Counselling psychologists work in a variety of contexts, including statutory and voluntary services, all of which have their own ethos and organizational understandings. For many colleagues, this involves therapeutic relationships with those who are experiencing mental health problems. Such problems have, historically, given rise to a variety of discourses that frame attempts to understand such experiences. These include the religious, supernatural, moral, medical and psychological. Such discourses frame the way we attempt to make sense of difference and each gives rise to its own classificatory systems as the means of imposing order and understanding on the unfamiliar, the different, the frightening and the distressing. While we acknowledge that the situated contexts of practice play an integral part in the development of our therapeutic work, we may be less aware of how the historical context too has played an important part in the way we view the world and, in the context of this chapter, the notion of disorder.

Much of our current classification of mental disorders, debatably referred to as Neo-Kraepelinian (Bentall, 2004; Horwitz and Wakefield, 2007), can be argued to have arisen from turn of the twentieth-century biological psychiatry and the Kraepelinian twin axes of dementia praecox and manic depressive psychosis (Berrios, 1996). Psychology too grew from the soil of this modern period, with its positivist discourse of scientific endeavour framing the accepted means of furthering knowledge (Gergen and Graumann, 1996), and offering a world-view which separates out, and prioritizes, scientific knowing over narrative knowing. As Ellenberger suggests, 'the science of a
certain period is always unconsciously determined by its ‘Weltanschauung’ (world-view)’ (1970: 201). This concept is a useful one here in that it delineates ‘a specific way of perceiving the world particular to a nation, a historical period, or an individual’ (1970: 201). One manifestation of a modernist world-view is evident in the medicalization of distress and its expression in our institutions and practices. Ahistoricism, oblivious to a notion of world-view, can give rise to acceptance of concepts such as disorder and diagnosis as statements of truth rather than culturally contextualized constructs. In this chapter, therefore, I invite you to consider evaluating the concept of disorder as a construct situated within a particular historical and cultural framework and to explore the implications this has for your practice. With this in mind I will discuss the contested nature of the concept of disorder before examining historical constructions of the concept, as illustrated by the notions of borderline personality and self-harm. Suggested topics for reflection and debate are interspersed in the text to facilitate further discussion, perhaps with colleagues or in training groups.

THE CONTESTED SITE OF DISORDER

What are mental disorders?

Historically the locations of counselling psychology practice have changed. Many more of our colleagues than in the 1990s now work in statutory organizations and indeed mental health services have increasing taken on psychological therapy as their own (see Chapter 20 on working in the NHS). One of the fundamental implications of this movement is how to retain a humanistic value base within a framework dominated by a medical model of distress in which treatment guidelines focus on disorder, in which the burgeoning industry of manualized, protocol-based therapy for specific disorder is promulgated, and in which therapy could be argued to be an adjunct to the politics of employment. Within such a framework therapies, and their research bases, are premised on the notion of disorder and its classification. Yet these constructs, as I will illustrate, are themselves contested sites which represent the conflation of many stakeholder agendas, past and present.

DISCUSSION POINT
How do you maintain a relational stance within a framework that emphasizes the treatment of disorder?
The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) defines mental disorder as follows:

Each of the mental disorders is conceptualized as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significant risk of suffering death, pain, disability, or an important loss of freedom. In addition this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example the death of a loved one. Whatever its original cause it must currently be considered a manifestation of a behavioural, psychological or biological dysfunction in the individual. Neither deviant behaviour nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual as described above. (APA, 2000: xxxi)

Thus, in a philosophical defence of a medical model of mental disorder, Resnek (1991) argued that a descriptive approach, as is evidenced above, is sufficient to account for mental illness. Theories, he suggested, may come and go but descriptions remain the same. Yet, the statement ‘in the individual’ is made three times within the DSM definition and is clear evidence of an epistemological, rather than descriptive, stance. Disorder, it tells us, almost without our noticing, is located firmly within the person, that is, within the brain, mind, personality or neuronal pathways of the individual. Social theorist and semiotician Barthes argued that in popular culture silent sign systems act to reinforce and normalize ideological presuppositions (Brown, 2005). In light of this, perhaps we can view the DSM and it’s near silent epistemological stance as just such an example, one in which we are encouraged to accept such a classificatory system of distress as the norm.

In addition, and contrary to Resnek’s (1991) view, descriptions do change considerably over time. Depression, for example, can only be categorized as a ‘mood disorder’ when underpinned by a culturally sanctioned construct of affectivity. As Berrios (1996) argued, this was not the case in nineteenth-century understandings of melancholia which focused on hypochondrias and delusion. Thus, Vassilev and Pilgrim argue, disorders such as depression or schizophrenia ‘actually refer to a set of complex psychosocial relationships which are closed off by the very act of psychiatric diagnosis’ and that ‘this closure is complete when the inherent social nature of diagnosis (its transactional and evaluative character) is not recognised’ (2007: 349). Finally, the apparently descriptive stance of the DSM belies that the research bases of classification are determined by statistical analytical processes that in themselves require decisions and choices. Thus, Cooper (2004) argues, classification of disorder is theory-driven despite its claims to the contrary.
DISCUSSION POINT
The statement that ‘disorders are a set of complex psychosocial relationships’ suggests that we cannot simply diagnose and treat them. What might this mean for your practice?

