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Articles

When She Was Bad: Borderline Personality Disorder in a Posttraumatic Age

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The advent of the posttraumatic stress disorder diagnosis has been welcomed by many as a recognition of the circumstances and needs of victimized women. This paper argues that the increasing application of the PTSD label to women formerly diagnosed with borderline personality disorder, rather than resolving the dilemmas inherent in use of the borderline diagnosis, has succeeded instead in further medicalizing women's problems and reproducing the previously existing caste system of diagnosis and treatment.

Within the past decade, two syndromes—borderline personality disorder (BPD) and posttraumatic stress disorder (PTSD)—have quickly become "women's" diagnoses, each for its own reason. It has been suggested that the increase in the application of the borderline diagnosis to women owes much to the fact that, over the decades, its diagnostic criteria have been reshaped to resemble those of the affective disorders, such that these criteria have come less and less to represent the "border" between psychosis and neurosis from which the disorder takes its name *(Kroll, 1988)*. In the case of PTSD, the scope of its application has broadened to include those individuals who suffer the psychological aftereffects of sexual or physical abuse, a large proportion of whom are women.

Designations of normality and pathology owe their origins not only to biological and psychological factors, but also to the sociocultural contexts in which individuals find themselves. The conceptualization of BPD embodied in the *DSM-IV (American Psychiatric Association, 1994)* continues to reflect a view of women's problems as inherently intrapsychically derived. Object relations theories concerning the origins of BPD that held sway for many years have very likely reinforced among clinicians the notion that, for the individual suffering symptoms designated "borderline," a problematic early mother-child relationship has resulted in developmental arrest and subsequent deformations of character. In contrast, PTSD is one of only a handful of diagnoses in the *DSM-IV* whose symptoms can be said to stem from situational causes alone. This in itself has rendered PTSD particularly attractive to feminist therapists, who have found in this "non-blaming" diagnosis a means of acknowledging the social/situational origins of certain psychological problems faced by women. On the other hand, the borderline diagnosis, with its overly ample boundaries and unclear applications has acquired an increasingly pejorative connotation. The view of one disorder as a consequence of character and the other as a consequence of fate cannot fail to have significant implications for the narratives of both therapist and client. Today, we might characterize BPD and PTSD as the "bad girl" and the "good girl," respectively, of psychiatric labels.

The question raised in this paper is whether, in the context of the long and painful history of the relationship between women and psychodiagnosis, feminist therapists, in "discovering" PTSD, have truly found the diagnostic promised land—or whether widespread acceptance of the diagnosis and the

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stress paradigm of illness upon which it rests represents a further embrace of the medicalization of women's problems. In addressing this question, the present paper will explore the implications for women of the effort to redefine BPD as a form of PTSD. It will be argued that this effort has resulted in a caste system of diagnosis and treatment that fails either to serve women labeled borderline or to eradicate the pernicious borderline diagnosis altogether. Issues that will be considered include the problematic result for women of the broad application of the stress paradigm of disorder; the paradox inherent in the psychiatric attempt to "normalize" stress responses by calling them disordered; and difficulties created by the attempt to fit BPD into new constructions of trauma-induced disorders.

BORDERLINE PERSONALITY DISORDER

"Its symptoms are so varied and obscure, so contradictory and changeable." Although these words might well have been found in recent descriptions of the criteria for the diagnosis of BPD, they were, in fact, used in 1833 by an eminent gynecologist, Samuel Ashwell, to describe the symptoms of hysteria, a condition about which he commented: "Few practitioners desire the management of hysterics." Half a century later, another medical man, neurologist Charles K. Mills, called hysteria "pre-eminently a chronic disease...[one] in which it is unsafe to claim a conquest" *(quotations cited in Smith-Rosenberg, 1972, p. 665)*.

Over a century after Mills's pronouncement, we cling to a diagnosis of *our* time—borderline personality disorder—that, despite its status as one of the most widely researched disorders, lacks consistent proof of validity or reliability *(Akiskal et al., 1985; Frances & Widiger, 1987; Kroll et al., 1981; Kutchins & Kirk, 1997; Lykowski & Tsuang, 1980)*. It is a diagnosis that has been applied to women at a rate of about seven to one over men *(Swartz, Blazer, & Winfield, 1990; Widiger & Weissman, 1991)*. And, although the diagnosis has been shown to be gender-biased in its application *(Adler, Drake, & Teague, 1990; Becker & Lamb, 1994)*, the psychiatric profession continues, just as did physicians Ashwell and Mills, to wrestle with its protean form, fret over the "management" of patients, and despair about the chronicity of the disease.

