Pathological Femininity and the Western Construction of Selfhood:

A Genealogy of the Borderline Subject

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Abstract

In the decades following World War II, psychiatry in the West became the dominant means for understanding and relating to suffering and distress. In an effort to challenge the systems that produce this suffering, it is important to examine the history of these diagnostic labels, which individualize suffering thereby removing persons from the context in which their suffering is produced. In this thesis I investigate the emergence of the diagnostic label Borderline Personality Disorder (BPD) within psychiatric knowledge and how this diagnosis has shifted over time. At present, the diagnosis is overwhelmingly applied to women and, of this heterogeneous group of persons, the strong correlation between them is a history of childhood abuse. Given this, I argue that the psychiatric formation of selfhood in BPD engenders the very systems which produce psychological distress. By privileging a particular way of being in the world and pathologizing the selfhood of trauma survivors, psychiatry prevents critical reflection of these systems by individualizing responses to suffering. Nikolas Rose (1996, 1999a, 2019) discussed the expansion of psychiatry as a means of understanding and relating to the self. Wirth-Cauchon (2001) has examined the gendered nature of borderline personality disorder and in doing so, has demonstrated the role of gender in informing the psychiatric conception of the self. Using Foucault's method of genealogy, I contribute to this literature by theorizing how the construction of selfhood is formulated upon a gendered, racialized, and queered *Other*. Genealogy destabilizes the psychiatric conception of selfhood by situating the expansion of psychiatry's knowledge of the self within specific sociocultural and historical epochs. This investigation calls for a critical reflection of the selfhood codified in these diagnoses and a recognition and acceptance of selfhood that is not predicated on heteronormativity and whiteness.

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List of Abbreviations

ASPD	Antisocial Personality Disorder
BPD	Borderline Personality Disorder
C-PTSD	Complex Post Traumatic Stress Disorder
DSM	Diagnostic and Statistical Manual of Mental Disorders
PD	Personality Disorder
PTSD	Post Traumatic Stress Disorder
SIB	Self-Injurious Behaviour
WWI	World War One
WWII	World War Two

Introduction

Psychiatric hegemony is no longer contained within the walls of the asylum. According to Nikolas Rose (2019), psy technologies and discourse are playing an increasing role in how we interpret our thoughts, behavior, emotions, and mental states. Rose writes, "psychiatry is shaping the very experience of living as its languages and diagnoses pervade the ways we understand and respond to our problems and think of those of our children, our relatives, and our own life course" (2019, p. 15). Psychiatric discourse and technologies are less visible as they are naturalized and more deeply embedded in the constitution of our social fabric, and indeed the self.

The term *psy* is used to refer to psychiatric knowledge, discourse, technologies, practices, and professionals. According to Rose, psy has diffused throughout Western society becoming embedded in systems of governance. Rose writes, "over a particular and limited historical period and geographical dispersion, the languages, techniques, forms of expertise, and modes of subjectification constitutive of modern liberal democracies - indeed of the very meaning of life itself - have been made possible by, and shaped by, the modes of thinking and acting that I term *psy*" (Rose, 1996, p.16, emphasis in original). The growth of psychiatry as a discipline and the diffusion of psy knowledge throughout media and popular culture discourse supported the demands of capital and neoliberalism, which placed new constraints on personhood through an increased emphasis upon individual responsibility. This has enabled psy knowledge to move beyond the sphere of madness to define normal and optimal personhood.

I am interested in problematizing our understanding of mental health and mental disorder by demonstrating how these are contingent upon normative conceptions of gender, sexuality, and race, and I undertake this problematizing through a genealogy of borderline personality disorder. Rose (1996) argued that we understand ourselves by signifying what we are not (1996, p. 26); therefore, through an examination of behaviors and persons deemed deviant and pathological, we can understand how normality is constituted, defined, and regulated. Borderline personality disorder (BPD) is one example of personhood that is deemed pathological, and thus requiring psychiatric intervention and management. My genealogy of the borderline subject demonstrates how our understanding of mental health has upheld normative conceptions of gender and how the construction of gender is contingent upon racialized conceptions of personhood. It is through the

concepts deviancy and pathology that we can understand the conditions of "normal", processes of subjectification, and the ideals and values that characterize our vision of mental health.

The construction of BPD as an individual mental pathology obscures the relations of power and domination that bring the borderline subject into being. Instead, we must ask what processes, procedures, and apparatus render the personality disordered? In delving further into predominant conceptions of identity and selfhood, this investigation is concerned with how a particular understanding of and relation to the self, as it is constructed through psychiatric discourse, enables "diseases of the self".

In the first chapter I examine the emergence of the *borderland*, which marks the union of psychiatry with a biomedical pursuit to establish deviance within the body. The merging of the two led Darwinian psychiatry to develop theories in which women's reproductive function rendered them predisposed to mental disorder. Chapter two reviews the psychoanalytic response to women's psychic distress, which challenged this biological determinism, but ultimately upheld an association between femininity and pathology. Psychoanalysis, particularly its offshoot ego psychology, was highly influential in informing a cultural shift in the Western conception of the self. Chapter three is concerned with this shift and the medicalization of the personality, whereby psychiatry attempted to quantify the boundaries of personhood. Chapter four considers the implications of this view of personhood for understanding trauma. Chapter five looks at the demands of neoliberalism on personhood leading to the pathologizing of dependency, which became a symptom of the feminized psychic disorders. Chapter six considers self-injurious behavior and the impact of individualizing suffering. In the final chapter, I investigate the racial encoding of anger and consider how the pathologizing of anger reproduces human taxonomies through the denial of personhood.

Employing Foucault's method of genealogy, the view of the borderline subject as lacking an authentic self is treated as part of a historical project. Rose writes, "no theory of the psyche can provide the basis for a genealogy of subjectification, precisely because the emergence of such theories has been central to the regime of the self whose birth must be the object of our inquiries" (Rose, 1996, p.10). In other words, my investigation into BPD does not attempt to uncover what

the borderline is or to define this subject, but to understand the processes in which a personality, and its expressions of gender, are rendered problematic.

Method

Foucault tailored his method to the task at hand; thus, his work does not offer a prescriptive methodology but is oriented around a way of seeing, or more specifically, a critical view of that which we take for granted. Foucault's genealogy was not concerned with creating an overarching theory. Instead, he posited an alternative way of thinking about and treating the self and society (Sawicki, 1991, p.11). Throughout his career, Foucault's method was subject to continuous change. He had initially been concerned with *archeology*, which placed knowledge propositions within their discursive formation. However, while Foucault continued to do archeology, in his later career, he became increasingly concerned with the social and cultural forces that shape discourse, thereby expanding his sphere of investigation to include both discursive and non-discursive practices.

The genealogical method is distinguished from traditional historical analyses by an immediate concern with the present. It acts as a diagnostic device, problematizing the present by examining relations of power and domination. Garland (2014) argues that three central elements underlined Foucault's genealogy: these included a diagnosis, conceptualization, and problematization of the present. In an interview, Foucault (1984) explains, “I set out from a problem expressed in the terms current today, and I try to work out its genealogy. Genealogy means that I begin my analysis from a question posed in the present” (cited in Garland, 2014, p.367). Foucault described the genealogical method as a “history of the present” (p.367). Genealogy and archaeology both share the critical aim of disrupting the present, however genealogy expands the purview of its investigation and in turn develops concepts that go beyond discursive analysis to include a broader concern with both said and the unsaid.

Genealogy provides what Tamboukou called a “counter-memory” (1999, p.203) in that it challenges those “truths” that have become deeply embedded in the constitution of our social fabric. Genealogy undermines a teleological vision of history and grand metanarratives by using discontinuities and highlighting contradictions. It seeks out the loose ends, dead ends, unrealized potential, and details that are obscured within the conventional historical narrative. For the genealogist, there are no hidden laws or metaphysical truths to be discovered, only a specific set of socio-historical forces which inform our relation to power. Through this relation to power, certain subjectivities are made possible, whilst closing off the potential for other modes of being.

This critical lens treats identity categories such as gender, sex, and sexuality as social and cultural constructs that are interpreted on the basis of broader social forces. Identity categories are in constant negotiation with forces as they undergo processes of emergence and descent. We cannot trace these processes to a singular apparatus of power, as they come from multiple and diffuse points of origin (Butler, 1999, p. xxxi). Genealogy traces these concepts through history by investigating the processes, procedures, and apparatuses that led to their emergence.

Using genealogy, my analysis will focus on the field of power through which the borderline subject is constituted but will also reference the function of knowledge in shoring up these dynamics of power. A genealogy of the borderline subject entails an analysis of social forces such as modernity and neoliberalism, which create pathologies by delineating the boundaries of acceptable personhood. Our systems of governance exercise their power through our knowledge of the self, limiting the potential for what is possible and making possible subjects which sustain these systems. Power constitutes our desires, and our very sense of what is possible (Sawicki, 1991, p. 10).

By describing the processes in which persons are made subjects, we can renegotiate the boundaries of gender subjectivity and personhood. The disruption of these deeply entrenched identity constructs enables us to understand how governing systems operate to inform our conception of personhood. The systems I am referring to are heteronormativity, patriarchy, white supremacy, and neoliberalism. Genealogy examines the knowledge that has naturalized these systems, and in doing so, opens new pathways of understanding (Tomboukou, 1999, p.210). Demonstrating the borderline concept's historical contingency allows us to create the potential for new, currently improbable, identities.

Chapter One Psychiatry's Expansion into the Borderland

Through a genealogical review of the borderland concept we are able to see how the development of what we know as BPD has been established over time. Whilst this concept has shifted and morphed, its beginnings have important implications for how we think of BPD and personality disorders (PD) more broadly today. The *borderland* is a concept created by nineteenth century Darwinian psychiatrist Henry Maudsley (1835-1913) that was used to expand the dominion of psychiatry. This concept was to broaden the definition of madness and thereby increase the number of people that fell within the purview of the emerging discipline of psychiatry.

Within Maudsley's borderland lurked those individuals who not only appeared mad, but also those who, Maudsley described as, *incipient* lunatics. According to Maudsley these persons appeared normal but bore the marker of biological defect and thus had lurked undetected. In describing the incipient lunatic Maudsley writes, "They may or may not ever become actually insane, but they spring from families in which insanity or other nervous disease exists, and they bear in their temperament the marks of this peculiar heritage" (1876, p.43). Adding, "In some persons it is so slight that no one would suspect its existence" (p.49). According to Maudsley only the trained eye of the psychiatrist could detect such insane neuroses. The work of early Darwinian psychiatrists such as Maudsley provided the theoretical underpinnings that would shape psychiatry's concern with identifying a biological marker for madness.

Darwinian psychiatrists during this period, then referred to as *alienists*, maintained that these lunatics held a degenerative gene that if allowed to reproduce would infect future generations and therefore posed an immediate risk to the health and security of the nation. Psychiatrists would emerge to police the boundaries of sanity and identify those degenerates that could pose a threat. Biopolitics, as will be discussed, was reliant upon the establishment of such boundaries and in turn, the need would enable biological psychiatry to emerge as a force of knowledge carving up the social world and legitimizing the execution of persons placed outside of the boundaries of humanity.

The concept of the borderland itself is not gendered, however Maudsley had strong views regarding the biological mandate of men and women, which are evident in the concept's application. Further

this concern with outlining a biological marker for madness shaped psychiatric responses to "deviant" women as they looked to women's reproductive function to uncover not only the cause of deviancy, but also to justify the social hierarchy in which women were placed lower on the evolutionary scale. Biology would not only be deployed to justify a gender hierarchy but also racial hierarchies. This concern with human taxonomies was popular at the time, in a climate of eugenics scientists were looking to the natural world to uphold their view of the social order (Haraway, 1978).

Psychiatric knowledge naturalized social hierarchies and used scientific exploration to embed these hierarchies in the material body. According to psychologist Hans Eysenck (2016), psychiatry has conflated what it considers to be the norm with its understanding of what is natural. Regarding the position of psychiatry, Eysenck (2016) contended, "Our feeling would be rather that biologically nature has created men and women to act in certain ways and that, quite regardless of statistical or ideal norms, behavior in accordance with these putative aims was normal and behavior counter to these putative aims was abnormal" (p.158). Throughout the history of psychiatry, it has remained intellectually powerful to use biology to establish the norm from which the individual is measured against the collective.

Through the annexation of social deviance psychiatry expanded its object of inquiry from madness to morality. In 1835 James Cowles Prichard developed the concept of "moral insanity", which he described as "insanity without delusions" meaning "madness consisting in a morbid perversion of the natural feelings, affections, inclinations, temper, habits, moral dispositions, and natural impulses, without any remarkable disorder or defect of the intellect or knowing and reasoning faculties, and particularly without any insane illusion of hallucination" (cited in Wirth-Cauchon, 2001, p.45). Thus, morally objectionable behavior could now be used as evidence of an underlying mental pathology. Moreover, this sickness, they argued, was the result of a biological defect, one that could be genetically inherited.

The Emergence of Biopolitics

Foucault's concept of *biopower* (1975-76) can help us to understand the relationship between the emergence of biological theories of deviancy and governing systems of power. Biopower refers to the state's increasing concern with the biological processes of its population, and the policies and

procedures implemented to influence these biological functions. According to Foucault (2003), biopolitics treats the population "as a problem that is at once scientific and political" (p.245). The state took it upon itself to not only discipline the population through the judicial system, but also to regulate its biological functioning by intervening in matters pertaining to birth, death, reproduction, fertility and longevity.

The emergence of biopolitics during the nineteenth century both created and was supported by scientific theories of biology and human variation. Psychiatry was not simply a way of interpreting political discourse in biological terms, nor was it simply a way of disguising political discourse as science, but it became a real way of thinking about governance, how to govern the mad and manage social deviance. In doing so, these systems of thought would fundamentally change how we conceptualize and relate to the social world. Biopolitics has continued to form the basis of our understanding of mental disorder and categories pertaining to race, class, and gender.

According to Foucault, the linchpin of the biopolitical system hinged upon the concept of race, which would enable the state to justify the killing of certain people based on their racial status. Foucault argued that in the biopolitical system political adversaries were treated as enemies not of the state, but as a "biological threat to the improvement of the species or race" (2003, p.256). Politicians used the logic of racialized taxonomies as a means of not only relating to other populations, but also managing their own. According to Foucault, the same ideological constructs used to execute and banish based on the category of race would also be applied to criminality and madness (Foucault, 2003, p.258). The belief that human differences were natural, given, and inescapable would support the belief that the preservation of these human differences was also moral. This is most clearly expressed in the proclamations of psychiatrists who saw social hygiene as necessary for addressing creeping degeneracy. Within the context of biopolitics, evolutionary theory functioned as the intellectual backbone for racialization and the establishment of human hierarchies.

According to historian of psychiatry Edward Shorter (1997), the development of the genetic perspective has been present in psychiatry since its emergence as a professional field during the nineteenth century. The founders of psychiatry Philippe Pinel and Jean-Étienne Dominique Esquirol both wrote extensively applying the concept of inheritance to psychiatric disorders (p.29).

By locating human variation in genetics and positioning these variations on an evolutionary scale, science and medicine were able to actively support the right to dominate and the right to kill as a means of upholding social order. Psychiatric knowledge could provide the state with the "moral" justification that it needed to banish and kill certain persons in order to "protect" the collective.

As the work of early psychiatrists and alienists indicates, psychiatry has upheld the *natural* order by identifying, diagnosing, and treating those it considered not normal, deviants that in accordance with evolutionary theory threatened social progress. Psychiatry has not been alone in this position. According to Donna Haraway (1978), this belief has been upheld throughout the natural sciences. The treatment of social norms as biological realities has meant that these norms are seen as natural, given and inescapable. Haraway (1978) writes, "to see the structure of human groups as a mirror of natural forms has remained imaginatively and intellectually powerful" (p.21). Using biology, scientists sought to establish structural inequality as a physical reality, arguing that some humans were less human than others, and others were not human at all.

Psychiatry placed itself at the center of such debates, entering the clinic, the courtroom, and the bedroom. In an effort to establish itself as a legitimate science, psychiatric knowledge has concealed and naturalized patriarchal domination through the treatment of women as biologically inferior and thereby predisposed to madness. In examining the reproduction of human taxonomies in scientific knowledge, Haraway argues, "the biosocial sciences have not simply been sexist mirrors of our own social world. They have also been tools in the reproduction of that world, both in supplying legitimating ideologies and in enhancing material power" (1978, p.25). Science operating under a pretense of pure objectivity has successfully concealed and naturalized patriarchal domination.

The Creation of the Borderland

The borderland refers to the murky boundary between madness and sanity to be policed by the emerging discipline of psychiatry. Maudsley, in developing the concept of the borderland, created the task of identifying those individuals who appeared "normal", but were biologically predisposed to mental disorder (Maudsley, 1876, p.43). The borderland expanded the sphere of madness to include the "insane temperament", those quirky, strange, not normal individuals whom Maudsley believed to hold a biological predisposition to madness. Persons who "without being insane,

exhibit peculiarities of thought, feeling and character which render them unlike ordinary beings and make them objects of remark among their fellows" (p.43). What were once considered quirks, or perhaps not thought of at all, now became symptoms of an underlying disease or biological flaw.

Andrew Wynter helped to popularize the theory of incipient lunacy, writing the *Borderlands of Insanity* (1875) in which he described a murky boundary between sanity and madness. In this Borderland lurked a "vast army of undiscovered lunatics" who lay in wait, either to later reveal themselves crossing the border or to pass their defective nature on to their children (cited in Taylor & Shuttleworth, 1998, p.280). According to Wynter, such persons "suffer from a paralysis of the moral sense; invariably they are untruthful, very commonly full of impure thoughts, and always eccentric in thought and action. They have long belonged to the Borderland of insanity" (cited in 1998, p. 280-281). The incipient lunatic would build upon Pritchard's theory of moral insanity, with each maintaining the need for psychiatry to distinguish the sane from the insane and the normal from the abnormal.

Psychiatry's objective was no longer concerned with curing the mentally sick and deranged but rather, identifying and segregating these individuals and those who had the genetic potential to become insane. As a major proponent of biological determinism Maudsley argued in *Responsibility in Mental Disease* (1876) that genetic inheritance secured a person's fate. Darwinian psychiatrists hoped to influence evolutionary processes by controlling the population's biological functions. This shifted the means for affecting change from the individual to the collective, and from the social to the biological, introducing a need for a programme of social hygiene. Maudsley envisioned his role, and that of psychiatry, as the protectors of evolutionary progress.

Degeneracy

Maudsley's theory of the borderland was underlined by a theory of degeneration. He had been attracted to the ideas of Benedict-Augustin Morel (1809–1875), a French physician who developed the concept of degeneration in 1857. Morel was struck by the peculiarity of his patients' looks, which led him to believe that social deviance and impaired mental functioning were the result of an inherited genetic fault. Building on the work of Jacques Joseph Moreau (1804–1884), he began to develop a theory of degeneration, which he applied to psychiatric disorders.

In *Treatise on Mental Diseases* (1860) Morel theorized that madness would spread through the population as degenerative genetics were passed through generations. The development of Morel's theory of degeneration coincided with Darwin's *Origins of Species*, which would support Morel in maintaining that if the natural progression of species was obstructed, evolutionary processes of deterioration would occur (Noack & Fangerau, 2007, p.113). Maudsley drew on Morel's theory of degeneration arguing that if incipient lunatics were to reproduce, their faulty biology would worsen as it is passed through future generations (Shorter, 1997, p.93). Influential German psychiatrist Richard Freiherr von Krafft-Ebing (1840 - 1902), shared in the belief declaring, "Madness, when it finally breaks out, represents only the last link in the psychopathic chain of constitutional heredity, or degenerate heredity" (cited in Shorter, 1997, p.95).

Much in the same way that nineteenth century race scientists constructed racial markers based on physical characteristics such as cranial measurements, psychiatrists such as Maudsley sought to establish physical markers as evidence of a mad person's degenerate biology. Maudsley was of the belief that insanity could be detected in the eyes, "a vacantly abstracted, or half-fearful, half-suspicious, and distrustful look" (cited in Shorter, 1997, p.97). These outward signs were taken to be the mark of an inward biological flaw, or as Maudsley described, an "invisible peculiarity of cerebral organization" (cited in Shorter, 1997, p.97). This concern with the cerebral organization has continued to inform the biomedical pursuit of the etiology of madness.

