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"It Comes Across as A Slapped-On Band-Aid":

A Critical Discourse Analysis of Therapy Experiences Shared by People with Borderline Personality Disorder

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ABSTRACT

Borderline personality disorder (BPD) is a highly stigmatized psychological label that is disproportionately assigned to cisgender women, LGBTQ+ persons, and/or survivors of childhood trauma. While current research identifies psychotherapy as the 'first line' treatment practice for addressing the needs of this population, several literature reviews have found that roughly half of those with BPD who attend therapy do not respond or continue to face significant levels of emotional distress following treatment. There has been very little research dedicated to understanding the lived experiences of therapy nonresponse among those diagnosed with BPD. As such, my paper has sought to address this gap by examining how people with BPD construct their personal lived experiences in therapy outside of formal research contexts. Using a critical discourse analysis (CDA) methodology, combined with theory from Mad Studies, I analyzed 60 discussion posts from one popular BPD-related group on Reddit. Ultimately, the results of my study suggested that people with BPD may experience therapy in a variety of diverse ways. In particular, participants' descriptions of their personal therapy experiences fell into five major themes: Therapy is not meeting personal needs, therapy is invalidating, if not infantilizing, therapy is hard work, therapy is an individual responsibility, and therapy is masking. Situating these themes within Mad theory and the existing BPD-literature, the final chapter of this paper aims to both complicate and offer potential explanations for why people with BPD express such perspectives. Finally, my paper also concludes by highlighting some of the implications that my findings hold for future social work practice.

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Chapter 1: Introduction

My interest in this specific area of research began two years ago when I stumbled across an article posted to the website Mad In America, titled "Trauma Survivors Speak Out Against Dialectical Behavioral Therapy (DBT)" (Donaldson, 2022). I had been taking an elective in psychology for my undergrad at this time and was learning about the symptomatology and recommended treatment practices for individuals who meet the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.; *DSM-5-TR*; American Psychiatric Association [APA], 2022) criteria for borderline personality disorder (BPD). All of the professors and peer-reviewed writings that I had encountered up until that point had sold me on the incredible, transformational nature of psychotherapies like DBT for addressing the complex needs of those who are assigned this diagnosis; yet, here was an article that complicated everything I *knew* to be true. That is, much to my initial surprise, a number of trauma survivors with BPD were pushing back against dominant narratives, likening their first-hand experiences in DBT to abuse.

What I found most interesting in their stories however was that survivors were not just critiquing the harmful attitudes or behaviours of a few individual clinicians, but rather, they appeared to be challenging the very treatment practices, theories, and epistemological frameworks that therapies such as DBT are built upon. Since this point, I have found myself thinking more broadly about this apparent gap between what clinical research states and the actual lived experiences of psychiatrized people. In particular, my research is critical of the way that we, as a society, are responding to those who report experiencing significant distress. Especially those whose emotional expressions do not conform to socially constructed standards for what is 'healthy.'

Considering the Social Impacts of Psychological Labels like BPD

Despite more and more psychiatric survivors detailing the harms they experienced at the hands of psychiatric interventions, it tends to be the voices of those who report positive mental healthcare experiences that get featured in the media (Cranford & LeFrançois, 2022). The reality however is that the act of receiving a psychiatric diagnosis alone can have detrimental impacts on a person's perceived credibility, and accordingly, how they are treated within society. For instance, reporting on previous U.S. based surveys, White (2022) found that over 50 percent of employers are hesitant to hire people who have been diagnosed with a mental illness or have been involved in the psychiatric system. Such discriminatory and stigmatizing practices are thought to be further amplified however against those diagnosed with BPD, in comparison to other psychiatric diagnoses. This has continuously been found to be the case within mental healthcare (Grambal et al., 2017) and psychological research contexts (Masland et al., 2023); a concern that will be looked at more in depth in the upcoming chapters of this paper.

Situating Myself as a Researcher

Before diving more into my research, I want to add that my interest in this topic also stems from a combination of my personal mental health experiences and the observations that I have noted in my professional work. I have long suspected that the emotional expression of feelings such as sadness, anxiety, and anger have been unfairly constructed as pathological and weaponized against myself as well as many other young girls; particularly as a means of denying our lived experiences within invalidating and/or abusive spaces. While trendy statement such as "everyone should go to therapy," have been echoed within my university classes and shared across various social media platforms, such messaging has often felt insensitive, if not ignorant. It was around the time that I started volunteering as a suicide crisis line responder, however, that I noticed I may be far from alone in these suspicions.

In this role I witnessed a trend among personal communications that I had with service users. That is, a considerable amount identified themselves to me as having BPD. Even more concerning, I can recall how many of these service users would vent about having to utilize crisis lines as a 'last resort' when professional mental health services such as therapy had been either inaccessible or had failed to meet their needs. These experiences, coupled with the articles I have read from psychiatric survivors online, have therefore paved the way for me to question whether our current psychotherapies, are appropriately structured to address the concerns that psychiatrized people hold.

Overall, I believe that this problem represents a very important, yet underexplored social issue, deserving of greater attention. At the same time, I am aware of my social positionality and limitations as a researcher on this topic. Although I have faced mental health-related stigma and have been in therapy myself, I do not have a BPD diagnosis. It is therefore possible that my contributions to this research area may be influenced by the personal values and worldviews that I hold as a non-psychiatrized person, which may differ from those with BPD whom I am seeking to learn from. With this disclaimer in mind, I hope to emphasize that how I choose to construct my analysis ultimately represents just "one way in which the data [can be] interpreted and does not represent a 'truth'" (Dyson & Gorvin, 2017, p. 789).

Chapter 2: Literature Review & Theoretical Framework

BPD is a complex mental health diagnosis that is highly stigmatized within mental health care settings and society. According to the *DSM-V-TR* (APA, 2022), individuals who meet clinical criteria for BPD are categorized as having unstable, emotional, and impulsive personalities, including a preference for concrete, "black-and-white" thinking, that can manifest as self-destructive behaviours. More specifically, various surveys and reviews report that three in four people diagnosed with BPD have previously attempted to end their life (Grambel et al., 2017; Lawn & McMahon, 2015; Leichsenring et al., 2023), with 10% of those completing suicide. This is a rate that is 50 times higher when compared to the general population (Grambel et al., 2017, p. 278). Taken together, individuals who are assigned a diagnosis of BPD are constructed within clinical science to be living turbulent lives marked by significant emotional distress.

In their review of the most up-to-date literature on BPD, Leichsenring et al. (2023) found that roughly 0.7-2.7% of the global adult population has been diagnosed with BPD, with this percentage rising to over 20% in hospital settings. Additionally, while in community samples the rate of men and women being diagnosed with BPD is close to equal, in clinical settings women represent 75% of those who receive the diagnosis (Ducsay, 2015; Leichsenring et al., 2023). The *DSM-5-TR* (APA, 2022) accounts for this disparity by citing differences in help-seeking behaviours between men and women. However, other scholars complicate such explanations by citing clinician, cultural and experimental biases that have historically pathologized women's stress and portrayed labels like BPD as "exclusively female disorder[s]" (Ducsay, 2015, p. 108). It is critical to note that, across the literature, the etiology of BPD-like symptoms has also been linked to early traumatic experiences (Fagan et al., 2022; Leichsenring et al., 2023; Nicki, 2016; Redikopp, 2018). That is, as many as 90% of people with BPD have reported prior experiences of abuse or neglect (Donaldson, 2022;

Nicki, 2016; Redikopp, 2018), with emotional abuse playing a key role in the severity of BPD-related symptoms (Kuo et al., 2015). Despite such striking findings, the *DSM-5-TR* (APA, 2022) continues to classify BPD without any direct mention of trauma as a common factor in the development of BPD.

Psychotherapy is currently recognized as the best practice and first-line treatment for people diagnosed with BPD (Lawn et al., 2015; Leichsenring et al., 2023). Over the last three decades, several intensive therapy modalities have therefore emerged to respond to the urgent needs of this population. These include dialectical behaviour therapy (DBT), mentalization-based therapy, schema-focused therapy, transference-focused therapy, and good psychiatric management (Tusiani-Eng & Yeoman, 2018). While studies measuring the effectiveness of these psychotherapies for those with BPD have generally found the same benefits regardless of which modality a person has chosen, various meta-analyses and qualitative studies have suggested that 40-60% of patients with BPD who receive psychotherapy do not respond meaningfully (Desrosiers et al., 2020; Leichsenring et al., 2023; Tusiani-Eng & Yeoman; Woodbridge et al., 2023). In other words, a significant percentage of people continue to experience the same, if not greater levels of distress and BPD-related symptoms following their engagement with structured psychotherapies (Nicki, 2016), indicating that initial treatment benefits may only be temporary or short term.

Research Justification and Search Strategy

Efforts to understand or improve the mental healthcare experiences of people with BPD are gaining increased attention in recent research publications (De-la-Morena-Perez et al., 2023; Desrosiers et al., 2020; Friesen et al., 2022; Grambal et al., 2017; Lawn & McMahon, 2015; Klein et al., 2022; Lohman et al., 2017; Tusiani-Eng & Yeomans, 2018; Veysey, 2014; Woodbridge et al., 2023). This may be due to the unique concerns associated with BPD as well as the high likelihood that clinicians will interact with this population in

their practice. Conversely, the above-mentioned rates of nonresponse to evidence-based psychotherapies among those with BPD indicate that the needs and underlying concerns of this population remain inappropriately addressed. Taken together, this literature review aims to summarize some of the most prominent barriers that people with BPD experience during therapy to better understand the phenomenon of nonresponse.

A combination of the following search terms was imputed into PubMed, PsycINFO and York University Libraries Omni catalogue: *borderline personality disorder* AND *experiences, perspectives, narratives,* AND *psychotherapy* AND *treatment barriers, stigma, discrimination, bias, nonresponse*. Following this search, reference lists of selected articles were also scanned for relevant sources. My search for appropriate literature was restricted to articles published between 2007-2023, to ensure that the most up-to-date information was being reviewed. Likewise, qualitative peer-reviewed articles that centered the direct perspectives of those with BPD were prioritized for inclusion as there was still relatively limited research detailing the first-hand accounts of those with BPD.

Selected Article Characteristics

The literature that was selected originated from Canada, the United States, Australia, New Zealand, the United Kingdom, and Spain. Generally speaking, participants in these studies were selected from one or more of the following groups: patients with BPD, their family members/caregivers, and clinicians. Most participants were therefore said to be over the age of 18, however one study interviewed adolescents with BPD who were between the ages of 13-17 (Desrosiers et al., 2020). Overall, study participants were predominantly female identifying, which was understood to be both a strength and a limitation depending on the research study. While this meant that most findings were not generalizable to men, feminist critics have argued that BPD is a largely gendered diagnosis that over-pathologizes and medicalizes traits more commonly associated with femininity (Nicki, 2016; Redikopp, 2018).

In this light, women are thought to be disproportionately harmed by current barriers to appropriate mental healthcare, treatment engagement, and arguably by the diagnosis itself.

Researchers in this area utilized a range of methodologies including grounded theory, constructivist grounded theory, interpretive phenomenological analysis, qualitative content analysis, narrative analysis, poetic inquiry, and online ethnography. Data was collected primarily through semi-structed interviews or comprehensive scoping reviews, however some studies made use of online surveys, websites, psychological questionnaires, phone call transcripts, and poems. Finally, it is also worth noting that researchers frequently used feminist, Mad studies, and critical psychiatry theories to analyze and identify their themes.

Convergent and Divergent Perspectives Within the Literature

Systemic Discrimination and a Culture of Stigma

Across the literature, those with BPD shared frequent encounters with stigma and discrimination, typically at the hands of clinicians who perceived patients with BPD to be, manipulative, attention-seeking, difficult, untreatable, or to be taking advantage of the system (Masland et al., 2023; Klein et al., 2022; Tusiani-Eng & Yeomans, 2018; Veysey, 2014). Reinforcing negative perceptions, the *DSM-5-TR* (APA, 2022) describes those who meet the criteria for BPD as “dramatic, emotional, or erratic” (APA, 2022). While harmful attitudes towards this population persist in healthcare settings, Masland et al.’s (2023) study, which examined the role that psychological research has played in perpetuating stigma against those with BPD, found little to no scientific evidence that people with BPD purposely act in ways to gain attention or deceive others. In fact, these authors recommended that seemingly ‘manipulative’ or ‘attention-seeking’ behaviours exhibited by those with BPD be reframed through a trauma-informed lens; whereby such behaviours may be understood as the only effective coping strategies that those with BPD have learned to reduce distress and ensure their basic needs are met within invalidating or abusive spaces. Similarly, in a discussion

paper which looked at the limited recognition of trauma within clinical practices related to BPD, Nicki (2016) suggested that behaviours associated with this diagnosis may be more representative of an underlying need to feel connected and to establish safe interpersonal relationships with others.

The presence of stigmatizing beliefs among mental health providers was found to pose many barriers for patients with BPD who sought out supports. On the one hand, negative attitudes have been used as a rationale for clinicians to deny people with BPD access to mental healthcare (Klein et al., 2022; Lohman, 2017), particularly women (Ussher, 2013). On the other hand, it became apparent throughout the literature that systemic discrimination against people with BPD negatively impacts the quality of care that patients receive as well as their level of engagement in psychotherapy. For example, in a recent study which investigated factors underlying nonresponse to psychotherapy, patients with BPD recounted how negative clinician attitudes led to increased feelings of shame, and a lack of safety or comfortableness to be vulnerable in therapy (Woodbridge et al., 2023). Likewise, in another qualitative study that examined discriminatory healthcare experiences among people with BPD, patients shared how negative messaging about BPD made them feel dehumanized, or as if they were "being abused all over again" (Veysey, 2014, p. 26). Together, these findings show how BPD has remained poorly understood and highly stigmatized among mental health providers, which inevitably shapes how likely patients with BPD are to participate in or benefit from psychotherapy.

Epistemic Injustice

Another theme that appeared in the literature was the concept of epistemic injustice. Briefly understood, epistemic injustice refers to the process by which a person or a group of people are discredited in their "capacity as legitimate knowers" (LeBlanc & Kinsella, 2016, p. 63). Although this term was not directly used by people with BPD to describe their care

experiences, patients often shared stories of not being believed or taken seriously by clinicians when trying to seek help (Friesen et al., 2022; Harvey, 2020; Lawn & McMahon, 2015; Veysey, 2014). This ongoing tendency for 'experts' to minimize or discount the lived experiences of people with BPD is seen not just as an individual issue but rather, Masland et al. (2023) argued, as part of a larger system that challenges the credibility of emotional suffering and pain. Moreover, this culture is said to directly contribute to poorer quality health care for people with BPD, while also playing a role in reproducing the invalidating or abusive environmental conditions that many people with BPD report being raised in.

