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SPECIAL ISSUE • Whose borderline is it anyway?

research article

The lability and liability of female 'borderline' sexuality: a feminist Foucauldian discourse analysis of Thompson et al's (2017) 'Sexuality and sexual health among female youth with borderline personality disorder pathology'

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The purpose of this discourse study is to deconstruct how a journal article published in *Early Intervention in Psychiatry*, 'Sexuality and sexual health among female youth with borderline personality disorder pathology' (Thompson et al, 2017), constructs the sexuality of young women diagnosed with 'borderline personality disorder'. The methodology used was Foucauldian discourse analysis, following Hook's (2001) recommendation to re-situate a text within its socio-political location and among its material correlates, as well as analysing its intra-textual discursive features. The process of analysis involved repeated close readings of the text by Thompson et al (2017), with a focus on binary oppositions within the text, and the power/knowledge nexus in which it is situated. The analysis identified three key discourses at work in the text: the discourse of the academy, the discourse of dichotomy, and the discourse of 'borderline' sexuality, which contains a conceptually unstable paradox concerning female 'borderline' sexual agency. The consequences of these findings, their historical context, and implications for practice and classification are discussed.

Key words borderline personality disorder • female sexuality • Foucauldian discourse analysis • psychiatric classification • pathologisation

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Introduction

'Borderline personality disorder' (BPD) is a controversial diagnosis which is regarded by many as pejorative and stigmatising (Paris, 2005; Shaw and Proctor, 2005; Campbell et al, 2020). In order to examine how young women diagnosed with BPD and

their sexual agency are discursively constructed in clinical literature, ‘Sexuality and sexual health among female youth with borderline personality disorder pathology’ (Thompson et al, 2017), a study published in *Early Intervention in Psychiatry*, was subjected to a feminist Foucauldian discourse analysis. This methodological approach was chosen in order to attend to both the textual features of the article and its socio-political and historical context, as well as the text’s active role in the subjectification of the demographic in question (Foucault, 1982). The process of analysis involved repeated close readings of the text, focusing on the binary oppositions and subject positions therein (Parker et al, 1996), followed by critical attention to the text’s material correlates, or the interventions and practices which are legitimated by psychiatric discourse (Hook, 2001). The psychiatric *logos*, or the system of knowledge in which ontological claims about the nature of mental illness are given authority and moral weight, is discussed from a poststructuralist perspective as a precursor to the discourse analysis.

Background

‘Sexuality and sexual health among female youth with borderline personality disorder pathology’, by Thompson, Betts, Jovev, Nyathi, McDougall and Chanen, is a clinical research paper published in 2017 in the journal *Early Intervention in Psychiatry*. Thompson et al’s (2017) study focuses on a sample of ‘fifty 15 to 24 yr-old females with 3 or more Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-IV) BPD criteria’ living in Melbourne, Australia. The article confirms the hypothesis, following statistical analysis of interview data, that ‘young women with borderline personality pathology’ demonstrate poorer ‘sexual health and safety behaviours’ and ‘greater uncertainty in sexual identity formation’ than a ‘nationally representative’ control group. The paper was published in a leading journal in the field of psychiatric practice, and the research was funded by the Australian National Health and Medical Research Council (NHMRC). This situates the paper firmly within the intersection of power and knowledge; the prestige of the journal and the funding from the NHMRC (who allotted \$71.6 million AUD to mental health research in 2016) ensure that the paper’s claims possess both academic gravitas and significant financial value.

This paper was selected from a search of contemporary scientific literature on BPD (a topic on which there are thousands of research articles in this style) and was chosen as an example of a research article concerning the mutually constitutive twin goals of measurement and management of the female ‘borderline’ subject. This paper was chosen purposively in order to facilitate a close, critical examination of how women with ‘BPD pathology’ are constructed within contemporary psychiatric discourse, a topic of particular relevance because of recent taxonomic shifts around ‘BPD’ (or ‘emotionally unstable personality disorder’) which indicate that the clinical concept in question is changing, and because of the controversial status of this diagnosis. As is standard practice in contemporary psychiatric literature, the paper uses clinical language to describe the bodies and activities of its subjects, and employs numbered subheadings and tables to present a quantity of statistical data on them. This mode of discourse is not merely descriptive, but active: Thompson et al (2017) make recommendations to mental and sexual health service providers regarding the early identification of ‘BPD pathology’ in young women and their clinical treatment.

