

Borderline personality disorder or psycho warrior?

The importance of context and language in understanding personality disorder.

Psychiatry has long since avoided any discussion of personal values. Values are woolly, they are touchy feely and they are unscientific. The move toward positivism in DSM III with its “descriptive rigor” moved away from any view of values. DSM - IV and its desire for evidence, observable criteria and measurement, took this even further. These moves are generally acclaimed, but is this positivism, vigour and credibility actually of any help? Would not a clearer statement about the values of psychiatric practise indeed be more helpful?

Psychiatry has thought that through this positivist rigor, we can focus upon salient observable facts and be therefore more precise in diagnosis and be more accountable, but to fact, not to values. The move to medicalise psychiatry is in fact a political rather than a scientific or moral action (Widiger 2002).

Rather than replace or do away with this rigor I would suggest we consider further the roles of values in extending our accountability to the people and the societies we serve rather than just our scientific credibility. Psychiatry has always had evaluative approaches, and we need to ensure that they move to the foreground rather than take a back seat in our work.

Psychiatry is all about personal values. Diagnosis and classification, seen as our most objective criteria, are themselves pervaded with value statements and judgements. Most diagnostic categories are clearly prefixed or suffixed with, “in the judgement of the clinician”, and they account for things such as culture and social appropriateness in decision-making. Values, however, reflect not just the current observable facts but also rather a range of preferences, predilections, esteems and predispositions to act.

Values have been at the heart of our classification and diagnosis for many years, it is not a new, modern, capitalist approach, as some critics would have you believe. The Sumerians and Egyptians made many references to madness. Before the industrial revolution Nathaniel Lee made his famous, some may now say inspirational, statement objecting to his confinement in Bedlam.

“They said I was mad, I said they were mad, and damn them they outvoted me!” Nathaniel Lee 1653-1692

Current developments in psychiatry mostly evolve from the BOGSAT method (Bunch of Guys Sat Around Table) of evolution or as it is more properly called the “Expert consensus model”. Much of the scientific validity of psychiatry relies upon nothing more than a vague set of values, pertaining to one brief point in time.

Psychiatry has long felt from its experts that, psychotic problems do not lie on a continuum of normal experiences or a normal distribution. Rather they suddenly become abnormal i.e. hallucinations and delusions (Threshold of dysfunction).

However, more and more recent information is suggesting that this may not be the case. If sanity and insanity do exist then they indeed probably do lie on a continuum. Perhaps people do not suddenly become mad or unmad. Perhaps Nathaniel Lee was correct in his simple conclusion.

The differences between the categories are usually based more in the opinions, values and judgements of others, no matter how much we objectify them.

Mental disorders themselves are defined as

“An involuntary organic impairment in psychological functioning” Widiger & Trull (1991).

There is immediately a value judgement in the impairment in psychological functioning and this threshold of dysfunction is probably most open to cultural bias at the point of demarcation i.e. when we define someone as dysfunctional. What is dysfunctional for one person may be another person's norm.

The context of artist, creator, spiritual or religious person, fame and wealth all can move an experience that may be seen as mad in some to understandable in others

Psychotherapy is equally as vulnerable, Simolas (1992) work clearly documents the unwitting presence of paternalistic, conservative and sexist values in marital therapy, “therapists are never neutral or objective”. Neutrality is both a myth and a fallacy. Simola goes on to suppose that rather than taking a non-values approach which is impossible a positive approach (Marxist feminist) is a much more constructive way forward where values are at least known, explicit and discussed.

Personality disorder is probably of all the fields we work in the one most open to values and therefore we should consider rather than deny the values involved.

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“An enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture”.

The key issues in personality disorders then are the relationships between the person and social norms Skene (2002)

When is behaviour excessive? Can behaviour be excessive objectively or does it have to be personally determined.

What are the relationships between excessive behaviours and mental disorders?

