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Borderline Personality Disorder: A Mental Disorder or the Medicalization of Social Undesirability?

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This article challenges the status of Borderline Personality Disorder (BPD) as a mental disorder in the DSM by examining the seemingly normative nature, symptomology, and epidemiology of the disorder, as well as by questioning its clinical validity in terms of diagnoses, symptoms and treatment. It discusses the implications of allowing normative assumptions to influence the medical science, and calls attention to the 'moral' nature of BPD and its associated symptoms. Empirical evidence is used to explore the clinical validity of BPD regarding treatment methods and success rates, as well as to examine the gender and age norms that appear to underline the epidemiology of the disorder. This article concludes that the parameters of BPD and its symptoms are indeed questionable and require further scrutiny by both philosophical and medical professionals, and that the idea of its removal from the DSM should be maintained as a consideration depending upon further analysis.

The idea that medical diagnoses, theories, processes and treatments should be based on scientific fact seems only logical. Medicine, after all, is a science. So it is reasonable to say that medical claims and diagnoses should never be primarily normative, or, in other words, based more on people's values than on proven facts of nature. Given the value-laden nature of the societies in which medicine is developed, however, it is not surprising that social norms do have the ability to influence this ever-changing and developing field. This is especially apparent within the younger fields of medicine, particularly psychiatry, which is less understood at the organic level than others and relatively lacking in objective physiological evidence. This essay calls attention to Borderline Personality Disorder (BPD), a personality disorder diagnosis listed within the *Diagnostic Statistics Manual of Mental Disorders*, and questions whether or not it should be considered a clinically significant mental disorder, as it is currently. Upon examination of the nature, symptomology, and epidemiology of BPD, the invasive role of social norms in the definition and diagnosis of this 'disorder' becomes strikingly clear. This essay will make the argument that, based on the various types of normative assumptions underlying the perpetuation of BPD as a mental disorder, as well as its arguable lack of clinical validity, the inclusion of BPD in the DSM as a mental disorder should be strongly questioned and potentially revoked upon further analysis.

The Impropriety of Normative Assumptions in Medical Science

Boorse (2004) addresses the issue of normativism in the study and description of what constitutes health. Boorse describes normativism as the belief that "all judgments of health include value judgments as part of their meaning" (p.78). He then distinguishes between ideas of 'strong normativism' and 'weak normativism', with the former claiming that health judgments are purely value statements with no descriptive meaning, and the latter allowing for objective, as well as evaluative, aspects in determining what it means to be healthy (Boorse, 2004).

Regardless of which view one takes, the result of the influence of norms in health

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judgments is fundamentally the same. It ultimately obscures the line between someone being 'unhealthy' in terms of defective bodily functioning, based on how humans were scientifically meant to function, versus someone being 'unhealthy' in terms of what other people deem to be undesirable, as opposed to desirable, functioning. As the effect of norms and values on ideas of unhealthy conditions increases, so does this obscured view of medicine and health itself.

Although all areas of scientific medicine are vulnerable to the intrusion of normative assumptions, psychiatry (a relatively new field of medicine) is particularly susceptible. There is such an extensive amount of unknown information about the exact processes and functioning of the brain (in terms of mental disorders) that many of the so-called illnesses psychiatry deals with are seriously lacking in organic, observable pathology. With so much room for interpretation in areas concerning 'healthy' cognitive and affective functioning, it is easy for normative values to overtake scientific evidence when it comes to defining and diagnosing psychiatric disorders.

However, this is not to deny the existence or clinical significance of all mental disorders. Some such disorders, including Schizophrenia, Major Depression, and Anorexia Nervosa, result in seriously debilitating, and sometimes fatal, symptoms, which clearly merit medical intervention. However, the line must be drawn somewhere. When it comes to defining and diagnosing personality disorders such as BPD, (which are so heavily underscored by normative assumptions,) it seems that, in the name of scientific integrity, the line may need adjusting.