In the biomedical paradigm, physical, behavioural and emotional symptoms are taken to indicate an underlying psychopathology with a pathophysiological basis in the brain, which can be corrected by therapeutic and pharmacological interventions. However, medical treatments for the 'borderline' condition are limited, as no single psychotropic medication is particularly efficacious for treating the wide range of emotional and behavioural symptoms associated with the disorder (Pascual et al, 2010). Due in part to the difficulties in treating 'BPD', the diagnosis provokes frustration and 'therapeutic nihilism' in healthcare professionals (Rayner et al, 2018; Campbell et al, 2020). It is well-documented that many 'borderline'-diagnosed people inadvertently elicit frustration, confusion, disdain and even mistreatment from their clinicians and nurses (Fraser and Gallop, 1993; Deans and Meocevic, 2006; Commons Treloar and Lewis, 2008; Woollaston and Hixenbaugh, 2008; Commons Treloar, 2009; Veysey, 2014). The stigma attached to the 'BPD' diagnosis is considerable, and the current model of the condition seems to be lacking in clinical utility.

This paper employs a Foucauldian discursive approach in order to deconstruct Thompson et al's (2017) article and its problematic construction of the 'young woman with BPD pathology'. In a discourse analysis of DSM-IV (APA, 1994), Crowe (2000) articulates how, given its status as the most authoritative psychological text in Western society, the manual's taxonomy of 'abnormal' behaviour implicitly presents a construction of normality. Deploying Bourdieu's (1977) proposition that an established order's naturalisation of its arbitrary rationale serves to obscure the cultural practices in which an individual is embedded and from which their actions emanate, Crowe destabilises the manual's claim to objectivity by articulating how the DSM-IV (APA, 1994) arbitrates normality based on a culturally contingent and politically salient value system. This reframing of a psychiatric text which makes its ontological claims on the basis of scientific, value-neutral epistemology as a repository of latent ideological tenets demonstrates the critical utility of the discursive analytic method – it facilitates the interrogation of that which seems unquestionable. Furthermore, Crowe connects the DSM-IV's (APA, 1994) implicit values to their material effects – for example, the importance of productivity to a neoliberal economic ethos, and the importance of moderation to maintaining established sex-role-appropriate behaviour. By extension, psychiatry itself is instrumental in upholding the social hierarchy through both overt disciplinary interventions and a less visible pedagogy of self-regulation; by aligning its rationale and techniques with broader social values, psychiatry constitutes a mode of governmentality (Rose, 1998; Crowe, 2000).

By reframing psychiatric classificatory texts as tools which enable the clinical management of people who are considered 'abnormal' or 'deviant' in some way, the normative assumptions that structure these texts can be examined more closely. Thompson et al (2017) focus specifically on the sexuality and sexual health of 'young women with borderline pathology', identifying sexuality as a key domain in which 'BPD pathology' expresses itself. 'BPD' is diagnosed much more frequently in women than in men (Sansone and Sansone, 2011), and criteria for 'BPD' diagnosis include 'significant impairments' in the subject's capacity for normal sexual intimacy and identity formation. It is taken for granted that a clinical study on 'BPD' may focus exclusively on women, and so this sampling decision is not accounted for by the authors. However, the fact that women are diagnosed with 'BPD' more frequently than men indicates the possible presence of diagnostic gender bias which manifests both in the judgements of psychiatrists and in the taxonomy of the disorder itself. Indeed, Busch et al (2016) argued that the overrepresentation of women in this

category is due to selection bias through prevalence data being derived mainly from clinical samples; they found that among a representative, non-clinical sample, men had higher rates of 'BPD' symptomatology than women when measured via self-report, and when measured via informant report, no gender difference was found.

The concept and use of 'BPD' is clearly tied up with ideas about gender. In the 1970s and 1980s, critical researchers established that men and women were held to different standards of mental health by psychiatry: women who over- or under-conformed to the feminine sex role of this era were both more likely to be made subject to psychiatric diagnosis than men, for whom 'excessive masculinity' was considered aspirational and unproblematic (Broverman et al, 1970; Chesler, 1972; Kaplan, 1983). Henry and Cohen (1983) found that 'BPD' pathologised behaviours in young women considered normal in young men, and Kaplan (1983) asserted that the Axis II personality disorders (including 'borderline', 'histrionic' and 'antisocial') were diagnostically indistinguishable in practice, and so the epidemiological gender skew ('BPD' and 'histrionic personality disorder' being overwhelmingly diagnosed in women, and 'antisocial personality disorder' in men) was due to diagnostic bias – a claim which attracted significant opprobrium from DSM-III authors (Kass et al, 1983). Subsequently, Becker (1997) drew attention to the 'affective loading' of the symptomatology as it was altered in the DSM-III to include fewer aggressive or psychotic symptoms and instead emphasise the condition's feminine-coded emotional and 'intropunitive' aspects. The overrepresentation of women in the 'borderline' category is not 'natural' or accidental, but is made to appear so by uncritical acceptance of the skewed gender ratio.