Can disorders be classified?

Classification is a means of making sense of the world. Haslam (2000) argues that empirical evidence suggests we are cognitively predisposed to essentialist thinking, something which makes evolutionary sense as a fundamental survival need to distinguish friend from foe. However, that we make sense of distress specifically through a medicalized classification of disorder, rather than, for example, via notions of demonic possession, humoral balance or witchcraft, is framed by our own historically located cultural worldview, and accordingly we are predisposed to classify and intervene in this manner. To illustrate, Lane (2007: 149), for example, argues that while ‘there is no evidential correlation between anxiety or depression with low levels of serotonin’, this association is part of modern neuromythology. Often readily accepted phrases such as ‘chemical imbalance’ have little evidential substance but act as placeholders for essentialist thinking (Haslam, 2000) containing within them the less visible, but equally powerful, unsubstantiated implication that ‘there is a normal ideal neurochemical state that can be achieved by rectifying individual brain chemistry’ (Mulder, 2008: 244).

Classification of mental disorder took a powerful turn at the beginning of the twentieth century with the work of German psychiatrist Emil Kraepelin (1856–1926). Kraepelin developed a nosology of psychiatric illness underpinned by a medical model that stressed aetiology and disease process and which was based upon the twin axes of manic depression and dementia praecox (Greene, 2007). Emphasis on the physical substrata of mental disease process was given further weight by the discovery of syphilis as the cause of general paralysis of the insane (GPI). GPI was a devastating, terminal condition and a major contributor to asylum admissions and deaths. The discovery of the syphilitic spirochete in the brain as its cause, and the drug salvarsan, as the first effective treatment, offered psychiatry both the opportunity to raise its previously poor medical collegial standing as well as optimism that similar physical causation of mental illness would be found in other conditions.

Yet it was psychoanalytic constructs that influenced the emergence of the early DSM, and psychiatrist and president of the APA, Adolf Meyer (1866–1950), was particularly influential. Initially immersed in Kraeplinian psychiatry, Meyer later argued for, and led the development of, a more socially based view of mental illness in which individual experiences were described as reactions, or responses to, individual circumstances rather than biological-based disease entities. It was this framework of individual response,
continuum of experience and behaviours as manifestations of unconscious conflict that underpinned the original DSM-I and its successor DSM-II. Only with the DSM-III was there a paradigmatic shift to the categorical classification of mental disorder, sometimes referred to as the rise of the second biological psychiatry (Shorter, 1997: 239) or neo-Kraepelinian in its epistemology (Mayes and Horwitz, 2005).

In its wake, this paradigm shift in DSM classification of mental disorder has brought about much debate. Mayes and Horwitz (2005), for example, have argued that it was based not on scientific endeavour but rather emerged from conflated professional, political, pharmaceutical and financial agendas. Discussion, as shown below, has also emerged on the nature of the categories. Whether, for example, mental disorders can be considered natural kinds is a much debated topic within the philosophy of psychiatry (Haslam, 2000; Zachar, 2000; Kendell, 2003; Cooper, 2004; Pilgrim, 2007).

DISCUSSION POINT
By what process have you and your clients become familiar with the belief that a chemical imbalance in the brain is the cause of depression? Can you identify any research evidence that supports this belief?

Are mental disorders natural kinds?

Perhaps the concept of ‘natural kind’ can best be outlined via a metaphor of a British pound coin. While the meaning of the coin and its transactions exist only through socially constructed agreement, the metals of which it is composed exist with specific and stable properties as discrete bounded entities, regardless of meaning systems. If mental disorders are natural kinds then, as Adriaens suggests, they need to be demonstrably ‘indifferent to changing conventions in psychiatric diagnostics, to differ categorically from each other, as well as from normality, and to be grounded in discrete biological causes’ (2007: 514). The debate as to whether mental disorders are natural kinds has focused largely on schizophrenia (Crow, 2000; Haslam, 2000; Bentall, 2004; Cooper, 2004; Read et al., 2004; Pilgrim, 2007). Following on from Kraepelin’s finding of the condition world wide, a universality thesis argues that schizophrenia is an integral part of an evolutionary function. Empirical evidence, Crow suggests, shows it to be a ‘language-based disorder that is connected with the adaptive functions of hemispheric lateralisation, whereby equi-balanced handedness appears to be linked to schizophrenia’ (2000: 123).

Other work, however, has suggested that the cluster of behaviours and symptoms we refer to as schizophrenia have only been in existence for around 200 years and that it is of viral origin, emerging as a consequence of urbanization in industrialized society.
(Ledgerwood, et al., 2003). By contrast, a heterogeneity hypothesis suggests that not only is schizophrenia not a natural kind, but it is ‘a reified umbrella concept constructed by psychiatry to cover a heterogeneous group of problems’ (Adriaens, 2007: 524) and that neither research or practice evidence supports the existence of such a unitary concept (Boyle, 1990).

