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# Lessons from the borderline: Anthropology, psychiatry, and the risks of being human

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Susanna: I didn't try to kill myself.

Dr. Potts: What were you trying to do?

Susanna: I was trying to make the shit stop.

*Girl, Interrupted* (1999)

As an anthropologist, I study western psychiatric categories and practices as historically specific technologies of moral (and, often, gendered) personhood. I am also a practicing psychotherapist. Along with other concerns, many of my clients meet the DSM diagnostic criteria for Borderline Personality Disorder (BPD). I have clients who cut themselves with glass, binge and purge, starve themselves into numb oblivion, burn words into their stomachs, have difficulty sustaining interpersonal relationships, dissociate, and regularly feel overwhelmed by strong emotions. The academic and clinical aspects of my work, coming as they do from distinct analytic positions, situate me uniquely in relationship to questions of gender, culture, and mental illness in general, and BPD in particular.

Clinicians generally detest working with borderline patients.<sup>1</sup> These clients can present as unpredictable, needy, hostile, overly dramatic, and emotionally draining. As McGlashan (1993: 241) observes: 'Officially, 'borderline' is a diagnostic label. Unofficially, in clinical parlance, it is synonymous with 'anathema.'" Gabbard (1997: 26) elaborates: 'A significant number of professionals within the industry regard borderline patients with contempt.' And as one psychiatrist told anthropologist Tanya Lurhmann (2000: 113), you look for the 'meat grinder' sensation: if you are talking to a patient and it feels like your internal organs are being turned into hamburger meat, she's probably borderline.

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My academic colleagues also find borderline personality disorder ‘anathema,’ but for entirely different reasons. For many, BPD represents the worst of psychiatry as a mechanism of regulatory control that is historically and culturally predisposed to find women defective and sick (Becker, 1997, 2000; Potter, 2009; Shaw and Proctor, 2005; Wirth-Cauchon, 2001). Women, they observe, are diagnosed with BPD far more often than men (Becker and Lamb, 1994), with the vague diagnostic criteria easily extendable to anyone doctors find inscrutable, provocative, or even merely annoying (Potter, 2006). BPD is arguably a go-to diagnosis within a medical system that disproportionately interprets strong emotions in women as symptoms of pathology (Skodol and Bender, 2003).

Here, I discuss some of my own views on borderline personality disorder from the perspective of a clinician-anthropologist. I highlight some key aspects of the dominant feminist critiques of BPD that inadvertently undermine vital components of their own agendas. I then offer an alternative reading that addresses these concerns.

## **BPD, psychiatric epistemology, and the ‘real’**

I know what it’s like to want to die. How it hurts to smile. How you try to fit in but you can’t. How you hurt yourself on the outside to try to kill the thing on the inside.  
Susanna, *Girl, Interrupted* (1999)

The current diagnostic parameters for BPD (American Psychiatric Association, 2000) define it as a personality disorder characterized by fears of abandonment, relationships where others are alternately idealized or demonized, an unstable sense of self, impulsivity, suicidal behavior, mood swings, feelings of emptiness, overwhelming anger, and stress-related paranoia or dissociative symptoms. Critics of the diagnosis point out that many of these characteristics are consistent with historically ‘feminine’ predispositions such as emotionality, dependency, and instability, while others lend themselves to differential interpretations based on gender norms and expectations. Casual sexual activity is more likely to be labeled ‘impulsive’ in women than men, for example, for whom such encounters are often socially normalized if not valorized. Terms such as ‘frantic’ or ‘inappropriate’ as qualifiers likewise entail judgments about appropriate ways to respond to abandonment or express anger that implicitly hold individualized rational self-mastery as the ideal (Gaines, 1992).

Given all of this, harsh critiques of BPD make a great deal of sense. But they only tell part of the story. The diagnostic parameters of BPD are often deeply resonant with clients’ daily lived experiences. In addition to their regulatory propensities, BPD diagnostic criteria capture a cluster of dispositions, emotions, behaviors, and experiences that hang together in discernable patterns, under certain conditions, for certain people, in certain historical and cultural circumstances. The overwhelming majority of these individuals are women.

My insistence that there is a ‘there’ there in BPD, and that it might disproportionately manifest in women, undoubtedly will raise eyebrows among some feminists. Yet I put it forth as a grounded feminist claim. Viewed from the level of cultural critique, BPD pathologizes and reinscribes ‘feminine’ emotionality and irrationality. Yet viewed from the *underside*, as experiential realities for clients, the characteristics of BPD can take on entirely different meanings. They indicate enormous resilience, adaptation, creativity, and a struggle to survive environments that have been invalidating, abusive, or erasing. Feminist critiques of BPD, by focusing primarily on the clinical discourses that shape regulatory processes, have tended to miss this vital component. Yet when we consider the characteristics of BPD as survival strategies – brilliant ones – for navigating negative early environments that disproportionately affect women (e.g. early sexual abuse), we are called to reconsider the rejection of BPD as necessarily anti-woman, and may even find within it leverage points for feminist claims.