Further evidence of those with BPD being subjected to epistemic injustice emerged from a variety of diverse stakeholder perspectives. For instance, studies examining structural stigma towards this population have suggested that many clinicians view BPD as a sign of moral failing rather than a legitimate mental health condition (Klein et al., 2022; Tusiani-Eng & Yeoman, 2018). Conversely, in an interview-based study which compared patient, clinician, and caregiver perspectives to improve the BPD care system, caregivers saw BPD as being a legitimate biological illness but expressed concern about patients being given control over their treatment (Friesen et al., 2022). One mother felt that patient-driven care was dangerous because "[patients] don't understand that BPD interferes with their ability to make good decisions…they'll make judgement calls and interpret wrong" (p. 16). Given these findings, it was unsurprising to discover that in other studies, patients who voiced complaints about discriminatory treatment faced increased stigma and had their experiences discredited by practitioners, solely based on having a BPD diagnosis (Donaldson, 2022; Veysey, 2014).

The current literature has illustrated several ways in which individuals with BPD are discounted as legitimate knowers and silenced within mental health care settings. Notably, the individual experiences shared by people with BPD and those who provide mental health services have also aligned with Mad study critiques that theorize how, on a systemic level,

psychiatrized people are perceived as having less knowledge and being incapable of making appropriate decision-making (Johnston, 2020). This unique type of systemic oppression that psychiatrized people face on the basis of being deemed 'mentally ill' is also understood to fall under the term sanism; an ideology that allows for the continued negative stereotyping of Mad people, and the widespread use of invasive, coercive, and/or forced psychiatric interventions (Liegghio, 2013).

In response to this stigma and erasure that people with BPD are exposed to in clinical settings, Redikopp (2018) proposes an alternative epistemological framework for engaging with madness and trauma in clinical practice: The borderline standpoint. The borderline standpoint is described as a "maddening of epistemic authority" (p. 90), that centers the feelings of people with BPD as both a valid and important source of knowledge. This framework is built upon feminist, critical psychiatry, and Mad study discourses regarding how the feelings and experiences of those with BPD are medicalized within mental health systems. Moreover, the borderline standpoint is intended to be resistant of the 'rational' Western frameworks that govern current mental health treatments for people with BPD.

Poor Mental Health Literacy

Limited mental health literacy about BPD was another common treatment barrier expressed by patients, caregivers, and clinicians throughout the literature. In particular, patients expressed the need for explanations about their diagnosis and the rationale for certain treatments in order to make informed decisions (Friesen et al., 2022). Additionally, in both a study by Larivière et al. (2015), regarding the recovery experiences of women with BPD, and a study by Gould et al. (2023), which examined the intersection of BPD and gender-diversity, knowledge of BPD was identified by participants as a common facilitator of their recovery. The literature has therefore shown a consensus that people with BPD should be fully informed throughout their treatment processes, which involves having the appropriate

information to understand ones diagnosis, the biopsychosocial factors that may contribute to its development, as well as the range of treatment options that may be available (Leichsenring et al., 2023). Despite this general agreement among researchers that mental health literacy is important for patients with BPD, the information that patients are receiving in mental health care settings has been found to be subpar. For example, in an online survey regarding the treatment experiences of 153 Australians with BPD, almost 40 percent of participants reported having never been offered explanations of what BPD meant by any professional. While in contrast, nearly 20% received explanations that they did not fully understand (Lawn & McMahon, 2015). Interestingly, this latter finding has also appeared as a factor leading to treatment disengagement among adolescents with BPD. In Desrosiers et al.'s (2020), qualitive interview-based study, one adolescent cited her psychiatrists frequent use of clinical jargon as a key issue that led her to consider leaving therapy.

Just as many patients expected transparency throughout their treatment process, many also felt that their families and loved one's could benefit from psychoeducation. For instance, in Friesen et al.'s (2022) study, patients believed that providing mental health literacy to caregivers in a language that is accessible would strengthen their support systems and allow for more people to understand their experiences. Throughout the literature, caregivers alike, indicated a desire for education. In a study which analyzed the transcripts of calls made to the BPD Resource Centre), Lohman et al. (2017) identified poor BPD-specific mental health literacy among caregivers as a significant barrier to mental health care. Specifically, this study found that most calls were made by caregivers and families who were seeking out educational resources to assist them in communicating with their loved one's with BPD.

While finding ways to incorporate patients loved one's within the treatment process has been recommended to improve general knowledge of BPD and reduce barriers to care, much of the research in this area has continued to focus on developing better trainings for

mental health care providers. In several studies, ameliorating poor mental health literacy through increased therapist education and supervision was thought to help providers to better understand the experiences of those with BPD, to reduce harmful clinician attitudes and discriminatory behaviours, and to provide more effective and accessible mental health care (Goudey, 2013; Hwang & Fujimoto, 2022; Klein et al., 2022; Lawn & McMahon, 2015; Lohman et al., 2018; Tusiani-Eng & Yeoman, 2018; Veysey, 2014). Likewise, providing therapists with better training on BPD was emphasized by Woodbridge et al. (2023) as a promising means of reducing therapy non-response within this population.

Current Psychotherapies Are Not Doing Enough

A final theme that was uncovered within my review of the literature was the inadequacies of western psychotherapies to address the complex needs of those with BPD. As Grambel et al. (2017) argued, existing therapies may not be structured to support the concerns of people with BPD as they cannot account for the significant heterogeneity of the diagnosis or its etiology. More specifically, since individuals are only required to meet 5 out of the 9 clinical criteria for BPD to receive a diagnosis (APA, 2022), there are up to 256 potential ways that a person with BPD can present themselves (Harvey, 2020). Furthermore, the current diagnostic understanding of BPD has largely erased the traumatic social environments that most people with BPD grow up, or continue to live in (Fagan et al., 2022); the effects of which have evidently impacted the treatments that people with BPD receive, often resulting in poorer quality care experiences.

In recent years, people with BPD and those closely impacted have made repeated calls for mental healthcare providers to commit to adopting trauma-informed principles in their attitudes and everyday practices (Friesen et al., 2022; Harvey, 2020; Redikopp, 2018). Similarly, across large online communities', individuals with BPD have spoken out about the harms of non-trauma informed therapeutic practices. In the article referenced at the start of

this paper, Rebecca Donaldson (2022), creator of the Facebook group titled “Stop Dialectical Behaviour Therapy,” critiqued how ‘gold-standard’ treatments like DBT teach people with BPD to individualize and accept personal responsibility over their emotional responses to trauma. Simply put, DBT is argued to construct those with BPD as the problem, rather than the often invalidating or abusive social environments that a significant percentage of this population have had to survive within. To reinforce such claims, Donaldson (2022) cites harmful experiences others have faced, including one individual who felt that some of the DBT skills they learned “echoed what an abuser would tell [them]” (para, 21). Moreover, she problematized DBT practices that discourage people from talking about their traumatic experiences and guide clinicians to label feelings like suicidal ideation as ‘problem behaviours’ in need of fixing; a concern that may be indicative of a larger critique regarding the limits of psychotherapy in general.

While evidence-based therapies can benefit those with BPD, scholars emphasize that the goal of treatment should not be to ‘cure’ or erase past experiences of trauma. As Nicki (2016) argued, therapeutic practices that attempt to minimize trauma or to discard the knowledge survivors have gained from their experiences can perpetuate greater harm. Some participants with BPD have instead recommended that the goal should be on recovery, as opposed to the dominant biomedical approaches that are generally taken up to address BPD. Recovery, as described by all participants in Larivière et al.’s (2015) interview-based study is an ongoing process rather than an outcome. That is, for these participants, recovery was understood to be a relatively subjective term that encapsulated an ongoing process of learning, developing greater self-worth, and seeing progress within and around themselves. Important facilitators of recovery and engagement in therapeutic practices that are identified within the literature included receiving compassion (Fagan et al., 2022; Veysey, 2014; Woodbridge et al., 2023) and hope from clinicians (Friesen et al., 2022; Larivière et al., 2015;

Middleton, 2007; Veysey, 2014). Additionally, Harvey (2020) proposed that relational responses should become an expected practice in BPD treatment, as recovery has also been associated with the development of safe therapeutic and social relationships (Friesen et al., 2022; Larivière et al., 2015; Veysey, 2014; Woodbridge et al., 2023). Again, several studies have recommended that clinicians find ways to incorporate the family and loved ones of those with BPD into the care process (De-la-Morena-Perez et al., 2023; Klein et al., 2022; Middleton, 2007).

Gaps and Future Directions

The negative treatment and poor mental health care outcomes that people with BPD experience are both well-known and documented within the literature. As identified in this review, some of the most prominent barriers to appropriate mental health care and treatment engagement for people with BPD included the high levels of stigma and discrimination often perpetuated by clinicians themselves; the erasure of BPD patients as legitimate knowers, capable and deserving of self-determination within their treatment processes; the staggering lack of mental health literacy specific to BPD that is accessible to patients, their caregivers, and clinicians themselves; and the debate as to whether western psychotherapies are even structured to fully address the complex and incredibly diverse personal, community, and societal needs of those diagnosed with BPD.

Nicki (2016) argued that research centering the experiences and perspectives of people with BPD is lacking, however, the results of this review have showed this literature gap to be slowly closing. At the same time, because poor mental healthcare outcomes and concerns related to BPD treatment engagement appear to have remained relatively stable over the last decade and a half, there is still a need for qualitative research to bridge the gap between theory and practice. One area of exploration for future research continues to be the phenomenon of treatment nonresponse among those seeking support for their diagnosis of

BPD. Outside of the study conducted by Woodbridge et al. (2023), there has been little to no direct research into the experiences of those who do not respond to psychotherapies or their insights as to why this might be. Moreover, the results of this study largely attend to factors such as improving access and readiness for therapy as well as individual patient and clinician characteristics. This study therefore does not critically examine potential underlying methodological concerns or epistemological assumptions that underlie how BPD-specific therapies are constructed and how people with BPD are expected to exist within society. There is evidently a need for future research to look more in depth at the discrepancy between clinical science, which maintains that psychotherapy is the gold standard for BPD, and the actual accounts of those with BPD that complicate these claims, or even suggest that psychotherapies may not be doing enough. Moreover, it is important that such research be informed by theories that critique dominant understandings and propose alternative frameworks for thinking about the care needs of those who meet the clinical criteria for BPD.

Theoretical Framing: Mad Studies

My research project was informed by the theoretical frameworks of Mad studies. The concept of "Mad studies" was first introduced in 2008 at a disability studies conference by Richard Ingram, who through his personal experiences and learnings, had come to view psychiatry as a process that has caused society far more harm than good (Ingram, 2022). While Mad studies is a recently established discipline, the ideas it is based upon are not new. More specifically, it is founded on the significant work and progress achieved by psychiatric survivor/ex-patient led movements, communities, and activists over the past several decades (Cranford & LeFrançois, 2022). The field of Mad studies also brings together diverse ideas about madness and distress from a broad range of disciplines within the humanities and social sciences (Beresford, 2022; Reaume, 2022) and is continuing to grow. Consequently, scholars

such as Cranford & LeFrançois (2022), argue that no individual or specific group can claim sole credit or ownership over its development.

This theoretical framework has been relevant to my research topic for several reasons. As will be further discussed, my research is interested in uncovering the diverse perspectives and potential counter-narratives held by people with BPD that are often silenced within traditional biomedical spaces. Mad studies is well suited for such a task because it is based on theory that, from its inception, have "focus[ed] on the experiences of Mad people as both interpreters of [their] past and present and as active agents in bringing about change" (Reaume, 2022, p. 102). In other words, Mad studies is concerned with positioning Mad people—people who have been constructed as mentally unwell and who have been subject to psychiatric interventions (LeBlanc & Kinsella, 2016)— at the forefront of knowledge production. This is different from other prominent theories such as anti-psychiatry and critical psychiatry which were initially promoted by mental health professionals or those already recognized as 'experts' (Reaume, 2022). In being one of the newest, more progressive frameworks adopted for addressing the ongoing harms that psychiatry has committed against Mad people, Mad studies, is therefore argued to do more to challenge power and generate social change (Beresford, 2022).

At the same time, Mad studies lends itself well to research based upon the first-hand stories of psychiatric users/survivors as it leaves space to be critical of how these stories run the risk of being understood through dominant resiliency or recovery narratives. Storytelling can be a powerful means of challenging injustice and imagining alternative ways of being in the world. However, as Voronka (2019) argued, psychiatrized people often learn to construct, or have their stories reinterpreted, in ways that support dominant psychiatric ideas and interventions. That is, while psychiatrized peoples are frequently pressured to share their personal experiences in an effort to be seen as more human in the eyes of mental healthcare

providers, if not engaged with carefully, such stories can easily be taken up to portray Mad people as "redeemable subjects" who can even be cured of their madness (p. 16).

My other motivation for adopting a Mad studies lens over other critical social work theories stems from how inclusive this theoretical framework appears to be of the diverse opinions that Mad people may hold about psychiatric practices. For instance, rather than focusing on one specific goal, such as abolishing psychiatry altogether, Mad studies offers up a space for people to find comfort and even pride in their Mad identity if they so choose (Reaume, 2021). This is relevant to my research interests given that some people with BPD do identify with, or feel empowered by their diagnostic label (Redikopp, 2018). Furthermore, many people with BPD do share positive experiences when seeking professional mental health services (De-la-Morena-Perez et al., 2023; Veysey, 2014). I believe that this theory has therefore allowed me to gain a more balanced and in-depth understanding of the diverse perspectives held by people with BPD who engage in therapy.

Currently, the direct application of Mad studies within my area of research is limited due to it being a more recently established discipline. In one study by Redikopp (2018), Mad studies was used among other theories, to critique how Western psychiatry has medicalized trauma through the creation of BPD as a diagnostic label. This article applied theory from Mad studies to propose an alternative means of engaging with and revaluing the experiential knowledge that people diagnosed with BPD hold; one that disrupts dominant discourses and falls outside of traditional Western epistemologies. In one other relevant study, Johnston (2020) applied Mad studies as their primary theoretical framework for examining how mental health users in Canada construct their relationships with clinicians. From a Mad studies perspective, this author examined how medical power was either challenged or upheld within online reviews written by service users. Based on the currently available literature, the

application of this theoretical framework to research involving the mental healthcare experiences of people with BPD appears promising.