Language has long been used to describe differences between us, from this came words like personality, character, temperament that by origin and definition describe difference. Hippocrates defined the bodily humour consisting of 4 primary temperaments defined by individual characteristics.

Sanguine	Melancholic	Choleric	Phlegmatic
Active	Sad	Angry	Calm

Whether an extreme condition represents a disorder is not intrinsically due to its extremity, for instance, weather. Most of the values occur low down i.e. Beaufort scale. As you increase the wind so difference increases. It is much the same in psychiatry but we don't refer to the weather as sick or disordered so why people?

The DSM III introduced a set of disorders collectively known as the personality disorders, indeed the definitions of personality disorders have been noted in psychiatry to be very similar to the definitions of personality itself Clark (2002).

The DSM parameters for diagnosis of BPD are a matter of subjective opinion based upon

- Range,
- Intensity
- Lability
- Appropriateness
- With early onset
- Longitudinally stable
- Be pervasive
- In a broad range of settings
- Inflexible
- Maladaptive
- Cause clinical distress or impairment in functioning

How many of these are not open to the influence of values?

Personality disorder has become a pejorative term, the importance of this label is not that it excuses nor understands but that it blames the person before us and further it vilifies and dehumanises them as people who are untreatable. Do we really mean that or do we mean it is difficult and complex, even hard work for us to help?

Our language today is getting further pathologised, we talk of emotional pain and distress as features of illness yet surely distress is a consequence of life events as is emotional pain.

Sensation pain i.e. a bang on the head is a specific neurological action to a specific neurological stimulus and is localised, emotions are neither specific nor localised nor is what we describe as emotional pain. Many people will consistently tell you that emotional pain is far harder to bear and be resilient toward than sensation pain, that is one reason why some people self harm, to replace emotional pain with sensation pain, Karl Marx once said that the only antidote to emotional suffering is physical pain!

The context in which BPD arises is evident, Trauma, abuse, violation.

Yet we still blame the person for their disorder rather than understand the context, in America this is changing with the debate to reclassify BPD as complex PTSD for these reasons. When we know the context we must review the idiopathic view. The fact that we ignore the evidence says much about our profession. In schizophrenia research Fuller Torrey now contends that the cause of schizophrenia is biological and singular, it is cat ownership in the second trimester of pregnancy (endogenous retrovirus theory) because 38% population had cats as children but 51% OF SCHIZOPHRENICS HAD CATS . Well 20% of population have been sexually abused yet 55-70% of people labelled BPD have been abused but we don't say abuse causes BPD.

Goodwin & Guze in the classic book, psychiatric diagnosis say that “Once aetiology is known psychiatrists tend not to continue providing care for people, it moves into the realms of some other discipline”. Aetiology unknown is the hallmark of psychiatry.

What we do know about borderline personality disorder is that people can be looked at in other ways than the pejorative, people can be seen as strong, as surviving not manipulating, being resilient not being disordered. Making sense of a mad world is how many people would describe their own context.

Perhaps most importantly when we know the context in which the experience arises, the cause if you like in medical language, then we know how to begin to put things right. If trauma be the context, recognition of this and understanding the importance of those events and how they affect you today can be part of the solution. If being an ongoing victim of early experience be the cause then understanding and moving from victim to victor is one route to your recovery.

BPD is a Harmful concept that says nothing of the origin of the experience or how to live with or move on from it, psycho warrior says that you are fighting back, you are resilient and you are emancipating yourself. I value the term psycho warrior, it describes people who are angry and fighting back, the Nathaniel Lees of our world, interestingly in my career the people who fight back, who aren't just “maintained” by the psychiatric system or are “stable” are the ones who fight back. It appears to me that the act of fighting back and finding your own explanations has become pathologised, this action of fighting back is a key part of attracting the BPD diagnosis, Psycho warriors are the people trying to make sense, trying to fight back, it is not they who are disordered but those who try to control them . Value the fighting it is a key to survival and thriving.