Thompson et al's (2017) focus on sexuality is also not without precedent: in a discipline with a history of pathologising genders and sexualities which fall outside of monogamous cis-heteronormativity, the arbitration of 'healthy' and 'unhealthy' female sexual behaviours has long been of particular concern to psychiatrists. Female queerness has historically been constructed as pathological (Drescher, 2015; Carr and Spandler, 2019); as have female hypersexuality (Lunbeck, 1987) and 'female sexual dysfunction', or a lack of expected levels of sexual desire (Jutel and Mintzes, 2012). The patriarchal and phallogocentric assumptions of the 19th-century sexological tradition which constructed normal female sexuality as passive and receptive have continued to inform modern expectations, both in medicine and in women's own understandings of their sexualities (Nicolson, 1993). This analysis will therefore attempt to re-situate Thompson et al's (2017) clinical analysis of the sexuality of 'young women with BPD pathology' within this history, in order to understand how the contemporary construction of women with 'BPD pathology' might contain or advance certain hegemonic discourses around gender and sexuality, as well as discourses regarding normality and psychopathology.

Methodology

In this paper, the journal publication of Thompson et al's (2017) study is subjected to a Foucauldian discourse analysis. A discursive approach conceptualises clinical objects, such as 'BPD', as a function of discourse – both the language used in their description (or textuality) and the institutions and social practices which govern their administration (or contextuality) (Lupton, 1998). Clinical discourse is polymorphic, originating from multiple source points, employed in a vast network of texts, and manifest in a host of practices and spaces. Clinical concepts, such as 'BPD pathology', are correspondingly diffuse and contingent; they reflect the complex politics and

normative assumptions of their paradigm more significantly than they capture any essential nature of their subjects. This approach is a significant paradigmatic departure from that of Thompson et al's (2017) text. Contemporary biomedical psychiatry locates clinical phenomena within individual brains and bodies, claiming biological aetiology. This individualisation of psychopathology functions on the assumption that psychopathologies are determined by essential physiological or neurochemical components, and are therefore ahistorical and impervious to context, sociality or changing discursive representations.

In the Foucauldian tradition, a discursive approach requires critical inquiry into the conditions of emergence of the object or subject in question – in this case, 'BPD' and the 'young women with BPD pathology' as described in Thompson et al (2017). This analysis aims to elucidate the specific conditions within which the 'borderline' concept is reproduced and substantiated. It is important to note that in the Foucauldian tradition, the motives and intentions of the authors of analysed texts are not in question – rather, the functions and capacities of the discourses employed in texts are the focus of critical attention. The importance of genealogy and materiality to an effective Foucauldian discourse analysis is articulated in a methodology proposed by Hook (2001) formulated from a close reading of Foucault's (1982) *The Subject and Power* and employed herein. This mode of analysis disrupts the linearity and ahistoricity afforded to such objects by their authors and their status as privileged knowledge: by 'eventualising' a discourse, its truth-claims are resituated in the political field and destabilised (Hook, 2001). The method of Foucauldian discourse analysis advocated by Hook (2001) takes a critical ethical stance: rather than simply describing discourse as a function of a text's rhetorical features, the analysis facilitates resistance through pan-textual discursive deconstruction by the reaffiliation of a discourse with its institutions, authorities and ideological bodies (Said, 1983). Hook's overtly politicised approach is considered unorthodox and controversial among some Foucauldians, and his analytic objectives differ from those of Parker and other discourse analysts; however, his work is included here to emphasise the connections between psychiatric discourse and the medical interventions and practices which are legitimated by it.