Overall, I believe that Mad studies has well-equipped me to examine my specific research question as it has offered me relevant language and knowledge to develop a more nuanced analysis of the data I collected. For instance, previously mentioned concepts like sanism, the unique and insidious form of marginalization and oppression that psychiatrized people experience, particularly within Western cultures (LeBlanc & Kinsella, 2016) and epistemic injustice, a specific form of sanist violence, often perpetuated by mental health professionals, in which Mad people's experiences are disbelieved and invalidated (Cranford & LeFrançois, 2022), are frequently referenced within Mad studies scholarship. These forms of discrimination are argued to be in direct opposition to Mad studies (Ingram, 2022), which does not try to disprove the mental healthcare experiences Mad people disclose. Rather, a Mad studies framework is one that intentionally chooses to believe those who have reported being harmed by psychiatric practices (Cranford & LeFrançois, 2022).

Chapter 3: Research Methodology & Design

Research Question

My research study has been guided by the following question: How do people with BPD construct their personal experiences in therapy within online spaces where they can retain greater anonymity; a factor that, based on the findings of my literature review, I hypothesized would add a layer of protection for those with BPD who have experienced judgement after making complaints or have had their perspectives discounted in mental healthcare settings.

Critical Discourse Analysis

The methodology that guided my research study is critical discourse analysis (CDA). CDA emerged during the late 1980s and its development has largely been credited to the work of Norman Fairclough, Ruth Wodak, Teun van Dijk, Gunther Kress, and Theo van Leeuwen (Blommaert & Bulcaen, 2000; Hidalgo Tenorio, 2011; Mullet, 2018). Among the work produced by these scholars, Fairclough's (1992) book *Discourse and Social Change* has been recognized as an important starting point for this methodological approach as it outlines a three-dimensional framework for explaining and analyzing discourse. In the first dimension of his proposed framework, the linguistic, grammatical, and organizational features of a selected text or speech, are described in detail. Following this initial analysis, scholars are instructed to move to the second dimension where they begin to generate interpretations regarding the context or purpose for which a discourse was created, shared, and reproduced across a society. Once these steps are taken, a third analysis is then conducted to explain the relationship that exists between specific discourse and current social practices. Close attention is given during this third dimension to the ways a discourse functions to either uphold or resist dominant systems of power, inequality, and injustice. To date, Fairclough's (1992) three-dimensional framework has been influential in paving the way for more CDA

approaches to emerge. His framework also reveals many key insights about the shared worldview that proponents of CDA adopt.

In alignment with Mad studies theory which argues that it is society that produces madness and distress (Beresford, 2022), CDA is rooted in constructivist ontology. Proponents of CDA operate from the assumption that reality is not objective or fixed, but rather, is constantly being constructed and remade through the everyday language and discourses people subscribe to. Simply put, "the way we speak about things constitutes the way we see them" (Dahlborg et al., 2023, p. 2). From this perspective, the knowledge or 'truths' that researchers seek to uncover are largely shaped by social factors that may be subject to changes as discourses evolve. A shared objective among various CDA approaches is therefore to generate social change by uncovering the conscious and unconscious ways that everyday discourses create, reproduce, or challenge power and equality within society (Blommaert & Bulcaen, 2000; Dahlborg et al., 2023; Hidalgo Tenorio, 2011). Once again, CDA complements Mad studies theory which shares similar aims but differs in its scope. Whereas Mad studies theorists have explored the lived experiences and personal narratives that psychiatrized people share, alongside how these stories may support or disrupt psychiatric discourses, CDA examines the link between discourse, power, and oppression across a broad range of populations and topic areas.

The application of CDA however has been especially recommended for research topics related to healthcare and caring professions. For example, Dahlborg et al. (2023) argued that CDA makes researchers conscious of how various phenomena such as perceived health status, treatment practices, and clinician-patient relationships may be the consequences of dominant societal discourses. In the context of my specific research questions, I believe that this methodological framework can encourage critical interrogation of diagnostic labels like BPD and the existing 'evidence-based' psychotherapies developed to treat symptoms

associated with such diagnoses. Rather than portraying these as objective phenomena, free from critique, I have applied a CDA approach to demonstrate how the language and practices we adopt in response to people who meet the clinical criteria for BPD can be thought of as socially constructed. Broadly speaking, the way we talk about and construct categories of mental health versus mental illness directly informs the types of practices we develop to manage them. Further, the way we talk about these categories are in part informed by the values and interests of those with social and political power.

Researchers such as Dyson & Gorvin (2017) have also stressed several specific benefits of using CDA with populations who have been assigned a diagnostic label of BPD. First, they argued that research on BPD has largely been dominated by positivist or realist assumptions which represent mental illness categories through a medical model lens. In other words, BPD has traditionally been perceived as a legitimate biological illness or defect located within the individual, that can be managed through clinical intervention. Qualitative-based methodologies such as CDA are therefore encouraged for their potential to uncover how such dominant discourses shape, or even limit, the way in which people with BPD are allowed to construct their identities and lived experiences**.** Second, Dyson & Gorvin (2017) argued that CDA is an ideal methodology for researchers who want to analyze "naturally occurring text" (p. 781). In this claim the authors appeared to be referring to verbal or written texts that already exist or are not necessarily elicited from an outside researcher. As one example, they discussed the application of CDA within social media-based research. Specifically, they suggested that the relatively anonymous nature of websites like Twitter have enabled social media users across the globe to share their most candid thoughts without fear of being judged or silenced. Taken together, CDA is a beneficial approach for exploring my specific research question as I am interested in examining the naturally occurring texts

that people with BPD have shared within online discussion forums as my primary form of data collection; the specific details of which will now be outlined in the next section.

Method

Sampling and Data Collection

To uncover how people with BPD have constructed their therapy experiences online, I collected a total of 60 discussion posts that were shared across several BPD related groups on Reddit within the last 1-2 years. Reddit is an online discussion forum-based platform made up of thousands of mini-communities called 'subreddits,' where users can go to post their opinions, experiences, or questions related to any topic of their choice. With over 73 million active daily users (Reddit, 2023), this site presents itself as a "highly rich resource of readily available 'real world' data for researchers" (Adams, 2022, p. 49). Reddit is also argued to offer its users greater anonymity as pseudonyms and single purpose/one-time use accounts are more commonplace, compared to other social media websites (Proferers et al., 2021). Due to the sensitive nature of conversations surrounding BPD, and the greater likelihood that users on Reddit may feel comfortable to share their perspectives due to their being less fear of identification, this platformed appeared to be an appropriate medium for my data collection.

The specific group that I gathered my data from was quite large, with almost 100 thousand members at the time of my study. Given its size, I felt that this group provided me with enough content and participants from various backgrounds to be considered representative of the general opinions held by people with BPD. Moreover, based on the results of a brief Google search, this group seemed to be one of the most easily accessible online communities in which people with BPD have chosen to discuss personal topics.

My search plan involved a purposive sampling strategy. To start, I imputed a combination of keywords into the search bar of this group to help me sift through large amounts of data and identify relevant posts in a more effective and timely manner. These

keywords included, ‘BPD’, ‘borderline personality disorder’, ‘therapy’, and ‘therapist.’ Following this initial step, I then screened each of the remaining posts to determine whether they were eligible for inclusion in my study. This second step was guided by the following criteria. First, the original poster needed to have either directly or indirectly identified themselves with the label of BPD. Second, their messages need to contain references to their own personal experiences of being in therapy. This could be either past or present experiences. In addition to these two requirements, only posts written in English were considered due to my own verbal and spoken language abilities. Given the nature of social media as well as my research question which speaks to people with BPD as a broad group, there were no exclusions based on geographical location, gender, race, age, or any other aspect of one’s social positioning. I recognize that this may have resulted in the inclusion of post that originated from anywhere around the world and from people with incredibly heterogenous lived experiences. It is my hope, however, that the diversity of my sample will represent a strength of my research as a noted goal of Mad studies scholarship is to produce knowledge that incorporates global perspectives and moves far beyond Western biomedical conceptualizations of madness and distress (Reaume, 2022).

Data Analysis

My overall data collection, coding, and analysis process was informed by Mullet’s (2018) framework for doing CDA, which borrowed upon and condensed the approaches of several CDA scholars. Following their guidelines, I conducted several scans of each Reddit post that had been chosen for further analysis. On my first read-through, I reviewed each post individually until I had developed a preliminary coding framework. My initial codes were then carefully refined until I was able to identify the most significant themes that emerged across the various posts. After establishing appropriate labels for these themes, I then read through each post a second time to analyze their ‘external relations.’ In other words, I

examined how the production of each post appeared to affect or have been informed by dominant social practices, norms, and structures. On the final scan of my data, I then turned my attention to the 'internal relations' of each post. This required me to analyze the language used by each Reddit user in order to uncover their individual intentions or objectives for writing their posts, how each person represented their issue and other important social actors, as well as how each post constructed the authors social positioning. For example, I paid specific attention to the titles of Reddit users posts, the frequency and repetition of certain words, and any metaphors or quoted phrases that individuals with BPD used to construct their therapy experiences.

As part of this overall framework for doing CDA, Mullet (2018), advised that researchers engage themselves in ongoing critical self-reflexivity. In my case, this involved noting down any relevant insights or lingering questions as they emerged throughout my analysis, while also taking into consideration how these may have affected my interpretations. Notably, an overarching trend that emerged while conducting each step of this analysis, which will be unpacked within the upcoming chapters, was how a significant number of Reddit posters' spoke about therapy in a more negative or unsatisfactory light. Contrary to the growing base of research that portrays mainstream treatments such as DBT as the best practice for supporting the complex needs of those with BPD (Lawn et al., 2015; Leichsenring et al., 2023), Reddit posters' adopted language that questioned or complicated such dominant ideas.

Ethical Considerations

The data that I have collected for my study comes from an open online subreddit and is considered to fall within the public domain. While technically exempt from ethics review, researchers who choose Reddit as a primary data source have a responsibility to address the unique ethical concerns that are raised by this type of online research. Such concerns relate to

the apparent lack of consent given by online users, the potential risks and harms that come with replicating data outside of the original context or purpose for which it was initially created, and the high likelihood that users could be identified or have their information traced back to them if their data is not adequately anonymized (Adams, 2024). This last concern has been argued to pose an even greater challenge for studies that choose to include word-for-word transcriptions of Reddit posts, since direct quotes can be easily traced back to their respective authors and subreddits through methods such as reverse searching.

To account for these ethical concerns and to ensure the increased protection of Reddit user's privacy, my study has put forward several countermeasures. First, every effort was taken to remove group names, usernames, dates and titles of specific postings, and any other identifying information that emerged in the data I collected. Second, following the recommendations of previous scholars, I made some small alterations to the wording, grammar, and/or sentence structures of Reddit users posts in order to protect against reverse-searching (Lyon et al., 2021). This step largely involved cleaning up the readability of each post (i.e., correcting spelling or grammatical errors). Most importantly, all changes were made in a way that preserved the overall meaning and tone of each post, as well as any salient phrases that Reddit users adopted to convey their experiences in therapy.

Ultimately, while my study focuses on the unique experiences that people with BPD are subject to within therapeutic spaces, it is important to acknowledge the role that scientific research has played in perpetuating harm against this population. More specifically, Masland et al. (2023) encouraged researchers to remember that "asking empirical questions and producing scientific knowledge is not a neutral action or an inherently useful pursuit. Rather, asking helpful questions with sensitivity and benevolence, is a component of good research" (p. 452). In other words, conducting ethical research is about more than just being respectful with how we handle data. Researchers must also ensure that the questions we ask are in line

with the needs of the communities who would be most impacted by the research. This involves taking responsibility for the language that we adopt to describe and interpret various social phenomena. Throughout my study, it has therefore been my intent to represent the data I have collected in a manner that is both respectful and does not further perpetuate stigmatizing discourses.

Chapter 4: Findings

Applying CDA, my overall findings critically interrogated the diverse ways that people with BPD construct their experiences in therapy on the social networking site, Reddit. Specifically, in this chapter I will be discussing the five most prominent themes that Reddit users from my sample wrote about in their posts. These are, therapy does not meet personal needs, therapy is invalidating, if not infantilizing, therapy is hard work, therapy is personal responsibility, and therapy is masking.

Therapy Does Not Meet Personal Needs

This first theme was made evident by the countless Reddit users who shared stories of receiving ineffective care or not gaining meaningful benefits from therapy. Phrases like therapy does not 'work,' therapy does not do 'anything,' or therapy does not 'help,' were routinely used by Reddit users to describe their personal experiences of seeking mental health support for BPD. Of those who wrote about therapy not meeting their needs, several also appeared to hold deeply ingrained expectations about the therapy process, which were often accompanied by a sense of disappointment, hopelessness, and frustration when their lived realities did not match these. For example, despite "reading that therapy is the only real solution for BPD," one user wrote about their decision to stop attending sessions after feeling that their therapist was not "doing any real work" with them (Participant 3). Similarly, another Reddit user shared their experience of being let down by the mental health system, writing, "I was told that therapy would help and it doesn't" (Participant 41). Both examples highlight the operation of a particular societal discourse that is being taught to people who meet the clinical criteria for BPD; that the problems experienced by this population can only be addressed through professional psychiatric intervention. This way of thinking assumes that therapy is a universal solution, but also the only option available to people with BPD, if they want to get better. Consequently, when therapy does not work, the implication stemming

from such discourses on mental health is that a person is simply out of luck, left to fall through the cracks.

While many users' posts appeared to be informed by this narrative, some challenged or complicated dominant ideas about how recovery among people with BPD is expected to go. More specifically, several posts highlighted important limitations regarding how Western therapies are being developed for people with BPD. Such was the case for one person who wrote about their experiences with a DBT therapist:

> The [therapist] seemed incredulous when I asked if I could talk about my trauma and horrific early life experiences, condescendingly implying that this "wasn't done". Am I insane for assuming that psychotherapy's core, especially with a trauma-centered disorder, would include some actual ability to speak about one's life experience and gain insight into the interplay of the past trauma and present manifestations? Am I the only one sick of hearing about DBT as a panacea for BPD? It comes across as a slapped-on band-aid rather than healing the wound internally (Participant 44).

