to soundboard ideas and consider new ways to manage obstacles through collaborative discussions with my supervisor (Russo & Thompson, 2012). These reflections prompted several changes to the original research proposal. For example, I decided not to recruit young people, an underrepresented voice in this field of research (Beckett & Warrington, 2015) because I had ethical concerns and felt it restricted the recruitment process. I also decided not to recruit via NHS ethics, was for two reasons, firstly to prevent a delay in the recruitment process, and secondly, not to limit the range of participants. These important changes led to an increased amount of time focused on the methodology stage (High & Montague, 2006).

The recruitment flyer was very general and open (Appendix 1), which was my intention as the aim of this study was to ask people with ‘BPD’ to share their experiences of ‘BPD’. The recruitment process posed some difficulties, as mentioned earlier one woman was reluctant to participate as she felt only a personal with ‘BPD’ could represent her voice. Furthermore, one woman shared her experiences of being diagnosed by her GP with ‘BPD’, but she had rejected the diagnosis, claiming her GP had misdiagnosed her. She reported she could not participate in the study as she did not have a diagnosis of ‘BPD’. I made efforts to encourage her participation as I was keen to know how she constructed her experiences and wanted to hear of the available discourses and subject positions she drew upon to enable her to reject the diagnosis. However, she felt her identity was not of a person with ‘BPD’ and thus would not be able to relate to the study.

Post recruitment, I wondered whether I had excluded a number of people from taking part in this study, based on the wording on the flyer and inclusion criteria. For example, if the research question was more open such as ‘have you ever been given a diagnosis of ‘BPD’, it may have encouraged a higher take up to the study for people who have been diagnosed but do not identify as having ‘BPD’.

In the recruitment material and the recruitment processes (e.g. emails/ flyers/ calls/ interviews), I positioned myself as a researcher in the field of Counselling Psychology, conducting a study in the field of ‘BPD’. I spoke with some people who showed an interest in the study and shared my motivations to conduct this study, including my professional experience working in the NHS. However, at no point had I made it explicit that I did not have a diagnosis of ‘BPD’. On reflection, this omission may have prevented uptake for those interested in the study and may have limited the talk of those who took part in this study. During the interview process, two participants asked me explicitly whether I had ‘BPD’, which I responded I did not. Despite my efforts to offer a critical and reflexive position during the interview process, I became aware that my identity as a person who does not have ‘BPD’ may have attributed to the inherent power imbalance between myself and the participants.

Foucault considers power as a relational process employed between people, (Foucault, 1978). I frequently engaged in reflexivity around the power dynamics embedded within the assigned positions, myself as researcher and those who chose to partake in this study, as participants. I considered whether these positions made it difficult for women to talk about aspects of their lives (Pugh and Coyle, 2000). Frosh (2003) mentions ‘every encounter is a site for the generation of new identity positions’ (p.1557). I therefore wondered if my identity as a Trainee CP and my rationale for this study may have positioned me as an ally, enabling talk in the interview process. Furthermore, my identity as a Asian, British woman may have facilitated talk, one who is familiar to the position as the ‘other’ in society. Attempts to flatten the power hierarchy involved keeping a reflective journal post interviews to note my thoughts, feeling and any issues relating to the power dynamics, as well as considering matters such as reimbursing travel costs, choosing a venue that the participants felt comfortable with, the set-up of the room. I informed the participants of the nature of study through discussions and the information sheet (Appendix 3) to ensure participants were clear of the expectations of their involvement. This was also to prevent the possibility where participants may mistake the research as therapy (Russo & Thompson, 2012). However I hoped the participants experienced the interviews as a therapeutic process, enabling them to share their journey so far of ‘BPD’ with me.

2.5.2 Personal reflexivity

Researcher positionality refers to the ‘perspective shaped by the researcher’s unique mix of race, class, gender, nationality, sexuality and other identities’ (Mullings, 1999, p. 337). Personal reflexivity involved the tension of my position of wearing ‘too many hats’ in my professional career (Seider, Davis & Gardner, 2007), and the exposure to dominant biomedical discourses. I noted these tensions in my journal and also discussed them further in supervision (Russo & Thompson, 2012). During the process of data collection, Wetherell (2003) suggests the importance of keeping neutral, informing the initial decision to bracket my own personal beliefs.

As a co-constructor in the interview, consideration was made of my contribution and preconceived assumptions (Potter and Wetherell, 1995), staying close to the aims and objective for the study as valuable conditions required to carry out this research (Willig, 2013). During the interview process, with my pre-existing knowledge of ‘BPD’, I tried not to impose on what the participants said during the interviews. Journaling my thoughts during this process, including my own positioning (Willig, 2013) increased my awareness to my inherent beliefs and attitudes of ‘BPD’. For example, I noticed how I became even more aligned to my feminist position whilst conducting the literature review. However, supervision helped me reflect on the research aims of this study.

Bourke (2014) urges researchers to self-scrutinize, with a specific reflection on the position of the ‘other’. In my journal, I reflected that my position as an Indian woman, often left me feeling ‘othered’ in society in various situations, for example job interviews, meetings or socialising with peers. These reflections helped me consider my position as the ’other’ and how it influenced the research process so far, including my interest in the feminist critique of ‘BPD’ and the critical psychiatry movement. The position of the ‘other’ shapes how I see the world and how I position myself within it, thus was considered as a contributing factor that influenced this piece of research, adopting a social constructionist perspective to ‘BPD’.

Furthermore, in relation to the participants of this study, I positioned myself as a researcher ‘in the middle’ (Breen, 2007). I do not identify as a member of ‘BPD’, which some may class as an outsider position (Kanuha, 2000), however as Breen (2007) highlights, the two ends of insider and outsider positions, are dichotomous and fixed. The outsider position felt too detached, as I was informed by own life experiences, my identity as a British-Indian woman in society as ‘the other’ to the White dominant western perspective (Taylor, 2001), thus locating myself in between the two dichotomous positions (Dwyer & Buckle, 2009).

As discussed my identity influenced the recruitment process, for example some people who were interested in the study decided not to participate because I did not have a diagnosis of ‘BPD’, thus positioning me as an outsider. It is possible that my identity meant recruiting people who identified themselves as ‘survivors’ of ‘BPD’ were difficult to recruitment, leaving them absent from this study. I also consider my lack of confidence in social media, affected the number of people recruited in this study. Had I engaged in some training on how to recruit via social media platforms, I may have felt more confident and equipped to recruit online.

Another challenge during the interview process was the slippage between my identity as a Trainee CP and researcher. Despite efforts to manage this conflict, I often found myself slipping between roles and wanting to offer therapeutic intervention. To reduce the tension, I made notes after each interview, which helped me build my confidence in the position as a researcher, improving my delivery in the interviews. My identity as a Trainee CP equipped me with the skills to build a therapeutic rapport with the participants, which helped gather information in the interviews.

2.5.3 Epistemological reflexivity

Epistemological reflexivity refers to the way the researcher influences the project in their theoretical approach (Willig, 2013). Reflexive awareness informed the research question at hand (Willig, 2019) and was considered throughout this study. I found deconstructing 'BPD' posed a greater task than anticipated and sought supervision, which was instrumental in helping me take a step back and look at what was being *done* through the language. A key topic of discussion in supervision, was the epistemological perspective of this study, which makes no absolute claims about reality. Frequent slippage to my personal beliefs meant I would often fall into a feminist, realist position, discovering a specific truth, but I soon developed a better understanding of the social constructionist perspective, which considers multiple 'truths' (Willig, 2013).

Self-knowledge is regarded as an invaluable pre-requisite for trainee counselling psychologists (McLeod, 1998). My self-knowledge developed, as my awareness of the epistemological position developed, naturally moving away from the positivist perspective and towards that of a critical realist. As a trainee CP, researching 'BPD', a critical realist perspective fitted best with my personal and professional values and beliefs (Willig 2012). Currently, I instinctively view the 'self' to exist between people in a social context (Burr, 1995) and hold in mind that individuals accessing mental health services may present due to unresolved conflict in their lives in relation to social inequalities (Shaw & Proctor, 2005). As I approach the analysis, I am mindful there may be further pulls to my personal, feminist perspective and have therefore made notes to remind me of the aims of this study.

2.6 Data Analysis

2.6.1 Analytical procedure:

Inspired by the work of Foucault, an FDA study focuses on the exploration of language and subjectivity (Willig, 2008). There are no specific rules to conducting FDA, however researchers have offered useful guidance to the approach (Parker, 1992; Holt, 2011; Willig, 2013; Arribas-Ayllon & Walkerdine, 2008). In order to enhance the quality and rigour of this study, this study follows Willig's (2013) six-stages of FDA to analyse the data. This analysis is concerned with the role of discourse and how they construct objects and subjects (Willig, 2013).

The six-stages of Willig's FDA procedure are outlined below (Willig, 2013):

- **Stage 1- Discursive constructions:** The primary focus of this stage is to identify the different ways in which the discursive object ('BPD') is constructed through talk, focusing on both the 'implicit' and 'explicit' references (Willig, 2013).
- **Stage two- Discourses:** This involved locating the various discursive constructions of 'BPD' with the wider discourses.
- **Stage three- Action Orientation:** The third stage is concerned with what is being *done* by the use of the various discourses addressed in stage two, exploring the possible functions and gains of the various discourses (Willig, 2013). This stage considers the function of the different discourses and how they relate to the various discursive constructions available in the transcript (Parker, 1992).

- **Stage four- Positioning:** This stage is concerned with the way in which discourses constructs subject and objects positionings. Subject positions are defined as ‘locations from which to speak and act’, which enable propositions for subjectivity (Willig, 2013, p.132).
- **Stage Five- Practice:** This stage is interested in the links between practices and discourses (Willig, 2013). Discourses inform practice, which can restrict practice or enhance opportunities and options. This aspect of the analysis is concerned with how some practices become legitimised, consequently reinforcing the discourses.
- **Stage Six- Subjectivity:** Particular ‘ways-of-seeing’ and ‘ways-of-being’ in the world are elicited from accessible discourses (Willig, 2013, p133). This stage considers personal agency and how a participant may experience the world, based on their subject position within specific discourses.

2.6.2 The process of analysis – a reflective account

Researcher reflexivity is of great importance when conducting all qualitative research. I kept a reflective journal during the process of this study, documenting the position, as co-constructor (Potter and Wetherell, 1995) and that of the ‘struggling researcher’ (Willig, 2013). Initially, my struggles were related to the theoretical assumptions, the epistemological position of this study and how best to account for subjectivity. Whilst thinking of how best to start the analysis, I was lucky to have open, invaluable discussions with my supervisors who offered strategies and advice on how to carry out the analysis, using Willig’s 6 stages of FDA. In relation to my tension regarding subjectivity, I was able to acknowledge the subjective experiences of the participants at stage 6 of the analysis, which would be made possible through exploration of subject positions (stage 4).

I followed Willig's (2013) proposal of reading each transcript line by line, making annotations with each phrase, which enabled an effective start to the analysis with more clarity and cohesion. The process then began focusing on the discursive object (stage 1) within the text, followed by the rest of the stages.

Stage 1: The process of data analysis involves interpretations of transcriptions (O'Connell & Kowal, 1995; Holt, 2011), followed by coding, understanding the function of text and choosing selections of extracts applicable to the research question. I initially read, re-read the transcripts and listened to the audio multiple times, considering the different ways, in which participants referred to 'BPD' (Demuth, 2013; Willig, 2013). I colour coded the different constructions including 'diagnosis', 'label', 'condition', 'it' and so forth. This information was then translated into an excel table, with a column for the discursive object and another to line reference (Appendix 11).

Stage 2: This process was shaped and influenced by my own social, political, and cultural background and knowledge. For example, the motivation for this study came with a desire to see changes in practice for people with 'BPD'. My long standing experience working within the NHS and my enthusiasm for social change, meant this study was carried out with a critical lens to the construction 'BPD', one that is critical of the taken for granted, predominantly psychiatric discourses. This meant I was able to notice talk shared by the participants' of their experiences of oppression, marginalisation and 'othering'. However, at times I struggled to notice talk that privileged the psychiatric discourse, which was discussed in supervision. I was able to take a step back and in essence park my own assumptions to one side. These reflections allowed me to appreciate the data from the interviews without my preconceived ideas, which led to some surprises. Having never conducted an FDA before, supervision helped me approach the next stages with further clarity. The initial excel table grew, with a column documenting the dominant discourses, followed by a column documenting my reflections during the analysis process (Appendix 12).

Stage 3: I found this stage challenging as I struggled to understand the concept of action orientation. Initially, I was confused between stages 3 and 5 and thus sought supervision to develop my understanding. This process helped me consider the function of the various constructions and what the participants gained from deploying these constructions (Willig, 2013), analysing what was being *done* in and with the text. My notes on the excel spreadsheet (Appendix 13) were limiting, however after completing the full six stages, I returned back to this stage with a greater understanding of FDA. This enabled me to go further in-depth in the analysis, focusing on the function of talk. In doing so, I was able to develop a sub section specifically focusing on this stage, which will be discussed later in the following chapter.

Stage 4: This study is concerned with how individuals with 'BPD' are positioned across dominant discourses, thus stage four was a key aspect of the analysis process. After discussing it in supervision, I felt confident to conduct this stage. I reflected in my diary that I was drawn to this stage as subject positions offered a way of addressing the participant’s subjectivity. My initial thoughts on subject positions were added to the excel spreadsheet (Appendix 13), but further developed whilst compiling the analysis chapter.

Stage 5: I found this stage challenging, as mentioned earlier I had got stage 5 confused with Stage 3. However, I managed to understand the importance of the relationship between discourse and practice by drawing on Willig’s (2013) guidance to focus on ‘what can be said and done from within different discourses’ (p.132), when analysing the data.

Stage 6: Subjectivity was held in mind throughout the analysis process as I was keen to analyse the implications for subjectivity, i.e. ‘what can be felt’ (Willig, 2013, p.133) from the way they were positioned in dominant discourses. I was keen to analyse the different ways people with ‘BPD’ could feel from the way they were positioned in dominant discourses. I colour coded the transcripts with my interpretations of subjectivity and made initial notes on the excel spreadsheet (Appendix 14). This was then developed during the write up.

2.7 Data quality and validity

According to Yardley (2017), qualitative data is limited to the researcher’s social and cultural perspective, and research aims for the study. This study aimed to uphold validity throughout the entire process through reflexivity and exploration of the research aims. The quantitative stance to research has been deemed ‘inappropriate’ for qualitative data, that compel a different approach to consider validity (Yardley, 2017). Changes were made throughout this study, including research questions, recruitment, and data collection, forming a process of adhering to research validity (Willig, 2013). Yardley (2000; 2008) suggests four key areas to ensure data quality and validity, outlined below in relation to this study:

Sensitivity to context: This study was carried out with sensitivity due to the concerns that the interviews might produce accounts of emotional distress. The possibility of distress was made clear via information sheets, debriefs and open discussions. Respect and sensitivity were maintained through the analysis and write-up; this study acknowledges women's talk of suffering but talk is analysed through a discourse approach. Sensitivity was considered to the use of language chosen to talk about women in the study, for example, the word 'victim' can depict individuals as 'passive' and the term 'survivor' can depict such individuals as 'strong' (Papendick, Bohner, 2017; Barry, 1979; Anderson & Gold, 1994). This tension was managed by recognising the participants as active agents, and using words that came from the text, that is, the term victim was used by individuals locating themselves within the discourse of victimhood.

Commitment and Rigour: Yardley (2008) encourages researchers to consider their personal and professional motivations, aims, language, social and cultural influences, as these factors inevitable influence and shape the findings of the study. A personal, reflective account was documented earlier in this chapter to address how these factors unavoidably influenced how the analysis took place (Yardley, 2008). Furthermore, reflective accounts focusing on the methodological procedure, epistemological position and data analysis process have also been explored earlier to enhance rigour. Yardley (2000) highlights the need for commitment and rigour by the researcher to ensure quality within the process. Through the process of engaging with the text regularly and consistent supervision, rigour and commitment was upheld.

This study was also conducted with a key focus on power, including that of the power inherent within the position as researcher that determines the interpretation, which requires ethical consideration (Willig, 2013). This study was carried out with passion and a commitment to the participants in all aspects of this study including, recruitment, data collection, interviews, and data analysis. In terms of the data analysis, the process of reading and re-reading, assessing, and examining the research was a meaningful process, promoting validity within the study (Potter, 2002). A reflective journal and discussions in supervision were key to enhance the quality of this study, for example sticking closely to the language of the text from interviews and what was being done in the text, helped find some surprises, thus improving the quality of the analysis (Parker, 1999). Yardley (2008) highlights the importance of providing a comprehensive account of how to code data to promote validity. This was an ongoing process, which began in the initial stages of data analysis procedure as tables (appendix 11) but turned into the final piece with revisions and reflections.

Transparency and Coherence: From the initial process of recruitment, all parties interested in participating in the research were given information about the research and the aims of the study. Information was sent across including an information sheet as well as consent forms, to all participants prior to interview. During the interviews, information sheets were revisited to ensure the participants were fully aware of the study, prior to completing the interview, as well as offering the opportunity to ask questions. All questions raised were answered for those who partook in the research and a debrief took place at the end of the interview. The analysis process was conducted with passion, with full immersion into the data, with necessary regular breaks, allowing space for reflexivity. Ethical considerations, reflections, journaling and discussions with supervisors were paramount in the research process to enhance coherence, ensuring the findings from the data analysis derived from the data itself, as opposed to preconceived ideas. This chapter documents clearly details of the recruitment materials and processes, alongside reflective accounts with details of how decisions were made, as a mean to promote transparency and coherence to this study.

Impact and importance: Qualitative research of good quality, focuses on social injustices, offering an alternative, proposing hope and change in practice (Denzin, 2005). Of key importance for this study was to understand how dominant discourses positioned those with 'BPD' as well as how those with 'BPD' positioned themselves and resisted dominant discourses. This motivation was driven by a passion to increase critical, alternative reflexivity in practitioners with the hope of influencing service improvement, policy makers, commissioners, and counselling psychologists (Kogan & Brown, 1998). Willig (2012) highlights the importance for research to explore discourse and practice that inherently hold biases. Thus, prompting the decision to choose a methodological approach that is less common than other qualitative methods within Counselling Psychology to research 'BPD'.

2.8 Ethical considerations

As a CP in training, this research complies with the British Psychological Society's (BPS) Code of Ethics and Conduct Guidelines (2018) ensuring that participants are 'given ample opportunity to understand the nature, purpose and anticipated outcomes of any research participation, so that they may give consent to the extent that their capabilities allow' (BPS, 2018). This study received approval from the Research Ethics Committee, City University (Appendix 1). There were two important ethical concerns identified during the ethics procedure of this research: the inclusion of possible vulnerable adults; and the potential for possible emotional distress. Skills and training as a CP Trainee were an advantage to manage possible sensitive issues during the interview. In addition, to minimise the possibility of emotional distress, participants were given the consent form (Appendix 4) and information sheet (Appendix 3) prior to the interview, to ensure they could make informed decisions about participating. This was repeated when meeting face to face for the interview prior to signing the consent form. Participants were aware they could withdraw from the study at any time.

Furthermore, a debrief took place (Appendix 7) offering a space for the participants to ask any questions or offer reflections, post interview. A debrief handout was given, detailing support services post interview (Appendix 8). City University policies were followed in the completion of this study, including information governance, health and safety, confidentiality and a risk assessment (Appendix 9) was completed taking into consideration measures for safeguarding. Research participants were informed of their rights to confidentiality as well as the limitations to the confidentiality policy, and all participants voluntarily consented to take part without coercion (BPS 2018). Participants' identities were protected through the use of pseudonyms and the identifiers were stored in a secure location. The storage of data adhered to the BPS (2018) code of ethics, specifying that all data will be destroyed after five years of completion.

2.9 Methodology Conclusion

To conclude, this methodological approach is informed by FDA, adopting a macro approach, with a specific focus on the wider context in relation to power. In adhering to the epistemological perspective, this study will be taking a critical realist position, recognising the importance of subjectivity produced, by subject positions. This chapter outlined the value and importance of validity, ethics and reflexivity. The benefits of FDA have been discussed in relation to the aims of this study, challenging the construction of 'BPD'. A key aspect of the FDA approach includes exploration of subject positions, to gain an understanding of the link between discourse and power. This study observes how participants, draw on dominant discourses to construct 'BPD', examining how truth and knowledge are produced as opposed to discovering truths.

3. Chapter Three: Analysis

3.1 Chapter overview

This study took a critical approach to the taken-for-granted discourses to understand the construction of ‘BPD’, how participants drew on different discourses to talk about ‘BPD’ and how through this talk different subject positions became available. The research questions that inform this analysis are ‘how do the discursive constructions of ‘BPD’ situate people with ‘BPD’, and what are the implications for their ways of being?’. This analysis found through the various discourses, participants dynamically moved between subject positions, offering different ‘ways-of-seeing’ and ‘ways-of-being’ in the world (Willig, 2013, p.133), demonstrating how some discourses restricted personal agency, whereas others enabled access to affect.

All participants who took part in this study were women (based on my assumption), thus the participants in this study will be referred to as women in the write up. This decision came my inherent feminist position, that supports the feminist perspective that ‘BPD’ is a gendered diagnosis (Shaw & Proctor, 2005; Wirth-Cauchon, 2001). The structure of the findings will be presented with reflection on three broad dominant discourses, including psychiatric, psychological and gendered discourses, with consideration to the various ways ‘BPD’ was constructed through the women’s talk. These findings draw on the first two stages of Willig’s Foucauldian Discourse Analysis (FDA) model. This write-up will also include sub-sections under each discourse focusing predominantly on subject positions, drawing on the fourth stage of Willig’s FDA. In doing so, the hope is to demonstrate the limited locations available through dominant discourses that women could speak from, as well as how women used agency to move between the available positions dynamically.

The data analysis found significant talk drawing on the psychiatric discourse, in which the women actively resisted gendered, pathological positions. These findings prompted the decision to add a subheading demonstrating the back-and-forth 'double-bind' women with 'BPD' faced under the psychiatric discourse. This sub-heading aimed to shed light on institutional psychiatric power, highlighting the importance of discourse, power and how subjectivity is produced through subject positions. The analysis found that women moved between subject positions to orient towards positive self-representations. Considering Willig's third stage, action orientation, these findings prompted the decision to create an additional sub-heading demonstrating the women's resistance to stigmatising representations.

Willig's fifth stage, practice, is weaved throughout the findings, paying close attention to the various practices made available or denied under the various discourses and subject positions. Willig's sixth stage, subjectivity, is also weaved throughout, referring to women's agency and how they experience the world through the various subject positions. By structuring the findings in this manner, the hope is to evidence the constraints women with 'BPD' face across dominant discourses, as well as signifying the value and importance of the non-medicalised positions on the women's identity achieved through the third sector.

I would like to reflect that in this analysis, I am making claims regarding the ways in which women construct 'BPD' and how they are positioned across dominant discourses. This analysis aims to deconstruct talk, questioning how the discursive constructions of 'BPD' situate people with 'BPD' and the implications for their ways of being. However, as co-constructor (Potter & Wetherell, 1995), I would like to acknowledge that this analysis is one 'reading' of what is being performed in the analysis (Willig, 2013). This reading is informed and shaped by my long-standing experience working in the NHS, my pre-existing knowledge of 'BPD', my position as a mother, feminist, and Counselling Psychologist (CP) Trainee, as well as my motivations to conduct an FDA study that challenges the taken-for-granted discourses of 'BPD' and my engagement with the research process. Furthermore, I recognize that my analysis in itself could also be deconstructed.

3.2 Psychiatric discourse

All the women in this study drew on the taken-for-granted psychiatric discourse to construct 'BPD' as a legitimate mental health illness. The psychiatric construction of 'BPD' as a negative, pathological condition positions women as patients under the supervision and care of psychiatric experts. Psychiatrists complete assessments, offering diagnoses as an explanation for certain ways of feeling and being in the world, activating technologies of psychiatric power (Foucault, 1979). Utilising Willig's approach, with specific attention to stage four, subject positions, it was possible to see the dynamics of power relations between 'experts' and 'patients'. The analysis found the 'patient' position 'othered' the women in this study (Lupton, 1997).

From the subject position of the patient, women drew on medicalised language, such as *“symptoms”, “traits”, “self-harm”,* and *“suicide”* when describing their feelings and getting better was talked about through language such as *“prognosis” and “reduction of symptoms”.* FDA made it possible to analyse how the women in the study, from the position of the patient, were objectified through language related to practice (Willig’s fifth stage of FDA), such as *“assessments”, “diagnosis”, and “medication”.* According to Foucault, psychiatric discourses are linked to economical, and political efforts aiming for social regulation (Foucault, 1991). These practices are legitimised and made powerful through their positions within medicalised scientific talk. Power is not necessarily held by individuals but is everywhere, circulating within society, lying within both discursive and non-discursive relations (Foucault, 1978).

3.2.1 The legitimate patient

The subject position of the legitimate patient, enabled within the psychiatric discourses, was considered to offer the women a more favourable identity, offering a reason for their feelings and behaviours that would otherwise position such women as ‘bad women’ in society. By applying the first two stages of Willig’s method, discursive constructions and discourses, the below extracts demonstrate how the women in the study drew on dominant discourses when constructing ‘BPD’. In particular, the below quotes demonstrate the implications of the psychiatric discourses in shaping the women’s subjective experiences. In the below excerpt, Tanya draws on the medical discourse, using language such as “*clusters”, “traits”, “symptomology”* to explain her feelings and behaviours:

‘I saw in a book once like, they had this like this diagram, it’s a line going this way and like that (using her hands to show the researcher the lines)…. and you have like cluster b traits, it’s like narcissistic, um socio what’s it, narcissistic, BPD, histrionic, and an antisocial and ….. where your traits are, and then you are not just like one, you can have some of this and some of that, so you can like, its more about your symptomology rather than you are this….Like nobody is the same. (Laughs)…….. Like, yeah, and at different points in throughout where your illness develops, sometimes you are going to be very histrionic and those traits will be at the fore front and other times. Those will be completely gone and then something else will happen and you’ll start, so like the emptiness of BPD I used to feel that like a lot when I was 15, 16, 17, 18, 19, and then that just disappeared and just went away, and I didn’t have that symptoms more but it was like I had other symptoms, so it’s very much not like it’s not like it’s not in a, it is in a state of flux its constantly changing.’ (Tanya, 53)

By drawing on Willig’s fourth stage, subject positions, as a ‘legitimate patient’, Tanya can offer a reason for her feelings of *“emptiness”,* a place in society where her feelings are reasonable. However, the legitimate patient locates Tanya within the psychiatric discourse that pathologises people with ‘personality disorders’ through language such as *“narcissistic”, “BPD”, “histrionic”, and “anti-social”.* Tanya’s laughter can be seen as a way of indicating the tension of occupying this position. Tanya drew on pre-existing knowledge from books as a way of relating to herself. Davies and Harre (1990) stipulate that people are both ‘products and producers of discourse’, in which identities are formed, thus as a producer, Tanya can choose how she wishes to position herself and move within the discourse, *“you* *can have some of this and some of that … sometimes you are going to be very histrionic and those … will be completely gone".*

Thinking of Willig's fifth stage, practice, and sixth stage, subjectivity, these identities offer Tanya different implications with what she can do and how she can feel, accounting for certain behaviours, for example, behaviours that she constructs as *"narcissistic"* or *"anti-social"*. These particular terms may have been chosen to share behaviours that Tanya may have at times felt shame towards or judged through the social discourse, yet through the psychiatric discourse, she was able to share them in this interview. This extract can be understood as Tanya's demonstration of personal agency when she associates 'BPD' as *"a state of flux"* and asserts *"nobody is the same".* Tanya's use of language can be seen as a form of resistance against psychiatric discourse that implies the identity of a 'BPD patient' is fixed and unable to change.

I understood Tanya to take up an 'expert' position, sharing her knowledge of 'BPD' with me, and that this flattened the power hierarchy with myself positioned as a researcher. Through these positions, I felt Tanya was able to share aspects of her identity that she may not have done otherwise. My interpretation of Tanya's quote is further shaped by my experience working in the NHS and trainee CP position. For example, I wondered if Tanya had been positioned in different ways by experts, which may have contributed to her talk of *"nobody is the same",* drawing on psychological discourses that promote individualised care and formulations, as opposed to psychiatric discourses that offer fixed diagnoses.

