



Re-authoring identity conclusions in borderline personality disorder

by Alicia Bruzek



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Abstract

This paper describes the use of narrative therapy with people who had been given a diagnosis of borderline personality disorder. In a context of significant stigma against persons with this diagnosis, perpetuated both within and beyond mental health systems, this paper shows how concepts of identity developed in narrative therapy were used to resist totalising identity conclusions and uncover possibilities for hope.

Key words: *borderline personality disorder; identity; trauma; diagnosis; narrative practice*

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The diagnosis of borderline personality disorder (BPD) comes with a lot of stigma, including within mental health systems. This can influence the identity of persons who are given this diagnosis: they often feel hopeless about the possibility of change because the problem has been located within them. As a narrative therapist in private practice, I have been interested in how I might use double listening to help people with a BPD diagnosis find new ideas about identity that differ from the story of hopelessness that many carry.

I have been applying narrative therapy principles and practices to my therapeutic interactions with two people who had been given a diagnosis of BPD, Levi and Dani¹, whom you will see quotes from throughout this paper. Dani and Levi are both straight, white and cisgender. In this paper, I describe how I worked individually with Dani and Levi (who did not know each other) to deconstruct some of the stigma associated with a BPD diagnosis. I introduce narrative understandings of identity as relational, distributed, performed and fluid rather than fixed and essential. And I show how these understandings opened possibilities for identifying preferred identity stories that had been obscured by narratives of BPD.

Borderline in the mental health system

In a collective document about BPD, the contributors wrote, "Borderline Personality Disorder is a diagnosis that can flatten a person's story down to a single note" (Sostar, Thomas, & Nault, 2020, p. 5). This single note often suggests that people with this disorder are "crazy", "overly emotional", "irrational" or "dramatic". In relation to resources produced for and about the BPD community, the BPD Superpowers group stated, "So much of what is available includes harmful stories about what kind of people have BPD, and how difficult and even dangerous it is to be in relationship with them" (Sostar et al., 2020, p. 4). Such discourses around BPD are perpetuated in counsellor education, professional development, within conversations among health-care providers, and in the broader culture in North America, where I live and work. Lester (2013, p. 70) observed that "clinicians generally detest working with borderline patients". During my own training, I was presented with extreme examples of what it might look like to work with people with BPD.

Attitudes like these drew me to using narrative therapy with people given this label. My experiences with people with a BPD diagnosis have been very different from what my education led me to expect. It often seemed that the effects of painful experiences they had been through had been mislabelled as something wrong with them. Dani was on state insurance, which often carries stigma in the US, and she had experienced many injustices in accessing medical care due to her diagnosis and insurance. She had a history of being subjected to gendered violence and had experienced unsupportive relationships that contributed to her distress. Levi had a history of invalidating and abusive relationships that contributed to the experiences that had been labelled BPD. When we centre the context of a person's life and the history of problems they are experiencing, it becomes possible to see how the injustices the person has been subjected to may have contributed to the problems they're facing. The idea that the person's problems are defined by some internal characteristic becomes less convincing.

I believe that some of the apprehension about working with clients labelled with BPD can be attributed to the description provided in the Diagnostic and Statistical Manual (DSM). The DSM-5-TR uses words such as "instability", "frantic", "intense", "imagined abandonment", "reactivity", "inappropriate, intense anger" and "sudden and dramatic shifts in their view of others" to define BPD (American Psychiatric Association, 2022). However, the DSM's language contains "judgments about appropriate ways to respond to abandonment or express anger" (Lester, 2013, p. 71). From a poststructuralist perspective, "concepts like 'pathology' and 'normal' are seen as social constructs derived from those beliefs and values that prevail in a particular context, determined by those who have the authority to 'name' these things as such" (Druker, 2014, p. 17). Many people given the label of BPD experienced trauma and/or invalidating environments growing up, yet these experiences become obscured by the diagnosis of BPD, which situates the problem within the person and not their history (Sostar et al., 2020). While these experiences can cause difficulties in the person's life, there are also questions if these experiences are "wholly and singularly negative" (Lewis, 2023). Deconstructing these ideas allows room for both difficulties and strengths and skills that might be related to BPD.