As this very bald outline suggests, varied and conflicting theories of schizophrenia and its existence illustrate the importance of critical appraisal of the concept of disorder as discrete entity. As Richards suggests, ‘Naming endows the named with discrete status, raises it to consciousness, changes how it is experienced and managed – changes, in short, its entire psychological character’ (2002: 24). As therapists and clients, we are active participants in this process which can powerfully and subtly alter the fundamental nature of the therapeutic relationship from that of I–thou to I–it (Buber, 1971).

**DISCUSSION POINT**

How might naming a disorder change the nature and focus of your therapeutic relationships?

**Is disorder a useful notion?**

Mental disorders may or may not be natural kinds but they are arguably ‘practical kinds’ (Kendell, 2003). Haslam (2000: 1003), for example, argues that classification is either about a need to develop a taxonomy which comes ever nearer to the ‘truth of biomedical causes of disorder’ or that we need to see it simply as a useful way to group people in terms of similarities of behaviour. Similarly, Mulder (2008) suggests that even if diagnostic categories are not discrete groups they may have clinical utility, and Sadler suggests of the DSM-III that it ‘improved reliability and facilitated communication between clinicians and researchers’ (2002: 12). But what assumptions underpin the notions of reliability, usefulness, utility and communication?

Kendell suggested of classification that ‘if it is the art of carving nature at its joints, it should indeed imply that there is a joint there, that one is not sawing through bone’, (1975: 65) High levels of dual diagnoses suggest that, rather than moving ever nearer to scientifically accurate diagnoses, what we are seeing may be a fundamental problem in the essentialist and reductionist notion of classification. If the concept of disorder does indeed cut through bone, then we need to question the usefulness of a group of people honing their mutual communication about it, developing expertise in it and coming ever closer in their shared understandings of it. Indeed, the notion of classificatory systems as a means of facilitating intra- and inter-professional communication could itself be argued to be the rhetoric of a hegemonic process. In such a process, the badge of
expert is displayed in the use of acronyms such as BPD (borderline personality disorder) or DSH (deliberate self-harm), and acts to close off the complexity of lived experience to empathic understanding.

We might also ask whether the notion of disorder is useful to the practitioner. Research into mental disorders seeks to exclude potential participants who do not meet clearly defined criteria for specific disorders, or who are considered to have a dual diagnosis. Practitioners, on the other hand, usually work within a somewhat different framework in which the client has been rather more broadly identified as experiencing emotional or psychological distress. While researchers may use DSM to facilitate inclusion/exclusion criteria for randomized controlled trials, in practice clients come context-bound and rarely so neatly packaged as the DSM would have us believe. How useful to practitioners are the results of the researchers’ work if it is based on highly selective populations created in artificial settings where real-life problems are separated out into a framework of dual diagnosis? Would best practice not be supported by greater value being placed on, and resources provided for, practice-based research evidence? (See Chapter 3 on the nature of evidence.)

Similarly, we can ask whether the notion of disorder is useful to the client. A client with anorexia, for example, may see the diagnosis of a disorder as the beginning of a process of externalizing a problem, facilitating the client and therapist in working collaboratively to find a more comfortable way of living. For others, being given a diagnostic label may be experienced as welcome evidence that perhaps their distress is not self-induced and thus paves the way for development of a less punitive self-concept. Yet for others, a diagnosis may represent a compromised identity which is both stigmatizing and socially detrimental. How the client makes narrative sense of the classification, however, is an oft-forgotten variable in the separation of scientific discourse from narrative understanding.

**DISCUSSION POINT**

How might the development of practice-based evidence best support your work with clients experiencing mental health issues?

**Disorder as personhood**

Appignanesi (2008: 447) suggests that diagnoses have the hypnotic power of master words, and certainly terms such as bipolar disorder, depression or schizophrenia can very easily slip into descriptions of personhood. Consider, for example, the word ‘lunatic’, which you would probably think of as a stigmatizing, global attribution of personhood and one which we would not now consider attaching to a human being. Yet are our
current terminological ‘-ics’ (including anorexic, schizophrenic or psychotic) any less stigmatized attributions of personhood or do we only hear them as acceptable because they are a part of today’s common parlance? If there are few stops on the therapist’s journey from seeing their client as ‘meeting the criteria for anorexia’ to ‘being anorexic’ to ‘being an anorexic’, we might wonder how the client with anorexia is to find a wider identity for themselves than the empty one they so often see as lying beyond the anorexia?

