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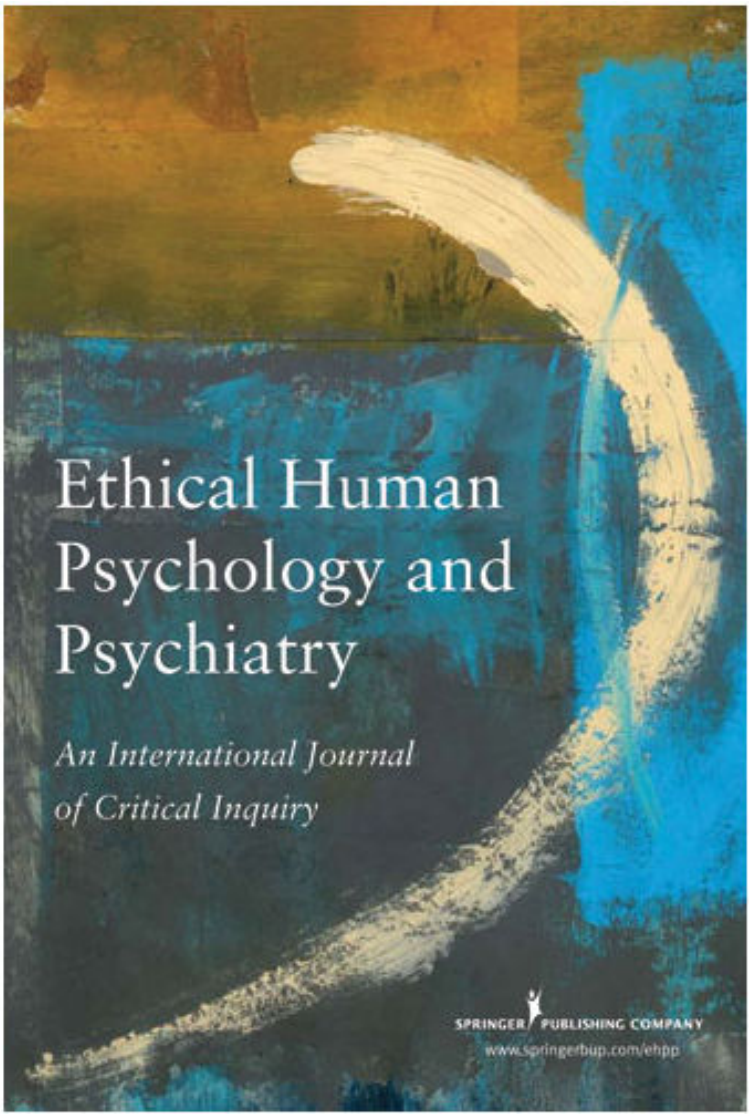
THE 'BORDERLINE' AS THE SOCIOCULTURAL ORIGIN OF BORDERLINE PERSONALITY DISORDER AND PSYCHIATRY



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Abstract

What are borderlines? Typically, they are markings that identify what is both accepted and rejected, and as such, they are places of both inclusion and exclusion. The *Oxford English Dictionary* (1989) defines *borderline* as "a frontier-line, or a boundary between areas or between classes." It also gives a second definition, applying *borderline* to the experiences of "verging on the indecent or obscene" and "verging on insanity." While the second definition seems to capture characterizations of women diagnosed with borderline personality disorder, the first definition reflects the experience of psychiatry at the borderlines of medicine. In this paper, I examine the implications of borderlines for both the borderline patient and psychiatry. Three sociocultural influences on the development of borderline personality disorder that place women on the borderline are examined: childhood abuse and neglect, postmodernity, and the feminization of women. Finally, biomedical psychiatry's attitude towards the borderline patient as "difficult" will be used to understand psychiatry's own position on the borderline as a marginalized medical specialty.

Introduction

Biomedical psychiatry is both helpful and harmful to its patients' well-being. It is helpful when it lessens feelings of anguish and contributes to a patient's sense of becoming the person she or he wants to be. Yet often unwittingly, psychiatry contributes to suffering when theory and practice require patients to shoulder the burden for societal problems. This often occurs inadvertently through practices for medicalizing psychic pain that arises from social distress. Psychiatry also can contribute to suffering when the effects of power relations between psychiatrist and patient are obscured by seemingly neutral scientific representations of suffering. These deleterious aspects of biomedical psychiatry have had a particularly profound effect on the *personhood* of individuals diagnosed with borderline personality disorder.

What do I mean by the word *personhood*? I derive *personhood* from conceptions of self, identity, and selfhood that recognize both individual and societal contributions to the experience of being a person. For instance, in his book *Dimensions of a New Identity* (1974), Erik Erikson describes *identity* as having two aspects, both a "sense" of self and a "sense" of belonging to a community. He states: "A sense of identity means a sense of being at one with oneself as one grows and develops; and it means, at the same time, a sense of affinity with a community's sense of being at one with its future as well as its history—or mythology" (pp. 27-28). More recently, Jerome Bruner (2002) echoed a similar sentiment stating, "we seem virtually unable to live without both, autonomy and commitment, and our lives strive to balance the two" (p. 78).

I prefer the word personhood to Erikson's choice of *identity* and Bruner's preference for selfhood, or the more common term *self*. The word *identity*, like the word *self*, is reflective, and as such, seems to erase the immutable connections existing between self and world. Whereas the word *person*, and by extension, personhood, implies membership in the community of people, and cannot be excised from the context of others in the way the word *self*, and its numerous hyphenated accounts—self-worth, self-esteem, self-reference, self-acceptance—all seem to imply. The term *self* can send us searching in lived experience for a

psychiatric and psychological construct that perhaps is not real beyond the theories that envision it. Whereas it would be difficult for psychiatry and psychology to exist without the self, the existence of the self has yet been proven essential for humanity (See Foucault, 1970).