Normative Influence in the "Moral" Nature of BPD and its Symptomology

Charland (2006) draws attention to the moral nature of Cluster B personality disorders in the DSM-IV, including BPD, and their symptoms. Charland points out that some of the key diagnostic markers of BPD such as inappropriate, intense anger and instability with interpersonal relationships are clearly "moral deficits in empathy towards others" (p.122). He further enforces this moral aspect of such symptoms when explaining, "It is impossible to imagine a successful treatment or cure for those conditions that does not involve some sort of conversion or change in moral character" (p.122). Some of the other symptoms of BPD, as outlined by the DSM-IV, are instability of self-image, effort to avoid abandonment, and potentially dangerous impulsivity (Zhong & Leung 2007, 81). In addition to such qualities, the DSM-5 includes diagnostic criteria for BPD such as the demonstration of hostility, risk taking behavior, and a lack of self-direction (APA, 2012). These symptoms also fundamentally imply deficits in or undesirability of a person's character.

So, the question is then how the apparent moral nature of BPD relates to normative influence. The influence of norms on what defines moral behavior within a given society can be seen cross-culturally, as different societies have different 'norms' outlining what types of social behavior and personal conduct are commended. An example of this can be found when comparing culture-specific moral ideologies such as Western individualism and Confucian relationalism (Bedford & Hwang, 2003). It is clear that, based on the symptomology of BPD, the people diagnosed with this disorder are given this label based primarily on the fact that they do not interact with others, express themselves, or conduct their daily lives in ways that are considered socially acceptable or desirable (lacking in empathy for others, distrust and paranoia in relationships, etc.).

However, there are many 'socially undesirable' personality characteristics that a person could have while being completely

mentally sound (e.g. being quick tempered, indecisive, overly argumentative, or self-conscious). It could be argued, in fact, that *all* people have socially undesirable or immoral aspects to their personalities to some degree. How then, can diagnosing people with an illness based on such qualities be medically justified? Such people may simply have a poor moral code according to society's standards, and assigning personality disorders to them would be merely excusing their behavior, as well as removing their moral accountability. A socially undesirable personality (as described by most of the BPD symptoms) should not be valid grounds for the diagnosis of a mental disorder.

A specific, more detailed, example of normative influence on the diagnostic criteria associated with BPD can be seen with the symptom of self-mutilation. Potter (2003) describes a definition of 'severe' self-mutilation as "the deliberate infliction of direct physical injury on one's own body...that involves cutting, maiming, destroying or altering a part of one's body in a socially unacceptable fashion" (p.2). It is important to note that this definition clearly states that this symptom is described based on what is considered 'socially acceptable' and what is not.

The major question raised throughout Potter's article is that of whether such acts are really 'self-mutilation' or are, in fact, a type of creative expression through the use of one's body. She questions the extent to which popular culture and psychiatry play a role in determining which acts are considered fashion statements and which are deemed pathological. In other words, what makes bodily alterations such as tattoos, piercings, surgical implants, and fasting fundamentally different than burning or cutting? It seems that the major difference may be simply that the latter two have not (as of yet), in current Western society, been deemed as socially acceptable. However, there was once a time when acts such as tattooing or piercing the body were viewed as grotesque and improper, and were seen only among social delinquents such as pirates, gypsies, and criminals (Potter, 2003). This is a far cry from the commonality of these acts today.

Potter (2003) attempts to make sense of this blurred line between what constitutes self-mutilation, as opposed to self-expression, when explaining, "The distinction between good and bad body modification...seems to amount to a difference between what the culture understands and does not understand (or what it is willing to understand or not)" (p.7).

Perhaps one way in which society justifies the separation of body-altering acts such as burning or cutting oneself from those like piercing and tattooing is by emphasizing the inherent danger and potentially lethal ramifications associated with the self-inflicted nature of the former two. The problem with making this differentiation, however, is that we cannot assume the intention behind acts such as burning or cutting. Their intended purposes may, in fact, extend beyond a form of self-expression in terms of physical appearance, but this still may not justify their status as a symptom of a mental disorder. Some people, usually referred to as 'masochists', perceive pain (self-inflicted or otherwise) as pleasurable. The concept of masochism is not new; Reik (1941) described it as an attempt to relieve anxiety, gain self-esteem, and to ultimately attain pleasure through methods of pain and punishment. Though the enjoyment of the 'pain' sensation may not be a socially acceptable characteristic for a person to possess, who is to say that seeking pleasure in this fashion – as opposed to another - is a sign of mental illness? Smoking, if looked at from a purely physiological standpoint, is a form of self-inflicted physical mutilation. It is simply more difficult to observe the majority of the physical marring because the anatomical parts receiving most of the injury are one's lungs. The majority of smokers are aware that it is unhealthy, and that it may eventually kill them.

