Nursing Inquiry 2008; **15**(3): 216–223

Feature

Personality disorders: illegitimate subject positions

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Accepted for publication 27 April 2008

CROWE M. *Nursing Inquiry* 2008; **15:** 216–223

Personality disorders: illegitimate subject positions

The diagnosis of personality disorder is common in mental health nurse settings and is a term often used without critical consideration. In clinical practice, the term *personality disorder* has pejorative connotations, which arise out of the way in which these behaviours are constructed as behavioural rather than psychiatric. The discursive construction of categories of personality disorder are inculcated into clinical practice and become taken-for-granted by those in practice culture. The construction of some personalities as disordered and, therefore, illegitimate becomes natural. This paper provides a critical analysis of the diagnosis and suggests an approach to mental health nursing care that is more legitimising for those people who receive psychiatric diagnoses.

Key words: critical theory, mental health, nurse–patient relationships.

Attempts have been made to categorise personality or character since the Ancient Greeks with Hippocrates suggesting that certain temperaments were associated with an excess of one of the four humours — blood (sanguine), yellow bile (choleric), black bile (melancholic) and phlegm (phlegmatic). The word comes from the Greek *persona* literally meaning 'mask' but mask did not mean disguise in Greek theatre, but rather it was used to typify a character. The interest in naming and classifying personality attributes has continued through to contemporary clinical practice. However, it seems that with attempts to classify the fundamental attributes of personhood, some personality traits have received more attention in psychiatric discourse than others. The effect of this attention has been to prescribe some subject positions as illegitimate.

This paper takes a position that is closely aligned with elements of what Pilgrim (2007) describes as radical constructivism because it challenges the assumption of abnormality. It assumes the subject precedes the object and emphasises diagnoses as context-specific human products. Diagnoses are deemed to be socially negotiated outcomes that reflect the cognitive preferences and the vested interests of the negotiators. The position taken in this paper acknowledges mental distress but strives to accept multiple ways of being in that distress without attributing fundamental abnormality to those subject positions. Although the behaviours associated with the distress may transgress social and cultural norms, they do not implicate the whole self. As Pilgrim (2007) notes, physical illnesses happen to us, whereas if we are mentally ill, the whole self is implicated.

The implication of abnormal selfhood is culturally determined. Discourses and institutional practices determine the legitimacy of certain subject positions while also invalidating others. Foucault (1988) has described the relationship that individuals have with the self and the formation of oneself as a subject as 'technologies of the self'. He proposed two principal elements to these technologies: theory (the attitude of self one wishes to employ and practice) and operations (usually directed at the body which change and shape the self along the trajectory of desired attitude). Through these technologies, the individual becomes an active participant in self-disciplinary procedures. Foucault suggests that the self is shaped by particular ways of thinking about the world through sets of culturally meaningful practices. He proposed that this required constant re-evaluation of the self

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against culturally determined performances of subjectivity. These subject positions can be regarded as those modes of being that constitute a sense of self. People have a range of subject positions from which they can respond to others. The performance of particular subject positions can be regarded as particular intersections of culture, gender, class and race. A sense of self is constituted by the repeated performance of particular subject positions and meaning is attributed to these performances. The meanings that can be attributed to subject positions are ascribed by cultural and social norms which through dominant discourses legitimise some positions and not others.

Wang (2004) has identified that western cultures hold a faith in the inherent separateness of distinct persons whose behaviour is organised and made meaningful primarily by reference to one's own internal repertoire of thoughts, feelings and actions rather than by the thoughts, feelings and action of others that is common to other cultures. In his study of children from European American and Chinese cultures, he found that self-constructs were culture specific and conceptualised along four dimensions: unique individual attributes vs. social categories; extent to which the self is viewed in a self-serving manner; the extent to which the self is composed of abstract dispositions vs. specific situation-bound characteristics; and the extent to which the self is characterised by inner personality traits vs. overt behaviours.

What could it mean for an individual in western culture if she/he is culturally defined as being fundamentally flawed at an essential level of the self — personality? If this self is constructed as illegitimate? This paper will critically analyse the diagnosis of personality disorder as it is described in the *Diagnostic and statistical manual–IV* (DSM-IV, American Psychiatric Association 1994). An exploration will also be made of what performances of subjectivity are endorsed by our culture by using the criteria for personality disorders as a reference point for abnormality. Mental health nurses regularly care for people who have received a diagnosis of personality disorder; therefore, a consideration of practice issues will also be addressed.