After Derrida (1978), Parker et al (1996) advocate for a deconstruction of the binary oppositions which undergird psychiatric discourse – 'sanity/insanity', 'health/illness' and 'normality/abnormality'. The use of such conceptual oppositions implicitly privileges one while maligning the other, informing the 'dividing practices' of the psychiatric institution (Parker et al, 1996). Thompson et al (2017) employ similar conceptual oppositions, privileges and dividing practices in their study, most visibly in their positioning of the 50 'young women with BPD pathology' and the 'nationally representative' control group on either side of the 'health/illness' binary. This discourse analysis therefore devotes particular attention to the binary oppositions present in the article and how they reflect psychiatry's normative assumptions.

Parker et al (1996) claim a deconstruction with political utility will relate its critical reading of a text to its institutional context, as Hook (2001) emphasises the importance of relating discourse to its material correlates. In order to explicate 'the discursive effects of the material, and the material effects of the discursive', Hook (2001: 538) recommends moving 'in and out' of the text. I accomplish this by directing critical focus to both the textual features of Thompson et al's (2017) article – its rhetoric, terminology and adherence to academic writing conventions – and also to the material effects from which, it will be argued, the study is inseparable. Psychiatric

discourse is tied to psychiatric practice: one does not appear without the invocation of the other, and Thompson et al (2017) repeatedly link their research to previous and potential psychiatric interventions upon their subjects. Accordingly, this analysis focuses on the intra-textual features of the article, which are then discussed in regard to the text's social, historical and political location and its material consequences. The analysis focuses first on the academic writing conventions which lend the text its disciplinary authority, then on the use of textual dichotomy as a dividing practice, and finally on the paradoxical construction of 'borderline' sexuality. These are then contextualised in a discussion of the historical origins and material consequences of 'borderline' discourse, and the uncertain future of the 'borderline' category.

Analysis

The discourse of the academy

The authorial voice in the article by Thompson et al (2017) is passive, impersonal and utilitarian, as is common in clinical research reports. The authority of texts of this kind lies in the validity and reliability of the study design, and the statistical significance of the results. This mode of scientific discourse invokes a rationality which employs empiricism, reasoned calculation, linguistic literality and objectivity to determine what does and does not count as 'real' (Crowe, 2000). The power of this discourse lies in its ability to determine what can be articulated, and consequently, what subject-positions are available (Hook, 2001). Thompson et al's (2017) constructions of the 'BPD' and 'control' subjects are given their gravity by the scientific discourse and academic writing conventions used to present them – for example, the use of referencing:

Adults with BPD report more sexual relationship difficulties (Zanarini et al, 2003), are more likely to engage in impulsive sexual activity (Sansone and Weideman, 2009), have an earlier age of onset for sexual intercourse, experience victimization from date rape (Sansone et al, 2008), have more sexual partners (Bouchard et al, 2009; Sansone et al, 2011). (Thompson et al, 2017: 2)

The justification of the authors' claims by the referencing of previous publications serves to outsource the responsibility for veracity, enabling the reader to take for granted that which is contingent. As is standard in academic literature, the authors set the originating point of the article's argument outside of the text: 'BPD' is already firmly codified in the pre-existing body of literature and is recapitulated by Thompson et al's (2017) study which, now published, joins and affirms the existing system of knowledge. Thompson et al's (2017) paper is therefore not unique or unusual; they draw upon and operationalise an already-existing discourse of 'BPD pathology'.

'BPD' developed into a discrete clinical object during the late 20th century, and was first entered into the DSM-III (APA) in 1980. It has been the object of countless clinical studies in the last four decades, each one referencing all that came before it in order to substantiate 'BPD' as a real, unitary condition. The concept of 'borderline' subjectivity is therefore mapped and affixed across multiple texts, creating a superposition of meaning which transcends textual confines and thus evades critique. This is the point at which the psychiatric discourse operating within Thompson et al (2017) is revealed to be pan-textual and polymorphic in origin; the authority of

the clinical text lies not only in its particular statistical content, but in its contiguity with other clinical texts. This pan-textual discursive synthesis reifies an omnipresent psychiatric *logos* which is self-sustaining and self-evident, and it is from this source that the 'borderline' discourse in question obtains its power (Foucault, 1982; Hook, 2001).

The discourse of dichotomy

The purpose of Thompson et al's (2017) research is the identification and study, through the gathering of empirical data, of a specific group of subjects: 'young women with BPD pathology'. The clinical gaze, which the reader is invited to don, is directed at these women. A counter-interrogation of this text therefore requires a redirection of the reader's gaze to the other subjects present in this paper: the control group, invoked as the normative obverse in the construction of the 'pathological' sample, and the authorial voice which constructs the two groups in opposition to each other.