This author challenged the widespread (and often unquestioned) acceptance of DBT as the 'gold-standard' for people diagnosed with BPD. By comparing DBT to a band-aid, and the effects of their traumatic experiences to that of a physical wound, this person argues that the standard treatments for this population are sorely inadequate. Moreover, they suggest that psychotherapies like DBT are failing to acknowledge the root causes of distress that people with BPD are subject to as they only address the negative symptoms of such complex and often systemic issues. This author positions themselves as being misled by the psychiatric industry. However, their questioning tone and readiness to dismiss their own perspectives as 'insane' also suggest that they perceive themselves as being alone in their experiences.

Reddit posters also pointed to broader structural issues that may contribute to not having their needs sufficiently met in therapy. In particular some raised valuable concerns related to the time-limited nature of mainstream psychotherapies. As one Reddit user wrote:

> Does anyone else struggle with feeling like therapy isn't often enough? I'm fortunate to be in a position to have therapy every week, covered by my health insurance. This has been the case since October 2023. Even still, one hour a week feels like we barely break the surface. As many of you probably relate, my mind goes a million miles a

> second and I have so many ups and downs, revelations, and anxieties throughout the week that actually working through anything in that hour feels futile. Also, it doesn't help that my therapist (who is overall really awesome, and I really like him) is very self-guiding meaning I can kind of talk about whatever during therapy (Participant 4).

As illustrated above, the rigid, time-limited nature of current psychotherapies can contribute to disappointments or treatment experienced as ineffective. Although this author appears to be careful with the language that they use to express their concerns with therapy (i.e., positioning themselves as grateful for being able to access regular services and representing their therapist in a positive light), they contribute to important alternative discourses regarding how current therapies may not be adequately structured to meet the needs of those with BPD or other complex mental health concerns. Likewise, their statement about "barely break[ing] the surface" during the one hour per week that is afforded to them, alongside how "futile" it feels for them to try and meaningfully address their concerns during this time, reinforces frustrations voiced in the previous example. That is, therapy for BPD may be structured in a way that only allows for the surface-level symptoms of people's problems to be targeted, rather than allowing people to explore the root of their concerns.

Divergent Perspectives on the Effectiveness of Therapy

While the effectiveness of mainstream therapies for those with BPD were frequently contested by Reddit users in my sample, some people expressed divergent views. Positive experiences during therapy were reported by users who experienced improvements in symptoms typically associated with BPD. As one person shared, "I started my recovery journey about three years ago and now I can finally feel a bit more in control and aware of myself and my emotions…I really think DBT therapy has saved my life" (Participant 55). Additionally, reflecting on their previous experiences in therapy, another person wrote:

> My therapy is working wonders…I still have bad days and depression, anger, and anxiety have gotten better but aren't totally gone, but I don't think that's the point. I just want to learn how to manage myself better, not be controlled by my emotions and not have such irrational reactions and psychotic episodes which therapy has definitely helped with. I am grateful! (Participant 37).

In both texts, Reddit posters with BPD emphasize how therapy helped them to gain "control" over their emotions; something which they position themselves as not having before seeking out professional support. The language they use in their posts, such as referring to DBT as "life-saving" and labelling their emotions as pathological, supports biomedical-model understandings of BPD. More specifically, these texts uphold the view that BPD is a legitimate biological illness that is be managed through clinical intervention.

Therapy is Invalidating, If Not Infantilizing

Many of the included posts also contained personal accounts of people with BPD having their perspectives silenced, dismissed, and devalued within therapy settings. Concerningly, several Reddit users shared experiences of being infantalized, that is, being made to feel child-like or less knowledgeable. Related to this issue, one person wrote about their psychiatrist's attempts to justify the emotional abuse they experienced from their parents and other therapists on the basis that they supposedly dressed "childishly" and made "immature and unrealistic" choices (Participant 35). Likewise, another person stated how their therapist had started speaking to them differently after diagnosing them with BPD, and would not make statements such as, "you're not acting in your right mind" (Participant 52). The process through which people with BPD are constructed as underdeveloped or irrational is not always obvious at first glance but can appear in more subtle ways. In reference to their experience of attending couples therapy, one Reddit user with BPD wrote:

> I try to shed light on the stuff she misconstrues and the whole time I'm talking, she and the therapist are exchanging looks, he's rolling his eyes, she's shaking her head and smiling, gesturing toward me like I'm a hopeless child who's lost his mind. Of course as soon as that starts, I get anxious and it gets incredibly uncomfortable and I get lost in the confusion of it. Every one of the last 5-6 sessions has left me so hurt and upset…I feel so mistreated (Participant 47).

Although this person's partner and therapist do not outwardly call him a child, the way he experienced their body language conveyed an overall lack of respect and a perceived sense of intellectual superiority. The image of a "hopeless child who's lost his mind" further

demonstrates how infantilizing treatment can harm the self-esteem and confidence of those with BPD who attempt to defend themselves. This is made evident by them feeling "lost in the confusion" of the mistreatment they faced. While together these posts offer insight into the harmful societal discourses that individual therapists may uphold about people diagnosed with BPD, users also explored the way that therapy itself, may feel infantilizing:

> The skills homework that my therapist tries to give me and almost all of the self-help stuff feels so patronizing that it makes me not want to engage in therapy/self-help. Being given things that seem like it's meant for a child just makes me angry and resistant and I just end up shutting down and not benefiting from it. Does anyone else experience this? How do you get over it and actually be open to trying skills that seem dumb or childish to you? (Participant 2)

Dominant discursive practices which position those diagnosed with BPD, as child-like are shown to do more than just affect the individual attitudes that clinicians hold. They may be deeply embedded in how therapies for such populations are being structured. Likewise, they may also reflect that there is a societally constructed understanding of how children are expected to behave and be treated in comparison to adults. Interestingly, this person holds somewhat contradictory views in their post. On the one hand, they seem to argue that it is the infantalizing nature of specific therapy approaches that have held them back from progressing in therapy. But on the other hand, their closing question identified themselves, specifically their personal 'resistance,' as the problem that's kept them for making progress.

Invalidation, however, was experienced by Reddit users beyond just infantilization. For example, one person shared their experience of trying to vent to their therapist about the challenges of securing employment as both a physically disabled and psychiatrized person:

> She kept talking over me and telling me my BPD doesn't define me, it's just an aspect of my personality, and I just need to assess my skills and get a resume together. I told her I felt she was being dismissive, and she told me her job was to push back but I told her, "not in that way." I was thinking more in a how can I do a high functioning task when I can't seem to do basic ones. I was quite direct and told her not to dismiss my emotions and talk over me when I am trying to express them (Participant 28).

This author challenged their therapists lack of acknowledgement towards the unique systemic barriers they navigate in their daily lives due to their social positionality. While labelling their

suggestions as dismissive, this authors response of "not in that way" was particularly notable as it implied a partial agreement that therapy should feel challenging, but not in manner that is dismissive of people's emotional experiences. Following this excerpt, the author of this text also went on to challenge the appropriateness of the specific therapy approach their therapist used, concluding, "I think it's bullshit and won't work for me but if I say so I'm afraid I'll be booted from therapy and won't get another therapist" (Participant 28). Here the power-relations between mental health providers and those with BPD is made more evident. This author appears knowledgeable of their needs yet, they are simultaneously aware of their lowered status as a psychiatrized person, accompanied by the authority their therapist holds over them to grant or restrict access to quality mental health care.

This hesitancy to voice complaints regarding the appropriateness of one's therapy, for fear of being subjected to further mistreatment or losing access to mental healthcare services, was a seemingly common concern raised within my sample. Despite such normalized fears, however, it is important to acknowledge that some Reddit users echoed stories of personal resistance in the face of invalidating treatment:

> Yesterday my therapist told me I was making a situation about me because I got upset and felt emotional…she looked at me as if I was doing something wrong and said, "why are you upset, it has nothing to do with you." I was okay with that yesterday and I accepted that. Today I'm angry about it. My life is my life. If I feel an emotion about something, I'm pretty sure I have the right to. Am I supposed to say, "that has nothing to do with me" and then look the other way if someone is being hurt in front of me? (Participant 27).

The automatic response from this therapist to invalidate their client's emotions is reflective of dominant western discourses which value individualism, objectivity, and 'rational' ways of knowing while simultaneously devaluing the perspectives of those deemed mad. By giving themselves permission to experience anger, however, this author appeared to reclaim a sense of power or personal agency over their life. Furthermore, the final sentence of this text may

have been informed by a broader social commentary on social injustice, followed by an outward rejection of the wilful inaction by those who are in higher positions of power.

Unfortunately, for other Reddit users, more drastic forms of resistance were often required to make therapists listen to their perspectives. This was the case for one user who whose therapist had continuously pressured them to sign up for DBT, despite their past negative experiences and repeated attempts to say no:

> I've stood up to her so many times and told her I don't wish to be pushed and forced into this treatment. I've literally had to walk out mid-session because I felt so disrespected that she's just not listening to me. And now she's texting me about it because I quit. I don't know what to do. I'm so angry, I'm crying and shaking. If I wanted to do DBT I'd do it when I was ready. I feel so backed into a corner" (Participant 25).

In this text, the author highlights the emotional impacts of not being taken seriously and having ones' needs ignored in therapy. Using the metaphor of being "backed into a corner," they position themselves as powerless and having little to no control over the type of care they want to receive. The therapist's coercive behaviour may also be linked to the paternalistic social practice wherein professionals are thought to know better than their clients and are given the authority to determine what is in the 'best interests' of their clients based on their own 'expert' knowledge, rather than their clients' preferences.

Therapy is Hard Work

Reddit users also constructed therapy as hard work. While several posts expressed a sense of concern or frustration regarding whether their therapy should feel so challenging, others appeared to accept this discourse more easily. That is, some went on to normalize hard work as a necessary condition of being in therapy and of recovery itself, which was generally conceptualized as the process of gaining more "insight" or control over ones' emotions.

Of those who fell into the first response, many shared stories of how their mental health had declined since beginning therapy. This was illustrated through statements such as "I'm starting to go home from therapy feeling worse than when I went in" (Participant 24), or

"started EMDR therapy and I'm losing my mind. I've honestly never felt worse" (Participant 32). In general, therapies specifically designed to treat BPD were portrayed as being intensive and requiring a tremendous amount of emotional labour. As one Reddit user articulated:

> The problem is now that I've started up therapy again, I don't feel as good. I did bring this up with my therapist and he said it's normal for those of us with BPD to forget the outside world during therapy since our feelings are quite overwhelming. I also have therapy 3 times a week (art, group, and individual therapy). And it makes sense, but now I'm wondering if I want to keep doing therapy? My life is starting again, and I don't want to be dependent and drained out from therapy. It's exhausting. So yeah, anyone else feeling this way? (Participant 20)

The amount of time that this Reddit user spent attending therapy each week was described as 'draining' or 'exhausting,' but could also be indicative of the larger societal expectation about self-improvement; that individual's must always be in a state of working on or fixing themselves. Even so, underlying this text was also a fear of being reliant on professional help. As this person argued, not only had therapy left them feeling worse, but it also prevented them from living their life as they would have liked.

Questions as to whether others shared the same feelings about therapy were also echoed by other posts. In particular, Reddit users seemed to be looking for reassurance on whether their experiences in therapy were 'normal' and if they would get easier. One user wrote, "I'm coming away from therapy each time feeling so much pain inside and I'm feeling like I'm struggling to cope. Has anyone else felt this way and does it get better?" (Participant 6). Likewise, another post asked, "has anyone else started DBT and felt more alone than they did before? I'm sticking with it, but I just wondered if anyone else went through this transition and found this period difficult, and if you have any advice for staying positive?" (Participant 49). These statements highlight how therapy can be triggering. Simply put, therapy may force people to experience emotions they do not feel prepared to carry. In both cases, the language of having to "cope" or "sticking with it" implies an expectation that those with BPD need to just learn to accept and tolerate the uncomfortable feelings therapy may

bring up. Additionally, by referring to their feelings of loneliness as being part of a "transitionary period,' the second person suggested that getting better in therapy is just a matter of waiting out one's negative emotions and staying hopeful.

As mentioned at the start of this section, however, not all Reddit users questioned whether therapy should be so challenging. In fact, some embraced the discourse of therapy being hard work. After attending their first therapy session, one person posted, "I feel optimistic for the first time in a long time. I have a lot of work ahead of me…I'm so thankful to feel like I'm finally getting the right support for my mental health" (Participant 19). In this context, the promise of hard work was spoken about as a reason to feel hopeful and as a sign of quality mental health care. Similarly, another person reinforced this idea that hard work is necessary for progress to take place. Reflecting on their experience in DBT, they explained:

> I honestly feel that recovery/healing, has been hard work and continues to be so. I have made my mental health and my recovery a priority, something I have to work at every day. Working at it every day is the only way that I feel it is possible to create a life worth living by being capable of handling distress. It's the only chance at real healing and change (Participant 55).

Working hard in therapy is defined here as the conscious effort to improve oneself every day. Without consistent effort, change is presented to be impossible. Interestingly, while this author suggested that working on one's mental health is a never ending, lifelong process, they suggest that such work will only ever offer those with BPD a "chance" at recovery. As such, an underlying discourse which seems to inform this text is that regardless of how much effort those with BPD puts into therapy, there is still no guarantee that they will truly 'recover.'

Therapy & the Notion of Personal Responsibility

Another prominent theme that showed up in the posts I analysed was the notion of personal responsibility. This theme often manifested itself in the form of internalised self-blame. In particular, when writing about their personal experiences in therapy, many Reddit posters adopted language that implied a sense of ownership or sole responsibility over their

perceived level of progress. For instance, in response to feeling that they were not “getting anything” from therapy one Reddit user voiced concern, writing, “I feel like I just can’t figure out what’s wrong with me. Most of the time I just don’t feel right” (Participant 1). On the other hand, another Reddit user, who experienced a gradual increase in symptoms since attending therapy stated, “I feel like such a failure and that I’m probably an exception. Therapy won’t work for me and I won’t ever get better” (Participant 24). In both instances, Reddit users internalized their perceived lack of progress as a sign of personal failing, which led them to adopt a more self-blaming, hopeless tone of voice. This shared dominant discourse underlying both texts is made even more explicit by another user who posted:

> I'm constantly reading how it's your fault if you don't try to get better and how you shouldn't have relationships until you can work on yourself. I do try, it just doesn't work. I have several severe mental health issues. Some of them make it hard for traditional methods of "help" to work….I have been to several therapists, counselors, social workers, community support etc... Some of them I have stuck with for multiple years, it's not like I’m quitting after a couple sessions. (Participant 5).