The history of the borderline concept and the BPD diagnosis is a history of the shifting sociopolitical contexts in which American psychiatry is embedded. It is not the purpose of this paper to recapitulate that history *(Aronson, 1985; Becker, 1997; Fine, 1989)*, apart from noting that personality disorders, of all psychiatric diagnoses, bear the most remote resemblance to medical disorders. For this reason, they are particularly vulnerable to changes in the social, political, and economic climate *(Kroll, 1988)*. Criteria for the disorder have been shaped over the years in such a way that BPD can now be viewed as an atypical affective disorder, given its core features of mood instability and dysphoria *(Kroll, 1993)*. It seems hardly coincidental that this transformation began taking shape as interest in and funding for research on affective disorders soared over the past two decades *(Kroll, 1988)*. Since women more frequently report symptoms of dysthymia and major depressive disorder than do men *(Kessler et al., 1994; Robins & Regier, 1991)* it is not surprising that the centrality of affective criteria in the *DSM-III-R (American Psychiatric Association, 1987)* and *DSM-IV* renderings of BPD has made the diagnosis a better "fit" for women than might previously have been the case *(Becker, 1997)*.

Like that of PTSD, the BPD diagnosis may be arrived at in a multitude of ways, such that one individual diagnosed borderline may not look like another with the identical diagnosis. Stone *(1990)* found 93 ways in which criteria could be combined and still yield a *DSM-III-R* BPD diagnosis (with the addition of a new criterion in *DSM-IV*, one shudders to think how many combinations are now possible). Given the broad reach of its criteria, it is little wonder that about 15% of inpatients and 8% of outpatients now carry the label "borderline" *(Stefan, 1998)*. In fact, borderline has become the most pejorative of all personality labels, and it is now little more than shorthand for a difficult, angry female client certain to give the therapist countertransferential headaches.

In a study attempting to isolate what they termed markers for BPD, Zanarini, Gunderson, Frankenburg, and Chauncey *(1990)* identified demandingness/entitlement, treatment regressions, and the ability to evoke inappropriate responses in one's therapist. Use of these behavioral indices as markers for BPD shows us just how far we can go in accepting a label that stands for an aggregate of behavior as a mental disorder *(Kutchins & Kirk, 1997)*. In an extreme variant on this theme, the borderline diagnosis is referred to as if it were equivalent to a symptom (e.g., "the outcome of group treatments was said to be adversely affected when a group

member had high levels of dissociation...*and a diagnosis of borderline personality disorder*" *[Cloitre, 1996, cited in Alexander & Muenzenmaier, 1998, p. 225, emphasis added]*). Circular arguments—that a person is demanding because she "has" BPD or that a therapist acted inappropriately because her client "has" BPD—do nothing to advance our understanding of so-called borderline phenomena.

Although the late 1960s ushered in an era in which it became almost *de riguer* for therapists to treat survivors of incest and sexual abuse, since the 1990s—the era of the recovered memory debate—therapists are increasingly aware of the risks implicit in treating victims of abuse. Among the clients who inspire the greatest anxiety and fear are those "with borderline-type dynamics" *(Courtois, 1999, p. 308)*. BPD has acquired the distinction of being the only diagnosis for which a failure to thrive (so to speak) in treatment and the countertransference reactions of the therapist serve as proofs of validity *(Becker, 1997)*.

In recent years, with the increasing recognition that many women to whom the BPD diagnosis has been applied have suffered physical, sexual, and other forms of childhood maltreatment *(Brown & Anderson, 1991; Coons, Bowman, Pellow, & Schneider, 1989; Goodwin, Cheeves, & Connell, 1990; Herman, 1986; Herman, Perry, & van der Kolk, 1989; Herman, Russell, & Trocki, 1986; Ogata et al., 1990; Stone, Unwin, Beacham, & Swenson, 1988; Surrey, Swett, Michaels, & Levin, 1990; Weaver & Clum, 1993; Westen, Ludolph, Misle, Ruffins, & Block, 1990; Zanarini, Gunderson, Marino, Schwartz, & Frankenburg, 1989)*, there has been a strong impetus to move away from the characterological blame *(Janoff-Bulman, 1985)* implicit in intrapsychic explanations for the etiology of BPD toward explanations that take these traumatic antecedents into account. As the antecedents are considered, BPD symptoms are increasingly discussed in terms of their relationship to external forms of stress, and it is this relationship that has been responsible for the frequent pairing of BPD and PTSD in the past decade. This conceptualization of BPD as a special instance of PTSD owes much to the stress paradigm of illness.