Narrative, however, is essential to the creation of personhood. Bruner (2002) points out "…it is through narrative that we create and re-create [what he calls] selfhood, that self is a product of our telling and not some essence to be delved for in the recesses of subjectivity" (p. 85). Since the creation of personhood occurs in community, it is a publicly mediated event, and thus it is not solely under the control of the person creating it. What persons can say about themselves, the sense of personhood they can develop, will depend on the stories they can tell as well as the stories that others are willing to listen to, acknowledge, and accept as viable and true. Inevitably, what others are willing to believe about us is going to affect what we are willing to believe about ourselves. Bruner states, "telling others about oneself is, then, no simple matter. It depends on what we think they think we ought to be like—or what selves in general ought to be like.... Our self-directed self-making narratives early come to express what we think others expect us to be like" (p. 66).

This point brings me to the focus of this paper, borderline personality disorder. In her book on borderline personality disorder, *Through the Looking Glass* (1997), psychotherapist Dana Becker claims, "there is no other diagnosis currently in use that has the intense pejorative connotations that have been attached to the borderline personality disorder diagnosis" (p. xv). Here are two examples. In her anthropological study of the education of psychiatry residents, *Of Two Minds* (2001), T. M. Luhrmann observes: "At one outpatient clinic, the category "borderline" was taught through the "meat-grinder" sensation: the chief resident explained to the others that if you were talking to a patient and felt as if your internal organs were turning into hamburger meat (you felt scared; you felt manipulated by someone unpredictable; still, you liked her), that patient most likely had a borderline personality disorder" (p. 113). The second example comes from psychiatrist Irving Yalom describing his patient, Marge, in his book, *Love's Executioner and Other Tales of Psychotherapy* (1989), which goes as follows: "It didn't take much experience to recognize the signs of deep distress. Her sagging head and shoulders said 'depression'; her gigantic eye pupils and

restless hands and feet said 'anxiety.' Everything else about her—multiple suicide attempts, eating disorder, early sexual abuse by her father, episodic psychotic thinking, twenty-three years of therapy—shouted 'borderline,' the word that strikes terror in the heart of the middle-aged comfort-seeking psychiatrist" (p. 227).

Who are the borderline patients these remarks describe? Typically, they are women (an estimated 70-77% of all borderline diagnoses) (See Widiger & Frances, 1989). They are characterized as angry and given to intense, unstable relationships, with a tendency to make suicide attempts as a call for help. The image of the borderline person is one who struggles to inhabit both self and society. They are described as having difficulty being alone yet wary of others. They are seen as terrified of both abandonment and domination, yet constantly flirting with both. Oscillating between extremes of clinging and withdrawal, submission and rebellion, they take their toll on those practitioners who try to help them. They are often characterized by their attempts to form "special" relationships with their therapists, in which ordinary boundaries are not observed. Many psychiatrists perceive borderlines as their most difficult patients (See Becker, 1997; Luhrmann, 2001; Wirth-Cauchon, 2001).

Women diagnosed with borderline personality disorder are also frequently survivors of childhood trauma and neglect (See Wirth-Cauchon, 2001). They are women subjected to socialization processes that result in many of the so-called symptoms associated with borderline personality disorder (See Becker, 1997). They live in a postmodern world characterized by high levels of trauma and instability (See Gottschalk, 2000). All three of these aspects of their personhood are important to telling their life stories. Childhood abuse survivors, however, are taught to hide the truth. Females are taught to defer to males' stories. And in our postmodern epoch, the existence of the self is contested. When it is evoked, the self is frequently described as unstable and constantly changing. This contradicts conceptions of the self as stable and immutable that have dominated modern Western thought (See Fee, 2000; Gottschalk, 2000).

I spent over a year attending a dialectical behavioral therapy group based on Marsha Linehan's Dialectical Behavioral Therapy (DBT) program. Unlike representations of borderline personality disorder that treated the patient as disordered, Linehan's DBT

program focuses on the aftereffects of the original invalidating environment of early socialization and taught patients to develop radical self-acceptance as the origin of meaningful healing. Linehan (1993) qualifies: "although acceptance of clients as they are is crucial to any good therapy, DBT goes a step further than standard cognitive-behavioral therapy in emphasizing the necessity of teaching clients to fully accept themselves and their world as they are in the moment. The acceptance advocated is quite radical—it is not acceptance in order to create change" (p. 5).

While I was aware of pejorative attitudes towards borderline patients, the group leader successfully used Linehan's program to move beyond stereotypical conceptions of the borderline patient. She created a validating environment for women who perhaps had previously known only invalidating environments. Witnessing the success of the dialectical behavioral therapy support group led me to explore why borderlines are perceived pejoratively, if not discriminatorily, and what this says about psychiatry. I believe that at the core of the problem is biomedical psychiatry's relationship with the personhood of its patients and its own position on the borderline of medicine.

I want to argue that it is not only the borderline patient that exists on the borderline of self and society, but psychiatry as well, and that much of the repulsion towards borderline patients is a reflection of the repulsion psychiatry has experienced as a medical specialty on the boundaries of science and what can be claimed as scientific objectivity. In her book, *Women and Borderline Personality Disorder* (2001), sociologist Janet Wirth-Cauchon argues, "the borderline is a site of contention, controversy, and struggle over boundaries, not only between the categories of disorder, but of the boundaries of madness itself, and of the limits of psychiatry" (p. 3). As far back as 1938, psychiatrist Adolph Stern defined borderline personality disorder as inhabiting "the borderline between neurosis and psychosis," and this ambivalence continues today in the treatment of these patients and their failure to be 'objectively' categorized (p. 467).