As was briefly discussed in the previous theme, the dominant discourse underlying the production of these texts is that recovery is simply a matter of working hard enough. By this logic, when therapy does not ‘work’ a person only has themselves to blame and is directed to look inward. This text also speaks to a related narrative which is that people with BPD or other mental-health related concerns cannot lead ‘healthy’ lives unless they engage in self-improvement, typically through medical or ‘professional’ therapeutic intervention. However, by posting about their previous experiences with therapists, this Reddit user presented an alternative, often silenced perspective. That is, regardless of much a person may try, therapy is not a one-size-fits-all solution and may simply not be beneficial for all people. Likewise in positioning their mental health concerns as far too severe for ‘traditional’ mental health supports to help, this user indirectly implied that current therapeutic interventions may not be suitable for those with complex issues, let alone people with BPD.

Nevertheless, when speaking retrospectively about their therapy experiences, many users preferred to accept personal responsibility, rather than examining the external or social factors that could have limited their potential to make progress:

> There hasn't been a single therapy program I have finished in my life. I impulsively quit all of them. I want to get into DBT but I've been told it's unlikely because I have poor compliance. I totally ghosted my counsellor for over a month until they had to end professional relations with me. Does anyone else have this issue? I definitely have not done enough to try and improve. I'm also off my medications cold turkey right now lmaooo (Participant 39).

Speaking in a self-deprecating, sarcastic tone, this user located the root of their problem—poor therapy compliance— within themselves. From their perspective, they simply have "not done enough to try and improve." The unintended consequence of this discourse however is that it leaves out a lot of critical information that may be necessary for developing a fuller understanding of this person's situation. For instance, what is it about the previous therapy programs they attended or the professionals they worked with that made it challenging to remain in therapy? Despite accepting personal responsibility for their lack of progress, this authors words call attention to the strict requirements that people with BPD are subjected to in order to receive access to mental health care. Specifically, this post offers insight into the ways that 'therapy resistance' may often be weaponized against clients with complex needs.

Overall, when recounting lessons learned from their therapy experiences, many discussed how accepting personal responsibility was a challenging but fundamental aspect of recovery. As one user who just started DBT wrote, "I am facing a lot of my destructive behaviours head on and having to take responsibility and repair a lot of damage, which is very healing but also very isolating" (Participant 49). Likewise, another user discussed their experiences in the group therapy component of DBT, sharing, "I have a hard time opening up, but the group only became helpful when I did" (Post #12). Progress in both cases was marked by looking inward and changing one's 'destructive' or 'therapy-interfering'

behaviours. Summarizing these ideas perhaps most clearly, another user posted about their recovery journey and experiences of going through multiple rounds of DBT:

> I paid attention, I was learning, but I wasn't really committed 100%. The reason I couldn't commit is because I was always reacting at first, I had no control of my emotions. The work does stir up a lot of trauma. So as much as I wanted to recover, I would shut down and go numb from time to time. As time went by, I could start to see the little changes, I started to feel different and good about myself in some areas. I was going back and forth constantly, from handling one crisis well to being a total mess that couldn't even get out of bed. I had to work harder on my truths, I had to not only listen but apply the skills I was learning. I had to fill in my diary card, I had to do the homework, it just really had to become a way of life (Participant 55).

The author of this text, like many others, characterized their recovery process as being non-linear and shaped by many highs and lows. However, in their attempt to rationalize their turbulent therapy experience this person blamed their initial lack of "commitment." For them, being fully committed meant buying into 'psy' discourses. They had to assimilate biomedical discourses about BPD, alongside specific therapy techniques, into their own way of thinking and doing; therapy had to become "a way of life."

Therapy & Masking

The final theme that my research has delved into is the concept of masking and how this has shown up within the personal therapy experiences of those with BPD. Masking, in a mental health context, can be understood as the act of camouflaging traits that are associated with a particular psychiatric diagnosis (McQuaid et al., 2023). Throughout all the posts I collected, several Reddit users spoke of the substantial pressure they experienced in therapy to minimize their BPD-related symptoms and conform to certain societal standards for what is deemed 'normal.' For many however this process was unintentional. As one user wrote in response to reading their therapist's notes:

> It's so easy for me to see that the person who is described by my therapist and psychiatrist is not truly me, but yet another mask I put up to seem like the perfect patient. I have lied my way through therapy and I have made my therapist believe that I am someone else, someone more palatable. I never meant to. (Participant 58)

Masking is presented here as a form of deceit as the author of this text expressed a sense of guilt that they had lied to their therapist about who they are. Underlying this response, however, is the dominant social norm regarding what it means to be a "perfect client" or to be "palatable." These ideas are arguably shaped by western values such as rationalism and liked to the stigma that people with BPD are routinely subjected to within mental health systems. This is further seen by another person who posted, "I've been in therapy for years, but I feel like I'm showing up for a job and using a customer service voiced version of what's wrong and how I've been feeling. I don't feel reluctant to open up, I just really don't think I know how to" (Participant 60). A customer-service voice may generally be associated with speaking in a calm, friendly, yet professional manner and can have the effect of making a worker appear more knowledgeable. In a therapy context, this voice prevents them from being open about their personal experiences. This person clarified however, that their lack of vulnerability was not intentional but instead a matter of not knowing how to be open. Both stories reveal the way that people with BPD may be socially conditioned to hide or downplay their emotional experiences in order to be perceived as credible by mental health professionals. With this in mind, masking may also function to protect those with BPD from being subjected to further stigmas and to ensure that their needs are being met.

Additional motivations for masking during therapy were provided by other Reddit users. For example, in reference to the challenges they experienced with trying to be open in therapy, one person explained:

> I realised that I'm never even half honest about my current or past mental states, health, and thoughts because 1. I don't trust anyone, 2. any complex or confusing thoughts that I try to voice are almost always perceived wrong, leading to hours of explaining, and 3. I don't want grippy socks (Participant 15).

The fear of being misunderstood or wasting time in therapy is evidently a significant concern for those with BPD, as was showcased in earlier themes. This text indicates however an added layer of stress that people with BPD may face when disclosing information to

mental health professionals. Their expression of not wanting "grippy socks" appears to be in reference to not wanting to be hospitalized; a social practice that many people with BPD continue to be subjected to, often against them on will. As such this text also brings up concerns around power in the therapeutic relationship. More specifically, the power that mental health professionals hold to make life altering decisions on behalf of clients who disclose their mental health statuses. Masking for many Reddit users was therefore seen as a preferable choice due to the potential risks associated with being vulnerable

At the same time, users who reported being fully open with their therapists also raised important concerns about other potential consequences. For instance, in response to accidentally becoming "too honest" while on call with their therapist regarding the suicidal thoughts they experienced, one person wrote:

> "The borderlines always want attention. Everything they say and do is for attention." I don't want her to think that about me! Because I know it's not true. I know I truly do want to die because I'm sick of dealing with my messed-up brain. It's all real. But after saying what I said today I'm so scared that my therapist is mad and that she won't want to see me anymore because now I'm a "liability". What if she never trusts my words again? I can't stand to be kicked to the curb again. I've had so many past therapists discontinue seeing me because I'm always too much for them. They just say bye and move on while I'm left on the side of the road feeling like I was just stabbed 50 times, feeling abandoned. (Participant 53)

Here, the issue of credibility emerged again. This author feared that their honesty, coupled by their diagnosis, would lead them to be stereotyped as "attention-seeking," a "liability," or as being "too much." Moreover, they outlined potential consequences that could follow if such stereotypes were applied to them. In particular, this author expressed worry whether their future suicidal thoughts might be dismissed or if they could lose access to their current therapy supports, forcing them to have to start all over again. Taken together, this text emphasizes the vulnerable position that those with BPD are situated in during therapy, alongside how power differences within the therapeutic relationship can influence a person's level of comfortableness to speak openly about their real thoughts and feelings.

Chapter 5: Discussion

Therapy is routinely presented as the most effective course of treatment for people with BPD. Complicating this, however, several studies have reported that nearly half, if not more, of those who attend therapy for BPD do not complete treatment (Desrosiers et al., 2020) or do not experience long-term progress (Leichsenring et al., 2023; Nicki, 2016; Tusiani-Eng & Yeomen, 2018; Woodbridge et al., 2023). In other words, a significant number of those with BPD continue to face high levels of distress or clinical 'dysfunction' following their involvement in the mental health system. My PRP uncovered potential explanations for this issue by exploring the first-person narratives of psychiatrized people themselves. Circling back to the question that guided my data collection and analysis process, this section will critically discuss the most common ways that people with BPD constructed their personal experiences in therapy on Reddit.

Situating My Findings Within Mad Studies and Current BPD Literature

My first theme, that current therapies may be failing to address the needs of those with BPD, was not necessarily a surprising finding. As I explored in my literature review, scholars have argued that the needs of those with BPD are highly complex and that current therapies are not structured to account for the significant heterogeneity of those who receive this diagnosis nor the etiology of their symptoms (Grambel et al., 2017). The dominant discourses that informed Reddit posters' initial perspectives of therapy and the effects that these discourses have had for those who perceived their care to be inadequate was therefore particularly notable. Many revealed that they sought out therapy after being led to believe that therapy 'works' for everyone, but also, that therapy is the only way for people with BPD to live meaningful lives. Consequently, when such expectations were not met, numerous Reddit users shared a sense of hopelessness, suggesting that their problems would never change. These findings echoed previous arguments made by Friesen et al. (2022), regarding

the sense of disillusionment participants with BPD have reported after experiencing their treatment as ineffective. Similarly, these authors hypothesized that their participants' initial hopes at the start of therapy were informed by assumptions that specialized therapies (i.e., DBT) are the only way to manage BPD. These assumptions, coupled with the reality of mental healthcare systems being largely under-resourced, was also believed to "contribute to the widely held misconception that BPD is incurable" (p. 17).

From a Mad studies perspective, the notion that therapy is always beneficial or that BPD can only be managed through professional intervention exemplifies the hegemonic influence that psychiatry has on western understandings of madness and distress. These assumptions illustrate how psychiatry has become the dominant paradigm through which people are allowed to understand these human experiences. At the same time, it is also through the ongoing circulation of these dominant discourses that psychiatry is able to assert a sense of legitimacy as an 'objective' or 'scientific' discipline; as opposed to alternative, collectivist-based understandings of madness and distress, which are in turn subjugated (Cranford & LeFrançois, 2022). Wipond (2013) notes however that the psychiatric community has yet to "scientifically identify any mental illness, and our treatment strategies are guesswork" (p. 258). Nevertheless, with only one epistemological framework for responding to madness and distress, the prevailing message is that only one appropriate course of treatment exists for those with 'mental illness'. Simply put, those who are perceived as mad are believed to require professionalized treatment if they ever hope to "recover into fully functioning, productive citizens" (White & Pike, 2013, p. 246).

While many Reddit users directly challenged dominant ideas about psychiatry in their posts (i.e., calling DBT a "slapped-on-bandaid"), it is equally important to attend to posts that spoke about positive therapy experiences. As mentioned in my findings, a few people shared gratitude for the therapy they received, with one person even constructing their therapy as

lifesaving. The way that people with BPD can report such vastly different perspectives and experiences with therapy may be explained by the heterogeneity of those with BPD, as well as the broader Mad community. In the words of Mad studies scholar, Diamond (2013):

> The diverse narratives of community members make it abundantly clear that not all people experience psychiatry in the same way, and in part, the diversity of experiences that people have with the psy complex accounts for the different solutions people view as appropriate for their healing, empowerment, and social change work (p. 73).

Moving beyond this discussion of whether therapy has adequately met the needs of those with BPD, a startling number of Reddit users perceived their therapy experiences as invalidating or infantilizing. This second theme can be linked back to the concept of epistemic injustice; an insidious "type of violence that targets and denies personhood" (Liegghio, 2013, p. 123). That is, epistemic injustice is the systemic practice through which mad knowledges are discredited or dismissed as seemingly 'irrational.' Scholars argue that mental health providers frequently perpetuate epistemic injustice, especially against those who have been assigned personality or psychotic disorders (Cranford & LeFrançois, 2022). Accordingly, the concept of epistemic injustice that emerged in my literature review can be applied to understand my findings. For example, like Reddit users from my sample, numerous studies featuring the perspectives of those with BPD have found frequent experiences of patients with BPD not being taken seriously or not being believed by clinicians whom they sought mental health support from (Friesen et al., 2022; Harvey, 2020; Lawn & McMahon, 2015; Veysey, 2014; Woodbridge et al., 2023). My study extends such findings as many Reddit users shared similar stories of having their voices silenced, dismissed, and/or devalued during therapy. At the same time, my study also contributes new knowledge. That is, Reddit posters emphasized how infantilization, a very specific form of epistemic injustice, often showed up within therapy settings.

This particular experience of being constructed as 'child-like' was not named directly in the BPD-related literature that I reviewed. One potential explanation for this comes from Mad studies scholars Mills & LeFrançois (2018) who suggest that, compared to other marginalized populations, "less attention has been paid to the metaphorics of the child in relation to madness and disability" (p. 504). As these authors go on to argue, there has been a long history in the West of using infantilizing metaphors to justify the exploitation and continued subjugation of colonized, racialized, disabled, and/or psychiatrized peoples. Within the field of psychiatry specifically, the metaphor of being childlike has worked to construct those deemed mad as 'wrongly' developed, incompetent, and incapable of appropriate decision-making. The metaphor of being 'childlike' is therefore thought to have a dual effect of positioning the state and its actors (i.e., doctors, psychologists, social workers, etc.) in a parental role over those with 'mental illness.' If mad people are simply like children, then psychiatric intervention, regardless of how coercive or violent, can be represented as "necessary, legitimate, and even benevolent" (p. 508).

Understood in this light, it may be insufficient to interpret the feelings of invalidation that many Reddit posters experienced during therapy as the result of individual therapist behaviours and lack of training (Goudey, 2013; Klein et al., 2022; Lohman et al., 2017; Tusiani-Eng & Yeomans, 2018; Veysey, 2014; Woodbridge et al., 2023), or even as a sign of BPD symptomatology (Desrosiers et al., 2020). Rather, infantilizing discourses may be deeply embedded in the epistemological frameworks that inform current diagnostic and/or treatment practices for those whose lives intersect with psychiatry.