THE STRESS PARADIGM

The assumption that there is a correspondence between particular types of disordered behavior and particular types of stress has long been a mainstay of the Western "scientific" or classical paradigm *(Cloward & Piven, 1979; Kleinman, 1988)*. In the contemporary rendering of the classical model, severe stressors—often conceptualized as changes in life events that are menacing or uncontrollable to some degree—produce a strain from which the individual seeks relief by engaging in coping activities intended to restore equilibrium. Those who are exposed to these stressors but who lack adequate social supports or methods of coping, will experience mental (or medical) disorder *(Kleinman, 1980)*.

Although, in the aggregate, several sets of recent studies focusing on the effects of environmental adversity have demonstrated that stress and adversity play an important role in the etiology of some psychiatric disorders, much of the evidence associating environmental stressors with *particular* disorders continues to be indirect, and it is unclear what importance to assign to the role of stress vis-à-vis the course of certain disorders *(Dohrenwend, 1998)*. It would appear, too, that in many cases the association between environmental adversity and disorder "is limited to stressful events of considerable magnitude" *(Stueve, Dohrenwend, & Skodol, 1998, p. 354)*.

Any discussion of the relationship between stress and disorder must take into account the social structure within which stressful conditions exist. Such conditions and the options available to us in coping with them are shaped by the sociohistorical context of our lives *(Cloward & Piven, 1979)*. Because the classical view of the causal connection between stress and disorder is both persistent and pervasive, as social changes lead to revisions in the prevalence rates and forms of disordered behavior, we will not only continue to uncover new stresses but may see the forms and distribution of disorder change radically even in the absence of equivalent changes in stress *(Cloward & Piven)*.

The Big Tent: PTSD and Its Widening Reach

PTSD has recently undergone just such a radical change in form and prevalence. This has been accomplished through an alteration in the description of the precipitants of the onset of PTSD, which has led to a large increase in its prevalence in a brief time span. In less than 20 years, PTSD has been transformed from a newly named syndrome *(American Psychiatric Association, 1980)* into a widely used and researched diagnosis *(Andreason, 1995; Kutchins & Kirk, 1997)*. In the *DSM-III* description of PTSD, stressful precipitating events had to be "outside the range of usual human experience"

(p. 236). Fourteen years later, with the publication of *DSM-IV*, trauma was redefined to include exposure to "an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" *(p. 427)*, events distinctly not outside the range of normal experience. This revision made it possible to conceive of the sexual and physical abuse perpetrated on large numbers of women as stressors that could lead to symptom development *(Kutchins & Kirk, 1997)*, and it represented, for many, an important acknowledgment of the effects of this abuse.

There is no doubt that consideration of the ways in which exposure to traumatic stress influences the development of girls and women is vastly preferable to a conceptualization of women's distress as deriving from intrapsychic phenomena. In fact, until their overall effect is appreciated, recent changes in the PTSD diagnosis appear to constitute a much needed validation of and response to the real suffering of victimized women. On balance, however, the benefits to women of these changes are questionable. The redefinition of trauma in *DSM-IV* has increased by millions the number of those eligible for a PTSD diagnosis and has identified those women who qualify for it as having a mental disorder *(Kutchins & Kirk, 1997)*. In addition, as abuse increasingly becomes synonymous with trauma, such a large number of symptoms and syndromes is being subsumed under the category "abuse" that the term may eventually lose all meaning *(Cushman, 1995)*.

There are 175 ways in which PTSD criteria can be combined in order for a PTSD diagnosis to be reached *(Kutchins & Kirk, 1997)*. Because of the amplitude of the category, and the diffuseness of its criteria, some of those individuals brought in under the new, enlarged PTSD tent are barely related—that is, some have no symptoms in common with others so diagnosed. Of course, a smaller tent would necessarily hold less room for insurance-reimbursed service providers in a mental health economy in which supply may well create demand *(Frank & Frank, 1991; Haaken & Schlaps, 1991; Kleinman, 1995; Kutchins & Kirk, 1997; Lamb, 1996)*. Put in historical context, the proliferation of the PTSD diagnosis may rival in scope the epidemic of hysteria and neurasthenia during the last half of the nineteenth century *(Eherenreich & English, 1978; Sicherman, 1977; Wood, 1973)*.