Nia also drew on psychiatric discourses when constructing ‘BPD’, accounting for a number of behaviours deemed socially undesirable:

‘Living in a constant state of feeling suicidal, never good enough, never trusting your own judgement, um massive fear of abandonment and um pushing people away but also wanting them to still kind of want you in some way, but scared to get too close in case … leave or whatever….um and just kind of being used to just never feeling happy, … safe or satisfied um…..I’ve also got severe insomnia anxiety and eating disorder and so many other things that kind of come from having BPD. Um and Its it just sort of, a lot of things really...really kind of overwhelming um…yeh...’ (Nia, 8)

In this account, through the subject position of the patient with ‘BPD’, Nia is seen to embody ‘BPD’, which helps her to explain the difficulties in her life, which she describes as *“really kind of overwhelming”* and *“never feeling happy”.* Nia’s talk, which draws on psychiatric explanations of ‘BPD’ and the comorbid association with other illnesses such as *“insomnia”, “anxiety”,* and *“eating disorders”,* can be seen to function as a way to account for her struggles with sleep, food and anxiety. Resonating with Laing’s (1990) assertion that no one has schizophrenia as they would a cold, Nia’s account demonstrates the tension of ‘being’ *“borderline personality disordered”.* In accordance with Burr (2003), ‘the way a person thinks, the very categories and concepts that provide a framework for meaning for them, are provided by the language that they use’ (p.8).

With the focus on language and Willig’s FDA framework, this extract can be understood as Nia’s embodiment of ‘BPD’, in which Nia’s identity became fused with ‘BPD’, reducing personal agency and significantly impacting her thoughts and feelings. With attention to Willig’s sixth stage, subjectivity, Nia demonstrates her autonomy and personal agency as she constructs ‘BPD’ *as “a lot of things”,* not fixed but fluid, thus enabling her to account for her individuality and engage with aspects of ‘BPD’ that are relevant to her. As with Tanya, Nia’s construction of ‘BPD’ is dynamic and complex, highlighting the ambiguity associated with the construction of ‘BPD’ (Miller et al., 2008).

The position of the legitimate patient offered the women in the study the opportunity of being believed, legitimising their experiences of suffering. The construction of ‘BPD’ as a medical illness was found to be an empowering construction, which validated the women’s subjective reality, as seen in Tanya’s quote below:
‘It was helpful for me to know finally that like to validate, the actually there was something was wrong……. didn’t want to believe that maybe I was making it all up.’ (Tanya, 45)

In this finding, Tanya’s construction of ‘BPD’ as a diagnosis permitted her legitimacy as a patient, which was more favourable than being positioned in society as a liar who was *“making it all up”.* Thus, with the consideration of subject positions, Willig’s fourth stage, the take-up of the patient position, offered a kinder self-representation and *“validation”,* gaining legitimacy from others in society. Tanya’s talk suggests that without the diagnosis, Tanya could be positioned in society as the ‘other’, as a ‘badly behaved woman’, in which her behaviours are considered intentional and something she can and should control. In contrast, the take up of the psychiatric discourse functions as a way to offer Tanya the power to be seen as justifiably unwell and genuine in her distress, endorsed by the psychiatrist who confirmed: *“something was wrong”.* Thus, this extract demonstrates the implications for subjectivity, Willig’s sixth stage, through the subject positions and Tanya’s rationale for the taking up of the psychiatric discourse.

Early in the analysis, I reflected in my journal that I held quite strong, fixed views on psychiatry, which caused some difficulties in the analysis and write-up. I took this tension to supervision, and with the support of my supervisor, I was able to address my inherent biases. Taking a step back and re-focusing on the language from the interviews with a social constructionist perspective led the analysis to a new insight (Willig, 2013), i.e. the medicalised construction of ‘BPD’ could be empowering from the women in the study, and the subject position of the patient could offer a sense of validation.

Nia also describes how the diagnosis of ‘BPD’ offered her a valid explanation for her distress:
‘Halleluiah moment, it was like now everything makes sense, now they understand not just depression or whatever.’ (Nia, 502).

For Nia, ‘BPD’ offers an understanding of something serious, as opposed to *“depression”,* which is referred to as ‘the common cold’ within mental health (Seligman, 1992). With Nia’s use of language, constructing ‘BPD’ as a serious condition, functions to strengthen her position as the patient. Thus, the action orientation of medicalising her suffering with a serious condition allows Nia to take up the position of one with a serious condition. In doing so, Nia is afforded the right to be taken seriously by professionals, enabling greater opportunities for specialist treatment than received by a patient with depression. Consequently, this suggests that without the diagnosis of ‘BPD’, her experience of suffering is considered less valid, reducing her eligibility for treatment. The wider implication of this quote suggests that in psychiatric discourses, women who express suffering are medicalised as patients with a mental health condition, such as ‘depression’, limiting what they can say and do.

For Erum, ‘BPD’ was also constructed as a “*serious”* health condition:
‘*Scary, finding that out. It sounded like something serious. But, on the other hand, it was almost a relief to have a reason or a name for something.’ (Erum, 201)*.

The use of the term “*scary”* indicates how ‘BPD’ has serious implications on health and wellbeing. Her talk functions to demonstrates her fears positioned as a woman with ‘BPD’ situated in the psychiatric discourse. Yet, similar to Nia and Tanya, without the diagnosis, Erum is at risk of being ‘othered’ without the diagnosis. Thus, the use of the word “*relief*”, denotes a sense of power granted to Erum, through the subject position of the legitimate patient, which opens up accessibility to resources and treatment.

Imani also spoke of validation gained from the position as the legitimate patient:
‘When I had my referral letter from the psychiatrist, I was so happy when I had it... felt really validating and I was like, finally part of a group that I could relate to, …..because again, erm, identity issues, whatever. And I was like, this is my proof,

like waving it around, like I'm one of you, like it's written on this paper by a psychiatrist, it must be true.' (Imani, 765).

This quote demonstrates that, as an institution, psychiatry legitimises certain practices and creates certain subject positions. The consequence of 'psychiatric expertise' can be seen as a means of validating Imani's suffering with a 'new truth', thus enabling her to identify as a legitimate patient. This analysis found that the *"referral letter",* a document authorised by a psychiatrist within the psychiatric discourses, created a reality that positioned Imani as a person with 'BPD'. The practice and process of receiving a diagnosis from the expert legitimised her narrative and offered *"proof"* of her subjectivity that she genuinely has a medical condition. Her words can be understood as an attempt to discursively form part of a group of people with 'BPD'. Her claim, *"I'm one of you",* suggests that 'BPD' offered her a sense of belonging and alignment with the other members of the support network, moving towards an 'ingroup' (Stets & Burke, 2000).

This analysis found that although psychiatric power validated these women's experiences through the legitimate patient subject position, it also undermined their experiences, positioning them as 'medicalised objects'.

3.2.2 Medicalised objects

By concentrating the analysis on subject positions, this study found that through the position of a 'BPD' patient, 'experts' were legitimised to treat women as 'medicalised objects'. Considering Willig's fifth stage of FDA, this study found 'experts' were legitimised to discharge 'medicalised objects,' i.e. women with 'BPD' with minimum professional attention and care. Dynamic changes in subject positions could be seen as a means of objectifying the women's experiences, resulting in a diminishing sense of self, thus demonstrating the impact of psychiatric discourse on personal agency and subjectivity. In the below extract, Tanya spoke about her first time entering the hospital as an adult, requesting *"help":*

'I was.. kind of went to the hospital next door and was like I need help … and they took me round the corner to adult mental health team who then referred me for an assessment. The.. diagnostic assessment, diagnosed me, gave me some medication and sent me on my way, which was a bit weird. They diagnose you after one assessment , they give you some mood stabiliser and then they are like bye.' (Tanya, 618)

This account demonstrates the rigidity of the patient's position within the psychiatric discourse and the implications for subjectivity. This extract shows the practices and processes that become legitimised and authorised through the take up of specific positions, i.e. as a patient, Tanya is *"assessed"* and treated with *"medication".* Tanya is located within technologies of psychiatric power that position her as a categorised object based on behaviours and symptoms and discharged (Foucault, 1979). With attention to stage six of Willig's FDA, this account could be considered linguistically mechanical and robotic, suggestive of how she experienced herself. The use of the word *"bye"* in a sarcastic manner could be seen to depict her feelings of being dehumanised and objectified. Furthermore, her reference to the word *"weird"* can be considered as a way to represent her tension experienced as a patient, where her treatment was not in accordance with her subjective experience.

From a discourse analytical perspective, the aim of this analysis considers Tanya's talk as a discursive act located with the discourse (Willig, 2013), in this case, psychiatry. Thus, with reflection on stage five of Willig's FDA, this extract demonstrates how power is wielded through the technologies of psychiatric services deployed by professionals who positioned Tanya as one who is chemically imbalanced to be treated through medication. The psychiatric discourse permits the objectification of people into patients (Eckermann, 1997) through an alignment with medical science, dismissing lived experiences and personal agency.

This extract could be interpreted in several ways. My interpretation of Tanya's language is shaped by my observations from working in mental health services and my experiences of difficulties in referring young people to adult services. My pre-existing knowledge of the limitations within adult services is predominantly positivistic and psychiatry-led, which contributed to the analysis that Tanya is positioned by experts as a medical object. As a researcher conducting an FDA, this analysis considered the role of technologies of power, intending to shed light on systems and practices for people with 'BPD'.

Nia also shared how she was 'othered' by medical health professionals in a hospital setting. In the below quote, it could be suggested that Nia is positioned as a medical object, dehumanised and ignored:

'No, .., they literally hook you up to a drip and you don't get anything more from them. I mean I was in hospital the last time… for three days and I didn't eat for the

whole three days, nobody cared, I didn't, I didn't touch my water, 'cause I was punishing myself um so I said right I'm not having food or water and they came and 'cause they give you a jug, and they say you haven't touched your water, so they have to give you a fresh jug, and that went on for three days, I never ate any food, at all, not even a biscuit, and nobody cared they literally were like, you know, they didn't speak to me, I don't think they said one word, they just come and do your blood pressure and that's it, and you kind, you go there and you..I mean now I'm used to it, but I'm guessing someone a teenager who whose in the same situation, they want a bit of understanding, sympathy, a bit love but you get absolutely nothing. Um, so I know now that that's not avenue that's gonn give you any help and mental health team they just come and tick their boxes that's it.' (Nia, 338)

This account focuses on subject positions, in particular Nia's position as a patient. Nia's words serves to show the dehumanising consequences of being positioned as a 'BPD' patient in a health setting. As such, Nia is reduced to a 'body' under surveillance that needs managing, dismissing a relational understanding or human, personal connection. Focusing on stage five of Willig's FDA, this extract considers the practices activated through certain positions within psychiatric discourses; for example, medical professionals are legitimised to treat Nia as an object. Drawing on Foucault's theory of the panopticon (1991), this account can be seen as a means to demonstrate the power dynamic termed 'disindividualised' (p.202), in which the patient is 'monitored' by a range of experts, offering visibility, yet in a dehumanised fashion. Thus, this analysis understands Nia's talk as a way of demonstrating the impact that a diagnosis of 'BPD' has on her life, through the lens of how she is constructed by others, including stigmatisation, social exclusion and discrimination (Johnstone, 1989; Johnstone & Boyle et al., 2018).

This account demonstrates that Nia is viewed as a statistic, not a person, resonating with the argument that the ‘tick-box culture’ overshadows professionals’ ability to connect and relate to patients’ distress (Proctor, 2016). Thus, drawing on Willig’s sixth stage, subjectivity, Nia is limited in what she can say and do in the psychiatric discourse in the position of the patient, whilst medical professionals are legitimised to objectify and ‘ignore’ her. Nia’s active resistance to taking care of herself is counter to the ‘good’ neoliberal citizen position, one who is expected to self-govern and take appropriate care of herself, accounting for her ostracisation *“they didn’t speak to me”.* Thus, the overlap of subject positions between social and psychiatric discourses positions Nia as the ‘other’ from other women in society who are encouraged to be resilient and able to regulate themselves (Gill, 2017).

It is possible to consider Nia’s reference to *“teenagers”* as a way of gaining empathy and strengthening her point in which she, like “teenagers”, is afforded the right to person-centred care and worthy of *“love” and “understanding“* from professionals. However, positioned as an *adult* with ‘BPD’, her identity slips between social and psychiatric discourses, where it is inferred that she should know better, whereas teenagers are not deemed accountable, thus denying empathy from professionals. Nia’s account and take up of ‘expert’ dominant discourses could be seen as a means to highlight how she could be constructed by others (‘experts’) as a medicalised object, yet this did not mean she constructed herself this way. Instead, her talk functioned to construct herself as an active agent, a person who was deserving of care and empathy from the health care professionals. This interpretation was informed by an understanding of Willig's (2000) research that found that whilst some women position themselves "in relation to expert discourses, they do not necessarily construct themselves in accordance with them" *(p.552).*

I was mindful that this quote could have been interpreted in many ways, yet my account was influenced by my inherent feminist position, as well as my values as a CP trainee, from which I empathised with Nia's words. With a macro focus, I could look back at the text as 'social action' (Willig, 2013, p119). Thus, I considered Nia's position as a patient within wider institutional systems and practices, which guided the above interpretation.

The women in this study spoke of varying battles to prove their illness for them to be considered legitimate patients. They spoke about the different ways they fought for their rights to diagnosis and treatment. In the below extract, Imani talks about how when she asked for help from her GP, was dismissed, so instead, she sought out a private psychiatrist:
' I had been to my GP, previously, … I said, you know, I've read this online, and I really think this is me and he was very dismissive, I remember that. I just remember him being like, …. I don't see how a diagnosis is going to help you, even though I said to him, I will try and get help. …. isn't that what medicine is, like, you get a diagnosis, and you treat it, like, it shouldn't be different for mental health, …. he was very dismissive and that was, kind of, the end of that conversation…So that's when I … so that's why I went privately…because I was like, well sod you, …. I was a bit powerless because that's what I thought I had. I thought I had BPD and I didn't

want the psychiatrist to be bias because … but I think my personal feelings of what I've got, must count for something, I guess and he was like, yes, no I think that anybody who is self-harming at 14 and engaging in these other, like stuff, destructive behaviours that you've talked about is, …so then I went back to my GP, clutching my, erm, diagnosis…, I said, you know, if you could refer me for DBT and he was like, yeah okay and then' (Imani, 775).

Through the use of the first two stages of FDA, identifying the discursive object and the wider discourses, this extract suggests Imani draws on the internet, *"I've read this online",* and the psychiatric discourse to validate and explain her behaviours by constructing 'BPD' as a diagnosis, "*I thought I had BPD"*. The internet could be seen to allow easy access to expert knowledge, providing Imani access to this as well as the knowledge gained from her own experience. Thus, Imani's talk serves to claim her position as a legitimate patient, one who has 'BPD', through self-diagnosis and draws on the psychiatric discourse to strengthen her knowledge about 'BPD'. In relation to action orientation, Imani can be seen to harness the psychiatric discourses and uses it to fight for her diagnosis.

In relation to the power dynamic between her and the GP, when dismissed by the doctor, Imani was positioned as a powerless object, "*I was a bit powerless".* However, Imani demonstrates power by actively seeking out a private psychiatrist, drawing from her position as an expert by experience. Concerning Willig's sixth stage of FDA, Imani asserts her personal agency, as she states, "*my personal feelings of what I've got must count for something",* even if it means going against her GP. Thus, knowledge is not limited to the GP or experts but is accessible to everyone, supporting Foucault’s (1978) claim that power circulates within society. Imani’s account demonstrates how the psychiatric discourse is rooted in medicine offering treatment and a cure, thus enticing people to take up the position of the patient. This can be seen through her subscription to the psychiatric discourse, *“this is me,”* and her hope for change, which functions to position experts as capable of helping her “*treat it”.* The patient position increases her power, permitting the referral for Dialectical Behavioural Therapy (DBT), demonstrating that power is not always oppressive (Foucault, 1978). However, her quote can also be seen to place responsibility onto the ‘experts’ to *“treat”* her.

Nicola demonstrated power in a different manner as she placed the responsibility of her care back on the experts. In the below extract, Nicola moves dynamically between subject positions as a way of maintaining her legitimate patient status, defending her rights for help, and actively placing the ownership of her treatment back on the ‘experts’:

‘They say to me things like [pause], “So, what would you like me to do for you?” And I say to them, “… well, I can’t really answer that question because I’m not a professional psychiatrist,” and… or psychology… or… or whoever I am seeing at the time. And then I’ll sit back, and I’ll say, “Alright then, I’ll rephrase this [pause]…” because I’m in the motor trade and one of my jobs is I’m a mechanic, a crash repair specialist….You bring your car into my garage [pause] and there’s radiator fluid pouring out all over the floor.” And they say, “Yeah?” “And you look at me and I say to you, ‘Okay, how would you like me to fix your car?’ – what would you say?” [Pause] and they’ll go, “Well, I don’t know. I don’t know how to fix your car.” And I

went, "Well, that's exactly it." I said, "So, how am I expected to answer that question?' (Nicola, 205).

Despite the limited subject positions available within the psychiatric discourse, Nicola actively resists the neoliberal citizen subject position encouraged by the medical professionals who ask her how they can help her. In relation to action orientation, Nicola's talk implies an expectation from experts for her 'cooperate' with them, "*So, what would you like me to do for you?".* The neoliberal citizen is one promoted through social and psychiatric discourses that endorse the concept of 'self-responsibilisation' (Rose, 1999). If Nicola 'cooperates' with the medical professionals, the experts could position her as a 'compliant' patient. Through resistance, she asserts power by relinquishing control and responsibility of care, relying on the 'experts', "*I can't really answer that question because I'm not a professional…".* Nicola is seen to use her identity as a mechanic to place the responsibility of her care onto the experts, just as the car is to the mechanic. The discursive strategy of repositioning accountability of care onto professionals can be seen to absolve Nicola from taking ownership of her treatment and behaviours, *"how am I expected to answer that question?"*.

However, implications of these subject positions can be seen to shape her subjective feelings, denying personal agency. In this text, it would seem that medical professionals do not want her to hand over the responsibility of care to them, resisting the 'reliant' patient position. Thus, her resistance risks a tension in how she is perceived by medical professionals, possibly as ‘defiant’, ‘difficult’ and ‘uncooperative’, in her treatment, limiting her rights to support.

This analysis was shaped by my observations drawn from my work in a mental health setting, wherein professionals who struggled with ‘uncooperative’ clients would look to discharge, thus relieving themselves from helping or supporting the client. It was also guided by my own experiences and tensions of holding a position as an expert, working within a heavily underfunded, goal-focused system that promotes cures as opposed to collaborative care.

3.2.3 ‘Serious’ or ‘Borderline’?

The word ‘borderline’ was questioned by some women in the study, confusing them as to whether ‘BPD’ was *“serious”* or *“borderline*” in nature. The psychiatric construction of ‘BPD’ suggests it is a condition that is *‘severe’* (APA, 2013), yet the term ‘borderline’ is contradictory suggesting the condition is on the verge of becoming something.

The below quote illustrates how Imani tries to understand what ‘BPD’ is and how it positions her as one who holds the diagnosis:

‘It sounds very severe, I think. Um, [pause] it’s that… it just makes… it does make you sound like there is something terribly and fundamentally wrong with you. Like, I know… I know BPD is maybe the old-fashioned term for it. Like, I… I see it referred to as ‘emotionally unstable personality disorder’ as well…. But ‘borderline’, it’s like, “Borderline between what exactly?’ (Imani, 35)

In relation to the first two stages of Willig's FDA, when Imani draws on psychiatric constructions of 'BPD' as something "*severe",* she is consequently positioned within the discourse as a person who is *"terribly and fundamentally wrong".* Thus, her talk suggests the take up of the psychiatric discourse pathologizes her and position her as the 'other'. Through action orientation, Imani questions the psychiatric construction, challenging the theoretical binaries within which 'borderline' supposedly lies. Thus, Imani's talk can be understood as a way of demonstrating the tension experienced in her position as a woman with 'BPD', who is 'othered' through the psychiatric discourse. As a form of social action (Wiggins, 2017), asking questions affords Imani the right to change her construction of 'BPD', which actively positioning herself in a favourable discourse. These new subject positions activate new opportunities of what Imani can do, her options for practice as well as access to her subjective experiences.

Nicola also shares some confusion about the term 'BPD':

'I thought it meant that I had borderline… I was borderline in [pause]… you know, like I was perhaps a borderline diabetic, or perhaps borderline asthmatic, or perhaps had a borderline……I looked it up and realize exactly what it was… because, again, it wasn't explained. [Pause] I thought, Holy crap, so that… that's what it is. But, oh, it isn't that I'm borderline on a… on a personality disorder – borderline personality disorder is the condition…and it is a serious condition. [Pause] then why the hell am I not receiving the treatment that I am receiving if [pause] I am notorious for self-harming?" Very seriously self-harming..,because I've got very significant scars.' (Nicola, 29)

Nicola initially associates ‘BPD’ with a physical, medical condition, constructing ‘BPD’ as a *“borderline”* health condition, *“perhaps had a borderline..”*, something that has not fully developed. In doing so, Nicola is positioned outside the medical discourses, thus undeserving of the position as a patient. However, Nicola’s quote demonstrates her personal agency and active engagement with the internet, “*I looked it up”,* which functions to increase her access to the psychiatric discourse. In doing so, Nicola is afforded power and knowledge, in which she talks of ‘BPD’ as a *“serious condition”,* offering an explanation as to why she is *“very seriously self-harming”’.* As such, Nicola is able to move into the subject position of the active, legitimate patient, claiming rights to treatment, “*why the hell am I not receiving the treatment”*. Thus, through Willig’s framework, drawing on subject positions and practices, this talk demonstrates Nicola’s movement between subject positions increases her access to processes and practices denied to her previous. Nicola’s talk of questioning why she is not receiving treatment, positions the ‘expert’ medical professionals as withholding of care.

3.2.4 ‘Lifelong or borderline’

In the analysis, ‘BPD’ was constructed as a ‘life-long’ condition, with varying options on how to manage this disorder. For example, the ‘compliant’ patient actively engages in their treatment, taking on board the advice from ‘experts’, practising self-regulation and regularly taking their medication; thus, a neoliberal citizen who manages and self-regulates ‘BPD’. Research has suggested that patients are considered ‘compliant’ when they employ the discursive strategy of regulation of behaviour (Thomas & Davies, 2005). The psychiatric discourse consequently suggests that patients are both responsible and not responsible for ‘BPD’.

With a particular focus on subject positions, this analysis found that any form of resistance placed the women in this study at risk of being positioned as a 'troublesome' object or one who was 'defiant' by health professionals. Feminists have critiqued the construction of 'BPD' as a gendered label assigned to 'bad girls' as a way to socially control and modify their behaviours (Becker, 2000). The women in this study were seen to take up the 'compliant' position, as seen below:

'I'm… so, I'm on three different types of medication, and I've pretty much accepted that I'll always be on three different types of medication for the rest of my life. To have a good life – to have, like, a fulfilled life – I'm going to have to be. I don't know if it means I… if it makes my life shorter or not, but I don't really care.' (Erum, 834)

Erum draws on the psychiatric construction of 'BPD' as a biological, incurable illness, positioning herself as a patient who will be required to take pharmacological treatment, *"three different types of medication for.. life"*. The practices and process legitimised within the psychiatric discourse, such as psychiatric treatment, offers Erum a way of managing her 'BPD'; thus, her compliance permits her to "*have a good life"*. Her questioning of whether her life will be shorter suggests some fear over the treatment, yet the desire for a '*fulfilled"* life, overrides the fear of dying younger, "*I don't really care"*.

This account was guided by my pre-existing knowledge of the society we live in, which favours the taken-for-granted psychiatric discourse and its approaches to emotional suffering. Furthermore, adding to my feminist position, I reflect on the dynamics women face when they access support from services, in which their experience of distress is often medicalised as a psychiatric illness. As a CP, I empathised with Erum's account, and to me, her use of language in some ways, positioned her as a survivor, who is persevering, despite the limited options.

Tanya depicted 'BPD' as an illness that "*is always going to be there*". In the below quote, she is seen to move dynamically between subject positions, which could be understood as a means to gain 'hope':
'Uh, …yeah the more I read and understood about it, the more I see it as sort of a spectrum and that sort of thing, and I mean when you are first diagnosed, you just think oh my God, like I am STUCK like this, and you just feel hopeless. This is for life and that's what it says everywhere, and you know it says that wherever you read, it's really difficult to get rid of…laughs. And there's all this stuff like oh yeah, 50% of people with BPD recover from BPD, and it's like but do you ever really recover, you know, you learn to manage your symptoms and you do get better, but you still struggle on a day-to-day basis…any increase in stress brings back the symptoms sort of thing, so.. It's always going to be there but just not as bad (Laughs) so like 'Recovery' in a, in the best possible sense, for me that's like I will never really be able to fully recover always have to pay close attention to managing my emotions and working hard, 'cause have to….. yeah before I felt quite hopeless about it and like it was kind of like a life sentence and I would not be able to change because they told you that this is what you are like and in reality that's not the case.' (Tanya, 127)

Considering Willig's sixth stage, subjectivity, this extract suggests that Tanya's sense of self was heavily linked to the psychiatric construction of 'BPD'. For example, when Tanya talks of 'BPD' as a fixed illness, she embodies a sense of hopelessness *"I am stuck",* a *"life sentence",* positioning her as a passive patient and limiting her agency. Psychiatric labels are considered to hold the power to 'saturate' a person's identity (Roberts, 2005, p.38). However, when she depicts 'BPD' as something that a patient can "*recover"* from, she has hope, dynamically moving into an active patient that is "*working hard"* to manage her emotions. Subject positions are a key aspect of discursive practice and everyday talk (Davies & Harre, 1990), which can promptly and dynamically change depending on the context and the persons speaking. Tanya is offered power when she takes up the subject position of one who engages in 'self-responsibilisation' (Rose, 1999), offering a favourable representation of self. Thus, this extract demonstrates that within the limitations of psychiatric discourse, Tanya can only gain a positive sense of self should she take up the position of the 'compliant' patient.

The analysis found that the women in the study drew on gendered talk depicting 'BPD' as a developmental phase, one from which women would eventually grow out of. In the below quote, 'BPD' is constructed as a feminine object related to immaturity and Tanya is positioned as a 'defiant girl' through the medical professionals' talk:

'But it's like just things like the comments they make, oh like I see a lot of girls like you know they improve within a few years you will be fine that's what, it was just sooo dismissive, I don't feel like I've ever had, I have never had a psychiatrist who really put themselves in my shoes. They just view it medical perspective they did not see me as not a label.' (Tanya, 417)

Drawing on Willig's third stage of FDA, action orientation, the function of the 'experts' gendered construction of 'BPD' reduces Tanya to the subject position of a 'defiant' girl, diminishing her power within this interaction and undermining her position as a legitimate patient. Tanya's talk could be understood as a way of expressing her frustration with oppression by the expert's subjective interpretation based on the social, gendered, and psychiatric discourses.

Similarly, Erum shared how she was positioned by a psychiatrist as a 'defiant' teenager, by the means of constructing 'BPD' as a developmental phase:

'*Well, there's things… there are certain things that I don't quite understand. Like, one of the …….they said that you grow out of it quite a lot. Quite often, people then stop having it. I was, like, ….. You might stop, say, maybe overdosing and self-harming because you've got, like, children and stuff. Does that mean you don't have it anymore? Does that…? I still don't really know that. Do you have to be overdosing and self-harming all the time to have it?..I… I… I still don't quite know. And, like, the psychiatrist went, "Oh, yeah, you might grow out of it. You'll always find things harder than most people, but you'll probably grow out of it." Like [pause]… like my… like… like when my children have eczema and they say, "Oh, they might grow out of it. It's childhood eczema." It's, like… but that's a physical thing….. So, I… that… that I find very confusing. If you've had it, and you've self-harmed and taken overdoses, and then you, sort of, stop doing that because, you know, you've got responsibilities, has it gone away? It doesn't feel like it has gone away. I just [pause]… I still get, like, the urges.' (Erum, 791)*

Considering Willig's third stage of FDA, action orientation, Erum's strategy of asking questions allowed her to challenge the dominant discourse (Wiggins, 2017) and the medical professionals' position as an 'expert'. In her talk of the medical professionals, 'BPD' is constructed as a feminine object, which young girls will *"grow out of"*, positioning Erum as a 'defiant' teenager who should have power and control over her behaviour. Thus, Erum is 'othered' by the medical professionals as one who has a choice in her suffering, contradicting the psychiatric understanding of the 'BPD' as a 'serious' illness (APA, 2013).