Essentialism has been defined as ‘the attachment of inherent qualities to individuals through structural belonging’ (Brown, 2005: 79) and attribution of disorder as embodied within the individual also overlooks the relational space between person and social environment. Vassilev and Pilgrim point to the importance of acknowledging lay relationships as the initial place in which attributions of mental illness are developed and that ‘psychiatric diagnosis can consequently be accused of being a form of vacuous scientific reification or of simply rubber stamping and codifying decisions made already by others’ (2007: 349). The value and outcome of therapy, however, perhaps lies less in curing the disorders it treats than in its provision of a relationship within which the client can build a coherent narrative, an experientially meaningful autobiographical account of their distress, that is constructed in the presence of another, shared and validated by the other. It is perhaps paradoxical that the very moment when postmodern views of the world facilitate multiple meaning systems and multivocality of voices, is simultaneously the moment when these very tenets of counselling psychology are in danger of being subsumed into the vast machinery of disorders’ institutions and practices?

**DISCUSSION POINT**

Why are some essentialist notions considered prejudicial, for example around disability, while others, such as diagnostic classifications, are culturally sanctioned and reified?

**Visibility of disorder**

Professional gaze settles variably on the problematization of particular clusters of behaviours that threaten contemporaneous cultural ideologies. At the turn of the nineteenth and twentieth centuries, for example, social concern about apparent declining physical health of the population was reflected in discourses of mental decline of nation and empire. This latter was given a powerful platform by the hereditarian psychiatry of Benedict-Auguste Morel (1809–1873) and Henry Maudsley (1835–1918) in France and Britain respectively. Psychiatric and educational focus settled on the emergence of a
perceived growth in the numbers of the weak-minded, that is, those on ‘the borderlands of imbecility’ (Jackson, 2000). The social construction of the feeble-minded as a group was both mirrored in, and developed by, the emergence of the eugenics movement and legitimated a discourse of necessary containment and segregation. Such individuals, however, needed first to be identified and made visible, and as Jackson suggests, ‘mental defectives were arranged on an axis of visibility in which the least visible were construed as the most menacing, a process which placed a premium on the precise recognition of the physical signs of deficiency’ (2000: 96). It was within this world-view of evidencing and making visible the signs of weak-mindedness that tests of intellectual functioning emerged. However we consider their use today, their origins are inseparable from the socio-political context in which a discourse of protection of society from invisible menace was privileged (See Chapter 5 on psychometric testing).

Thus, disorders are not simply located within the individual, but rather are socially and historically constructed in partnership with provision. With the de-institutionalization of psychiatry, Vassilev and Pilgrim suggest that ‘forms of mental disorder, once locked away out of sight and out of mind, now appear in public spaces’ (2007: 351). Consequently, dangerousness, in those deemed personality disordered, has become defined as an important construct, one which has taken central place in recent reviews of mental health legislation. Borderline personality disorder too is currently a highly visible, and somewhat feared, diagnostic category. The client who struggles to contain their emotions is not contained and held within current service provision structures and so becomes a highly visible ‘problem’ upon whom the gaze of the psychologist is turned. I will now turn to the concept of borderline personality and its history in more detail in order to illustrate this process.

**DISCUSSION POINT**

It has been suggested that we are in the middle of an epidemic of depression. Might this be alternatively constructed as the interplay of the politics of employment and the power of the pharmaceutical industry?

**THE HISTORICAL CONSTRUCTIONS OF DISORDER**

**Borderline personality disorder**

In *An Age of Anxiety*, W. H. Auden (1948) sparked the notion of human behaviour as a reflection of cultural experience and that mid-twentieth-century Western society, immersed as it was in war, Cold War and nuclear threat, was one dominated particularly
by anxiety. Reisman et al., (1961) developed this theme, suggesting that social character types may be ‘formed at the knee of society’ (1950: v). On this basis, the emergence of the borderline personality could be argued to represent a mirror to a Western society characterized by meaninglessness and emptiness, one which finds vacuous attempts at relationship in its impulsive need for shopping, work, substance misuse or other relationship substitutes (Lunbeck, 2006: 151). Certainly there is ample evidence of this in the vast, domed, marble-floored shopping malls where attempts at meeting others are played out in fear of abandonment and isolation but which, missing the mark, find only quasi-fulfilment in the substitute of the purchase. Are these not characteristics similarly identified in those labelled as having borderline personality disorder? The impulsive, often self-destructive, behaviour that gives temporary release only to be followed by emptiness, fear of abandonment and ongoing need for relationship? Thus, Rose argues, scientific psychologization may be ‘a kind of shadow play, in which the vicissitudes of knowledge claims are merely the ghostly projection of outside forces’ (1996: 104).