Deconstructing the problem

The first step in my work with Levi and Dani involved deconstructing negative identity conclusions each had acquired through interactions with the systems and culture around us. Levi initially viewed himself as having something fundamentally wrong with him, which he saw as leading to judgement, hate and rejection from others. Both Levi and Dani had been invited into viewing themselves as not being good enough to be in relationships with other people. They both had ideas about what others are willing to do in their relationships, including statements by Dani such as, “no one can tolerate my anxiety” and “no one wants to put time and energy into me”, and statements from Levi such as “other people have all the power” and “I have to fit the mould for people to stay”. Both Levi and Dani used the words “inferior” and “failure” because they were different from how they had been told they were supposed to be.

What I often heard while deconstructing stories with these two individuals was hopelessness. Each had been told that BPD was part of who they were and that they would have to change who they were to have the things they wanted, like relationships and success in life. This led to many stories of not being heard, not feeling valued by others, and not believing they could ask for anything due to their “over-reactions”. When we started meeting, I heard many thin descriptions in which Dani and Levi each saw themselves as the problem. This led to feeling defeated and unable to make changes in relation to the problem. Dani said, “I’m not the type of person that can keep people around”. Despite these discourses and experiences, they wanted something different for themselves.

Levi and I spent a lot of time connecting different ideas, beliefs and experiences through mapping them visually, through deconstructive questioning, and through metaphors. The visual map shown in Figure 1 shows factors influencing Levi’s idea that he was “not good enough”. As we were exploring these influences, I asked, “Are these ideas you have about yourself or are these coming from somewhere else?” This led to conversations that deconstructed dominant gender discourses that had previously had Levi judging himself negatively in relation to certain masculine norms. Levi responded that he was okay with himself and thought he had a right to be upset in abusive situations, but that discourses around gender (that men are supposed to be “unattached”, “unemotional” and “sexually motivated”) and others’ views of him in

his past relationships brought in the “not good enough” feeling, which in turn, made him believe something was fundamentally wrong with him. He likened the “not good enough” feeling to a creature from the Harry Potter movies called a Dementor (Cuarón, 2004), which feeds on happy memories, leaving only despair. Levi said the problem “sucks the happiness from my life”. This experience-near description illustrates the way BPD can be viewed by people labelled with it: the effects of the stigma and judgement surrounding BPD can be more distressing than the symptoms listed in the DSM.