With a focus on Willig's fourth stage of FDA, subject positions, and stage six, subjectivity, the overlap of subject positions, on which Erum's presentation is both pathologised and minimised, creates tension as to how Erum can feel echoed by her confusion. Her compliance in ceasing self-harm is constructed as a form of maturity, ignoring her subjectivity, suffering and ongoing urges. Thus, it could be considered that the psychiatrist positioned Erum through visible ('immature') and non-visible ('mature') understandings of pain. Erum's identity is seen to slip between discourses depicting 'BPD' as a lifelong condition and a developmental phase. By constructing 'BPD' as a lifelong condition, Erum is positioned as one who will *"always find things harder",* thus extending Erum's position as the 'other' for life, dictating a permanent struggle to her subjective experience.

This analysis shows that irrespective of whether 'BPD' is constructed as 'life-long' or something to 'grow out of', the women in the study are positioned as responsible for their behaviours. The 'good patient' subject position was one who was 'responsible' and able to control and manager her behaviours. Brown (2018) discusses the shift within the 20th century, in which society has been heavily invested in the ‘behavioural turn’, promoting individuals to feel empowered through behavioural modification, particularly in the field of health.

In the extract below, Tanya moves dynamically between positions, taking up the position of the ‘good patient’ and distancing herself from the ‘problematic patient’:
‘I have met a lot of people, they are ill, and they just can’t be honest enough to themselves, to admit, that they need to take responsibility for the fact, that, although they didn’t ask for this, and they didn’t deserve it but they are stuck with this, and they gotta do something about this, but they just refuse to (laughs) I don’t know, like and the only way out is to fight for the help that you need, and work hard at it, ‘cause nobody else is going to change anything around you, that’s how society is, we’re very, we like to individualise (laughs) problems (laughs), instead, like looking at the social environment, (laughs).’ (Tanya, 185)

Drawing on subject positions, Willig’s fourth stage of FDA, Tanya positions herself as ‘different’ to other people with ‘BPD’, adopting a favourable position as a ‘good’ patient who is actively taking responsibility for her ‘BPD’. In her talk, recovery and empowerment are achieved through taking personal responsibility for an unwanted illness, demonstrating neoliberal values around individual choice and accountability. Self-governance and disciplining her own body and behaviour (Foucault, 1991) offer her closer alignment to normative society. While Tanya talks of the need to be responsible (Rose, 1999), she is also critical of this, commenting on the individualisation of modern society. Tanya moves dynamically between positions, describing herself as someone who exercises agency and choice as a means of distancing herself from the position of the problematic patient.

Considering Willig's sixth stage, subjectivity, Tanya's talk of the social environment followed by her nervous laugh could be understood as a form of tension between subject positions, deflecting some anger. For example, Tanya is positioned in a way that if she explicitly spoke of "*how society is",* she could risk her identity slipping into the position of a problematic patient who does not take personality responsibility. Tanya demonstrates power and resistance, positioning herself as a strong and responsible patient, "*fighting"* to be seen favourably within modern society. Research has shown that people diagnosed with stigmatising illnesses, such as 'BPD' often feel the need to fight to be seen in a positive perspective (Goffman, 1959).

3.3 The double bind

This study found that the way 'BPD' is constructed by experts in the medical profession had detrimental consequences on how the women in the study were positioned, often within restricted, gendered subject positions. The various subject positions both opened up and simultaneously limited resources, thus positioning women in a double bind. The analysis found that the women had to perform in certain ways, not only to gain legitimate patient status but also to maintain this. For example, one expectation for the subject's position as a legitimate patient was to present through physical appearance as 'abnormal'; women who physically appeared 'normal' risked losing their status as a patient, enabling experts to withhold or limit access to support. These women needed to demonstrate their suffering physically, yet such demonstrations risked positioning these women as "*attention-seeking*". Furthermore, another key expectation for the legitimate patient was to be responsible for controlling 'BPD', yet compliance and management of 'BPD' posed positioning the women as "*not severe*", thus denying eligibility of the patient status.

3.3.1 'Why can't you just try and be a bit more normal'

An FDA approach to this analysis enabled a focus on the relationship between power, discourses, practice, subject positions, and subjectivity. In accordance with the FDA framework, identities are formed through interaction with people, socially constructed as opposed to something fixed (Willig, 2013). In the below quote, Erum shares how she is 'othered' by an 'expert' psychiatrist:

'One psychiatrist said to me once, "*Why can't you just try and be a bit more normal?" I remember that.'* (Erum, 452)

By adopting Willig's FDA framework, this extract demonstrates how Erum, a patient in the psychiatric discourse, is positioned by the psychiatrist as both capable of being 'normal' as well as incapable due to her 'BPD'. Through language, the psychiatrist has positioned Erum as both 'sick' and 'defiant', in which her identity slips across medical and social discourses. Research has found that psychiatrists' construction of 'BPD' places a negative attribute on patients, including shame and discrimination (Gergen, 1994). The contradictory subject positions move Erum from the legitimate patient who is justifiable mentally unwell to a 'socially defiant' subject position, creating significant tensions in what she can do, how she sees herself, and her subjectivity. Szasz (1997) proclaimed that mental health institutions are implicitly coercing individuals to the role of the ‘psychiatric patient,’ which prevents them from assuming their own identity.

This interpretation was shaped by the various positions I occupy, predominantly my experience working in the NHS as a mental health practitioner and, with that, my exposure to the taken-for-granted psychiatric discourse. I have witnessed professionals position clients in the fixed binary positions of ‘normal’ and ‘abnormal’, which was raised in this interview. As such, I noted feelings of frustration, how I felt about the way Erum was treated within health services. During the analysis, I was guided by the discourse analytical perspective, which cannot make assumptions or claims of ‘true’ emotions that Erum may be experiencing such as frustration or anger. Instead, using the FDA framework, this interpretation considers Erum’s talk as a discursive act located with the discourse (Willig, 2013), in this case, psychiatry. For me, the action orientation of Erum’s choice of words raises awareness of the stigmatisation and oppression experienced by people with ‘BPD’, including how she is positioned by experts.

3.3.2 “Full-blown” ‘BPD’ vs “you’re one of those”

Tanya spoke of how she needed to prove her suffering to ‘experts’ in order for them to believe her, so she could get access to support.

‘I wasn’t getting any help or therapy, it was like, the only way they are gonna take you seriously is if you’re like full blown BPD, which is a really damaging and destructive way..it’s like you’re being told you’re just like, you’re just not ill enough, and its bit like... you’re not severe enough so you have to like, I don’t I never ever regret,..there was a point it was a conscious thing, like the only way I’m gonna get help is if I scream and somebody listens, …. if you’re silent, you just get left behind,

they don't listen to you, so eventually I just got help because I got worse and worse and worse.' (Tanya, 1147).

By applying Willig's third stage of FDA, action orientation, the above extract demonstrates Tanya's resistance to professionals' who positioned her as a defiant, faulty object, a 'spoiled identity' (Goffman, 1963). Her talk functions to place accountability on medical professionals, who let her down, *"I wasn't getting any help",* as the contributing factor shaping her behaviours and embodiment expression of "*full-blown" 'BPD'.* Hacking (1986) writes that diagnoses sculpt people's sense of self, producing behaviours that would not occur without these formal identifications. This quote demonstrates the tension of limited available discourses within which Tanya can position herself. She is constrained in the psychiatric discourse in the position of the patient, yet outside the psychiatric discourses, her suffering becomes invalidated, and she risks her position as a socially defiant woman. Her talk could suggest that she was initially positioned by 'experts' as a stigmatised object, which "*forced"* her to take up a particular stigmatised identity as one at risk of hurting herself. Only after demonstrating "*full-blown" 'BPD'* was she accepted by 'experts' as a legitimate patient who is eligible and deserving of therapeutic treatment.

The positioning theory is useful to consider in this extract as it describes how subject positions are limited and dependent on the available discourse, influencing the accessibility of power available to people (Davies & Harre, 1990). Such subject positions can unknowingly place people in positions of greater harm, causing further detriment to their selfhood (Davies & Harre, 1990); in this case, the "*full-*

blown" 'BPD' patient. Tanya explains her actions as a consequence of professional neglect, prompting her to take the position of an active patient who requires support. Thus, subject positions can be taken up, resisted, accepted and rejected (David and Harre, 1999) as a process of negotiating one's identity.

Drawing on my position as an Indian woman, I felt a familiarity with the notion of a 'spoiled' identity in relation to my race and gender against dominant discourses that position white people as the 'norm'. This interpretation may have been shaped by my personal identity and experiences of stigma. I further analysed this extract with my learning around the positioning theory, exploring the association between positions, subjectivity and identity formation.

The analysis found that the acts of self-harm positioned women in this study as undeserving of care. In particular, Nicola shared how she was positioned by a paramedic as the 'other', despite her legitimate crisis for help after self-harming. Nicola described how the paramedic positioned her as an 'underserving' patient in comparison to people who are 'deserving' patients in need of paramedic care:
"There was one paramedic that was awful, though. He was just, like, 'Oh, right, okay, so you're one of those.' You know, 'You… you're wasting my time. You've cut yourself. It's your own fault when clearly I should be treating somebody that is having a heart attack that really can't help themselves.' And that really upset me because it was, like [pause]… it's really difficult to try and explain." (Nicola, 416)

Drawing on Willig's fourth stage of FDA, subject positions, and sixth stage, subjectivity, this extract demonstrates the power relations between the paramedic, who positions Nicola as the ‘other’. ‘Otherness’, in which one of the binary positions is typically more privileged and desirable than the other, is a key aspect of identity formation (Wetherell & Edley, 2014). The paramedic positions people with heart attacks as genuine, privileged and in need of help, as opposed to Nicola, who is positioned as one who is in control and has agency over her actions, positioning her as responsible for the current medical emergency. Thus, Nicola is positioned by the expert as at fault, supporting research that suggests women with ‘BPD’ are commonly seen to experience blame by medical professionals (Shaw & Proctor, 2005).

Foucault (1967) stipulated that mental health illnesses are bound up with social judgements about morality. In this extract, Nicola’s morality is tied up with the act of self-harm; her open request for help undermines the authenticity of her distress. Furthermore, as a woman, Nicola occupies the societal position as the ‘other’ to the man, who is considered the ‘norm’. The act of self-harm further positions her outside the realms of social norms (Wirth-Cauchon, 2001). The paramedic is obligated to ensure Nicola is treated yet holds power to position Nicola as ‘irresponsible’, ‘undeserving’ and ‘selfish’ for wasting his time when ‘genuine’ patients need his help, reducing her sense of power and agency. This finding resonates with the neoliberal discourse of ‘responsibilisation’ (Rose, 1999), which advocates personal responsibility and control for conduct. As a legitimate patient, Nicola’s need for medical attention for self-harm is absolved of self-governance (Lemke, 2002). Yet, when the paramedic positions her as an ‘irresponsible’ woman, Nicola’s subjective experience is affected, and she finds it “*difficult”* to offer a rationale for the self-harm.

Despite her resistance to the paramedic, in the interview, Nicola later applies some judgement to herself, positioning herself as both ‘deserving’ and ‘undeserving’ of care. In the below extract, she talks of a time she was seen by a nurse at the Accident and Emergency (A&E) department after self-harming:

‘Every so often, she is reaching across, and she is wiping my eyes. And she is not saying… she is not saying anything. And I know that they are rushed off their feet. …. and I know that they need the cubicles….and I know that I don’t really… really need to be in that cubicle. But they are not… she is refusing to let me go and sit in the waiting room….. she’s sitting there, and she’s holding my hand, and she is wiping my eyes, and she is not letting me go back out into the main waiting room…She’s just sitting there… she didn’t say a word’ (Nicola. 443)

This analysis is informed by the Willig (2013) framework and the way the women who participated in the study talk about themselves is an indication of what can be made possible through the available subject positions in the dominant discourses (Willig, 2013). In this extract, Nicola navigates a complex terrain of subject positions as one who is both ‘undeserving’ (moral discourse) and ‘deserving’ (medical discourse) of care from the medical services, questioning her rights and responsibilities of what is ‘allowed’, shaping her subjective experience. The ambivalence and ‘othering’ depictions of herself change through the nurse’s understanding of Nicola’s presentation as one that is ‘unwell’ and ‘deserving’ of care. As a patient, Nicola is afforded the right to take up the ‘sick role’ (Parsons, 1951), exempt from social-normative expectations and released from self-regulation. As a result, Nicola is permitted fair deviation from socially acceptable behaviours of a non-sick person, allowing professionals to become accountable and responsible for the patient's care. Research suggests that within the healthcare system, NHS practitioners provide care and support for those who are ill and will extend their care even further during emergencies and crises (Carpentier & Ducharme, 2003), as seen by the nurse in the above extract, "*holding*" Nicola's hand and "*wiping*" her eyes, providing Nicola with the opportunity to "*feel"* that she is deserving of the care.

In comparison to the above extract where Nicola was afforded care and respect, Erum shares how she was subjected to hostility and violence from a nurse, despite being positioned as a legitimate patient in a medical setting:
'One lady made a mistake with my medication, but she was apologetic. And I just, sort of, told the next person in, like… like, a jokey way. And then she came in… they must have told her, and she came in and started shouting at me, that I had mentioned it, and she threw something at me and just stormed off. And then when I complained about her, they said, "Oh, well, maybe she was upset. Maybe you should talk to her.' (Erum, 568).

An FDA approach focusing on subject positions demonstrates the power relations that lie within the dichotomy between the patient and nurse. In this extract, Erum is positioned as a 'borderline', unworthy and denied the rights given to other patients accessing services from nurses. This position enables the nurses to persecute Erum with verbal and physical abuse when she deviates from the 'compliant', 'passive' patient position. Thus, Erum is seen as the subject of a misuse of power by the nurses, 'othered' against 'healthy' patients. Erum's attempt to express her personal agency by making a complaint was dismissed and understood to be the reason for the hostility she received from the nurse, placing her as responsible for resolving the complaint. This account echoes previous research that demonstrates people with ‘BPD’ are at serious risk of unethical treatment from medical professionals, including nurses and psychiatrists (Black et al., 2011; Bodner et al., 2011; Westwood & Baker, 2010) in the form of emotional and physical abuse (Bonington & Rose, 2014).

3.3.3 ‘Catch-22’

The analysis found various ways in which the women were positioned based on how the professionals constructed ‘BPD’. Earlier in the analysis, it was mentioned how Tanya demonstrated the tension moving between the subject position of the legitimate patient to the “*full-blown” ‘BPD’* patient position in order to gain therapy. Yet, this analysis found that the active moves between subject positions comes with social and moral judgement from experts, ‘othering’ Tanya in different ways. In the extract below, she speaks about being positioned as “*attention seeking”*:

‘*Like there was a point where things could have been like , I could avoided so much trauma out of hospital admissions and everything like that if at first they had listened and not just treated me like I was a problem so like because you go there and then they say that the message you get is you are not worth their help so like you end doing more drastic drastic things because you’re in so much pain and you need help and the only way to get help is by making them listen to you and the only way to make them listen to you is for them to see it, that something is physically wrong and they can’t see it unless like you cut yourself or whatever and even then they’re like attention seeking borderline and then you just get sent away as well and it’s* *like a catch 22, you can't do right yeah,. (laughs)….but the only way I manage to get help in the end was because I was in and out of hospital so much and they're like oh now you can have some like therapy, laughs, do you know what I mean, before that I was asking, desperately pleading, like I'm telling them I'm so distressed like, every day is like, so so so so like a living hell and they just didn't care, until I ended up in hospital they just didn't care, nobody listened.' (Tanya, 347).*

In the above extract, Tanya was positioned by professionals as 'problematic'. Moving between subject positions, enacting 'BPD' through self-harm positioned her as a "*full-blown*" 'BPD' patient and an "*attention-seeking*" woman by professionals, offering significant implications for her subjectivity. Jaworski (2010) talks about gender and suicidal behaviours, in which men are positioned as 'serious' as they are 'completers' of suicide, whereas women are positioned as 'attention-seeking' and 'attempters' of suicide. Research has found that women are predominantly positioned in double bind positions, trapped and considered 'mad' if they comply or rebel (Shaw & Proctor, 2005; Ussher, 1991). This extract could be seen as a way of demonstrating the limited subject positions offered within psychiatric discourse, shaping how Tanya could experience herself and what she could do, thus going in and out of the hospital. The 'availability of subject positions in discourse has implications for possibilities of selfhood and subjective experience' (Willig, 2013, p.139).

It was not until the medical professionals positioned Tanya as 'genuine' in her distress, which permitted movement into the 'legitimate' patient position, that activated a new system of support. Without the psychiatric expert opinion, Tanya was positioned as a ‘troublesome’, “*attention seeking”* object, deprived of therapy and support, despite her position as a vulnerable woman in society “*desperately pleading”*.

This account was shaped by my position as a CP in training, working within the NHS system, as well as my feminist position. I felt great empathy for Tanya, reflecting on the various difficulties and societal pressures women face when accessing mental health services. In order to avoid assumptions based on my personal values and experiences, I returned to Willig’s FDA model, focusing on the constraints Tanya faces based on her position as a woman with ‘BPD’, as one who has a legitimate diagnosis and the repercussions of not having the diagnosis on her identity.

Nicola shared how she was positioned as a child by professionals due to the act of self-harm. Professionals were seen to draw on a social, moral discourse of self-harm as an ‘attention seeking’, childlike behaviour for which she needed reprimanding, and this influenced how they positioned and consequently treated Nicola:

‘I’ve been referred to CAT. The… the amount of times I’ve been referred… they [stutters]… they just… I got ref… I… I went back… they used to tell me off for self-harming. And they’d say, “Next time you feel like self-harming, you call us. You call us.” (Nicola. 75)

Nicola talks of CAT professionals as authoritative and parental figures, positioning her as a child who is *“told off”* for ‘bad’ behaviour, that is, self-harm. The power imbalance between the two positions enables professionals to imply that Nicola is able to control her acts of self-harm, thus positioning her as non-compliant in relation to her treatment. This quote demonstrates the continued tension women with ‘BPD’ face, positioned across dominant social and psychiatric discourses. The action orientation of Nicola’s talk could service the function of highlighting the double bind that women with ‘BPD’ face. Indeed, those who express and externalise their distress through self-harm are typically positioned as ‘attention-seeking’, overwhelmingly ‘othered’, in a ‘Catch-22’, double bind position.

I understood Nicola’s talk as a means of sharing her frustration of being unable to express herself without being penalised and positioned by experts in an ‘abnormal’ or ‘faulty’ position. This analysis was shaped by experience working in mental health services and knowledge of the pressures practitioners face when focusing on reducing risks. I understood Nicola’s talk as addressing the issues of risk-averse talk, which is prevalent within mental health services. Furthermore, I reflected on the power dynamics between the practitioner and patient roles, drawing on Rose’s (1999) theory of self-governance and accountability as a means of social control.

During the interview, Nicola spoke about the actor, Robin Williams to strengthen her personal narrative as one who is medically unwell, battling with a serious life-threatening illness:

‘You know, like a lot of people that threaten suicide – “If you were going to do it, you would have done it by now. Oh, you seemed happy enough at the time…” that [stutters]… like they would have said that about Robin Williams before he put a rope around his neck.’ (Nicola, 102)

Research demonstrates that people with ‘BPD’ experience high levels of stigma and are constructed as ‘attention-seeking’ (Markham, 2003; Fraser & Gallop, 1993; Hazelton et al., 2006). Nicola’s reference to actor Robin Williams can be seen as a counterpoint to the psychiatric discourse that positions her as ‘attention seeking’. Drawing on action orientation, the function of Nicola’s talk suggests that self-harm or suicidal behaviours are seen by professionals as serious when it is kept private, despite medical discourses promoting patients to actively seek help. Furthermore, the behaviour of asking for help or not asking for help seems to shape how a person is constructed. Robin William was positioned as genuinely suffering as he did not seek help, yet Nicola, a woman who asks for help, is positioned by experts as one who is not serious and disbelieved as she “*would have done it by now”.* Ultimately, Nicola is positioned by experts as an ’attention-seeker’, supporting Jaworski’s (2010) point about gendered understandings of suicide, where men are deemed serious, and ‘completers’ and women are ‘attempters’. As such, this account demonstrates how confusing and frustrating it is for a woman with ‘BPD’ who expressed their suicidal feelings to medical experts but was dismissed and positioned by them as “*happy enough*”.

3.3.4 ‘You’re not severe enough’

Women who positioned themselves as ‘functioning’ and shared their successes were at risk of being positioned by medical professionals as “*not severe enough”,* thus justifying a decision not to offer these women treatment.

Imani illustrates the struggles accessing treatment from services as she could not be both successful and functioning, as well as a legitimate patient seeking help:

‘I think, with me, I’m quite lucky in that I’m on the mild end of the… of the spectrum. Um, so, I think you will probably, during your research, talk to a lot of people who are very severely affected by it. But it was a lot worse when I was a teenager and in my early 20s. I think a lot of it, you know, has gotten better with age, which is apparently [pause]… um, a positive prognosis of BPD is that it does get better with age, but I… I definitely used to be a lot worse…Um, so, [pause] yeah, it… it has not changed for me. Sometimes I feel like a bit of a fraud because… because I am on the mild end of the spectrum, and I… I… I hear about people who just can’t function in their day-to-day lives. Like, I have been to the NHS and asked for DBT – uh, dialectical behavioural therapy – and they were just, like, “You’re not severe enough.” And that was quite invalidating. And… and… like, obviously… obviously, I want treatment to go to people who really need it and who are really suffering, but I was a bit like, “Argh, but I’m in so much pain.” And, like, yeah, it felt [pause]… you know, it felt [pause]… it was just upsetting, um, because when you are in that kind of pain, you want to work on it and get better [pause] a normal, contributing person in society….’ (Imani, 116)

In this above extract, ‘BPD’ is constructed as a spectrum, which can vary from ‘mild’ to ‘pervasive’. This contrasts with the medical construction of ‘BPD’ as a fixed entity. Drawing on subject positions, Imani orients towards the “*milder”* end of the spectrum as a way to position herself as a ‘good’, active patient. In doing so, Imani is able to align her identity with a “*normal, contributing person in society”.* Implications of positioning herself as more ‘severe’ on the spectrum place her at risk of being positioned by experts as one “*who just can’t function in their day-to-day lives”*, marginalised and disapproved in society (Catthoor et al., 2015).

Willig’s fifth stage of FDA enabled an interpretation, which focuses on what practices and resources are made possible through subject positions. For example, as one who is positioned in the generalised and binary fixed position of ‘mad’, Imani would be entitled to DBT but positioned as ‘sane’ or ‘functioning’, she is denied access. These positions have implications on what Imani can do and feel. Thus, drawing on Willig’s sixth stage, the result of the fixed binary position shapes how Imani sees herself, i.e. as a “*fraud”,* minimising her subjective state, in which the extent of her pain goes unnoticed. Imani’s position on the ‘milder’ end of the spectrum and talk of successes is seen to minimise and override her right to pain, positioning her as “*not severe”* within psychiatric discourses and denying her access to DBT treatment.

Physical appearance was a key aspect of how medical health care professionals positioned women with ‘BPD’. Nia shared how her efforts to conform to normative gendered expectations that promote self-care in health and beauty (Gardner, 2001) risked her legitimacy as a patient.

She shared how her appearance contrasts with her internalised subjective experiences, yet professionals were able to use her appearance as a rationale to position her as *“alright”*, questioning her position as a legitimate patient:

‘I’ve had experiences where they’ve walked in and said ….oh well you know you, you’ve brushed your hair, have nail varnish on, so how bad is it, you look alright to me, I’m going to sign you off ..and just him saying that makes me want kill myself again because I just think what the fuck you know.’ (Nia, 316).

Adopting an FDA framework, with particular attention to Willig’s fourth stage, subject positions, and sixth stage, subjectivity, allowed an analysis of power relations between subject positions and how such positions influence one’s sense of self. Nia’s talk demonstrates the use of power through language, in which the experts' speech functions to objectify Nia, aligning ‘BPD’ with her physical appearance and dismissing her personal agency. Through the expert’s use of language, Nia is positioned as a non-legitimate patient, thus implying you must look a certain way in order to occupy the position of the legitimate patient.

Research has shown that women are often positioned as objects of talk, frequently sexualised in nature and prized for their use to ‘others’ (Frederickson & Roberts, 1997). Women are expected to constantly self-develop, grow, and reflect whilst also working on beautifying themselves (Elias et al., 2017). Nia portrays the tension between societal and psychiatric discourses, in which attempts to appear ‘normal’ denies her visibility and legitimacy as a patient.

Nia illustrates how she is caught between two prevailing discourses of the psychiatric and gendered discourse that limit the way she can be seen and understood. This analysis understands Nia's talk as a form of resistance against the dominant discourses, as she contests the opinion of the experts and expresses her disbelief and anger: "*what the fuck*". Nia discursively positions the medical professionals as 'experts' who failed in their job, which, in turn, positions them as accountable for her suicidal feelings. However, her positioning of experts in such ways risks positioning herself as one who cannot be helped or is misunderstood by experts. These constructions have a strong influence on how Nia would feel about herself.

This analysis was shaped by my position as a woman and CP trainee, drawing on societal attitudes and assumptions as to what constitutes a desirable woman. As such, I had positioned Nia as a woman who was angry, as she stated, "*what the fuck*". As a CP trainee, I analysed the text phenomenologically, sharing her beliefs; thus, I consciously put on the 'researcher' hat and focused on the implications of her talk, with particular focus on Willig's fourth and sixth stages of FDA.

In the interview, Nia shared another example of how she was 'othered' by health professionals based on her physical appearance:

'I've recently asked for my medical notes from the doctors, and it's got on there, oh yeah she came saying she was feeling really bad and um but she had a flower in her hair and I'm like why would you even, ..what what it's just…just..I'm speechless when I come across things like this, I really am because they literally, they literally go on your physical appearance you know if you, you are able to out a little bit of

lipstick on, but with me because I feel so bad on the inside I don't want them to see that on the outside and I'm insecure anyway so I put make up on to, as a mask you know, but they think, oh you know you got make up on so there's nothing wrong with you. And these are professionals, you know, you're supposed to go to these people when you need help, and they behave like that, you lose all faith and trust, in all of them, literally it's just ..it's just unbelievable.' (Nia, 324).

Nia demonstrates how the legitimate patient position comes with certain notions of how she ought to behave and appear. In this quote, expert health professionals position Nia as a non-legitimate patient as she was able to maintain her appearance. It could be suggested that Nia's distress is rendered invisible to the practitioners through 'masking' (Goffman, 1959). Subjectively, Nia's talk could be considered an expression of agency, as being treated by medical professionals as suspicious. Thus, in order to maintain the position of the legitimate patient, Nia needed to demonstrate little to no agency. As a way of resistance, Nia complains about the expertise of medical professionals, suggesting they should be able to work with her emotional pain, see it as distinct from her physical appearance and understand her 'masking' (Goffman, 1959). She presents herself as a patient who has been let down, losing *"all faith and trust"* in medical professionals.

The analysis found that women in the study were not only objectified in their appearance or behaviour but also that they had to minimise aspects of themselves to medical professionals to keep their position as legitimate patient.

In the quote below, Erum's educational achievements are ignored, suggesting she could not be seen as 'educated', 'normal' and 'functioning' whilst also holding a legitimate 'BPD' patient position:

'What's your highest education level?" So, I said, "Well, I've got an MA, my master's". She just laughed. She said, "Yes, we all have a master's in life. Did you get any GCSEs?" And that… this was a social worker. [Laughter] like, she didn't believe me, like. [Pause] um, that's what I mean when people think you're stupid… And the psychiatrist, he's really nice, Dr XXX. But, again, he talks to me, and he tells me things really slowly. Most of the things I already know, so I just, sort of, nod along.' (Erum, 460).