In her analysis of interviews with more than 40 feminist therapists, Marecek *(1999)* observed that many of them found PTSD to be the only acceptable (i.e., nonstigmatizing, nonblaming) psychiatric diagnosis for women, as this portion of an interview with one of those therapists illustrates:

> Almost all my clients have PTSD and I tell them what it means. I say, "This means you are having a normal reaction to trauma. You're not having a sick reaction to trauma. You're having a normal reaction to trauma." The reason I like PTSD as a diagnosis and I'm glad it's there is that it says right in the definition that this is a normal response to trauma that most people would have. *(p. 163)*

For all the desire to make it so, the normalization of stress responses cannot be accomplished through our fervent attachment to the PTSD diagnosis. Although the diagnosis seems "new" in its uses, those uses reflect the application of the classical stress/disease model to age-old stressors. Reliance on the stress model can have disturbing implications for the representation of women's experience. There is no single stressful experience in response to which most individuals develop PTSD *(Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Yehuda & McFarlane, 1995)*. Thus, because PTSD is by no means a universal response to abuse, and because its symptoms are considered involuntary, those symptoms can only exist as the constituents of disease *(Lamb, 1996)*. We cannot, as some have suggested, conceptualize PTSD as a "normal" response to trauma *(Hamilton & Jensvold, 1992)* and call it a disorder at the same time. Of course, as soon as we name a set of responses to stress "disorder," we employ science to justify its medicalization. Not only, then, does acceptance of the widespread use of the PTSD diagnosis for women imply acceptance of a reductionistic theoretical framework that subordinates context to individual reaction, but medicalization further separates that reaction into its psychological and biological components.

Those insistent on viewing psychiatry as a science are bent on validating diagnoses through the identification of so-called biological markers or neurobiological substrates *(Andreason, 1995)*. In the years that have followed the decision to give a name to posttraumatic stress, a disorder that was originally considered to be an acute psychological reaction to a severe stressor in the environment—a mind/body phenomenon—is increasingly being viewed as a biological disorder. Countless studies are now being performed on the biological concomitants of PTSD *(Murburg, Ashleigh, Hommer, & Veith, 1994; Shalev, Orr, & Pittman, 1993; van*

der Kolk & Saporta, 1993; Yehuda & McFarlane, 1995), and it has even been suggested that sex differences in behavioral response to traumatization may be hormonal *(Wolfe & Kimerling, 1997)*. Even where the biology of PTSD is not reified, the dichotomization of the psychological and the environmental persists, as exemplified by Wolfe and Kimerling's statement that, "Whether a differential vulnerability for PTSD in women relates to underlying or intrinsic characteristics...*as opposed to external factors* remains unclear" *(p. 202, emphasis added)*.

THE OVERLAP BETWEEN PTSD AND BPD

In the age of the "new" PTSD, we are confounded in our ability to view BPD and PTSD as categories separable from each other. Both diagnoses have been termed "catchall" or "wastebasket" categories because of the overinclusiveness of their criteria as well as the amplitude of their boundaries *(Kroll, 1993)*. Not only do they frequently overlap symptomatically, but each is comorbid with so many other disorders that it is difficult to justify the perceived close relationship between the two diagnoses on the basis of comorbidity alone.

Personality disorder categories are by no means mutually exclusive, a fact that has been restated frequently by members of the psychiatric community itself *(Lilienfeld, Van Valkenburg, Larntz, & Akiskal, 1986; Oldham et al., 1992; Pope, Jonas, Hudson, Cohen, & Gunderson, 1983; Stangl, Pfohl, Zimmerman, Bowers, & Corenthal, 1985; Widiger, Frances, Spitzer, & Williams, 1988; Widiger & Rogers, 1989)*. Most individuals who have been diagnosed with a personality disorder such as BPD also meet criteria for at least one additional personality disorder *(Fryer, Frances, Sullivan, Hurt, & Clarkin, 1988; Widiger & Rogers, 1989)*. Almost half of those who qualify for either a BPD or a histrionic personality disorder diagnosis meet criteria for the other disorder.