NURSING CONCERNS

There has been considerable interest in personality disorders in the nursing literature since the 1990s (Crowe 1996; O'Brien and Flote 1997; Mercer, Mason and Richman 1999; Nehls 2000; Weber 2002; Crowe 2004; Glen 2005; Perseius et al. 2005; Bjorklund 2006). The general theme throughout this literature is that we need to re-consider a psychiatric approach to care and as nurses focus more on the client's experience of distress. It has been argued that the psychiatric model provides nurses with limited treatment options and facilitates feelings of inadequacy, anger and resentment towards clients who have received this diagnosis (Nehls 1998; Krawitz and Watson 1999; Crowe 2000b). Warne and McAndrew (2007) have suggested that categorical labels evoke a wide range of conscious and unconscious responses and that mental health nurses need to recognise the defence mechanisms involved. Feely, Sines and Long (2007) has proposed that diagnostic manuals, which act as points of reference for professionals, encourage healthcare staff to proffer medically related diagnoses and mental health nursing has contributed actively to this process.

Wright, Haigh and McKeown (2007) have proposed that individuals with personality disorder provoke a range of negative emotions, a dimension of which is the moral judgments that are brought to bear in the appraisal of people and their behaviour. When clinical discourse becomes laced with morality tales and value judgements, individuals are casted as undeserving of care and can fail to achieve the status of patients in the same way as others with different diagnostic labels. Bowers (2003) has proposed that mental health nurses need alternative and viable schemas for the interpretation of behaviours associated with the diagnosis of personality disorder. She suggests that these approaches should be less judgmental and drawn from psychological approaches. It has been proposed that a diagnosis of personality disorder evokes a moral judgment (Glen 2005) that strongly influences how nurses respond to the diagnosis.

PERSONALITY DISORDER

The DSM-IV (p. 629) defines personality disorder (PD) as

> An enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.

In the DSM-IV, the PDs are identified as axis II disorders and grouped into three clusters based on descriptive similarities. Cluster A includes paranoid, schizoid and schizotypal: individuals with these disorders often appear odd and eccentric. Cluster B includes antisocial, borderline, histrionic and narcissistic: individuals with these disorders often appear dramatic, emotional or erratic. Cluster C includes avoidant, dependent and obsessive–compulsive: individuals with these disorders often appear anxious or fearful (p. 630). This suggests that subject positions imbued with eccentricity, emotionality, exaggeration, theatricality or timidity can be regarded as abnormal and requiring psychiatric intervention. It has been suggested that the use of categories and

axes diminishes the in-depth scrutiny of mental processes and contextualises the disorders horizontally (Rogler 1997) and therefore at a superficial level. Despite the suggested distinctions between the axes, the DSM-IV also asserts that the first two axes may not be 'fundamentally different' (p. 26), thus confirming the methodological confusion inherent in the system of classification; for example, where is the line to be drawn between social phobia and avoidant PD, or between schizophrenia and schizotypal PD, or between obsessive–compulsive disorder and obsessive PD?

It is highly debatable whether a substantial amount of the criteria provided as evidence of PD represent clinically significant distress or impairment in functioning. The following are some examples where it is difficult to understand how the behaviour is either distressing or impairing to the point of requiring psychiatric intervention, for example:

- Schizoid PD (p. 568): 'appears indifferent to the praise or criticism of others';
- Schizotypal PD (p. 645): 'behaviour or appearance that is odd, eccentric or peculiar';
- Histrionic PD (p. 568): 'consistently uses physical appearance to draw attention to self';
- Narcissistic PD: 'is interpersonally exploitative, that is, takes advantage of others to achieve his or her own needs';
- Paranoid PD (p. 637): 'persistently bears grudges';
- Antisocial PD (p. 651): 'consistent irresponsibility';
- Dependent PD (p. 669): 'urgently seeks another relationship as a source of care and support when a close relationship ends';
- Obsessive–compulsive PD (p. 672): 'is excessively devoted to work and productivity to the exclusion of leisure activities and friendships'.

Because the text claims to be atheoretical, it provides no rationale for why some traits can be regarded as abnormal and it also fails to take the person's context into consideration. It would seem reasonable that someone might act in an exaggerated manner when under considerable stress. The traits mentioned above could be regarded as more of a social rather than psychiatric concern.