The American Psychiatric Association (APA) "Practice Guideline for the Treatment of Patients with Borderline Personality Disorder" (2001) describes borderline personality disorder as having a large affective component and suggests treating borderlines with

antidepressants. Empirical studies are lacking to support this interpretation and treatment of borderlines. In fact, some studies suggest the affective component more likely occurs in a relational context rather than endogenously, or in the individual (See Becker, 1997). With borderlines making up a substantial portion of psychiatric inpatients and outpatients, changing interpretations of the disorder today may be motivated as much by the profits earned by pharmaceutical companies as by scientific evidence, thus introducing a new borderline between "good" and "bad" science. Becker argues, "the 'prize' of BPD is a substantial one because those individuals diagnosed borderline seem to represent a substantial portion of persons seeking outpatient mental health treatment. If BPD patients are grouped diagnostically with depressives rather than identified as individuals having trouble getting along in life, they naturally will require antidepressant medications and treatment by psychiatrists rather than by other, nonmedical, therapists" (1997, pp. 61-62).

Contention around the diagnostic categorization of borderline personality disorder and the proper treatment of these patients reflects conflicts in the taxonomy, theory, and practice of psychiatry in general, as well as psychiatry's own position on the borderline. Psychiatry's position on the borderline has a long history, dating back to the nineteenth century and its first efforts to become a medical specialty. No longer satisfied to be a moral agent in service of the Church, and benefiting from government control of asylums, psychiatry began its long quest to become a medical specialty (See Showalter, 1985; Lunbeck, 1994; Goodson & Dowbiggin, 1990). For it to do so, psychiatry needed to replace a predominantly moralistic perspective of insanity with a scientific model of mental illness that had the same constraints on representation, diagnosis, and treatment as any other disease model (See Foucault, 1994). To be a medical specialty, psychiatry could no longer attempt to heal morally flawed individuals; instead, the goal would become assisting biological beings to function in their environments. What was once a moral *flaw* became a *handicap* potentially treatable as a chronic illness. Escaping suffering became correlated with accepting a diagnosis and treatment. Sickness thus replaced suffering, and with it, patienthood replaced personhood.

This shift from personhood to patienthood required a special relationship to evolve between the psychiatrist and the patient (although not the sort that borderline patients are characterized as attempting to create). Rather, the relationship between physician and

patient has been described as prototypical of the Enlightenment project of modern science and necessary for the creation of rationality as the central principle of medical therapeutics. Historians of science Morris Vogel and Charles Rosenberg (1979) relay: "the key to understanding therapeutics at the beginning of the nineteenth century lies in seeing it as part of a system of belief and behavior participated in by physician and laymen alike. Central to the logic of this social subsystem was a deeply assumed metaphor—a particular way of looking at the body and of explaining both health and disease"—that adhered to the principles of rationalism, particularly both parties' acceptance of rationalistic explanations of disease and health (p. 5). It also entailed that the physician hold an elevated social position in relation to the patient that required complete trust in the physician's perceptions of disease. This occurred not only through the prestige of medicine, but also through the creation of patienthood.

In the turn from the person to patient, this subject of objective discourses is created without a voice, while the physician becomes the objective, unmediated seer of suffering. With this perspective, certain aspects of the person are extracted and given priority over other aspects according to scientific theory rather than the concerns of the patient. Psychiatrist Neil Sheurich (2000) tells us this is the very definition of modern medicine: "physicians as authoritative arbiters of objective diagnoses and definitive treatments" (p. 462). While it has become the norm for physicians and other health care practitioners to translate a patient's idiosyncratic descriptions of suffering into their specialty's terminology, psychiatry is unique among medical specialties because it alone is poised to treat *personhood*.

At the basis of such interactions is an unequal power distribution, which is likely the basis of the "difficulty" associated with borderline patients. Psychologist Alisha Ali (2002) states: "this unequal distribution of power/knowledge is particularly problematic for psychiatric patients who, through the process of internalizing their psychiatric labels and diagnoses, become complicit in the subjugation and distortion of their own self-knowledge" (p. 235). Complicity, however, does not necessarily imply willingness, as the borderline patient's behavior demonstrates.

The Significance of a History of Abuse & Neglect

This brings me to my first observation about the sociocultural conditions of borderline patients: the prevalence of childhood abuse and neglect that is at odds with the Enlightenment-style of doctor-patient interaction. One study found 71% of people diagnosed with borderline personality disorder had a history of childhood physical abuse and 62% had exposure to domestic violence (Wirth-Cauchon, 2001, p. 66). The same study identified sexual abuse in 68% of borderlines. Another study observed that 55% of the borderline patients it studied had experienced "physically forced, unwanted sexual contact" (Huff, 2004, p. 43). Besides maltreatment, childhood emotional neglect is also believed common to people diagnosed with borderline personality disorder (See Becker, 1997; Wirth-Cauchon, 2001; Huff, 2004).

The link between abuse and personality disorders is thought to be one of causality. In one study in New York of 793 mothers and their children, those children "who experienced verbal abuse in childhood—compared with those who didn't—were more than three times as likely to be diagnosed as adults with borderline, narcissistic, obsessive-compulsive and paranoid PDs [personality disorders]" (Huff, 2004, p. 44). In another study in New York that followed 639 families for twenty years, "children with documented instances of child abuse or neglect were more than four times as likely to develop a PD in early adulthood..." (Huff, 2004, p. 44).

At the basis of experiences of chronic childhood abuse is a profound loss in the capacity to trust, particularly in persons that take the role of caregiver. And why should victims of abuse invest in developing trust? As abuse survivors, the construction of personhood has been shattered. Unable to trust love, they are profoundly disempowered in a shared social world. Abuse splinters the construction of personhood that is formed and sustained in relation to others. Personhood exists in a crucible that melds one with others, yet abuse disconnects people, severing fundamental attachments to family, friendship, and community that persons without a history of abuse might never question. The word "self" seems to be particularly appropriate for abuse survivors, as it captures the sense of isolation that characterizes their

experience of personhood. Childhood abuse throws its victim into search for personhood, yet often only finding an isolated and alienated self.