The incurability of biological misfortune meant discipline served no real purpose and rehabilitation was not possible. The alternative was to sterilize and exterminate such persons in order to protect the collective. As Foucault describes, it became a cause for "taking control of life and the biological processes of man-as-species and of ensuring that they are not disciplined, but regularized" (2003, p.246-247). Morel pitted such degenerates against humanity's progress, arguing that "the degenerate human being" is "the greatest obstacle to this progress through his contact with the healthy portion of the population" (cited in Shorter, 1997, p.94). In 1895, Valentin Magnan described degeneracy as a "social menace" writing, "One must not forget that the degenerate is often a dangerous individual against whom society must defend itself" (cited in Shorter, 1997, p.95). The degenerate was positioned outside of the bounds of humanity, opposing evolution and progress.

Our contemporary analysis of personality disorder came about through the notion of the borderland and the belief that quirks and peculiarities were expressions of a deeper pathology. This biological concern has maintained the hegemonic means of understanding and responding to "mental disorder." Psychiatry established itself as a science and medical discipline through this biological perspective. In doing so, it reified human taxonomies and which in turn served to uphold the prevailing ideas of gender and morality.

The Feminization of Madness

Both Maudsley and Darwin believed that women were biologically inferior. Maudsley, however, differed from Darwin in that his work conveyed rather visceral misogyny. He possessed extreme and negative views regarding women, even for his time (Collie, 1988, p.50). Such beliefs have had lasting implications for psychiatry's aim to shore up evolutionary progress. During the nineteenth century, massive shifts in the economic and political landscape required new legitimating ideologies to maintain structural hierarchies. Proof of natural inequalities was needed to counter the appeal for equal rights (Libbon, 2007, p.82). Madness lost the mythic, mystic, spiritual quality of its predecessors. It was now a pathology located in women's bodies for science to explore. Appignanesi (2008) writes,

> "In 1815 the two writhing, brutish and chained male personifications of madness in front of bedlam were replaced by figures of women - 'a youthful, beautiful, female insanity.' Madness, at least in representation, it would seem, was becoming feminized and tamed, no longer wild, raving, and dangerous, but pathetic" (p.43).

Following industrialization and urbanization in the nineteenth century, women have continued to outnumber men in asylums (Ussher, 2011, p.1). Emerging scientific knowledge played a key role in legitimizing the prevalence of women in public asylums. In *Body and Mind* (1873) Maudsley argued that women's natural state was prone to "mental and physical derangement" periodically each month.

> “Most women at the time are susceptible, irrational, capricious, any cause of vexation affecting them more seriously than usual; and some who have the insane neurosis exhibit a disturbance of mind which amounts almost to disease. A sudden suppression of the menses has produced a direct explosion of insanity, or occurring some time before an outbreak it may be an important link in its causation” (Maudsley cited in Busfield, 1996, p.143).

For psychiatrists of this period, biology was destiny. Maudsley went further to argue that the refusal of this destiny was immoral. He wrote that “an imperfectly developed reproductive system is a moral deficiency” (cited in Collie, 1988, p.51). Maudsley responded to women’s entry into higher education by advocating against their inclusion on the basis that consuming too much mental energy threatened their reproductive function. Similarly, German neurologist Paul Julius Mobius argued, “If it were possible for the feminine abilities to develop in a parallel fashion to those of the male, the organs of motherhood would shrivel, and we would have hateful and useless hybrid creatures on our hands” (cited in Libbon, 2007, p.86). According to the scientific theories of Maudsley and Mobius, women’s engagement in the public sphere threatened the survival of the species.

The concept of inheritance was taken up by British surgeon John Furneaux Jordan (1830 -1911), who argued that certain women possessed a biological defect that made men want to hit them. In *Character as Seen in Body and Parentage* (1896), Furneaux Jordan writes, “Several years ago I noticed that a very large proportion of women who came into the hospital suffering from injuries inflicted by their husbands had, as a rule, something peculiar about their personal appearance” (p.1). Furneaux Jordan identified physical markers such as skin that is “clear, delicate, perhaps rosy,” hair that was “never to heavy or long,” eyebrows that were “spare and refined,” and upper spinal curvature that produced a “somewhat convex appearance to the back and shoulders” (p.2). He recommended that men should be careful to look over their prospective wives for any such physical traits. This belief that victims of domestic violence were somehow responsible for their victimization is echoed later in the twentieth century. I elaborate upon this further in chapter four, where I consider the high rates of child abuse among those diagnosed with BPD.

The expansion of the concept of madness to include persons who “lurked” in the borderland occurred as part of a broader effort to establish social hierarchies as biological realities. Therefore,

while the borderland concept is not explicitly gendered, its application is. The feminization of madness meant that expanding the concept disproportionately impacted women, who Darwinian psychiatrists deemed to be biologically predisposed to madness. In particular, those women challenged prevailing social norms. In the following section, I consider the *female malady* known as hysteria, which Jimenez (1997) described as a precursor to BPD. Hysteria is of particular interest because it captures two dominant conceptions of women's mental disorder, biomedical and psychoanalytic.

Hysteria

Hippocrates was the first to use the term hysteria to describe an illness he believed to be caused by a "wandering womb." According to this theory, a sexually unsatisfied womb or uterus would result in poisonous humours that would infect the body and cause madness (Tasca et al., 2012, p.111). Through the biomedical lens, hysterical women were believed to have inherited some defective character, which the crisis of puberty had triggered. As the crisis stemmed from their reproductive function, women's hysteria, psychiatrists argued, was derived from unsatisfied sexual and maternal drives.

Hysteria was characterized by extreme emotionality, the vague syndrome also included trances, fits, paralysis, choking, and hair-tearing (Scull, 2002, p.6). Its symptoms appeared to have no organic origin, leading nineteenth century American neurologist Silas Weir Mitchell to describe the disease as "mysteria", a "nosological limbo of all unnamed female maladies" (cited in Sicherman, 1977, p.41). In 1873 he developed the "*rest cure*," a therapy based on sensory deprivation which entailed "seclusion, massage, electricity, immobility and diet" (cited in Showalter, 1985, p.138). These women were forced into a state of womblike dependence. The doctor established his total authority over the patient by removing her from the home and confining her to bed rest. Showalter (1985) suggested that, "The goal was to isolate the patient from her family support systems, unmask her deceitful stratagems, coerce her into surrendering her symptoms, and finally overcome her self-centeredness" (p.137).

French neurologist Jules-Joseph Dejerine deployed the rest cure. He described his morning rounds writing, "I ask each patient how she spent the night. I explain patiently to her that the symptoms of which she complains do not have the significance that she attributes. And I do not go to the next

patient until I see by her answers that conviction is sprouting in her own mind" (cited in Shorter, 1997, p.141). This example demonstrates the historical practice of minimizing women's suffering and denying their experience in favor of psychiatric authority. As will be discussed in chapter four, persons diagnosed with BPD are accused of trying to convince others of the unique depth of their suffering (Cauwels, 1992, p.80).

Psychiatry's view of hysterical women was one of general disdain. British physician H. B. Donkin wrote, they "delight in annoying others, groundless suspicion, and unprovoked quarrelsomeness are of very common occurrence: and the instances of self-mutilation and wondrous filthy habits are numerous" (cited in Showalter, 1985, p.133). Maudsley considered his hysterical patients to be manipulative liars, writing, "believing or pretending that they cannot stand or walk, only to lie in bed all day asking for the sympathy of their anxious relatives. They are perfect examples of the subtlest deceit, the most ingenious lying, the most diabolic cunning, in the service of vicious impulses" (cited in Appignanesi, 2008, p.98). Weir Mitchell writes, "The sense of moral obligation [in the hysteric] is so generally defective as to render it difficult to determine whether the patient is mad or simply bad" (cited in Sicherman, 1977, p.41). The rest cure saw to it that whether mad or bad, the hysterical woman would be forced to submit to man's dominion over her.

The division between genders and the public and private sphere produced what Ehrenreich & English (2005) described as a sexuo-economic relation, whereby women's dependence on men was seen as the height of femininity. Her sickness was evidence of her purity and her morality, too virtuous for the brutal ongoings that took place in the spheres of men. By contrast black women and women of color were not given such exemptions from hard work (Ehrenreich & English, 2005, p.126). This will be discussed further in chapter seven where I examine the impact of racial tropes upon women's access to mental health services.

Despite this association of white middle class femininity and dependency, the hysterical woman was abhorred for her illness. As Showalter (1985) has pointed out, her refusal to be self-sacrificing and her demand for attention meant that the "hysteric", unlike the "anorexic", ran counter to ideal femininity. Hysterical patients were seen as "personally and morally repulsive, idle, intractable, and manipulative" (Showalter, 1985, p.133). She was disdained for her refusal to carry out the

nurturing duties of mother and wife. These descriptions of the hysterical character were translated into BPD.

Chapter Two Psychoanalysis and the 'Dark Continent'

During the nineteenth century it was widely accepted by physicians and psychiatrists that women's reproductive function was the origin of their mental distress. Psychoanalysis developed a different but corresponding narrative that did not locate mental distress in the body but in the girl's psychic development. Psychoanalysis upheld the association between femininity and pathology by creating a theory of women's sexual development, which made them vulnerable to masochism and the formation of narcissistic and false selves. This narrative has been highly influential in informing our understanding and treatment of women's psychic distress. As will be discussed in chapter seven, psychotherapist Mary Pipher (1996) drew on this history to create a contemporary image of girlhood as a tumultuous period in which the cruelties of the world impacted the development of the young girls "authentic self."

Hysteria was popularized by French neurologist Jean-Martin Charcot (1825-1893) before taking on a more psychological meaning in Sigmund Freud's work. Charcot had aimed to anchor the disorder in the nervous system, as opposed to the reproductive system, thereby treating hysteria as a neurological disorder. In doing so, he challenged the prevailing neo-Hippocratic view of gender that had characterized much of the work on hysteria. Charcot did not produce a general theoretical treatise on hysteria, instead producing in-depth clinical case studies in which he diagnosed and recorded ninety male patients with hysteria (Micale, 2008, p.124).

In writing an obituary for Charcot, Freud stated how hysteria had occurred in men far more than one would expect. However, he argued that the illness was frequently interpreted as alcoholic intoxication and lead-poisoning (Appignanesi, 2008, p.128). Furthermore, Charcot identified symptoms in men traditionally only recognized in women, such as *globus hystericus*, the sensation of a ball rising in the throat, a symptom previously attributed to a wandering womb (Micale, 2008, p.160). His work on hysterical men was not part of "a self-conscious desire to challenge the gender regime of the day" but rather to anchor the disorder in the nervous system (Micale, 2008, p.122).

In spite of Charcot's recognition of hysteria in men, the vision of the feminine hysteric continued to develop in his work, with women as his most famous case studies. This can in part be the result of prevailing attitudes towards the disorder in men. Micale (2008) writes, "the *Salpêtrière*

physicians at the height of the heroic positivist era chose not to publicize this new knowledge, in either textual or iconographic forms, to the scientific world at large" (p.127). Charcot's hysterical young women attracted the attention of the wider medical community leading some of his patients to become quite infamous.

Of these women, the young Augustine was viewed as the quintessential hysteric, described as "sweet, capricious, willful, and far too saucy for her age" (cited in Appignanesi, 2008, p.130). Augustine was considered intelligent, temperamental, and attention-seeking. In 1876 at age fifteen, Augustine was committed by her mother to the *Salpêtrière,* where she was placed in Charcot's care. Augustine displayed all textbook symptoms of a hysterical attack: a fit accompanied by "seething pain in the right ovary", the sensation of a "ball rising from stomach to throat", "accompanied by palpitations, agitation, speeding heart, difficulty in breathing", and "rapid eye movement" (Appignanesi, 2008, p.130). Her muscles would contract, adopting a "tonic rigidity" that would reflect the symptoms of epilepsy. Following these fits, Augustine communicated various emotional states, "*attitude passionnelles*", as she enacted "seduction, supplication, erotic pleasure, esctasy and mockery" (Appignanesi, 2008, p.137). Charcot captured Augustine's expressions of madness in photographs entitled *Extase* and *Erotisme* (Lunbeck, 1994, p. 209). After spending many years in the hospital Augustine tried to escape. Her first attempt failed, leaving her with a broken leg. Once her leg healed, she made another daring attempt, but this time disguised as a man (Appignanesi, 2008, p.138).

Preceding her entering Charcot's treatment, Augustine's family had used her as a pawn in their sexual exploits. She was raped by her father's employer, having been gifted to him as a proxy by her mother. Accounts such as these led some feminist and social historians to describe hysteria as the "daughters disease" (Showalter, 1993, p.288), a means for voiceless young women to express their distress at the lack of social or intellectual opportunities available to them and protest their lack of bodily autonomy. Lunbeck (1994) suggests that hysteria was used "less as a proxy for symptoms than as an epithet expressive of… [psychiatrist's] disdain for troubling aspects of womanhood" (p.226). As will be discussed further in the fourth chapter, persons who experience sexual violence have historically had their response to trauma treated as evidence of an underlying mental disorder.

The Talking Cure

Freud worked with distinguished Viennese internist Josef Breuer, who was treating hysterical women in his popular clinic (Scull, 2009, p.258). Together, Freud and Breuer developed *Studies in Hysteria* originally published in 1895, which demonstrated an openness to women's complaints that had previously not been heard by the medical profession. Both sympathized with the plight of their hysterical patients. They acknowledged that restrictive feminine roles and the burden of domesticity were taxing for many of these women, who were often described as highly intelligent and possessing extraordinary will.

Psychoanalysis was revolutionary because it involved listening to women, thereby destigmatizing discussions around topics such as sex, trauma, and marital unhappiness. Freud even went as far as arguing that, "the cure for nervous illness arising from marriage would be marital unfaithfulness" (cited in Appignanesi & Forester, 1992, p.4). Moreover, he recognized that women's psychic distress was produced by the restrictive demands of civilization. Leading Freud to suggest, "Nothing protects her virtue as securely as illness" (cited in Appignanesi & Forester, 1992, p.4, emphasis in original). Women were placed in a struggle between their sexual desires and their sense of duty, the further she adhered to her duties at the expense of her desire, the more neurotic she became. Psychoanalysis would not judge desires as weak or bad. It was not moralistic, at least in principle.

Freud and Breuer's work contrasted the Victorian portrait of the hysteric as sinful and wicked with a sympathetic and, at times, admiring view. Yet this remained plagued by a romanticism that would further gender the diagnosis. In *Studies in Hysteria* (2004), Breuer describes hysterics as "the flower of humanity, a sterile, admittedly, but also as beautiful as forced blooms" (p.241). For Breuer, the hysteric is the forced bloom of domesticity and civilized cultivation. In Britain, the response to their work was predominantly critical and condemning. The "talking cure" was not widely used, with Darwinian psychiatrists describing it as "stimulating the worst impulses of hysterical patients - egotism, deceit, shamelessness, [and] volubility." These psychiatrists and physicians were annoyed by the indulgence in the women's sexual fantasies, seeing it as a sordid morass (Showalter, 1985, p.162). Lunbeck (1994) suggests that "hysterical girls, like hypersexual girls, piqued their prurient curiosities" (p.225).

Pathological Femininity

The psychoanalytic model developed by Freud recognized women's trauma. However, it interpreted this trauma using a masculinist lens, thereby perpetuating the association between femininity and pathology. Freud became concerned with developing a grand narrative and an overarching psychoanalytic theory of the unconscious. While he acknowledged that women diagnosed with hysteria were often both highly intelligent and deeply constrained by their social roles, his theory would ultimately deny their knowledge and experience.

To understand the “riddle of femininity,” Freud (1933) became concerned with “how a woman develops out of a child with a bisexual disposition” (p.116). In an attempt to solve this riddle, Freud linked femininity with the little girls' sexual development, creating his theory of “penis envy”. According to Freud, this envy characterized the development of femininity. He argued, “We ought rather to recognize this wish for a penis as being *par excellence* a feminine one” (p.129, emphasis in original). Freud believed that women could only find satisfaction in having a child, which he described as “the most powerful feminine wish” (p.128). Freud’s grand narrative thus upheld the Aristotelian belief that “woman is a failed man” (Tasca, Rapetti, Carta, Fadda, 2012, p.112).

Just as Freud emphasized the passivity of women, he naturalized aggression in men. He writes, “That the accomplishment of the aim of biology has been entrusted to the aggressiveness of men and has been made to some extent independent of women's consent” (1933, p.132). Given this statement in which he suggests that rape is a product of biology, it is somewhat contradictory that Freud suggested his patients accounts of sexual abuse were fantasy (p.120). But, by doing so, he could elaborate his Oedipal theory and use accounts of abuse as further evidence of women's pathology.

In his lecture on femininity Freud develops his analysis of the feminine character describing women as shallow, narcissistic, envious, and lacking a sense of justice. Freud (1933) writes, “Thus, we attribute a larger amount of narcissism to femininity, which also affects women’s choice of object, so that to be loved is a stronger need for them than to love” (p.132). This narcissism and women’s propensity for physical vanity is accorded by Freud to their original sexual inferiority,

their lack of a penis. Women's narcissism exists to compensate for their "shame, which is considered to be a feminine characteristic par excellence" (p.132).

Brennan (1992) writes, "Freud's woman not only has an unfortunate character. She is also less likely to be curious, to have intellectual capacity for research, … or be able to withstand adversity. She is more subject to repression. She is masochistic." (p.6). Indeed, for Freud, "masochism, as people say, is truly feminine" (1933, p.116). In his theory of the girls' sexual development, Freud further develops the notion of pathological femininity. Wallace (2000) maintains that Freud "gave 'scientific' veracity to a notion of 'normal femininity' which reinforced that patriarchal ideal of woman as 'adored sweetheart' and 'beloved wife'" (p.51).

While Freud's work was premised upon listening to women's concerns, these concerns were relegated in favor of his grand theories of psychic development. Moreover, as opposed to taking women at their word, Freud chose to interpret their narratives as symptoms of their mental disorder. In doing so, he silences women by creating a subjectivity in which madness continues to be a female malady. This issue will be developed further in chapter four on trauma, where I examine the epistemic violence that occurs when one is labeled mad.

Woman-as-chaos reinforced the need for a benevolent father or psychiatrist. In this way, Cixous (1981) has suggested that man constructs himself through his exploration of chaotic feminine desire. The association of women with mystery, darkness, and the chaotic, endowed men, such as Freud, with the rationality to conquer the unknown. Feminine sexuality as a "dark continent" (cited in Brennan, 1992, p.5) upheld the association between insanity and femininity and positioned femininity as something pathological to be conquered by man. Just as Freud generalizes his view, privileging a man's perspective as that of the "rational human," he also generalizes femininity as that which matches middle-class women's femininity.

An examination of the diagnosis of hysteria in men illustrates the continued association of femininity with pathology. Psychiatrists and physicians saw the disorder as evidence of the worst characteristics inherent in women's disposition, their weak-willed, overly emotional, and mutable constitution. In 1883 French physician Auguste Fabre argued, "all women are hysterical and… every woman carries with her the seeds of hysteria" (cited in Showalter, 1993, p.287). When men

began presenting these same symptoms, they began to undermine the notion of hysteria as a feminine folly.

Hysterical Men

The view of hysteria as a feminine illness meant that these symptoms in men were considered shameful and "effeminate". Moreover, to be a man with hysteria would threaten his sexual identity. Showalter (1993) highlighted this suggesting, it is "as if the feminine component within masculinity itself were a symptom of disease" (p.289). Men who demonstrated symptoms of hysteria were believed to possess an inferior will, such as that of women, who were unable to control their emotionality. As Wood (2001) explains, "the ubiquitous gender stereotypes which typically assigned the characteristics of self-absorption and irresolution to the allegedly weaker organization of women", simultaneously "credited men with the will-power and reason with which to surmount them" (p.59). Thus, hysteria was seen as evidence of women's intrinsically pathological feminine folly, leading the same symptoms in men to be seen as pathology found only in weak men of inferior will. So, while men and women shared the same signs and symptoms of distress, these were interpreted through a gendered lens in which femininity was invariably an expression of sickness.

Following WWI, the prevailing belief in the biological origins of hysteria was challenged by returning soldiers who, traumatized by warfare, displayed hysterical symptoms. As the work of Showalter highlighted, the symptoms of hysteria in men destabilized the normative gender conceptions that characterized the illness and the "ideology of absolute and natural difference between women and men" (Showalter, 1985, p.167-8). This prejudice led to an unconscious collaboration between sick men and male doctors to avoid the diagnosis. The stigma associated with the illness would lead to new names for its expression in men, such as *shell shock*. Physicians would go to great lengths to distinguish neurosis in men from the female malady hysteria (Wood, 2001, p.60). However, despite such efforts to distinguish the two, men who displayed symptoms of hysteria were feminized through their expression of psychic distress.