An anomaly in a text that bases the measurement of disorder on the quantity of criteria present is that the text also requires that some criteria are given more significance than others; for example, 'A failure to conform to social norms leading to repeated arrests' is regarded to be of higher diagnostic importance than 'a lack of remorse or reckless disregard for the safety of others' (criteria for antisocial PD, p. 650). 'Frantic efforts to avoid abandonment' and 'a pattern of unstable and intense interpersonal relationships' are regarded as being of higher diagnostic importance than 'recurrent suicidal behaviour' or 'severe dissociative symptoms' (criteria for borderline PD, p. 654). This weighting of some symptoms as more significant than others suggests a bias towards censuring more socially disruptive behaviours rather than personally distressing ones.

The diagnostic criteria also repeatedly count what could easily be regarded as the same symptom as two different criteria; for example, how is it possible to differentiate a 'grandiose sense of self-importance' from 'showing arrogant or haughty behaviours' (p. 661)? Or is 'needs others to assume responsibility' different from 'urgently seeks relationships as a source of care and support' (p. 668)? Or 'is preoccupied with details, rules, lists, order, organisation or schedules' different from 'shows rigidity and stubbornness' (p. 672)?

The diagnosis of PD is generally made by self-report or by behavioural observation. Cooper (2004) has noted that all observations are theory laden, so the preferences of the observer need to be identified. The observer's preferences are constructed by self-interest, professional interest and external interests particularly those of the health insurers and researchers. The descriptions of psychiatric symptoms are socially constructed for particular purposes.

AUTHORITY

The DSM-IV asserts its claims for authority by exercising its access to 'expertise': the method used in compiling the classification system in a 'three-stage empirical process that included (i) comprehensive and systematic reviews of the literature; (ii) re-analyses of already-collected data sets; and (iii) extensive issue-focused field trials' (p. xvii). Rose (1996) has suggested that expertise is reliant upon particular types of knowledge colonised by professions. He described professions as 'interest groups seeking to further their own financial and moral status by securing exclusive control over the terms in which particular social concerns are framed, and over the loci of power within various social apparatus' (Rose 1996, 84). Social power is attained through claims to possess knowledge and technical skills not available to others.

The assertion of expertise that is embedded in its history and its connections to other discourses underpins the DSM-IV's claims to authority. In describing the history of personality disorders in the context of the DSM-IV, Millon and Davis (1995, 3–28) describe how the first clinical interest in personality arose when psychiatrists at the end of the 18th century were drawn into the age-old arguments concerning free will, and whether certain moral transgressors are capable of understanding the consequences of their acts. The first psychiatrist to organise personality into categories was Kraeplin in 1913; however, many theorists began proposing

different classificatory systems until attempts to reign in the confusion was a driving force behind the DSM-1 (American Psychiatric Association 1952). The original conceptualisation of personality disorders in the DSM was markedly different to the current approach. It focused less on categories of abnormality and more on disturbance of a less-enduring nature. This text had five subclasses of personality disorders — personality pattern disturbances, personality trait disturbances, sociopathic personality disturbance, special symptom reactions and transient situational personality disorders.

Subsequent revisions of DSM were driven by the push for recognition of more disorders and to align it with the International Classification of Diseases (World Health Organization 1994). The revision which pre-empts the current text, and was the most conceptually significant, was the DSM-III (American Psychiatric Association 1980) which was explicit in its aim to expunge theoretical biases and to establish a separate axis for personality disorders. As Mayes and Horwitz (2005) have identified, the basic transformation in the DSM-III was its development and use of a model that equated visible and measurable symptoms with the presence of disease. The symptom-based model allowed psychiatry to develop a standardised system of measurement. Such a standardised measurement benefited numerous interests.

Many issues converged to force psychiatrists to consider changing definitions of mental disorders and what constituted optimal treatment for them: psychiatry's marginal status within the medical profession, the increasing reluctance of insurance companies and the government to reimburse long-term talk therapy, the need to treat formerly institutionalised seriously mentally ill persons in the community, the growing influence of medication treatments, and the growing professional threat from non-physicians (Mayes and Horwitz 2005). The DSM-III contributed significantly to a biological vision of mental health — which stresses the neurosciences, brain chemistry and medications — superseding the psychosocial vision that had dominated for decades. It created new and enormous incentives for pharmaceutical companies to create new drugs. The DSM-III positioned psychopharmacology on a growth trajectory that various institutions — insurance companies, managed care organisations, pharmaceutical companies and the government — propelled significantly in subsequent years as they responded to the DSM-III's new diagnostic guidelines and the research incentives it fostered (Mayes and Horwitz 2005).