Psychiatrist Judith Herman tells us childhood abuse and neglect, like all traumatic events, "…undermine the belief systems that give meaning to human experience. They violate the victim's faith in a natural or divine order and cast the victim into a state of existential crisis" (1992/1997, p.51). Herman, in her book, *Father-Daughter Incest* (1981/2000), fittingly begins the chapter, "The Daughter's Inheritance," with the following quote from Mary Wollstonecraft Shelley's *Mathilda* (1819), where Shelley describes the existential affects of abuse: "My father had forever deserted me, leaving me only memories which set an eternal barrier between me and my fellow creatures … [His] unlawful and detestable passion had poured its poison into my ears, and changed all my blood, so that it was no longer the kindly stream that supports life but a cold fountain of bitterness corrupted in its very source. It must be the excess of madness that could make me imagine that I could ever be aught but one alone; struck off from humanity; bearing no affinity to man or woman; a wretch on whom Nature had set her ban" (p. 96).

Shelley's remarks imply personhood involves how one envisions oneself as an individual as well as a member of a group, or even humanity. The experience of the survivor has been described as one of waiting, in many ways, for the inception of a new identity, one that can be inclusive of all experiences and every memory, not just those society will recognize, validate, and thus accept as normative of its members (See Fraser, 1987). And perhaps this is part of the "difficulty" of borderline patients: the profound dissonance between the actual experiences of abuse and the stories that abuse survivors typically are allowed to author. If the story of her experiences is not voiced in her culture's history, where, then, does she belong?

In the APA (2001) guidelines for treating borderline personality disorder, the authors advise "clinicians may find it useful to keep in mind that often patients will attempt to redefine, cross, or even violate boundaries as a test to see whether the treatment situation is safe enough for them to reveal their feelings to the therapist" (p. 12). Yet that explanation seems skewed towards preserving Enlightenment conceptions of the doctor as author of the patient's story

when the significance of telling one's story as one remembers it—and not according to the symptomatology of disease—is believed central to developing personhood. Ali (2002) observes, "the replacement of their voice with the voice of the expert/authoritarian figure, is just symbolically a repetition of abuse" (p. 239). This is particularly problematic when the therapist is a man and the patient a women, as such dynamics invariably are embedded with the unequal power dynamics that exist between women and men (See Herman, 1981/2002). Honoring the story would involve working with the borderline patient's knowledge—the wisdom of her experiences—to develop and refine it, rather than replace it with a foreign mode of understanding. To do otherwise only perpetuates the experience of alienation, both in her person and the community from which she feels excluded.

Less antagonistically, attempts can be made to find and create in the therapeutic encounter the possibility for personhood to unfold without the repetition of constraints that neglect, or even obviate, the *other* story, the one untold. Borderline patients may be responding to the intimacy of therapy, its reminders of those first relationships with caregivers. For the abuse survivor, this may mean an invalidating environment and/or one without boundaries, and the onus is on the therapist for creating safety and showing the patient the way to community and personhood (See Linehan, 1993). This will be almost impossible if the borderline patient is seen as a threat to the boundaries of psychiatry and the psychiatrist. As Luhrmann (2001) puts it: "…a psychiatrist who is anticipating the need to protect herself is alert for very different cues from those anticipated by a psychiatrist who feels the need to protect a patient" (p. 118).

It may be the case that some psychiatrists (likely due to their training) can only offer the borderline patient an atomized, self-contained sense of personhood, or *self*. Trauma, as it is represented by modern psychiatry, has been rendered an individual's psychological response that can be explained coherently as existing solely in the individual self. This move to place trauma in the self results in the loss of meaningful ties to what it means politically to be a victim as well as the existential crisis and lost personhood that chronic violence like childhood abuse produces.

A shift from treating pathology as disease, to treating pathos as suffering, would benefit interactions between the psychiatrist and the borderline patient. This shift would entail moving away from listening solely for the presence of disease. It would involve listening for the untold story and fostering remaking the tale. It would require shifting away from the isolated self in the story to a new story of a person with membership in community. Sheurich (2000) remarks, "a physician must acknowledge patienthood, but she or he must promote personhood, the autonomous creation of the life story, wherever possible" (p. 475).

Healing is unlikely with only an awareness of how abuse affects the isolated self. Childhood abuse and neglect is also a social problem in need of a social solution. Healing the self simply isn't enough. Louise Armstrong, author of *Rocking the Cradle of Sexual Politics: What Happened When Women Said Incest* (1994), argues: "What is needed…is the courage to *know*, the courage to *understand*; the courage to think and speak in one's own language, and to make that language heard in the larger world…. This would require that women reclaim their own experience, and adopt skepticism that one can find empowerment by turning power over to the 'experts'" (p. 273). Fulfilling Armstrong's agenda would likely require letting go of the self as the central focus point of treatment, replacing it with personhood.

The Postmodern Connection

The conception of the atomized self isn't a mistake, or fluke in the history of psychiatry, but rather is foundational of the Enlightenment project and the creation of the modern selfhood. The problem today, however, is that we no longer live in the epoch that spawned Enlightenment attitudes toward science and its subjects, yet are living in a period of transition, the *postmodern*, in which we have inherited outmoded ways of viewing the world that don't quite fit our experiences and observations. This brings me to the second sociocultural condition of persons diagnosed with borderline personality disorder: the present postmodern era. According to David Levin, what makes our era postmodern is the recognition that modernity has failed and that something must replace it—although what, we are not sure. He states: "modernity ends, since it is, in part, a question of culturally shared

consciousness, as people begin to realize that there is a critical distance that separates them from the thinking and living they have inherited…. But postmodern thinking also begins with a strong sense—articulated, however, only with difficulty—that we are living in a time of transition, a moment between two epochs: the known and the unknown" (As cited in Fee, 2000, p. 8). In a time of transition, existing at the borderline gives a privileged view. The difficulty associated with women diagnosed with borderline personality disorder may, in part, be their expression of their unenviable, yet privileged viewpoint. Perhaps it is the shrillness with which this message is delivered that is found so off-putting—not with the sweet sound of the dove, cooing to a new morning, but with the cries of a beast ensnarled in a trap with no recognizable means of escape.