With attention to subject positions, there is a clear power imbalance between Erum, as the patient, and the 'experts' in this quote. Drawing on Willig's third stage, action orientation, this analysis demonstrates the social worker's talk, *"yes, we all have a master's in life",* disclaims Erum's talk and position as an educated person, discrediting her level of qualification as genuine. Positioning Erum as educated, with a master's, could have threatened the dynamic power relation with the social worker, so much so that Erum could be positioned as the 'expert'. This quote demonstrates that in accordance with the social worker, Erum could not hold both the 'expert' and 'patient' positions. Erum's talk of the psychiatrist positions her as uneducated, whilst he is positioned as the 'expert' with all the knowledge. Erum's laughter can be seen as a signal of her frustration with the power imbalances. Despite portraying herself as an educated person, Erum nods and plays along in the uneducated subject position. Her compliance could be understood as a motivation for ‘maintaining face’ (Goffman, 1967) as losing face has potential interpersonal consequences, as it might threaten the expert’s authority and lead to a rupture in the doctor/patient relationship. Equally, it could be seen as a discursive strategy to maintain a positive self-image, as the person who discredits another is at risk of social backlash, not only ‘destroying another’s image’ but also their own (Goffman, 1967, p.106).

3.4 Psychological discourse

With a focus on Willig’s second stage of FDA discourses, this analysis found that psychological discourses were drawn upon by the women in the study, constructing ‘BPD’ as a response to trauma. The psychological discourse was seen to offer kinder, more empathic ways for the women to see themselves in comparison to the medicalised model that pathologises the individual’s personality as a deficit, removing the emphasis from the trauma. Centring on Willig’s fourth stage, subject position, the analysis found that the shift from patient (psychiatric discourse) to client (psychological discourse) activated particular interventions and access to therapy, thus increasing power. With focus on Willig’s sixth stage, subjectivity, this study found that the position of the client offered the women in the study accessibility to hope, the means to manage their suffering, and a mutual understanding from others for their pain and behaviours.

Trauma explanations constructed ‘BPD’ as a *“reasonable response to trauma”*, understanding women’s presentation, emotions and behaviours as *“reasonable”* as opposed to ‘pathological’ as seen within psychiatric discourses. Trauma explanations of how ‘BPD’ diagnoses were acquired showed that the women drew on psychological and psychiatric discourses, which positioned them as both patients and clients. The women in the study referred to various types of traumas and abuse, including emotional, mental, physical, sexual, domestic and incestual abuse, suggestion an association between trauma and 'BPD', supporting research that suggests many women who have been diagnosed with 'BPD' are often survivors of trauma and abuse (de Aquino Ferreira et al., 2018; Wirth-Cauchon, 2001; Castillo, 2000; Herman, Perry & Van der Kolk, 1989). This study found that the psychological discourse offered the women different ways of how they could see themselves, moving between positions such as client, victim, survivor, and shaping their subjectivity.

3.4.1 Survivor of trauma

Nicola positions herself as a survivor of multiple traumatic and abusive life experiences, including mental, physical and sexual abuse. In the below excerpt, she talks about an array of events in different contextual settings, including her family, place of work and intimate relationships in which she was a victim of abuse.

'I have been struggling with mental health for a very, very, very long time – since my early teens. I've had a lot of issues in my life. I had abusive parents – mentally abusive. I had a physically abusive brother. I had, um, a physically abusive boyfriend. I have been sexually abused in my workplace, and sexually harassed in my workplace. Um, so, there was a lot going on. A lot happened.' (Nicola, 23)

In this account, the use of the psychological discourse enabled Nicola to position her parents, brother, (ex) boyfriend and people from work as abusive and herself as a victim of abuse. As such, the position of the victim makes it possible for her to experience empathy, compassion and understanding and places accountability for her pain on the perpetrators of abuse. Drawing on stage three of Willig's FDA approach, action orientation, Nicola's function of drawing on the psychological discourse meant she was able to take up the position as a victim of abuse, a position from which she can explain the seriousness of abuse, trauma and injustice she has experienced throughout her life. Nicola's use of the word "*very"* multiple times could be seen as a discursive strategy to highlight the significance and seriousness of her pain and her endurance, thus positioning herself in the present as a survivor of trauma and abuse.

Positioned as a survivor, Nicola's account can be seen to place responsibility for her struggles with her mental health on the abusers in her life, who have created the struggles, which is significantly different to the psychiatric discourse that positions Nicola as a woman who has a 'borderline personality'. The change of subject position (from patient to survivor) offers Nicola significant powerful repercussions on how Nicola could see herself and gain empathy, shaping her subjective feelings. Through the position of the survivor, Nicola could draw on social and contextual factors to understand her pain, for example, the phrase "*a lot happened",* as opposed to psychiatric talk that suggests her distress is biological.

Whilst writing up this account, I was mindful of the language I used in the analysis. This comes from my training as a CP and position as a social constructionist that understands language as constituting reality (Burr, 2003; Holt, 2011). Thus, I sought supervision to soundboard these contentions, which was extremely helpful as it enabled me to stand back and reflect on the analytical method. In doing so, the language I used in this analysis came directly from the text, as opposed to how I, the researcher, wanted to position them. I believe reflexivity in the data analysis process helped improve the quality of the analysis.

This study found that Nicola was not the only woman who spoke of multiple traumatic experiences in the construction of ‘BPD’. In the below extract, Nia talks about incidences of domestic abuse, incest, and a childhood without a mother in the construction of ‘BPD’:

‘Husband was very controlling so, I think for me, that’s how the BPD developed really was... And my mum left when I was 3. Um.. there’s that, the history of sexual abuse in my family but that happened when I was… well for like for a long time , there’s a whole like, I can see how it happened, ‘cause it’s not like you’re not born with it, it’s your personality developed because of your experiences, when you look at it, it’s no wonder, it’s perfectly reasonable that I would have developed this BPD. Buts it’s like now, no amount of therapy can take it away. It’s just, it can just help me kind of understand, um, and not keep blaming myself for how I feel, ‘cause I have so much guilt and hate and everything for myself, and therapy it, its helps me to stop blaming myself as much, you still do because its engrained in you, but you know you try, and sort of step back and say, this, everything in your life is not your fault, it’s basically because of the circumstances and be kinder to yourself…(long pause).’ (Nia, 164)

Considering Willig's sixth stage of FDA, subjectivity, Nia's talk of trauma opened up her access to personal agency and the power to share parts of her personal narrative that may not have been done so easily from the position of the patient. Nia positions herself as a survivor of a *"controlling husband",* "*sexual abuse",* and one whose "*mum left",* which allowed her to share and experience her pain, as well as represent herself positively as one who was harmed, abused, controlled and neglected, enabling empathy and admiration for her survival. Nia's assertion of "*it's not like you're not born with it"* and "*everything in your life is not your fault"* can be seen as a form of resistance against social discourses that position her as "bad," and psychiatric discourses that position her as 'mad'. The shift in subject positions affords her the opportunity to represent herself as a survivor, which functions to orient herself away from blame, which is *"engrained"* through competing discourses, to increasing self-compassion where she can "*be kinder"* to herself.

In the interview, Tanya drew on trauma explanations crossing between psychiatric and psychological discourses of trauma in the construction of 'BPD'. Psychiatric discourses enabled Tanya to position herself as a patient in relation to 'Post Traumatic Stress Disorder' (PTSD)/ 'Complex PTSD', and the psychological discourses of trauma allowed Tanya to position herself as a survivor of trauma. In the below quote, Tanya constructs 'BPD' as a "*reaction to trauma":*

'A lot of it is a reaction to trauma as well so you can see most of the symptoms have ..if you see it in the context of trauma then it's an actually a reasonable response to that isn't it like and that's why there is so much debate about PTSD, Complex PTSD, you know 'cause the symptoms really overlap.' (Tanya, 102)

The trauma explanations open up a new way for Tanya to position herself and discuss her subjective feelings. In this extract, Tanya can be seen to utilise trauma discourses as an explanatory framework for her behaviours, one that invokes empathy and understanding from others, mitigating a troubled identity. Trauma discourse enables her to explain and rationalise her feelings and behaviours. In this account, Tanya's use of the word "*actually*" could suggest a contention and resistance to both the psychiatric discourse that pathologises her and the wider social representations that position people with 'BPD' as 'bad'. Tanya also demonstrates her knowledge and takes up an 'expert' position through talk of the mental health diagnoses, *"PTSD" and "Complex PTSD"*.

The questioning of *"*PTSD*"* or 'Complex PTSD' can be seen as an attempt to put forward a positive self-representation through a 'non-blaming' construction (Becker, 2000) that does not target her personality but experiences of trauma. Tanya's use of the words *"symptoms really overlap",* enables her to move between positions in the psychiatric discourse as a patient of 'PTSD' and 'Complex PTSD', increasing her power and access to various resources. Taking a critical realist epistemological position meant this analysis could account for Tanya's personal agency and her take-up of different subject positions (Burr, 2003; Willig, 2000).

I had reflected on whether Tanya's take-up of the 'PTSD' and 'Complex PTSD' discourses was a way of sharing something outside the text. Through my own research and journey of understanding 'BPD', I was in a position to pay close attention to the unspoken content of Tanya's talk (Frost, 2009). I wondered whether Tanya had considered whether the way she was positioned and treated by experts would have been different had she received a diagnosis of ‘Complex PTSD’ as opposed to ‘BPD’. Furthermore, whether the position of a patient with ‘Complex PTSD’ would have changed her construction of herself, as well as how experts constructed her identity, on reflection, I would have asked further questions to explore the possible implications of her references to the terms ‘PTSD’ and ‘Complex PTSD’.

Imani shares how she came to acquire ‘BPD’ in the below passage as a result of consistent, stressful social, contextual factors:

‘I’ve moved around a lot…as a… a kid, we moved around a lot, which I think… like, I think I’ve got BPD as a result of both environmental and hereditary reasons..On my dad’s side of my family, it’s rife with mental health problems, physical health problems and, like, substance abuse, blah blah...a lot… well, you know, and when you’re a kid, like, that’s hard. That’s really hard. Like, I’ve been to, like, seven different schools, I’ve moved cross-country several times, I’ve lived in [pause]… so… so, like, when people ask me where I’m I’m from like, “I don’t really know how to answer that.” It’s, like, I’ve lived in X,Y,Z,A,B and now C. So, it’s not just, like, moving to the village next door. Um, so, I think that contributed to my diagnosis because I had to be able to cope in different situations. Um, obviously, people in X are different to people in Y, so you have to, kind of, adapt to their way of life, and their mannerisms, and how they talk, to fit in as a kid. ….. um, I’m trying not to get off-topic.’ (Imani, 320).

Imani's explanation of 'BPD' as a result of significant stress, "*we moved around a lot",* allows her to position herself as a survivor of a stressful childhood, permitting her to share her narrative in which she felt compelled to adapt with each move "*to fit in"*, affecting her sense of self. One interpretation of this account, with attention to Willig's fourth stage, subject positions, could position Imani as a victim of a family who has "*mental health", "physical health",* and *"substance abuse"* problems, accounting for her subjective experiences of pain. The construction of *'BPD' as a result of both environmental and hereditary reasons"* allows Tanya to position herself as a survivor of societal stresses, as well as a patient within the psychiatric discourse, thus increasing her access to a variety of resources. Imani's application of psychiatric discourse does not necessarily mean she constructs her identity solely in accordance with this (Willig, 2000).

The use of the word "*hereditary"* could be considered as a discursive tactic to deflect and resist psychiatric discourse linking a biological causality of 'BPD' to her family's health problems, which is outside of her control and accountability. This account can be seen as Imani's way of demonstrating the significance of early childhood events marking a crucial role in the construction of 'BPD'.

The psychological discourse offered the women in the study a vocabulary that normalises responses to adverse social life experiences, as well as support and space to position themselves as 'normal'. The analysis found that some women referred to 'DBT' as a therapeutic approach they had received, whereas some did not specify what type of therapy they had received but did refer to the therapeutic relationship with their counsellors and therapists. This study found the relationship between client and therapist is different to that of patient/doctors, offering the women access to their subjectivity and a normalising, non-pathological talk.

3.4.2 "I felt like a normal person for once'

In the below extract, Tanya presents herself as 'normal' after having Dialectical Behavioural Therapy (DBT) therapy:

'My DBT therapist was amazing and like within that year that I was in DBT, the change that I saw like, I managed to like go to back to college, and do an access course, which was quite intense but yeah reduced my drug use, reduced my drinking, like, stopped self-harming, didn't have any more hospital admission, my life just improved completely, I felt like a normal person for once, like for once I felt stability, I never had that before, and I felt a little bit content in life, I never had a time in life when I was actually happy so that therapy was very good for me, laugh..And she like, I just completely I just completely subscribed to that approach, the non-judgementalism, and working on practical solution in life, a lot of people don't like DBT because they get to chat shit and talk about their past, laughs,…But I don't want to do that, so you know, fine with me, you kind of have to buy into it, for it to work, and I spent years reading about it, and being like this is the best therapy for me, it is the gold standard treatment for BPD, I think and so like I was trying to get that for years because I knew that was my best chance out of here, yeah she was really great, I loved my therapist (laughs).' (Tanya, 714)

This extract can be seen as Tanya's way of explaining how the subject position of a DBT client provided her with the resources to not only *do "normal"* things (college, access course) but to *feel "normal"*. Her construction of DBT as *a "gold standard"* treatment offers Tanya power, hope and release from dominant discourses. For example, this account can be seen as a way of demonstrating her freedom from *“hospital admissions”* and *“self-harm”* (psychiatric discourse), as well as ‘bad’ behaviours such as *“drug” and “alcohol”* use (social discourse).

This account can be seen as a discursive strategy to reconceptualise ‘BPD,’ in which Tanya was offered a new way of seeing herself, moving away from a patient to an active client. Tanya’s talk signifies a profound change in what was enabled through the position of a DBT client, with an *“amazing”* DBT therapist, accessing positive self-representations *“for once I felt stability”.* Tanya’s active changes can be seen as her way of showing parts of herself that she is proud of, including accomplishing DBT, accessing college, as well as her capability of love, and maintaining positive relationships with her therapist, whom she *“loved”.* Tanya positions herself as a *“normal”* person in society post-DBT therapy.

The findings show how the position of the client offered the women in the study to be subjects with personal agency, which offered a variety of possibilities of how they could feel. In the below extract, Nicola spoke about how her counsellor understood her feelings of anger:

‘*I had a really lovely counsellor called xxx, who would [pause]… she’d just sit and listen. And [pause] she [pause]… yeah, she [pause]… and there was another one a lady here called xxx, and she was lovely too. And she [pause]… she’d get why I was angry…..and she would say [pause]… she wouldn’t always agree with me while I was angry. And she would say [pause], “But has it not occurred to you that*

that might be happening because of that?" You know, she would not [pause]… she'd get me to see the bigger picture, [pause] and then [pause] try and make me look at it another way…..[Sighs] I'm…. I wouldn't even say that's mindfulness. I'm not if it is or if it isn't. I don't know. But she would always get me to see the bigger picture, and so would xxx [sniffs]. So, I always had a good relationship with my counsellors. xxx (Nicola, 328)

Nicola demonstrates how she was given the opportunity to be seen and understood by her counsellor, whom she describes as *"really lovely",* which significantly differs from her talk of psychiatrists earlier on in the analysis. Nicola is presented as capable of having meaningful relationships with professionals, which differs significantly from the psychiatric talk that 'othered' her as 'attention-seeking' and 'defiant'. The counsellors offer Nicola *"another way"* of looking at her feelings of anger, as opposed to persecution from social and medical discourses (Johnstone, 1989), in which her anger was a symptom of a 'disordered' illness (psychiatric discourse), or positioned her as a 'bad' woman, deviating from idealised societal values of calm and caring (social discourse). The client-therapist dynamic facilitated a place for Nicola to move freely in her narrative, creating 'stories of self' (Charmaz, 1999).

Nicola's use of the term *"bigger picture"* functions to locate Nicola as a subject in a wider, social, environmental context (Proctor, 2017), which in turn facilitated a space for her to feel heard, validated, and understood (Baker et al., 1997), including her anger. Thus, considering Willig's FDA model, this analysis demonstrates that women with ‘BPD’ are able to reconstruct their position as women with ‘BPD’ by drawing on a trauma discourse.

Similarly, Nia, positioned herself as a client in a relationship with her therapist to allow her space to access her subjective feelings:
‘I had a lot of frustration and anger cos I had no way of expressing the kind of pain I was in, its only recently in therapy, she said to me you know you can cry its ok its healthy, and you know now …if I’m watching some... something on telly that makes me cry, I let myself cry and kind of fight myself not to cry and sometimes you feel better afterwards but I still have to……., I don’t want to be doing it every time I meet my friend for a coffee,…. cos when someone cries around me that makes me feel uncomfortable so I know it must make them feel uncomfortable and if it’s all the time they’ll just stop inviting me round.’ (Nia, 102)

Nia demonstrates how the relationship with her therapist enabled her to account for her feelings of anger and sadness and offered her ways of expressing them through crying. Within the psychological discourse, describing crying as *“healthy”* allows Nia to position herself with normative behaviours, as opposed to behaviours that are pathological (psychiatric discourse) or too feminine (social/gendered discourse), increasing access to her emotions, behaviours and power. Nia’s account can also be seen as a way to demonstrate the tension of subject positions of the client (psychological discourse) and woman in society (social/gendered discourse), limiting the amount of crying she engages in to prevent herself from being considered an outsider amongst her friends and general society.

As a CP trainee, I noted my inherent bias in which I preferred the psychological discourse over the psychiatric. My personal experiences working in the field of counselling psychology, my interest in specific modalities, and my own values may have influenced these analyses. For example, the quotes I chose in this thesis could be seen to privilege the psychological discourse, as opposed to the psychiatric discourse.

Drawing on Willig's fourth stage, subject positions, Nia draws on the client position. Through her talk, it was possible to consider the significance of relational power, for example, the relationship between the client and therapist allowed the women in the study to reconstruct their identity, freeing access to their emotions. Nia drew on feelings of invisibility and disconnection enabled through the subject position of the client:

'I'm a ghost, I literally feel like I'm not there, I feel see through. Like I have to look in the mirror to see that I'm even real, um ….And things like that people can't even understand unless they've got that thing themselves, You never feel like you're living in reality….You just feel estranged and I can't they've my therapist, couple of them have said I have attachment disorder, which means I won't allow myself to attach to people but it's the same with um with physical things, I don't keep anything, I won't hold on to anything of sentimental value, I don't have things from years ago, I don't like, I just don't seem to have, I don't have an attachment to anything, um, feel like if I had to imagine an image of that feeling- it's like you got a flower and it's just standing on the grass it's got no, it's not attached, it's just literally being plonked there, and that's how it feels.' (Nia, 133)

Nia can be seen to use metaphors such as a *“ghost”* and detached *“flower”* to account for her subjective feelings through the position of the client. The use of metaphors can be seen to demonstrate a state that is unavailable in dominant discourses; thus, the visualisation of the *“ghost”* and *“flower”* enables an understanding of emotions beyond words. The therapist in the extract explains Nia’s presentation as an *“attachment disorder”,* which offers Nia a reasonable explanation for why she cannot hold attachments to people and objects. This account illustrates how the position and practices of the client-therapist dynamic enabled clients to explore their subjective experiences.

Arguably, the therapist can be seen to have ‘othered’ Nia as one who is attachment ‘disordered’, thus placing her as an outsider in society, limiting her ability to possess attachments. The metaphors could be considered her expression of alienation from the self. This account can be seen to exhibit the power that discourse has on affect and embodiment (Wetherell, 2012), shaping her sense of self and behaviour (Hacking, 1986). Discourses are productive (Foucault, 1972) in that they are constitutive of a person’s identity. These findings show how the relationship between two people, client and therapist, has a significant role in shaping people’s sense of self.

3.4.3 ‘Why didn’t you use your DBT?’

The analysis found that some women positioned as clients were at risk of reproach from their DBT therapists. Erum’s account demonstrates the power dynamic between client and therapist when the client deviates from the ‘good’ DBT client position:

‘But then I had someone who died, that I knew, and I was quite distressed, and I had cut a few times. And I went to see her, and I felt like she had been telling me off. “Why didn’t you use your DBT? Why didn’t you use your ….Why didn’t you do that?” Like, I almost felt like I was being told off.’ (Erum, 496)

In this extract, the discussion could be understood as a means of demonstrating the role of power through subject positions. Through Erum’s words, the dynamic between the therapist and client denotes a parent-child dyad, in which the therapist is positioned as the parent whose role is to reparent the client (child), working on modifying and controlling their behaviour of self-harm. Such positions grant the ‘experts’ the right to *“tell off”* clients, similar to that mentioned within the psychiatric discourse. The therapist also positions Erum as a person with the capacity for self-monitoring and regulation at all times, including times of grief, thus denying and disempowering access to her subjective experience.

Rose (1999) argues that ‘psy’ disciplines foster individualism and self-regulation in their practice, which Rose claims is both a myth and unachievable. Research has also shown that self-harm offers people a sense of control in times of great powerlessness (Longden & Proctor, 2012), yet people with ‘BPD’ are often made to feel blame and responsibility for their behaviour (Shaw & Proctor, 2005).

I analysed this account, drawing on my position as the CP trainee. I considered the function of her talk, drawing on both the text and my experience of working with clients who engage in self-harm. Erum drew on the notion of accountability that reminded me of the tension many feel working in the NHS – *“telling off”* their clients in order to uphold the status quo that professionals are ‘experts’ who can somehow obtain the power to *stop* their clients from self-harming. This quote made me consider the possible repercussions of constructing the act of self-harm as ‘empowering’ (Longden & Proctor, 2012) within an NHS setting.

3.5 Gendered Discourse

Research suggests that grouping and positioning women as different from the ‘norm’ creates a world in which some people will have access to more power than others (Proctor, 2017). The analysis found that ‘BPD’ was talked about as a feminised construction, which positioned women as ‘dangerous temptresses’ through media representations. The women were also positioned by themselves and others (friends, family, and professionals) as ‘bad mothers’. These positions depersonalised and ‘othered’ women with ‘BPD’ as distinct from normative ideas of what constitutes a loving, caring woman. Feminist research suggests women have been positioned in gendered discourse for centuries as a way of ‘othering’ them in society, with the use of language such as devils (Ussher, 1991), witches (Shaw & Proctor, 2005), ‘hysteria’ and ‘BPD’ (Jimenez, 1997; Becker, 1997).

Whilst conducting the analysis and, in particular, when writing up the gendered discourse sub-section, my feminist values were invoked, prompting discussions in supervision to help challenge my own biases and taken-for-granted assumptions. Thus, to enhance the quality of this analysis, I have tried to remain transparent and open regarding my involvement in the research process (Frost, 2009). I tried to remain focused on the language of the women that were interviewed as opposed to my own preconceived ideas. However, I believe my values and experiences have shaped the way I presented these findings because, for example, my position as a mother meant I attended more to the implicit aspects of talk, such as the use of metaphors to account for feelings that could not be described with language (Frost, 2009).

3.5.1 Dangerous temptresses

The internet was a key resource that offered the women in the study access to knowledge. However, the internet was also seen as a vehicle promoting a culture of stereotypical gender discourse, placing women within limited subject positions (Punday, 2000; Baker & Potts, 2013). In particular, Nicola spoke about how the internet search engine Google illustrates people with 'BPD' as promiscuous individuals who *"sleep around".* The principle of monogamy is historically and culturally located in religious, moral, and social discourses and is one valued by contemporary society (Kraeger & Staff, 2009). As women are often diagnosed with 'BPD' (Kaess et al., 2014; APA, 2000), discourses that associate women with 'BPD' as 'promiscuous' serve to 'other' women with 'BPD' as different and outside normative societal values and expectations.

In the below quote, Nicola attempts to negotiate her identity as a woman with 'BPD' against the internet:

'*[Inhales] um, and he [pause]… I told him that I had a borderline personality about six months into our relationship and cried, because I was scared to tell him, [pause] just because of the notoriety of the condition, because when you Google it, the first thing it says is that, uh, 'people with borderline personalities sleep around a lot' [laughter], and we don't. Really, we don't [laughter], you know, which is why I said,* *“If I tell you about this, I don’t want you to go and google it [laughter], you know, because it’s just, like… seriously,” you know [laughter]. “Well, don’t [laughter].’ (Nicola, 748)*

In modern society, women are typically judged for promiscuity with derogatory language, whereas men are typically rewarded for sexual activity (Marks & Fraley, 2005). Behaviours considered sexual deviation are linked to identity, creating objects of stigmatisation and discrimination (Goffman, 1963), maintaining the status quo of which behaviours are ‘normal’ and ‘deviant’ (Adler-Nissen, 2014). Thus, the often-used representation of women with ‘BPD’ as ‘promiscuous’ prompts Nicola’s fears and sadness of how she is portrayed, *“cried…I was scared to tell him”,* demonstrating a powerless against a dominant discourse that questions her morality in terms of sexual conduct through the diagnosis ‘BPD’. Her laughter can be understood as a tension of how she will be understood by her partner, as she does not want him to have access to a representation of herself that positions her as one who may engage in casual sex with multiple partners. Such portrayals of women maintain the idea that women are sexually alluring (de Beauvoir, 1952), positioning women with ‘BPD’ as essentially predatory.

Thinking of power across dominant discourses, such positions could be seen as attempts to shame women and limit sexual talk amongst women. Nicola asserts herself as one who does not sleep around and resists the taken-for-granted talk of women with ‘BPD’ that suggests otherwise, perhaps as a way to hold a positive self-representation to both myself (the researcher) and her boyfriend.

The media is a powerful institution that plays a key role in how society views people with mental health illnesses (Rose, 1998). During the interview, women were asked about media representations of ‘BPD’. Some women talked about ‘BPD’ with sexualised language, positioning those with it as predatory, alluring those they attract, thus depersonalising women with ‘BPD’, limiting what can be said or done. Research suggests that ‘mad’ women are often depicted as sexualised objects (Kromm, 1994).

In the below extract, Tanya defends her self-representation against the various, highly sexualised media representations of ‘BPD’:

‘*There’s a bit of mix, a lot of it is negative , fatal attraction um…they just… they just see you like a manic pixie dream girl bitch you know like, everyone’s around you like a moth to a flame, and then suddenly you burn everyone, (chuckles) and just like, that’s just like you’re objectified, as like the fem fatal who’s really quite happy, you wouldn’t want to be with her in the end(sniffs) Yeah.. chuckles…I loved eternal sunshine of the spotless mind, she seemed like she had a lot of ...I thought that was quite accurate portrayal of how it feels sometimes, um, I haven’t really seen anything else that portrays BPD.’ (Tanya, 911)*

Tanya uses glamourised representations, such as the ‘manic pixie dream girl’ with ‘BPD’, a stereotypical female character portrayed in romantic movies as quirky and sexy, playing to the male character’s needs and desires (Condis, 2019). Considering Willig’s third stage of FDA, action orientation, Tanya’s use of the word ‘bitch’ at the end could be understood as ‘other’ women with ‘BPD’, suggesting such women are not the heroines in movies, instead are undesirable and unfriendly.

Similarly, the media portrayal of women with ‘BPD’ as a ‘moth to the flame’ implies that women with ‘BPD’ are seductive, with an alluring beauty, yet have the capacity to abruptly ‘burn’ others, reinforcing the image of women with ‘BPD’ as ‘evil’ and ‘unpredictable’.

Another popular media trope mentioned in this extract of people with ‘BPD’ is the ‘femme fatale’, an attractive woman with an erratic nature of being a ‘maneater’ (Minowa et al., 2019). As such, those allured are positioned as victims of such predatory women, who are unpredictable and hold the capacity for violence. Women are thus positioned as equally desirable and evil.

These representations draw on gendered talk depicting women in ‘othering’ positions ranging from religious descriptions of women, such as Eve who tempted Adam into sin (de Beauvoir, 1952), to witchcraft talk that portrays women as ‘witches’, mystical, with the capacity to do evil to others (Ussher, 1991). This study found that women with ‘BPD’ are described in the media as essentially mad and unpredictable in nature (Ussher, 2011). Tanya describes the portrayal of the character from the film ‘Eternal Sunshine of the Spotless Mind’ as *“quite accurate”*. This character is not spoken about as a media trope; instead, the talk functions to offer a visual representation of a character to *explain “how it feels sometimes”.* Tanya stops herself from talking about this character, possibly as a way to position herself positively, as ‘negative’ descriptions of the character directly impact how she would be positioned as one with ‘BPD’.

My analysis of these accounts was shaped by my identity as an Indian woman, who, as stated before, is familiar with an 'othering' identity. This meant I was able to empathise with Tanya's predicament, where she struggled to see self-identity in a 'positive' way across media. Thus, her talk of tropes and demeaning subject positions explored the implications of subjectivity.