In the third theme that my study identified, Reddit users characterized therapy itself as being an incredibly difficult and painful process that required constant hard work. A concerning piece that emerged out of this theme however was that many of these same participants related this hard work to feeling progressively worse in therapy and not knowing

whether it was worth it to keep attending therapy. The question of whether dominant therapy approaches are doing more harm than good for some people with BPD seems to be underexplored within existing literature. In one study where young people with BPD problematized both the quality and level of difficulty of the therapy services they received, researchers even took it upon themselves to dismiss such perspectives and reinterpret them in individualistic, biomedical understandings (Desrosiers et al., 2020). For instance, these authors reinterpreted several adolescents' rationales for not wanting to engage in therapy or not finding it helpful to talk to a therapist about their personal problems as experiential avoidance. More specifically, while arguing that "exposure to painful feelings and memories are an inevitable part of therapy" (p. 9), these authors also claim that compared to non-BPD patients, those with BPD are simply less willing to accept the emotional "sacrifices that are inherent to any treatment" (p. 12). Not only do such statements write off the perspectives of those with BPD who critique dominant psy practices, they flip the problem back onto individual pathology. The assumption becomes that, if people with BPD want to create meaningful change in their lives, they must refrain from questioning psychiatric knowledge and instead learn to accept exposure to emotional pain as a condition of being in therapy and being 'healthy'.

This concept, otherwise known as distress tolerance, is one of the four key skills that people with BPD are introduced to in structured psychotherapies like DBT; the other three being mindfulness, interpersonal effectiveness, and emotional regulation (Chapman & Dixon-Gordan, 2020). Some Mad Pride activists have pushed back against this messaging that psychiatrized people should simply accept distress, however. For instance, in their 2014 zine titled "This Insane Life," Mad Pride Hamilton & Hamilton Mad Students' Collective advocated against DBT's distress tolerance skills, arguing that "systematic oppression causes

distress, and this distress is intolerable. We need to acknowledge this distress and then use the frustration and anger that comes along with it to make change (p. 20).

Still, across the posts that I collected, a few Reddit users embraced the emotional labour that therapy demanded from them, positioning it as an overwhelming, yet essential, condition of being in therapy and/or recovery. Similarly, participants with BPD in Woodbridge et al.'s (2023) interview-based study saw therapy as a 'painful' but 'necessary' process that involved a willingness to tolerate significant discomfort. Participants from this study also shared a belief that long-term change only became possible once they committed themselves to "do[ing] the hard work, inside and outside of sessions" (p. 6). Therapy, in this context, was constructed as "a lot of work that consumes everyday" (p. 6). This narrative that psychiatrized people must always be working on themselves in order to adhere to the social standards for what is normal is pervasive not only in therapy settings, but within broader social policies and texts. Under dominant psy discourses, Voronka (2013) explains that there is no space for alternative ways of knowing and being to emerge or be recognized as valuable. Instead, the "eradication of madness is always the rule. Normalization is always the goal" (p. 319). Additionally, while the state has increasingly become preoccupied with funding early intervention initiatives, the prevailing idea is that 'mental illness' is a lifelong condition that must always be surveilled and managed.

Related to this notion that therapy is hard work, a fourth way that Reddit posters constructed their therapy experiences was as a personal responsibility. Specifically, my study found that those who internalized their perceived level of progress or 'failure' during therapy, also tended to adopt a more self-blaming, hopeless tone. When therapy did not 'work' Reddit users assumed something was wrong with them. This finding aligned with past literature that has connected individualizing mental health discourses to increased feelings of shame and lowered self-esteem among those with BPD (Fagan et al., 2022). At the same time, this

tendency to locate the problem within the person is arguably far too reductive given that chronic emotional invalidation, abuse, and/or trauma have been cited in the development of BPD-like symptoms (Fagan et al., 2022; Kuo et al., 2015; Leichsenring et al., 2023; Nicki, 2016; Redikopp, 2018).

From a Mad studies lens, the personal responsibility and internalized blame that those with BPD face during therapy can be explained as a by-product of neoliberalism and mainstream psychiatry. Both of which "individualise responsibility and frame understanding in terms of individual rather than social causes and analysis (Beresford, 2022, p. 8). Psychiatrized people are first conditioned, through their everyday interactions with these dominant systems, to believe that the root of their problems lies within them. Then, they are then called to take responsibility for their mental health, often through a range of individual self-help strategies (Morrow, 2013). This phenomenon is exemplified in my findings and reinforced by previous studies where those with BPD have spoken about the importance of accepting personal responsibility over their mental health in therapy. For example, one participant in Friesen et al.'s (2022) study felt that people with BPD "need to make [themselves] resent for healthcare and want to be well" (p. 12). Likewise, in Woodbridge et al.'s (2023) study, participants with BPD described the need "for patients to accept their role in contributing to their own problems" by engaging in "truthful self-reflection (p. 9).

Returning to the findings of my study, it was especially interesting to witness how some Reddit users narrated their experiences through what Voronka (2019) refers to as the 'psychiatric gaze.' That is, some Reddit users structured their experiences according to dominant 'psy' discourses. As Voronka (2019) argues, to have their experiences valued by those in positions of authority, Mad people learn to tell stories in a way that emphasizes personal resiliency in the face of hardship followed by an eventual recovery from their 'mental illness.' This way of thinking about recovery has been criticized however for how it

places blame on those who do not follow a linear or traditional path to self-improvement and makes people less likely to continue utilizing future mental health supports (Tang, 2022).

The final theme to discuss is the notion of therapy and masking. This was a notable finding of my study since the concept of masking has received little attention in the context of BPD. While more often explored in the autism literature, scholars Pryke-Hobbes et al. (2023) argue that people from various marginalized identities use masking strategies to "present themselves in ways that are acceptable to others, even to the detriment of their own well being" (p. 2). This pressure to hide aspects of oneself or to downplay the severity of one's problems in order to be accepted by clinicians showed up often within therapeutic spaces for people with BPD on Reddit. In particular, individuals in my sample felt pressured to be a 'perfect client,' to be 'palatable,' or to use a 'customer-service' tone of voice while in their therapist's presence.

Lee (2013) describes how this tendency to conform to certain behavioural expectations is a lesson picked up by psychiatrized people during in-patient treatment settings. That is, many of those who have been hospitalized without their consent learn to comply with their clinician's demand so to present themselves as 'recovered' by clinical standards and increase the likelihood of being discharged more quickly. While my study does not focus directly on forced mental health treatments, a significant number of those with BPD are subjected to this practice. For instance, in Lawn & McMahon's (2017) survey of 153 Australians with BPD, two-thirds reported previous experiences of being involuntarily hospitalized. This finding may explain why the possibility of being placed in a psychiatric ward is an ever-present fear carried by many Reddit users. Furthermore, in this context, it is perhaps even more understandable why some Reddit users felt afraid to remove their 'mask' and be fully honest with their therapists.

Based on the findings of my study and previous literature, I would argue that masking strategies might be better understood as an act of self-preservation for those diagnosed with BPD. Ultimately, as Lawn & McMahon (2017) proposed, trust, or lack thereof, is "at the core of the BPD experience" (p. 511). When trust was lost or not yet earned, people with BPD have expressed feeling unsafe to ask for help during a crisis (De-la-Morena-Perez, 2023), to disclose their diagnosis with a new therapist (Goudey, 2013), or to be vulnerable about their mental health in general (Fagan, 2022). Similarly, Reddit users did not hesitate to call out how lack of trust showed up in therapy spaces. The reality is that there has been a longstanding tradition of people in positions of power speaking and acting on behalf of those who have been deemed mad (Reaume, 2022). By withholding information, individuals with BPD may therefore be exerting what little control they have over their therapy process. As suggested by parents of adolescents with BPD in Desrosiers et al.'s (2020) interview-based study, such behaviours may represent important expressions of "autonomy."

Limitations of My Study

This study has aimed to revalue the diverse knowledges that those with BPD hold regarding their personal and collective needs. Utilizing anonymized Reddit posts as my main data source, I hoped to deconstruct the specific language and power relations that inform how people in online BPD communities, who have frequently had their knowledges dismissed by mental health professionals, are able to construct their lived experiences in therapy. I am optimistic that studies like mine can help to not only improve but re-imagine current care practices for this population—and those who are deemed by society to be mad, in general. I recognize, however, that my study also has limitations. Most notably, I found it challenging to decipher information regarding the social demographics of those who posts I collected.

Beyond identifying with the label of BPD, Reddit users did not disclose personal information about their social positioning. Likewise, as posts tended to be written in the first

person, the majority of my sample did not indicate their preferred pronouns which meant that I could not make assumptions related to gender identity. This limitation is unsurprising given the nature of online research. As noted in Chapter 3, participation on Reddit is largely through the use of pseudonyms which creates natural barriers for collecting demographic information (Proferers, 2021). Not having this information however may have prevented my study from having a more nuanced, intersectional analysis; a relevant concern given that BPD has been disproportionately diagnosed among cisgender women with histories of trauma (APA, 2022; Donaldson, 2022; Ducsay, 2015; Kuo et al., 2015; Leichsenring et al., 2023; Nicki, 2016; Redikopp, 2018), as well as people who identify as LGBTQ+ (Gould et al., 2023). My analysis may therefore not account for how the experiences of those with BPD in therapy may be uniquely shaped by factors such as trauma, gender and/or sexuality.

Considering this limitation of my study, I am also mindful that my findings reflect the perspectives of just one subreddit where people with BPD can go to share their thoughts and find community. Due to the nature of my study, compounded by the limited time frame and resources that I had to complete this project, my findings may not be generalizable across other online groups where people with BPD gather to share their lived experiences.

Implications for Social Work & Concluding Thoughts

Despite these limitations, my research offers several implications for social work. theory and practice. Notably, Reddit users constructed their therapy experiences in a negative light, complicating dominant care practices for supporting those with BPD. Suggestions for improving the mental health care of those with BPD have generally focused on issues of access, psychoeducation, or individual clinician attitudes and competency. As a result, the mental health system has largely directed their resources towards getting more people with BPD into therapy, expanding the reach of psy discourses across various social institutions, and developing even more specialized trainings for service providers. What is left out of such

responses is the understanding that, “the ways in which services are designed, and the assumptions that they operate under, may reproduce the very inequalities they purport to ameliorate” (Morrow, 2013, p. 327). One implication for critical social work practice is therefore as follows: not only must workers remain acutely aware of the role society plays in generating distress (Beresford, 2022), we must take an active stance against reproducing the same oppressive conditions that psychiatrized people have been exposed to from an early age.

Part of this starts with workers acknowledging the limitations of mainstream therapies and their work itself. For many, therapy alone is simply not enough and may represent a temporary ‘band-aid-like’ solution. Rather than perpetuating the discourse that therapy is a fundamentally good thing for people with BPD and the only way that this population can lead meaningful lives, social workers should seek to be transparent with their clients. This could mean naming the systems of oppression that are at play during therapy. As well it could mean inviting space for clients to deconstruct dominant ways of thinking about BPD, alongside what emotional expressions are allowed to be publicly expressed.

Another piece to consider is that the type of language we adopt. As Liegghio (2013) argued, epistemic violence occurs “when the details of people’s lives are reinterpreted into professional explanations and formulation” (p. 125). The interpretations we make as mental healthcare providers hold power. While the use of clinical jargon in therapy spaces may be experienced as dehumanizing by some people with BPD (Desrosiers, 2020), such language can obscure what little scientific basis underlies psychiatric diagnoses and treatment practices (Shimrat, 2013). How we speak evidently has real material effects on the lives of others and, in the context of my study, can either limit or enrich the possibilities for how those with BPD can construct their identities. To move forward, social workers must recognize madness or “mad talk” (Liegghio, 2013) as a legitimate and valuable way of knowing. As Mad studies scholars have proposed, madness is an embodied form of knowledge (Leblanc & Kinsella,

2016); it reveals “a lot about human experience and how to support persons experiencing distress or crises, if they require support at all” (Cranford & LeFrançois, 2022, p. 78).

It is important that social workers allow psychiatrized people to determine the language that is most appropriate to represent their identities or the complex details of their lives. While some people with BPD constructed their experiences with mainstream therapies in a positive light or even preferred to understand their realities through dominant psy discourses, the findings of my study demonstrate that for many, therapy has generated more harm than good. As I conclude my research, I am reminded by Reaume (2022) of the significance of practicing humility while offering these suggestions. Those diagnosed with BPD, let alone those who have been deemed mad by society, are an extremely heterogenous group. It is impossible to know whether the theories proposed by Mad studies will remain relevant among those deemed mad in the several decades to come. Ultimately, we must remain mindful that alternative ways of thinking about and responding to madness not only exist but are constantly being co-created.

References

Adams, N. N. (2022). 'Scraping' Reddit posts for academic research? Addressing some blurred lines of consent in growing internet-based research trend during the time of Covid-19. *International Journal of Social Research Methodology, 27(*1), 47-62. https://doi.org/10.1080/13645579.2022.2111816

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Beresford, P., & Russo, J. (2022). Introduction. In P. Beresford, & J. Russo (Eds.), *The Routledge International Handbook of Mad Studies* (pp. 1-16). Taylor and Francis. https://doi.org/10.4324/9780429465444

Blommaert, J., & Bulcaen, C. (2000). Critical discourse analysis. *Annual Review of Anthropology, 29*, 447-466. https://doi.org/10.1146/annurev.anthro.29.1.447

Chapman, A. L., & Dixon-Gordon, K. L. (2020). *Dialectical behavior therapy*. American Psychological Association.

Cranford, J. M., & LeFrançois, B. A. (2022). Mad studies is maddening social work. *Zeszyty Pracy Socialnej, 27*(3), 69-84. https://doi.org/10.4467/24496138ZPS.22.013.17252

Dahlborg, E., Boman, Å., Eriksson, H., & Tengelin, E. (2023). Encircling discourses—A guide to critical discourse analysis in caring science. *Scandinavian Journal of Caring Sciences*. https://doi.org/10.1111/scs.13194

De-la-Morena-Perez, N., Corral-Liria, I., Sanchez-Alfonso, J., Becerro-de-Bengoa-Vallejo, R., Losa-Iglesias, M., & Jimenez-Fernandez, R. (2023). Experiences of women diagnosed with borderline personality disorder: Perception of motherhood, social, health, and construction of gender. *Perspectives in Psychiatric Care, 2023,* 1-10. https://doi.org/10.1155/2023/5345101

Desrosiers, L., Saint-Jean, M., Laporte, L., & Lord, M. M. (2020). Engagement complications of adolescents with borderline personality disorder: navigating through a zone of turbulence. *Borderline Personality Disorder and Emotional Dysregulation, 7*(1), 1-15. https://doi.org/10.1186/s40479-020-00134-6

Diamond, S. (2013). What makes us a community?: Reflections on building solidarity in anti-sanist praxis. In B. A. LeFrançois, R. Menzies, & G. Reaume (Eds.), *Mad Matters: A Critical Reader In Canadian Mad Studies* (pp. 64-78). Toronto: Canadian Scholars' Press.