Zanarini et al. *(1998)*, in studying the pattern of comorbidity of BPD with Axis I disorders, found that the symptoms of female borderline inpatients overlapped frequently with those of mood disorders—and with anxiety disorders and eating disorders as well, but not to such an extent. Rather than viewing this comorbidity as proof of how blurred are the boundaries of BPD, the researchers maintained that these comorbid disorders can "mask" an "underlying borderline psychopathology" *(p. 1733)*, thereby disguising "true" borderline symptoms. Their solution to this dilemma is to maintain that the extensive comorbidity itself serves as a marker, establishing the uniqueness of the diagnosis by discriminating BPD from other Axis II disorders. The fact that 75% of the BPD patients in the study exhibited a certain pattern of comorbidity and 75% of other Axis II patients did not was all the evidence these researchers needed to establish the validity of BPD.

This formulation rests upon two erroneous assumptions. One is that the personality disorders are valid categories. Another is that finding what has been put there to find (i.e., finding the affective criteria that have been included in successive revisions of the BPD category by successive *DSM* committees) and applying those same criteria to inpatients, constitutes proof of the validity of the disorder. This process is akin to that of parents searching for eggs at an Easter hunt; the outcome is certain even if the legitimacy of the enterprise is suspect.

In this same study of 504 inpatients, Zanarini et al. *(1998)* found that 56% of those with BPD diagnoses also met the criteria for PTSD. Like BPD, PTSD has criteria that overlap with symptoms of affective disorder. Major depression and dysthymia have been shown to be among the features most frequently found to be comorbid with PTSD *(Wolfe & Kimerling, 1997)*, as well as anxiety symptoms common to social phobia, simple phobia, and panic disorder *(Kessler et al., 1995)*. Research findings indicate that preexisting major depression may increase an individual's vulnerability to PTSD symptoms following exposure to severe traumatic stress *(Resnick, Kilpatrick, Best, & Kramer, 1992)*. Since symptoms of anxiety and depression are frequently experienced by those diagnosed with both BPD and PTSD, and PTSD, like BPD, is significantly more prevalent among women than among men *(Breslau, Davis, Andreski, & Peterson, 1991; Kessler et al., 1995)*, it may be that the study of the relationships among gender, depression, and anxiety will prove more valuable than current attempts to locate the ever-shifting boundaries between the two diagnoses.

THE NEWEST CASTE SYSTEM

There are several current schools of thought about the relationship between BPD and PTSD. One view holds that BPD represents a developmentally based deformation of personality that oc-

curs as a result of early, prolonged experiences of childhood abuse, rendering an individual particularly vulnerable to developing PTSD symptoms in response to later stressors *(Gunderson & Sabo, 1993a; Kolb, 1989)*. Gunderson and Sabo *(1993b)*, proponents of this view, have stated that the person who develops borderline personality features in adulthood "was never previously 'normal'" *(p. 1906)*. Their contention is that, currently, many adults with histories of childhood trauma are being misdiagnosed as having PTSD—that is, that PTSD can "mimic" personality disorders *(Kolb, 1989; Ochberg, 1991)*. This assertion does not admit of the possibility that certain personality configurations may increase individuals' vulnerability to developing chronic symptoms of PTSD, that personality problems may function as a selector of those who are exposed to potentially trauma-inducing situations, or that personality disorder may follow from trauma *(Green, Lindy, & Grace, 1985)*.

Another perspective is that BPD is actually chronic PTSD that has been integrated into the personality structure *(Herman, 1992; Herman et al., 1986; Landecker, 1992)*. According to this conceptualization, chronic (i.e., prolonged and repeated) stress can result in the development of behavior patterns that are adaptive or compensatory but that cannot be distinguished from personality traits *(Kroll, 1993)*, and many women who have been exposed to chronic trauma are incorrectly being diagnosed as having personality disorders, particularly BPD.

BPD as Complex or Chronic PTSD

An ever larger group of advocates suggests that those women with histories of abuse (e.g., physical abuse, sexual abuse, maltreatment) who are currently diagnosed as having BPD suffer from this chronic or "complex" form of PTSD or fit into some category situated between personality disorder and BPD *(Alexander & Muenzenmaier, 1998; Brown, 1994; Courtois, 1999; Herman, 1992; Herman et al., 1989; Lerman, 1996; Zanarini et al., 1998)*. The case is frequently made that the PTSD diagnosis helps to create a more beneficial treatment context for women currently labeled borderline, since it rids the term of the disagreeable connotations that continue to cling to BPD, while offering the possibility for a situationally focused rather than a more blaming, intrapsychically focused psychotherapy. The notion that construing the client's situation as trauma-based is more likely to elicit from the therapist feelings of warmth and empathy, along with a greater willingness to identify with the client and believe in her ability to change *(Brown, 1994)*, is indeed a happy thought. The reality, however, may be far different.