The analysis found that people with 'BPD' were portrayed in the media as *"dangerous", "violent",* and *"lunatics*". Feminists suggest that the concept of 'BPD' replaced 'hysteria' during a time of significant changes in gender roles, which found women in more employment, thus 'BPD' encompassed both traditional 'feminine qualities such as depression and impulsiveness, as well as contemporary values commonly considered as masculine traits such as aggression (Jimenez, 1997, p.163). Thus, expressions of anger place women at risk of a pathological diagnosis of 'BPD', whereas such behaviours are deemed typical for men (Barrett & Bliss-Moreau, 2009).

Imani shares how the media depicts people with 'BPD' as violent and dangerous, creating tensions against her sense of self as one who has 'BPD':
'I read a lot of trashy magazines. Like, real-life magazines, like 'That's Life!' and 'Love it!' and 'Chat' and whatever. And it's all about, like, real-life struggles, like people who have… this is really morbid, but just, like, you know, people who are sharing their stories of, like, surviving cancer, or losing their children, or surviving domestic abuse, or [pause]… you know, stuff like that. And whenever I see BPD mentioned in magazines or newspapers, it's always 'they're murderers'. They're always murderers. They're always rapists……..Um, yeah, sorry, I haven't [pause]…

like, you've asked me about this… reminded me here. So, it wasn't just Girl, Interrupted that I saw. It was… it's in these magazines. And whenever I see BPD mentioned, it's always, like, 'this person is erratic' and 'they're a lunatic' and… or they've just outright killed a load of people. Like, [pause] they've killed their partners, their own children, they've set fire to things. Yeah, it's… it's horrific…….Um, and then I'm just, like, "Well, I've got the same diagnosis as these people." Like, [pause] you can see… you can see why people, like, bunch us all together. Like, I'm not a murderer or an arsonist, and it's… it's… it's horrible to, kind of, be clumped together, yeah.' (Imani, 163)

Imani drew on media discourses in particular magazines that position people with BPD as violent, erratic, dangerous criminals, *"rapists", "murderers",* and *"arsonists"* – 'othering' people with BPD from normative society. Imani's use of language, *"they're always murderers,"* emphasises a 'truth' that BPD is consistently portrayed as an 'evil' and morally reprehensible construction belonging to a violent, erratic and dangerous person. Imani demonstrates power in her talk by resisting the media constructions, *"I'm not a murderer or an arsonist"*. From an action orientation perspective, this extract could be seen as Imani's way to distance herself from such evil depictions through the use of the third person pronoun 'they'. Language such as *"murderers"* and *"rapists"* represents talk stereotypically associated with 'madmen', yet language such as 'erratic' is stereotypically associated with 'feminine' traits, hence suggesting that 'BPD' is a construction that holds both stereotypical masculine and feminine traits.

Research has shown that since the Victorian period, women have been referred to as the ‘dangerous sex’ (Ussher, 1991; Showalter, 1987) in speech that positions them as ‘irrational’ and ‘erratic’, linking madness to their sexuality. Statistically, more women are diagnosed with ‘BPD’; thus, such talk of ‘BPD’ can be seen as an attempt to attack the essentialist, feminised characteristics of a woman, to de-feminise women who serve to challenge societal norms. Attempts to depersonalise such women distance them from the idealised societal values of sensitivity and warmth (Prentice & Carranza 2002). Feminists suggest that psychiatry punishes women who reject femininity and present ‘non-female’ traits (Chesler, 2005; Jimenez, 1997).

During the interview, Tanya struggled to identify anyone famous with ‘BPD’, yet when she does recall someone, she mentions a man, a famous sportsman:
“Hmm..there like an American dude, basketball or footballer? He comes out with it, yeah he was like abusive to his wife, he had a drinking problem, and then he was like I got BPD oh,” (laughs). (Tanya, 905)

In this account, drawing on Willig’s third stage of FDA, action orientation, the function of Tanya’s talk suggests that a famous sportsman strategically used ‘BPD’ to justify and account for his abusive, violent behaviour and *“drinking problems”*. ‘BPD’ could be seen as a communicative strategy to obscure discourses of men’s violence against women. Tanya’s laugh could be understood as a form of resistance, expressing how ridiculous the depictions of ‘BPD’ are in society when associated with violent men. This analysis found that ‘BPD’ is constructed through the media in multiple contradictory ways from predatorial, promiscuous, absent, abusive and masculine. This finding reflects how ‘BPD’ is a vague construction (Miller et al., 2008), affecting how women with ‘BPD’ connect and associate their sense of self with ‘BPD’.

The analysis found that ‘BPD’ was a problematic object, accounting for behaviours deemed *“impulsive”* and *“self-destructive”,* such as *“suicide attempts”*, *“self-harming”, and “binge-eating”,* thus positioning women as the problematic ‘other’. This was demonstrated through Imani’s talk seen in the below quote:

‘It’s someone who has exhibited a large proportion of the following behaviours over a significant period of time…. Um, so, impulsive and self-destructive behaviours, so, um, things like suicide attempts, or self-harming, or binge drinking, binge eating, overspending, that kind of thing. Someone who experiences intense emotional pain, um, and someone who has [pause] very frequent unpredictable mood swings. So, you can be pretty happy and confident for, what, maybe a few hours, and then a few hours later you’ll be really sad, and then you’ll be really angry and irritated, and then [pause], you know, something else. Um, I also think it’s someone who has an unstable self-image – so, someone who can’t tell [pause] which emotions are valid and which ones aren’t. Like, that’s something I struggle with a lot. I often don’t know where the BPD just starts and where… and where… and where I do. So, yeah, someone who doesn’t have a strong self-image as well – like, they don’t have a good sense of who they are, what they enjoy, um, [pause] because you tend to mimic the personalities, um, gesticulations and behaviours of the people around you.’ (Imani, 5)

By drawing on psychiatric, psychological and sociological discourses, Imani is seen to 'other' herself within the above quote. Imani's talk suggests a level of masking (Goffman, 1959), in which she is 'othered' in society for her 'self-destructive' behaviours or considered to have 'an unstable self-image' within psychological/psychiatric discourses. Her mention of *"mimicking"* suggests the need for women to 'mask' their authentic selves in order to align themselves within normative society (Goffman, 1959). Imani is also considered passive and objectified within the psychiatric discourse, in which she requires input from 'experts' to tell her *"which emotions are valid".* Considering Willig's framework, particularly the fourth stage, subject positions, the position of the 'other' across competing discourses demonstrates significant implications on Imani's subjectivity. Imani's embodiment of 'BPD' through the subject position of the legitimate patient denies her personal agency, so much so that she does not know where she ends and the 'BPD' starts.

Research has shown that diagnoses play a vital role in shaping individual identities and are fundamental to how they live their lives (Gillman et al., 2009). This quote demonstrates the struggles Imani faces as a woman, positioned within competing discourses as the 'other', denied the right to experience emotions, including sadness and anger, without these being defined as 'self-destructive'.

3.5.2 'Bad' mothers

The analysis found that women spoke about 'BPD' in association with the position of mothers. The gendered principle of caregiving is documented in social and psychological discourses, in which 'good mothers' are selfless, providing for the overall needs of their children (Brown et al., 1997; Hays, 1996); thus, any deviance places mothers at risk of moral judgement and social rebuke. Historically, psychodynamic theories have proposed that 'BPD' was a result of insecure attachments (Hengartner et al., 2015), poor attachments with primary caregivers (Bowlby, 2005), or passed on by 'BPD' mothers (Masterson, 1976).

Critiques of psychoanalytical and psychiatric discourses suggest that the focus on the role of mothers in children's health and wellbeing promotes a discourse of mother-blaming (Ussher, 1991). Sociological literature also emphasises the role of mothers over fathers, held responsible for their children's welfare (Weusten 2011), in which 'good mothers' are self-sacrificing (Brown et al., 1997; Hays 1996). Mothers whose children deviate from societal norms are positioned as 'bad mothers' who have 'failed' in their roles by not producing a 'healthy' child (Horton-Salway & Davies, 2018). Thus, motherhood is a highly prized constitution of womanhood in modern-day society, in which some mothers are validated and accepted whilst others are not (Chavis, 2016).

In the below extract, Erum talks about her mother as someone who positions herself as responsible for her daughters' 'BPD', whilst her father is positioned as distant from 'BPD' talk:

'Oh, my mum likes to try… she almost tries to deny it because she thinks that that would mean it was her fault….So, she almost tries to deny it, so I don't mention it to her.

R78: Okay. And your sister? [Pause] well, how does… like, how does she talk about borderline personality disorder?

P78: [Pause] um, [pause] she [pause]… she doesn't really say. But she's more [pause]… she… she uses it as an excuse to be horrible, I think. [Pause] um……. She uses it almost like a weapon, like she can get away with being horrible because… and she'll be like, "Oh, well, I've got BPD." So, I don't… she doesn't really say much. And my dad never mentions anything like that.' (Erum, 310)

With a focus on subject positions, this analysis understood 'BPD' as associated with women, Erum, her mother, and her sister. Erum's mother is positioned as one who is potentially accountable for the 'BPD'. Talk of her mother's denial could be seen as a way to avoid scrutiny and blame. However, in reference to Erum's sister, 'BPD' is constructed as a weapon, permitting her bad behaviours. Women in this talk are positioned in various ways, using discursive strategies to uphold a positive sense of self. The father's talk is non-existent, resonating with the idea that 'BPD' is highly feminine in nature, thus a gendered diagnosis (Shaw & Proctor, 2005). Contemporary discourses of 'good mothering' stress the role of mothers to be selfless, providing for the overall needs of their children (Brown et al., 1997; Hays, 1996).

During the interview, Nia constructs herself as a mother without her children and shares how she is constructed by others in society, influencing how she positions herself:

'*I got three kids and they don't live with me, which is another horrible story, I haven't seen my youngest, she's 7 for nearly a year. But it's like sometimes I'll go days without even thinking about her she lives with her dad, um, because it's almost like* *to think about it is too painful so people say these are your kids, how are you not doing everything you can to see them but I …and I know it's not right, and it's not normal, I literally cant, have attachments with people,..okay a lot of that was my first husband, and I was really young and he always threatened to take them away from me.' (Nia, 144)*

As a mother without her children, Nia is seen by others as not doing enough in her role, drawing on the societal understanding of mothers as 'superwomen' (Gross, 1998). She is positioned in wider, well-established, dominant discourses as the 'other' that stipulates she should be with her children. Nia situates herself as misunderstood and powerless, unable to uphold the status quo of 'motherhood'. Whilst acknowledging her position as the 'other', a 'bad mother' by others in society, she attempts to orient herself in a positive light, offering a rationale linked to an inability to have attachments, *"I literally can't, have attachments",* and her past relationship with her first husband *"a lot of that was my first husband".* Medical and psychoanalytical discourses enable Nia to defend her position in society as unable to form attachments, offering a rationale for her deviation from the representation of the idealised 'good mother'.

By doing so, her sense of self is distanced from the notion of a 'bad mother', instead positioning herself as one who cannot form attachments with them, an 'unavailable' mother. This talk affords her the right to be seen empathetically by others, offering some moral ground, as opposed to the position of a 'bad mother', which has damaging consequences for her subjectivity. Her account can also be seen as an attempt to demonstrate her position as a 'survivor' who manages to cope and avoid her pain by not thinking about her children.

I felt I could get a closer understanding of Nia’s position as a mother defending her identity from societal expectations of the ‘super’ mother by drawing on my own position as a mother and experiences in maintaining this status quo. Through discussions with my supervisor, we considered multiple functions of Nia’s talk, which I assume were drawn on our positions as a mother. Thus, the attention to Nia’s position as a mother may have enriched the interpretation provided.

The study found that women with ‘BPD’ were positioned in society as unstable, requiring monitoring and surveillance, offering implications for their subjectivity. In the below quote Erum shares how her GP, social worker and midwives positioned her as a mother with ‘BPD’:

‘*Yeah. Like, um, this social worker, XXX, I had when the kids were small – she was really nice. And I went to my GP once, when I felt really bad, and he said, “Oh, I’m going to call social services.” That was the first… his first thing was his concern for the kids, rather than me. And I went and I phoned XXX, and XXX spoke to him and said she wasn’t at all concerned with how I looked after the kids and the kids were fine. And I’ve been to him since. Well, except occasionally – like, you know, when you just want an appointment for something physical, I’ll go. But I’m never going to him for that sort of reason again because you don’t want to talk to someone if their immediate reaction is to say, “Oh, well, I’m going to call social services then,” and that… so [pause]..And every time when… because each time I got pregnant, with both pregnancies, the midwife immediately calls social services – apparently they have too…I remember being terrified the first time. I thought they were going to try and take the baby away or something, but they didn’t…But I was terrified.’ (Erum, 586)*

Erum’s account demonstrates that she was subjected to a form of penalisation from her GP and midwives, who threatened to call social services. Her position as a woman with ‘BPD’ affords her the right to access support from services, including her GP, when she feels down; however, her support is overshadowed by her position as a mother with ‘BPD’ by health professionals. The GP and midwives position Erum as an ‘unfit mother’ based on their values and beliefs, drawn from dominant discourses on what constitutes a ‘good mother’, warranting their actions to call social services. ‘Risk management’ is fundamental in contemporary literature on ‘good’ and ‘responsible’ mothers (Lee, Macvarish & Bristow, 2010).

Thus, mothers who seek help for their emotional struggles are at risk of social judgement, reducing their level of power and agency in mothering to conform to societal expectations to be ‘selfless’ (Hays 1996). Erum moves between positions of a woman with ‘BPD’, a pregnant woman with ‘BPD’ and a mother with ‘BPD’, each situation placing her at a disadvantage in society due to her gender. This account demonstrates the power dynamics at play within the health and social care institutions, designed to enforce social control through surveillance (Foucault, 1979), coercing Erum into silence, limiting her subjectivity, *“I’m never going to him for that sort of reason again”.* Erum is positioned as powerless, thus *“terrified”* of the possibility of losing her children. Erum’s fear is of legitimate concern as research has shown that women diagnosed with ‘BPD’ have been discredited in the courts of law, often losing their children (Stefan, 1998). Thus, mothers with ‘BPD’ are at significant risk of being ‘othered’ within medical/expert discourses, placing them at risk of losing their children.

With reflections on power, the subject position of the ‘BPD’ patient demonstrates how significantly Erum’s identity is impacted by the experts, considering the process of ‘othering’ and its consequences on personal agency. Erum’s mention of the social worker can be seen as a form of resistance to the way she is positioned in society by her GP and arguably by society itself. This discursive strategy can be seen as a way of proving she is a ‘good’, ‘responsible’ mother, thus, aligning her identity to how she constructs herself. This study found that women who self-harmed were placed in limited subject positions. Such behaviours deviate against social understandings of what constitutes healthy, beautiful women; thus, responses to those who self-harm often entail anger, fear, disgust and shock (Gardner, 2001).

In the below quote, Erum shares how she ‘othered’ due to her engagement in self-harming or suicidal behaviours:

“Okay. So, one time, I took an overdose. It wasn’t, like, long after my grandmother had died, so my uncle told my mum that I was very selfish for doing that after she’d died. [Pause] um, [pause] and, like, if I was to, say, do anything… if I had… when I’ve got the kids, I know people would say, “Well, that would be very selfish of you,” if you were to, say, kill yourself or hurt yourself when you’ve got small children.” (Erum, 102)

Drawing on subject positions, Erum is positioned by her uncle as ‘selfish’ as she took an overdose. Erum recognises how she is situated as the ‘other’ by her uncle and wider society. Erum provides an insight into societal judgement should she continue to engage in self-harm or suicidal behaviours; as a mother with ‘BPD’ she would be positioned as a ‘selfish’ mother; thus, she could avoid criticism if she stopped such expressions of pain. Throughout history, women have been placed in gendered roles as the primary caregiver, housewife and homemaker; mothers, in particular, are talked about as selfless, whose life becomes focused specifically on the overall needs of their children. Her account could be seen as a way of sharing how limited the role of a mother is, in her ability to express her feelings, especially in ways that deviate from societal norms that advocate health and beauty (Gardner, 2001).

3.5.3 Stigmatising representations

This study found that women with ‘BPD’ were negatively depicted, including *“manipulative”, “dangerous”,* and *“nasty”.* Research has shown that people with ‘BPD’ are often described as ‘manipulative’ (Lester, 2013; Markham, 2003; Markham & Trower, 2003; Fraser & Gallop, 1993). All the women in the study constructed ‘BPD’ as a stigmatising object, thus, supporting research considering ‘BPD’ as a stigmatising label (Bonnington & Rose, 2014; Catthoor et al., 2015; Stalker et al., 2005).

In the below extract Imani talks about how ‘*loved ones’* of people with ‘BPD’ talk about people with ‘BPD’ using stigmatising language:

“The same kind of websites that I go on, because there’s are a lot of online communities and forums for – like I was… I was telling you about earlier – um, loved ones of BPD sufferers. And they are all like, “Just end this relationship now.” Like, “This person will never change. They are emotionally manipulative and horrible.” Um, like, “It’s a waste of time.” Uh, and they are really, really toxic, and

really hurtful…Like, [pause] it's one… it's one thing having BPD, but it's another, like, being self-aware, and aware of your behaviours, and then, like, trying your best to change, but not always feeling like you are in control. And then other people are just, like, hating you anyway…. So, yeah, I… yeah, these are very boring answers, because I… I genuinely don't get much of a reaction, ….……. But also, people know me very well, and I think some people are surprised, because they are like, "Oh, but you are really successful, and you're such a nice person, and you have lots of friends." (Imani, 257)

Considering Willig's fourth stage, subject positions, *"loved ones"* of 'BPD' and people with 'BPD' are talked about using very different vocabulary. For example, 'loved ones' from online forums position themselves as *"loved ones"*, which could be understood to serve the function of distancing themselves from people with 'BPD', whom they depict as *"toxic", "manipulative",* and *"horrible"*. The binary positions can be seen as a way to 'other' people with 'BPD', positioning *"loved ones"* in a better light. Imani's account can be seen to resist these representations by positioning *"loved ones"* as bullies and trolls, inciting hate, affording Imani access to some moral ground, thus power. In relation to Willig's third stage, action orientation, Imani's efforts of declaring the subject as *"boring"* can be seen as a discursive strategy to disclaim the comments made by those on the online forum. Instead, Imani draws on her friends' positive representations. Using her friends' positive reports allowed Imani to position herself as *"relatively successful and normal"* and negate the dominant discourses surrounding the depiction of people with 'BPD'.

‘You don’t seem like you have a personality disorder’

The findings of this study showed that women were portrayed in society or themselves as ‘stigmatised others’, with a particular association to shame. Shame is considered an affect associated with the notion that a person is integrally ‘bad’ or flawed (Lewis, 2000). Existing research into ‘BPD’ suggests it is a challenging diagnosis, which places those with the diagnosis in a stigmatising position (Ross & Goldner, 2009; Woollaston & Hixenbaugh, 2008; Hazelton et al., 2006). This study found that women with ‘BPD’ spoke about shame on an interpersonal level, including discussions with friends, families and peers. Shame has been researched as a key emotion in people with ‘BPD’ (Linehan, 1993; Rizvi, Brown, Bohus, & Linehan, 2011).

The analysis found that ‘BPD’ is not commonly understood by people in society, thus positioning people with ‘BPD’ as ‘others’. In the below quote, Erum positions herself as someone who has “Bipolar" as that is more commonly understood:

‘So, well, I feel quite ashamed of it as well. Like, I wouldn’t… unless it’s people I know. Well, sometimes I tell people I’ve got bipolar because everyone knows what that is.’ (Erum, 209)

With a focus on subject position, this analysis views Erum’s take-up of the position as one who has ‘bipolar’ evokes more empathy from people in society, as opposed to ‘BPD’, which could evoke judgement. ‘BPD’ is constructed socially as something shameful, which Erum takes up, impacting her subjectivity *“feeling quite ashamed”.* Erum demonstrates resistance and personal agency, as she positions herself as having a choice as to what she tells people about whether she has *“bipolar”* or ‘BPD’.

Tanya shared how her diagnosis of ‘BPD’ was viewed as a stigmatising object by her friends:

‘Um….my friends kind of, when I told them that I was diagnosed with that, they were just like oh but you don’t seem like you have personality disorder, you know just that stigmatised thing, and I felt like, that really like, a part of me broke inside, my best mate would be like, for her to invalidate me like that, was quite upsetting and it meant like I just had to hide things, because nobody understood ..’ (Tanya, 757)

This quote demonstrates that ‘BPD’ is a problematic object whereby the person holding the diagnosis is at risk of social judgement. Tanya’s account shows that people with ‘BPD’ are expected to behave and perform in particular ways for their pain and suffering to be legitimised and understood. This quote shows how Tanya’s ‘BPD’ was rejected by her peers; as such, Tanya positions her friends as discriminators, taking up the position as a victim of discrimination and stigmatisation, affording her feelings of sadness and invalidation from her friends.

Imani also talks of how people with ‘BPD’ are expected to present in certain ways in order to hold a position as one with ‘BPD’: *‘I think some people are surprised, because they are like, “Oh, but you are really successful, and you’re such a nice person, and you have lots of friends.” I think they’re a bit like, “Oh, well, it can’t be that bad, because you are relatively successful and normal.” (Imani, 270)*

Imani offers positive self-representations of someone who is *“really successful”, “nice”, and friendly* whilst also positioned as one with ‘BPD’. The positions pose some tension as dominant discourses, such as those in psychiatry, position people in fixed, binary positions, i.e., ‘mad’ or ‘sane’ (Wetherell et al., 2001). Imani demonstrates resistance by positioning herself as successful and having a ‘BPD’ diagnosis. Nevertheless, the position of one who is successful and functioning denies her subjective feelings, demonstrating that one needs to physically present as ‘bad’ in order for her feelings to be considered valid. The term *“relatively”* can be discursively seen to position herself as ‘good enough’ in society.

The analysis found that shame extended beyond people with ‘BPD’ to the identities of their partners and family, demonstrating a level of stigmatisation due to association with people with ‘BPD’. Erum stated:

‘Yeah. Well XXX my other half, his family are so weird about it. ………..XXX mum said, “Oh, no, no, granny might see or hear,” so she paid £20 for me to get in, rather than using my form, and just in case granny heard or it’s embarrassing. ……his sister, she is… she is quite high-flying. She likes a bargain. So, she will always use [laughter] my DLA so that we don’t have to pay or something. Um [pause], and no-one else must know. It’s a whole big secret because his… XXX and his mum are very ashamed of it. Like, he works in xx, and he’s… and I’m not allowed to go to xxx just in case I say or do something that I’m not supposed to.’ (Erum, 283)

In this extract, Erum is talked about as an object of shame and embarrassment by her mother-in-law and husband. This account can be seen as a form of 'courtesy stigma' (Goffman, 1963), in which Erum's mother-in-law engages in such displays of public disapproval as a result of her direct association with a stigmatised person. Incidences of stigma can be seen to create binary positions of 'us and them' (Adler-Nissen, 2014), positioning Erum as the 'other'. However, with her sister-in-law, Erum is an object of convenience, impishly taking up the position of a disabled, borderline person to get access to things for free. Erum's description of how she is treated by her husband suggests that she is 'othered' from the normative roles and duties of a wife, such as attending his place of work. Her 'BPD' is talked about as a *"secret"*, thus silencing a part of herself and reducing her personal agency.

3.6 Resisting Stigmatised representations

The analysis found that although the women in the study drew on dominant discourses, they also resisted elements of these discourses. This aspect of the finding is concerned with Willig's third stage of FDA, action orientation, demonstrating that women established their personal agency, resisting positions such as *"attention seeking", "bad mothers", and "murderers"*. Whilst accepting 'BPD' as a diagnosis, these women also demonstrated resistance against the position of a passive patient, resisting negative assertions about their personhood. Resistance and moving between subject positions enabled the women to draw upon various discourses to be seen positively. An example of this was how all women drew on the trauma discourse to account for events in their lives, positioning themselves as survivors of trauma, placing accountability for their suffering onto the perpetrators of abuse or social, contextual factors over which they held little to no control.

3.6.1 I'm not a difficult person

Nicola constructed 'BPD' as something difficult and 'tricky' to treat, resisting pathological positioning as a 'difficult' patient. She asserts in the below quote, "*I'm not a difficult person"* explaining her distress in terms of social, contextual factors:

'It boils down to the fact that [pause] it's… it's a tricky one to treat. And… and as a result of it, [pause] phy… uh, physicians or… or whatever, you know, don't want to treat it, are scared to treat it, or just [pause] ignore it [laughter] [sniffs], [pause] you know. Because I'm not a difficult person, [pause] but when I'm in a bad place, I need help, just like anyone else's that needs help, [pause] you know. But it doesn't mean to say I shouldn't [pause] get the help because of my diagnosis. [Pause] because I'm just as at risk as everyone else'. (Nicola, 637)

This account could be seen as a way of Nicola positioning herself as one who is powerless over her 'BPD', a condition that is 'tricky', as a way to gain understanding and empathy into her subjective reality and accessibility to resources. She can also be seen to deploy a discursive strategy of normalisation to position herself as one who is *"just like anyone else",* resisting psychiatric talk that positions her as the 'other' and undeserving of the 'help' associated with 'BPD'. This description illustrates Nicola's resistance to a stigmatising label.

This analysis found that the women in the study took up positive subject positions that offered positive self-representations, drawing on a strengths-based language, offering powerful influences on their sense of self. One way this was achieved was by aligning their identity to a group. The social identity theory stipulates that a social identity is a person's sense of belonging to a particular group (Hogg & Abrams, 1988). Through a social comparison process, people who feel aligned with and belong to a group form part of the ‘ingroup’, whereas those who do not belong to the group are categorIsed as part of the ‘outgroup’ (Stets & Burke, 2000). In this study, a few women spoke about social support through charities and online forums, which offered opportunities for new ways of viewing themselves and, consequently, their subjectivity.

3.6.2 ‘Have you ever heard of Project Semicolon?’

In the interview Nicola also shared how she made friends with another, through her position as one who has a tattoo of a semi-colon.

‘*Have you ever heard of Project Semicolon?........(Researcher nods) …...I have a semicolon. Well, I have a big tattoo, but… a semicolon. And he said to me [sniffs] [pause], “I noticed you have a semicolon.” And (unclear 00:55:17) up to people that say that. You know, they’re… “What have you got a semicolon tattooed on you for?” And there are people that don’t know anything about it. Or there are the people that say, “I noticed you’ve got a semicolon” – they’re the people that do. So, I said to him, “So, why are you asking about my semicolon?” And he leaned across and said, “Well, if I told you that I’d crashed my Porsche into a bridge and spent six months recovering in The Priory, you’d know why I’m commenting about your semicolon.” So, we’ve been friends ever since. So, he understands.’ (Nicola, 729)*

Project Semicolon is an organisation founded by Amy Bleuel that aims to support people suffering with their mental health. When a writer chooses to continue a sentence rather than end it, a semicolon is used; thus, a semicolon is used here to represent the decision to continue a life rather than choose suicide. Drawing the focus to subject positions, Nicola's reference to the tattoo can be a way of positioning herself as an expert by experience who has knowledge and insight regarding contemporary mental health charities. The tattoo can be seen as a symbol of solidarity, a non-verbal communication offering mutual understanding and support amongst people affected by suicide. Those who recognise the symbol are positioned as 'insiders' to this knowledge, offering the possibility for social alliance towards them. Nicola's tattoo can be seen as symbolic power, a part of her identity which can be hidden or exposed as and when Nicola chooses. However, for those who may not be aware, it can also be a way of initiating conversation and educating people about self-harm and suicide.

When Nicola asked, *"have you ever heard of Project Semicolon"* during the interview, I nodded and smiled but chose not to speak about it. I believe these non-discursive forms of communication enabled Nicola to share talk of the project. Furthermore, I felt a shift in the power dynamics, whereby she was educating me about the project, positioning herself as the expert and me as solely the interviewer. I also felt that personal experiences such as my age (early thirties), access to discourses on positive mental health, including those from specific celebrities who have a semicolon tattoo, and talk shared with me by young clients who have shared their semicolon contributed to my interpretation.