By contrast, DSM-IV-TR locates borderline personality disorder firmly within the individual, who displays:

A pervasive pattern of instability in interpersonal relationships, self image and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts. (APA, 2000: 710)

Nine criteria are outlined as indicative of the disorder: fear of abandonment, unstable relationships, identity disturbance, impulsivity, recurrent suicidal behaviour, affective instability, chronic feelings of emptiness, anger management problems and transient paranoid ideation or dissociative symptoms. Diagnosis requires the presence of five of these (APA, 2000: 710) Additionally, borderline personality disorder is organized as an Axis 2 diagnosis, but often associated with co-morbidity on Axis 1. The National Institute of Health and Clinical Excellence (NICE) offers evidence of the prevalence of borderline personality disorder as between 0.7 per cent and 2 per cent in the general population; about 20 per cent of in-patients in psychiatric wards; between 10–30 per cent of psychiatric out-patients; and suggests that 75 per cent of those diagnosed are women. Within the prison population it suggests estimates of 23 per cent prevalence among male remand prisoners, 14 per cent among sentenced male prisoners and 20 per cent among female prisoners (NICE, 2007: 2).

While the above discourse implicitly conveys a knowledge-based understanding of a disorder, the following statement from NICE regarding causation suggests otherwise:

Specific causes of borderline personality disorder have not been identified. Although the processes that lead to its development remain a matter of debate, it appears likely that borderline personality disorder develops through the accumulation and interaction of multiple factors, including temperament, childhood and adolescent experiences and other environmental factors. (2007)
Could the human condition itself not be attributed to these same causes? Such a
generalized portrait, Masterson (1988) suggests, has developed as a waste-basket notion,
a view supported by NICE that the ‘diagnostic label tends to divert attention from help-
ing the person to overcome their problems and can even lead to the person being
denied help’ (2004:21). Equally, concepts such as co-morbidity and axes are themselves
problematic. Co-morbidity, it could be argued, is nothing more than a reified discursive
mechanism that acts to separate the non-separable. The notion of axes also has difficul-
ties. Axis 1 is designed for the reporting of clinical conditions, and Axis 2 for the report-
ing of personality disorders or mental retardation. Yet these are separated on a
questionable assumption of Axis 2 personality disorder presentations as enduring char-
acteristics of an individual, a notion, not only empirically unsupported but one which
also requires underpinning by what is a debated conceptual understanding of the ‘nor-
mal’ personality as individualized, autonomous and enduring.

Evidence for the embryonic emergence of notions of a borderline personality dis-
order can be found in the late 1890s as, for example, in the work of Rosse, professor
of nervous diseases at Georgetown University who wrote of ‘a class of persons stand-
ing in the twilight of right reason and despair’ (1890:32). The concept of borderline
personality disorder, however, is a twentieth-century construction, one that gradually
uncoupled itself from the concepts of neurosis and psychosis within psychoanalysis
and psychiatry.

The formal history of the concept of the borderline personality is usually credited as
beginning with a seminal paper in 1938 by New York psychoanalyst Adolph Stern
(1879–1958). Stern’s paper was representative of contemporary analytic discussions con-
cerning the emergence of the ‘new patient’, that was, the apparently increasing num-
ers of clients who did not fit conventional patterns of neuroses but exhibited a broad
range of problems that found expression in problematic transferences:

There is a degree of immaturity and insecurity that is not present in the ordinary
transference neurosis with which we are familiar. (1938:63) … so intense an
affective involvement can this attachment become that attention to this aspect of
the transference takes up an inordinate amount of time. (1938:66)

Thus the rationale for conceptualization of the borderline patient was located firmly
within psychodynamic theory and the transference relationship. This relational concep-
tualization of the borderline was furthered by Main (1957), whose influential object
relations research paper ‘The ailment’ focused less on characteristics of the individual
deemed ‘borderline’ and more on the interaction between client and therapist. This
intersubjective space was, he suggested, the location where relational complexities
evolved and ‘sentimental appeal’ from the patient enmeshed with ‘arousal of omnipo-
tence’ in the nurse (1957:136).

While psychoanalytic approaches were evolving an understanding of the border-
line patient based on transferential relationships, within psychiatry the focus was on
psychopathological features of such patients. Here the borderline concept was detaching from schizophrenia. Hoch and Polatin (1949), for example, argued that the borderline patient evidenced a form of schizophrenia which they termed 'pseudoneurotic schizophrenia', based on a differential analysis of the features of psychoneuroses and schizophrenia. Similarly, Rapaport et al. (1946) conceptualized the borderline as one of 'preschizophrenic personality structure', in which patients' structured thinking (as measured by the Wechsler adult intelligence scale) was normal while unstructured thinking (as evidenced by Rorschach tests) was disordered.

However, this idea of the borderline as a vacillating position between neurosis and psychosis was transformed fundamentally by an emerging notion, introduced by Schmideberg (1959) and Kernberg (1967), of the stability of such a personality structure. While Schmideberg (1959) introduced the idea of the patient as 'stably unstable', Kernberg, argued of such patients that 'their personality organization is not a transitory state fluctuating between neurosis and psychosis' (1967: 279). He introduced the term 'borderline personality organization' as more accurately describing the specific, stable, pathological personality organization that he evidenced. This developing notion of an enduring personality structure was firmly consolidated by neo-Kraepelinian descriptive psychiatry, which, although with a different underpinning epistemology, similarly described borderline personality as 'characteristic of most of adult life' (APA, 1980: 306).