The Hysteric becomes Borderline

Critical socio-historical literature has highlighted the correlation between the diagnosis of hysteria, and what they argue is its modern counterpart, BPD (Cahn, 2014; Cohen, 2016; Jimenez, 1997; Lunbeck, 2006). The two have striking similarities, which Cahn (2014) draws attention to writing, "Combine anger and sex, replace the hysteric's psychosomatic bodily pains with the borderline tendency to inflict pain on her own body, and the Victorian 'hysteric' emerges as the postmodern 'borderline'" (p.260). Each diagnosis has captured all manner of symptoms and been characterized by what are considered undesirable and exaggerated feminine attributes. Lunbeck (2006) writes, "The exemplary patient of modernity, it was widely agreed, was no longer the hysteric… but the empty, grandiose narcissistic and the histrionic, manipulative, impulsive, and self-destructive borderline" (p.152).

By examining Freud's theory of pathological femininity, we are able to see how the character traits which he described as *truly* feminine are those traits that are later fashioned into the personality disorders predominantly diagnosed in women. Psychoanalysis built on the work of Darwinian psychiatrists in reinforcing the inferiority of women and the association between femininity and mental disorder. Moreover, we see that like hysterical women, the borderline diagnosis silences their narrative by privileging a psychoanalytical vision of healthy normal personhood. Experiences that counter this narrative are reinterpreted and may be used as further evidence of their pathology.

In the following chapter I examine the rise of ego psychology in the U. S. I discuss how diseases of the self emerge from an individualistic view of personhood, which came to prominence through ego psychology. Psychoanalysis has underpinned the dominant understanding and conception relating to trauma in the West. Through the medicalization of the personality, the West's construction of personhood leads to the pathologizing of childhood trauma survivors. By exploring the emergence of ego psychology and the medicalization of the personality we can denaturalize the Western construction of personhood and its pathologization of human responses to trauma.

Chapter Three Medicalization of the Personality

Neoliberal governance necessitated a particular relation to the self, which translates social ills into individual problems and individual pathologies. By constructing the autonomous subject, psychiatric knowledge provides ideological support for the treatment of deviant and disordered individuals who fail to meet or comply with neoliberal expectations. Nikolas Rose (1999a) explains, "The relations between psychotherapeutics and political power reveal not the devastation of the psychic autonomy and security of the self, but the fabrication of the autonomous self as a key term in analyses of social ills and cure, as the object of expert knowledge, as the target of systems of moral orthopaedics" (p.220).

Neoliberal demands on personhood are essential for understanding the pathologizing of deviant femininity in BPD. Diseases of the self emerge through the medicalization of the personality. Before an individual could have a personality disorder, psychiatry had to establish the boundaries of personhood. Through a critical examination of the dialectical relationship between psychoanalysis and psychiatry, we can see the medicalization of a psychoanalytic concept, the ego, and the use of authenticity as a concept for measuring healthy, *normal* personhood. I begin my discussion by looking at the role of psychoanalysis in forming the basis for understanding the *self*. Following this, I consider the widespread concern with the concept of identity and its relation to the newly developed concept of the ego. Authenticity became a concept for assessing one's ego. Moving into the twentieth century, cultural critics lamented the decline of the authentic subject. They argued that social upheaval caused identity confusion and the production of false, or inauthentic, selves. Psychiatrists shared this concern, but those of the psychoanalytic persuasion focused on interior explanations for this identity loss. Producing object relations theory, they argued early childhood trauma was producing psychic instability and disturbed egos.

At the beginning of the twentieth century psychiatry re-orientated itself around defining "normal personhood". The discipline moved outside of its traditional concern with neurosis and psychosis, expanding its sphere of investigation to include everyday people and the psychology of everyday life. Setran (2006) writes, "By the 1930s… the focus upon rehabilitative life adjustment was expanded both in scope and in potential cultural influence. Within the field as a whole, the exclusive concern for individuals with mental and emotional disorders gave way to a concern for

the mental health and adjustment needs of the broader population" (p.174). Psychiatry became newly concerned with patients who had previously been seen by family physicians or not seen medically at all (Shorter, 1997, p.291).

In order to determine the norm, psychiatry began fashioning conceptual tools for measuring the human psyche and one's interior world. Foucault (1980) described this project as "the mental normalization of individuals" (p. 116). To establish the *normal* person and scientifically quantify the boundaries of personhood, psychiatry imbued within each person the personality as a typology with measurable objective/clear criteria. In a similar fashion to Maudsley's theory of the borderland, psychiatrists redefined insanity through their new concern with the personality and in doing so expanded their purview to the whole human endeavor.

Where cultural critics have emphasized the social dislocation and dissociation that occurred with modernity, Giddens (1991) makes an important point in highlighting certain unifying qualities in modern society. He discusses how the reconceptualizing of time "established a single 'world' where none existed previously" (p.27). Modernity's "calculation of time and the ordering of space" required a conception of personhood that would span one's life trajectory (Giddens, 1991, p.16). He suggests that the defining characteristic of modern individuality is the emphasis upon self-reflexivity (p.76). Through this reflexivity we see the development of selfhood as a narrative, with each individual possessing a sense of self that covers the course of their lifespan and can be translated into their autobiography. This autobiography provides the individual with their core sense of "self-identity" (p.76). This conceptualization of identity emphasized personal responsibility, which Giddens captures writing, we are "what we make ourselves" (Giddens, 1991, p.75).

Today the notion of the personality is rarely questioned, moreover its existence as an organizing principle for our social world is often taken for granted. But this was not always the case. Lunbeck (1994) describes the shift in the terminology used to denote personhood from the Victorian notion of "character" to the psychological concept of the "personality". The latter only came into common usage at the turn of the twentieth century (p.68) alongside other social, political and cultural shifts that marked a turn toward individualism, such as industrialization, capitalism, surveillance (Giddens, 1991).

I endeavor to denaturalize this construction of selfhood by demonstrating its emergence through a specific set of historical circumstances and their impact upon knowledge production. This construction of selfhood is neither objective nor is it benign, it has served to inform our relation to ourselves and others and, importantly, to power. Power is enacted through this knowledge of the self; therefore, in reflecting upon the creation of the personality, we are able to understand how such a creation upholds certain systems and certain forms of governance. In later chapters, I argue that this construction of selfhood is gendered as well as being encoded with heteronormativity and whiteness.

Of these developments, the rise of organization and in particular, the rise of modern bureaucracy produced a new class of persons, that of middle management. In *Culture as History*, Warren Susman (1984) writes on the impact of the emergence in the 1930s of “a class of bureaucrats: managers, professionals, white-collar workers, technicians, mechanics, salespeople, clerks, engineers” (p.xxi) maintaining that, “this middle class provided the source and the inspiration for the new modal psychological type that was to become the ideal for the new culture” (p. xxii).

The notion of character was imbued with explicitly moral connotations (Westbrook, 1985, p.483), emphasizing “duty, work, honor, integrity”, and “manhood” (Lunbeck, 1994, p.69). The concept of the personality differed from character in that it transposed the meaning of selfhood into subjective experience. Personality encompassed one’s psychological well-being emphasizing “self-confidence, integration, and social adjustment” (Setran, 2006, p.174). It encompassed a growing concern with how one felt and how their peers felt about them.

The emergence of this new class redefined success as personal distinctiveness. Material expression through the concept of lifestyle was integral to this pursuit (Giddens, 1991, p.81). Lifestyle enabled subjects to cultivate their identity and self-expression through their exercise of choice. The means to success were based less on hard work, diligence, and will-power and more upon one’s likeability, confidence, and self-expression. Businessman and entrepreneur Orison Swett Marden writes in *the Masterful Personality* (1921): “so much of our success in life depends upon what others think of us”.

Setran (2006) argues that "Despite the 'inward turn' implied by personality rhetoric, the clear emphasis of personality-minded theorists was to equip students with the personal tools necessary to 'fit in,' to 'adjust' effectively to others" (p.185-186). This need to fit in produced a paradox whereby one should be themselves, but this self had to be likable to others. As Susman (1984) writes, "One is to be unique, be distinctive, follow one's own feelings, make oneself stand out from the crowd," he contended, "and at the same time appeal—by fascination, magnetism, attractiveness—to it." (p.280).

Personality gained increased significance as mental hygienists, those persons now considered psy professionals, became concerned with the expression of one's inner self, "the development of an individualized sense of identity" (Setran, 2006, p.177). With a new emphasis upon self-actualization, the self became something to be explored through soul searching expeditions. As will be discussed later in this chapter, by redefining success and citizenship a new pathology emerged, if a person failed to cultivate that sense of uniqueness, of distinctiveness, they were described as possessing an 'as-if' personality. Such a personality was not only identified as abnormal, but also pathological.

During the Second World War psychiatry played a new and important role in identifying those "at-risk" individuals who they deemed unfit to serve in the military (Shorter, 1997, p.298). The traumatized soldiers of the First World War had produced a task for psychiatrists to detect those persons who are likely to be made insane by the experience of war. In the process, the US War Department produced a manual of psychiatric disorders *Technical Bulletin, Medical 203 - 1943,* which would legitimize and standardize psychiatry's authority on character analysis (Bourne, 2011, p.71-72). This character analysis depended upon the personality as an organizing construct which psychiatry could measure.

Psychiatry's interest in classifying the personalities of soldiers promulgated a belief in the self as an entity from which a person could be estranged and that this estrangement was responsible for social maladjustment (Bourne, 2011, p.74). Psychiatry located the pathology in the person, as opposed to a view that social systems themselves produce "maladjustment" by creating distress. This pathologizing of selfhood depended upon the creation of the psychological self and an emphasis upon individual responsibility. During this period, Gonick (2006) describes a shift "in

relations between the state and its citizens from a focus on state-building (through the development of government programs in support of citizens during the post-war period) to concern for *making the individual responsible*" (p.5, emphasis in original).

Authentic Selfhood

The increased prominence of psychoanalysis in the United States between the 1940s to 1960s provided ideological support for this emphasis upon individual responsibility. Descendants of Freud made refugees by WWII fled to the United States, where they became significant proponents of ego psychology (Wallerstein, 2002). In their newfound home, they replaced Darwinian psychiatrists in prominent chairs in the American Psychiatric Association and American medical schools, where they introduced psychoanalytic concepts to the understanding and treatment of mental disorders (Wallerstein, 2002, p.142). Of these, Wilhelm Reich (1950) was highly influential in constructing the basis for personality disorder. As a proponent of ego psychology, Reich developed a classification system for organizing persons into character typologies. Drawing on Freud's work and his theory of the ego, Reich theorized that these character typologies were "expressed in a specific attitude or *way of being*" (p.44, emphasis in original). He argued that the role of psychoanalysis was to understand the origin and meaning of the *ego's armour,* "that part of the personality which forms the boundary between instinctual life and the outer world" (1950, p.146). The analyst would peel back the patient's armour and decipher the ego as an independent mental construct. Reich suggested that mental disorders, such as hysteria, were character types. Hysteria thus shifted from being an illness or disease to a facet of one's personhood.

Psy professionals and cultural critics together discursively constructed a *new* patient, one plagued by feelings of inadequacy and emptiness. They argued that the people were experiencing a crisis that stemmed from the absence of an authentic self. According to psychoanalysts and cultural critics, the tormenting feeling that plagued the "new" (borderline) patient was due to the American character's decline. The psychiatrist who wrote the borderline diagnostic criteria, Theodore Millon, shared this belief, arguing that "where a society's values and practices are fluid and inconsistent, so too will its residents evolve deficits in psychic solidity and stability" (1987, p.363). He envisioned the instability and fluidity of late capitalism producing false selves, which led to feelings of "emptiness, aimlessness, futility" (Lunbeck, 2000, p.318).

The erosion of the American identity became a widely accepted cultural criticism, leading to popular works such as a *Man's Search for Himself* (1953)*, On Becoming a Person; a Therapist's View of Psychotherapy* (1961), and *The Quest for Identity* (1958). In these texts, the concept of identity took on a more subjective meaning, one "denoting a robust conception of authentic and fully realized personhood" (Lunbeck, 2000, p.318). Psychoanalyst Erik Erikson discussed the loss of identity writing, "the patient of today suffers most under the problem of what he should believe in and who he should — or, indeed, might — be or become" (cited in Lunbeck, 2000, p. 318).

In *the Culture of Narcissism* (1980), Christopher Lasch argued that "every age develops its own peculiar pathology" and that the American self was in cultural and characterological decline (p.428). Lasch shared Millon's sentiments, arguing that America's unstable and fragmented society had produced empty, aimless, and discontented persons. In describing the new patient Lasch (1980) writes, "Psychoanalysis... today finds itself confronted more and more with a poorly organized and impulsive character" (p.426). Lasch described the new patient as narcissistic, superficial, detached, and unsatisfied (p.426-432).

In psychoanalytic literature, the borderline character was gradually forming. It was refashioned from a form of schizophrenia to a character pathology characterized by a false or inauthentic self. Julia Kristeva (1995), writing on the false self, described the modern person as "living in a piecemeal and accelerated space and time, he often has trouble acknowledging his own physiognomy; left without a sexual, subjective, or moral identity, this amphibian is a being of boundaries, a borderline, or a 'false self'..." (p.7). This character was defined more by what it was not: the absence of firm borders, thus giving the portrait an indistinct quality.

Helene Deutsch, a former student of Freud, created a formative portrait of this new inauthentic person. Deutsch articulated a form of personhood that was incomplete and deficient using the term 'as-if' to describe these people who gave you the "inescapable impression that the individual's whole relationship to life has something about it which is lacking in genuineness and yet outwardly runs along 'as-if' it were complete" (Deutsch, 1942, p.302). She argued that whilst 'as-if' personalities may adhere to social and cultural expectations, they did so in a way that was

superficial and inexplicably lacking. Beyond their appearance of normality belies something much deeper, an impoverished ego that leads others to ask, “What is wrong?” (Deutsch, 1942, p.302).

Persons may be unaware that they lack such authenticity. Helene Deutsch writes, “there are the individuals who are not aware of their lack of normal affective bonds and responses, but whose emotional disturbance is perceived either only by those around them or is first detected in analytic treatment…” (1942, p.301). This is reminiscent of Maudsley’s description of the incipient lunatics, when he refers to those individuals who “without being insane, exhibit peculiarities of thought, feeling and character which render them unlike ordinary beings and make them objects of remark among their fellows” (Maudsley, 1876, p.43). Psychoanalysts in a similar vein to the Darwinian psychiatrists before them, expanded the boundaries of mental disorder through this new focus upon authenticity as a measure of pathology. Much like the incipient lunatics, the ‘as-if’ personalities were those odd or peculiar persons who were only detectable to the trained professional.

Psychoanalyst Carl Rogers discusses the process of becoming a person and develops therapeutic guidelines for uncovering one's *true* self. This process entails “getting behind the mask”, peeling back the layers of inauthenticity that shroud the person’s authentic self (Rogers, 1961, p.108). In describing this revelation with one of his patients, Rogers (1961) writes, “You can see her examining the mask she has been using, recognizing her dissatisfaction with it, and wondering how to get the real self underneath, if such a self exists” (p.109). Rogers does not question the existence of the self, rather he is suggesting that perhaps this woman is lacking an *authentic* self. Psychoanalysts could help in “removing the false faces which they had not known were false faces” (p.110).

Persons diagnosed with BPD often consider themselves alienated, estranged and failing the predominant social standards. Unlike psychoanalysts, they often do not attribute this to an absent or false self (Miller, 1994). The patients interviewed by Miller felt that “rather than having an impaired sense of self, they seemed to have a sense of themselves as impaired” (1994, p.1216). As the work of Miller highlights, these persons felt that in being who they were, they could not meet the expectations demanded of them. Their accounts highlight self-blame; however, it also opens space for critique of the social systems and the expectations that these systems place on persons. As will be discussed further, psy literature has ascribed the borderline’s feeling of inadequacy to a “*false*” self.

Aligning with the cultural critics such as Lasch, Rogers (1961) suggests that inauthentic layers of culture function to conceal a person's true self. Thereby locating the production of inauthentic or false selves as part of a wider cultural trend occurring within America at the time. Rogers, in his theory of the self and its conflict with the demands of culture, began to link the psychoanalytic argument of interior disorganization with the premise of cultural critics. For Rogers the true and authentic self was something that the individual had to cultivate and through his therapies engage in a process of *self-realization*. With this new subjective formulation of identity and the self, the boundaries of sanity and madness became further blurred, thus demanding psychiatric authority and interpretation.

Pathological Personality

The new patient reflected a paradigm shift in how psychiatry conceived of mental disorder. The proliferation of this new patient, accordingly, was rhetorically constructed through their psy discourse. Psychiatry contested the boundaries of psychopathology but did not question its legitimacy as an organizing concept. This expansive rubric enabled the discipline to drastically broaden its purview and reorient itself around establishing the boundaries of what it considered normal personhood (Lunbeck, 2006, p.167). Psychiatry captured those persons who were neither wholly psychotic or neurotic, but inauthentic and therefore disturbed.

Psychoanalyst W. Fairbairn (1994) was heralded as one of the first to develop a rich portrait of the new patient. This portrait corresponded to Deutsch 'as-if' personality and indeed continues to characterize the current formulation of BPD. Fairburn writes, "the schizoid individual is often able to express quite a lot of feeling and to make what appear to be quite impressive social contacts; but, in doing so, he is really giving nothing and losing nothing, because… he is only playing a part" (Fairburn, 1994, p.16). Again, in Fairbairn's work you see the analogy of the actor or imposter being used to describe the pathological personality.

In the text *Schizoid Factors in the Personality* (1994), Fairbairn reconceptualized personality disorder. It became something not limited to a group of abnormal persons with behavioral problems, but according to his theory, all persons, if not the vast majority, suffered from a schism in their personhood. Schizoid conditions were broken down into typologies: the condition

Schizophrenia proper, personality type, character type, and state or transient episode. As such schizoid could be a "relatively minor or transient disturbances of the reality-sense, e.g. feelings of 'artificiality'" (Fairbairn, 1994, p.5). Such character features were described as detachment, which "may be masked by a facade of sociability or the adoption of specific roles; and it may be accompanied by considerable emotionality in certain contexts" (p.7).

These character traits, Fairbairn theorized, were the result of "splits of the ego", which all persons, he argued, were capable of once pushed to their depths. Accordingly, some level of ego splitting was present in everyone, borrowing Melanie Klein's premise that "the basic position in the psyche is invariably a schizoid position" (cited in Fairbairn, 1994, p.8). In Fairbairn's formulation, schizoid becomes a feature of the normal personality. Fairbairn argues that nobody has had such perfect development as to possess a fully integrated ego. Therefore, this psychopathology is no longer abnormal psychology. Instead, in maintaining that no one is perfect, mental disorder was reconceptualized in "degree rather than kind" (Lunbeck, 1994, 68).

The use of a conceptual scale blurred distinctions between madness and sanity, thereby changing how psychoanalysis conceived of mental disorder. The non-schizoid ego becomes only a theoretical possibility. Fairburn (1994) noted, "Indeed it is difficult to imagine any person with an ego so unified and stable at its higher levels that in no circumstances whatever would any evidence of basic splitting come to surface in recognizable form" (p.8). Rather than depathologizing persons, within this paradigm the basis of the personality is pathological. Just as the borderland had expanded madness to include incipient lunatics, in a similar vein psychoanalysis expanded the definition of mental disorder and in doing so made schizoid the norm and an ordered, or healthy integrated ego only a theoretical possibility.

Expanding the rubric of madness increases the number of persons that fall within the psychiatric purview and thus psy authority on defining our understanding of the self. Psy knowledge encodes an account of and relation to the self, constructed on heteronormativity, gender, and whiteness. I will elaborate upon this further in the following chapters, but for now, I want to highlight how expansive psy knowledge has been in shaping how we conceive of our distress and the distress of others.

The categorization of personality types naturalizes an individualized view of personhood and treats the person as distinct from the social systems in which they live. How we conceive of selfhood has important implications for shaping our social world as it is this concept that is used to understand and respond to deviancy. As Bourne (2011) highlights "...it is essential to neoliberal culture's expectations of individual responsibility to keep notions of trouble, danger and disorder centrally bound up with the concept of dysfunctional *persons* rather than dysfunctional (social) *system*s" (p.85, emphasis in original). The notion of authentic selfhood shifts the responsibility to the individual, thereby placing the fault within their individual personhood. As Bourne has pointed out, this ontological positioning of deviance has important implications for how we understand and respond to the suffering of others. Alongside this psychoanalytic interest in authenticity, psychiatry deployed a view in which the disordered personality is conceptualized as being a disease.

