BPD, CPTSD, and Identity:
The Discursive Construction of Diagnostic Possibilities

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Last spring, *The Guardian* published an article discussing the diagnostic overlap between Borderline Personality Disorder and Complex Post-Traumatic Stress Disorder. The article noted that many abuse survivors felt that they had been misdiagnosed with BPD, resulting in undue stigma, mismatched treatments, and unnecessarily poor prognoses. The article asked, "What if these patients didn't have disordered personalities, but were suffering the psychological consequences of childhood abuse?"

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But what if that's the wrong question? What if so-called disordered personalities *are* the psychological consequences of childhood abuse? What if trauma doesn't always look how the medical establishment and the media have taught us to expect? How can a disorder be *post*-traumatic if a child never experiences a time pre-trauma?

As someone diagnosed with BPD without a clear-cut history of trauma or abuse, I have long wondered about these definitions and boundaries. These disorders--the people I've met with them, the experiences we've shared, the stories we tell--have so much in common. What exactly are the differences between BPD and CPTSD that lead to the difference in stigma, stereotypes, and prognoses? Are they really differences of experience, or are they differences in how experiences are described, framed, or constructed?

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Motivated by these questions, I used discourse analysis to examine the diagnostic features in DSM-5 for BPD and PTSD. In this presentation I'll describe my research design, share some findings, and conclude by examining lived experiences to consider implications.

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As I said, I began this project because I wanted to know how apparently similar lived experiences come to be associated with such different stories and stereotypes. I say "apparently similar" based on the stories my peers have shared with me and that I've read on sites like The Mighty, a website that aims to foster community among people facing "health challenges." From these stories, I've come to suspect that despite overlapping lived experiences, people diagnosed with these disorders relate quite differently to their diagnostic labels. I wondered whether such differences could be traced back to the DSM itself. I asked, how does the language used to describe and define these disorders differently figure the person diagnosed, their possibilities, and their relationship to the diagnosis itself?

I chose to use discourse analysis to explore these questions because, as James Gee writes, "Looking closely at the structure of language as it is being used can help us uncover different ways of saying things, doing things, and being things in the world" (2011, p. 9). The term "discourse analysis" encompasses a number of approaches; I followed Gee, using the lens of Systemic Functional Linguistics to explore how grammatical choices impact and create meaning in diagnostic texts.

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Unfortunately, there were some obstacles with selecting comparable texts for analysis. Because complex PTSD is not yet recognized in the DSM, and the ICD eliminated BPD at the same time that it introduced CPTSD, I settled on the PTSD and BPD entries in DSM-5 for my analysis. This means that some features specific to complex PTSD were not included, but since complex PTSD is essentially defined as PTSD-plus, I think my conclusions hold up.

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First, let's look at shortened versions of the diagnostic criteria for BPD, PTSD, and CPTSD, derived from the DSM and ICD. BPD is in blue, on the left, while PTSD and CPTSD are on the right, in red and plum, respectively. As you can see, there are some similarities here: issues with affect regulation, reactivity, self-image, negative feelings, and relationships. Of course, there are differences too. I am not here to argue that BPD and CPTSD are the same thing, but I do want to trouble the idea of a clear-cut distinction between them, or perhaps more accurately, the implications of that distinction.

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For my analysis, I took the full-sentence versions of the diagnostic criteria from the narrative Diagnostic Features section of the DSM entries and analyzed their main clauses. Before we look at the results, it's important to note that there are many more diagnostic criteria for PTSD than for BPD, so while I analyzed 22 PTSD clauses, there were only 10 for BPD.

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Here's an example of what this process looked like and what kind of data it produced. This sentence comes from the DSM-5 diagnostic features for PTSD:

> Commonly, the individual has recurrent, involuntary, and intrusive recollections of the event.

The first and easiest thing to look for is modalization--indications of frequency or probability, or of how certain the speaker is. This can take two forms: adverbs like "commonly" and modal verbs like "may." Even though the modal element here is "commonly," it still indicates lower certainty or frequency than no modalization at all--for example, if it simply said, "the individual *has* recurrent, involuntary, and intrusive recollections."

The next element is theme, the element that comes first and tells what the sentence will be about. Typically, it's also the grammatical subject, but not always. Here, the first participant is "the individual." The sentence will focus on "the individual" and give information or make a comment about them.

Finally, the verb tells us what type of process is happening and what participant roles are entailed in that process. Systemic Functional Linguistics identifies eight types of process: material, mental, verbal, behavioral, possessive, attributive, identifying, and existential. "Has" is possessive, so the participants are the possessor and the possession. This implies that "intrusive recollections" are a separate entity from the individual, something outside their core selves that they own.

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I found that two main themes cut across both texts: "the individual," or the candidate for diagnosis, and the disorder itself or its symptoms. I've broken down the process-type and modality data along the lines of these themes, because knowing what a sentence is *about* is crucial to understanding the implications of the other elements, as well as the different focuses of the two texts.

In the majority of the criteria for BPD, "the individual" is the theme. Meanwhile, for PTSD, "the individual" is the theme slightly less than half the time, while the disorder or its features make up the rest. So BPD is defined mostly by reference to the person, while PTSD is split between the person and the symptoms or the disorder itself.