But this clinical history of the borderline personality did not develop in a social void and there are two other threads to consider. These involve the changing nature of institutional provision for the mentally ill and the necessary development of a meta-theory of the normal personality from which to hang the notion of the disordered personality. Of the first, in the early twentieth century, internationally asylums were increasingly unlocking their doors in attempts to reduce the stigma of admission which, it was argued, prevented patients and families seeking the benefits of early treatment. In England and Wales, the 1930 Mental Treatment Act enabled admission to a mental hospital without certification. Consequently, institutional psychiatry's engagement with the neuroses began in earnest.

Of the second, notions of personality emerged only as part of a wider psychological world-view in which the rather different Victorian notion of 'character' as moral, and trainable, gave way to twentieth-century conceptualizations of personality as autonomous, individualistic and stable. Within this framework contemporaneous psychological study focused on the enduring traits of 'normal' personality. Thus, historically located conceptualizations which define 'normal' similarly define the different or unusual and act to produce and confirm that deemed 'abnormal'.

Currently, this modernist world-view of personality as individualized, stable and autonomous is giving way to postmodernist views of personality as more fluid, intersubjective and embedded in relationship. Within this evolving framework, Fonagy concludes that 'the behaviours and experiences clustered around the notion of borderline personality disorder do not comprise an intractable, stable organisation but rather they
remit in relatively short periods’ (2007: 3). Links et al. (1998), for example, found that 53 per cent no longer met criteria for borderline personality disorder at seven years follow-up; Zanarini et al. (2003) found that at two years follow-up 34.5 per cent no longer met criteria, a figure which rose to 49.4 per cent at four years and at six years was 68.6 per cent, and Paris et al. (1987) found that 75 per cent no longer met criteria for borderline personality disorder 15 years after first admission. Thus, given the very uncertainties surrounding borderline personality disorder it might, as Pilgrim (2001) suggests, itself be considered a ‘disordered concept’.

Borderline personality disorder may also be seen as a disordered concept in its power to invite anxiety in health care professionals. Paradoxically, although optimism and therapeutic persistence are important in working with clients deemed to have borderline personality disorder (Linehan, 1993), optimism is lower for borderline personality disorder than either depression or schizophrenia (Markham, 2003: 607). Thus, a catch-22 situation arises whereby the very labelling of someone as having this ‘disorder’ may in itself become a predictor of likely poorer outcome for the client. If this is an experiential cluster that develops from difficult childhood experiences, which remits over a period of time and is negatively connotated with good outcome, the adoption of a descriptive psychiatric model of disorder within which to locate such experiences appears to be destructive. Perhaps twentieth-century conceptualizations of the ‘borderline’ replaced nineteenth-century conceptualizations of ‘lunatic’ whose process similarly implied a trajectory of hopeless chronicity.

Recent psychological approaches are instead adopting a life-course perspective in which such clusters are understood as problems of psychological development (Winston, 2000) with markers in abuse, neglect or otherwise traumatic childhood events that trigger disturbances of identity and selfhood. Such a conceptualization sits comfortably with postmodernism’s shift of emphasis from personality as a fixed individualized structure to a much more intersubjective relational experience and is entirely consistent with the philosophy of counselling psychology in which ‘there is a particular focus on the wide range of human psychological functioning across the life span, which leads to a consideration of ways of addressing developmental obstacles and promoting developmental change’ (BPS, 2008: 5). Fongay argues that in adopting a developmental framework ‘we are likely to see behavioural organizations that we currently term personality disorders as age specific adaptations to biopsychosocial pressures, which are best treated by developmentally specific interventions’ (2007: 3) Such psychological therapies currently include mentalization, cognitive analytical therapy, interpersonal therapies; schema-focused cognitive therapy and dialectical behaviour therapy.

In conclusion, borderline personality disorder can be argued to be a historically constructed disorder that is currently in the process of being psychologically reconstructed. By contrast, in self-harm we see distress that is currently viewed as evidence of disorder rather than disorder itself, although there are concerted efforts to have it considered as a disorder in its own right. In the next section I will use self-harm to illustrate a process by which a disorder may come to be constructed.
DISCUSSION POINT
The nature of service provision co-creates problematic behaviours. To what extent do you think this statement reflects the position with regard to clients experiencing behaviour clusters labelled as borderline personality disorder?

Self-harm

The Nice Guideline CG16 (2004) defines self-harm as ‘self-poisoning or self-injury, irrespective of the apparent purpose of the act’. Although it can occur at any age, self-harm is predominantly found in adolescents and young adults (Meltzer et al., 2002a). Estimates of its occurrence range between 4.6 per cent and 6.6 per cent (Meltzer et al., 2002a) to 13 per cent of young people aged between 15 and 16 (Hawton et al., 2002), with incidents in adolescence girls three times as many as in boys (Meltzer et al., 2002b).