Psychiatry hasn't entirely caught up with postmodernity, and continues to exist predominantly as a modern institution. Led by the assumption that society is sane, it seems to aspire to returning people to the shared social order and away from their idiosyncratic conceptions of reality. When Philippe Pinel, Jean-Martin Charcot, Sigmund Freud, Pierre Janet, and others began this modernist project in the nineteenth century, psychiatry perhaps had the authority to assert that one model of the mind was normative and all others should be sacrificed. We, however, no longer live in their era, but at a time when what constitutes sanity is as contentious as the legitimacy of the institutions that seek to define it.

I take the postmodern to begin after World War II and to be birthed by unrelenting trauma. Since the Second World War, we have witnessed continual genocides and econocides, the disintegration of the nuclear family, and a media compelled to sensationalize each turn of events (See Gottschalk, 2000). Even if you have been fortunate enough not to experience trauma personally, you witness it regularly through media. Constantly viewing trauma and its effects contributes to a profound sense of uncertainty about one's morality and spurs the continual creation of personhood that has become the hallmark of the postmodern self. Indeed, postmodern selfhood has been compared to just one more commodity, traded and exchanged, not unlike any other product, idea or style (See Gottschalk, 2000). Rather than a solid and stable modern self in search of permanence, a postmodern personhood predominates that is recognized by its fluidity, its capacity to adapt to changing and sometimes mutually exclusive relationships, its focus on process rather than permanence,

and its emotional reactivity which such continual change engenders. In his article, "Escape from Insanity: 'Mental Disorder' in the Postmodern Moment," Simon Gottschalk points out, "…DSM-IV provides a label for such rapid emotional shifts; it organizes such dispositions and others with the diagnosis of a 'borderline personality disorder'" (2000, p. 29).

In our postmodern world, stable illness identities clash with a sense of the world as protean and instable. The DSM is caught in this confusion, interpreting postmodern suffering through modernist conceptions of the self. Gottschalk asserts "…if we posit postmodern selfhood as a mutable, liminal, multiple, interdependent, and interactive process, then relying on DSM-IV diagnoses will prevent us from understanding it, since DSM-type diagnoses rest on—and reproduce—the idea of a stable, self-contained, and isolated modern self" (2000, p. 21).

Anthropologist Clifford Geertz identifies the modern conception of self as that "…bounded, unique, more or less integrated motivational and cognitive universe, a dynamic center of awareness, emotion, judgment, and action organized into a distinctive whole and set contrastively against other such wholes and against a social and natural background…" (Geertz, 1979, p. 229). Arguably, this is the self psychiatry often tries to reproduce in its patients. But Geertz reminds us that the Western modern self is "a rather peculiar idea within the context of the world's cultures" (p. 229). Many argue it is undeniably a Western white male subject that psychiatry creates through theory and practice, often pathologizing the feminine experiencing as a result. Philosopher Moira Gatens argues that "while the male subject is 'constructed as self-contained and as an owner of his person and his capacities, one who relates to other men as free competitors with whom he shares certain politico-economic rights…[t]he female subject is constructed as prone to disorder and passion, as economically and politically dependent on men…'" (As cited in Rose, 1996, p. 6). Such representations of the feminine experience likely influence the borderline's experience of patienthood as well as why she is found to be so difficult. It is her excess of femininity—seen as well beyond the 'normal' characterization of women as fickle and moody and in need of control—that some believe is envisioned as pathological. This brings me to the third sociocultural condition of women diagnosed with borderline personality disorder: the feminization of women.

The Feminization of Women

While child abuse is almost equally distributed between the sexes, borderline personality disorder is predominantly diagnosed in women (See McDonald & American Humane Associates, 2004). This has suggested to some that part of what is being treated when a person is diagnosed with borderline personality disorder is the female condition, that feminization *itself*—that is to say, the developmental process of becoming a woman—has pathologizing effects on girls and the women they eventually become (See Becker, 1997; Wirth-Cauchon, 2001). Becker points out that the borderline category is representational of the norms of femininity taught to women (1997). She believes these norms can be detrimental to women's mental well-being, particularly with regards to issues of dependency, attachment, and the emphasis on caretaking others at the expense of the self that characterizes the development of most girls and female adolescents. Janet Wirth-Cauchon (2001) similarly argues, "…femininity becomes disordered if not pathological in order to adapt to a pathological and disordered socialization" (p. 29). Self-defeating attitudes seen as common to women are portrayed as the result of feminine socialization. These include: difficulties with assertiveness; the premature renunciation of needs; the reversal of nurturing roles; the conversion of anger into compliance; the conversion of self-assertion into caring for others; and a readiness to accept blame for what goes wrong in relationships (See Westcott, 1986).

At issue for the developing girl and the mature woman is often how to remain an individual committed to her authentic experience while being with others. However, historically in the field of psychology, most attention has been focused on the development of a unitary, separate self. Since this is not the experience of the feminine gender, the mental health sciences may redouble the pathologizing affect women already feel as second-class members of society. Developmental theorists have tended to see development as a process of separating oneself out of the matrix of others (See Becker 1997). With this view, a healthy person experiences connectedness as an "active act of integration," and an unhealthy person experiences connectedness as the "passive failure of differentiation" (Becker, 1997,

p. 81). Yet this implies the feminine experience of socialization is unhealthy since feminine development typically is more focused on connectedness than the creation of autonomy.