During the 1970's there was a push by Robert Spitzer, the new head of the DSM-III committee, to revolutionize psychiatry by pruning psychoanalysis from the Diagnostic and Statistical Manual of Mental Disorders (DSM). Spitzer had a background in psychoanalysis, but he desired to establish the discipline of psychiatry as a branch of medicine proper through an emphasis upon specific, research based, quantifiable criteria for categorizing mental disorders. All categories were to be "data orientated, relying heavily on observation rather than on deductions from theory" (Spitzer cited in Decker, 2013, p.174).

Lunbeck (1994) discussed psychiatry's application of metric thinking to personhood, which came about through the concept of feeblemindedness and their effort to measure intelligence. Psychiatry borrowed a metric paradigm from early psychometric physicians and endeavored to quantify the norm for a person's mental faculties (p.48). This interest later shifted to a desire to establish normal personhood. Using metric thinking, they aimed to create a system for measuring the extent to which a personality was disordered. Psychiatry and psychoanalysis worked together to create what became the study of personology and psychopathology. As they defined the boundaries of personhood, they simultaneously utilized the metric framework and applied it to this study thereby "bringing both the personality and metric thinking concurrently into psychiatric thought proper" (Lunbeck, 1994, p.68).

Psychopathology was a far more malleable concept than feeblemindedness had been, comprising eccentricities, peculiarities, oddities and quirks, however psychiatrists soon discovered that metric testing, which had enabled their claim to scientific authority on feeblemindedness, could not in the same way be applied to personality disorder. It proved to be a rather indeterminate organizing concept, "so elusive that some wondered whether it referred to anything at all" (Lunbeck, 1994, p.65). Personality disorders were disliked by psychiatrists for their amorphous and shifting nature. The borderline concept was particularly controversial. While it was cherished by psychoanalysts, borderline disorder was disdained by those psychiatrists wanting to increase the discipline's scientific credentials (Decker, 2013, 195).

Millon was a major proponent of personology, he was of the belief that each person possessed a personality that could be understood, measured, and categorized through scientific investigation. Millon maintained that "the intrinsic cohesion of persons is not a mere rhetorical construction, but an authentic substantive unity" (2005, p.529). He further believed that to be borderline was to be estranged from this self, thereby lacking unity. In writing on the final stage of personality deterioration Millon (1969) suggests that "at this extreme point, there is a total estrangement from self, an inner void and a sense of nothingness and petrification" (p.305). This feeling of emptiness has been interpreted by psychiatrists as evidence of pathology, interpreted literally as lacking a *self*.

Millon argued that personality disorders should be considered in every diagnosis. The focus shifted away from behavior as a means of detecting insanity to an emphasis upon personality functioning, recording abnormalities that may not be initially detected in behavior. A person may seek help for their anxiety, sadness, or feelings of emptiness and these were to be treated as potential evidence of an underlying personality disorder. For psychiatry, the experience of psychological distress could be evidence of a disturbance in their personality. Moreover, Wirth-Cauchon (2001) notes that, "clinicians [were] encouraged to record a personality disorder for all patients" (p.60).

Millon, in working on the DSM III advisory group helped define and establish guidelines for determining whether the personality was disordered. He formulated a multiaxial system which placed personality disorders on a separate axis to other forms of mental disorder. The logic followed that pathologies of the personality could coexist with other mental disorders, which were

on axis I. These mental disorders were considered diseases, whereas according to Millon personality disorders were not considered a disease. Millon maintained that in each instance the entire matrix of the person needed to be considered and not just their immediate symptoms. However, this effort is contradicted in that it is an aggregate of symptoms that is used to diagnose BPD. Moreover, Bourne (2011) suggests that when the disease model is applied to personhood, the person is reconceptualized as *being* a disease (p.78). Mental disorders on axis I do not have this same implication. For these disorders, the person *has* a disorder, whereas for axis II the very person and the attributes that make up that person are seen as symptoms of a disordered self.

The implicit judgment remains on the person and their flawed *character*, thereby continuing the nineteenth century concept of moral insanity. The pejorative connotations of borderline disorder suggest that whilst this moral judgment is rarely acknowledged, it has shaped the analyst's understanding and relation to the person labeled as borderline. This vision of the self as scientifically quantifiable enabled psychiatry and psy professionals more broadly to assess whether persons possessed disturbed personhood. The concept of a unified self can be understood as developing from the self-identity and the theory of the self as possessing an autobiographical narrative. As will become clearer in later chapters, this construction of selfhood is gendered, heteronormative, and predicated on whiteness.

The treatment of personality disorders, which is individualized, further upholds this notion of the person as being a disease. The distress that the person experiences is not seen to be the result of their environment, but rather is located in their personhood. Their self is therefore conceived of as the origin of their illness. Whereas the person who is experiencing the distress locates their source of pain elsewhere, they do not envision their personhood as the origin of their pain, it is the psychiatrist who makes this attribution.

Borderline

The term "borderline" was coined in 1938 by Adolf Stern to refer to the boundary between psychosis and neurosis. As a psychoanalyst Stern believed that these persons had regressed to an earlier stage in their ego's development, the narcissistic stage. In doing so, "they had withdrawn libidinal energy from the outside world and turned it upon themselves" (Wirth Cauchon, 2001, p.3). Before its clarification in the DSM III, borderline was a heterogenous concept referring to:

“borderline states”, “preschizophrenic” personality structure, “psychotic characters”, “borderline personality”, and some literature was ambiguous as to whether the diagnoses of “ambulatory schizophrenia” and “pseudoneurotic schizophrenia” also referred to borderline (Kernberg, 1975, p.3). This gave it an elusive quality, leading a number of psychiatrists and psychoanalysts to describe borderline as a metaphor. This metaphor would refer to someone who was neither completely neurotic nor psychotic, but on the border.

In the 1950s, when the borderline concept developed its clinical significance, it was done based on a concern with a fragmented or unstable self. This concern with the self can be seen as part of the broader therapeutic movement that was occurring at the time with the rise of ego psychology. Robert P. Knight shared in the belief that the social maladjustment stemmed from a disturbance in the ego’s functioning. The behavioral symptoms of the disorder, Knight lists as “hysteria, phobia, obsessions, compulsive rituals” were seen as acting in defense of this weakened ego (cited in Wirth Cauchon, 2001, p.53).

Otto Kernberg (1975) distinguished “borderline personality organization” from schizophrenia and, in doing so, developed BPD as a distinct disease entity. As a major proponent of postwar ego psychology, Kernberg suggested that BPD was characterized by a “specific and remarkably stable form of pathological ego structure” (1975, p.3). Reiterating Stern's work, he too argued that these persons “occupy a borderline era between neurosis and psychosis” (p.3). Kernberg described these persons as possessing blurred ego boundaries, leading to “a lack of anxiety tolerance,” “lack of impulse control,” and a “lack of developed sublimatory channels” (1975, p.22). The “blurring of ego boundaries” described as an inability to distinguish one's self from others fully is a critical element of BPD, and this failure is what gives rise to aggression, which Kernberg found to be a staple of the borderline personality. The borderline's aggression is coupled with a lack of empathy towards those with whom they've formed intimate bonds.

In the DSM III, borderline was separated from schizophrenia and made into its own unique personality disorder, or “character type,” but there continued to be a lack of understanding. Borderline was criticized as being both vague and elusive. It was used by analysts and psychiatrists when they were unsure of their patient's status. Psy professionals used borderline to refer to persons who they considered not “normal” but had not determined the nature of their abnormality. BPD

took on pejorative connotations as it developed into a character type, described as “unpredictably contrary, manipulative and volatile” (Millon, 1987, p.32). Borderline was applied to so-called “difficult” patients that therapists considered a heavy burden. A study carried out by Perry and Klerman (1978) found that there were over 104 different criteria for diagnosing Borderline Personality Disorder, and of these the only consistent criteria applied was that the patient's behavior was considered “adaptive” and “appropriate” (Bourne, 2011, p.75). This inconsistency led Millon to urge clinicians, “the borderline concept should not be used as a wastebasket for clinical indecision” (1969, p.305).

Clinical psychologist Michael W. Glazer (1979) shared a similar concern. He questioned the cause of borderline’s increased popularity describing the diagnosis as “faddish”. Glazer argued that, “hardly a month goes by, it seems, without a new book, a new conference, a new clinic whose subject matter is the borderline phenomenon” (1979, p.376). Glazer suggested that the term borderline was “untrue to itself” with “logical inconsistencies, inappropriate metaphors, and its depiction of a distorted view of psychic functioning” (p.379).

By 1984 BPD was the most commonly diagnosed PD (Wirth-Cauchon, 2001, p.58) and by 1985, 40% of psychiatric literature was written on the subject of borderline disorder (p.62). This popularity led Michael Stone (1986), a prominent psychoanalyst who had written on borderline disorder, to confess to being “haunted by the dark suspicion that the subject had gotten out of hand” (p.432). The borderline diagnosis has been controversial from the outset. As illustrated by the widespread popularity of the work of Lasch (1980), something in this narcissistic borderline person had resonated with society more broadly, and as the rise of diagnosis suggests, this has important implications for how we envision our own personhood and that of others.

In discussing the influence of psy knowledge, Marecek & Gavey (2013) maintain that, “with diagnostic idioms now part of everyday meaning-making and often central to personal identities, people throughout society have a stake in them” (p.5). The way in which we conceive of madness and insanity is a means of prioritizing a particular view of “reality”, and it follows that through these concepts we define what is considered a socially acceptable way of *being*. The medicalizing of the personality has meant that the parameters of what is considered normal, healthy and socially acceptable are more rigidly defined and enforced. This has important implications for disqualifying a particular view of reality, often in favor of a psychiatric view. We are all placed on the continuum

of disorder and it is to what extent we are deemed disordered by the expert that determines whether our worldview is an acceptable reality or whether our disturbed personhood has clouded this view.

There is an inherent contradiction in the borderline concept as it has morphed throughout history. It had ontologically positioned subjects on the border. However, as it developed in psychoanalytic discourse, it referred to *borderlessness*. The borderline's shifting meaning created a paradox whereby the application of the word negated its original meaning. The concept lacked distinct boundaries, leading one to ask, what was borderline referring to? Indeed, many psychiatrists have historically shared this concern. In an effort to counter the problem with diagnostic rigidity, Millon and others have advocated for borderline, as well as the other PDs to be placed on a continuum. In doing so, the concept that once referred to the unchartered territory of insanity, the borderland, and then referred to a form of schizophrenia that was neither psychotic nor neurotic, now itself has no borders. In its new form, it is intended to denote a distinctive character pathology; the difficulty lies in delimiting such a pathology.

Chapter Four From Seductress to Trauma Victim

In creating the borderline personality, psychiatry established a theory of personhood as quantifiable and indeed knowable through psychiatric assessment of presented symptoms. The personality, as a mechanism for conceptualizing and categorizing different modes of being, has had important implications for our understanding of trauma. In this chapter I discuss how this analysis of trauma has been shaped by a psychiatric vision of morally acceptable behavior that is underpinned by normative assumptions of gender. I discuss firstly the association of BPD with pathological femininity before then considering the history of sexual violence among those diagnosed as borderline. This section centers on an important debate around BPD and its legitimacy as a psychiatric diagnosis. Specifically, I consider the arguments for relabeling BPD as Post Traumatic Stress Disorder (PTSD) given the prevalence of trauma among those diagnosed. While this call comes from the need to attend to the sexism that adheres to the BPD diagnosis, the move to PTSD is, as I explain below, still suffused with problematic gender and ontological assumptions.

As Lunbeck (2006) discussed, together cultural critics and psychiatry helped to accomplish a vision of the borderline person as possessing unstable selfhood and lacking a core identity. In describing BPD and its association with instability Janice Cauwels (1992) writes, “Trying to define BPD is like staring into a lava lamp: what you see is constantly changing. This common observation adds another level to the metaphorical nature of BPD: the illness not only *causes* instability but *symbolizes* it” (p.82, emphasis in original). With the creation of the DSM III during the 1980’s, this instability became synonymous with unrestrained femininity.

Before being developed into a character pathology in the DSM III, the borderline concept had not been envisioned as a feminine disease. In fact, the borderline patient was often referred to using male pronouns (Lunbeck, 2006, p.157). Millon predominantly referred to his theoretical borderline as *he*, as did Kernberg and Kohut. That said, Deutsch (1942) in developing the ‘as-if’’ personality, which closely resembles the predominant conception of borderline today, referred to this character type as being feminine. Deutsch identified borderline features in both men and women, however, her work suggested that femininity was inauthentic or performative and that restrictive social roles had produced in women a conformism thereby denying their authentic selfhood.

When borderline was formulated into a personality disorder, separated from schizophrenia, and no longer a mental state but a way of *being,* the borderline concept was developed into a feminine character type. It placed persons in a double-bind by casting them as dangerous and imperiled. Instead, the borderline subject's ontological construction demonstrates that while there are some pragmatic defenses for the diagnosis, these are complicated, if not undermined, by its pejorative connotations and the prevalence of childhood abuse. The personality traits that define the disorder, such as being manipulative and sexually promiscuous, lay fault not within the systems that continue to reproduce this violence but within the borderline personality. This finding problematizes the legitimacy of the borderline construct as a therapeutic mechanism. The diagnosis highlights a striking tendency toward blaming survivors and pathologizing their strategies for coping with trauma.

The New Female Malady

In an interview with Cauwels, Otto Kernberg discusses the categorization of PDs into “clusters” in the DSM III. He maintained that “there are as many males as females with BPO [Borderline Personality Organization], and they are moved into one or another personality constellation by the cultural expression of their symptoms” (cited in Wirth-Cauchon, 2001, p.71). Gender is used explicitly as an organizing principle for distinguishing between different personality types. Millon confessed that he did not understand the logic behind this further categorization stating “[I] never quite understood the importance of those dimensions that led us to cluster personality disorders in the manner described” (cited in Cauwels, 1992, p.61). BPD was grouped with other “female maladies”: dependent personality disorder and histrionic personality disorder.

Psychiatrist John Gunderson, the man credited with “de-mystifying” the borderline concept, synthesized the convoluted and often heterogeneous theory into a stand-alone definition and in doing so created a character pathology, one symptomatic of all the fears associated with modern women and unrestrained femininity. Gunderson identified borderline traits as: “intense unstable relationships in which the borderline invariably is hurt”; “repetitive self-destructive behavior, often designed to make others rescue the borderline, particularly when she is threatened by loss”; “chronic fears of abandonment and panic when forced to be alone”; “chronic unpleasant emotions

and the inability to enjoy satisfaction or well-being for any length of time"; "distorted thoughts and perceptions, often in response to lack of structure" (Cauwels, 1992, p.77).

Psychiatrist Joel Paris highlighted this in writing, "It's as if whoever wrote the definition had females in mind" (cited in Cauwels, 1992, p.143). Gunderson did in fact have women in mind having developed his definition based on his work during the 1970's-80's with women institutionalized at the psychiatric facility known as McLean (Bourne, 2011, p.75). During the 1980s the borderline diagnosis became officially recognized as a feminine disorder with the DSM III stating, "The disorder is more commonly diagnosed in women" (cited in Wirth Cauchon, 2001, p.66), while men have been predominant in the PD antisocial personality disorder (ASPD), with Dr Paris writing "BPD and antisocial personality disorder are possibly two versions of the same thing" (cited in Cauwels, 1992, p.143).

Psychiatric conceptions of PDs had a broad impact on popular culture, which can be understood in part as the result of psychiatry's success in democratizing their knowledge. The DSM was put into layman's terms so that its definitions of mental disorder could move beyond the psychiatric elite and deployed among other psy-professionals. This expansion enabled the DSM III to go where its forebears had failed to reach. It took on greater significance in informing popular conceptions of mental disorder and in doing so helped to cement the image of the borderline woman in popular culture. This borderline character became the archetypical femme fatale, a way to represent to the masses the newly gendered aspects of BPD.

Merri Lisa Johnson (2010), writer and academic diagnosed with BPD, describes this image of the borderline character:

> "Borderline personality wears a red miniskirt and smokes magic cigarettes with boys who dream of being wild and wake up with cold sweats. She is a WET WILD SEED. Sometimes borderline personality is medical shorthand for patients who make their doctors uncomfortable. Unstable, mercurial, self-injurious, contradictory, seductive clingy, the term BORDERLINE PERSONALITY has borderline personality. It is in crisis, It is poised to self-destruct." (p.97).

The distinguishing feature of BPD from other ‘feminine’ mental disorders, such as hysteria (now histrionic personality disorder), Jimenez notes, “is the inclusion of anger and other aggressive characteristics, such as shoplifting, reckless driving, and substance abuse. If the hysteric was a damaged woman, the borderline woman is a dangerous one” (Jimenez, 1997, p.163). This characterization of pathological femininity captured the public’s attention and was interpreted in popular films such as *Fatal Attraction (1987)* and *Single White Female (1992)*. The films depict their borderline characters, both of whom are white women, as manipulative, seductive, angry and dangerous.

Johnson (2010) in summarizing the plot of *Fatal Attraction* points out the collective repudiation of the borderline woman:

> “*Fatal Attraction*, the second highest grossing film of 1987, dramatized American fears of *attachment gone awry*. In it, a woman named Alex Forrest (Glenn Close) seduces and becomes obsessed with a man named Dan Gallagher (Michael Douglas) to the point of stalking him, his wife, his daughter, and their ill-fated pet bunny. Despite the apparent presence of mental illness in this woman - who fakes a pregnancy, cuts her leg with a butcher knife, slits her wrists, and dissociates in the strobe light of her dark living rooms as she switches a table lamp on and off and on and off - the audience is poised to cheer when Alex meets her violent end” (Johnson, 2010, p.32-33, emphasis in original).

The narrative of the film thereby reinforces a belief that women such as Alex are unworthy of sympathy or aid. Alex committed an offence, not only for her pursuit of a married man but importantly by exploiting her sexual power. The feminine psychopath is not to be empathized with; rather, she is collectively repudiated and condemned. Women with BPD are considered blameworthy agents thus deserving of punishment rather than help.

This picture plays to the illusion of women’s sexual power over men. Psychiatrist Richard Chessick (1966) described one of his borderline patients as using seduction as a means of gaining power writing, “Thus, by using seduction and sexuality, she could trap unwitting males into becoming slaves and then break them down so that they begged her to stay with them” (cited in WirthCauchon, 2001, p.66). Johnson (2010) describes her own desire to disrupt couples from

delusional monogamous existence, seeking out romantic affairs with married men and women. But the extent to which she wielded power over such persons could be questioned.

Women who do realize and exploit this "sexual power" are depicted as not only mentally unstable but also a social menace. In a review of *Fatal Attraction*, Amy Taubin highlights the depiction of women's sexuality as dangerous, "sexually eager women is just a gasp away from the castrating Medusa, the murderous phallic mother, and that if sex is not contained by marriage, it will be the end of civilization as we know it" (cited in Wirth-Cauchon, 2001, p.172). For her tirade against the nuclear family, Alex is seen as deserving of a violent end. In the same way as preceding female maladies, sexuality was central to psychiatry's demarcation of specifically women's mental disorders, and the further designation of them as being either good or bad.

Shifting Gender Roles and Backlash

Critical feminist scholars, such as Chan (2014) and Jimenez (1997), draw on the work of Susan Faludi (1991) in arguing that BPD, much like hysteria, is a backlash to shifting gender roles. Accordingly, psychiatry has functioned as a means of social control and through diagnoses such as BPD, psychiatry has policed and upheld gender norms. Jimenez points out that where BPD differs from its predecessor hysteria is bound up with psychiatry's re-evaluation of acceptable behavior in accordance with shifting social values.

This will be discussed in further detail in the following chapter where I consider the shifting social and cultural demands of neo-liberalism and how these have impacted our understanding of BPD. At present, I consider how borderline came to be predominantly associated with women, the parallels to the archetypal feminine disorder – hysteria – and how the development of each of these psychiatric disorders coincided with periods in which traditional gender norms and values were being challenged and rejected.

As discussed in the second chapter, the development of hysteria occurred when the prevailing Victorian norms were showing signs of strain. Women were challenging their confinement to the domestic sphere and their class as secondary citizens at the service of the family. Hysteria pathologized women who were at the time rejecting heteronormativity through their refusal to

engage in sexual relations. These predominantly young white women were described as being prone to emotional outbursts and having a tendency to counter what was asked of them. Hysterical women demanded that they be cared for, countering the prevailing social expectations that they care for others. Jimenez (1997) argued that in response to the challenges presented by feminism, psychiatry reacted by treating their defiance as evidence of mental disorder.