3.6.3 ‘She’s so easy to talk to’

Nia shared different representations of what people with ‘BPD’ can be like, from *“in your face”* to *“quiet ‘BPD’”:*

‘I’ve started making friends with people with BPD and initially I didn’t want to because a lot of people with BPD can be um..in your face and loud and um I can’t and maybe it I don’t know, I don’t know what it is, I don’t like people who are unpredictable or hyperactive, it’s just makes me feel uncomfortable. But a.. a couple of people I know from……are quiet, what I would call quiet BPD, you know more introvert. And just being around them, this one girl um she’s so, she’s so easy to talk to, everything I say she totally gets it, she’s got the same thing and um, so I’m trying to make more friends, because I don’t trust people and I get disappointed very easily.’ (Nia, 262)

In this extract, the analysis concerns stage four, subject positions, and six, subjectivity, of Willig’s FDA. Nia demonstrates how people with ‘BPD’ are not all the same, acknowledging personal differences in presentation. Through comparisons drawing on social and psychiatric understandings of women with ‘BPD’ as *“unpredictable or hyperactive”,* Nia distances herself from them, recognising the wider societal perspective on how women with ‘BPD’ are understood but also positioning herself as different from these positions. Nia dynamically moves between positions as a woman with ‘BPD’, allowing her to account for her feelings of mistrust and own her feelings and behaviours. Nia also shows that she can align herself with *“quiet”* women with ‘BPD’, who understand and facilitate an environment that enables her to talk without judgement.

These various representations suggest that women with 'BPD' can be quiet, caring, loving, nurturing and *"easy to talk to",* offering new self-representations for Nia to take up and position herself. These positive self-representations resonate with findings from research where people with 'BPD' tend to describe themselves with altruistic personality traits (Dammann et al., 2011).

In the below extract, Imani talks about being a member of a mental health charity and online forum [redacted] for people with 'BPD' as *"a bit more positive"*.

'*Um, the NHS is a bit more clinical about it, whereas* [redacted]*, u- m, and charities like* [redacted]*, they tend to be a bit more, like, "Oh, here are experiences of people who've had it and how they have coped with it, and here's what you can do to get better." Like, "Oh, here's mindfulness and, you know, here are stories from other people that you might want to read to help you." It's a bit more positive. Like… like, I love the NHS, and I will never badmouth the NHS, but, like, they… they are there to, kind of, I guess, [pause] diagnose, and [pause] treat, and do the clinical side of things. Whereas mental health charities like* [redacted] *and* [redacted]*, it's like, "Okay, well, you've got this condition, like...so have all these other people. Like, it's… it is okay. It's not the end of the world, like. Come and join our writing group or our art group, or do some mindfulness, or here's where you can go in an emergency, or…" (Imani, 203)*

This analysis focuses on stage four, subject positions, and stage six, subjectivity, of Willig's FDA. Imani describes the charities as *"positive",* reconstructing people with 'BPD' with a non-medicalised approach, thus offering her support and hope, *"here's what you can do to get better".* Charities are seen to validate Imani through exposure to positive narratives and accounts of other people with 'BPD', offering new ways of shaping her identity as a person with ‘BPD’. This points to the different discursive resources available to individuals located as charity members against a patient within the NHS. However, the NHS are positioned in society as ‘heroic’, an institution that ‘saves lives’; thus, Imani quickly adopts the position of pro-NHS. The discursive action of ‘never badmouthing NHS’ can be seen as an example of ‘stake inoculation’ (Potter, 1996); an attempt to mitigate against censure for being an ungrateful patient, recognising the wider, dominant perspective of the NHS as heroic. Thus, the damage limitation allows Imani to hold and move between the positions of a patient within the NHS and a member of the charity group.

One avenue of recruitment was via a mental health charity, [redacted]. In the below quote, Nicola uses her position as a member of the charity to construct ‘BPD’ and position herself through a non-medicalised lens:

‘Um [pause], they don’t. They don’t really talk about any… any condition. They are just aware of it, and they know that it’s a nasty condition. But there are quite a few people here that have it, um, [pause] and cope with it. We don’t really discuss any condition as a whole because there are so many people here that have so many different conditions that we just all get on with it. It’s… there… there’s, sort of, one lady that has got my condition and something else and physical problems. So, we don’t want to say, “Oh, well, my problem is better than your problem,” or, “That’s better than that.” It’s, like, “Oh, so you’ve got that too? So, I understand that,” and it... because we all support each other, and that’s what is really lovely about it.’ (Nicola, 558)

Focusing on subject positions, the position as a member of the charity that offers a non-medicalised construction of ‘BPD’, Nicola is afforded the space to connect with others, offering her a sense of belonging and a social identity that belongs to an ‘in group’ (Stets & Burke, 2000). The *“nastiness”* of ‘BPD’ is attributed to ‘BPD’ as opposed to Nicola; thus, non-pathological talk offers Nicola new ways of self-representation. She is afforded a degree of normalisation within the group, a sense of support and mutual understanding, and increasing hope and power. In this account, Nicola shows that she can be a positive member of society who has friends, people who have ‘BPD’ and those who do not. She can position herself as someone who needs help and gives help, where the power dynamics between people are equal.

During the interviews, the women were asked if ‘BPD’ had offered them anything, and Imani drew on some of her personal strengths as a result of ‘BPD’:

‘*Um [pause], I think another advantage is it makes you a lot more empathetic, .. I think I would imagine most people on the spectrum would say that because you.. know what it…you know what it feels like to hurt that much. So, [stutters] when other people are hurting, you’re like, “Oh, I get that.” Like, I’m not just going to tell you to snap out of it or get over it. “Oh, that really sucks. Yeah, I can understand that feeling, like, because you just want to lash out and do this,” you know….So, yeah, empathy and, um, [pause] professional.. financial success- beneficial..and yeah,…... I don’t think I’d be as successful without it; you know?’ (Imani, 366)*

Drawing on Willig's FDA model, firstly stage one, this account demonstrates how 'BPD' can be seen as an empowering object. Imani's construction of 'BPD' as a strength can be seen as an empowering construction, positioning herself as one who is *"successful"* and *"empathic".* These positive self-representations include strength, independence and empathy, qualities valued by society. Thus, drawing on stage four, subject positions, as an empath, Imani has insight and understanding of other people's pain and anger. Imani constructs *"lashing out"* as an understandable reaction to social stress, which could be seen as an intelligible response. This contrasts with how such behaviour is interpreted within other contexts – within social discourses as 'bad behaviours' and psychiatric discourses as pathological. As such, Imani's positive representations can be considered a form of resistance to the dominant discourses.

3.7 Reflective summary & Conclusion

The process of conducting this analysis was emotionally challenging, drawing on my feminist values, my identity as a mother, 'other' as an Indian woman and my position as a CP trainee. Supervision was a key provision that enabled me to remain focused on the aims of the study, preventing slippage between various roles and positions I occupied. The choice of methodology, Willig's FDA, allowed me to present the findings in this manner, which I felt quite proud of achieving. However, I was new to the analytical framework, which required much processing to reach this final write-up.

This study found that most women emphasised the pathological aspect of ‘BPD’ within psychiatric discourses, legitimising their eligibility for help and access to resources. Through Willig’s fourth stage, subject positions, I could demonstrate the constraints women with ‘BPD’ face across dominant discourses. Women demonstrated through talk their ongoing battles within psychiatric discourses that ‘othered’ them, placing them within gendered double bind positions. How one presented had serious implications for how they would be treated; for example, one who ‘functions’ was deemed *“not severe enough”,* one who self-harms was deemed *“attention-seeking”,* and one who wears makes up may be considered ‘normal’. These positions justified medical professionals’ decision to deny treatment. The women discursively constructed their identity in relation to ‘BPD’; albeit limited by the position of the patient, they were able to dynamically move between positions to demonstrate a positive sense of self.

This study also found that the women were active agents, advocating the importance of social and contextual factors and their role as a woman in the current climate of society, in line with their experience of pain and suffering. The position of the client achieved through psychological discourses enabled access to empathy when they recounted their experiences of suffering and trauma. Reframing ‘BPD’ in the context of trauma offered women the power to reconstruct their identities, resisting psychiatric and sociological discourses that positioned them as ‘bad mothers’ or ‘badly behaved women’, instead positioning themselves as having been wronged by others and society. Women demonstrated strong awareness and insight into the stigmatising nature of the diagnostic label ‘BPD’ and discursively resisted the positions, establishing power.

Drawing on Willig’s third stage of FDA, action orientation, I found that women’s take-up of non-pathological talk enabled them to share stories and aspects of their identity, normalising and de-stigmatising their experiences. This study also found the various ways women resisted dominant positions afforded by the prevalent discourse, taking up positions that offered more favourable, kinder, positive self-representations and drawing on strengths-based language to offer new ways of being understood and new ways of experiencing themselves. Through mutual understanding and connection, the women in the study were able to see themselves as something more than ‘BPD’. This study found that the women’s access to non-pathological talk was achieved through settings such as charities.

Chapter Four: Discussion

4.1.Introduction

This chapter will offer a discussion on the methodological approach, Foucauldian Discourse Analysis (FDA) and what it offered this study, followed by a brief discussion on the key findings from analysis. This chapter also explored implications of the findings for Counselling Psychologists (CP) Trainees in terms of service provision, training and practice, epistemological and personal reflexivity. Limitations and recommendations for future studies are also considered.

FDA offers a useful framework to understand what 'BPD' is, adopting a critical lens to the taken for granted truths within dominant discourses including psychiatry. Adopting a FDA framework, to research how people diagnosed with 'BPD' construct their experiences is rare (Dyson & Gorvin, 2017). This study analyses how discourses, position such people and shape their sense of self and personal experience. FDA enabled an exploration of the power dynamics between the women who took part in the study and others, including professionals, friends, charities and so forth. Through the use of FDA, the analysis found 'BPD' is considered a fluid, inconsistent classification embedded within social and psychiatric discourse. How professionals within the dominant discourses perceived the women with 'BPD' in the study influenced how the women were positioned, impacting their level of treatment and support from the service. Women with 'BPD' were often placed within gendered, 'othering' subject positions influencing their subjective feelings and sense of self.

The women in this study demonstrated resistance and used strategies to navigate the constraints of limited and limiting, ‘othering’ subject positions, dynamically moving between subject positions within contemporary discourses, in order to be seen favourably and to gain validation and appropriate treatment. The shift between positions increased their situational power, enabling access to resources and treatment exercising their personal agency.

4.2 Key findings

This study found the women with ‘BPD’ were placed in limiting and restricted positions within available discourses. Although women were offered validation from the psychiatric discourse, they were equally at risk of being pathologized, ‘othered’ or at risk of being positioned within a double bind between what constitutes as ‘normal’ and ‘abnormal’. Furthermore, the women were placed within restricted gendered ‘othering’ positions, weaved through the psychiatric and gendered discourses in which women were judged based on their appearance, femininity and behaviours.

4.2.1 Gender and violence

This study was open to all genders, yet interestingly only women were recruited, supporting findings that consider ‘BPD’ as a diagnosis predominantly given to women (Shaw & Proctor, 2005; Johnson, Shea, Yen, Battle, Zlotnick, Sanislow & Zanarini, 2003; Kaess et al, 2014; American Psychiatric Association, 2000). This study supports findings that considers ‘BPD’ to be a diagnosis that is often given to women, not only to those who conform to the social construction of femininity but those who defy it (Wirth-Cauchon, 2000). For example, women who deviate from the idealised calm, caring, motherly construction of femininity, and instead express feelings of anger were ‘othered’ just as women who presented after having self-harmed. Women who were perceived as defying normative constructions of the idealised mother were also positioned as ‘bad’ mothers.

Talk of motherhood was not an area that was considered as a key aim of this study but was an interesting finding. Sociological discourses perpetuate the depiction of mothers as self-sacrificing, placing their children’s needs over their own (Brown et al., 1997; Hays 1996), thus, motherhood is a highly prized constitution of womanhood in modern-day society, in which some mothers are validated and accepted, whilst others are not (Chavis, 2016). ‘Bad’ mothers are considered accountable for creating a ‘broken society’ through ‘choice’ (Centre for Social Justice, 2013, p.4). Thus, ‘bad’ mothers are not only considered to be ‘failing’ in their roles as mothers but are considered to threaten the ‘social order’ (Lawler, 2000, p.2).

Contemporary research highlights the additional pressures for motherhood, known as ‘intensive mothering’, in which the ideal mother is one who is fully focused on their child, emotionally attentive and available (Duberley & Carrigan, 2012, p.633). ‘Progressive’, ambitious, hard-working women, have been portrayed in the 1980’s and 1990’s as ‘super women’, i.e., those who are able to balance motherhood alongside career ambitions (Rottenberg, 2018). In contemporary, neoliberal society women are encouraged to be self-sufficient and financially independent, successfully having an advanced career balanced with motherhood (Banet-Weiser et al., 2020).

In this study, women with ‘BPD’ were seen to navigate their identity across the contemporary discourses to offer justifiable explanations as to why they may not appear to be socially conforming to such standards of ‘motherhood’. For example, one woman who identified as a mother, demonstrated her efforts of responsibility and self-governance through compliance with her medical treatment to avoid being depicted as a ‘selfish mother’ and risk losing her children, whilst another woman discursively used ‘BPD’ as an explanation for her inability to have attachments to her children, distancing herself from the position of a ‘bad mother’.

Research has shown that the media plays an important role in how the public understands people with mental health problems (Rose, 1998). This analysis also found women drew on media representations of ‘BPD’, positioning women outside the traditional idealised feminine traits such as ‘promiscuous’ as well as drawing on language associated with traditional depictions of masculine traits include aggression and violence (Courtenay, 2000; Williams, 2003). This supports existing feminist research that considers ‘BPD’ as a diagnosis given to women who defy the notions of traditional femininity (Wirth-Cauchon, 2000).

The analysis also found a key theme around anger and violence. In existing society, anger and violence are considered masculine traits and women who display anger are more likely than men to be diagnosed with a psychiatric illness (Ussher, 2011; Barrett & Bliss-Moreau, 2009). This study found anger, whether internalised, through expressions of self-harm and suicidal behaviours, or externalised, through verbal expression, placed women at serious risk of criticism and misrecognition (Xie et al., 2021), positioning the women within an ‘insidious double bind’ in which they were labelled mad whether they complied with traditional forms of femininity or rebelled against it (Ussher, 1991, p. 280). Feminists have researched the ‘double-bind’ entrapment which women face, both when expressing and internalizing anger (Shaw & Proctor, 2005). Historically, research suggests that women were considered to value traits such as dependency, domesticity and passiveness (Renzetti & Curran, 1995), yet contemporary research draws on ‘neoliberal feminism’ (Rottenberg, 2018) in which women are encouraged take full accountability of their wellbeing, whilst balancing their careers and the needs of their families. This study found the presentation of self-harm and suicidal presentations positioned the women in the study as “*attention-seeking",* supporting research that highlights women who engage in such behaviours are considered ‘*attention-seeking’* and ‘attempters’ of suicide (Jaworski, 2010).

Existing research has found self-harm was reported by participants as a key aspect in regard to their sense of agency and control (Walker, 2009) and helped manage feelings of powerlessness (Longden & Proctor, 2012), offering an alternative understanding to dominant discourses of self-harm. This study found self-harm was still a highly stigmatizing behaviour that placed the women in the study at risk of moral judgement by those who treated them including paramedics and nurses.

The women in this study were also positioned as vulnerable ‘objects’ through the psychological discourse of trauma, as victims and survivors of abuse and violence. All of the women drew on talk of trauma, dynamically moving away from the psychiatric discourse that placed them as one who has something pathologically wrong with them or their personalities, instead orienting towards a discourse of victimhood, facilitating empathy and kinder self-representations. Research has shown that many people diagnosed with ‘BPD’ have experienced prior abuse (de Aquino Ferreira, et al., 2018; Wirth-Cauchon, 2001; Castillo, 2000; Bradley et al., 2005; Johnson et al., 2008). In line with previous studies (Abram et al, 2003; Kessler, 2000), this study found all of the women reported prior trauma, some reporting multiple traumas, including sexual abuse and one spoke of incest (Stone, 1992).

These findings show that ‘BPD’ as a diagnosis can be seen as an oppressive act, legitimised through the discourse of psychiatry. Research suggests the act of diagnosing women with ‘BPD’ prevents women from talking about their experiences of gendered violence, abuse and trauma, positioning them not in line with their victimhood, but as patients who need to be cured (Becker, 2000). This contributes to shaping a cultural and institutional world that fosters and normalises abuse and violence towards women (Berns, 2001). Interestingly, research investigating men with ‘BPD’ found that men too had experienced ‘complex trauma’ (Evans, 2016), demonstrating a link between ‘BPD’, complex trauma and power. Psychiatry can, therefore, be seen to remove the focus away from the trauma and acts of violence. Such findings give rise to Longden’s (2010) proposal that urges practitioners to move away from asking people ‘what’s wrong with you’ and focus on questions such as ‘what happened to you’ (p. 258), promoting trauma focused approaches.

4.2.2 The double bind

This study found women with ‘BPD’ took up the psychiatric discourse in complex ways. On the one hand, psychiatric explanations served to validate them, offering an understanding for their difficulties, affording them the right to the subject position of the ‘legitimate patient’. On the other hand, the psychiatric discourse positioned these women in restricted subject positions, often contradictory. For example, constructing ‘BPD’ as a lifelong illness as well as something that the women can grow out of, created tensions in how these women understood ‘BPD’, influencing their sense of self, as one who has ‘BPD’. The women demonstrated resistance in their talk, constructing ‘BPD’ in ways that offered more favorable ways to be positioned. Constructing ‘BPD’ as a spectrum/ continuum, compromised of various traits, which one can move along, allowed some women to be seen in different ways, allowing for change and individuality, resisting the position as one who incurable.

Women negotiated their sense of self, through the variety of positions they took up, yet these movement between positions placed them at risk as the ‘other’ within another discourse, creating tensions in their sense of self. Burt (1997) suggests the diagnosis ‘BPD’ not only promotes the inequalities placed on women but legitimises the practice to continue gender bias. This study supports feminist theories of gender bias in psychiatric practice, as the women were frequently positioned in double bind subject positions, such as ‘attention seeking’, ‘bad mothers’, ‘abnormal’, restricting access to resources and treatment and limiting personal agency. This study also supports existing feminist research implying women with ‘BPD’ are often caught in a double bind (Shaw & Proctor, 2005; Ussher, 1991).

Furthermore, findings from this study support existing research that propose ‘BPD’ as a stigmatizing diagnosis (Rivera-Segarra et al., 2014; Sansone & Sansone, 2013; Koehne et al., 2013), which places those with the diagnosis at risk of marginalization and oppression (Bonnington & Rose, 2014). The subject position as a patient with ‘BPD’ placed one of the women in this study at risk of both emotional and physical violence, supporting prior research that found people with ‘BPD’ were subjected to physical and psychological violence from public health professionals (Bonnington & Rose, 2014). This study, adopting a FDA framework, allowed the exploration of subject positions, demonstrating how power within such discourses has serious implications for those who are objectified and oppressed (Foucault, 1979).

This study aimed to highlight the practices that take place, legitimized through the technologies of psychiatry, such as the assessment processes, processes for treatment, enactment of knowledge and medication. These technologies enabled the experts to treat people as they perceived them. This study found that the diagnosis of ‘BPD’ was highly dependent on how the psychiatrist/ professionals interpreted i.e., ‘assessed’ the women’s presentation. Furthermore, encounters with medical professionals, were morally risky for the women in the study as they were frequently positioned as ‘pathological’, deviating from ‘normality’, non-conforming and even uneducated. Thus, ‘BPD’ as a diagnostic classification imposed a ‘spoiled identity’ (Goffman, 1963) on the women in this study, shaping their sense of self, generating behaviours that may not have occurred without the existence of the diagnosis (Hacking, 1986).

Those who did not conform to the expectations of the medical professionals of 'BPD', were at risk of not having a diagnosis, not receiving treatment and facing discharge from services. One woman spoke of needing to perform in ways to demonstrate her distress to psychiatric practitioners in order to access treatment. However, women who showed their 'BPD' through acts such as self-harm, were at risk of social judgement, positioned as undeserving of help and having a 'choice' in their behaviours, despite having 'BPD'. Johnstone (1989) highlights that to offer a person '*a diagnosis in psychiatry, unlike in general medicine, is to introduce them into a role and a life of stigma, social exclusion and discrimination, which would be a struggle even for the emotionally resilient* '(p. 63). This study demonstrated the power psychiatric discourse had on affect and embodiment (Wetherell, 2012), in which some women spoke of 'BPD' as something that was belonging to them, something they possessed, i.e., 'my BPD', consequently shaping how some women in the study viewed themselves. Thus, supporting Foucault's argument that discourses are productive and constitutive of one's identity (Foucault, 1972).

According to Gill (2017), the female body is consistently depicted as a 'source of power and as always unruly, requiring constant monitoring, surveillance, discipline and re-modelling in order to conform' (p.149). These findings suggest that the women in study were situated within competing discourses that positioned them as 'unruly', requiring social control (Foucault, 1979). As such, one woman in particular was seen to conceal her strengths in order to maintain the position of the patient and save face (Goffman, 1967), as losing face threatened the psychiatrist's position of authority, which could have led to a rupture in the doctor/ patient relationship. Women had to negotiate the technologies of psychiatric power (Foucault, 1979).

This study found women were often restricted by the binary of ‘normal’ and ‘abnormal’, generated by the discourse of psychiatry (Mackenzie & Murrary, 2021). This limited their talk of strengths as it risked their legitimate status as a patient and access to the resources available. The data from this study found that women who did not conform to the psychiatric norms of women with ‘BPD’ were positioned outside the psychiatric discourse, permitting services to deny or end treatment. Such positions were based on the assessment of the medical professional, thus suggesting the women’s distress was based on how professionals interpreted it.

This study found conformity to gendered constructions of femininity, drawing on health and beauty (Gardner, 2001), placed the women at risk of not getting a diagnosis as they appeared ‘high functioning’ and ‘not severe enough’. It also positioned them at risk of being discharged from services as they appeared *“alright”* to the practitioners. One woman spoke of how her use of lipstick was considered in clinical descriptions by psychiatrists to determine her eligibility as a legitimate patient in need of support and treatment, linking personal suffering to physical appearance. This study found that women positioned as ‘good’ patients were those who actively engaged in their treatment, adopting neoliberal values including self-regulation, behavioural modification (Brown, 2018) and self-responsibilisation (Rose, 1999). However, those who demonstrated compliance by taking their medication, accessing their therapy and ceasing self-harm, paradoxically placed themselves at risk of being considered “*not severe enough”,* denying access to treatment and support, thus unknowingly positioning themselves as well as mental health services as redundant. Women are situated within discourses that promote neoliberal ideology, placing expectations on women to govern themselves and demonstrate an autonomous, individualized self (Rose, 1999). This study also found that women who presented as successful and independent were considered ‘too well’, ‘othering’ them and denying their place within psychiatry. Thus, these findings, which to my record have not been researched before, demonstrate that psychiatry has expectations on how people need to appear and behave in order to gain access and treatment.

Depending on the context, women with ‘BPD’ were understood in various ‘othering’ ways, for example, ‘dangerous’ in contemporary social discourses, ‘pathological’ within psychiatric discourses and ‘survivors of trauma’ within psychological discourses. This study found that women with ‘BPD’ were at risk of being positioned within the category of ‘deserving’ and ‘undeserving’ care and treatment based on the interpretation of the medical professionals. Those positioned as ‘too functioning’ were classed as ‘undeserving’, placing them at risk of not receiving psychiatric care, just as women who were positioned as ‘attention-seeking’. The way women with ‘BPD’ were positioned enabled or restricted access to resources and treatment, thus affecting their sense of self.

Drawing on all of the findings regarding the double bind, this study found psychiatric discourses positioned women with ‘BPD’ within two overarching categories of the ‘deserving’ and ‘undeserving’ psychiatric patient. Within the category of the deserving patient, the analysis revealed various representations of the legitimate patient: ‘abnormal’, “*full-blown” ‘BPD*’, ‘compliant’ and ‘sick’. Within the category of the ‘undeserving’ patient, the analysis revealed a number of subject positions, including the ‘attention seeking’ woman, ‘immoral’ or one who was ‘normal’ or ‘not severe enough,' thus 'too well' to be deserving of the legitimate patient status. The contradictions and overlap between the 'deserving' and 'undeserving' categories were heavily based on the medical professional's interpretation, defining the available resources and treatment for women with 'BPD' and shaping their sense of self. This study found that the psychiatric discourse objectified the women in the study, with severe implications for their sense of self. This study found that women who rejected the diagnostic classification would lose their positions as one whose suffering was legitimate, thus placing them at risk of being positioned as undeserving, immoral and failed women in society. This study demonstrated that the only hope for the women to retain personal agency was to escape the diagnostic category; abandoning psychiatric talk enabled the women to be seen as something more than a diagnosis, offering significant implications to their identity.

4.2.3 Situating selves within discourses

This study found that discourses position women with 'BPD' in restricted positions, yet as Foucault (1978) highlights, power is not always oppressive. As Goodley & Rapley (2001) write 'where there is power…there is resistance' (p.230). The women in the study were seen to resist pathologizing, gendered positions imposed on them via dominant, taken for granted discourses, by moving between subject positions, allowing them to draw on different discourses to validate their subjective feelings, enabling them to position themselves and see themselves more favourably. Examples of such resistance were achieved by drawing on psychological discourses through the subject positions of the client.

The position of the traumatised survivor was seen to increase empathy and self-compassion. Research has found that many women who have been diagnosed with ‘BPD’ are often survivors of trauma and abuse (de Aquino Ferreira, et al., 2018; Wirth-Cauchon, 2001; Castillo, 2000; Herman, Perry & Van der Kolk, 1989). This study found women with ‘BPD’ drew on talk of trauma to explain their diagnosis of ‘BPD’, crossing both psychological and psychiatric discourses.

The subject position of the client allowed the women in this study an understanding for their feelings of anger and distress, drawing on the women’s life experiences, social and contextual factors as opposed to constructing ‘BPD’ as solely biological. Understanding one’s distress through the discourse of trauma, positioned women away from the notion that something is wrong with them and shifts the focus to what happened to them (Longden, 2010), thus offering new ways of shaping their subjectivity (Willig, 2011).

One of the women in the study drew on talk of her therapist, positioned as one who acknowledged her trauma and worked through strategies to help the woman see herself as ‘normal’. Lester (2013) suggest ‘BPD’ is a ‘disorder of a relationship, not of personality’ (p.74), suggesting people are not restricted to a life-long illness, but instead can understand and even remove ‘BPD’ through a relationship. Research has shown the importance of a ‘collaborative exploration’ as a way of talking about the value of equality, connectedness, mutuality, individualised care, promoting an equal platform between the individual accessing help and the individual offering help (Cheetham, Holttum, Springham, Butter, 2018). This study suggests an absence of such mutuality and collaboration between the role of ‘medical experts’ and ‘patients’, emphasizing the issue of unequal power relations (Johnstone, 1989; Proctor, 2017). In contrast, within psychological discourses, the women were positioned as clients, working with counsellors or therapists, reconceptualizing their presentation within the context of trauma, which allowed space for personal agency and empathy. It enabled access to talk of life experiences that may have been difficult to access within the medical and social discourses, without the risk of further prejudice.

Through action orientation, women in the study took up positive self-representation such as the role of a member within groups in society, which enabled talk of normalisation. The non-medicalized position, through charities and support groups, allowed the women to see themselves with a positive sense of self, through mutual understanding and belonging and some women spoke about the value of being understood by people, with/ without ‘BPD’. Research offering positive representation of people with ‘BPD’ are limiting and to date, there is one study that has found that people with ‘BPD’ align themselves with altruistic traits such as ‘friendly’, ‘sensitive’ or ‘cooperative’ (Dammann et al., 2011). These findings were supported in this study, which found women with ‘BPD’ considered themselves to have many strengths and put forward positive self-representations which portrayed them as ‘successful’, ‘empathic’, ‘easy to talk to’. These positive self-representations offer a dichotomous alternative to the stereotypical, stigmatised representations including language such as ‘difficult’, (Ross & Goldner, 2009; Woollaston & Hixenbaugh, 2008), ‘dangerous’ (Wilstran et al., 2007; Woolaston & Hixenbaugh, 2008; Markham, 2003) and ‘manipulative’ (Markham, 2003; Markham & Trower, 2003; Showalter, 1987).