Donaldson, R. (2022, August 12). *Trauma survivors speak out against dialectical behaviour therapy (DBT*). Mad in America: Science, Psychiatry and Social Justice. https://www.madinamerica.com/2022/08/trauma-survivors-speak-out-against-dialectical-behavioral-therapy-dbt/

Ducsay, G. C. (2015). *Borderline personality disorder: A contemporary feminist perspective* (Publication No. 3687007). [Doctoral dissertation, The Chicago School of Professional Psychology]. ProQuest Dissertations & Theses Global. https://ezproxy.library.yorku.ca/login?url=https://www.proquest.com/dissertations-theses/borderline-personality-disorder-contemporary/docview/1667768833/se-2

Dyson, H., & Gorvin, L. (2017). How is a label of borderline personality disorder constructed on Twitter: A critical discourse analysis. *Issues in Mental Health Nursing, 38(*10), 780-790. https://doi.org/10.1080/01612840.2017.1354105

Fagan, S., Hodge, S., & Morris, C. (2022). Experiences of compassion in adults with a diagnosis of borderline personality disorder: An interpretative phenomenological analysis. *Psychological Reports, 125*(3), 1326-1347. https://doi.org/10.1177/00332941211000661

Fairclough, N. (1992). *Discourse and social change*. Policy Press.

Friesen, L., Gaine, G., Klaver, E., Burback, L., & Agyapong, V. (2022). Key stakeholders' experiences and expectations of the care system for individuals affected by borderline personality disorder: An interpretative phenomenological analysis towards co production of care. *PLOS ONE, 17*(9), 1-26. https://doi.org/10.1371/journal.pone.0274197

Goudey, R. (2013). *The impact of female gender on borderline personality disorder*, (Publication No. 3566608). [Doctoral dissertation, The California School of Professional Psychology]. ProQuest Dissertations Publishing.

Gould, W. A., MacKinnon, K. R., Lam, J. S. H., Enxuga, G., Abramovich, A., & Ross, L. E. (2023). Detransition narratives trouble the simple attribution of madness in transantagonistic contexts: A qualitative analysis of 16 Canadians' experiences. *Culture, Medicine and Psychiatry*. https://doi.org/10.1007/s11013-023-09838-0

Grambal, A., Prasko, J., Ociskova, M., Slepecky, M., Kotianova, A., Sedlackova, Z., Zatkova, M., Kasalova, P., & Kamaradova, D. (2017). Borderline personality disorder and unmet needs. *Neuro-Endocrinology Letters, 38*(4), 275–289.

Harvey, L. (2020). *Meet me at the border: Exploring individuals' experiences of being labelled with borderline personality disorder using poetic inquiry and a feminist, relational psychoanalysis* (Publication No. 28647800). [Masters dissertation, University of London]. ProQuest Dissertations & Theses Global. https://ezproxy.library.yorku.ca/login?url=https://www.proquest.com/dissertations-theses/meet-me-at-border-exploring-individuals/docview/2570463053/se-2

Hidalgo Tenorio, E. (2011). Critical discourse analysis, an overview. *Nordic Journal of English Studies, 10(*1), 183–210. https://doi.org/10.35360/njes.247

Hwang, W., & Fujimoto, K. A. (2022). Email me back: Examining provider biases through email return and responsiveness. *Journal of Counseling Psychology, 69*(5), 691-700. https://doi.org/10.1037/cou0000624

Ingram., R. A. (2021). A genealogy of the concept of Mad Studies. In P. Beresford, & J. Russo (Eds.), *The Routledge International Handbook of Mad Studies* (pp. 93-97). Taylor and Francis. https://doi.org/10.4324/9780429465444

Johnston, M. S. (2020). "He sees patients as lesser people": Exploring mental health service users' critiques and appraisals of psychiatrists in Canada. *Disability & Society, 35*(2), 258–279. https://doi.org/10.1080/09687599.2019.1634524

Klein, P., Fairweather, A. K., & Lawn, S. (2022). Structural stigma and its impact on healthcare for borderline personality disorder: a scoping review. *International Journal of Mental Health Systems, 16*(1), 1–48. https://doi.org/10.1186/s13033-022-00558-3

Kuo, J. R., Khoury, J. E., Metcalfe, R., Fitzpatrick, S., & Goodwill, A. (2015). An examination of the relationship between childhood emotional abuse and borderline personality disorder features: The role of difficulties with emotion regulation. *Child Abuse & Neglect, 39*, 147-155. https://doi.org/10.1016/j.chiabu.2014.08.008

Lawn, S., & McMahon, J. (2015). Experiences of care by Australians with a diagnosis of borderline personality disorder. *Journal of Psychiatric and Mental Health Nursing, 22*(7), 510-521. https://doi.org/10.1111/jpm.12226

Larivière, N., Couture, E., Blackburn, C., Carbonneau, M., Lacombe, C., Schinck, S.-A., David, P., & St-Cyr-Tribble, D. (2015) Recovery, as experienced by women with borderline personality disorder. *Psychiatric Quarterly 86*, 555–568. https://doi.org/10.1007/s11126-015-9350-x

Lee, J.-E. (2013) Mad as hell: The objectifying experience of symbolic violence. In B. A. LeFrançois, R. Menzies, & G. Reaume (Eds.), *Mad Matters: A Critical Reader In Canadian Mad Studies* (pp. 64-78). Toronto: Canadian Scholars' Press.

LeBlanc, S., & Kinsella, E. A. (2016). Toward epistemic justice: A critically reflexive examination of 'sanism' and implications for knowledge generation. *Studies in Social Justice, 10*(1), 59–78. https://doi.org/10.26522/ssj.v10i1.1324

Leichsenring, F., Heim N., Leweke F., Spitzer C., Steinert C., & Kernberg O. F. (2023). Borderline personality disorder: A review. *JAMA, 329*(8), 670–679. https://doi.org/10.1001/jama.2023.0589

Liegghio, M. (2013). A denial of being: Psychiatrization as epistemic violence. In B. A. LeFrançois, R. Menzies, & G. Reaume (Eds.), *Mad Matters: A Critical Reader In Canadian Mad Studies* (pp. 122-129). Toronto: Canadian Scholars' Press.

Lohman, M. C., Whiteman, K. L., Yeomans, F. E., Cherico, S. A., & Christ, W. R. (2017). Qualitative analysis of resources and barriers related to treatment of borderline personality disorder in the United States. *Psychiatric Services, 68*(2), 167–172. https://doi.org/10.1176/appi.ps.201600108

Lyons, M., Bootes, E., Brewer, G., Stratton, K., & Centifanti, L. (2023). "COVID-19 spreads round the planet, and so do paranoid thoughts": A qualitative investigation into personal experiences of psychosis during the COVID-19 pandemic. *Current Psychology*, *42*(13), 10826-10835. https://doi.org/10.1007/s12144-02102369-0

Mad Pride Hamilton & Hamilton Mad Students' Collective. (2014). This insane life: Mad students edition [zine] (A. de Bie, Ed.). *Mad Pride Hamilton*, (2) http://hdl.handle.net/11375/25051

Masland, S. R., Victor, S. E., Peters, J. R., Fitzpatrick, S., Dixon-Gordon, K., Bettis, A. H., Navarre, K. M., & Rizvi, S. L. (2023). Destigmatizing borderline personality disorder: A call to action for psychological science. *Perspectives on Psychological Science, 18*(2), 445-460. https://doi.org/10.1177/17456916221100464

McQuaid, G. A., Strang, J. F., & Jack, A. (2023). Borderline personality as a factor in late, missed, and mis-diagnosis in autistic girls and women: A conceptual analysis. *Autism In Adulthood*, 1-27. https://doi.org/10.1089/aut.2023.0034

Middleton, H. (2007). Critical psychiatry. *The Mental Health Review, 12*(2), 40-43. https://doi.org/10.1108/13619322200700021

Mills, C., & LeFrançois, B. A. (2018). Child as metaphor: Colonialism, psy-governance, and epistemicide. *World Futures, 74*, 503-524. https://doi.org/10.1080/02604027.2018.1485438

Morrow, M. (2013) Recovery: Progressive paradigm or neoliberal smokescreen? In B. A. LeFrançois, R. Menzies, & G. Reaume (Eds.), *Mad Matters: A Critical Reader In Canadian Mad Studies* (pp. 323-333). Toronto: Canadian Scholars' Press.

Mullet, D. R. (2018). A general critical discourse analysis framework for educational research. *Journal of Advanced Academics, 29*(2), 116-142. https://doi.org/10.1177/1932202X18758260

Nicki, A. (2016). Borderline personality disorder, discrimination, and survivors of chronic childhood trauma. *International Journal of Feminist Approaches to Bioethics, 9(*1), 218-245. https://doi.org/10.3138/ijfab.9.1.218

Proferers, N., Jones, N., Gilbert, S., Fiesler, C., & Zimmer, M. (2021). Studying Reddit: A systematic overview of disciplines, approaches, methods, and ethics. *Social Media + Society*, 1-14. https://doi.org/10.1177/20563051211019004

Pryke-Hobbs, A., Davies, J., Heasman, B., Livesey, A., Walker, A., Pellicano, E., & Remington, A. (2023). The workplace masking experiences of autistic, non-autistic neurodivergent and neurotypical adults in the UK. *PLOS ONE, 18*(9), 1-24. https://doi.org/10.1371/journal.pone.0290001

Reaume, G. (2021). How is Mad studies different from anti-psychiatry and critical psychiatry? In P. Beresford & J. Russo (Eds.), *The Routledge International Handbook of Mad Studies* (pp. 98-107). Taylor and Francis. https://doi.org/10.4324/9780429465444

Redikopp, S. (2018). Borderline knowing: (Re)valuing borderline personality disorder as (counter) knowledge. *Word and Text: A Journal of Literary Studies and Linguistics, 8*(1), 77-92.

Reddit (2023, December). *Homepage*. https://www.redditinc.com/

Tang, L. (2022). Upcycling recovery: Potential alliances of recovery, inequality and Mad studies. In P. Beresford, & J. Russo (Eds.), *The Routledge International Handbook of Mad Studies* (pp. 266-275). Routledge.

Tusiani-Eng, & Yeomans, F. (2018). Borderline Peprsonality disorder: Barriers to borderline personality disorder treatment and opportunities for Advocacy. *The Psychiatric Clinics of North America, 41*(4), 695–709. https://doi.org/10.1016/j.psc.2018.07.006

Ussher, J. M. (2013). Diagnosing difficult women and pathologising femininity: Gender bias in psychiatric nosology. *Feminism & Psychology, 23*(1), 63–69. https://doi.org/10.1177/0959353512467968

Veysey, S. (2014). People with a borderline personality disorder diagnosis describe discriminatory experiences. *Kōtuitui: A New Zealand Journal of Social Sciences Online, 9*(1), 20–35. https://doi.org/10.1080/1177083X.2013.871303

Voronka, J. (2019). Storytelling beyond the psychiatric gaze: Resisting resilience and recovery narratives. *Canadian Journal of Disability Studies, 8*(4), 8–30. https://doi.org/10.15353/cjds.v8i4.522

Voronka, J. (2013). Rerouting the weeds: The move from criminalizing to pathologizing "troubled youth" in The Review of the Roots of Youth Violence. In B. A. LeFrançois, R. Menzies, & G. Reaume (Eds.), *Mad Matters: A Critical Reader In Canadian Mad Studies* (pp. 309-322). Toronto: Canadian Scholars' Press.

White, K., & Pike, R. (2013). The making and marketing of mental health literacy in Canada. In B. A. LeFrançois, R. Menzies, & G. Reaume (Eds.), *Mad Matters: A Critical Reader In Canadian Mad Studies* (pp. 239-252). Toronto: Canadian Scholars' Press.

White, W. L. (2022). Re-writing the master narrative: A prerequisite for mad liberation. In P. Beresford, & J. Russo (Eds.), *The Routledge International Handbook of Mad Studies* (pp. 76-90). Routledge.