There is no doubt that positing situational rather than intrapsychic antecedents for the disorder represents a considerable advance in our thinking about both the etiology and the treatment of BPD. Nonetheless, the move to replace the BPD diagnosis with PTSD, "complex" or otherwise, is problematic. It is mistaken to assume that physical and sexual abuse are at the root of all difficulties experienced by women currently diagnosed borderline, or that the existence of abuse alone should determine the focus of psychotherapy. However, this view is apparently held by some therapists, as expressed in the following excerpt from an interview with one of them:

> There's lots of women who get labeled as borderline who have those characteristics but it comes out of twenty years of being beaten by their husbands or a severe incest. If you treat that as borderline personality disorder versus PTSD [laughs] you get really different outcomes....There's a continuum of sexual violence, and most women have experienced some amount by the time they're eighteen, and so I recognize that, and I recognize how it constricts their lives that way... *(Marecek, 1999, pp. 162–163)*

It has generally been assumed that, because women are more often subject to sexual abuse than men, gender is a risk factor for the development of PTSD *(Waites, 1993; Wolfe & Kimerling, 1997)*, an assumption that is frequently held for BPD as well. Landecker *(1992)* reiterated this common point of view and its corollary, that posttraumatic stress, as the response to childhood abuse, is "implicit in most borderline diagnoses" *(p. 236)*.

It has been recognized, however, that not all women diagnosed as having BPD have been physically or sexually traumatized, and that multiple factors in interaction with each other can produce the various symptom constellations we currently call BPD. It has also been argued that these symptom constellations under no circumstances should be considered a unitary disorder *(Becker, 1997; Kroll, 1988, 1993)*.

The linear connection among gender, risk for victimization through traumatic sexual/physical abuse, and BPD or PTSD symptoms fails to take into account that the ways in which individuals express distress (i.e., deviate behaviorally from societal norms) are historically and socially determined.

As was noted above, individuals' experience of stress is shaped by aspects of the sociohistorical context of stress, by their own interpretations of stressful events, and by their evaluations of the options available to them in coping with those events *(Cloward & Piven, 1979)*. Female development implies exposure to sexualization and devaluation in their many guises, regardless of the occurrence of overt abuse *(Becker, 1997; Westkott, 1986)*. There are differences among individuals, however, in the degree and persistence of exposure to stressful events, as well as in their vulnerability to stressors. There are also differences between the sexes in the perception of what is traumatic—that is, in the interpretation of the conditions they face and how symptoms are expressed *(Kessler et al., 1995)*.

When PTSD was originally considered for inclusion in *DSM-III*, a question arose as to how specific the stressor should be: Should there be a different diagnosis for symptomatic responses to each type of traumatic event? It was quickly determined that PTSD was a unitary disorder that resulted from exposure to many types of traumatic events *(Andreason, 1995)*. One could argue, however, that within the wide range of individual responses to different dysfunctional environments or traumatic events there are many symptomatic (as well as nonsymptomatic) configurations, only some of which can be thought of as PTSD *(Graziano, 1992; Lamb, 1999)*.

A developmental psychopathology perspective applied to the symptom constellations currently called PTSD and BPD certainly points toward conceptualizing both the severity of the stressor(s) and the experience and expression of distress along continua. We know that the severity of the stressor may or may not predict the kind, severity, or persistence of symptoms *(Rutter, 1990)*. The developmental psychopathology framework accounts for the multiple mediators of stress and response to stress in a way that no diagnostic system—with its insistence on disorders as categorical entities with discrete, delimiting criteria sets—can do. For Herman *(1992)* to conceive of the sequelae to chronic trauma as a spectrum of conditions as opposed to a single disorder, and then insist that the syndrome that results from persistent trauma be given a name of its own (i.e., complex posttraumatic stress disorder) appears contradictory, at best.