### **Illness expressions and the cultural semiotics of morality**

Then what’s wrong with me, huh? What the fuck is going on inside my head? Tell me,  
*Dr. Val*. What’s your diag-nonsense?  
Susanna, *Girl, Interrupted* (1999)

Diagnostic categories provide explanatory models through which people can narrate their experiences and make sense of their behaviors. They also enable forms of regulatory control through which individuals may be constrained within prescribed forms of being deemed morally acceptable. It is well-trod ground in the social sciences, and particularly within medical/psychological anthropology, that people enact illness and distress in culturally patterned ways and according to social conventions and expectations. It is similarly widely accepted that diagnosticians generally find what they are looking for and miss what they are not. Over time and across cultures, illness categories and explanatory models vary widely, reflecting prevailing beliefs, values, and anxieties about proper moral persons.

Such observations have led many theorists to view illness categories, especially psychiatric ones, as products of social discourse with little, if any, stable grounding. Because something like melancholy is less readily observed than something like a broken arm, it is arguably more easily manipulated within epistemologies of regulation. And because many psychiatric conditions are entangled with issues of moral personhood, they are especially powerful mechanisms for curtailing forms of being deemed undesirable by majority standards.

Yet the fact that illness expressions are culturally patterned does not necessarily mean that what diagnostic and criteria describe is an entirely post hoc conjugation. Nor does it mean that expressions of suffering invariably conform to clinical expectations or available idioms of distress (if that were the case, the DSM would not need the pervasive NOS categories).

In engaging with BPD as a cultural phenomenon, then, it is not enough to identify a self-referential semiotic system whereby people manifest the characteristics of BPD because they are induced to live under the description of the disorder. In addition to assuming a relatively consistent mapping of symptoms and diagnosis (which is rarely the case), such an argument presumes that, just as there are motivations for clinicians to interpret women's symptoms as BPD, there are motivations for women to adopt BPD-like forms of illness expression and to seek BPD as an explanatory model. Yet the diagnosis of BPD is hardly something to which people aspire. It is a highly stigmatized label. When we examine inducements for acting under the description of any condition, then, we must also consider the moral valence of this condition within local economies of engagement.

This leaves us in a challenging epistemological space. Do the characteristics of BPD constitute a culturally elaborated idiom of distress? Or is BPD a clinical fiction? In either case, feminist critiques have tended to work from the top down; that is, to consider how psychiatric discourses lead clinicians to read women's behavior in certain pejorative ways. What tends to drop out of such analyses is the possibility that many women really *do* struggle with the behaviors and experiences associated with BPD, and that *this* can be as much a source of feminist critique as dismantling the diagnostic encrustations that surround it.

## Undermining deconstructions

How we think about these issues matters critically for how we respond to individuals who are perceived to meet the DSM criteria for BPD. Here, I find theoretical physicist Dirac's (1930) descriptions of quantum theories of light to be useful. When we ask a wave-like question, he observed, we get a wave-like answer. When we ask a particle-like question, we get a particle-like answer. We cannot ask both questions at the same time, yet holding both together is critical for understanding the qualities and behavior of light.

Cultural critiques of psychiatric diagnosis entail asking wave-like questions and getting wave-like answers. The diagnosis of BPD is not infrequently invoked for reasons of gender bias, clinical incompetence, staff frustration, or any number of other reasons that have little to do with the client herself. Without a doubt, BPD is a social construction whose deployment is patterned along gendered lines. When we ask how BPD functions as a regulatory mechanism via its invocation of gendered cultural assumptions, then, we get answers at that level of analysis. And these are critically important.

At the same time, it is a mistake to therefore assume that *all* instances of the diagnosis are without basis; and certainly, few theorists would go so far as to make such a claim. If we allow that, at least in *some* cases there is *some* basis for the diagnosis of BPD, we have to then ask what that basis is. This is where the particle-like questions become important. If the diagnosis is not entirely fabricated out of thin air, it is incumbent upon us feminist theorists to attend to the conditions upon which it rests, to theorize the connections between such conditions and the

symptoms associated with BPD, and to do so with as much commitment and vigor as we have deconstructed the symptom criteria and category themselves.

## **BPD and the challenges of non-existence**

I understand BPD somewhat differently than my clinical colleagues who see it as a dysfunction of personality and my academic colleagues who see it as a mechanism of social regulation. In my view, BPD does not reside within the individual person; a person stranded alone on a desert island cannot have BPD. Nor does it reside within diagnostic taxa; if we eliminated BPD from the DSM, people would still struggle with the cluster of issues captured in the diagnosis. Rather, BPD resides – and only resides – *in relationship*. BPD is a disorder of relationship, not of personality. And it is only a ‘disorder’ because, as I explain below, it extends an entirely adaptive skill set into contexts where those skills are less adaptive and may cause a great deal of difficulty. Yet due to the contexts in which the skills were developed, the person has a great deal of trouble amending them (Linehan, 1993). Since BPD resides in relationship, BPD can also be *attenuated* through relationship: it is not a life-sentence, and it is not even necessarily problematic if managed constructively.