In a 2005 study by Oncken et al. involving 537 adult smokers, 95% of them identified premature death as a risk of their habit. Knowledge of specific risks such as cardiovascular, oral, and pulmonary disease was also high (93%, 89%, and 94%, respectively). Despite such knowledge many smokers maintain the behaviour, because, (in part,) of the pleasurable and relaxing effect it provides. Society does not try to claim that all smokers are suicidal, despite the well-known inherent danger of the self-inflicted act. In the same sense, if burning or cutting the skin makes someone feel good, or helps fill some sort of perceived void as a cigarette might for a smoker, how can it be asserted that they are any less mentally healthy than a person who partakes in any one of societies' 'acceptable', albeit potentially life-threatening, vices.

Since the content of what any given culture understands or accepts as normal is dynamic and constantly changing over time, one must wonder how parameters such as these can ever truly be a legitimate basis for describing mental illnesses and their symptoms.

Lack of Clinical Validity for BPD and its Symptomology

Not only are the morally-based symptoms of BPD heavily normative and utterly lacking in objective pathology, they are also lacking in clinical validity. Elliot (1996) states reasons why personality disorders may not be genuine clinical conditions. Elliot makes several convincing arguments which question the clinical validity of personality disorders such as BPD, such as the fact that there appears to be no physiological abnormalities associated with personality disorders, and that often these conditions are not necessarily unwanted by the owner. Elliot (1996) also addresses the fact that personality disorders diagnoses often have no effective treatment. In the case of BPD, there are studies in which a conservative level of effectiveness is shown for the use of cognitive behavioral therapies with BPD patients. However, it is important to note that such trials are often limited to patients with symptoms of a suicidal and severely dysfunctional nature. A clinical trial by Linehan et al (1991) showed the effect of dialectical behavior therapy (DBT) for the treatment of chronically parasuicidal women with the BPD diagnosis. As compared to the control group who received 'treatment as usual', the patients who received DBT displayed fewer and less medically severe incidences of parasuicide, were more likely to remain in therapy, and spent fewer days as psychiatric inpatients. Unfortunately, no between-group differences were found for measures of depression, hopelessness, reasons for living, or thoughts of suicide following treatment. Another study (Linehan et al, 1994) found that DBT was more effective for improving general and interpersonal adjustment for females with severely dysfunctional BPD than was the usual community treatment. However, the findings suggested that though DBT was effective in improving control of maladaptive behavior and stress tolerance, it did not necessarily increase the actual happiness or satisfaction of the patients. A limitation of both studies was that the homogeneity of the trial groups made it unclear whether results were generalizable to less severely dysfunctional, non-suicidal, or male BPD patients.

If successful treatment is unlikely to accompany the BPD diagnosis, except for perhaps in the most extreme cases, and the disorder itself is often not considered an undesirable or unwanted entity by the owner, of what clinical use is the diagnosis? It is true (as mentioned above) that there are a couple of objective, clinically significant DSM-IV symptoms of BPD, such as severe dissociative symptoms or recurrent suicidal behavior (Zhong and Leung 2007). These symptoms can be life-threatening and clearly require intervention and an attempt at treatment, no matter how futile. However, only five of nine possible DSM-IV criteria must be present for this diagnosis to be

made, so suicidal and/or dissociative symptoms may not even be present in a number of the individuals who have been labelled with the disorder. Though laid out differently in the way it lists BPD symptomology, the *DSM 5* (APA, 2012) essentially outlines much of the same criteria, briefly mentioning dissociative symptoms and suicidal thoughts and behaviors as possible (but not necessary) symptoms for diagnoses. It is clear that the clinical validity of Borderline Personality Disorder and its diagnostic criteria are questionable at best. Though many people displaying the 'milder' and more subjective symptoms of BPD may certainly be experiencing considerable distress and emotional pain, labelling them with this diagnosis could do more harm than good. An example of this would be, if, because of the nature of their symptoms, they are unlikely to find success in the associated treatments, and being given this label ends any attempts to find other possible reasons for and/or ways to remedy their angst.