The 'young women with BPD pathology' are described, in the article's introduction and discussion sections, using a list of symptoms:

- 'problematic sexual health'
- 'unstable sexual identity'
- 'unstable and intense interpersonal relationships that might involve *costly* relationship tactics'
- 'impaired sexual function'
- 'precocious sexual behaviour'
- 'the *tumultuous* nature of their interpersonal relationships'
- 'poor social cognition and *impaired* problem solving skills' (Thompson et al, 2017: 1–2, emphasis added).

Descriptions of 'instability', 'uncertainty' and 'indecision' are particularly frequent, as are 'impairment' and 'dysfunction'. These terms invoke standards of stability and functionality which are never explicitly discussed, but against which the 'pathological' sample fall short. As Kirk and Kutchins (1997) articulate, the DSM's use of 'impairment' and 'dysfunction' implies the existence of objective, empirical standards of normal psychological function where no such standards exist. Similarly, dimensions of stability, certainty and decisiveness go undefined, except for the suggestion of their presence in the 'healthy' controls. The control group – a sample of data provided by 204 female respondents to a nationwide health and relationships survey, matched on age, gender and geographical location – are described as 'nationally representative', and therefore used by Thompson et al (2017) as the benchmark of normality in the absence of explicit standards. The results of the statistical analysis are structured by comparisons between the two groups:

- 'The BPD pathology group was significantly more likely to engage in sexual activity at a younger age than their peers (Table 1).'
- '[The BPD group] engaged in oral sex with significantly more men in their lifetime.'
- 'The BPD group was significantly more likely to be in a casual relationship ($n = 16/39, 41.0\%$), compared with controls who engaged in steady relationships ($n = 123/155, 79.4\%$) ($\chi^2 = 14.42, df = 4, P = .006$).'

- 'More of the BPD group identified as being attracted to both sexes (BPD 18%, control 4.4%), or same sex attracted (BPD 8%, control 1%), or were undecided about their sexual orientation (BPD 10%, control 0%).' (Thompson et al, 2017: 3)

Statistical data is used to legitimate and objectivise the dividing practice separating the abnormal subject from her normal peers. Although the subjects invoked here in the binary distinction of 'BPD' and 'control' groups are essentially phantasms produced from the organisation of numerical data, they conjure images of two opposing subject-positions available to young women. The 'control' girl is imagined as healthy, stable and moderate in her actions; she preserved her virginity for longer until having safe, consensual sex; she is probably straight, prefers steady to casual relationships, and most likely has never been 'coerced into having sex'. The 'young woman with BPD pathology', however, is unhealthy, unstable and impulsive; she had sex young, and most likely unprotected; she has had many sexual partners of various genders; she smokes more, drinks more heavily, and has probably been raped at some point in her life. This constellation of behaviours has the presence of 'BPD pathology' as its anchoring point; the anchoring point for the 'control' characteristics – the organising principle of the group, with which it is introduced by Thompson et al (2017) in the abstract – is the claim to being 'nationally representative', and the 'control' group is granted privileged status by this defining point. The 'BPD' group represent little more than their own pathology.

It is noteworthy that some data points in the study contradict this binary opposition. For example, there was little difference in sexually transmitted infection (STI) rates between the 'BPD' and 'control' groups; the 'BPD' group were less likely to have used contraception during their first sexual experience but were more likely than the 'control' group to use contraception in their current relationship; and the 'BPD' group were more likely to be in a longer-term sexual relationship at the time of interview, and reported similar rates of sexual pleasure as the 'control' group. However, when these contradictions are acknowledged, they are usually used to reinforce rather than question the binary distinction; earlier adoption of contraceptives and lower STI rates are attributed to exposure to early-intervention services for 'BPD' patients which included safe sex education. This may be interpreted as a tendency, on the part of the authors, to defer to the discourse over the data in order to uphold the proposed ontological distinction between their 'borderline' and 'nationally-representative' subjects.