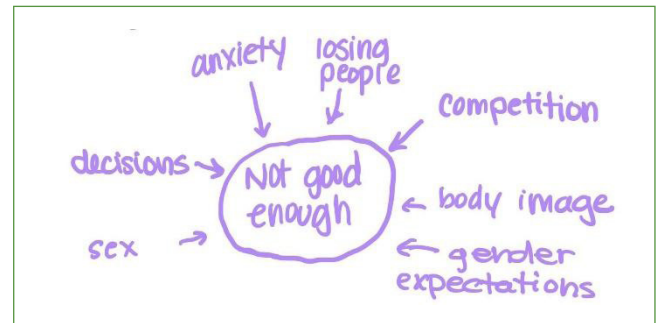


Figure 1. Mapping the “not good enough” feeling

A second theme of identity that was deconstructed with Levi was the idea of “being abnormal” or “doing things wrong”. We used the metaphor of a courtroom in which Levi was defending himself against what the problem and other people had to say about him. This courtroom image was drawn from the ways Levi described the problem. Keeping in mind the narrative therapy ethic of not taking an expert stance, I checked with Levi to see whether this image resonated with his experience with the problem. He agreed that it did and confirmed that he was willing to work with this metaphor. I asked, “I wonder what you did to deserve to be on trial?” and “Do you agree you should be there?” Levi thought about this for a bit and said he did not think he had done anything to deserve it. This seemed like a turning point for us: a shift away from fighting against the problem, and towards a focus on Levi stating his case, and through this reducing the amount of space the problem was taking up in his life. This fit with Michael White’s (2007, pp. 31–34) ideas about using metaphors that don’t invoke conflict or combat with the problem. Instead of battling the problem, Levi was defining and articulating who he knew himself to be outside of the problem story. Alternative metaphors might include “reclaiming one’s life from the effects of the problem, escaping the effects of the problem, revising one’s relationship with the problem, educating the problem, negotiating with the problem, organising a truce with the problem, taming the problem, undermining the problem” (Carey & Russell, 2002, p. 80).

Levi and Dani each also felt they had to fight for acceptance or belonging within their communities. Levi identified ideas about having to prove himself, and believed that if he did, he would be accepted, feel like he belonged and have a right to live. Dani said she felt like two separate people: one she had to be when pretending to be “normal” and one that reflected how she felt inside. We discussed many of the effects of these ideas. Both Levi and Dani were exhausted by the pressure to conform or “fit the mould”. The problem had them avoiding relationships at times, despite wanting to connect with people, because they didn’t think they were capable of relating adequately with others. This led to feelings of anger, hurt, frustration and sadness.

While asking deconstruction questions with people labelled with BPD, I have been conscious that it can be unhelpful to encourage the person to move away from the BPD label if they find it useful. The BPD Superpowers group wrote that “for many of us, finding the language of BPD was a moment of intense relief and validation” (Sostar et al., 2020, p. 14). However, as we deconstructed the effects abusive experiences might have had on their lives, I asked if there were other names we might want to give this problem besides BPD. So far, those I have asked this question have wanted to keep calling the problem BPD. They related to the criteria listed in the DSM, and didn’t want to lose that understanding by calling it something else. Dani had been working on finding community, and having this label to use helped her find others online with similar experiences and provided opportunities to share her own story. I appreciate that through narrative therapy I can allow space for this self-identification, while at the same time seeking to thicken the story.

A narrative view of identity

Michael White (2001, 2004) described how negative identity conclusions can take over, leaving people feeling stuck. He offered ways to open space for the development of new identity conclusions. White wrote, “to claim one’s own voice can be a powerful strategy in the face of the imposition, by others, of authoritative and negative accounts of one’s identity” (White, 2004, p. 134). Pathologising ideas about BPD had my clients feeling stuck and defined by limiting conclusions about themselves. Dani and Levi had each received messages about their identity from many sources and experiences, which we began to deconstruct. Through this process, they were able to move towards having their own ideas about their identities.

Gene Combs and Jill Freedman (2016, p. 213) described identity as “a project we are pursuing” rather than a fixed set of qualities. The understanding of identity in narrative therapy can be understood as “relational, distributed, performed, and fluid” (Combs & Freedman, 2016, p. 213). The relational aspect of identity is shaped by how others perceive and respond to us and their expectations of us. An understanding of identity as distributed means the stories that constitute a person’s sense of “self” are held in different locations, including “other people’s memories” and “hospital records” (2016, p. 213). Performed identity focuses on action and agency. “With each action we take, we establish a scaffold from which other actions are possible” (2016, p. 214). Seeing identity as fluid establishes it as a process rather than a static trait. I drew on these aspects of identity to help Dani and Levi have more say in their identity.

Relational

For my clients with BPD, dominant stories of identity are often defined by traumatic experiences in past relationships or negative identity conclusions from the mental health system. One way I focused on relational identity with Levi and Dani was through thinking about the ways I was interacting with them in our sessions together. I recognised the impact that past abuse might have on their interactions, and that aspects of the problem may be associated with ways they responded to in order to survive. In our relationship, I was hoping to give Levi and Dani different experiences of themselves by both acknowledging the effects of abuse and treating them as people with knowledge about themselves. In the process of therapy, we are participating in the creation of identity conclusions, so I wanted to be aware of this in our work together.