Wipond, R. (2013). Pitching mad: News media and the psychiatric survivor perspective. In B. A. LeFrançois, R. Menzies, & G. Reaume (Eds.), *Mad Matters: A Critical Reader In Canadian Mad Studies* (pp. 253-264). Toronto: Canadian Scholars' Press

Woodbridge, J., Townsend, M. L., Reis, S. L., & Grenyer, B. F. S. (2023). Patient perspectives on non-response to psychotherapy for borderline personality disorder: A qualitative study. *Borderline Personality Disorder and Emotion Dysregulation, 10*(13), 1-15. https://doi.org/10.1186/s40479-023-00219-y

Appendix

PANEL ON
RESEARCH ETHICS

Navigating the ethics of human research

TCPS 2: CORE 2022

Certificate of Completion

This document certifies that

Grace Mugford

successfully completed the Course on Research Ethics based on the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2: CORE 2022)

Certificate # 0000744199

18 October, 2023

Codes	Frequency	Location of Themes	Potential Subthemes				
Ineffective care	19 posts	1, 3, 4, 5, 7, 8, 10, 13, 21, 22, 24, 26, 35, 38, 41, 44, 45, 50, 52	Therapy isn't working/not making progress; going through multiple therapists/treatments ("finding the right fit")				
divergent perspectives - positive therapy experiences	13 posts	12, 19, 34, 37, 42, 47, 46, 48, 49, 51, 55, 56, 59	Therapy or specific aspects of therapy are beneficial/or were initially helpful; positive therapeutic relationship; therapy saved my life				
Therapy is invalidating/stigmatizing/infantalizing (Epistemic injustice)	19 posts	2, 16, 25, 27, 28, 29, 31, 32, 36, 43, 44, 46, 47, 48, 52, 54, 57, 59					
Therapy is uncomfortable/triggering	14 posts	6, 14, 20, 23, 24, 30, 32, 33, 40, 46, 47, 49, 51, 55					
personal responsibility, blame, and failure	13 posts	1, 2, 4, 5, 8, 12, 21, 24, 29, 37, 38, 39, 49, 55					
Masking in therapy/fear of being fully open or honest	10 posts	15, 18, 28, 31, 36, 38, 43, 48, 53, 58, 60					
Giving up on therapy	8 posts	1, 3, 13, 14, 17, 21, 47, 50					
Ideas about specialists/specialized care	8 posts	3, 16, 22, 26, 29, 33, 35, 57					
waste of time/desire for therapy to be productive	6 posts	4, 11, 14, 17, 21, 50					
Desire for community/relational-based therapy	5 posts	9, 12, 36, 43, 44					
Resistance/Standing up to therapist	4 posts	2, 25, 27, 28					
therapy is the only option/running out of options	4 posts	3, 5, 21, 41					
limited time/desire for more time in therapy	4 posts	4, 12, 22, 42					
lack of genuine care/support	4 posts	13, 21, 33, 41					
Are my experiences normal?	3 posts	6, 7, 30,					
not following clients needs	3 posts	16, 17, 25					
can't be saved/helped mindset	3 posts	16, 21, 24					
Unmet expectations about what therapy is	3 posts	41, 44, 45					
Unfair treatment expectations	3 posts	8, 28, 31,					
Narrow construction of BPD	2 posts	28, 48, 57					
power imbalances in therapeutic relationship	2 posts	8, 25,					
Not sure how to approach therapy	2 posts	1, 14					
Fear of being dependent on therapy	2 posts	11, 20					
issues are too complex to address	2 posts	5, 15					

Title of Post	Codes								
1. What do I get from therapy?	not sure how to approach therapy								
	Not seeing progress								
	no acknowledgement of BPD diagnosis								
	internalised blame/responsibility --- something must be wrong with me								
	questioning whether to continue with therapy								
2. Therapy feels patronizing	therapy practices feel patronizing/child-ish								
	therapy resistance								
	Individual responsibility/blame --- overcoming therapy resistance, becoming more **open** to changing								
3. What type of therapy and therapists have worked for you?	Therapy is the only solution/option for BPD	**Dominant Discourse: "therapy is the only real solution for BPD"... BPD is a condition that is bad, must be treated, and can only be addressed through professional therapeutic care**							
	not doing "real work" in therapy								
	Therapy disengagement/dropout								
	General counselling is not meeting their needs								
4. Therapy frequency	frequency/duration of therapy is not enough								
	making progress/getting to the root of the problem feels pointless								
	Desire for greater productivity/structure --- exploratory approach i not ideal								
	personal commitment to change								
	limited by lack resources								
5. what do you do when therapy and medication doesn't work?	Societal/internalised Blame --- Mental health is an individual responsibility	**Dominant discourse: "It's your fault if you don't try to get better and you shouldn't have relationships until you can work on yourself" .... "not trying hard enough"**							
	Therapy isn't working								
	hopelessness								
	emphasis on personal effort to change								
	Exhausted all options								
	Going through multiple therapists/approaches								
	Issues are too complex for mental health workers								
	Feels crazy								
6. Started therapy	Therapy is painful								
	Struggling to cope								
	Questioning if this is normal								

7. Does anyone else feel like therapy isn't doing anything?	Therapy is not helping/doing anything						
	Questioning if this is a common experience						
	scolded by therapist						
	unfair expectations for how progress/change should go						
	limited of progress						
	self-criticism/blame --- I am the one holding myself back						
	Individual responsibility to change						
8. Feeling pretty triggered af after a therapy session	power dynamic/imbalnce --- desire to prove oneself to therapist	**"'working on myself/treatment' shit" - resitance against this "trick"**					
	Initial hesitancy/awkwardness to try therapy						
9. mentalization-based group therapy, any experiences?	benefits of relational/community based approaches						
	multiple attempts to find a good therapist/therapy is about finding the right fit						
10. Did therapy help you? And if yest, how so?	therapy hasn't worked						
	not sure if therapy is worth it						
	Fear of being dependent on/needing therapy						
	fear of being constructed as "so mentally ill"						
11. Please help I am scared I am addicted to therapy??	Fear of wasting time in session --- linked to pressure to be productive						
	Therapy was helpful/a positive experience						
	benefits of community						
	wish therapy was longer						
	high therapist caseload resulting in lack of personal attention/remembering and connection from clinicians						
12. BPD Group Therapy Questions	Therapy works when you are **open** - personal responsibility						
	therapy does not work for me/feeling the same						
	Going through multiple therapists (finding the right fit)						
	Therapist doesn't care or take clients issues seriously						
13. Therapy doesn't work	wanting to quit as a form of resistance/revenge						
	not sure how to approach therapy						

	exploratory approach is not ideal /desire for more structure/productivity						
	need to be patient --- therapy takes time						
	Therapy is uncomfortable						
	urge to quit therapy						
14. Starting therapy	I NEED help						
	difficulty being honest about mental health concerns --- fear of being institutionalized or not being understood						
15. Is anyone actually 100% honest with their therapist and if not do u have someone u are 100% honest with	trust issues						
	issues are are too complex and often misundertood						
	ignored, dismissed, invalidated, misunderstood in therapy						
	not focusing on the clients primary concerns						
	no one can help me						
	inappropriate therapist behaviour						
16. Experience I had with online therapy	expectation that specialization should = quality care						
	history of poor therapy compliance						
	not working on what the client wants						
	wanting to quit therapy						
17. Therapy	Therapy feels like a waste of time						
	downplaying/hiding how I am doing						
	consequences of self-awareness						
18. hiding. even in therapy	misplaced praise from therapists						
	therapy makes me feel optimistic						
19. Had my first therapy session today since discovering BPD	antincipating a lot of work ahead						
	finally getting the right support	????????????					
	feeling worse in therapy						
	fear of being dependent on therapy						
20. Therapy is taking up my life?	separation between living your life and being in therapy						
	going through multiple therapists --- searching for the "perfect fit"						
	waste of time						

	lack of genuine support -- aspect of just wanting money						
	can't be saved						
	exhausted all options						
	close to giving up						
21. Therapy really is a waste of time, isn't it?	self-blame/worthlessness/hopelessness for not being able to find good care						
	finding the right fit						
	need for specialized treatment						
	therapy isn't doing much so far						
22. BPD therapy questions	Desire for more long term, slowed down, one-on-one care						
	Therapy is very heavy/triggering						
23. I'm not sure what I think of group therapy	Problem-saturated single story of people with BPD						
	Therapy is has helped a little but hasn't gotten to the root of the problem	!!!!!					
	initial progress has plateaued	?????????					
	feeling worse then when I started therapy						
	feeling like a failure - internalized blame						
24. DBT group therapy (your experience?) please help	hopelessness --- therapy won't work for me/I will never get better						
	Past negative experiences in DBT						
	not focusing on clients prefered issues						
	disrespecting/not listening to clients boundaries						
25. Therapist direspecting my boundaries about DBT	Resistance - standing up to therapist, enforcing wishes, and walking out						
	feeling trapped/powerless/disrespected						
26. How do you find a therapist that specializes in BPD?	Needing a specialized treatment in order to get better						
	current therapy is not working						
	Therapist invalidates/dismisses/minimizes clients emotions						
27. Therapy	Resistance - anger "I have the right" to feel my emotions						
	therapist talks over and dismisses client when they try to express themselves						

	unfair expectations of person with BPD						
	Resistance - standing up to therapist						
28. fought with my therapist	Fear of being punished for making complaints --- losing access to therapy and future care						
	Narrow construction of BPD (does not acknowledge heterogeneity)						
	Dismissive, questioning people with BPD's capcity to be knowlegable/self-aware						
	Individual failure/blame --- somethings wrong with me						
29. Therapist said half of me has BPD and half doesn't. Does anyone else relate to this?	Expectation that specialization should = answer, discovering the truth						
	healing = identifying the problem						
30. Crying while doing DBT therapy	crying even more since starting therapy						
	Is this normal?						
	Therapist doesn't fufill promises						
	Therapist Contempt/lack of respect						
	Performing in therapy --- Pressure to appear 'well-behaved'/'normal'/'rational'...lying about severity of problems to avoid being shamed						
	infantalized/treated as non-human/dismissed						
31 Unbelievably harsh treatment from both therapist and psychiatrist	abuse of power/unprofessional/injustice						
	progress is expected to look a certain way and take place quickly						
32. Recently diagnosed with BPD and also started EMDR therapy and I'm losing my mind	never felt worse - feels like they're losing their mind						
	never being believed						
	therapy is just an added stressor to cope with						
	therapy is triggering/more harmful than helpful						
	lack of genuine care or support as a human						
	therapists making false promises						
	expectations about "specialized" treatment						
33. i need therapy from therapy	unprofofessional/ineffective treatment -- not having needs respected						
	postive therapeutic relationship						
	being treated as more than a client						

34. Therapist ghosting me?	feeling abandoned and wanting to change therapists						
35. My therapist just dumped me	having to go through multiple therapists						
	Therapy isn't helping/losing progress						
	being referred to a BPD specialists feels like abandonment						
	feeling broken						
36. Is anyone else's therapist kind of dismissive about the term bpd?	therapist is dismissive of clients view of their personal experience						
	"pretending to be normal"/minimizing distress						
	having to learn about BPD by themself rather than by their therapist						
	DBT emphasizes personal responsibility to change						
	scared to voice complaints for fear of losing therapists approval						
	desire for more community support to feel less alone						
37. Question about meds/therapy	behavioural therapy is a process, not an immediate solution						
	therapy is working wonders	!!!!! important quote					
	Helping yourself, takes time, hard work, patience						
	Therapy does not erase your problems but instead helps you control your emotions, become more rational						
	grateful for therapy						
38. Has anyone ever gone to therapy and fully recovered?	in and out of therapy						
	trying really hard to appear "normal"						
	emphases desire to get help while internalising problems and feeling like a failure						
39. i keep quitting therapy	poor therapy complience						
	not doing enough to improve						
40. DBT: pros, cons, worth it??	uncomfortable with new DBT therapist						
	feels pathologized by therapist						
	perception that DBT is supposed to be "a magic bullet"						

41. Therapy does not help, what can I do?	therapy doesn't help/seeing no progress/not getting anything out of therapy						
	running out of options/feeling hopeless						
	feeling that no one understands or genuinely cares						
	unmet expectations in therapy --- therapy is supposed to help						
42. What's after DBT?	fear of stopping therapy/having to find a new therapist						
	too short term						
	positive therapeutic relationship/effective care based on actually understanding client and not overreacting	????? divergent perspectcive on effective care					
43. Alone and my therapist doesn't understand me	Desire to meet others with BPD						
	Stigmatization of people with BPD - constructed as "nightmare people"						
	inability to be honest with therapist						
44. Type of therapy to ask for?	Therapist dismissed/spoke down to client about their requests -- left feeling naaive						
	unmet expectations in therapy --- therapy should be trauma-informed, and should provide you with "basic self-insight"						
	Feels DBT is only a band-aid solution	!!! important Quote					
	feeling isolated and wanting connection						
45. Does therapy actually help	DBT is not helping						
	Unmet expectations about therapy						
	Working really hard but feeling unstable since recieving BPD diagnosis						
46. I think my therapist glorifying my BPD	feeling really uncomfortable/unsafe to continue being open with their therapist						
	Therapist raises voice at client & shuts down/dismisses/minimizes clients concerns						
	Therapist glorifies BPD						
	Therapist is unfit and dangerous to treat pwbpd						
	Therapy has helped overall	?????					
	individual therapy was helpful; seeing initial benefits in couples therapy	?????					

47. Couples Therapy Wrecks Me Every Time	Therapist rolls eyes & gestures towards client like they are a "hopeless child who's lost his mind"						
	incredibly uncomfortable in therapy/left feeling so hurt, upset, and mistreated						
	wanting to quit couples therapy						
48. Therapist who diagnosed me with BPD is now questioning the diagnosis, but it feels like it's coming from a place of ableism?	Positive experiences with therapist overall based on feeling safe, and trust						
	pathologization --- treating client differently since recieving BPD diagnosis						
	used to minimize and not be open about the severity of her problems out of fear						
	construction of BPD as such a "heavy and horrible thing"						
	"you're not acting in your right mind"						
	narrow idea of what BPD looks like						
	feels that their pain is being invalidated						
	DBT helps	???					
49. Loneliness & Therapy	feeling more alone since starting DBT/therapy is difficult						
	Personal responsibility over change/healing						
	benefiting from the skills						
	identity is suffering --- "hard to be anything but 'someone with BPD'"						
50. Options besides therapy?	Terrible experience with therapy, multiple attempts at therapy						
	difficulty finding a qualified therapist						
	wasting my time						
	giving up on therapy						
51. Therapy vs. career (when we can't have both)	Spent teen years in and out of therapy						
	inpatient DBT has helped a lot, but...						
	DBT always got overwheming leading to dropping out						
	limited access to therapy in their area						
	separation between being in therapy and being able to chase one's dreams						
	little acknowledgement of BPD						
	lack of attention/forgetfulness from therapist						

	"not the right fit"						
52. My therapist doesn't want to label me with BPD	brushing of clients concerns						
	therapist is not well informed about BPD						
	fear of being to honest with therapist/ fear that this will lead to being kicked out of therapy						
53. Super embarrased about something I told my therapist over the phone (suicidal talk) and now I'm freaking out	fear of losing all credibility						
	negative past experiences with mental health providers -- history of being constructed as "too much" and being abandoned						
	DBT therapist is mean, homophobic						
	therapist doesn't listen/minimizes clients perspectives and concerns						
54. DBT therapy	therapist pathologizes client						
	therapy saved my life	!!!!!! Important quote					
	therapy is hard work/initially tedious/ a lot to handle/ triggering						
55. DBT Therapy	changing in therapy is about one's level of personal commitment						
	positive/supportive therapeutic relationship						
56. Very stupid question from an 18 y/o with bpd	difficulty applying techniques in real life						
	only seeing progress within the therapy room						
	feeling misunderstood/invalidated/stigmaztized because of their BPD diagnosis						
	narrow/limited understanding of BPD						
	challenges of finding a therapist, especially one that specializes in BPD						
57. BPD diagnoses invalidated by therapist	feeling vulnerable about bringing up their diagnosis in therapy						
58. i read my therapy notes	masking to seem like the perfect patient, to become more palatable --- feels that they lied their way through therapy	!!!!! Important quote					
	making so much progress in therapy despite initial challenges with therapist being pushy						
59. Felt dismissed in therapy	therapist doesn't acknowledge/minimizes clients reality/perspective						
	therapy feels like showing up for a job --- using customer service voice when talking about their experiences	!!!!!! Important					

60. therapy	not knowing how to be open						