BPD, similarly, has been seen as a response to second wave feminism and the challenges feminists presented to men's dominance. Whilst feminism drew attention to the issues of domestic violence and marital rape, psychiatry created a figure of the borderline woman, the manipulative seductress, which reinforced the fallacy that through their sexual power over men women had the upper hand. In the text *Siren's Dance: My Marriage to a Borderline: A Case Study* (2003) American psychiatrist Anthony Walker describes his one and a half year marriage to Michelle, a woman diagnosed with BPD:

> "He can't understand how such a beautiful, sexy young woman would want to kill herself ... Despite warnings from his teacher, friends and father, he falls deeply in love and is drawn into her world, only to emerge with great difficulty a year later. Walker, an outgoing, athletic, cheerful young man, relinquishes more and more of himself to Michelle and gradually becomes isolated, depressed, devious and even violent as he tries to cope with-and ultimately escape from--Michelle. Walker, who now treats teenage girls with borderline personality disorder, is not an expert writer. His dialogues often sound as if the speakers learned English as a second language. But this intimate narrative, showing how the best intentions of a naive, compassionate young doctor can lead him straight to hell, will fascinate readers who've dealt with similar situations firsthand" (2003, p.64).

This double-think repositioned men as mere hapless victims of the whole romantic endeavor, reinforcing the belief that women, through their sexual prowess, secretly had the upper hand. In writing on hysteria, Lunbeck (1994) discusses this ideological inversion.

> "The language of seduction - of feminine wiles masquerading as feminine submission - sustained the widely accepted fiction that women had the upper hand in the negotiations of

> heterosexuality, and it imputed an aura of contingency to those negotiations that veiled only imperfectly their inevitability" (1994, p.219-220).

The borderline woman becomes a scapegoat, upholding the status quo by disguising the power dynamics embedded in heteronormativity. Prior to the creation of the diagnosis BPD, Phyllis Chesler (1972) highlighted in her work, which is a rather scathing condemnation of psychiatry's reinforcement of gender norms, the not infrequent occurrence of sex between patients (predominantly women) and therapists (predominantly men).

Such sexual abuse as "treatment" occurred even among the most politically radical psychiatrists, including the anti-psychiatry movement. David Cooper advocated for sex with patients, which he called "bed therapy" and was blind to potential ethical issues, himself having sexual relations with one of his patients, a twenty-year-old old mute woman (Showalter, 1985, p.247). The result is vulnerable persons, particularly those women deemed mentally unwell, being diagnosed as mentally unstable by the very persons who advocate for rape, which they describe as "therapy." The men who committed and advocated for rape are the same men who create medicolegal discourse. Women are accused of being sexually manipulative—thereby continuing a long established practice of victim-blaming.

I highlight this history because it has important implications for contextualizing borderline character traits such as "manipulative" and "seductive." The borderline diagnosis became a convenient means for psychiatrists to protect themselves against malpractice suits. This enabled the psychiatrist to lay blame for their impropriety with the magnetism of the patient. If evidence of sexual misconduct occurred, the borderline woman's claims could be sufficiently refuted with evidence of her flawed character captured in the diagnostic label itself. The borderline was accused of possessing sexual powers against which her therapist was not immune.

Gutheil (1989) is one psychiatrist who, having recognized the prevalence of sex between patient and therapists, attempted to give further credence to the borderline patient's portrait as seductive. Gutheil (1989) discusses sexual violation by therapists and the contribution of those diagnosed as borderline persons to their own victimization. He tries to clarify that he is not blaming the patient, nor is he exonerating the therapist from their "boundary violation." The purpose of his article is to

demonstrate that "borderlines are particularly likely to evoke various kinds of inappropriate behavior, including sexual misconduct, from therapists" (Cauwels, 1992, p.363). Furthermore, he argues that of the false accusations made against therapists, those accusations are made predominantly by borderline persons.

Stigma and the Issue of Volition

To be borderline is to be considered difficult, tiresome, and unlikable. One psychiatrist explained to anthropologist Tanya Lurhmann, "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" (Lester, 2013, p.70). This is further captured in Glazer's analysis, "therapists will readily own up hysterical, obsessive-compulsive, even schizoid traits in themselves, but never have I heard one identify with borderline traits" (1979, p.378). The borderline label has been reserved for difficult patients who evoke negative feelings in the psychiatrist.

Borderline persons, much like their hysterical sisters of the Victorian period, have also been viewed as disingenuous: they *can* control themselves and *choose* not to, acting instead in ways that are counter to what is expected of them. Luhrmann, in describing borderline patients, writes, these are the "patients you don't like, don't trust, don't want… One of the reasons you dislike them is an expungable sense that they are morally at fault because they choose to be different" (cited in Cohen, 2006, p.163). Bourne (2011) raises this issue in discussing volition. There is a contradiction in which psychiatry claims to recognize the person's suffering as evidence of illness, yet illness would imply that the patient has no control and is therefore not blameworthy. However, this illness is simultaneously positioned within their self and thus considered to be something that they do have control over.

The establishment of responsibility within the individual is pivotal in the diagnosis of BPD and PD more generally. Writing on personality theories, Ellis, Abrams, & Abrams (2009) maintain that "unlike most psychological disorders, disorders relating to personality are the least likely to be recognized by those who have them", "consequently, people with disordered personalities will tend to view the world and those in it as acting badly, rather than seeing themselves as the problem" (p.438-439). The role of the psychiatrist is thus to convince the patient that the source of their

suffering and psychic distress derives not from others, or unjust systems, but from their *self*. "Understanding oneself as shameful implies that responsibility is ascribed to one's own flawed nature" (Bourne, 2011, p.81).

Here we can see the remnants of Pritchard's (1835) concept of *moral insanity*, which he used to refer to those deviant individuals who showed no defect in their intellect or reasoning. Gutheil described the borderline person's ability to convey "a sense of normality or even excellent functioning" (cited in Jimenez, 1997, p.163). Borderline persons have been attributed with the ability to behave in what are considered adaptive and appropriate ways during psychiatric analysis, and therefore, to the frustration of the therapist, "appear" normal. But according to the psychiatrists and psychoanalysts, they saw beneath this façade.

This issue of volition becomes particularly problematic when we consider that 70% of those diagnosed as borderline have a history of childhood sexual abuse (Shaw and Proctor, 2005, p.486). This finding led Clare Shaw, survivor-activist, and Gillian Proctor, activist and clinical psychologist to argue that "BPD is a powerful new manifestation of this tendency to deny the extent and impact of childhood sexual abuse" (p.486). When Herman asked Kernberg for his opinion on the prevalence of sexual abuse in borderline patients, he replied "Oh yes, I see it all the time", "And I have no idea what to make of it" (cited in Cauwels, 1992, p.244).

In the article entitled *Discriminating Borderline Personality Disorder from Other Axis II Disorders* (1990) the authors Zanarini, Gunderson, Frankenburg, and Chauncey suggest that "many borderline patients have a desperate need to convince others of the unique depth of their affective suffering" (cited in Cauwels, 1992, p.80). Persons diagnosed as BPD describe the desire to have their experience, and the impact of that experience, recognized. Psychiatry has interpreted this desire as evidence of a pathological character.

The borderline diagnosis is distinguished from other PD's by the combination of failed interpersonal relationships and anger. Therefore, whilst the clinician will locate the "disease" within the individual's flawed character or *self*, this disturbance can only be detected in relation to others. As Lester points out "a person stranded alone on a desert island cannot have BPD" (2013, p.74). This naturally leads us to question how we understand persons diagnosed with BPD.

Anthropologist ET Hall captures the significance of connection, explaining “It is the corrosive daily frustration, the inability to communicate and establish meaningful relationships that is so soul-shrinking” (cited in Miller, 1994, p.1218). Instead of locating the disturbance within the individual, it is more adequately understood in relation to social integration and disturbed systems that reproduce violence through the denial of personhood.

Psychiatric diagnoses serve to condition persons to the social norm, and in doing so, create less tolerance of human differences and diversity. BPD is applied to persons deemed deviant or thought to counter prevailing social norms. The diagnosis becomes a mechanism through which persons are conditioned to systems and can therefore be understood using Foucault's concept of a *normalizing society*, “a society in which the norm of discipline and the norm of regulation intersect along an orthogonal articulation” (2003, p.253). The diagnostic label BPD stands at this intersection. By labeling those who challenge the psychiatry's vision of normative personhood, BPD serves to discipline and regulate *deviant* femininity. It is disciplinary in that it establishes fault within the individual's personhood, which is a form of epistemic violence. It is regulatory, for once labeled BPD, a person's behavior will be interpreted based on this label. This issue of discipline and regulation will be further discussed in the following section.

BPD as Complex-PTSD

The focus of the BPD diagnosis has been in identifying persons with pathological selfhood, not in addressing the overwhelming amount of sexual abuse experienced by patients and providing the necessary help and support for the aftermath of such trauma. This is evidenced by the pejorative connotations of the diagnosis and the labelling of such persons as difficult, manipulative, and attention seeking. Labelling survivors rather than the abuse as “disordered” would lead one to critically assess the role of psychiatry in protecting the systems that enable such abuse. Trauma is re-configured as individual pathology, and the survivor of trauma is told that their coping mechanisms are evidence of their flawed personhood.

In attempting to address this victim blaming, psychoanalysts such as Judith Herman (1997) have argued that the diagnosis BPD should be re-labeled as complex-post traumatic stress disorder (C-PTSD) in order to recognize the role of trauma in the etiology of the personality disorder. This has

been attractive to a number of feminist and critical psychiatrists who are challenging the pejorative connotations of borderline disorder. I suggest that this call to re-label the diagnosis is at risk of continuing the pathologization of deviant femininity under a new rubric.

The concept *complex trauma* is deployed in psychiatric literature to refer to ongoing harm, or harm experienced over a sustained period. C-PTSD is differentiated from PTSD in that the trauma is not attached to a specific event but produced through ongoing abuse and insecurity during the child's development. This concept was first coined by critical psychiatrist Judith Herman in her highly influential work *Trauma and Recovery: The Aftermath of Violence-From Domestic Abuse to Political Terror* (1992, 2001) advocated for an understanding of the psychological impact of sexual and domestic violence, which she maintained was similar to the experience of war, specifically PTSD. Herman suggested that PTSD differed from C-PTSD due to the sustained nature of violence experienced during an important developmental period, which in turn produced more complex symptoms.

Herman’s work countered psychiatry’s history of denial, minimization, and concealment of child abuse and the significance of its impact on psychic stability. Herman’s research on BPD considered the effects of childhood trauma on personality development. Along with colleagues Perry, van der Kolk, and Hoke, Herman (1990) argued that “Many of the most troubling and difficult features of the disorder become more comprehensible in light of a history of childhood trauma. Most important patients become comprehensible to themselves” (p.42). Recognition of the role of trauma in the etiology of BPD normalizes and validates the emotional responses. However, this experience is recognized through a psy lens meaning that persons re-interpret their experience using this knowledge, which is different from being recognized on one’s own terms.

Gunderson (1994) contends, “Any psychiatric or other medical diagnosis should have a meaning that is tied to the disorder's etiology and can inform clinicians about the therapeutic possibilities” (p.12). The finding that an extensive majority of persons diagnosed as borderline were abused as children demonstrates the extent to which psychiatric constructs have historically obscured the etiology of persons suffering. The biomedical model privileges a view of psychic distress as individual pathology and continues the work of early Darwinian psychiatrists in seeking the genetic or neurological cause of such pathology. Within this paradigm, persons are removed from

their social and historical context. Shaw & Proctor (2005) write “BPD - which is defined with no reference to trauma - effectively decontextualizes the experience of distress from its social causes, paying occasional lip service to the prevalence of histories of abuse among the diagnosed population before going on to locate distress and difficulty firmly within the individual" (p.487).

A partnership between the feminist aim of recognizing the impact of trauma and this biomedical approach has led to studies such as *Borderline Personality Disorder, Impulsivity, and the Orbitofrontal Cortex* (2005), which maintained that using neuroimaging we can detect “differences in the prefrontal cortex in people with borderline personality disorder, compared to healthy subjects” (p.2360). In detecting these neurobiological markers of trauma, Tseris (2013) has conferred that this approach offers some solace to persons by acknowledging the impact of their trauma. But recognition based on one's neurology is not without its challenges and limitations. Slaby (2010) raises the issue of reducing persons to their brains, thereby replacing personhood with “brainhood” (p.402).

In attempting to address the stigmatizing effect of the label “borderline”, Walker and Kulkarni (2020) have argued that BPD should be reconceptualized as a “trauma-spectrum condition” as opposed to a personality disorder. They suggest that “re-framing BPD as a trauma-spectrum disorder could improve clinicians’ attitudes, help reduce stigma and inform trauma-conscious treatment strategies” (Walker and Kulkarni, 2020, p.1). For Walker and Kulkarni the current treatment of borderline as a constellation of symptoms, rather than a consequence of previous trauma, disguises the origins of the person's suffering/distress. BPD becomes synonymous with “flawed character” and applying such a stigmatizing label to already vulnerable persons only deepens their self-blame and further perpetuates their mental anguish.

The hegemony of the biomedical lens has meant that human responses to traumatic experiences continue to be understood in the same way as physical diseases, that is, to say that psychic distress derives from the individual's brain chemistry or genetic makeup. Studies such as *Borderline Personality Disorder, Impulsivity, and the Orbitofrontal Cortex* (Berlin, H., Rolls, E., & Iversen, S., 2005) are part of this effort to uncover pathology within the individual’s neurochemistry. This combination of medico-psychiatric knowledge further naturalizes diagnostic constructs such as BPD and thus more deeply entrenches these human taxonomies without critically reflecting upon

their social and cultural contingency. Tseris (2013) highlights this issue using the example of neuroscientific research into the etiology of PTSD. In the article *Smaller Hippocampal Volume Predicts Pathologic Vulnerability to Psychological Trauma* Gilbertson et al (2002) scan the brains of persons diagnosed with PTSD to determine its biological etiology.

> "Recent human studies show smaller hippocampal volume in individuals with the stress related psychiatric condition posttraumatic stress disorder (PTSD). Does this represent the neurotoxic effect of trauma, or is smaller hippocampal volume a pre-existing condition that renders the brain more vulnerable to the development of pathological stress responses?" (p.158)

Within the biomedical paradigm the context in which the distress is occurring is ignored whilst psychiatry pursues more tangible material qualifiers of mental disorder that support their claim to scientific legitimacy. This is reminiscent of Furneaux's (1896) analysis of battered wives, whom he diagnosed with a hereditary defect that made men want to hit them. Each of these treat the person who experiences the abuse as being defective and in some way inviting the abuse upon themselves. Tseris (2013) has argued that notions of women's biological inferiority continue to permeate the treatment of trauma through the biomedical lens that is often uncritically applied to persons who experience trauma.

Psychoanalytic therapeutic approaches, unlike the biomedical model, give recognition to trauma in the etiology of mental distress; however, these approaches continue to treat a person's response to trauma as maladaptive. Through their development of a *master narrative* for navigating and shaping one's understanding of trauma, they continue to locate disorder within the individual (Tseris, 2013, p.157). I this concept here to refer to the hegemony of trauma for understanding human experience. The master narrative regulates the terms for recognizing the person's experience, shaping the response to that person preceding the traumatic event. Tseris (2013) cautions us against the uncritical expansion of trauma, suggesting that by broadening the concept, there is a danger of diminishing one's own understanding of the experience favoring a broader cultural narrative. Specifically, Tseris (2013) is concerned with the impact of expanding the concept of trauma upon our understanding of gender-based violence, and the risk of obscuring women's voices (p.157).

Psychoanalysis has argued that C-PTSD impacts the personality structure, thereby creating the personality disorder. Trauma understood in this way defines the person thereby becoming an organizing concept or master identity. Moreover, this master narrative is conceptualized through the psychiatric lens, which in turn limits, conceals and denies ways of understanding and relating to trauma that are not hinged upon the biomedical model and psychiatric knowledge. As will be discussed in the following chapters, these knowledge systems are premised upon a construction of selfhood that is gendered, heteronormative, and white.

Re-labelling BPD as PTSD attempts to address the victim blaming that is imbued in the borderline diagnosis by recognizing the vulnerability of persons who experience childhood trauma. Further it endeavors to show the impact of unresolved trauma in placing persons at greater risk of revictimization. Traumatized persons are considered more likely to put themselves in risky situations. This view cites the cause of victimization in women's behavior. "Such individualized depictions of sexual threat once again invites focus on the individual and her erroneous perceptions and damaged character" (Reavey and Warner, 2003, p.156).

Whilst giving recognition to the person's experience of abuse, this analysis of trauma still places the expectation for change within the individual. Egan (2016) highlights that this is still an individualized approach and as such continues to conceal the role of the gender hierarchy and heteronormativity in producing structural violence. Childhood abuse is not seen as a collective issue but a "personal vulnerability" and through this de-politicization the survivor is constructed as outside of the norm, thereby positioning them as *Other* (p.104). Reavey and Warner (2003) discuss this emphasis on individual responsibility writing, "She does not behave as 'normal' women behave and the choice to lead a healthy sexual life rests on her individual ability to 'change'. She must, therefore, engage in a process of self-discipline in order to save herself from further attack" (p.157).

Psychiatry's favoring of a singular narrative for tracing the etiology of psychic distress has the consequence of subsuming other forms of knowledge and experience. Philosopher Michel Harr (1996) maintains that, "psychology has always idolized superficial unities for fear of facing the unsettling multiplicity at the depths of being" (p.16). In writing on adult survivors of child sexual

abuse, Suzanne Egan (2016) notes that "a causal relationship between past sexual assault and current adult sexual problems, including sexual victimization, is taken as given" (p.104). The master narrative risks hiding or neglecting the present gender and heteronormative power dynamics that contribute to the persons distress.

Whilst feminist scholarship has critiqued psychiatric diagnoses for their ability to reinforce gender normativity and heteronormativity, there are two important counter arguments that should be taken into consideration. Lester (2013) suggests that the BPD diagnosis captures a lived experience shared by many women, and thus provides a window of opportunity for examining that shared experience. Lester (2013) argues that critiques of the borderline diagnosis fail to recognize "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" (p.73, emphasis in original). I would caution against circular arguments for further investing in diagnostic constructs, whilst persons will express their psychic distress in socially and culturally sanctioned ways, we must be careful not to naturalize the systems that produce these sanctions.

Secondly, clinical psychologist Sally Swartz (2013) challenges the argument that diagnostic labels are inherently bad or "anti-feminist". She argues that in fact these classifications can save women's lives by helping clinicians to understand their needs and providing them with adequate care. Indeed, persons have been both harmed by and healed by psychiatric practices. However, the latter should not prevent us from critically considering the origins and implications of such diagnoses. This tension between help and harm will be discussed further in the final chapter where we examine the impact of racism and racial tropes in preventing black women from accessing mental health services.

The DSM has used the experience of distress and suffering as a means of measuring the person's mental disorder, but within this framework you have the inevitable problem of conditioning persons to a system, rather than challenging the systems that produce their distress. To treat certain behaviors and experiences as "deviant" is based on a particular view of morality within this system. The value judgments embedded in diagnoses such as BPD only pathologize the individual and disguise the systems that produce massive power imbalances, which inevitably lead to suffering.

A feminist critique must address these structural inequalities in order to contextualize the person labeled borderline.

The theory of BPD as a form of PTSD suggests that the diagnostic construct has some validity. It assumes that borderline refers to something coherent that can be objectively measured. But again, not all persons diagnosed with BPD have experienced trauma. The diagnosis refers to a heterogeneous group of persons who may have some similarities, but ultimately no singular etiology. Thus changing BPD to PTSD would still fail to account for the different experiences of persons labeled. The diagnostic label remains limited to an aggregate of character traits deemed by psy knowledge as pathological.

In the following section I consider the implications of the diagnostic label on persons' ontological security. The creation of a singular narrative that is deployed through psychiatric knowledge has the impact of hiding, concealing, or potentially distorting the lived experience of the person labeled borderline. The label attempts to qualify and quantify the boundaries of their personhood placing unique, complex, and heterogenous persons within one stable psychiatric category. Once placed within such a category, the person's self-knowledge is relegated in favor of psychiatric knowledge.