Self-harm is currently viewed not as a disorder, but as a criteria of several DSM disorders; that is, borderline personality disorder, dissociative disorder and bulimia nervosa (APA, 2000). Most regularly it is seen as a part of borderline personality disorder, and approximately half of those attending casualty departments are deemed to meet the criteria for borderline personality disorder (Haw et al., 2001). Yet conceptualization of self-harm within a framework of disorder is only one cultural interpretation of many historical world-views that encompass, for example, blood-letting as communication with the gods, or later as a treatment for the insane. Uncritical acceptance of terminologies can have a tendency to be played out on the person of the client who subsequently carries the burden of that social belief for society, in this instance the client who self-harms, and in this section I will focus particularly on cutting, the most commonly used means of self-harming (Hawton et al., 2002).

Jenny had a history of anorexia in her teenage years, which subsequently developed into bulimia. She experiences this latter as a dreadful burden and is self-deprecating about being unable to restrict her eating anymore, something on which she had placed a high personal value. In addition to making herself sick, Jenny cuts herself on a regular basis, along her arms, her stomach and the tops of her legs. She is clear that this is not about suicide, or attention seeking – although the latter is something she has been told by others – but about the sense of relief that she gets when she cuts herself, an effect which she describes as emotionally anesthetizing.

It seems therefore that both professional and lay perceptions are framed by a medical model. The former view cutting as likely evidence of disorder while the latter, as
evidenced by Jenny’s understanding, is articulated as anaesthesia. It is within this interplay of lay and professional discourses that cultural ideologies develop and are mutually reinforced. Historically, however, cutting has been framed within discourses of communication, religiosity and treatment. Blood-letting has been in existence as long as recorded information has been available and evidence for the use of phlebotomy by the ancient Egyptians, for example, has been found in the 65-foot long Ebers Papyrus (Ventura and Mandeep, 2005). While detailed explanation for its use by the ancient Egyptians is unavailable, argument has been made that the importance the river Nile, and its annual flooding, to the survival of the people was mirrored by bodily notions of channels and tributaries and their management through the use of phlebotomy (Thorwald, 1962).

Crossing the ocean to the ancient Mesoamerican civilization of the Mayans, the process of blood-letting was again central to cultural belief, this time in the form of communication between the people and their gods. An understanding of Mayan beliefs and their gods is enormously complex and well beyond the scope of this chapter; communication with the gods, however, was central to a belief system in which the survival of the people depended on relationship and communication with their gods. Kings, nobles and priests were ritually bled, their blood mixed with bark paper, the mixture burnt and the smoke ‘nourished the gods with the divine forces they had implanted in the human body so aligning the earthly world with the supernatural realm’ (Sokolow, 2002: 25).

Ancient Greek society, on the other hand, framed blood-letting within a structure of humoral medicine. The fundamental theoretical constructs of the Hippocratic school stressed the need for balance and complimentarity between the four world elements of fire, earth, water and air, and the four body humors of blood, phlegm, bile and black bile. Health within this understanding became a matter of balance both within the body and between body and environment. Good health depended on a balance of the humors. Intervention, with the aim of rebalancing, was the remit of the physician and could be achieved by the prescription of diet, rest, exercise or, in a case of plethora (excess of humors), by blood-letting or purging of the digestive system. Thus, for the Greeks, the concept of blood-letting was very firmly conceptualized as a treatment for illness within a framework of humoral medicine.

Humoral medicine long remained the mainstay of medical understanding within Western cultures and, in the medieval period, became intertwined with Christian constructs. The notion of priest physician was integrated with understandings of illness and pain as representations of the suffering of Christ. In consequence, between the ninth and sixteenth century, periodic blood-letting was part of the regimen of religious communities where men and women were bled at regular intervals throughout the year for spiritual prophylaxis, their blood representative of the blood of Christ.

Humeral notions of blood-letting were also influenced by astrological notions during the medieval period and prophylactic blood-letting, as a form of health promotion, was also part of a way of life for those outside the religious communities who were susceptible to plethoric ailments, that is, ones of excess and imbalance of particular humours which threatened the maintenance of a healthy balance in the body. Timings
of bleedings were specified in the many medieval health regimes, and such advice is evidenced in the excerpt below from the most well-known of these documents, the Regimen Sanitatis Salernitanum:

These are the good months for phlebotomy – May, September, April –
Which are lunar months just as are the Hydra days.
Neither on the first day of May nor the last day of September or April
Should blood be drawn or goose be eaten.
In the old man or in the young man whose veins are full of blood
Phlebotomy may be practiced in every month.
These are the three months – May, September, April –
In which you should draw blood in order to live a long time. (Flarington, 1920: 149)

Subsequently, in the development of modern medicine humoral notions of excesses and blood-letting conflated with understandings of madness. Voltaire (1764), for example, described the treatment of madness as ‘baths, blood-letting and diet’ and Pinel (1806) argued that ‘It is a well established fact, that paroxysms of madness are in many instances prevented by a copious bleeding’ (both cited in Morgan and Lacey, 1998: 484). Blood-letting, therefore, far from being considered a manifestation of disorder, was variously framed by notions of communication with the gods as treatment within classical and medieval humoral medicine and as a means of managing madness.