For developing girls and adolescents, the act of differentiating between separation and individuation is not as important, nor as prominent in their lives, as the act of differentiating between states of separation and connectedness. Much of this has to do with expectations of women. Traditionally, circumstances were not expected to arise that would require a woman to have an individuated self. This is related to our society's expectation that the primary responsibility of women is to nurture others. And while Western women today have more roles to choose from them simply being a wife, homemaker, and mother, evidence suggests that the development of girls and adolescents have yet to catch up with the opportunities now available to women (See Stake, 1992). In particular, the requirement for good behavior, defined as an excessive concern for the needs of others, can alienate women from their genuine desires and feelings and stand in the way of achievement and self-fulfillment. As Becker (1997) observes, "this lesson of 'others first' not only implies the lesser importance of her own needs but also raises the possibility that her needs will never be met, or that they will be met only in exchange for meeting the needs of others" (p. 100). Is it any wonder, then, that borderlines are often perceived as manipulative?

The following two examples of teen girls talking about their lives reveal their negotiations of separateness and connectedness. The first is Janet, who is in the ninth grade and is 14-years-old. Talking about peer dynamics, she says: "When you are in a big group of people and they are like saying something like about another person and you want to tell them to stop, but you are surrounded by a whole group, you really can't say, you just can't, because they would get mad at you, you know. And it is better if you don't speak up because you can just walk away and leave them alone and they can be with their ideas and you can still have your own thoughts. But, I don't know" (Rogers, Brown & Tappan, 1994, p. 2). The next quote comes from Heather. She's in the tenth grade. Talking about her relationship with her father, she says: "I got into this big debate with my Dad, uh, he's a debating kind of person, you know, and he almost always wins…. So I was saying one thing, and I really did not agree with him…. By the end, I could see his point better than mine, so I guess you could say that

we agreed" (Rogers, Brown & Tappan, 1994, p. 21). In both of these examples, we can identify that the push for connection is greater than the need for individuation.

Susan Harter (1990) gives an image of developing female adolescents, such as Janet and Heather, in which the failure to navigate relational waters can result in the failure to develop an integrated and meaningful personhood that honors private thoughts and feelings within the context of shared norms and beliefs. She portrays evidence of this in terms of the *self* that includes "…a distorted or unrealistic self-concept, failure to integrate the self across multiple roles, conflict over seeming contradictions within the self, maladaptive or distressing displays of false selves, and definitions of the self that rely primarily on the standards and desires of others" (p. 354). Many of these characteristics are witnessed in adult women diagnosed with borderline personality disorder.

When the socialization of women is recognized as a central aspect of the borderline's story, borderline traits are seen less as markers of a pathologized self and more as adaptive responses to social norms of chronic invalidation and devaluation. The identity confusion often associated with borderlines is seen not as the failure to experience autonomy, but rather as a failure to experience healthy relatedness. Overly dependent behavior is seen as the lack of an ability to sustain one's own subjective reality while simultaneously sharing a consensual reality with others.

Modernity's doctor-patient relations are not unlike the feminine development process that leaves many women feeling dependent on others to legislate their emotions and identity. Feminist psychiatry tries to get around Enlightenment-style doctor-patient interactions that lead to the continual subversion of the female story. Feminine psychiatry, Ali (2002) tells us, is "…a new mode of knowledge-formation in which meanings are constructed dialogically to include a hybrid of scientific clinical knowledge and phenomenological self-knowledge that capitalizes on the power/knowledge nexus" (p. 236). She further states, "in this way, both the traditional 'object of study' (e.g., the patient) and the traditional 'expert' (e.g., the scientist or clinician) possess pre-existing forms of knowledge which together can generate progressive forms of knowledge that did not previously exist" (p. 239). Ali identifies three principles underlying this approach (p. 237). First, it involves creating a partnership between

the clinician and the patient based on egalitarian principles. Second, it requires making central, in both clinical and theoretic work, the impact of societal disempowerment on women. And third, it entails including social action as part of the work of healing, focusing on the need to change social norms that hinder women's development of well-being. The endpoint may be described as the capacity to experience both autonomy and relatedness without sacrificing the person, or her story.

Psychiatry on the Borderline

The three sociocultural influences on borderlines that I have discussed—a history of abuse and neglect, postmodernity, and the feminization of women—support replacing patienthood and the self with personhood and a focus on the person in community. Psychiatry might also benefit from such a shift in perspective on the patient. Despite promises of universality in an arsenal of pills and through the DSM, biomedical psychiatry has never succeeded at the Enlightenment project, which has kept it teetering on the borderline. Inevitably, the experience of personhood sneaks back in, along with the messy, often-inexplicable motivations for why people act as they do, make the choices they do, and often suffer in unique ways.

And why shouldn't personhood impede upon patient treatment? Telling the story of suffering has a long history of success in relieving emotional burden and is likely necessary for the creation of a meaningful sense of personhood. According to Bruner (2002), without the power to narrate our lives, we might not even know who we are. He avows, "selfhood can surely be thought of as one of those 'verbalized events,' a kind of meta-event that gives coherence and continuity to the scramble of experience. However, it is not just language per se but narrative that shapes its use—particularly its use in self-making…. Don't we, too, have to tell the event in order to find out whether, after all, 'this is the kind of person I really mean to be'?" (p. 73). As I will argue, the symptoms of a disease are a flimsy stand-in for meaningful narratives of personhood.

Traditionally, listening to stories has been thought to impede the physician's capacity for objective observation, and objective observation is considered the basis of being a good physician. We can speculate that the difficulty associated with the borderline patient takes root in the training of would-be psychiatrists, who spend their first years learning to prioritize objective awareness over empathy and the capacity to care. Psychiatry residents, fresh out of medical school, yet not board-certified, typically begin their introduction to treating psychic suffering in the hospital where they learn to identify disease in a setting devoid of the context of their patients' individual lives—the same lives their patients found too difficult or too chaotic to bear. Luhrmann (2001) saw that "in the hospital, the way psychiatrists learn to admit patients and present them to supervisors encourages them to think of psychiatric illness as an organic disease, a "thing" underlying and generating the symptoms" (p.25). Typically, it is not until the practice of identifying disease in suffering has been sufficiently well learned that the resident is exposed to patients in an outpatient setting in which issues of the patients' interactions with others begins to play a role. By then, the reductionist approach is well established, and not taking this approach is to be less-than-scientific. It may even be morally discomforting to those committed to practicing psychiatry according to the professional standards established in the hospital setting. As Luhrmann observed, "for many young psychiatrist, at least in residency, the moral authority of science outranks the moral authority of helping people one person at a time" (2001, p. 181).