CHALLENGES

Tyrer (2005) has identified that there is no satisfactory way of deciding on the boundary between normal and abnormal personality. Deciding when these problems constitute a 'disorder' or remain within normal variation is an arbitrary decision, and it is quite wrong to think that those with personality disorder are fundamentally different from the rest of the population (Tyrer 2005). Despite its claims to scientificity, the apparent lack of scientific rigor in the DSM-IV has been challenged by many authors (e.g. Millon and Davis 1995; Kutchins and Kirk 1997; Pilgrim 2001; Horwitz 2002) and there are a considerable number of problems related to the reliability, validity, comorbidity, diagnostic instability and the poor treatment specificity of the PD diagnoses. Mirowsky and Ross (2002) have identified that calculation of disorder from the enumeration of a set of symptoms has significant implications for those who fall within the required quantity of symptoms and for those who just fail to meet the requirement.

As Brendel (2002) has noted, the way in which psychiatry names and describes a disorder inevitably leads to decisions about how to treat the disorder. Diagnoses are not only a form of communication but because they construct a concept in a particular way, they are techniques of professional control (McPherson and Armstrong 2006). However, despite claims to expertise and authority, psychiatric diagnoses are not determinate and fixed but rather open to other possible explanations. Formal psychiatric diagnoses do not fully capture a patient's unique situation, set of experiences or adaptive practices (Brendel 2002). If we are to understand another person, we need to spend time getting to know them in a therapeutic relationship.

ILLEGITIMATE SUBJECT POSITIONS

Previous work has identified that the text of the DSM-IV constructs normal subject positions as unitary, productive, rational and moderate (Crowe 2000a). The criteria for the PDs reflect these transgressions against normative expectations:

- Lack of moderation — 'excessive social anxiety that does not diminish with familiarity' (schizotypal PD, p. 645); 'affective instability due to marked reactivity of mood' (borderline PD, p. 654); 'inappropriate intense anger' (borderline PD, p. 654); 'shows self-dramatisation, theatricality and exaggerated expression of emotion' (histrionic PD, p. 658); 'exaggerates achievements or talents' (narcissistic PD, p. 661).
- Lack of productivity — 'repeated failure to sustain consistent work behaviour' (antisocial PD, p. 650); 'avoids occupational activities that involve significant interpersonal contact' (schizoid PD, p. 664); 'has difficulty initiating projects or doing things on his or her own' (dependent

PD, p. 668); 'shows perfectionism that interferes with task completion' (obsessive–compulsive PD, p. 672).

- Lack of unitariness — 'failure to conform to social norms with respect to lawful behaviours' (antisocial PD, p. 649); 'ideas of reference' (schizotypal PD, p. 645); 'identity disturbance' (borderline PD, p. 654); 'requires excessive admiration' (narcissistic PD, p. 661); 'needs others to assume responsibility for major areas of his or her life' (dependent PD, p. 668).
- Lack of rationality — 'suspects without sufficient basis that others are exploiting, harming or deceiving him or her' (paranoid PD, p. 637); 'odd beliefs or magical thinking that influences behaviour' (schizotypal PD, p. 645); 'is over conscientious, scrupulous and inflexible' (p. 672); 'has difficulty making everyday decisions' (dependent PD, p. 668); 'believes he or she is "special" and unique' (narcissistic PD, p. 661).

It can be inferred from this that a normal personality must therefore take up subject positions that display these expected norms of moderation, productivity, unitariness and rationality. These expectations are inherently biased in relation to gender, class and culture (Crowe 2000a). The text itself has identified that three of the PDs are diagnosed more often in females (dependent, histrionic and borderline). Six of the PDs are more commonly diagnosed in males (paranoid, schizoid, schizotypal, antisocial, narcissistic and compulsive). To be consistently productive, moderate, unitary and rational would seem impossible to maintain in all contexts. If the person should come under psychiatric surveillance as a consequence of distressing life experiences, she/he is vulnerable to a pejorative diagnosis that has enduring implications.