One aspect of relational identity is the person’s impact on others. Ideas about BPD suggest that people with this label are not capable of having positive or healthy relationships. Experiences of having a positive impact in relationships challenge the problem story. In one session with Levi, he talked about his sadness at a co-worker moving to a different job. I used this as an opening for a re-authoring conversation, asking about what Levi might have contributed to the relationship with the co-worker. He initially did not think he had contributed anything. Through further exploration, Levi identified some things that were special about the relationship and that he contributed to, such as talking about shared interests and seeking this person out. These were both ways of interacting that departed from

his usual avoidance of relationships. Levi and I also explored ways he was caring in relationships, rather than letting the idea that he was a “jealous”, “clingy” or “anxious” partner take over the story, which was how past abusive partners had described him. He identified ways he had been there for his partners at times when they needed him. Finding unique outcomes related to Levi’s contributions to others helped to thicken Levi’s view of himself and suggested a storyline that might not fit with ideas about what relationships are like for someone with BPD.

Levi also had people who supported him along the way, and he developed different ideas about himself through reflecting on their interactions. Levi had two past therapists who had “fought for” him through “sharing the burden”, building trust, sticking with him through hard times, and allowing him to share anything without breaking the relationship. He also had an experience of an ex-girlfriend’s stepfather seeing the abusive ways she was interacting with him and standing up for him to his partner, as well as letting him know he deserved something different. This was meaningful in validating Levi’s experiences of the abusive ways of relating in this relationship and moved away from the idea that someone with BPD is always the problem in a relationship.

Distributed

For someone with a diagnosis of BPD, medical records may tell a very different story about the person’s identity than what we might find in other distributed identity stories. Dani and I worked through her medical records from another agency, and she stated her own ideas about what was said. To do something different, I tried to be open and transparent about what I was including in the records I kept, and I asked for Dani’s input. I use narrative language in my notes rather than pathologising or negative language. We also talked openly about the power structures at play in the medical system that might be supporting the stigma she experienced.

I asked questions to explore stories of skills and abilities that might be located in other settings, such as work, or in other relationships, such as friendships. Levi and I continued to explore the ways he felt successful and accomplished in the context of work, where he felt valued for his contributions. He said, “to me, I am successful” when it came to life outside of romantic relationships. He was able to lead a team and received positive feedback from supervisors and

peers. This suggested that others held stories of his skills in building relationships and in leadership. In my sessions with Dani, we talked frequently of her different experience of herself as a parent in relationship with her children, compared to other relationships in her life. She was able to advocate for her children and worked to relate to them in ways that were supportive and protective. To extend stories about new identity conclusions into the future, we talked about how she might transfer the skills that her children would recognise to her other relationships. Ideas that others might hold about the person, whether it be their co-workers or their children, can provide openings to alternative stories about distributed identity.

In our early meetings, I created a document with Levi about the effects of the Dementor on his life and documented the stand he took against this. This helped us determine which parts of the problem weren’t working for him and what was important to him. For example, Levi said he kept to himself when the Dementor was present, which he believed was positive because it kept him safe. However, other aspects of the Dementor had negative effects on his relationships, such as feeling like a failure or thoughts of losing everything. This helped us to take a different approach to therapy. I did not make assumptions about what the problem was on the basis of his diagnosis. Instead, he was deciding what was best for his own life. We came back to this document from time to time to review what Levi wanted in his life that this problem was not supporting. By documenting this, we were creating a different view of himself and the problem.