What does it mean to say BPD is a disorder of relationship? Most people diagnosed with BPD grew up in situations where their very existence as a person with independent thoughts and feelings was invalidated (Minzenberg et al., 2003). Sometimes, this entailed chronic abuse, either physical or sexual. Sometimes it was more of a grinding parental indifference. People diagnosed with BPD overwhelmingly experienced their early lives as involving constant messages that they do not – and should not – fully exist. Here, of course, gender becomes relevant in terms of how children are treated by caregivers and the culturally appropriate strategies available managing developmental challenges.

It makes perfect sense that a girl growing up in a context where her physical existence, psychological existence, or both felt constantly threatened might become fearful of being left alone and unprotected. Developing a finely tuned radar for others’ emotional states while also knowing that the person who cares for her one minute might hurt her the next might easily lead to fluctuating attachments and difficulty developing a stable sense of self. Perhaps in an attempt to derive some sense of her material imprint in the world or to manage strong affect that was disallowed or invalidated, she might engage in behaviors associated with either intense pleasure or pain. Paranoid ideation and even dissociation could be entirely adaptive skills in a context where damage was not only possible, but likely. In short, all of the symptoms associated with BPD could be viewed as adaptive responses to an environment that tells a child she is forbidden to exist as her own person and that she will encounter grave consequences should she try.

What becomes problematic is that, as this girl becomes an adolescent and then an adult, such survival strategies are often misread (for many of the reasons critics of BPD have pointed out) as communicating things quite the opposite of what she intends and a looping effect comes into play. If a person with such strategies happens come into a clinical setting, she is likely to find that her skills not only do not translate;

they become her undoing (Aviram et al., 2006). What were once survival skills are now deemed 'frantic' or 'inappropriate' or 'manipulative,' or 'paranoid.' When a person is continuously misunderstood by others (especially those, like therapists or doctors, whose job it is to understand her), when her experiences and attempts to connect are continuously viewed as scheming or inauthentic, it is perhaps not surprising that rage and despair and feelings of emptiness become entrenched. And she fares little better in the world of academic critique where her struggles are deconstructed as artifacts of psychiatric discourse. She is caught, yet again, in a paradox of existence where to 'be' in any form, from any angle, renders her inauthentic.

## **Lessons from the borderline: Anthropology, psychiatry, and the risks of being human**

Crazy isn't being broken, or swallowing a dark secret. It's you, or me, amplified.  
Susanna, *Girl, Interrupted* (1999)

Anthropologists have long been interested in the cultures of illness and healing. One of the most useful contributions of this work is the recognition that such cultures can and do change, despite their rootedness in regimes of knowledge that naturalize them as truth. The vitality of the debate about BPD from many disciplinary positions, as well as from individuals diagnosed with BPD themselves, signals that we are in the midst of such a shift (e.g. Johnson, 2010; Pershall, 2012; Reiland, 2004; Van Gelder, 2010). This is enormously exciting. Through challenging embedded bias, honoring the testimonies of individuals, questioning of our own motivations, and renewing a commitment to reduce injustice, silencing, and suffering, our intellectual, clinical, and human potentialities are being stretched and, if we are fortunate, will continue to grow.

What I find most compelling about my clients with 'borderline' symptoms is that they are still struggling to exist despite the deep conviction that they do not deserve to do so. And they are still struggling to connect with others, despite being told again and again that they are manipulative and controlling and difficult. Far from being inauthentic, then, these individuals are reaching out into the world in the most honest, direct, vulnerable ways they possibly can, all the while bracing for the invalidation and hostility that they know is likely to follow. They cannot help but reach for connection, and to hold out faith, however dim, that they will find it. I find this incredibly inspiring; it puts front-and-center the impulse for growth and health that I believe exists in all of us, no matter how encrusted with despair, dysfunction, hopelessness, or defeat.

I learn from these clients every single day. Their struggles and their resilience humble me. They remind me that intellectual critique is but one piece of a much larger puzzle, and that they have experiences that deserve to be heard and validated, even when (perhaps especially when) they challenge our interpretations. They push me to become a better scholar, a better clinician, and, I hope, in the end, a better human being. Those who resist working with these clients



therapeutically or deny their existence epistemologically elide the incredible strength, resilience, creativity, and integrity of many of these people. The work is raw. It is challenging. But it is real. And above all, it is human.

## Note

1. I am mindful of the linguistic and social distinctions entailed in the appellations 'borderlines' or 'borderline patients' versus 'people with BPD' or 'people diagnosed with BPD'. I use each of these terms in a manner consistent with the context I am discussing.

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