The way in which the discourse on PD classifies certain behaviours is part of a dialectical process in which cultural norms identify some behaviours and experiences as unacceptable. Rose (1999) suggests that psychological discourse offers particular ways to understand personhood and particular techniques for managing the self that allow a person to be the self-steering, responsible free citizen governed by consent rather than coercion. This facade of choice, agency and self-responsibility permeates clinical responses to PD — there is an implication that the person is responsible for her/his behaviour and must therefore control it. This is a significant incongruence within psychiatric discourse — PD is constructed as a neurobiological disorder yet the person is held responsible for it. In clinical practice, the term PD has pejorative connotations which arise out of this expectation that the person can control their behaviour if they choose to. The discursive construction of categories of PD are inculcated into clinical practice and become taken for granted by those in that practice culture. The construction of some personalities as disordered becomes taken for granted and the natural order of things.

The process of rendering subject positions as illegitimate occurs through two discursive steps: (i) the construction of a set of traits is identified as a disorder and therefore abnormal. Illegitimacy is conferred upon any subject given a psychiatric diagnosis because faultiness and incompetence are assumed in the process. (ii) Not only is the person with a diagnosis of PD constructed as abnormal (as is anyone with a psychiatric diagnosis) but she/he is assumed to be faulty at the fundamental level of personhood. Their subjectivity is abnormal. It is therefore a process of double illegitimacy with the discursive construction of PD meaning a fundamentally flawed person. This effectively undermines the right of such damaged subjects to care and treatment. The consequence of this is a clinical attitude of pessimism about the potential for effective treatment.

LEGITIMISING SUBJECT POSITIONS

What does this mean for mental health nursing practice? There is a strong argument for the removal of these diagnoses from the DSM. This is not to deny the very real distress experienced by some people that becomes labelled as PD. Nursing is a discursive practice that takes place in an environment of discursive complexity with psychiatric discourse competing with other discourses, for example, managerialism. Despite this, there have been, as noted above, a range of innovative nursing interventions that focus on the behaviour rather than the person (e.g. Buchanan-Barker 2008).

In clinical practice, the diagnosis of PD is often comorbid with other mental disorders particularly affective and anxiety disorders. The axis I disorders are usually the focus of treatment and it is interesting to note how frequently the symptoms are constructed as PD fade away when the affect or anxiety is treated. There are no recognised treatments for PDs other than borderline, so it seems unethical to construct a person's behaviour in this way and then have no treatment response.

Borderline personality disorder is the exception on a number of levels. It is a PD that brings people to psychiatric services without the person necessarily having an affective or anxiety disorder. It is also a PD for which there are a number of treatment options (Bateman and Fonagy 2003; Bateman and Fonagy 2004; Hazelton, Rossiter and Milner 2006), and is a PD that frequently has an identifiable antecedent — sexual or other abuse. For these reasons, there is a strong argument for these symptoms to be reconstructed as

complex post-traumatic stress disorder (McLean and Gallop 2003).

Because it is unlikely that PDs will be removed from the DSM in the next version due in 2010, mental health nurses need to reconsider the use of this diagnosis and the way in which they respond to people given the diagnosis. The diagnosis has disparaging connotations that may disguise the issue such that it may be used when a person does not control their behaviour in the way the nurse considers appropriate or does not respond to nursing intervention within a particular timeframe or that the nurse finds the person's behaviour difficult, challenging, confronting or non-compliant. Instead of resisting these behaviours, nurses need to consider the person's experience and facilitate the development of less distressing subject positions.

The use of psychiatric discourse limits the practice of mental health nursing to medication dispensers and agents of social control in relation to those people whose behaviour is so challenging and disturbing. It is being proposed that a discursive approach to providing mental health nursing care for someone experiencing overwhelming distress is a more legitimising approach to care. This involves the following aspects:

- recognising the nature of the distress;
- making connections between how the person has learned to cope with their fears and her or his current distress;
- situating the fear and distress in its sociocultural context;
- promoting acceptance of difference;
- exploring alternative subject positions for managing distress.

The aim of this approach is to assist the person experiencing overwhelming distress to develop alternative subject positions that demonstrate an awareness of the sociocultural context of the development and expression of that distress, and represent a self-image that is more emotionally aware and can engage in interactions with others as an equal participant. The focus of these interventions is to encourage awareness of how the person positions her- or himself in relation to others, and the patterns of interaction that perpetuate the feelings of distress.

Recognising the nature of distress

The recognition of the nature of the person's distress can begin by seeking information about the person's feelings and relationships with others, particularly incidents in which their distress is triggered. This recognition is part of a psychotherapeutic process of recognising the person and accepting their differences while helping that person to recognise and accept her or his self and develop alternative, more fulfilling subject positions. If an individual's behaviour is recognised as symptomatic of a personality disorder which suggests a lack of hope, this may intensify the person's distressing feelings.