The discourse of 'borderline' sexuality: lability and liability

The 'young women with BPD pathology' in Thompson et al's (2017) article manifest their deviance not just psychologically, but physically, in their sexual health and behaviours:

- '[Adults with BPD] are more likely to be coerced into having sex [Sansone and Sansone, 2011a), and to have impaired sexual function (Schulte-Herbruggen, Ahlers, Kronsbein et al, 2009).'
- '[The BPD group] had a greater number of male partners with whom they had sexual intercourse, or oral sex within the previous 12-month period (Table 1).'
- 'Rates were similar for pubic lice, genital warts, wart virus (HPV), genital herpes, syphilis, gonorrhoea, gardnerella and trichomoniasis, Hepatitis A, B and C. The

1 exception being that the BPD group had a significantly higher incidence of Candida/Thrush ($\chi^2 = 6.23$, $df = 1$, $P = 0.013$).

- 'More of the BPD group identified as being attracted to both sexes (BPD 18%, control 4.4%), or same sex attracted (BPD 8%, control 1%), or were undecided about their sexual orientation (BPD 10%, control 0%). The BPD group was less likely to be only or mostly attracted to males (BPD pathology 82%, control 95.6%).' (Thompson et al, 2017: 3)

Thompson et al (2017) invoke a circular logic, common in psychiatry, whereby the presence of frequent and uninhibited sexual behaviour and 'BPD pathology' become mutually reinforcing. This creates a signficatory loop connecting symptom and pathology – *explanans* is confused with *explanandum*, and vice versa. Experiences, decontextualised, become 'symptoms' of a latent pathology which can only be detected by the identification of 'symptoms', to the exclusion of anything which does not reinforce the diagnosis (Stoppard, 1997). Crowe (2000) attributes this to most DSM disorders being of 'unknown aetiology' – despite programmes of neurophysiological and psychopharmacological research, psychiatry often struggles to make stable ontological claims about its subjects.

In the absence of a neurological substrate to which 'BPD pathology' can be attributed, Thompson et al (2017) put the sexual body in its place. As value-neutral as the scientific discourse appears, implicit cultural standards of normalcy are invoked in the discussion of 'borderline' subjects' sexual practices. The body of the 'young woman with BPD' becomes, in this text, both the material site of a potential public health crisis and an object of social concern, as Thompson et al (2017) discuss the rates of sexually transmitted disease and unplanned pregnancy in their subjects. Additionally, by aligning sexual promiscuity and queer orientations with illness, madness and abnormality, Thompson et al (2017) privilege the relative chastity and heterosexuality demonstrated by the 'control' girls as healthful and exemplary.

The equation of non-normative sexual behaviours with psychopathology neglects the roles of sexual desire, social context, and others' actions in the production of sexual experiences. In statements such as 'core BPD pathology features of unstable interpersonal relationships and impulsivity are evidenced in the young women in this study who engaged in sexual activity at an earlier age, with less protection, and with more partners and in the context of more casual relationships' (Thompson et al, 2017: 5), frequent sexual activity is assumed to indicate the presence of a pathologically disordered personality and not, for example, an enjoyment of sex within a cultural norm of casual dating – or, conversely, higher rates of unwanted sexual experiences and coercion. Additionally, the data on first sexual experiences is concerning: the mean age results for 'age when first had vaginal intercourse', 'age when first had oral sex with a male' and 'age when first had sex with a female' are all lower for the 'BPD' group than the 'control' group and are, importantly, below the minimum legal age of consent in Australia (16). These data are presented without critical exploration, aside from a note which casts doubt on the validity of the mean age for 'age when first had sex with a female', which is reported as 8.26 years old. This is concerning, because these figures might be indicating instances of statutory rape and/or childhood sexual abuse, rather than consensual sexual experiences. The authors refer to these worryingly low ages as evidence of 'precocious sexual behaviour', which is framed as a natural consequence of 'BPD pathology'.

Similarly troubling is the discussion of data on sexual assault:

Young women with BPD pathology were significantly more likely *to be coerced* into unwanted sexual experiences, and forced or frightened into engaging in sexual acts. This finding has been reported in adults with BPD (Sansone et al, 2011; Sansone et al, 2011; Sansone and Sansone, 2011b) and many patients with BPD have a past history of sexual abuse or rape. These findings suggest that these problems continue from youth into adulthood. Among young women with BPD pathology, *sexual coercion and sexual assault constitute important clinical problems that require active clinical enquiry and well-defined management.* (Thompson et al, 2017: 5, emphasis added)

In this statement, sexual assault is located within ‘borderline’ subjectivity – the presence of pathology, it is claimed, increases the likelihood of their assault, rather than indicating their *having been assaulted*. This point is presented in passing, without comment on the part of the authors. The chronicity of the phrasing here is vitally important: it implies that the presence of ‘BPD pathology’ precedes and determines the infliction of violence (‘more likely *to be coerced*’, not ‘more likely *to have been coerced*’). By this account, the young ‘borderline’ woman is the originating point of the violence she receives, by virtue of her ‘BPD pathology’.