Epistemic Violence

To deviate or challenge the norm is to risk being told that you cannot take care of yourself. As Frye points out, removing one's self-determination "...is the most fundamental kind of harm" (Frye, 1983, p.70). This harm I refer to here as *epistemic violence*. We must ask ourselves; how can we help distressed and suffering persons outside of the psychiatric and bio-medical models? Both tend to obstruct and conceal the lived experience of a person's suffering by privileging one lens, which inevitably forecloses other avenues of self-understanding. Persons are "sewed up" into a psychiatric label that becomes a part of who they are, and in doing so, the label conceals other forms of expression (Guilfoyle, 2013, p.86). Ussher highlights this in writing, "labelling us mad silences our voices… the rantings of the madwoman are irrelevant, her anger impotent" (1991, p.7). By individualizing and depoliticizing, psychiatric labels have the effect of undermining a person's ability to subvert systems of power and their potential for multiple expressions of being.

The person experiencing distress is compelled to relinquish their knowledge and experience in favor of the psychiatrist's expert knowledge. This is significant, for it is through these diagnostic labels that we are interwoven into the social fabric. Maria Liegghio (2013) discusses epistemic violence as "a denial of being." She writes, "from my experience, humanity is denied not necessarily by the debilitating transformations associated with illness... nor by the prejudices and discrimination associated with being socially constructed as having a 'mental illness', but rather by a particular type of violence that targets and denies personhood" (p.122).

Epistemic violence can be further understood in relation to Judith Butler's (2004) theory of recognition. Butler writes, "But if the schemes of recognition that are available to us are those that 'undo' the person by conferring recognition, or 'undo' the person by withholding recognition, then recognition becomes a site of power by which the human is differently produced" (Butler, 2004, p.2). Epistemic violence places limits and boundaries on a person's ability to achieve recognition. The borderline's desire for recognition is used as evidence of flawed character, therefore the desire for recognition becomes the very means by which a person is "disqualified as a legitimate knower" (Liegghio, 2013, p.122). Their own knowledge and experience is denied and reconstructed as further evidence of their illness or disorder.

Under this rubric they no longer possess self-knowledge unless it fits within the psychiatric framework. Through epistemic violence persons are reduced to a singular mode of selfhood that aligns them with psychiatry's knowledge and practices. Liegghio (2013) discusses the way in which psychiatric institutional processes and procedures "render the individual and their subjective experiences into a sort of non-existence and what is left are those professionalized constructions, the labels that are supposed to represent an illness" (p.124). For the diagnostic label BPD, the pejorative implications of this diagnosis are a further assault on an already fragile sense of selfhood.

Lani, who had experienced childhood abuse, describes the negative impact of being labeled borderline:

> "I know that things are getting better about borderlines and stuff. Having that diagnosis resulted in my getting treated exactly the way I was treated at home. The minute I got that

> diagnosis people stopped treating me as though what I was doing had a reason. All that psychiatric treatment was as destructive as what happened before. Denying the reality of my experience - that was the most harmful. Not being able to trust anyone was the most serious effect… I know I acted in ways that were despicable. But I wasn't crazy. Some people go around acting like that because they feel hopeless. Finally I found a few people along the way who have been able to feel OK about me even though I had some severe problems. Good therapists were those who really validated my experience" (cited in Herman, 1997, p.128).

This concept of epistemic violence can help us to understand the high rates of persons diagnosed as borderline terminating their treatment. In carrying out his research, Gunderson found that "roughly half of the borderline patients in both inpatient and outpatient settings discontinued treatment before 6 months" accompanied by the "harsh devaluation of the therapist's usefulness" (1994, p.15). This has led persons diagnosed with BPD to be labeled as not amenable to treatment. Their dismissal of psychiatry is further used as evidence of their character pathology, as opposed to evidence that psychiatric therapies are inept or harmful. Bourne writes "placing the patient into a shamed role, ascribing a flawed nature to them, locates responsibility within the individual and deflects attention from theoretical and therapeutic inadequacy" (2011, p.81).

BPD replaces the person's knowledge with a two-dimensional caricature of a feminine villainess. The epistemic violence relies on the construction of the person as dangerous, as a threat to either themselves or society (Liegghio, 2013, p.125). Therefore, stigma upholds their disqualification as legitimate knowers through the construction of mad as dangerous. This may not necessarily mean that these persons pose a danger to others, but they have been deemed to pose a danger to themselves.

Aitken and Logan (2004) examined the labeling and classification systems implicated in women's entry into secure care. Their work highlights that victims of violence are at a high risk of themselves being labeled as dangerous. "Where violence had occurred, it was often associated with the sequelae of abuse…" (p.263). Of the population in high secure hospitals in England, which provide care for those deemed to have criminal or violent propensities, women are more likely to be diagnosed as personality disordered. 53% of women in these facilities have been classified as

psychopathic, compared with 26% of men (2004, p.263). This suggests that women who are deemed violent are also considered to be more fundamentally disturbed than their male counterparts. To be labeled disturbed removes one's ability to attain recognition along with their ability for self-determination. In chapter six we will see why this is also significant for understanding the BPD symptom self-injurious behavior.

Pathologizing Adaptive Responses to Trauma

Shaw and Proctor (2005) argue that the borderline diagnosis pathologizes survival and resistance strategies for coping with trauma. The symptoms used as evidence of a character disorder are human adaptations to the experience of trauma and mechanisms for survival. What, in one instance, functions as life-preserving may in another prove life-threatening. Lester (2013) suggests that the diagnosis may help us to understand these survival strategies better. Lester argues,

> "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" (2013, p.72).

Swartz (2013) highlights the significant impact of the social environment upon the person, writing,

> "It is common for us to discover layer upon layer of trauma in histories of our clients, with ongoing depression and anxiety a way of life, barely discernible as a problem through the obscuring traffic of multiple stressors, sudden changes, and challenges to material safety" (2013, p.44).

Whilst Lester makes an important point in acknowledging symptoms of BPD as survival mechanisms and coping strategies, by treating the individual without addressing the systems that produce psychological distress we are unable to fundamentally address the cause of suffering, specifically, the ideologies that create human hierarchies and justify violence against those deemed less than human.

Only by contextualizing the person and recognizing their histories and validating their experiences instead of ascribing them to the realm of fantasy can we create meaningful change and challenge the systemic violence that such persons have been forced to endure. As Lester (2013) highlights, the disordered personality is not an individual intra-psychic condition, rather the disorder is situated within the person's relationships with others. Embedded in these relations are moral judgments that, if overlooked, will continue to uphold social inequality.

Suzanne Egan (2016) has argued that whilst the current framework for conceptualizing trauma has been useful in providing survivors of sexual assault with a sense of power and control, it also continues to place survivors outside of their socio-political context and in a position of ontological insecurity. Specifically in referring to the concept of complex trauma, Egan maintains that "this deployment appears *both* enabling, used to advocate for victims and to assist them to regain control over their lives, *and* disabling, producing the 'adult survivor' as a constrained and problematic subject position" (2016, p.96, emphasis in original). The re-labelling of BPD as C-PTSD will fundamentally continue to treat the subject as essentially flawed. C-PTSD does not address the belief that such persons have a disturbed character that needs to be adjusted.

No diagnostic category can capture the complexity of human responses to sustained violence and abuse. Such categories inevitably reify ideas about sexuality and gender relations and, in doing so, either place persons outside the bounds of recognition or recognize them as being pathological. In the instance of the latter, the person is seen as the product of their experience of trauma, thereby concealing *other* ways of knowing/being. Diagnoses are overly simplistic, and it is in this simplicity that they are harmful through their unquestioned reproduction of the very systems that cause psychic distress.

Without addressing the ontological position of borderline persons, who are predominantly survivors of childhood abuse, we unwittingly reinforce the systems that enabled that violence to occur by placing the responsibility on the individual. The ontological conception of personality disorders means that the individual is still deemed blameworthy for behavior that is considered by psychiatry to counter prevailing social norms/standards. The expectation for change is placed upon the individual, and not the systemic violence that led to their psychic distress, and in spite of their experience of ongoing pathological violence towards them, the expectation is that they will adapt

to the new expectations demanded of them. There is little tolerance for dependency, anger, and affective instability deriving from their experiences of trauma. Instead the effects of trauma are interpreted as evidence of an inherent mental disorder.

Chapter Five Neoliberal Subjectivity and Pathological Dependency

Neoliberal governance operates through the Western conception of the self. As was discussed in chapter three, looking at the medicalization of the personality, psychiatry has played an important role in this conception of personhood. Central to the neoliberal development of personhood is the notion that the self is something to be individually cultivated. In this chapter, I consider firstly the pathologizing of dependency and the factors that contribute toward this pathologization, and following this, I discuss the diseases of the will and opportunities for salvation.

If, as Foucault (2005) suggested, to know oneself is to become a subject (p.120-129), then to have a disturbance in this relation to the self is a threat to one's status as a subject. As discussed in the previous chapter using the concept of epistemic violence, to be regarded as mad is to be placed in ontological insecurity. The person's behaviors and experience become evidence of their madness if they differ from the psychiatric vision of healthy personhood. Once the label BPD is applied, the mad person's self-knowledge is only taken as further evidence of their madness. This is not an existential matter but of material significance, whereby the denial of subjectivity is the denial of a particular way of being. The mad person becomes the target of discipline and regulation.

The role of gender in constituting acceptable modes of selfhood means that our subjectivity is intimately connected to our ability to conform to social and cultural expectations of gender. Gender is inflected in mental illness and thereby informs our relationship to the self and our existence as subjects. The symptoms of BPD act as markers in guiding our understanding of not only what is considered pathologically gendered personhood but also what is deemed optimal under neoliberalism. Here I examine how normal/healthy personhood has been defined under neoliberalism and the relationship between mental health, gender, and *authentic* selfhood.

Passing as Sane

Showalter (1985) formulated an in-depth analysis of the association of women and femininity with mental disorder in what she described as *the Female Malady*. Showalter’s work has demonstrated that our understanding of sanity is intimately connected to our performance of gender. To counter prevailing gender norms is to risk being disciplined and regulated, and yet the association of

femininity with pathology has created a paradox in which the performance of femininity may also lead one to be deemed mad. Showalter in discussing Janet Frame's experience of institutionalization, wrote, "...female inmates are instructed to regard themselves as 'naughty girls' who have broken a set of mysterious rules that have to do with feminine conduct" (1985, p.211). One may breach feminine conduct by behaving in a manner deemed masculine or may adhere to "feminine" conduct but in a manner deemed pathological.

Persons diagnosed with BPD have broken these rules of gendered conduct, Chessick (1966) writes, "I have designated this group of patients as *borderland patients*, because they seem to lie on the periphery of psychiatry, on the periphery of society, and on the periphery of penology" (p.600, emphasis in original). Today such persons continue to be placed in the borderland, positioned outside the boundary of acceptable personhood. The rules of gendered conduct change according to shifting modes of governance and so too does our conception of what constitutes mental illness. Neoliberal subjectivity demarcates acceptable ways of being, and BPD is the violation of what is considered acceptable neoliberal personhood.

Peta Cox (2013) describes socially acceptable behavior for riding the bus and the complex, but unspoken, social dialogue involved in passing as (in)sane. Cox's account highlights the instability that is intrinsic to our performance of (in)sanity, which entails the careful reading and enactment of social cues. Drawing on the work of Butler's analysis of gender and performativity, Cox demonstrates that (in)sanity is contingent upon the continuous performance of rituals in accordance with, or violation of, social and cultural norms. The extent to which a person is deemed to be mentally disordered is conditional upon their ability to pass, whether that be passing as sane or passing as insane.

Cox points out that one's ability to pass as sane depends on whether they are able to hide or conceal emotional states. As Cox describes, "Passing as sane occurs when a person who is experiencing psychological distress or non-normative emotional states or cognition manages to avoid displaying these states in the presence of others" (2013, p.100). The extent to which a person is considered (in)sane is dependent upon one's ability to keep up appearances. You may not feel "okay" but the ability to hide/conceal mental distress, i.e. to go to work, is taken as evidence of mental health/ sanity. Cox writes, "It is thus not solely a person's symptoms or internal state but, rather, that

individuals embodied responses to the symptoms that determine how 'mentally ill' the person is deemed to be" (p.104).

In the previous chapter on trauma, I discussed that BPD can only exist in relation to others. Thus, it marks the failure to act according to prescribed social norms that are coherent with one's given identity. Given that persons diagnosed with BPD are predominantly women, there is a correlation between the performance of one's (in)sanity and the social and cultural expectations of femininity. Johanna Meehan (2000) writes,

> "Getting gender right both in one's own identity constitution and performance, and in interpreting the identity of others, is almost as fundamental a pre-condition for the intelligibility of speech and action as is mastering the other pragmatic rules coordinating intersubjectivity" (p.41).

Gender is a mechanism through which the self is both constructed and rendered intelligible. Because the self is constituted through one's performance of gender, a disturbance in the self can be understood as deriving from a glitch in that person's performance of gender. BPD can therefore be understood as a failure or disturbance in one's performance of gender. If having a self means "getting gender right", as Meehan puts it (2000, p.41), then BPD and its lack of self, or its inauthentic self, is therefore getting gender *wrong*. Jackson (2006) writes,

> "The self is not separate from the social but a dimension of it since it is the possession of reflexive selves, our ability to locate ourselves in relation to others, that makes sociality, and the interpretative processes on which it rests possible" (p.115).

The *inauthentic* self is produced by lapses in one's performance of gender, and disrupting gender is thus synonymous with psychic instability. If we understand ourselves as the manifestation of socially located biographies, then gender is an apparatus through which the self is mapped. Gender underlies our understanding of mental health/illness through its delineation of acceptable modes of selfhood. By acting as both the constitutional and interpretative framework, gender enables and constrains a particular understanding of and relation to the self. Our ability to pass as sane is contingent upon our ability to act according to prescribed gender norms. What is it about the

borderline's performance of typically “masculine” or “feminine” characteristics that attracts the diagnosis of a disturbance in the self? Through the psychiatric conception of “impulsivity” we can see the way in which the different diagnoses ASPD and BPD reflect gendered understandings of mental health/illness.

ASPD is predominantly applied to men with a ratio of 3:1 (Alegria, A., Blanco, C., Petry, N., Skodol, A., Liu, S., Grant, B., & Hasin, D., 2013, p.214). There has been some debate among psychiatrists as to whether ASPD and BPD are two expressions of the same pathology or whether they are fundamentally different pathologies altogether. With Kernberg writing, “There are as many males and females with BPO [borderline personality organization], and they are moved into one or another personality constellation by the cultural expression of their symptoms”, and Dr. Siever arguing, “I think that antisocial personality disorder is not the same as BPD because it’s missing the affective component” (cited in Cauwels, 1992, p.143). The predominance of men diagnosed with ASPD and the predominance of women diagnosed with BPD provides a window into not only the gendered nature of expressing psychic distress, but also the extent to which a behavior becomes evidence of pathology is dependent upon who is exhibiting that behavior.

The literature on men diagnosed with BPD is limited. Of the research, the overwhelming majority is on women with BPD, which, as Bayes and Parker (2017) point out, makes a comparative analysis based on gender difficult. There are some efforts to counter the gendering of the diagnosis with Bayes and Parker (2017) echoing Kernberg arguing that it occurs just as frequently in men (p.197). They suggest that men with BPD may present their symptoms differently and are therefore diagnosed with ASPD. Considering that the diagnosis is defined by a set of character traits, if persons do not exhibit such characteristics, it may lead one to ask on what basis are they diagnosed BPD? Bayes and Parker (2017) discuss the genetic etiology of BPD and ASPD, writing this “genotype - which is associated with the risk of psychopathology after stressful life events… may be more likely to lead to depression in females and antisocial behavior in males” (p.198). Thereby making BPD and ASPD two expressions of the one genotype.

The antisocial personality type is characterized as “morbid liars and swindlers”, “who were glib and charming but lacked an inner morality and sense of responsibility to others”, the “professional criminals” and “morbid vagabonds” (Millon, 2004, p.183). Millon (1969) notes that these

antisocial and aggressive personality types are sanctioned in society and often find a niche for themselves whether it be in the business, military, or political world. Millon (1969) contending that, “It is all too evident in the machinations of smooth tongued politicians whose benign façade cloaks a corrosive lust for power that drives them to espouse repressive legislation and militant foreign policies” (p.267).

ASPD attracted a significant amount of attention within psychiatric literature, however this interest shifted over time with BPD becoming a more widely discussed personality disorder. In 1975 37% of articles on personality disorders were on ASPD, with BPD making up only 18%. But by 1985 psychiatric interest in personality disorders had reached new heights and with this expansion BPD increased in prominence becoming 40% of total articles, with ASPD at 25% (Wirth-Cauchon, 2001, p.62).

Both ASPD and BPD share the concept impulsivity as evidence of pathology, however this concept is defined differently in each diagnosis. Its shifting emphasis demonstrates the gendered nature of what psychiatry considers socially acceptable behavior. In ASPD, there is an emphasis upon work, the interview guide for the DSM 5 asks, “How often have you walked off a job or quit without any other work in sight?” (Zimmerman, 2013, p.122). It also mentions impulsive spending, difficulty planning, and a tendency to move from place to place. In this instance impulsivity is taken as evidence of mental instability or disturbed personhood when it impacts upon the person's ability to sustain long term employment.

Impulsive behavior is defined differently under the diagnosis BPD. Impulsive borderline behaviors are characterized as gambling, spending, alcohol misuse, drugs, shoplifting, reckless driving, driving under the influence and eating binges. The DSM 5 interview guide asks, have you “had one night stands or brief sexual affairs?” and/or “gone on eating binges” (Zimmerman, 2013, p.115). Some of these behaviors would be considered typically “masculine”, such as reckless driving and brief sexual affairs. When these behaviors are exhibited by a woman, they conjure the dangerous and reckless character as depicted in *Fatal Attraction* (1987).

I discussed in chapter two, Charcot’s work endeavored to counter women's predominant association with hysteria by suggesting that the disease occurred as frequently in men (Micale,

2008, p.160). Both Charcot's work and Bayes and Parker (2017) attempt to disrupt the prevailing gender difference in psy diagnoses. In doing so, each encountered psy's extensive history of pathologizing deviant femininity. To counter this pathologization is difficult because as the work of Bordo (2003) illustrates, it is part of a broader Western philosophical tradition in which women are cast as the *Other*. I elaborate on her work further in the following chapter.

Pathological Femininity

Critical psychiatrist Dana Becker (1997) has suggested that "many BPD symptoms are severe manifestations of the problems commonly reported by 'normal' women" (p.118). This point is of interest to us for two reasons: (1) who defines normal and on what basis?; (2) if BPD is a common experience for many women, are these symptoms in themselves pathological? Related to this second question we might also ask; on what basis these symptoms are unique to women? Dependency has remained an important indicator of the "feminine" mental disorders. In this section, I consider the coercion of women into a position of dependency, and why certain behaviors are pathologized as dependent.

Frye (1983) discusses the coercion of women into a state of dependency writing,

> "...the forces of men's material and perceptual violence mold Woman to dependence on Man, in every meaning of 'dependence': contingent upon; conditional upon; necessitated by; defined in terms of; incomplete or unreal without; requiring the support or assistance of; being a subordinate part of; being an appurtenance to" (p.77).

Just as the performance of femininity may lead one to be condemned as mad, women are in a double-bind, having been coerced into a position of dependency, which then may be taken as evidence of their pathology. Those personality disorders predominantly diagnosed in women have shared the symptom dependency, which was developed into its own personality disorder. The pathologization of dependency led Kaplan (1983) to ask, "Why is dependency considered so subjectively distressing or impairment, causing that it earns in its expression the diagnosis of a personality disorder?" (p.789). As will be discussed further, the concept is interpreted according to prevailing social and cultural norms, which have feminized dependency in the West.

Psychiatrist Irvin Yalom described “borderline” as “the word that strikes terror into the heart of a middle-aged, comfort-seeking psychiatrist” (cited in Herman, 1997, p.123). Cahn (2014), Jimenez (1997), Shaw & Proctor (2005) have argued that the borderline patient, much in the same way as the hysteric patient, is seen as deviating from rationality and individuality. Traditionally these two qualities have been viewed as masculine preserves, as was discussed in chapter one. Neoliberal governance demands each of these characteristics from its subjects, thus rendering their binary oppositions emotionality and dependency as counteractive to neoliberal personhood.

The woman diagnosed with BPD is defined in relation to her heteronormative masculine partner. As is the case with other feminized disorders, *histrionic disorder* and *dependency disorder*, the emphasis is upon their interpersonal relationships, and more specifically, their romantic relationships. The borderline patient depends on others and unlike her hysterical sister of the nineteenth century, this dependency is deemed to be evidence of underlying pathology (Jimenez, 1997, p.160). She is defined by a need to be loved, and it is this need that leads her on a path to self-destruction.