Recalcitrant, entrenched, and unflinching personhood, the kind that borderline patients can produce, may be seen as a threat to the biomedical representations of suffering that make psychiatry a medical specialty and the psychiatrist an objective observer. Psychiatry responds with a two-tiered system of health care, buttressed by the DSM and distinctions between Axis I and Axis II disorders (See APA, 1994). This system edifies biological disorders and separates them from the personality disorders, creating a caste-like system of mental health care. The distinction between Axis I and Axis II disorders has been described as an attempt to buttress psychiatry's once sagging reputation, and elevate itself above the social workers and psychologists that were quickly invading its turf during the middle part of the twentieth century (See Becker, 1997). Psychiatry's own struggles with the borderline between science and non-science, medicine and social welfare, disease and social ills, is embedded in the caste-like structure of the DSM and the attitudes it engenders towards

patients. Not only does Axis I confirm that mental illness is indeed a biological disorder, it brings about favoritism in supporters of the biomedical model of mental illness. As one psychiatric resident stated: "I have more respect for Axis I. I feel better about it. If they're really depressed, have all the neuro-vegetative symptoms, you feel like they came by their diagnosis honestly. The same thing if they're manic, have classic psychotic symptoms—it's exciting. You think, oh, they have a real diagnosis, you can treat it with medication, and you can also give them the benefit of the doubt. They've got genetic loading to have this terrible disease. On the other hand, Axis II is almost like an insult" (Luhrmann, 2001, p. 115).

The difficulty experienced with borderlines is thus partially due to difficulties inherent to the professional project of psychiatry and the lack of validation psychiatry receives from this relatively large patient population. In part, the borderline is difficult because she is not a medical patient, but stubbornly a person whose problems are neither explained with a disease model nor empirically treated with medications. This does not stop practitioners from comparing borderlines to their Axis I counterparts, with whom they typically come up short. For instance, Judith Beck, the Director of the Beck Institute for Cognitive Therapy and Research describes Axis I patients as more trusting of therapists that Axis II patients. She states: "Axis I patients often come to therapy believing 'I can trust my therapist, this is going to work.' Axis II patients may think things like 'I can't trust my therapist, she might hurt me,' or 'if I listen to my therapist it will show how weak I am and how strong she is'" (Dingfelder, 2004, p. 48). The assumption here is that we are witnessing cognitive distortions on the part of the Axis II patient. Yet if we entertain seriously the borderline positioning of psychiatry and the need for medical professionalism that it engenders in many of its members, perhaps the doctor-patient encounter warrants suspicion. Perhaps the borderline is the veritable canary in the coalmine that harks not of impending death, but rather is uncomfortably aware that the emperor has no clothes. Rather than described as "difficult" patients, perhaps borderlines are better understood as "resistant" patients. Borderlines are resistant to being in the lower caste of patients. They are resistant to being dismissed because they lack a biological basis for their suffering. They are resistant to the annihilation of personhood that modern conceptions of the patient require.

It should come as no surprise that persons diagnosed with borderline personality disorder quit treatment an estimated 70% of the time (See Dingfelder, 2004). Those patients that stay Sheurich (2000) describes as feigning powerlessness, even if unconsciously, in order to adopt an extreme caricature of patienthood rather than having no personhood at all. Sheurich portrays these individuals as giving up on personhood, and as accepting patienthood as the last resort. It is, he believes a "metamorphosis of demoralization into incapacity," and while at times this may be taken for "playing dead," at other times patienthood is a mask of anger for the continual subversion of the person who must exist as patient if she is to have any hope of healing (2000, p. 472).
Why, then, do some borderlines continually return to psychiatry, often becoming permanent fixtures of inpatient wards and day treatment programs? Believing in the power of narrative, I like to think that they hold the basic desire to tell their life stories, or at the least, to have the opportunity to create one that is coherent and makes sense. Modern psychiatry is good at constructing illness identities, replacing a complicated, messy past with a litany of symptoms. But that could be the problem. Sheurich observes, "…due to medicalization, the stories patients tell are increasingly illness-saturated; illness stories are eclipsing life stories" (2000, p. 470).

The borderline patient who complies with her psychiatrist's interpretation of suffering as illness may only be, once again, colluding with someone she perceives as more powerful than herself. As historian of science Ian Hacking (1995) has pointed out, we tend to behave in ways that are expected of us, especially by authority figures. Hacking calls this the *looping effect of humankind's*: "people classified in a certain way tend to conform to, or grow into the ways that they are described" (p. 21). And if a person is experiencing a crisis, as many are when they initially find themselves in the psychiatrist's office, this effect will be pronounced as the patient attempts what Erikson (1974) has referred to as *pseudospeciation*, our attempt to simplify when under stress, sacrificing personal knowledge, even ethics, for the hope of once again feeling safe (p. 28).

What might be the best practices for treating borderline patients? Sheurich (2000) advocates creating a postmodern medicine, which would shift from a strict focus on patienthood to the negotiation of patienthood with personhood in the doctor-patient encounter. Sheurich's

postmodern medicine is three-part, and makes central to the management and care of the patient 1) the patient's belief system, 2) the practitioner's expectations, and 3) the surrounding cultural milieu. The goal cannot be to fashion a particular type of patient story, most notably, the illness narrative, but the capacity to tell stories about oneself in the creation of personhood and community. In a postmodern world, the fixed meanings associated with stable illness identities are limiting. What is needed is a sense of personhood that has the capacity to accept the radical contingency of life while staying engaged with others. This is something I witnessed was difficult for many of the borderline patients in the DBT group I attended. With a more fluid and protean postmodern medicine, the patient may continue to model her behavior according to the psychiatrist's representation of her illness, yet she may also learn that she can have multiple, even contradictory stories and can develop the capacity to revise them as necessary in ongoing life struggles and relationships. Then, maybe, both physician and patient can let go of the tired, modern story.