The trouble with trundling a large group of so-called borderline women off to the shelter of the widening PTSD tent is that it will not serve the purpose of eliminating the borderline diagnosis. It will merely remove those women who have histories of clear-cut traumatic antecedents and PTSD symptomatology from the borderline group, leaving behind a residual group of "true" borderlines. That this is already occurring was made evident by Courtois *(1999)* in a recent clinical text:

> The transference projections of interpersonally victimized patients can be very challenging and difficult to manage and are often similar (if not identical) to those identified with personality disturbances, notably borderline personality. *(p. 174)*

This statement suggests that the "interpersonally victimized patients" and those with "personality disturbances" are not always one and the same. "Borderlines" become a separable group, identified as "difficult to manage." And the author has unwittingly provided a blueprint for the diagnostic and treatment hierarchy that is now taking shape. The first tier of that hierarchy is occupied by those who have not been severely victimized; the second by those who have been more severely victimized over a prolonged period, or who have borderline personality characteristics—what Courtois, in another section of her book, referred to as "a posttraumatic personality" *(p. 87)*, but which might more aptly be termed a borderline in posttraumatic clothing. When we begin to create hierarchies within the PTSD or complex PTSD categories, are we not still knee-deep in the Big Muddy of psychiatric terrain?

THE GOOD PATIENT AND THE BAD

The Burden of the Borderline Diagnosis

No amount of fiddling with the present designations, it would seem, will eliminate use of the BPD diagnosis in actual practice. It has not been demonstrated conclusively that clinicians can make this diagnosis with any reliability *(Kutchins & Kirk, 1997)*, and practitioners continue to find interpersonal difficulties—both within and outside the treatment relationship—sufficient evidence for the existence of BPD *(Kutchins & Kirk, 1997; Walker, 1994)*. Within the confines of offices, agencies, and institutions, the BPD and PTSD diagnoses are often quite loosely and interchangeably applied by clinicians. Witness the following statement by Walker *(1994)*:

> Many therapists who treat incest survivors believe that such a diagnostic category [PTSD] would permit greater access to appropriate treatment focusing on the situational trauma and its subsequent sequelae....Other therapists *find the personality disorder diagnosis more to their liking. (p. 113, emphasis added)*

Despite the apparent offhandedness with which both diagnoses are often applied in practice, it is no casual matter for a woman to carry a BPD label. Stefan *(1998)*, in a study of court law, found that women diagnosed with BPD are often considered mentally disabled and, as such, subject to involuntary institutionalization or medication and loss of child custody or parental rights. They likewise are often discredited as witnesses in court cases involving rape or sexual abuse. All of this is in sharp contrast to the way women diagnosed with PTSD are treated. Whereas women who receive diagnoses of PTSD are more likely to benefit under the law on the basis of their disability, women given a BPD diagnosis are not usually thought to be mentally disabled to the extent that would permit them to receive educational or disability benefits, or to recover damages in an abuse case.

Relationship Management: For Borderlines Only?

The discussion of transference and countertransference in the literature on trauma theory and PTSD differs substantially depending on whether or not the client is a "straight-up" PTSD client or one who is labeled as having BPD or its equivalent (e.g., Courtois's *[1999]* "posttraumatic personality"). In the trauma/PTSD literature, for example, discussions of countertransference often give a substantial place to descriptions of such phenomena as "vicarious traumatization" *(McCann & Pearlman, 1999, p. 520)* and "empathic stress" *(Wilson & Lindy, 1999, p. 520)*. Both types of response, it is maintained, can result from continued exposure on the part of therapists to clients' reporting of their trauma stories. These reactions are evoked as a result of the therapist's exposure to the client's *experience*. When the borderline client enters the treatment discussion, however, the client herself and the *relationship* between therapist and client become the focus, as this statement by Ochberg *(1991)*, in a discussion of a treatment model for PTSD sufferers, illustrates:

> Certain coexisting disorders, particularly borderline personality, may be impossible for the posttraumatic therapist to manage according to the principles of PTT. For example, collegiality may be misinterpreted as intimate friendship, and a willingness to intervene with criminal justice may lead to insatiable requests for help with personal affairs. *(p. 14)*

Again, the term "manage," with its evocation of nineteenth century "moral management" of the mad *(Showalter, 1985)* and its reminders of more recent calls for "limit-setting" and "rigid frames" or boundaries in the treatment of individuals with BPD *(Reiser & Levenson, 1984, p. 258)* continues to be applied to this subgroup of treatment candidates. Just as much of the literature on treatment of the borderline client often includes lengthy discussions of relational nightmares-to-be, the literature on trauma therapy includes special disquisitions on how to handle the personality-disordered type of client, who is further marginalized even among her alleged sisters in trauma.