Performed

To explore performed identity, I focus on the decisions my clients make and what these mean about their identity. I ask about the skills, knowledge and abilities that have made a difference in their life and how they view themselves. One part of this is putting the “symptoms” in the context of the person’s past negative and abusive experiences. I ask my clients about ways they resisted the effects of traumatic events or skills they developed. Reynolds (2020) has argued that we should assume that what people do makes sense, and that people are trying to be safe. These ideas can totally shift the perspective on BPD when compared to what the medical model might say. I applied Reynolds’s assumptions in my conversations with Levi and Dani about how they had used skills and knowledge to engage in acts of resistance and how the ways they responded made sense in surviving the situations they

were in. This fits with the connection between BPD and trauma that is often seen. I had conversations with Dani and Levi about the effects of their traumatic experiences and how these experiences might have changed how they interacted with others or how they viewed themselves.

With Levi, we focused on how his actions in relationships had been responses to betrayals and abusive interactions, but these responses had been framed as revealing a problem within himself. We talked about how certain feelings he got were an indicator of something off in the relationship, rather than a problematic reaction.

Dani described the loss of important relationships in her life and how she had responded to these losses when she was younger, including through drinking alcohol and separating from things around her. We discussed how traumatic events could contribute to people trying to cope in ways like these, and we also discussed the steps Dani had been taking to move in different directions in her life, such as her efforts to stop drinking alcohol and begin taking care of her mental and physical health in ways that were important to her.

I ask questions about what steps the client is taking to make changes that take them in preferred directions. One example was when Dani recognised that even when the problem took over, she was able to keep herself safe from suicidal thoughts. She was able to reach out for help and hold on to important things in her life. Through many steps Dani had taken, she was now able to separate from suicidal thoughts and believed that she had things to live for. We discussed the ways Dani had prepared for the steps she had taken and what she had learnt about herself. In another example, Levi identified steps he had taken to feel better, including “having an open mind”, meditation and having different experiences in therapy relationships. The problem story would not have predicted that they would be able to take these steps, and through exploring these exceptions to the problem story, Dani and Levi came to believe that new things were possible.

I ask about the person’s stances and what these might say about what they value. Dani described an argument with her significant other and mentioned it being different to usual. As I asked more questions about this unique outcome, Dani explained that she had taken a stance in support of her anger after a history of being told that her anger was problematic. As we explored the effects of taking this stance,

she described how it had moved her in a preferred direction that helped her accept herself: “I don’t want to change myself”. Diagnostic criteria suggest that any anger experienced by someone with BPD is problematic. I think taking a stance for anger was a helpful act in this case because anger can be a necessary response to stay safe or respond to abusive circumstances. Implicit in the diagnostic criteria are gendered discourses which suggest that female anger is not okay. My approach supported Dani to decide on her own reaction, to identify her own values and to back up her stance. Dani identified that she wanted “a zest for life back” and Levi identified that the problem was a “hindrance to my aspirations” and that he wanted to “stand against rejection and judgement”. Dani was engaged in actively shaping her own life rather than being acted upon. She took a stand “for a life that has less pain”. She had been experiencing health problems and previously had felt dismissed or unheard in medical settings. She decided that she wanted to take care of herself in a different way. This gave her ideas about herself as someone worth advocating for.

Fluid

Working with identity as fluid rather than fixed invites us to consider who we might want to become, rather than who we “truly are”. I used scaffolding conversations to identify and explore what kind of people Dani and Levi might wish to become. This involved reflecting on the significance of actions they had taken. Dani advocated for her child who had chronic health issues. This unique outcome had her believing she could be an expert on herself and her children. Dani then began using these skills to also advocate for her own medical and mental health treatment. Advocating for herself helped her move towards a preferred story of herself as someone deserving of care. Stories and stigmas around BPD had previously kept Dani from speaking up about what she needed in medical and mental health settings, and she often said that she didn’t want people to think she was “making it up”.

In discussing Levi’s relationship with his co-worker, it was meaningful to explore how he had felt safe in this friendship – an experience that would have not been predicted by the diagnosis of BPD. This opened up the possibility of considering that a romantic relationship might not be the only place he could feel accepted. This gave him a new idea that other types of relationships were possible, even if the problem still had a hold on some of his thinking.