Within those categories, different types of process dominate, and the use of modalization varies. When "the individual" is the theme in BPD, which is most of the time, the processes are largely behavioral and rarely modalized. These are sentences like "Individuals with borderline personality disorder *make* frantic efforts to avoid real or imagined abandonment" or "Individuals with borderline personality disorder *display* impulsivity." The criteria are things that the individual *does*, and they are stated with surety and fixity--they *certainly-always* do those things.

When "the individual" is the theme in PTSD--less than half the time--behavioral processes also dominate, but they are universally modalized. Only *some* of the criteria are things that the individual does, and they *always* allow for the possibility of variation. Possessive and attributive processes make up the rest. This indicates that after behavior, criteria about the individual are defined in terms of their relationship to phenomena-- "having" certain experiences or "being" certain ways, like "quick-tempered" or "reactive."

When the disorder or its symptoms are the theme, other processes come to the fore. These are sentences like “Negative alterations in cognitions or mood ... begin or worsen after exposure to the event” or “Concentration difficulties... are commonly reported.” In the few BPD sentences with such themes, the processes are existential or identifying--simply stating that a phenomenon occurs, or identifying it as a key feature of the disorder.

The PTSD sentences with disorder or symptoms as theme, which make up more than half the text, are mostly split evenly among identifying, existential, and attributive processes. Attributive processes assign some quality or characteristic to the subject--here, things like being “associated with the traumatic event” or being “common among people with this disorder” are attributed to the specific symptom or to the disorder itself. The individual is not a participant in these clauses at all.

From these differences in process type, we see that where BPD is mostly defined in terms of the individual’s behaviors, PTSD is split between behaviors individuals *may* engage in, experiences or characteristics they may *have*, and phenomena that seem to exist independent of the individual.

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These layers of meaning show that the two disorders are framed in significantly different ways. While BPD is defined in terms of a person’s habitual behaviors, with certainty and fixity, PTSD is defined with a broader range of reference points and much more room for variation and possibility.

To me, this suggests that borderline personality disorder is located within the person and relies on a concept of personhood as static and stable--if a behavior is habitual now, it stretches

out that way indefinitely into the past and future. Beyond noting that the pattern of symptoms must be present by early adulthood, there are almost no mentions of time, change, or causality in the diagnostic features of BPD. If a person has this disorder, they basically always have and, at least to some extent, always will. There is no reason; it's just the type of person they are. They are a *disordered person*.

The diagnostic features of PTSD, on the other hand, are full of references to time and causality, as the disorder hinges upon the occurrence of a traumatic event. The disorder is something outside of or added onto the person themselves. There are "alterations" to personality, behavior, feelings. An individual's way of being in the world is understood as changeable, subject to their experiences. The person existed prior to--continues to exist separate from--the disorder, and there is a possibility of recovering that person. They are a *person with a disorder*.

These differences shape the identities and experiences of people diagnosed with these disorders. The simplest example is this: I can say "I *have* borderline personality disorder," or I can say "I *am* borderline." I can say "I have PTSD," but I can't really say "I am PTSD," or "I am post-traumatic-stress-disordered." Saying "I am borderline" is how we internalize and identify with the idea of the static, always-already disordered person. We understand BPD as part of us, inextricable and unchanging. This is a belief that precludes "recovery" from the parts of the disorder that hurt us or the people we love. This is a belief that offers us no other vision of our lives beyond perpetual suffering.

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This divide can be seen in many of the stories I've read on The Mighty. A writer in the CPTSD forum says, "My experiences and my mind itself can take me into some pretty choppy

waters" (Wood, 2019). Another says, "Part of me is disheartened that even after years it will still take yet more time, but then I remember I'm repairing over two decades of damage" (Smith, 2017). These authors see their CPTSD as something separate from their core selves--something to do with their "experiences and mind," or a form of damage that can be repaired.

Meanwhile, on the BPD forum, I've seen post after post with sentences like these:

- "I will always be 'a borderline girl.'... I know I will struggle for the rest of my life." (Shandi, 2019)
- "Walking hand-in-hand with borderline personality disorder means ... recognizing it as a part of me." (Murphy, 2019)
- "For the first time in my life, [when I was diagnosed with BPD] I felt I had something that was a part of my identity." (McColey, 2018)

One astute writer, Marie Stella McClure, notices and questions this way of thinking: [Slide 12]

> "Do we really want BPD to be 'forever?' To have such a hold on us that we have no power over our own selves? Why is it so hard to accept that we can get better? That we can take steps? That there is always help, even if it is not on our front doorstep? We buy so much into our disorder that we forget there is a person much bigger than BPD locked inside and struggling to get out." (2018)

The very fact that she has to ask these questions, however, speaks to the pervasiveness of this perspective. McClure asks, "Why is it so hard to accept that we can get better?" My answer emerges from the results of my discourse analysis: even though treatments and possible recovery are mentioned in the DSM, the idea that we can't get better, that we *are* our disorder, is enshrined in the very language used to describe and diagnose us.

I don’t have a solution to this problem, but I believe that noticing it is a decent start. We know that how we name things influences how we experience them. I’m not sure about abandoning BPD altogether, or ignoring the ways its features can be persistent and painful. But I think changing the way we talk about it might just reduce the stigma and suffering associated with the condition, and I think we can learn from the way we talk about PTSD and CPTSD. We might also consider moving beyond either of these models, towards a spectrum approach, a dimensional approach, or seeing these so-called disorders as part of a neurodiverse galaxy of experience. But any of these paths comes down to the way we talk about things. We have choices, and we can language our way to new and different possibilities.

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