Higonnet (1986) discusses the feminization of suicide in 19th century literature, the “development of the Ophelia complex, the suicidal solution is linked to the dissolution of self... The abandoned woman drowns, as it were, in her emotions” (p.71). In this tale, the dissolution of the women’s self is caused by her need to be loved, or as Higonnet describes, “woman lives for love, man for himself” (1986, p.72). Historically it has been considered normal, healthy even, for women to orient their life around the men in their world. Frye (1983) argues that women have been coerced into centering men and their interests. We can see the continuation of these ideals embedded in the different personality disorders.

These old ideas live on as illustrated by the predominance of men diagnosed with ASPD which is characterized by an effort to attain power or material gain with disregard for the law or for the rights of others, in contrast the predominance of women diagnosed with BPD, which is characterized by dependency and a desire to be loved. Whilst adhering to a very archaic stereotype of femininity, BPD demonstrates the shifting expectations that are placed upon the gendered subject. To depend on another for your happiness violates the neoliberal governance that demands

autonomy. Moreover, that one's happiness is contingent upon another is both a failure to live as an autonomous subject and contradicts neoliberal values of freedom and choice.

As the personality disorders BPD and ASPD suggest, both exaggerated forms of masculine of feminine behavior may be considered pathological if they undermine the neoliberal system of governance. Persons must therefore carefully navigate the space in between, what are considered healthy demonstrations of gender, healthy or "authentic" personhood, versus false demonstrations of gender, "inauthentic" or disturbed personhood. As is illustrated through the concept of dependency, the performance of gender is not stable, what may be considered perfectly healthy in one century may be deemed evidence of sickness in the following century.

The neoliberal ideals of autonomy and rationality stand in stark contrast to these older ideals of feminine subjectivity. In discussing the difficulties, particularly for women, in navigating these contradictory expectations, Wirth-Cauchon (2001) argues that "women are in a representational and experiential double-bind - caught between two ideologies, that of a traditional essentialist feminine identity, on the one hand, and the psychologically defined norm or ideal of healthy, normal selfhood on the other" (p.6). The latter is now bound up with a very neoliberal conception of the rational and autonomous subject, and as will be discussed, this subjectivity has developed from a heterosexist view of the masculine subject.

Autonomy as a Masculine Preserve

Griffin (2007) has discussed the way in which neoliberal discourse is predicated on heteronormativity, which not only refers to sexuality, but also privileges a particular, masculine, heterosexual way of being in the world. Griffin writes, "One effect of contemporary neoliberalism's inherent heteronormativity is to associate successful human behavior almost exclusively with a gender identity embodied in dominant forms of heterosexual masculinity" (2007, p.221). Moreover, what it means to be an autonomous subject is rooted in a structural division in which social reproduction, caring, and family remain within the private sphere. Autonomy is predicated on the person's ability to keep these public and private spheres distinct.

Not all dependency is pathologized under neoliberalism. The work of Kaplan (1983) highlighted this in evaluating the concept of dependency in the DSM III. Kaplan (1983) discusses how dependency in men is not treated as pathological so long as it fits within heteronormative system of governance, i.e. man depends upon wife to take care of children, cook, clean etc. The work of Arlie Horschild (1989) in what she described as the second shift, demonstrated that women continue to carry out these domestic duties, along with their full time work. Dependency is thus shaped by a profoundly gendered view in which men's dependency is sanctioned and therefore rendered invisible.

Neoliberalism's "facts of the marketplace" have been transmuted into desirable character traits. These ideals of competitiveness, individualism, efficiency are positioned as desirable social characteristics, which are interpreted on the basis of what it means to be a sovereign "economically masculine, white and European individual" (Griffin, 2007, p.230). The notion of autonomy has been constructed on the basis of the neoliberal vision of freedom, a vision that has been framed around the typically masculine subject. And these ideals have come to underpin our vision of happiness, and in turn our notion of what is good and what is healthy.

Becker (1997) highlighted the rephrasing of criteria for *dependency personality disorder* between the DSM-III-R to DSM IV. "Fear of being abandoned" added "afraid of having to take care of herself" and "devastated by the end of relationship" included "urgently seeks another relationship" (p.117). This is indicative of shifting value judgements based on neoliberal expectations of mental health and autonomous selfhood. Under neoliberalism, it became no longer socially acceptable for Ophelia to pine after her lost relationship. Moreover, her economic dependency is now considered evidence of her mental instability.

Under neoliberal governance women are expected to be autonomous subjects, however as feminist scholars such as Frye (1983) have illustrated, women have been coerced into a position of dependence. Our vision of dependency privileges a way of being shaped by a masculinist conception of autonomy. Within the system of heteronormative patriarchy, men's dependency on women for unpaid labor is naturalized and hidden. The neoliberal vision of autonomy renders women's historical position as dependent subjects pathological, thereby concealing the women's work that continues to receive no economic validation.

As will be discussed in later chapters, this pathologization of dependency is not limited to economic dependency, but also women have been expected to construct their identity on the basis of their husband's personhood. Women are caught in a double-bind where neoliberalism expects them to cultivate autonomous selfhood as defined on the masculine subject and simultaneously continue to carry the social, cultural, and historical burden of a heteronormative patriarchy that continues to define them in relation to men.

The Politics of Emotion

Sara Ahmed (2014) discusses how our ideals around happiness have a way of orienting us in the world through what she terms "affective economies" (p.219). In *The Cultural Politics of Emotion*, Ahmed (2014) discusses the role of emotion in positioning ourselves in the world by tying into our vision of morality and upholding structural inequality. Ahmed highlights the relationship between what makes us feel happy and what makes us feel good, which, in turn, is defined as good and moral. "Certain things become good *because they point toward happiness* (2014, p.219, emphasis in original). This relationship between happiness and morality leads to negative feelings being understood as immoral, especially if they impinge on someone else's happiness. Ahmed explains, "We can thus re-describe citizenship as a technology for deciding whose happiness comes first" (2014, p. 225).

In discussing the relationship between happiness and structural violence, Ludwig (2016) writes "[the] *promises of happiness* operate as neoliberal technology of power that support a capitalist mode of production that is built upon plural/flexible and diverse enterprises where each of them promises individualized satisfaction and individualized well-being" (Ludwig, 2016, p.421, emphasis in original). The mad undermine this individualized view of psychic distress by bringing what is considered a private affair into public view. That neoliberalism is structured upon this division means that public displays of insanity disrupt neoliberal governance.

As the work of Ahmed (2014) demonstrates, in highlighting the problem, you become the problem (p.224-5). To be unhappy is morally perverse. In *Responsibility in Mental Disease*, Maudsley writes, "Now, these signs of *moral perversion* are really the first symptoms of mental

derangement…" (Maudsley, 1989, p.67, emphasis added). So what is it about dependency that is so morally perverse? Its perversion stems from its challenge to the demands of neoliberal personhood. The woman diagnosed with BPD becomes a problem because she highlights this tension between these demands and the denial of women's autonomous personhood. In her dependency, she reveals women's coercion into positions of dependency and the failure of neoliberalism to liberate her from this dependency.

In failing to conceal their emotional states and pass as sane, mad individuals challenge neoliberal private organization of care, family, and social reproduction. By displaying one's psychic distress, or acting mad, one is disrupting the neoliberal ethic of freedom that is given to the individual and the rational subject. By refusing to contain what is considered a private (and individual) issue, the mad person reveals breaking points in the system. They disrupt the ideals that conceal systems of inequality, particularly the narrative of freedom.

Unstable Relationships with Unstable Women

Examining the borderline symptom of impulsivity, and specifically in relation to promiscuity and sexual agency, we can see yet again the historical baggage of feminine subjectivity countering acceptable modes of personhood under neoliberalism. Sex under neoliberalism becomes a means through which the autonomous subject can exercise their individual freedom and pursue happiness. Nicolson (1993) writes, there are "cultural expectations that each individual has a right and duty to achieve and give maximum satisfaction in their sexual relationships" (cited in Braun, 2005, p.414). Ludwig (2016) argues that the sexual politics of liberalization have been central to the maintenance of neoliberalism. Through sexuality, neoliberalism recasts its norms and values as freedom and tolerance, "the ideal of sexual self-determination has come in to replace the ideal of sexual self-control" (Ludwig, 2016, p.419).

Psy knowledge has included one night stands within the rubric of impulsive behavior. Such behavior is pathologized to the extent that it challenges the demands placed on subjects by heteronormativity, patriarchy, and neoliberalism. As is illustrated through the rubric of sexuality, these systems of governance place contradictory demands on persons. Thus while neoliberalism sanctions sexual self-determination, psy knowledge continues to reflect patriarchal notions of good

and moral sexuality. Leading to the contradiction in which one is encouraged to exercise sexual agency, but this agency may equally be deemed evidenced of pathology once labeled impulsive.

The desire to be loved is cast as a feminine need, one that presupposes the female malady, dependency. Impulsivity, much like the concept of dependency, is interpreted on the basis of social/cultural norms and values, more specifically in accordance with neoliberal autonomy. Concealed in this narrative of self-determination is the extent to which our choices are constrained. Egan (2016) argues, “that sexual empowerment, promoted and practiced in the context of wider gender inequalities, has the potential to reinscribe heteronormative positions in which a young woman is judged on the basis of her (agentic) sexuality” (p.104). Whilst agentic sexuality is sanctioned under neoliberalism, the experience of sexual violence pathologizes the individual through its failure to recognize the systems that reproduce sexual violence. Within the context of heteronormative patriarchy, the individual who experiences sexual violence is pathologized and furthermore, accused of inviting this violence through their expression of sexual agency. As discussed in the previous chapter, this de-contextualizing leads to the person who experienced sexual violence being held responsible for their experience through a model that re-inscribes their distress as individual pathology. They are placed in a double-bind in which on the one hand they are told that they have sexual agency, and on the other hand, if they are to lose this agency or have it taken from them, then they are cast as pathological and ultimately responsible.

Femininity and Unstable Men

Femininity as counter to neoliberal values does not exclusively pathologize women, but also men who are considered to be feminine. Whilst the borderline diagnosis has been predominantly applied to women, of the men diagnosed with this disorder there is a tendency to view them as feminine and that this femininity is linked to their psychic instability. As mentioned in chapter two, Wood (2001) in discussing the psychiatric response to men whom they diagnosed as hysteric, highlights the feminization of these subjects, referring to them as “pale and delicate” and “fat, pale-faced, effeminate looking men” (p.66). Moreover, it was argued that these men possessed an inferior will, which had led to their psychic downfall (see also Micale, 2008 for analysis of hysteria in men).

Here you have the association of will power and self-control as a masculine character trait, a view that was expressed by early Darwinian psychiatrists. Thus, the expression of psychic distress and expressive affect in men are treated as a failure to successfully enact the masculine identity prescribed for them. As Wirth-Cauchon writes, “men’s borderline ‘pathology’ is interpreted in relation to failures or lapses in masculinity” (2001, p.114). Moreover, psychiatrists readily linked these men’s distress to their sexual identity. Psychiatrist Joel Paris states, “It has been shown that a larger percentage of male borderlines than we would expect are homosexual, and that’s interesting” (cited in Cauwels, 1992, p.143). This example illustrates the role of heterosexism in diagnosing mental pathology.

Femininity and homosexuality in men diagnosed as borderline are interpreted as evidence of, or indeed the cause of, their mental pathology. Wirth-Cauchon (2001) articulates this point writing,

> “The more infrequent cases of men diagnosed as borderline, by contrast, are described as rigid and defensive, and their rage is not defined as evidence of an emotionally or structurally unstable self. Yet lapses in masculinity, signaled by a so-called deviant sexual orientation and what are perceived as more feminine behaviors, are linked in the narratives with the threat of destabilization of self” (p.117).

Whilst women diagnosed with borderline disorder are deemed to have a fluid or unstable self, men are in contrast accused of being rigid. Moreover their anger is not taken as evidence of psychic instability, but their displays of what are deemed typically feminine characteristics are.

Epidemics of the Will and Technologies of the Self

Millon (1969) described the disturbed personality writing, “They rarely persevere and attain mature goals: their history shows repeated setbacks, a lack of judgment and foresight, a tendency to digress from earlier aspirations and a failure to utilize their natural aptitudes and talents” (p.306). To be considered a functioning personality not only must you function as an autonomous self, but further you must pursue self-realization. This project of self-realization demands from us greater self-awareness and self-surveillance. It is predicated on the idea that to be one’s self is to know one’s self. Millon (1969) adds, “many of these patients have shown flashes of promise, stability

and achievement, but these periods are usually short lived" (p.306). The rubric of personality disorder is expanded to assess one's ability to cultivate a self.

This emancipatory project of cultivating a self enshrines a particular way of being in the world. Persons become plagued by the paradox of achieving liberated selfhood through their consumption, whilst exercising self-control and self-restraint. This leads to the emergence of what Eve Sedgwick (1993) describes as "epidemics of the will" (p.130-142). In discussing the emergence of the addict, Sedgwick highlights the shift from *drug use*r to *addict* during the twentieth century, which placed new constraints upon subjectivity.

This addict identity placed the subject into a state of perpetual insecurity. Sedgwick (1993) describes,

> "From the situation of relative homeostatic stability and control, she is propelled into a narrative of inexorable decline and fatality, from which she cannot disimplicate herself except by leaping into that other, even more pathos-ridden narrative called *kicking the habit*!" (p.131, emphasis in original).

With this new narrative comes a new emphasis upon self-control. Moreover, not only are drugs endowed with addictive capacities, this rubric is expanded to encompass any and all human activities. Addiction is no longer limited to chemical compounds but expanded to include basic human needs.

There is a shift in emphasis from that which gets the person high, the substance, to the person with the addictive personality. In this way, not only is the intake of substances addictive, but equally the denial of substances, or for example food. Control, self-control becomes addictive. The person addicted to exercise tells us that the body itself can become a source of addiction, and so emerges *diseases of the will*. Whether something is addictive or not therefore depends not on control as such, but one's ability to exercise choice. No longer did you need to break a law or to harm others, or yourself, but an "unhealthy" predilection to certain behaviors became evidence of a disturbed self. This leads to what Sedwick (1993) describes as the "*propaganda of free will*" (p.133).

This propaganda re-establishes a connection between a lack of will power and psychic instability with the emphasis on choice and the individual freedom. This freedom demands self-restraint, and in turn the exercise of consumption/restraint becomes a means for developing selfhood. According to Foucault (2005) this testing of willpower is a Western value that extends back to Ancient Greece. He describes the Pythagoreans technique for testing one's willpower by resisting food (p.48-49). Will-power is used as a tool for cultivating the self, or as a technology of the self. As discussed in the following chapter, it is also typical of the Western conception of mind/body dualism and the use of the materiality of the body for cultivating a higher self.

Under neoliberal governance, through the medicalization of the personality these technologies for cultivating selfhood took on increased significance. Bad habits became evidence of disturbed personhood and psychiatry developed techniques for people to address these undesirable attributes or patterns of behavior. Nikolas Rose (1999a) writes, "Through self-reformation, therapy, techniques of body alteration, and the calculated reshaping of speech and emotion, we adjust ourselves by means of the techniques propounded by the experts of the soul" (p.11). Psy technologies not only aid in bringing deviants into line, but also cultivate better subjects. With the expansion of psychiatry's purview, personality disorders ushered in a directive, making better, happier, neo-liberal persons of us all.

If one fails to exercise their freedom to choose and their self-restraint the diagnosis identifies this failure as a mental pathology placing greater demands of the individual and their ability to engage in self-surveillance. The expectation is on changing or bettering the self as opposed to challenging the systems that remain disguised by this notion of choice. One is no longer coerced into dependency but chooses to be dependent. Ophelia is expected to engage in self work, and to fashion herself into an autonomous subject. Her dependency is no longer acceptable; she must better herself by overcoming the historical baggage of her past.

Gonick (2006) discusses this in her analysis of the two discursive subjectivities that emerged during the 1990's, *Reviving Ophelia* and *Girl Power*. Gonick (2006) argues that,

> "...both Girl Power and Reviving Ophelia participate in the production of the neoliberal girl subject with the former representing the idealized form of the self-determining

> individual and the latter personifying an anxiety about those who are unsuccessful in producing themselves in this way" (p.2).

Each of these subjectivities are made in the image of young middle class girls who are told that they can be whoever they choose to be.

Gonick (2006) writes,

> "I want to suggest that the Girl Power and Reviving Ophelia discourses are a form of 'psychological knowledge' in that they disseminate new procedures for understanding oneself as a girl and acting upon oneself to overcome dissatisfactions, realize potential, gain happiness, and achieve autonomy. They function together as a technology for the production of certain kinds of persons" (p.18).

The borderline subject has through their dependency failed to achieve autonomous selfhood and thus, like the character Ophelia, has countered the new demands placed on feminine subjectivity. The neoliberal emphasis upon making the individual responsible transformed her dependency upon others, and in particular her romantic partner, from something that was expected of women to evidence of mental disorder. Within this form of governance emerges epidemics of the will, which reinforces a belief in this individual responsibility. Ophelia was not alone in her pathological inclinations, "Alcoholics, bulimics, phobias, obsessives and the anxious could now have their behavior managed back to normality through an expertly designed programme employing the systematic use of sanctions and rewards" (Rose, 1999a, p.239). Psychiatric knowledge codifies subjectivities and helps manage persons back to health as defined under neoliberalism. Through the creation of techniques for the self, psychiatry upholds the neoliberal vision of happiness, orientating subjects towards acceptable modes of gendered selfhood.

Chapter Six
Self-Injurious Behaviour and the Pathologization of Deviant Femininity

"*Then I started cutting because I was so confused 'cause I was so angry. I was so emotional. I wanted to die but I couldn't. It was the only thing at that point that could actually calm me down*"

(cited in Ntshingila, Poggenpoel, Myburgh, & Temane, 2016, p. 117).

The diagnosis BPD interprets a person's psychic distress as evidence of their pathology and proceeds to locate this pathology within their personhood. The use of psychiatric and psychoanalytic knowledge of the self to interpret that person's behaviors and experiences poses a threat to alternative constructions of personhood, specifically those not predicated upon a white, middle class, heteronormative, and gendered subjectivity. The diagnosis creates a space of ontological insecurity whereby persons diagnosed with BPD have their understanding and experience invalidated if it counters psy knowledge. In this chapter, I argue that the knowledge systems available to women for constructing selfhood deny their recognition as subjects. In the West, selfhood has been constructed upon the gendered, heteronormative and racialized subject. This means that the tools for relating to and understanding the self reproduce these axes which marginalize alternative ways of being. Power is enacted through knowledge of the self, because it is through this knowledge that we make sense of our experiences and the experiences of others.

Theorizing Recognition, the Body and the Self

In theorizing the link between selfhood and self-harm, I draw upon the work of Judith Butler (2004) to argue that the borderline symptom self-injurious behavior is produced by a failure to achieve recognition, and that this lack of recognition causes psychic distress. When one's experience of being in the world is not consonant with the cultural repertoire available for understanding and relating to the self, persons encounter a disjunct between their experience and the knowledge available for understanding and navigating that experience.

The means through which persons must create a sense of self is constrained in advance by patriarchy, white supremacy, neoliberalism, heteronormativity. One's experience of being in the

world is interpreted based on the knowledge provided to them by these governing systems, which recognize particular ways of being in the world while denying and concealing others. The person cannot relate to others when the knowledge available to understand and relate to the self precludes their subject position. Persons are unable to produce a sense of self when this knowledge warps their experience of being.

To say that power is enacted through the systems that we draw upon to inform our sense of identity is to acknowledge the privileging of particular knowledge of the self, psychiatric knowledge of the self, which has encoded a particular subject position. Butler writes, “The failure to conform to these norms puts at risk that capacity to sustain a sense of one’s enduring status as a subject” (2004, p.191). As is the case with BPD, being diagnosed as pathological threatens one’s enduring status as a subject. The disordered self is disqualified as a subject, just as, through epistemic violence, they are disqualified as legitimate knowers. They no longer know themselves, and therefore their experience of being in the world is no longer recognized. In this position of ontological insecurity, the person, no longer a subject, must traverse an abyss and perhaps we can conceive of self-injurious behavior (SIB) as an attempt to traverse this space.

Psychiatry provides persons with knowledge to understand their suffering and relate to the self but written in this psychiatric diagnosis are the knowledge systems that uphold and reproduce the systemic violence that leads persons to become distressed. Gender is one of which there are many axes for orienting ourselves in the world. It codifies our conception of selfhood and informs our understanding of, and relation to, the self. Furthermore, gender sets the terms upon which our personhood is recognized. The social and cultural norms encoded within these axes inform our interactions with governing systems and our ability to connect with others.