Implications of Social Norms in BPD Epidemiology

Another aspect of BPD, in which the influence of social norms (gender norms, specifically) can be seen quite clearly, is in its epidemiology; specifically in regards to gender and age norms. Approximately 70-75% of those diagnosed with BPD are female (Zhong & Leung 2007), which is an extreme majority. Potter (2003) describes some of the ways in which gender stereotyping and discrimination historically, and presently, make women's behavior particularly vulnerable to pathologization. Potter explains that women's anger at moral injustices is often mocked, ignored, pathologized, and minimized by men because cultural conventions associate female anger with hormones, cuteness, or bitchiness. Potter specifically relates this social phenomenon to BPD when hypothesizing that the distress shown by women diagnosed with BPD may not be exclusively a characteristic of the disorder, but instead may allude to the general experience of being female in our culture.

Proctor (2007) addresses the fact that, although women have made many strides over the past few decades in the quest for equality, some important discrepancies remain; women are still underpaid compared to men, are underrepresented in positions of power, still take on the most of the responsibility in terms of childcare and maintenance of the household, and are sexualized by the media. On top of this, they are taught from a young age to strive towards both a physical and behavioral norm of feminism that, if not met, will subject them to stigmatization. Proctor notes that women who are diagnosed with BPD are often members of marginalized populations such as single mothers, lesbians, and other types of females who "are considered to have 'failed' to live up to cultural, moral, and normative expectation of what it is to be a woman in this society" (p.110).

The extreme gender imbalance present in the diagnosis of BPD makes one seriously question whether or not the existence of this disorder may be society's way of medicalizing - and therefore delegitimizing - the opinions and behaviors of females who simply do not conform to what is considered socially acceptable conduct. The suppression of women is no new topic in Western culture as well as numerous other cultures world-wide. Although it is presently assumed to be a practically diminished issue in most modern societies (in comparison to its role in past centuries), perhaps gender discrimination is simply manifesting in new ways, such as in the development and perpetuation of new medical conditions like personality disorders.

Another questionable aspect of the occurrence of BPD is the fact that symptoms of this disorder generally first appear during

adolescence, reach their peak in young adulthood, and seem to decline in middle age (Zhong & Leung 2007, 78). Interestingly, the transition from adolescence to young adulthood is often a natural period of social rebellion (e.g., in school, against parents, against the law) for individuals of both genders. Almost everyone experiences this rebellion to some extent, although some youths may certainly act out more frequently or in more drastic ways than others. This does not necessarily mean, however, that they are suffering from a mental disorder.

When attempting to understand the variation in attitudes, coping strategies, and behaviors of adolescences, the role of environment and childhood experience must be considered. Bandelow et al. (2005) conducted a study comparing the prevalence of traumatic childhood life events for patients diagnosed with BPD compared to a 'healthy' control group. Almost every patient reported that they had experienced traumatic events during childhood (only 6.1% did not), while 61.5% of the control group failed to report any such events. Among the identified influential factors were sexual abuse, poor parental rearing styles, neurotic disorders within the family, and being separated from parents. This correlation between traumatizing early-life events and BPD diagnosis raises the question of whether such patients are, in fact, experiencing a mental illness, or whether their problematic behaviours are the product of coping responses they have developed to deal with an aversive childhood.

One must wonder if parents are eager to accept this diagnosis in their adolescent child as a relieving excuse for displeasing behavior, or even to free themselves of parental guilt. This possible conflict of interest for parents and other societal authority figures further perpetuates the idea that the BPD diagnosis may merely be a tool for dismissing and pathologizing the behavior of those acting out against socially-defined, normative rules of what is acceptable.

Conclusion

In addressing some of the ways in which societal norms underline the moral nature, symptomology, and epidemiology of Borderline Personality Disorder, as well as casting doubt upon its clinical validity, this essay has essentially questioned the legitimacy of BPD's current status as a mental disorder. Although the removal of disorders from the DSM is a serious undertaking, which in itself may present ethical issues, it is clear that the parameters of this disorder and its symptoms require further scrutiny by both philosophical and medical professionals. If, in fact, the diagnosis of BPD is not clinically valid, and is simply a socially-constructed way of medicalizing 'undesirable' personalities and behaviors among populations such as women and youth, then its removal from the DSM is not only logical, it is an ethical necessity.

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