Non-medicalised charity settings also offered the women the opportunity to take up the position of an active member of society, connecting with others, which in turn offers the opportunity of a social identity that belongs to an ‘ingroup’ (Stets & Burke, 2000). By offering alternative understandings of the world, new identities and ways of understanding the self, became available. One of the women in the study openly affirmed their mental health status having a semi-colon tattooed on their body. Project semi-colon is an organisation, which aims to support people suffering with their mental health, encouraging people to share their narratives of struggles with their mental health. In contemporary society, the semi-colon has been seen in the media promoted through celebrities including Selena Gomez, empowering people news ways of positioning themselves. Davies and Harre (1990) stipulate people are both ‘products and producers of discourse’, in which identities are formed, thus as a producer the woman’s active talk of a semi-colon could be seen as a way to align her sense of self to a discourse that serves to destigmatise and normalise talk of mental health.

As such, this study found that women in the study were able to move between the positions, drawing on positive self-representations, de-stigmatising talk and accessing support from charities that normalised and understood their distress. These positions offered the women kinder, positive and hopeful ways of understanding themselves, validating their feelings including anger, thus in turn, increasing their accessibility to power.

4.2.4 Analysis Summary

This study shows that women with ‘BPD’ can be categorised as ‘too well’ or ‘not well enough’, limiting and restricting their access to treatment and support. Women with ‘BPD’ who presented as functioning via their education, wearing make-up, being in a relationship or having a career risked their legitimacy as patients within psychiatric discourse. These women were not receiving the care and treatment they deserved due to being positioned by medical professionals as ‘too well’. Furthermore, women were seen to conceal their strengths in order to maintain their position as the patient and avoid the risk of being positioned as ‘too well’. To my knowledge, this data from this research was not found in other studies. These findings show that women with ‘BPD’ need to perform and present in certain ways in order to gain access to treatment. Alignment to discourses of social conformity and gendered norms creates tensions and risks their legitimacy status as a patient. Thus, women with ‘BPD’ are unable to have both a diagnosis and be considered ‘successful’ in contemporary society. This thesis found that the women in the study navigated through the various discourses in order to demonstrate their distress.

Current understandings of people with ‘BPD’ include ‘symptoms’ such as difficulties managing emotions and interpersonal difficulties (APA, 2013). However, existing research on people with ‘BPD’ does not offer the understanding that such people are academically bright, career-focused, and capable of having positive interpersonal relationships, which was found in this study. Previous research has also found that people with ‘BPD’ are manipulative (Lester, 2013; Markham, 2003; Markham & Trower, 2003; Fraser & Gallop, 1993; Showalter, 1987) and bring out transferential headaches amongst professionals (Becker, 2000). This study found that women with ‘BPD’ positioned themselves and others with ‘BPD’ in positive, destigmatising positions using language such as *"supportive"*, *"easy to talk to",* and *"normal"*, building on limited research that found people with 'BPD' describe themselves as 'sensitive, caring, helpful or friendly' (Dammann et al., 2011, p. 521).

To summarise, the women in the study were pathologised and positioned as failed women in society through the psychiatric discourse. However, alternative discourses such as the psychological discourse, which understood their suffering in the construction of trauma, or charity settings, which drew on non-pathologising talk, enabled them to be seen as 'normal' and retain agency.

4.3 Relevance to Counselling Psychologists and implications for practice

These findings tie into the contextual factors of the NHS, in which services and resources are heavily under-resourced. The NHS can be considered target-driven, a system focused on payment by results, moving towards a 'tick-boxing culture' increasingly removed from 'human relating' (Proctor, 2016). The standardisation process within the NHS has raised ethical and moral concerns (Wainwright, 2015), dismissing the significance of the therapeutic relationship (Cooper, 2008). This study has been carried out at a time when the NHS has been subject to a long period of austerity measures. Economic limitations produce a culture which filters down to the patient and explains how the women in the study are encouraged to be 'self-governing' (Lemke, 2002), demonstrating an autonomous sense of self (Rose, 1999).

In the field of CP, the therapeutic relationship is considered the vehicle for change, with the primary focus on improving the client's wellbeing. Research has shown that the quality of the therapeutic relationship between CP and client has been a key factor in the client's progress (Martin et al., 2000; Carper, 1979; Rogers, 1957; Horvath & Symonds, 1991). The role of a CP involves the ability to establish a meaningful relationship, considering the importance of wider factors such as social, spiritual, cultural, and physical influences in a holistic manner. CP practitioners need to focus on both the client's distress as well as their context (Johnstone et al., 2018). This study found numerous ways of understanding 'BPD'; however, the psychiatric discourse prevailed, both within the context of services that offered women support and how they came to understand themselves.

Despite the alternative understandings of 'BPD' within psychological discourse through attachment, trauma and so forth, women's distress was understood within dominant and limiting discourses. For CP, this study allows room to consider the social, political, and cultural contexts of those seeking help (Proctor, 2018). This study also encourages CPs to engage in reflexivity and self-awareness, including in relation to power dynamics in practice (Proctor, 2018). Increased awareness on how women with 'BPD' are situated across dominant discourses can allow CPs to improve practice by aiming to facilitate mutual understanding so as to develop meaningful relationships with clients.

A significant tension for CPs is that they are located within health-based services, which predominantly privilege outcomes and 'evidence-based', 'short-term interventions'. This renders a culture of 'tick box' exercises, removing the focus `from the therapeutic relationship and the experiential presentation of distress (Proctor, 2016). Cognitive Behavioural Therapies (CBT) are considered more favourable within health settings as it is aligned with research based on ‘modernism and the rationality of science’, yet from a Foucauldian perspective, CBT dictates the ‘right’ way to think, feel and behave (Proctor, 2017, p.75). As practitioners, CPs need to consider the application of power in the therapist's role through reflexivity and frequent supervision. CPs would benefit from being mindful of the stigmatisation that people with ‘BPD’ potentially experience and how this might influence presentations during meetings. This study found that encounters with professionals often left women with ‘BPD’ at risk of moral judgement; thus, professionals need to consider their use of language and how they position the women seeking help. It would be helpful for professionals to consider the client’s distress as inseparable from the social, cultural and political environment (Johnstone et al., 2018).

A key aim of this study was to promote further reflexivity for CP practitioners. This study highlights the significance of non-pathological talk, allowing women to understand themselves with positive self-representations, including the ability to position themselves as normal. Implications for practice include an increased awareness of the language that is used and the power it holds. CPs may benefit from considering the implications of non-pathological talk, formulations and conceptual advancements in future practice. Furthermore, the findings in this study may offer CP a degree of confidence to challenge taken-for-granted outdated practice, offering an alternative, compassionate way of understanding the distress of those seeking help.

4.3.1 Non-pathological talk

A counter discourse to the biomedical discourse adopts a de-pathologizing approach, promoting the wellbeing of individuals at its heart. De-pathologizing offered significant positive influences on the women's selfhood offering new ways of seeing themselves, shaping positive subjectivity. The turn towards de-pathological language can be considered as a growing socio-political movement, for example Watson (2019) in her book, writes about the need to 'drop the disorder', moving away from psychiatric talk towards one that normalises and promotes the health and wellbeing of people. The genealogy demonstrated the disappearance of talk such as 'drapetomania', a disorder of 'slaves' who tried to escape their 'owners' (Schwartz, 1998) and 'hysteria,' empirically evidenced as a 'mental disorder' and removed from the DSM-III in the 1980's (Tasca et al., 2012). Thus, 'pathological' illnesses have become 'depathologized' (Drescher, 2015) over time through social action. The removal of what was considered worldviews and 'facts' highlight the ongoing issues with the field of psychiatry and its practices. Activists, critical practitioners, feminists urge the removal of 'BPD' from the DSM due to its inherent association to gender and lack of research identifying biomarkers (Biskin & Paris, 2012).

It may help practitioners to consider what 'BPD' denotes in today's society in relation to power and social inequality, and how such factors could influence the dynamics of the therapeutic relationship, including transference/ counter transference, reducing ruptures in the relationship. Furthermore, for future practice, it is imperative for therapists to reflect on their world view and how it influences their therapeutic practice with clients (Willig, 2018).

4.3.2 Formulations

In the field of Counselling Psychology, practitioners are trained to focus on developing formulations with clients as opposed to diagnosing, adopting an idiosyncratic approach to the client's experiences, and understanding their difficulties as a process, not something that is fixed. Horn et al., (2007) promoted the use of individualized formulations as opposed to a diagnosis as a two-way process between the client and practitioner, promoting an equal relationship. Formulations can be considered as a co-constructing hypothesis between the individual accessing help and the person offering help, (Johnstone, 2018) reflecting on factors such as relationships, social factors, power, and intersectionality. Lester (2013) stipulated that people with 'BPD' held 'brilliant' survival mechanisms to cope with often invalidating early environmental life experiences such as physical, emotional or sexual abuse, promoting the importance of prescribing hope and validation in therapeutic practice. Women in this study also demonstrated significant strengths and resistance against limiting, pathologizing, gendered double bind positions. Formulations offer the ability to promote hope, identifying strengths, distinct to the client as opposed to using language that positions them at fault or 'disordered'.

As a CP Trainee, it is imperative to reflect on what battles both genders face, their position in society and how contextual factors implicitly effect subjectivity; in this study the particular focus was around how women are positioned within the discourses of 'BPD'. A key incentive to conduct this study was to shine a light on power inequalities that exist within relationships including the role of a CP and client. Power is a significant issue that presents in psychological distress; thus CPs would benefit to consider its active role within therapeutic practice.

4.3.3 Conceptual advancements

Within the field of psychiatry, advances in research by prominent feminists (Herman, 1992; Cauwels, 1992) have advocated the place for a counter discourse to ‘BPD’, through the categorisation of trauma related illnesses such as Post Traumatic Stress Disorder (PTSD) and Complex PTSD. Diagnosis such as PTSD and Complex PTSD offer empathic, warm and hopeful responses from practitioners as opposed to individuals diagnosed with BPD clients, who rendered negative responses giving practitioners ‘counter transferential headaches’ (Becker, 2000). However, the field of psychiatry and the classification of mental health illness system has been heavily critiqued for dismissing the individualised experiences of childhood trauma and silencing women’s suffering (Beresford, 2002). The biomedical framework is deemed confusing and paradoxical, proposing individual’s responses to life are both ‘normal’ and ‘disordered’ (Hamilton & Jensvold, 1992).

Reframing ‘BPD’ to ‘PTSD’ may acknowledge existence of trauma, yet the term ‘disorder’ fails to truly acknowledge the wider societal dilemmas faced, including the experience of abuse from males to females (Becker, 2000). From a genealogical perspective, ‘BPD’ has been compared to constructions such as witchcraft (Shaw & Proctor, 2005), hysteria (Becker, 1997), PTSD, and Complex PTSD (Becker, 2000), demonstrating continued oppressive acts of psychiatry towards women, as noted by Florence Rush (1996), ‘*the words may change but the melody lingers on’*. CPs would benefit from considering the use of psychiatric diagnosis in relation to our own personal attitudes and beliefs, the practice of counselling psychology, power and its effects on personhood.

A key implication for this study is to help CPs consider ways to improve therapeutic practice. There is a growing range of psychotherapeutic therapies that promote non pathological talk as the foundation principles, including humanistic, pluralistic therapies (Cooper & McLeod, 2007). One relatively new model includes the Power Threat Meaning Framework (PTMF), created as a conceptual alternative, to the dominant psychiatric model, moving away from psychiatric constructions instead offering the construction of ‘troubling behaviour’ (Johnstone & Boyle et al., 2018).

The PTMF encompasses social, biological, and psychological influences in one’s life, viewing people as essentially ‘social beings,’ thus the experiences of emotional distress are considered inseparable from the social and cultural circumstances (Johnstone et al., 2018). The model views behaviour as existing on a continuum of ‘normal and ‘abnormal’ as opposed to fixed within the individual. The ‘power’ aspect of the model refers to several different kinds of power, coercive; legal; economic and material; interpersonal; biological and embodied, social and cultural capital and ideological (Boyle, 2020). This model focuses the individual’s narrative, exploring how an individual navigates through their own adversities and traumas in life, as well as considering the possible ‘threats’ a person is at risk from. Thus, the idiosyncratic focus allows individuals to explore the personal meaning of their distress.

4.3.4 Policy shift

Studies implementing a discourse analysis are conducted to explore matters around power and social injustice. This study highlights significant issues women with 'BPD' face, including meeting eligibility of services, obtaining a diagnosis, gaining specialist treatment with/ without a diagnosis, stigmatisation and oppression. This study found the way the women were perceived by practitioners denoted the type of service they were going to receive. The NHS has seen serious cuts in resources under the argument of 'efficiency savings', in which many services have been tendered out to, too often, the cheapest provider (Proctor, 2016). This analysis found references to the experience of practitioners engaging in 'tick box' exercises impeding the focus away from a human connection to clients. The study suggests that commissioners, service managers and quality leadership teams would benefit from considering service provision, supervision provisions and innovative, empowering, socially inclusive practice aimed at de-pathologizing and instead offering help.

One recommendation would be to rethink the terminology around eligibility criteria, in which women are believed and treated as equals in their accounts, for example if they would like an assessment for a diagnosis, for it to be accepted, not questioned, dismissed or refused. Furthermore, it was apparent that many women wanted access to therapies; if this could have been achieved without a diagnosis, it begs to question how many would still seek a diagnosis. Respectively, services are stretched due to the way the NHS is currently run, yet it is clear that access to therapy is not as easily accessible. Movement towards embracing and promoting social inclusion may also empower not only the people seeking help but those working within the systems, increasing staff retention. It is important for all staff irrespective of gender, training, race, age, etc. to feel they are able to express themselves within services and taken seriously. For example, CPs who are given a choice to discuss with their client, options for treatment, as opposed to recommending CBT as the initial modality, could be considered an example of client-focused care, as well as valuing the role of CPs within multi-disciplinary teams. Systemic changes are required as services are overly focused on the management of risk and caseload as opposed to delivering ethical, client-focused practice. Navigating and implementing reflexive practice, within the current healthcare service is of great need, worthy to the population seeking help.

4.4 Epistemological & Personal reflexivity

4.4.1 Epistemological Reflexivity

Discourse analysis strives to analyse how discourse shapes our understanding of the world, with particular focus on social and political relationships (Lester & O'Reilly, 2016). The FDA was seen as a valuable framework to deconstruct what 'BPD' is, providing insight into how language and practices powerfully position people; in particular, how social/ psychiatric discourses limit and restrict what support the women in the study could access and how they could see themselves. Reflexivity was crucial as a research process, taking into consideration the number of factors that influenced the study. Holt (2011) writes that FDA studies require researchers to engage in 'reflexivity, research positioning and accountability and scrutiny of the language used to present the research' (p. 90). Reflexivity allowed further transparency in this study, on my own positioning, on the constructions that have influenced the final analysis and the final write up (Burr, 2003). Research positioning refers to the perspective based on the researcher's individual background factors including race, gender, class, and other identities (Mullings, 1999).

The various positions I occupy, such as my identity as an Asian, woman, wife, mother, feminist, practitioner within the NHS, CP in training, all influenced this study in different ways including the rationale for the study, the methodology, the analysis process, and final write up. In order to demonstrate transparency (Yardley, 2000) I have been unambiguous about my thoughts and position on the subject 'BPD' in supervision. Supervision and supervisory feedback were instrumental in this process of writing this final format, aiding my awareness and reflexivity on my biases, avoiding speculation, staying true to the text. The process of epistemology reflexivity involved the focus on my position as a researcher that considers multiple realities with a social constructionist epistemology.

4.4.2 Personal reflexivity

The journey on this course and completing this study has changed my identity (Willig, 2013), in which I became acutely aware of my feminist alignment. My awareness around epistemology and ontology is life changing and for that learning I am extremely grateful. Whilst embarking on this academic journey, I focused on language and critically questioned everyday talk. Personal therapy and the use of my reflective journal, offered me space to reflect, increasing my self-knowledge (McLeod, 1998) as well as invaluable discussions with colleagues and my supervisors. The genealogical discussion enabled me to consider and reflect on the different understandings of women's positions in society and the battles taken to obtain respect and equality. This study found the women worked very hard to resist a stigmatising identity, presenting themselves in a positive light without judgement.

Reflections about my age, gender and race, made me consider whether some women felt they could open up more and talk of things such as media, project semi-colon, websites and so forth due to a mutual understanding of age/gender. Also, the position as a CP Trainee, may have facilitated the women's participation in this study, that may have been difficult to do with a psychiatrist, due to fears of repercussions. For example, I had considered that some of the talk in the interviews may not have occurred with perhaps an older, white male. As an Asian woman it could be assumed that there was a mutual understanding of oppression and social injustice, influencing the way the women answered in the interview.

Reflecting on the work of Holt (2011) on discourse analytic approaches, raises the question who 'wins' and 'loses' from a discursive process. A 'win' from this study could be the emphasis of the women's voices, one that is perhaps absent from dominant discourses, that highlights the restrictions and limitations in which they are positioned within, impeding their subjectivity. This research has changed me as a person and my practice, as one who is more in touch with the complexities and subject positions women with 'BPD' face within dominant discourses.

4.5 Limitations and future research

A key limitation of an FDA study relates to the matter of subjectivity (Burr, 2003). Despite linking subjectivity to the use of subject positions in Willig's FDA approach (Willig, 2013), this study is limited to the discussion of subjectivity in relation to discourse. Although an FDA offers a useful framework to understand what 'BPD' is, allowing a critical lens to the taken-for-granted truths within dominant discourses, in the matters around embodiment and subjectivity, including the emotional meanings and attachments associated with particular subject positions are considered by many as limiting within the FDA framework (Willig, 2000; 2013).

A dual-lens approach incorporating both a phenomenological approach (such as IPA) alongside FDA may have offered a richer analysis, privileging both language and experience, looking at what was being said and done in the text. Wetherell (1998; 2007) encourages the use of a synthetic approach by focusing on the discursive constructions as well as the wider social context. Wetherell (1998) suggests a micro approach offers an additional layer to the analysis of language by observing interpersonal communication, individual repertoires and performativity features. Jones (2003) suggests that the micro approach also allows consideration of absences and silences. This study adopted a macro approach and offered some acknowledgement of non-discursive elements such as laughter, but it was not the key focus. Foucault's approach has been described as 'anti-hermeneutic', criticised for its lack of concern with finding meaning or 'truth' but instead a version of knowledge (Wetherell & Potter, 1992).

Feminists have disputed Foucault's approach that reduces people to docile bodies dismissing the value and importance of personal agency (Allen, 2014) and focusing on power removes the focus away from participants' subjective first-hand experience (Lafrance & McKenzie, 2014; Sergiu, 2010; Saukko, 2010). However, through Foucault's theory around technologies of the self, individuals are formulated as active agents creating their identities in modern society, shining a light on various ways of being in the world (Gavey, 2011). This FDA investigates the 'social, psychological and physical effects of discourse' to generate knowledge of the wider social and historical context and how this shapes an individual's self-agency and subjectivity (Willig, 2013, p138). Thus, FDA approaches highlight the social processes within modern society affecting participants' accounts (Foucault, 1995; Sergiu, 2010), tackling socio-political matters relating to gender (Butler (1997) and offering a dynamic relationship between the self and societal structures (Proctor, 2017).

Given the opportunity to redo this study, I would have made some changes, particularly in data collection. Recruitment via social media was a missed opportunity, which on reflection, could have increased the number of participants, possibly even outside of the UK, reaching a wider availability of discourses. On reflection, the barrier and hesitation in using social media came from a lack of experience using it as a recruitment process and a lack of confidence in using these platforms for professional purposes. Access to participants who have rejected the 'borderline' identity would greatly benefit future research, considering how they made sense of their experience of receiving and rejecting the diagnosis. It is possible that with the progression of talk promoting a de-pathological understanding of suffering, such as ‘A Disorder for Everyone’ and open online forums, this may become more achievable in the future. Having completed the study, if I were to recruit participants now, I would be in a better position to offer a rationale to those who shared an interest but were possibly hesitant about my intentions for the study. Future research could also benefit from a collaborative stance, conducting research jointly with a person who has the experience of being diagnosed with ‘BPD’. Their pre-existing knowledge, lived experiences, and ‘expert’ position could enhance the quality of research and reduce the power imbalance in the research process between participant and researcher.

Although interviews are an acceptable method to collect data in an FDA study (Willig, 2013; Holstein & Gubrium, 2004), they have also been heavily scrutinised as a method of demonstrating naturally occurring talk (Speer, 2007). Thus, the addition of a focus group may have enabled the women in the study to feel more comfortable sharing their experiences with other women who also identify as having ‘BPD’. I believe it may have been easier for the women to have spoken more openly with each other, offering a power balance and sense of mutuality, as well as spontaneous discussions, which may not have been achieved from the one-to-one interviews. During the write-up, the power inherent in the researcher/participant relationship became more apparent as I created pseudonyms for the women in the study. If I were to conduct future studies, I would ask participants if they would have liked to have chosen their own pseudonyms or if they would have liked their names to be included in the study. Furthermore, reflecting on the critical realistic epistemological position, the choice not to collect demographic data was a missed opportunity. The decision not to gather demographic data, including gender, age, ethnicity, education and occupation, prevented the ability to locate the women in their concrete realities. In addition, I chose to refer to the participants as women as a means of highlighting the gendered nature of ‘BPD’. However, in retrospect, I now see this as an inherent assumption on my behalf of the participants’ gender. My decision not to collect demographic data, prevented the ability to verify this information.

During the recruitment process, it was only women who took an interest in this study. ‘BPD’ is theorised in the context of attachments and child development (Hengartner et al., 2015; Holmes, 2003; Fonagy, Target & Gergely, 2000; Mahler, 1971) and talk of motherhood was not an area initially considered but demonstrated to be an interesting finding. Psychodynamic theories have been criticised for failing to factor in the role of the father and their contribution to children’s developmental journey, with an overemphasis on mothers (Allan, 2004; Birns, 1985; Lewis, 1986). It would be useful to consider this gap for future research exploring the role of fathers, amongst those diagnosed with ‘BPD’.

4.6 Concluding remarks

Overall, this study demonstrates the complexity and layers of gendered talk, especially within psychiatry and social discourses. The psychiatric discourse, through the diagnosis of ‘BPD’ allowed the women in the study to position themselves as patient, enabling a form of validation, giving a name to their distress.

However, the psychiatric discourse positioned women with ‘BPD’ within two key categories of the ‘deserving’ and ‘undeserving’ psychiatric patient. Within the category of the deserving patient, the analysis revealed several ways to be considered a legitimate patient; ‘abnormal’, *“full-blown” ‘BPD’*, ‘compliant’ and ‘sick’. Within the category of the ‘undeserving’ object, the analysis revealed a number of subject positions including the ‘attention seeking’ woman, ‘immoral’ or one who was ‘normal’ and/or ‘not severe enough’ thus ‘too well’ to be deserving of the legitimate patient status. Such positions were often gendered, given by the ‘experts’ in the medical field, influencing the available resources and treatment available for women with ‘BPD’ and impacting their sense of self.

This study adds new findings to the field of ‘BPD’ with regards to how women with ‘BPD’ are positioned within a double bind in which women with ‘BPD’ can be ‘too well’, restricting their access to treatment. These findings encourage practitioners to deliberate on their own social, moral and epistemological position and consider the implications ‘BPD’ has to people receiving the diagnosis. Furthermore, this research found women resisted the subject positions by drawing on psychological discourses, constructing ‘BPD’ as a response to trauma. This thesis has provided some insight in how the women in the study were positioned in dominant discourses that inherently positions them as the ‘other’. This study shows how these women drew on positive self-representations, altruistic characteristic and talk of strengths, resisting stigmatising talk demonstrating personal agency and power. In this way, I hope the thesis offers different ways of understanding women with ‘BPD’. It is my hope that these findings offer the premise for healthy debates and conversations about how ‘BPD’ is understood and its place within counselling psychology.

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Appendices

Appendix 1: Recruitment flyer

Department of Psychology City, University of London

Would you like to talk about

'Borderline Personality Disorder?'

I am a Trainee Counselling Psychologist at City University of London and would like to interview you if you have a diagnosis of 'Borderline Personality Disorder'. You would be asked to talk about 'Borderline Personality Disorder' by attending either:

- A small focus group of 4 young people lasting approximately 90 minutes **OR**
- A one-to-one interview lasting approximately 60 minutes

Reasonable travel expenses will be reimbursed

For more information about this study, or to take part, please contact:

Student: Reena Devi – [redacted]

Supervisor: Dr Julianna Challenor- [redacted]

Tel: [redacted]

This study has been reviewed by, and received ethics clearance through the Psychology Research Ethics Committee, City University London [ethics approval code PSYETH (P/F) 17/18 111]

If you would like to complain about any aspect of the study, please contact the Secretary to the University's Senate Research Ethics Committee on [redacted]

Appendix 2: Participant Information Sheet

Title: How do individuals diagnosed with 'Borderline Personality Disorder' construct 'Borderline Personality Disorder': A Foucauldian discourse analysis

I would like to invite you to take part in a research project. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would entail for you. Please take time to read the following information carefully and discuss it with others if you wish. Please do not hesitate to ask if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

The purpose of the study is to explore how participants understand the term borderline personality disorder". The researcher hopes to share the findings to help improve services especially within mental health settings.

Why have I been invited?

You have been invited because you are aged 18+ and have received a diagnosis of 'Borderline Personality Disorder' (BPD).

Do I have to take part?

Your participation in this research is voluntary. It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without giving a reason. You will not be penalised or disadvantaged if you withdraw. Your involvement and participation in this research does not affect your treatment or support within services provided with the support groups or charity.

What will happen if I take part?

Your participation will involve attending either

- A focus group, whereby you are invited to talk about ‘BPD’ in a small group setting with the researcher and approximately three other people also diagnosed with ‘BPD’. This would last approximately 90minutes or
- A one-to-one interview with the researcher lasting approximately 60 minutes

After the interview or focus group you will be invited to stay for a de-brief session where you will be given the opportunity to give feedback on your experience. A debrief information sheet with helpful information will also be given to you. The information gathered at the interviews and focus groups would be audio recorded to help me analyse the findings. No personal details will be used in this research.

Expenses and Payments (if applicable)

All participants will be offered reasonable reimbursement for travel.

What do I have to do?

In this study you will be asked to talk about ‘BPD’. Participants are encouraged to feel relaxed and talk freely about their views on the questions asked. You do not have to bring anything with you. We request everyone is treated equally, with dignity and respect.

What are the possible disadvantages and risks of taking part?

It is possible that you may feel some distress when sharing personal and emotive information. You may find it difficult talking about your experiences. You however will have the choice of not answering the questions if you do not want to. You are free to withdraw or take a break at any part of the research without giving a reason.

What are the possible benefits of taking part?

The aim is of this research is to offer a space for you to express your voice and share your thoughts with a researcher. Your involvement will contribute to the learning of professionals and clinicians in mental health, social care and educational settings. You may feel a sense of satisfaction from knowing your involvement may offer insight in service development as well as informing professionals, service users and parents/ carers.

Will my taking part in the study be kept confidential?

All information will be kept on a password-protected laptop and stored in a locked and secure location. The researcher and research supervisor are the only people who have access to the information collected. All audio recordings will be kept on an encrypted device. If the project is abandoned before completion, the data will not be published and will be destroyed. The researcher will make every effort to remove any possible identifiable data.

What will happen to the results of the research study?

You will be given the opportunity to have a copy of the final write up. The data will be published in my thesis, which will be stored at City University of London's library and available online with City Research Online. A journal article may be published and accessed by the public in libraries and online. The findings will be shared with social care, mental health services, education, charities and appropriate agencies.

What will happen if I don't want to carry on with the study?

You are still free to withdraw without giving a reason. You can withdraw from the study up to 5 weeks after data collection.

What if there is a problem?

If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone [redacted] You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: How do individuals diagnosed with 'BPD' construct 'Borderline Personality Disorder': A Foucauldian Discourse Analysis.

You could also write to the Secretary at:

[redacted]

City University London holds insurance policies, which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone’s negligence, then you may have grounds for legal action.

Who has reviewed the study?

City University London Psychology Research Ethics Committee has approved this study.

Further information and contact details

If you have any questions about this study or why you have received this information please contact me on the following:

Reena Devi (Student Researcher) [redacted]

Julianna Challenor (Research Supervisor) [redacted]

Thank you for taking the time to read this information sheet.