In just such an example of treatment segregation, Alexander and Muenzenmaier *(1998)* have discussed why certain women, those with histories of psychosis, acute suicidality, and substance abuse, and those who "have been diagnosed as having borderline personality disorder are generally excluded from trauma groups" *(p. 225)*. They noted that "Research also suggests that women with complex sequelae to early sexual abuse may not benefit from traditional group work" *(p. 225)*. Given the company it keeps here, the term borderline takes on the meaning "chronic" or "severe."

The "Borderline" and Trauma Therapy

When stress and the responses to stress constitute the symbolic vehicles through which clinician and client attend to the client's idiosyncratic experience *(Cloward & Piven, 1979; Kleinman, 1988)*, trauma becomes centralized "as an essential category of human existence, rooted in individual rather than social dynamics and reflective more of medical pathology than of religious or moral happenings" *(Kleinman, 1995, p. 177)*. In their discussion of incest resolution therapy, Haaken and Schlaps *(1991)* argued that this centralization of trauma in psychotherapy may obscure other events and relationships that exist alongside, or predate, the sexual abuse trauma, and that it comes to define the client's sense of self, thereby potentially foreclosing other important domains available for exploration. The therapist's persistent focus on sexual abuse may be perceived by clients as a demand, both tacit and overt, to focus on this issue, and many women, seeking to be "good," responsive clients, will not resist this demand. The centralization of trauma in treatment may also put those clients at a disadvantage who cannot be considered either victims of specific abuse or compliant, well-behaved victims. "Borderline" women, many of whom are diagnosed with BPD precisely because they present relational challenges in treatment as elsewhere, may fall into this group.

Paradoxically, trauma-focused therapy fits well into the medical model, notwithstanding its proponents' views and sentiments to the contrary *(Marecek, 1999)*. When trauma is centralized, not only do medical metaphors such as wound, injury, brokenness, and pain pervade the language of the therapeutic encounter, but healing and recovery become the goals of psychotherapy *(Marecek, 1999)*. The diagnostic criteria for PTSD emphasize the persistence of symptoms, and the experience of posttraumatic stress is deemed pathological because it persists, a view that implies that it is not normal for individuals who have been traumatized to continue to suffer *(Kleinman, 1995)*. In fact, the view of suffering implicit in the *DSM* is that we humans should not have to endure it—that suffering should be terminated. As our Western ideology would have it, we need endure nothing; we can even "work through" our memories *(Kleinman, 1995)*.

Whereas for PTSD sufferers, "recovery," "resolution," or "reparenting" are held out as possible—even probable—outcomes, for those labeled with BPD hope is not often proffered, even though the facts do not support the perception of a wide disparity in the chronicity of the two disorders *(Kessler et al. 1995; Kroll, 1993)*. In one of a number of child custody cases involving women diagnosed with BPD, the court found that the mother, because of her disorder, was

> ...not likely to benefit from counseling, ...not likely to respond to treatment [and] that such persons...are resistant to social services and are very unlikely to recognize or deal with their problems, and that the [mother] is in that category. *(Stefan, 1998, p. 252)*

CONCLUSION

While the notion of recovery fits well with our American ideas about the power of human agency to overcome great odds, of late we find ourselves revering the victim, leaning toward the reactor rather than the actor *(Lamb, 1996, 1999)*. It may be that such a preference implies, as Kaminer *(1993)* has suggested, a societal sense of resignation—a posture of defeat in a world in which little makes sense, much is accident without explanation, and character is separable from fate. Mention was made earlier of the false distinction between character and fate that has affected our current conceptualizations of BPD and PTSD. In the absence of that distinction there would be no "bad girls" and "good girls," just women whose suffering—and the context of whose suffering—needs to be understood.

It may also be that our continued attachment to the stress paradigm, and to PTSD as its current diagnostic exponent, causes us to fail our women clients in the very task that we had hoped to accomplish, namely, altering the conceptualization of their suffering as a highly individualized phenomenon. It has been this very view that has persistently justified the separation of women's distress from its sociopolitical contexts on the basis that stress has universal effects on individuals *(Kleinman, 1995)*. Medicalization contributes to the social control of women through expansion of the definition of madness, and leads us in pursuit of cures for the "disease" of PTSD.

The promised land of PTSD has turned out to be a wasteland, most particularly so for the "bad girl" borderline client. Our deference to the gods of medicine, who have so kindly allowed us the PTSD diagnosis, has not helped us to resolve the societal dilemmas implicit in males-to-female abuse. It has simply deferred the abolition of the borderline diagnosis and its hideous connotations for another day, and perhaps a much later day at that.

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