Establishing connections

The nurse can then help the person to make connections between the sources of distress and the impacts of this on her or his life. This involves helping the person to put into words something that is often very painful and requires a trusting relationship with the nurse. This involves a trust in their skills and their ability to contain strong outpourings of feelings. The establishment of connections also involves enabling the person to see how patterns from the past shape and give meaning to the present. This involves exploring how apparently disconnected present-day experiences, behaviours and feelings may be connected to past fears and anxieties.

Situating the distress in its sociocultural context

The nurse can assist the person to explore their experiences of distress within the sociocultural context that they occurred. This is a sociocultural context in which some subject positions are apportioned more value than others. Such positions reflect the western cultural norms of unitariness, rationality, productivity and moderation. Feelings of distress may be reinforced by considering the problem as faulty individual functioning without taking into account the person's sociocultural context.

The nurse can begin this by raising questions about the values and beliefs that underpin the person's perspective of distressing events to enable the person to begin their own questioning. This questioning can be used to explore how these culturally imposed values and beliefs may be contributing to or maintaining feelings of distress.

Promoting the acceptance of difference

The nurse could help the person accept difference in the way she or he may experience a sense of self and the attributions they make about others. An initial step in this process is to help the person identify and name these feelings. The nurse can encourage the person to explore the expectations that she/he has of others and begin to hypothesise about what others may expect of them. The emphasis is on helping the person to develop the capacity to reflect on their own and others' behaviour and interactions. An important aspect of this process involves helping the person to manage ambiguity and contradictions in their relations with others.

Exploring alternative subject positions

This nursing approach can also provide the person with the opportunity to engage with different subject positions in her/his interactions with others. These subject positions can be regarded as those modes of being that constitute a sense of self. People have a range of subject positions from which they can respond to others. The performance of particular subject positions can be regarded as particular intersections of culture, gender, class and race. A sense of self is constituted by the repeated performance of particular subject positions and meaning is determined by the subject positions to which people have access. The meanings that can be attributed to subject positions are developed through relations with others and the experiences of acceptance or rejection. The experimentation with alternative subject positions within the support of the nurse–patient relationship allows for this creation of meaning.

Although this approach may be feasible in nurse–client relationships where the nurse has the time, environmental support and resources available, it may need to be modified as set of underlying principles in a range of more acute settings.

This approach to mental health nursing care acknowledges Wright, Haigh and McKeown's (2007) assertion that nurses need to challenge alienating constructions and re-establish supportive and caring approaches grounded in purposeful, therapeutic interpersonal relationships. It involves a re-engagement with the person rather than the diagnosis. They suggest that there is a need to reconstruct personality disorder in terms of the available alternative theoretical constructs that regard it as part of human development, perhaps linked to psychological harm or trauma. This opens up possibilities for compassion and empathy.

CONCLUSION

The ideological tactic of psychiatric discourse is to link its claims to scientific and medical discourse. Its rhetorical tactic is to utilise a textual voice of authority by supporting its claims with reference to a scientific method and the development of axes and categories to substantiate its claims to expertise. The strategic tactic of the DSM-IV is to link its diagnostic categories to insurance funding, research funding and healthcare service funding. The discourse on PD represents a particular social reality regarding the performance of particular subject positions that demonstrate productivity, rationality, moderation and unitariness.

The classification of personality as disordered is a process fraught with problems with significant social and cultural consequences. As it currently exists, it is a process imbued with power differentials which provides some professional groups with greater power and influence and subsequent economic advantage. An alternative may be to look beyond the category and pay more attention to the nature of the individual's distress.

Personality disorder diagnoses are an example of the discursive construction of a particular entity that once named is taken for granted in clinical practice. However, this paper has argued that these constructions are culturally determined, and are therefore not fixed truths. The main concern of this critical analysis was to open up discussion among mental nurses of alternative ways of understanding. Such understandings will also be discursively constructed but it is hoped that they will place the person's experience of distress as the focus rather than the system of classification.

If mental health nurses attend to the person's story and their experiences while also being cognisant of how they have come to construct these experiences within psychiatric discourse, it is possible to engage with that person in a way that could offer an effective avenue for change to occur. Latent potential for change can become lost to opportunity when the nurse becomes bound to preconceived notions of outcomes associated with the diagnosis of PD. The nurse can legitimise the person's experience by taking a discursive approach to the therapeutic relationship.

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