Appendix 3: Participant consent form

Title: How do individuals diagnosed with ‘Borderline Personality Disorder’ (BPD) construct ‘Borderline Personality Disorder’: a Foucauldian discourse analysis

Ethics approval code: **PSYETH (P/F) 17/18 111**

Please initial box

1.	I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records. I understand this will involve: • Either participating in a focus group with a maximum of 4 participants, group facilitator/researcher or participating in a one-to-one interview with the researcher • Allowing the focus group or one-to-one interview to be audio recorded • I understand that what I say will be anonymised to minimise the risk that other people who read the findings can identify me.	

	• I understand that the findings from this research may be published and available for the public in a journal or online.	
2.	This information will be held and processed for the following purpose(s): • Doctoral research • I understand that any information I provide is confidential, and data will be encrypted and kept in lockable storage. • I understand that what I say will be anonymised to minimise the risk of other people, who read the findings, identifying me. No identifiable data will be published or shared with any other organisation. • I understand that I have given approval for the data to be used in the final report of the project, and future publications. • I consent to the use of sections of the audiotapes in publications. • I understand that the audio recordings will be destroyed upon completion of the research study. Written records of audio data will be kept for ten years following the completion of the research.	

3.	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any time up until 5 weeks after data collection.	
4.	I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	

Name of Participant Signature Date

Name of Researcher Signature Date

When completed, 1 copy for participant; 1 copy for researcher file.

Note to researcher: to ensure anonymity, consent forms should NOT include participant numbers and should be stored separately from data.

Appendix 4: One to One Interview Schedule

Title: How do individuals diagnosed with ‘Borderline Personality Disorder’ (BPD) construct ‘Borderline Personality Disorder’: a Foucauldian discourse analysis

1. I would like to hear what you have to say about ‘BPD’
2. What is ‘BPD’ to you?
3. Tell me about yourself in relation to ‘BPD’
4. Have you changed the way you see ‘BPD’? If so, can you tell me a bit more
5. I would like to know if ‘BPD’ does anything to you/for you?
6. How do people in the mental health services talk about ‘BPD’? (Prompts: Nurses, Doctors, Therapists, Psychologists, Social workers, In patient vs. Community setting). Has the way they talk about ‘BPD’ changed? If so, can you tell me a bit more?
7. How do friends and family talk about ‘BPD’? Has the way they talk about ‘BPD’ changed? If so, can you tell me a bit more?
8. How do people in schools and educational settings (or work) talk about ‘BPD’? Has the way they talk about ‘BPD’ changed? If so, can you tell me a bit more?
9. Is there anything else you would like to say about ‘BPD’? Is there anything we have not spoken about ‘BPD’ that you would like to share?

Appendix 4: Focus group schedule

Title: How do individuals diagnosed with ‘Borderline Personality Disorder’ (BPD) construct ‘Borderline Personality Disorder’: a Foucauldian discourse analysis

Opening question	1. I would like to hear what you have to say about ‘BPD’
Construction	2. What is ‘BPD’ to you?
	3. Tell me about yourself in relation to ‘BPD’
	4. Have you changed the way you see ‘BPD’? If so, can you tell me a bit more
Function	5. I would like to know if ‘BPD’ does anything to you/for you? Is there anything positive about ‘BPD’? If so can you tell me a bit more? Is there anything negative about ‘BPD’? If so can you tell me a bit more?
Positions	6. How do people in the mental health services talk about ‘BPD’? (Prompts: Nurses, Doctors, Therapists, Psychologists, Social workers, In patient vs. Community setting).
	7. How do friends and family talk about ‘BPD’?
	8. How do people in schools and educational settings (or work) talk about ‘BPD’?
	9. Has the way they talk about ‘BPD’ changed? If so, can you tell me a bit more?

Additional Information	10. Is there anything else you would like to say about ‘BPD’? Is there anything we have not spoken about ‘BPD’ that you would like to share?

Appendix 5: Debrief Schedule

Title: How do individuals diagnosed with 'Borderline Personality Disorder' (BPD) construct 'Borderline Personality Disorder': A Foucauldian discourse analysis

Thank you for taking part in the study.

I would like to ask some questions now that the study is over.

1. How did you find the experience of taking part in this focus group/ interview?
2. How do you feel taking part in this research?
3. Would you like any additional information from me as the researcher?
4. Is there any feedback that you would like to give me about the way the focus group/ interview has been carried out?
5. Is there anything that could have been done better or differently?

Once again, thank you for your participation.

Appendix 6: Debrief Information Sheet

Title: How do individuals diagnosed with 'Borderline Personality Disorder' (BPD) construct 'Borderline Personality Disorder': a Foucauldian discourse analysis

DEBRIEF INFORMATION

Thank you for taking part in this study. The information you provided in this study will be used to analyse how individuals use language to talk about 'BPD'. The aim is for the study to address, educate and improve service delivery, which could be of benefit to future individuals accessing mental health services.

If you would like to be informed about the outcome of this research please let me know so I can send you a copy the thesis. If you would like to withdraw from this study you have 5 weeks to notify me either in person or via email. If you choose to withdraw your data will not be analysed and will not be published.

There is a possibility that the research may have evoked an emotional response. Please speak to your GP or support groups if you would like additional support. To find a therapist please visit the British Psychological Society website on www.bps.org.uk or the British association for counselling and psychotherapy www.bacp.co.uk.

Details of services, helplines and charities are also noted below that may be of some help:

[redacted]

We hope you found the study interesting. If you have any queries or concerns regarding the study please do not hesitate to contact me at the following:

Research Student: Reena Devi – [redacted]

Research Supervisor: Dr Julianna Challenor- [redacted]

Ethics approval code **PSYETH (P/F) 17/18 111**

Thank you once again for your participation in this research

Appendix 7: Ethics form

CITY
UNIVERSITY OF LONDON
EST 1894

Psychology Department Standard Ethics Application Form: Undergraduate, Taught Masters and Professional Doctorate Students

This form should be completed in full. Please ensure you include the accompanying documentation listed in question 19.

Does your research involve any of the following? ***For each item, please place a 'x' in the appropriate column***	**Yes**	**No**
Persons under the age of 18 *(If yes, please refer to the Working with Children guidelines and include a copy of your DBS)*		x
Vulnerable adults (e.g. with psychological difficulties) *(If yes, please include a copy of your DBS where applicable)*	x	
Use of deception *(If yes, please refer to the Use of Deception guidelines)*		X
Questions about topics that are potentially very sensitive *(Such as* *participants' sexual behaviour, their legal or political behaviour; their experience of violence)*		X
Potential for 'labelling' by the researcher or participant (e.g. 'I am stupid')		X
Potential for psychological stress, anxiety, humiliation or pain	X	

Questions about illegal activities		x
Invasive interventions that would not normally be encountered in everyday life (e.g. vigorous exercise, administration of drugs)		x
Potential for adverse impact on employment or social standing		x
The collection of human tissue, blood or other biological samples		x
Access to potentially sensitive data via a third party (e.g. employee data)		x
Access to personal records or confidential information		x
Anything else that means it has more than a minimal risk of physical or psychological harm, discomfort or stress to participants.		x

If you answered 'no' to all the above questions your application may be eligible for light touch review. You should send your application to your supervisor who will approve it and send it to a second reviewer. Once the second reviewer has approved your application they will submit it to [redacted] and you will be issued with an ethics approval code. You cannot start your research until you have received this code.

If you answered 'yes' to any of the questions, your application is NOT eligible for light touch review and will need to be reviewed at the next Psychology Department Research Ethics Committee meeting**.** You should send your application to your supervisor who will approve it and send it to [redacted]The committee meetings take place on the first Wednesday of every month (with the exception of January and August). Your application should be submitted at least 2 weeks in advance of the meeting you would like it considered at. We aim to send you a response within 7 days. Note that you may be asked to revise and resubmit your application so should ensure you allow for sufficient time when scheduling your research. Once your application has been approved you will be issued with an ethics approval code. You cannot start your research until you have received this code.

Which of the following describes the main applicant? ***Please place a 'x' in the appropriate space***	
Undergraduate student	
Taught postgraduate student	
Professional doctorate student	x
Research student	
Staff (applying for own research)	
Staff (applying for research conducted as part of a lab class)	

1. Name of applicant(s). (All supervisors should also be named as applicants.)

Reena Devi Julianna Challenor (Supervisor)
2. Email(s).
[redacted] [redacted]
3. Project title.
Title: How do individuals diagnosed with ‘Borderline Personality Disorder’ (BPD) construct ‘Borderline Personality Disorder’: A Foucauldian discourse analysis
4. Provide a lay summary of the background and aims of the research. (No more than 400 words.)

“Borderline Personality Disorder” (‘BPD’) is a highly controversial diagnosis in the DSM-5 (APA, 2013). Most research has been completed using quantitative approaches. Some qualitative research has looked at areas of stigmatisation, experience of treatment in-patient and the subjective experiences of young people, adults and professionals. Such studies have often adopted methodologies such as Interpretative Phenomenological Analysis (IPA), Thematic Analysis and Narrative studies. ‘BPD’ as a medical construction has been critiqued as an approach invalidating emotional distress. Research has criticised the diagnosis as inconsistent, stigmatising and inappropriate.

Feminists have argued that the term ‘BPD’ is another form of oppressing women who have experienced trauma and abuse (Shaw & Proctor 2005).

Anti-psychiatry critics have explored how the construction of madness in women can be traced in history to witchcraft (Szasz, 1972). The diagnosis of hysteria can be disputed as a scientific attempt of controlling women (Foucault, 1967). Discourses used to describe women who were considered ‘mad’ or ‘hysterical’ were ‘difficult’, ‘deviant’ and ‘disturbed’. Similarly, contemporary discourses of people with ‘BPD’ are of ‘manipulation’, ‘difficult’, ‘disturbed personality’ and ‘unwell’. The label ‘BPD’ can be viewed as a modern way of pathologising emotional distress and experiences of survivors of abuse.

This study aims to take a critical perspective on how participants construct ‘BPD’. I will be employing a Foucauldian Discourse Analysis (FDA) to analyse the discourse collected from focus groups and one to one interviews. As a counselling psychologist trainee my aim is to offer a critical perspective to the current construction and discourses available around the label ‘BPD’.

The literature review found a gap in qualitative research, which adopts a critical stance.

5. Provide a summary of the design and methodology.

The study will use a qualitative design. Participants will be given the opportunity to take part in a focus group or a semi structured one-to-one interview. The participants will be individuals aged between 18+ diagnosed with ‘BPD’. A maximum of two focus groups (of a maximum of four participants in each group) will be offered and a maximum of six semi-structured one-to-one interviews. Services will be notified once there are enough participants have been recruited. Focus groups and semi-structured interviews will be audio recorded and transcribed.

The methodology will be Foucauldian discourse analysis (FDA) using Willig’s (2013) 6 stages approach. This involves identifying discursive constructions, discourses, action orientation, positioning, practice and subjectivity.

The method is a macro approach to language and will help gain an understanding of what is being done through language and action orientation (Willig, 2013). FDA accounts for subject positions and the socio-political issues around power imbalance and social injustice. Language will be analyzed and regarded as a version of 'truth' and reality based on the participant's social, historical, and cultural influences.

6. Provide details of all the methods of data collection you will employ (Eg., questionnaires, reaction times, skin conductance, audio-recorded interviews).

Pre-research, a pilot focus group with colleagues will take place to help offer the researcher further reflexivity on the interview schedule, room layout, tone, pace and overall facilitation of the group. This will not be carried out with individuals who have a diagnosis of 'BPD' so as not to have to discard analysable data. A pilot interview will also be trialled with a colleague to offer further reflexivity on the interview schedule. If there are significant changes to the interview schedules an amendment form will be completed.

All participants will be given the option of taking part in a focus group or one to one semi structured interview. Prior to commencement of the study consent (Appendix III) will be sought. Participants will also be given an information sheet (Appendix II) about the study. This will be prior to the study to ensure participants have time to consider their choice to part take in the study.

Recruitment will take place via accessing support groups and charities including [redacted] There will a maximum of two focus groups will be run with a maximum of four participants. Each focus group will last approximately 90minutes. Focus groups will be audio recorded with consent (Appendix III) and will be transcribed. A debrief (Appendix VII) will take place after the focus group for approximately ten minutes and all participants will receive a de-brief sheet (Appendix VII). FDA will be applied to the discourse to analyse the data. Please see Appendix IV for the focus group schedule.

There will be a maximum of six semi structured one-to-one interviews lasting approximately 60 minutes. Interviews will be audio recorded with consent (Appendix III) and transcribed. A Debrief (Appendix VII) will take place after the interviews lasting approximately ten minutes and all participants will be given a de-brief sheet (Appendix VII). FDA will be applied to the discourse to analyse the data. Please see Appendix V for the interview schedule for the semi-structured one-to-one interviews.

If travel presents as a difficulty, one-to-one interviews will be offered via Skype. Participant information sheets (Appendix II) will be provided via email and discussed before scheduling a date for the interview. A debrief (Appendix VII) will be completed to the participants post interview. A de-brief sheet (Appendix VII) will be emailed to all participants. Questions will be open ended. Prompts will be used to facilitate discussion.

Data storage: All audio recordings will be recorded and stored on an encrypted device following City, University of London, policies and guidelines. Encrypted, downloaded data and printed transcripts will be stored in a locked cabinet at the researcher's home. All digital documents will be password-protected and will not

be shared with anyone other than the research supervisor. City University's Information Governance, confidentiality and safeguarding policies will be followed.

7. Is there any possibility of a participant disclosing any issues of concern during the course of the research? (e.g. emotional, psychological, health or educational.) Is there any possibility of the researcher identifying such issues? If so, please describe the procedures that are in place for the appropriate referral of the participant.
All service users will have capacity to consent to the research. A participation information sheet will be given to inform participants of the nature of the study (Appendix II). Consent will be obtained verbally and in written format (Appendix III). A debriefing session (Appendix VI) will be held at the end of the focus group or one-to-one interview and a debrief sheet (Appendix VII) including details of services and helplines will be given to participants. Participants may share distressing information and experience emotional distress when talking about 'BPD'. Participants will be told that they can withdraw from the study at any time. If a participant voices any significant risk of harm to themselves or others I will contact my research supervisor and ensure appropriate services are contacted following City's policies and procedures. Participants may be signposted to their GP or [redacted]

[redacted]

8. Details of participants (e.g. age, gender, exclusion/inclusion criteria). Please justify any exclusion criteria.

Inclusion criteria:

Research participants will be of any gender, aged 18 and over, and will have received a formal diagnosis of emerging 'BPD' or 'BPD' from a medical or mental health professional. Individuals will be recruited from support groups and charities such as [redacted]

Exclusion criteria:

Children under the age of 18 years will not be used in this sample collection due to ethical factors. Individuals without a diagnosis will not considered. Individuals who present intoxicated or under the influences of alcohol/drugs will not be able to take place for their own safety and for quality of textual data.

9. How will participants be selected and recruited? Who will select and recruit participants?

Participants will be recruited by through support groups and charities such as [redacted]. The researcher will make contact with the manager of support groups and charities and will email across information regarding the nature of the study, recruitment flyers and information sheets.

Participants will be asked to make contact with the researcher via email or telephone should they wish to participant or discuss the study further. Recruitment will be on a first come first-serve basis. Once sufficient number of participants has been recruited, professionals will be informed.

A purposive sampling method will be used as the researcher is specifically interested in individuals who have received a label of ‘BPD’. Two small focus groups (of up to 4 participants) will be carried out as well as one to one semi structured interviews.

The researcher hopes to collate data in a natural setting, such as an established support group setting for the focus group. This will help increase the validity of natural flow language. A neutral setting will be sourced for one-to-one interviews such as a university or charity building. Skype interviews will be offered if travel is a difficulty.

Disability access, directions, parking details and reasonable travel costs will be taking into consideration and participants will be reimbursed for expenses.

10. Will participants receive any incentives for taking part? (Please provide details of these and justify their type and amount.)

There will be no incentives given. The aim of this piece of research is to help offer a voice for individuals who have been marginalised.

11. Will informed consent be obtained from all participants? If not, please provide a justification. (Note that a copy of your consent form should be included with your application, see question 19.)

This research will comply with the British Psychological Society's (BPS) Code of Ethics and Conduct Guidelines (2014) ensuring that participants are 'given ample opportunity to understand the nature, purpose and anticipated outcomes of any research participation, so that they may give consent to the extent that their capabilities allow' (BPS, 2014).

All research participants voluntarily consent to take part in the research without coercion (BPS, 2014, p31). Participants will be informed of their rights with withdraw at any point of the focus group and one to one semi structured interviews up to six weeks post data collection.

Informed consent (Appendix III) will be obtained verbally and in a written document prior to the commencement of the research.

12. How will you brief and debrief participants? (Note that copies of your information sheet and debrief should be included with your application, see question 19.)

All research participants will receive an information sheet (Appendix II) prior to the commencement of the study.

All participants will be debriefed (Appendix VI) at the end of the focus group or one to one semi structured interview. A de-briefing information sheet (Appendix VII) will also be given which details of helplines and services.

13. Location of data collection. (Please describe exactly where data collection will take place.)

The researcher will be aiming for a natural setting such as an established support group setting to promote natural flow language. If this is not possible a neutral, non-clinical setting will be offered such as a University or Charity office building.

If participants are unable to travel, alternative arrangement such as one to one interview will be offered via Skype will offered. In this instance, the information sheet (Appendix II) will be given in advance via email to ensure it has been read and agreed prior to the study. A debrief sheet (Appendix VII) will be sent post interview via email.

13a. Is any part of your research taking place outside England/Wales?

No	**x**	

Yes		If 'yes', please describe how you have identified and complied with all local requirements concerning ethical approval and research governance.

13b. Is any part of your research taking place outside the University buildings?		
No		
Yes	x	[redacted] 2. Support groups 3. Skype
13c. Is any part of your research taking place within the University buildings?		
No		
Yes	x	If 'yes', please ensure you have familiarised yourself with relevant risk assessments available on Moodle.
14. What potential risks to the participants do you foresee, and how do you propose to deal with these risks? These should include both ethical and health and safety risks.		
There is potential for risks with this study due the nature of the topic being investigated i.e. 'BPD'. Ethical concerns include the possibility of participants experiencing emotional distress. All research participants will be given an information sheet (Appendix II) prior to taking part in research and have the opportunity to take withdraw. A debrief sheet (Appendix VII) will also be given after		

the research to ensure appropriate services and support is available to the participants. I will contact my research supervisor and ensure appropriate services are contacted if participants present with high risk of harm to themselves or others. Participants may be signposted to their GP or [redacted] All risks will be managed with adherence to City's policies and procedures. Health and Safety risks will be risk assessed prior to the commencement of the study. Fire safety and safety evacuation information will be shared with participants prior to starting the focus-group or one-to-one semi structured interviews. The lone working policy will be adhered to and arrangements will be in place with the research supervisor. Please see risk assessment (Appendix VIII). Disability access will be taken into consideration to ensure the most appropriate settings are offered for participants. If participants are unable to attend a focus group or prefer a one to one interview, arrangements will be offered to accommodate this with an interview conducted via Skype.
15. What potential risks to the researchers do you foresee, and how do you propose to deal with these risks? These should include both ethical and health and safety risks.

For health and safety concerns, the researcher will ensure another adult is present in the building. Lone working and risk management policies will be adhered to. Please see risk assessment (Appendix 8). The researcher is studying and training to be a Counselling Psychologist. The researcher will maintain their role as a researcher during this study and will signpost participants to appropriate services if they are in need of therapeutic support. There is a potential risk that the researcher may be emotionally impacted by the study. A personal diary is maintained throughout this course alongside personal therapy to explore personal and professional development. In addition supervision will be sought if needed.	
16. What methods will you use to ensure participants' confidentiality and anonymity? (Please note that consent forms should always be kept in a separate folder to data and should NOT include participant numbers.)	
Please place an 'X' in all appropriate spaces	
Complete anonymity of participants (i.e. researchers will not meet, or know the identity of participants, as participants are a part of a random sample and are required to return responses with no form of personal identification.)	
Anonymised sample or data (i.e. an *irreversible* process whereby identifiers are removed from data and replaced by a code, with no record	

retained of how the code relates to the identifiers. It is then impossible to identify the individual to whom the sample of information relates.)	
De-identified samples or data (i.e. a *reversible* process whereby identifiers are replaced by a code, to which the researcher retains the key, in a secure location.)	x
Participants being referred to by pseudonym in any publication arising from the research	**X**
Any other method of protecting the privacy of participants (e.g. use of direct quotes with specific permission only; use of real name with specific, written permission only.) ***Please provide further details below.***	
17. Which of the following methods of data storage will you employ?	
Please place an 'X' in all appropriate spaces	
Data will be kept in a locked filing cabinet	**x**
Data and identifiers will be kept in separate, locked filing cabinets	**X**
Access to computer files will be available by password only	**X**
Hard data storage at City University London	
Hard data storage at another site. *Please provide further details below.*	
18. Who will have access to the data?	
Please place an 'X' in the appropriate space	
Only researchers named in this application form	**X**

People other than those named in this application form. *Please provide further details below of who will have access and for what purpose.*	

19. Attachments checklist. *Please ensure you have referred to the Psychology Department templates when producing these items. These can be found in the Research Ethics page on Moodle.

Please place an 'X' in all appropriate spaces

	Attached	**Not applicable**
***Text for study advertisement**	**x**	
***Participant information sheet**	**X**	
***Participant consent form**	**X**	
Questionnaires to be employed		**x**
Debrief	**X**	
Copy of DBS **Online DBS service – confirmed by Programme on professional components**		x
Risk assessment	X	
Others (please specify, e.g. topic guide for interview, confirmation letter from external organisation) **Interview schedule for** participants	**x**	

20. Information for insurance purposes. **(a) Please provide a brief abstract describing the project**
This study aims to critically explore how individuals diagnosed with ‘Borderline Personality Disorder’ (BPD) construct the label ‘BPD’. This study takes a social constructionist perspective. The study hopes to identify the different discourses individuals draw on to construct ‘BPD’. This will allow for insight into the action orientation of language and the function it has in society. Subject positions will also be explored through the available discourses. Subjectivity will be accounted for through the available discourses used by individuals when constructing ‘BPD’. A maximum of two focus groups with no more than four individuals and a maximum of six one-to-one semi structured interviews will used to collect data for analysis. Audio recording will be transcribed and coded. Transcripts will be analysed using FDA using Willig’s (2013) 6-stage method.
Please place an ‘X’ in all appropriate spaces

(b) Does the research involve any of the following:	**Yes**	**No**
Children under the age of 5 years?		**x**
Clinical trials / intervention testing?		**X**
Over 500 participants?		**x**
(c) Are you specifically recruiting pregnant women?		**x**

(d) <u>Excluding</u> information collected via questionnaires (either paper based or online), is any part of the research taking place outside the UK?		**x**

If you have answered ‘no’ to all the above questions, please go to section 21.

If you have answered ‘yes’ to any of the above questions you will need to check that the university’s insurance will cover your research. You should do this by submitting this application [redacted] <u>before</u> applying for ethics approval. Please initial below to confirm that you have done this.

I have received confirmation that this research will be covered by the university’s insurance.

Name ………………………. Date………………………

21. Information for reporting purposes.		
Please place an 'X' in all appropriate spaces		
(a) Does the research involve any of the following:	**Yes**	**No**
Persons under the age of 18 years?		x
Vulnerable adults?	x	
Participant recruitment outside England and Wales?		**x**
(b) Has the research received external funding?		**x**

22. <u>Final checks.</u> Before submitting your application, please confirm the following, noting that **your application may be returned to you without review** if the committee feels these requirements have not been met.	
Please confirm each of the statements below by placing an 'X' in the appropriate space	
There are no discrepancies in the information contained in the different sections of the application form and in the materials for participants.	**x**
There is sufficient information regarding study procedures and materials to enable proper ethical review.	**X**
The application form and materials for participants have been checked for grammatical errors and clarity of expression.	**X**
The materials for participants have been checked for typos.	**X**

23. Declarations by applicant(s)	
Please confirm each of the statements below by placing an 'X' in the appropriate space	
I certify that to the best of my knowledge the information given above, together with accompanying information, is complete and correct.	**X**
I accept the responsibility for the conduct of the procedures set out in the attached application.	**x**
I have attempted to identify all risks related to the research that may arise in conducting the project.	**x**
I understand that **no** research work involving human participants or data can commence until ethical approval has been given.	**x**

	Signature (Please type name)	**Date**
Student(s)	REENA DEVI	11/12/2017
Supervisor	Julianna Challenor	13.12.17

Appendix 8 : Ethical approval letter

Psychology Research Ethics Committee

School of Arts and Social Sciences

City University London

[redacted]

03 April 2018

Dear Reena and Julianna

Reference: PSYETH (P/F) 17/18 111

Project title: ***How do young people (YP) diagnosed with 'Borderline Personality Disorder' (BPD) aged 18-25 construct 'Borderline Personality Disorder': A Foucauldian discourse analysis***

I am writing to confirm that the research proposal detailed above has been granted approval by the City University London Psychology Department Research Ethics Committee.

Period of approval

Approval is valid for a period of three years from the date of this letter. If data collection runs beyond this period you will need to apply for an extension using the Amendments Form.

Project amendments

You will also need to submit an Amendments Form if you want to make any of the following changes to your research:

(a) Recruit a new category of participants

(b) Change, or add to, the research method employed

(c) Collect additional types of data

(d) Change the researchers involved in the project

Adverse events

You will need to submit an Adverse Events Form, copied to the Secretary of the Senate Research Ethics Committee [redacted] in the event of any of the following:

(a) Adverse events

(b) Breaches of confidentiality

(c) Safeguarding issues relating to children and vulnerable adults

(d) Incidents that affect the personal safety of a participant or researcher

Issues (a) and (b) should be reported as soon as possible and no later than 5 days after the event. Issues (c) and (d) should be reported immediately. Where appropriate the researcher should also report adverse events to other relevant institutions such as the police or social services.

Should you have any further queries then please do not hesitate to get in touch.

Kind regards

[redacted]

Appendix 9: Online Recruitment post template:

CITY
UNIVERSITY OF LONDON
EST 1894

Dear ……

My name is Reena and I am currently completing a professional doctorate in counselling psychology. As part of my doctorate I am conducting a thesis, which questions how individuals diagnosed with ‘Borderline personality disorder’ construct ‘borderline personality disorder’. This research takes a critical perspective of ‘BPD’, with the hope to improve mental health services. I will be conducting interviews or a focus group (if 3 to 4 individuals request an interest in this). I am willing to travel and am also able to reimburse reasonable travel costs.

The main inclusion criteria for the study include:

- To be aged 18+
- To have received a diagnosis of ‘BPD’, ‘Emotionally unstable personality disorder’ or emerging ‘BPD’ at some point in your life.

Thank you for your time and consideration. Please feel free to email me if you would like to discuss this further on [redacted]

If you would like to complain about any aspect of the study, please contact the Secretary to the University’s Senate Research Ethics Committee [redacted]

[redacted]

Ethics approval code PSYETH (P/F) 17/18 111

Appendix 10: Psychology Department Risk Assessment Form

Please note that it is the responsibility of the PI or supervisor to ensure that risks have been assessed appropriately.

Date of assessment: 22/11/2017

Assessor(s): Julianna Challenor

Activity: Focus Group/ One to One Semi structured interviews

Date of next review (if applicable): February 2018

Hazard	**Type of injury or harm**	**People affected and any specific considerations**	**Current Control Measures already in place**	**Risk level** Med High Low	**Further Control Measures required**	**Implementation date & Person responsible**	**Completed**
Focus group/ Interview in another building- possible risk	Lone working – risk to others	Researcher / Participants	The aim is to use a natural setting such as an established support group however if this is not possible I aim to use	Low	N/a	Research to be carried out April 2018 Reena Devi	

of harm to self or other			a neutral setting such as a University or charity setting. I will ensure another staff member is present in the building. In addition I will notify my researcher of the details of my proposed times for the start and end of the study. A code word will be set up in case of emergency.			Julianna Challenor	
		Participants				Reena Devi	

Confidentiality of participants Building- University/ Support group/ XXXX	Disability access Health and Safety/ Fire safety	Participants	I will ensure participants are offered alternative sites if the buildings do not have disability access I will familiarise myself with all policies and will inform participants of fire exit	Low Low	Alternative site/ Skype	Reena Devi	

Contacts

School Safety Liaison Officer: [redacted]

University Safety Manager: [redacted]