References

Ali, A. (2002). The convergence of Foucault and feminist psychiatry: Exploring emancipatory knowledge building. *Journal of Gender Studies, 11*(3), 233-242.

Armstrong, L. (1994). *Rocking the cradle of sexual politics: What happened when women said incest*. New York: Addison-Wesley Publishing Company.

Association, A. P. (2001). Practice guideline for the treatment of patients with borderline personality disorder. *Supplement to The American Journal of Psychiatry, 158*(10).

Association, A. P. (1994). *DSM-IV: Diagnostic and statistical manual of mental disorders* (Fourth ed.). Washington, DC: American Psychiatric Association.

Becker, D. (1997). *Through the looking glass: Women and borderline personality disorder.* Boulder: Westview Press.

Bruner, J. (2002). *Making stories: Law, literature, life*. New York: Farar, Straus and Giroux.

Dingfelder, S. F. (2004, March). Treatment for the 'untreatable'. *Monitor on Psychology,* 46-49.

Erikson, E. H. (1974). *Dimensions of a new identity: The 1973 Jefferson lectures in the humanities*. New York: W. W. Norton & Company, Inc.

Fee, D. (2000). The broken dialogue: Mental illness as discourse and experience. In D. Fee (Ed.), *Pathology and the postmodern: Mental illness as discourse and experience* (pp. 1-17). London: Sage Publications.

Foucault, M. (1994). Psychiatric power. In P. Rabinow (Ed.), *Michel Foucault: Ethics, subjectivity, and truth* (Vol. One, pp. 39-50). New York: The New Press.

Foucault, M. (1970). *The order of things: An archaeology of the human sciences*. New York: Random House.

Fraser, S. (1987). *My father's house: A memoir of incest and of healing*. New York: Ticknor & Fields.

Geertz, C. (1979). From the native's point of view: on the nature of anthropological understanding. In P. Rabinow & W. M. Sullivan (Ed.) *Interpretive social science: A reader.* (pp. 225-241). Berkeley: University of California Press.

Goodson, I., & Dowbiggin, I. (1990). Docile bodies: Commonalities in the history of psychiatry and schooling. In S. J. Ball (Ed.), *Foucault and education: Disciplines and knowledge*. New York: Routledge.

Gottschalk, S. (2000). Escape from insanity: 'Mental disorder' in the postmodern moment. In D. Fee (Ed.), *Pathology and the postmodern: Mental illness as discourse and experience* (pp. 18-48). London: Sage Publications.

Hacking, I. (1995). *Rewriting the soul: Multiple personality and the sciences of memory*. Princeton: Princeton University Press.

Harter, S. (1990). Self and identity development. In S.S. Feldman & G.R. Elliott (Eds.) *At the threshold: The developing adolescent* (pp. 352-387). Cambridge, MA: Harvard University Press.

Herman, J. M. (1981/2000). *Father-daughter incest*. Cambridge: Harvard University Press.

Herman, J. M. (1992/1997). *Trauma and recovery: The aftermath of violence— from domestic abuse to political terror*. New York: Basic Books.

Huff, C. (2004, March). Where personality goes awry. *Monitor on Psychology,* 42-44.

Linehan, M. (1993). *Skills training manual for treating borderline personality disorder.* New York: Guilford Press.

Luhrmann, T. M. (2001). *Of two minds: An anthropologist looks at American psychiatry* (2nd ed.). New York: Vintage Books.

McDonald, W. R. & Associates, A. H. (2004). *Child maltreatment 2002*. Retrieved October 16, 2004 from http://www.acf.hhs.gov/programs/cb/publications/cm02/ index.htm.

Lunbeck, E. (1994). *The psychiatric persuasion: Knowledge, gender, and power in modern America*. Princeton: Princeton University Press.

Rogers, A. G., Brown, L. M., & Tappan, M. B. (1994). Interpreting loss in ego development in girls: Regression or resistance? In A. Lieblich & R. Josselson (Eds.), *Exploring identity and gender* (Vol. 2). Thousand Oaks: Sage Publications.

Rose, N. (1996). *Inventing our selves: Psychology, power, and personhood*. New York: Cambridge University Press.

Scheurich, N. (2000). Hysteria and the medical narrative. *Perspectives in Biology and Medicine, 43*(4), 461-476.

Showalter, E. (1985). *The female malady: Women, madness, and English culture, 1830-1980*. New York: Pantheon Books.

Stake, J. E. (1992). Gender differences and similarities in self-concept within everyday life contexts. *Psychology of Women Quarterly*, 16, 349-363.

Stern, A. (1938). Psychoanalytic investigation of and therapy in the borderline group of neuroses. *Psychoanalytic Quarterly*, 13 (2), 124-139.

Vogel, M. J., & Rosenberg, C. E. (Eds.). (1979). *The therapeutic revolution: Essays in the social history of American medicine*. Philadelphia: University of Pennsylvania Press.

Westkott, M. (1986). *The feminist legacy of Karen Horney*. New Haven: Yale University Press.

Widiger, T.A. & Frances, A. J. (1989). Epidemiology, diagnosis, and comorbidity of borderline personality disorder. In A. Tasman, R.E. Hales, & A.J. Frances (Eds.), *Review of Psychiatry*, vol. 8, Washington, DC: American Psychiatric Press.

Wirth-Cauchon, J. (2001). *Women and Borderline Personality Disorder: Symptoms and Stories*. New Brunswick: Rutgers University Press.

Yalom, I. (1989/2000). *Love's executioner and other tales of psychotherapy.* New York: Perennial Classics.