Thompson et al’s (2017) understandable focus on the vulnerability of ‘borderline’ women inadvertently invokes some problematic ideas. Through the discursive strategies used in this article (which is contiguous with much of the contents of the well-established field of clinical research from within which this article emerges), ‘borderline’ sexuality is constructed as a collection of pathological impulses, propensities and relations which present hazards to both the subject and those around them. ‘Borderline’ sexuality is therefore defined by its simultaneous lability (as in suggestible, easily aroused and unstable) and liability (meaning both unsafe and legally responsible). The stereotypical ‘borderline’ woman possesses an active sexual appetite, pursuing relations with many people, but she is also easily manipulated or coerced into sex. At the same time as her sexuality is framed as rapacious and undiscerning, her agency is minimised – her desires are not genuine but pathological desires, so her relationships are inevitably dangerous and unhealthy. And she is ultimately liable for her hazardous sexuality: even when the traumatic external origins of sexual ill-health are made blatantly clear, as in the ‘borderline’ group’s histories of sexual assault, it is the ‘borderline’ woman herself who must be medically managed and made to bear responsibility. Here we find the ‘borderline sexuality’ paradox: the ‘borderline’ woman is afflicted with a simultaneous lack and excess of sexual agency, rendering her both irresponsible and responsible for her pathologically volatile sexuality.

Discussion

This construction of the ‘young woman with BPD pathology’ and her unstable, volatile sexuality emerges from a decades-old body of literature which includes countless clinical studies such as that of Thompson et al’s (2017) paper. Together, these texts work to cumulatively validate the existence and naturalness of ‘BPD’. The psychiatric stereotype of the ‘borderline’ woman thereby emerges through a panoply of texts which have real, material consequences for her treatment. Clinical practice guidelines,

therapeutic interventions, psychopharmaceutical treatments, and interactions between 'borderline'-diagnosed patients and mental healthcare professionals are concomitant with the discursive construction of the disorder. Consequently, even the most subtle or implicit prejudices and misapprehensions about the 'borderline' subject, when woven throughout the literature, can have serious consequences for patients. Therein lie 'the discursive effects of the material, and the material effects of the discursive' (Hook, 2001: 538).

Thompson et al (2017) are undoubtedly concerned about the health and personal safety of the 'borderline' women in the study, and take seriously their vulnerability and wellbeing. But the discourses employed by the authors in order to account for the vulnerability and sexual health of the women in question contain two key problems which emerge through critical analysis: the pathologisation of queerness and promiscuity, and the individualisation/responsibilisation of sexual violence. Frequent and non-heteronormative sexual activity is identified by the authors as an indicator of 'BPD pathology', as is a history of sexual assault or coercion. The association of female promiscuity and queerness with severe psychopathology is concerning, and reflects a latent ideological position which must be considered in the context of Western psychiatry's involvement with historic biopolitical programmes to pathologise, govern and eradicate sexual 'deviancy'. Homosexuality and promiscuity in women have long been subject to pathologisation due to the embedding of patriarchal Christian moral codes into the medical and psychological sciences of the West (Nicolson, 1993; Ussher, 2018; Drescher, 2015; Carr and Spandler, 2019). The abusive, punitive, shame-based psychiatric practices to which queer and sexually active women were made subject throughout the 20th century may have been mostly discontinued, but the discursive strategies which legitimated them are upheld by the text in question.

Additionally, the discursive reduction of sexual violence to an individual psychiatric problem is troublesome. While sexual violence can undoubtedly cause post-traumatic stress responses in its survivors which can sometimes be alleviated by psychiatric care, this text discursively frames sexual assault itself – not post-traumatic stress responses to sexual assault – as a clinical problem requiring medical management. This discursive medicalisation expands the jurisdiction of psychiatric inquiry while inhibiting the interrogation of sexual violence in socio-political terms and pathologising survivors' emotional responses. Considering this in addition to the belief that 'borderline' women are constitutionally promiscuous or poor at setting sexual boundaries, it is unsurprising that they are often shamed and mistreated within healthcare settings: they may be assumed to be at least partially to blame for the sexual violence visited upon them. The discourse of 'borderline' sexuality abets the discipline (and frequently, the punishment) of survivors and the invisibilisation of the perpetrators of sexual assault.