As humoral medicine declined, however, so the process of phlebotomy became increasingly distrusted and marginalized, although this was by no means synonymous with the development of notions of self-harm as we currently understand it. Although French psychiatrist Esquirol (1772–1840) alluded to ‘suicide simule’ (Berrios, 1996: 445), self-harm in the nineteenth and early twentieth centuries was generally undifferentiated as a concept, remaining encapsulated within legal and religious understandings of suicide as a criminal and moral offence. The conceptual uncoupling of self-harm from suicide began in the second half of the twentieth century (Stengel and Cook, 1958), influenced by the incorporation of the neuroses into psychiatry and by the decriminalization of suicide in 1961. Conceptual separation of attempted suicide was given a political platform in the Ministry of Health Circular (1961) which highlighted that for every one completed suicide there were an estimated six attempted suicides. The latter, it suggested, should be treated as a medical and social problem, with all cases presenting to hospital being offered psychiatric assessment. Revised legal and health service frameworks therefore legitimated delineation of attempted suicide, which began to attract terms such as deliberate self-injury or self-poisoning (Kessel, 1965), parasuicide (Kreitman et al., 1969) and deliberate self-harm (Morgan, 1979).

Potter et al., (1999) suggest that ‘truth, certainty and evidence may be seen as situated practices’, and with discursive legitimation of self-harm came empirical research. This supported the construction of a differentiated parasuicide population, whose predominant age range was 20–29, closely followed by the under-20s. Consequently, an
embryonic concept of self-harm emerged that was delineated around the notion of intent (Kessel, 1965), and interest rose in why this newly perceived group was increasing in incidence while simultaneously completed suicide rates were falling.

Conceptual construction continued apace with the hegemonic abbreviation of deliberate self-harm to its initials DSH as the badge of common medical understanding. In addition, the shifting status of blood-letting towards accepted discourse of disorder was concurrently evidenced in DSM-III-R (APA, 1987: 347) where as ‘recurrent suicidal threats, gestures, or behaviour, or self mutilating behaviour’ it became one of eight criteria of borderline personality disorder, although interestingly the status of intent has been removed.

A further reframing of blood-letting from communication with the gods through its conceptualization as a treatment to one of disorder is currently underway in arguments that these behaviours should be considered a DSM disorder in themselves. American psychotherapist Steven Levenkron, for example, argues that ‘in the most severely pathological forms, self-mutilation can be classified using the following diagnostic criteria’:

- Recurrent cutting or burning of one’s skin.
- A sense of tension present immediately before the act is committed.
- Relaxation, gratification, pleasant feelings and numbness experienced concomitant with the physical pain.
- A sense of shame and fear of social stigma, causing the individual to attempt to hide scars, blood or other evidence of the acts of self-harm.


Self-harm is not (yet) a diagnostic category, although the above classification clearly attempts to define it as such. Yet if loss of blood engenders a sensation that is variously interpreted according to religious experience, treatment effects, or as self-induced anaesthesia, then apparent decontextualization of the notion of disorder is meaningless. Disorder is itself a cultural interpretation.

This is not to detract from the very real suffering associated with the need to let blood in this way, nor the need to offer help to alleviate such distress. History, however, suggests we loosen the discursive armour of expert treating disorder and, as the National Inquiry into Self-Harm among Young People invites us, ‘remain rooted in the core professional skills and values of empathy, understanding, non-judgemental listening, and respect for individuals’ (Brophy, 2006).

**DISCUSSION POINT**

What does self-harm mean to you, and how does this understanding impact on your perceptions of your clients?
CONCLUSION

Categorization is a psychological process that has long since engaged humanity in its attempts to impose sense on the environment in which it found itself (Haslam, 2000). However, that we make sense of distress through a medicalized classification of disorder is framed by our own ‘Weltanschung’, and mental disorder is a conceptual framework and not a natural kind. By the end of his career, Kraepelin himself suggested that in categorically distinguishing manic depressive psychosis from dementia praecox ‘the suspicion remains that we are asking the wrong questions’ (Kraepelin and Beer, 1992: 527). Perhaps we too are asking the wrong questions. Paul Tillich (1988: 118) coined the term ‘thingification’ to describe how a culture may objectify its people, alienating them from humanness. In considering therapy as the treatment of mental disorders, are we not ‘thingifying’ counselling psychology?

I have attempted to offer some arguments for the constructed nature of the concept of disorder, its subdivisions into reified packages of experience and the implications of this for therapeutic process. Vassilev and Pilgrim suggest that ‘there is no single theory that can tell us everything about a phenomenon; the best we can hope for is to zoom in and out and change the angles of our observation to improve our understanding’ (2007: 350). In this chapter I have attempted to zoom in on a historical perspective in order to invite you to critically evaluate and debate the conceptual phenomenon of disorder and its impact on the nature of therapeutic process.

REFERENCES


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