Keeping these ideas front of mind while working with Dani and Levi allowed re-authoring conversations to happen that were really different from dominant ideas within the mental health system and society. They allowed Levi and Dani to identify that they did have skills in relationships and in survival that had served them well, while also identifying preferred directions they wanted to move in that fit with their own hopes for their lives. This moved away from the idea of the self as something static and towards an idea that identity is something you are actively crafting through your actions.

Intentional states

In considering all these aspects of identity, narrative therapists focus on intentional states, rather than internal states. Intentional states include a person's intentions, purposes, values, beliefs, hopes, dreams, principles of living, commitments and stances that are behind actions (Carey & Russell, 2003, p. 31).

Lester (2013, p. 75) stated, "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". This echoes the continued efforts I have seen Levi and Dani make to have the relationships and lives that they want. A focus on intentional states brought forward what kept them wanting to move in these directions.

In my work with Levi, we discussed his previous experiences of therapy and the work he had done since then. He identified various things that were different, such as no longer "struggling with existence", being more okay with being alone sometimes and feeling more "stable", which fit with the value he placed on establishing a romantic relationship. We discussed what these steps meant for him and for the directions he wanted to go, which was not having the problem take over his relationships and cause fears that led him to not show up in the ways he wanted to. He believed it was important to accept and understand your partner and was seeking to include people in his life who shared these values. These discernments represented a developing stance about the types of relationships he wanted, despite the problem inviting him to believe that these types of relationships weren't possible for him.

Dani's intention was to provide a different life for her children than she had growing up. She had taken steps to ensure she related to her children in ways that were not harmful. She valued her children's wellbeing and hoped that they would not have to face the problems she had faced in her life. This had led her to consider her own ways of interacting to make sure she was supportive and giving her children what they needed. She took a stance against abusive ways of relating to others in order to be there for her children in the way she wanted to be.

Accountability

In the mental health field, practitioners are given power to decide things about a client's life. We can decide if their choices and traits are healthy or unhealthy, right or wrong, good or bad. Through learning and using a narrative therapy worldview, I wanted to be more accountable for my effects on my clients with a BPD diagnosis. I have worked to abandon the approach of expert knowledge in favour of what Sostar, Thomas and Nault (2020) called "borderline wisdom". I have also tried to take up their call to:

- "question the assumption that BPD = bad, broken, dangerous, or irrational"
- assume the person is responding to real and valid situations and emotions
- "trust that individuals are experts in their own experience"
- honour the dignity and agency of the person
- check in to make sure what I'm doing is supportive
- act in solidarity with people with BPD in resisting stigma and harms perpetuated in health care settings, and support them in accessing preferred forms of help (Sostar et al., 2020, pp. 29–40).

These ideas take a stance against the pathologising ways of working that discourses in the mental health and medical systems can recruit us into.

Conclusion

The practices I have described in this paper have been helpful in resisting the stigmatisation of people with a BPD diagnosis. I think it is very hard to work with someone in a helpful way when you have ideas about them that are negative or that carry assumptions. Through the ways in which we did things differently in the therapy room, Levi and Dani began to feel more hope that they could make change in their lives. These practices have also taken pressure off me to have the answers. They allowed me to focus on what is important to the person rather than imposing ideas on them.

I have felt a more comfortable and open relationship with my clients using these ideas and have received feedback that they feel this as well, and that they appreciated having control over what happened in therapy. Eliciting feedback about directions that might be helpful enabled us to go in directions that I may not have picked up on otherwise. This allowed Dani and Levi to discuss the problem in an experience-near way and move in directions that fit best for their lives, rather than directions that were imposed on them.

Through this process, I was able to see the strength and resilience of Levi and Dani. Focusing on narrative views of identity when working with them opened up new possibilities about the directions they could go that were previously obscured by the stigmatised label of BPD. I hope these ideas can contribute towards a more hopeful and generative way of working with people given a diagnosis of BPD or any stigmatising diagnosis.

Note

¹ All names have been changed to protect the identity of the participants

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