The prognosis of the 'borderline' concept is uncertain. Mental healthcare professionals' negative attitudes towards 'BPD' patients – chiefly, the belief that they are manipulative, deceitful, reckless, obstinate and incapable of recovery – are systemic and well-documented (Fraser and Gallop, 1993; Deans and Meocevic, 2006; Commons Treloar and Lewis, 2008; Woollaston and Hixenbaugh, 2008; Commons Treloar, 2009). The considerable stigma has prompted many to question whether the potential benefits of this diagnosis outweigh the harms (Paris, 2005; Shaw and Proctor, 2005; Campbell et al, 2020). This is not the only evidence-based critique of the continued usage of the diagnosis. There is also a significant body of research which links the development of 'BPD pathology' to trauma: 70–91 per cent of the 'BPD'

population are estimated to have experienced childhood trauma or sexual violence (Herman and van der Kolk, 1987; Herman et al, 1989; Brown and Anderson, 1991; Meichenbaum, 1994; Castillo, 2000; Schulte–Herbruggen et al, 2009). The authors who voted to keep ‘BPD’ in the DSM-5 (APA, 2013) did so despite vocal opposition in favour of renaming or recategorising the condition as a trauma disorder variant in order to enshrine the evidence base for traumatic aetiology in the taxonomy (Porr, 2001; Lewis and Grenyer, 2009). Historically, colloquial names for diseases have been replaced by scientifically informed descriptive titles once aetiology and pathogenesis are made visible and verified – but as Paris (2005) points out, the modern psychiatric classificatory system is based on presentation, not pathogenesis, and reorganising its contents will not automatically improve the lot of its subjects. We may be nearing the time when ‘borderline’ is finally retired and replaced by a name less corrosive to the wellbeing of those to whom it is applied, but professional antipathy towards ‘borderline’ patients is the consequence of an archaic moralism that may be too deeply embedded in the discipline to be alleviated by language alone.

Conclusion

Thompson et al’s (2017) article forms part of a wider programme within psychiatry to reframe trauma and distress as endogenous psychopathology, individualising problems of interpersonal and sociocultural origin in order to legitimate psychiatric interventions. This biopolitical project is purportedly motivated by the principle of value-neutral scientific inquiry, but is replete with moral and political standards of normalcy which often go unexamined. While the discourses of scientific objectivism and academic writing conventions are open to critical deconstruction, there are fewer opportunities for resistance to material practices when psychiatry, in contemporary society, is totalising. Critical analyses such as this should therefore form part of concerted effort to challenge harmful psychiatric discourses and their material consequences. The persistence of the ‘borderline’ concept is a feminist issue, and a truly liberatory feminist praxis is obliged to critique the modern fixation on psychiatry as saviour when psychiatry has historically been used as a tool of oppression. To challenge the validity of ‘BPD’ is to challenge the pathologisation of a certain kind of woman, a certain mode of sexuality, or a certain pattern of emotional responses to sexual violence – and by extension, to challenge the very epistemological grounds of the discipline.

As Janet Wirth–Cauchon explained, ‘as a category based on a metaphor of the border, [the “borderline” concept] is “holographic”, providing a condensed image of the larger culture of psychiatry’ (Wirth–Cauchon, 2001: 3). The psychiatric *logos*, which produces the conditions of possibility by which ‘BPD’ is permitted to emerge as a real, natural entity, has its most fundamental conceptual cracks and voids illuminated when one holds the ‘borderline’ up to the light. Working on the ‘borderline’ positions one at the outer limits of psychiatry’s realm of authority, and prompts a confrontation with the discipline’s history of pathologising those who fall outside the narrow bounds of societally acceptable gendered and sexual behaviour. I argue that because of this history, a ‘borderline’ diagnosis risks stigmatising the recipient to such an extreme degree that it renders the point at which they access mental healthcare into yet another site of potential danger and abuse. The lack of empathy received by ‘borderline’-diagnosed people is a systemic and severely harmful problem which should not be perpetuated

any further by retrogressive clinical discourse. I therefore invite the reader to challenge the usage of this diagnosis and the reductive classificatory logic which gives it authority.

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