Foucault is useful in theorizing the function of power as both a coercive and creative force. Power exerts control over the body through our knowledge of the self. I use the concept *technologies of the self* to describe those practices, modalities, rituals enacted by the subject directed at transforming or changing their mode of being. These technologies are an assemblage of knowledge systems, which persons deploy to shape conduct. Such technologies enable us to reconceptualize selfhood not as an intrinsic quality but as an interplay between power and the body. Butler (2004) has argued the body exceeds its materiality in becoming the locus of power (p.15). Butler writes,

"...power acts upon the body, very specifically, in the very formulation of bodily passion in its self-persistence and knowability" (p.193). The body is a site for contesting or submitting to power. Whilst SIB is an engagement with power, it can neither be totally conceived of as a challenge to power, nor a submission to power, but a manifestation of the relationship between governing systems and the body. The body is the site of struggle with power, upon which knowledge of the self is transposed, thus it is through the body that systems are upheld or dismantled. Knowledge of the self is predicated on the engagement of the material body with these systems of governance.

Self-Harm and BPD

Self-injurious behavior is one of the defining characteristics of borderline disorder. It is one of five interview criteria that must be met in order to receive a diagnosis of BPD. The other four are frantic efforts to avoid real or imagined abandonment, instability of interpersonal relationships, identity disturbance, and impulsivity (Zimmerman, 2013, p.114-5). In the Interview Guide for Evaluating DSM-5 Psychiatric Disorders and the Mental Status Examination, Zimmerman (2013) lists the following questions:

> "Have you ever been so upset that you told someone that you wanted to hurt or kill yourself?"
> "Have you ever made a suicide attempt, even one that wasn't very serious?"
> "Have you ever been so upset or tense that you deliberately hurt yourself by cutting your skin, putting your hand through a glass window, punching a wall, burning yourself, or anything else like that?" (p.115)

The interview guide links suicidal intent with self-harm, however there is some disagreement among psychiatrists with Klonsky, Oltmanns, & Turkheimer (2003) defining self-harm as "the intentional injuring of one's own body without apparent suicidal intent" (p.1501). Another criteria for receiving BPD diagnosis is impulsivity which also encompasses a number of behaviors that psychiatry places within the rubric of self-harm, including one night stands, or brief sexual affairs, intoxication with alcohol, reckless driving, driving high or intoxicated, binge eating, or behavior that could have resulted in being hurt (Zimmerman, 2013, p.115).

The classification of certain behaviors as evidence of pathology, or particular persons engaging in these behaviors as pathological, is imbued with a moral vision of healthy behavior. That is to say, it is interpreted on the basis of prevailing social and cultural visions of morality. Certain behavior may be considered healthy or normal when displayed by one particular person and pathologized in another. As the work of Susan Bordo (2003) has highlighted, what qualifies as SIB depends on whether such behaviors are socially sanctioned. Therefore, in order to understand whether a behavior is a manifestation of SIB we must examine that behavior within the context of prevailing social and cultural norms. In examining the Western relationship to the body, we are able to see how manifestations of SIB are shaped by available knowledge systems for relating to the self. Further, gender, heteronormativity, and whiteness are codified in this relation to the self.

The borderline symptom SIB can be understood as the manifestation of the Western construction of the self and particularly women's construction of selfhood. This self-hood has been underpinned by the Cartesian split between the mind and body. The knowledge of the self propounded by psychiatry and psychoanalysis has been based upon the Western conception of mind-body dualism. This philosophy, once applied to the gender binary, casts women in the role of the body and reinforces men’s moral and spiritual authority over the body.

The association of women with the body has led to difficulties in their ability to construct selfhood based on the knowledge made available to them. The Western construction of selfhood as an intrinsic quality stems from Enlightenment ideas of the universal and rational subject (Rose and Kalathil, 2019). This enlightened subject has been formed upon the basis of the *Other,* the gendered, racialized, queer Other. This Other consists of those subjectivities that are denied recognition or are interpreted on the basis of systems that distort their experience of being in the world. This Other is created as that which the enlightened subject must overcome.

The father of psychoanalysis thereby upheld the view of women as the *Other.* In chapter two I discussed Freud’s description of feminine sexuality as a “dark continent” (cited in Brennan, 1992, p.5). Freud claimed that penis envy produced in women a greater desire to be loved than to love (1933, p.132). Higonnet’s (1986) discussion on the feminization of suicide highlighted this historical project in which women’s selfhood is constructed on the basis of their heteronormative relationships. The woman who loses her relationship thus faces the dissolution of the self (p.71).

This serves to deny her construction of autonomous selfhood by reinforcing a heteronormative vision in which women construct their personhood on the basis of man. This expectation was counteracted by neoliberalism whereby dependency became a marker of failed personhood and thus pathology.

Psychoanalysts continued to align authenticity with the masculine subject, developing theories that describe femininity as a mask. Joan Riviere (1929) in *Womanliness as Masquerade* argued that

> "The reader may now ask how I define womanliness or where I draw the line between genuine womanliness and the 'masquerade'. My suggestion is not, however, that there is any such difference; whether radical or superficial, they are the same thing" (cited in Russell, 1999, p.176).

Riviere suggests femininity itself is a mask, rendering all feminine self-expressions false. The metaphor of the mask implies that there is something beneath, an authentic self, which has in turn, upheld the association of women with the Other.

Martin Stein (1989) diagnosed his patient Ms V. as borderline on the basis that she lacked authentic selfhood. Stein interprets her appearance as evidence of her psychic instability. He accuses her of dressing like "a street walker one ten to fifteen years younger than her stated age" (cited in Wirth-Cauchon, 2001, p.123). Ms. V. refuses to wash and refuses to remove her makeup, instead choosing to apply layer upon layer. According to Stein, Ms. V's obsession with makeup and fear of going without it indicated an absence of selfhood. Stein writes, "One thing was certain through her facial-makeup, she created a sense of self and identity…" (cited in Wirth-Cauchon, 2001, p.125). Stein observed her attempts to create different "faces" through makeup as a desire to construct a sense of self.

This lack of selfhood has been a prominent theme in psychiatric descriptions of borderline women. Whilst psychiatry accused these women of lacking an authentic or stable self, they simultaneously reinforced the association of women and the body and thus women's need to construct selfhood in a hetero-partnership. In examining the pathologization of dependency, we are able to see that prior to the formation of the neo-liberal subject, women were instructed to develop their sense of self on

the basis of their husband. Women did not belong to themselves but instead were to seek to find themselves in another, masculine, subject.

Constructing Selfhood Under Heteronormativity

Within the context of heteronormativity, psychiatrists such as Erik Erikson have reinforced a belief that women should form their subjectivity within a heteronormative relationship. Erik Erikson maintained that,

> "something in the young woman's identity must keep itself open for the peculiarities of the man to be joined and of the children to be brought up. I think that much of a young woman's identity is already defined in her kind of attractiveness and in the selectivity of her search for the man (or men) by whom she wishes to be sought" (cited in Chesler, 1972, p.7677).

By adding that women's identity is based upon her choice of husband, Erikson leaves no room for her own personhood. Women, and in particular women diagnosed with BPD, find themselves in a precarious subject position, between this notion of an authentic or true self, and the parallel theory of selfhood constructed on the basis of a heteronormative relationship.

Ms V. illustrates the contradictions placed upon women's construction of selfhood. She shares with Stein her history of abusive relationships asking, "Why do all these men use me? … why don't they like me for me?" to which Stein responds, "Maybe it's because of the way you look!" (cited in Wirth-Cauchon, 2001, p.124). Ms. V is accused of lacking an authentic self, evidenced by her exaggerated feminine appearance, which Stein suggests prevents her from attracting a good man. Simultaneously, she is expected to mold her selfhood in a hetero-relationship, which according to Stein, her appearance prevents her from doing. Her attempts to construct a self without a heteronormative relationship are criticized for being inauthentic, and her inauthenticity prevents her from attaining the relationship that she so desires.

Women's performance of gender is contingent upon their engagement with the body as a means of constructing their selfhood. They are pathologized for both engaging in this project and failing to engage in this project, or at least in the instance of the latter, failing to construct the body in a

manner that adheres to dominant norms and values. This was evidenced in the case of women such as Ms. V whose efforts to construct a self are taken as evidence that she had no identity beyond her layers of makeup. Women are sneered at as superficial or vain creatures (Meyers, 2002, p.100) and yet their ability to pass as sane is immediately tied to their ability to engage with the body as a means of cultivating the self.

Psychiatrists and psychoanalysts have been attracted to the use of metaphors such as the mask to link the behavior of their distressed patients with their theories of individual pathology. Rather than locating their client within the systems that produce their distress, they have individualized their clients' suffering, preferring to locate the etiology of distress in their personhood. By challenging the normative position in which their subjectivity is recognized, women who challenge the sex role may experience a loss of subjectivity. Becker (1997) highlights discussing women's experience of anger, a masculinized trait that is often pathologized in women. Becker writes, "For women, the experience of anger itself can bring with it a sense of separateness, difference, aloneness" (p.121). Showalter (1985) describes how feeling *unreal* is a common motif among schizophrenic women. Showalter (1985) writes,

> "The 'withness' of the flesh, and its proper management, adornment, and disposition, are a crucial and repeated motif in the schizophrenic woman's sense of themselves as unoccupied bodies. Feeling that they have no secure identities, the women look to external appearances for confirmation that they exist" (p.212).

The term "withness" implies that the body is separate/ distinct from the self, however simultaneously the self is imprisoned within the body thus *withness* refers to this feeling of imprisonment. This mind/body dualism is captured in Whitehead's epigraph of *the Heavy Bear*, "the withness of my body", that is to say that the body is *not* me, but *with* me. "The body is experienced as *alien*, as the not-self, the not-me" (Bordo, 2003, p.144, emphasis in original). Bordo (2003) describes withness as "that of disjunction and connection, separateness and intimacy" (p.2). Through this separation of the mind from the body, the latter becomes a vehicle for cultivating selfhood. The increased surveillance of the self, in turn producing increased surveillance of the body. For women, surveillance of the body has particular significance in constructing their personhood. The knowledge systems available to women have codified their relationship with their

material bodies. In doing so, the manifestations of their psychic distress are likely to be expressed through this relationship.

The Heavy Bear

In Western philosophy the body has been portrayed as an obstacle to the self that must be overcome in order to achieve self-realization. In *The Heavy Bear Who Goes With Me,* Delmore Schwartz (1967) captures the disdain for the physical body that has permeated Western culture. This body is “clumsy”, it “lumbers”, it hungers, it howls, it trembles at its own mortality (cited in Bordo, 2003, p.1-2). Schwartz draws on Plato’s ideas in which the body is an “epistemological deceiver”, distorting and hiding the real behind the transient. The body obstructs our spiritual development through its needs, dependency, and its surrender to baser instincts, becoming a prison or cage from which the soul or the spirit must be liberated.

In *Unbearable Weight: Feminism, Western Culture, and the Body*, Bordo (2003) discusses the crystallization of culture, arguing that pathologies are not a deviation from established social and cultural norms but represent more or less extreme manifestations of these values and beliefs. Bordo (2003) writes, “I take the psychopathologies that develop within a culture, far from being anomalies or aberrations, to be characteristic expressions of that culture; to be, indeed, the crystallization of much that is wrong with it” (p.141). Bordo argues that the cartesian dualism causes self-injurious behaviors, such as anorexia, by pitting the mind against the body.

Depriving the body of its needs becomes a test of one’s will. In discussing the starvation of the body, Jennifer Woods describes as the “absolute purity, hyperintellectuality and transcendence of the flesh”. She writes, “My soul seemed to grow as my body waned; I felt like one of those early Christian saints who starved themselves in the desert sun” (cited in Bordo, 2003, p.148). The body is starved, not to appear thinner, although this is culturally positioned as desirable, but to cultivate the self. The denial of the body’s need for food is used as a technology for developing the self.

The West has treated the body “as animal, as appetite, as deceiver, as prison of the soul and confounder of its projects” (p.3). In the chapter *Miroir, Memoir, Mirage: Appearance, Aging and Women,* Meyers (2002) describes this disconnection between the body and the self. The mirror

confronts aging women with a reflection that they do not recognize as their own, "instead of encountering the face one has identified with, however ambivalently, one confronts an alien image" (p.149). The person rejects their body as not reflecting their true self. Meyers (2002) discusses aging here, but I suggest the BPD symptom self-injurious behavior can be understood through this separation of the mind from the body, which can manifest in the body becoming "alien."

The mind/body dualism has created feelings of shame and disgust towards the body. Sara Ahmed (2004) outlines the work of emotion in orienting us in the world. Ahmed describes the feeling of disgust as pulling away, "the body recoils from the object" (p.85). By separating the mind and body, it is the body from which one recoils. The body's materiality is treated as a means for producing a self and an obstacle to cultivating oneself. Within the heteronormative matrix, the body is the site from which women try to construct a sense of self. This does not lead to embodied selfhood, as the body is treated as being separate from the mind. Knowledge of the self predicated upon the cartesian dualism produces a tension whereby women are denied authentic personhood through their association with the body.

Masochism and Self-Injurious Behaviour

Feminist scholarship has highlighted the moral judgments embedded in the pathologization of women's behaviors as self-injurious. Dana Becker (1997) notes, "It may seem odd to consider some forms of self-injurious behavior as more deviant than others, but when behavior is matched against gender norms, deviance does become a question of degree" (p.135). The extent to which a particular behavior may be deemed self-injurious depends upon whether it is socially sanctioned, and further *who* is engaging in the behavior.

Masochism was described by Freud as truly feminine (Freud, 1933, p.116), a view which has held sway in psychoanalysis and psychiatry more broadly. More recent psy literature has upheld this association maintaining that women internalize their distress (Bayes and Parker, 2017, p.198). As was discussed in chapter 2, Freud theorized that these masochistic impulses stemmed from the "suppression of women's aggressiveness which is prescribed for them constitutionally and imposed on them socially…" (p.116). Whilst acknowledging the social constraints placed on

women, Freud theoretically links the development of women's masochistic impulses to their "constitution", which contributed toward his theory of penis envy.

The "feminine" mental disorders such as hysteria and dependency disorder are also characterized by this emphasis upon masochistic impulses. Psy knowledge has pathologized women's efforts to navigate the space in which their personhood has been denied and, furthermore, has treated their coping mechanisms as evidence of a disordered self. By locating disturbed personhood as the root of one's suffering and locating this disturbance within the individual, psychiatry treats women's experience of violence and the violence of having this experience misrecognized as evidence of their intrinsic pathology.

By linking masochism to femininity the latter becomes pathological by design. That is to say, femininity is thereby predicated on the desire for self-harm. Rather than acknowledge the social constraints placed upon women that silence them, and thus prevent them from being able to externalize their anguish, psychiatry has viewed masochism and the internalization of psychic distress as some intrinsic aspect of women and femininity. The high rates of trauma experienced by persons diagnosed as BPD are indicative of a culture that has hidden and concealed sexual violence. Psychiatry played an important role in perpetuating this culture of violence. As discussed in the fourth chapter, the work of Herman (1997) challenged this history of silence and distortion. The perpetrators of such violence are supported by this culture and the damage that this causes is not only individualized but also denied space and recognition.

Recognition and the Self

If the knowledge available for understanding and relating to the self cannot account for one's experience of being in the world, persons will struggle to locate themselves in that world. They find themselves caught between knowledge systems that may either withhold or suspend recognition. The knowledge available distorts experiences that challenge prevailing gendered, heteronormative and racialized constructions of personhood. Thus, disturbances in the self are not individual pathology, but the pathology lay within the distortion of persons' experience and the denial and withholding of their personhood.

Misrecognition plays an important function in the manifestation of SIB because it is through our knowledge of the self that we locate ourselves in the world and in relation to others. To be misrecognized, or to have one's personhood denied prevents persons from being able to connect or feel connected. In this position of ontological insecurity, self-injurious behavior becomes a mechanism through which persons try to grapple with their understanding of and relation to the "self".

To say that the self resides in our interactions with others is to relocate disturbed personhood. As Erikson demonstrated in advising that women should wait for heteronormative couplement before forming their identity, women are encouraged to form their identity in relation to others. Nancy Chodorow (1978) argued that women constructed their sense of self in relation to their mothers. Berger (1974), Bordo (2003), and Higonnet (1986) suggest that women are plagued by the twofold self-awareness in which she is told to construct both a *true* and *authentic* self whilst simultaneously she must define herself in relation to others. This relational self is then described by psychoanalysts as being inauthentic, or 'as-if'. The construction of the women's self renders her particularly vulnerable to pathologization. For whilst she must construct herself in relation to others, as we all must do, the feminine self is interpreted as a false. By examining the role of gender in constructing the self and the self as relational, it becomes evident that gender produces certain ways of being and denies others. Thus, disturbed personhood is rooted in the gendered construction of the self.

Persons who are unable to achieve recognition will express their distress using the cultural repertoire available to them. The Western philosophical tradition has created a split between the mind and the body, and in doing so, has cast women as the body. Within this tradition, technologies of the self are used to play upon the materiality of the body in order to cultivate or transcend the self. Women's construction of selfhood leads to difficulties in achieving recognition because of her association with the body.

Psy knowledge reproduces the systems that cause self-harm and distress by treating these as something particular to femininity and women as opposed to social and cultural practices. This knowledge disguises the violence of gender, heteronormativity, and race by locating the disorder within the individual. Self-injurious behavior is not an individual pathology, but part of a broader social and cultural landscape in which in being denied recognition, persons are compelled to

internalize their responses to "the multifaceted and heterogeneous distresses of our age" (Bordo, 2003, p.141)

SIB becomes a means through which persons may interrogate their sense of self. In the absence of recognition, which posits an inability to form connection, persons engage in behaviors that stem from a desire to achieve recognition. These behaviors may either counter prevailing social and cultural norms, or conversely may be the ultimate expression of social and cultural ideals, as depicted in Bordo's crystallization of culture. In each instance, persons will engage in SIB according to the social and cultural language made available to them.

To have your experience of being in the world mis-recognized is to have your desire for bodily autonomy interpreted as narcissism, or your experience of violence described as masochism, to have your anger treated as irrational, and to have your attempts at connection described as seductive and manipulative. These character traits are considered the defining features of BPD. They represent the codification of "deviant" femininity into a psychiatric label. Becker (1997) points out that deviant femininity is barely distinguishable from normative femininity. This led Becker to suggest that BPD features are generally shared by women (p.118). This conception of femininity and the pathological traits imbued in it are far from being something intrinsic to biological makeup or sexual development but are created in the interest of and in response to the systems of governance that intersect to create gendered subjects.

Chapter Seven White Femininity and The Racialization of Anger

I conclude our genealogy of the diagnosis BPD by examining anger, a defining character trait of the "borderline" personality. I argue that the expression and reception of anger is gendered and racially coded and that the pathologization of anger re-establishes social hierarchies. By examining anger—specifically whose anger is legitimized and whose anger is ascribed to an innate disturbance in personhood—we are able to see the demarcating of social boundaries embedded in gender, heteronormativity and whiteness. I begin this chapter by examining psychiatry's construction of white women as victims of their biological makeup, which has emphasized their innate fragility and irrationality. This has maintained a paternalistic view in which white women need to be cared for by men, whether psychiatrist, or husband. I discuss how the BPD diagnosis has been constructed on the basis of this white subject.

Following this, I examine the discursive construction of black women's anger, drawing on two racial tropes, "the angry black woman" and "the strong black woman". These racial tropes are constructed upon the basis of white supremacist and patriarchal insecurities, as Black feminist critic Barbara Christian points out, controlling images of black women have served as "a dumping ground for those female functions a basically Puritan society could not confront" (cited in Collins, 2000, p.73). These racial tropes delegitimize and depoliticize black women's anger ascribing it to an innate racialized character trait. Through an examination of these racial tropes we are able to better understand anger as a force for change and consider the implications of the recent inclusion of black women under the BPD label.

Black women have been excluded from accessing mental health services. Their suffering has been delegitimized and concealed by white supremacist systems that codify their bodies placing them outside of the borders of humanity. When included, black women receive racially coded diagnosis and treatment. Whilst inclusion is necessary for access to potentially lifesaving services, these services continue to be premised upon a white subject and thereby reinforce a mode of selfhood that both undermines and pathologizes the experience of racial violence and trauma. Further, because BPD is encoded on the basis of white subjectivity it reproduces epistemic violence by denying black knowledge and experience of being in the world.

Anger

A study by Carla Sharp, Jared Michonski, Lynne Steinberg, Christopher J. Fowler, Christopher B. Frueh, and John M. Oldham (2013) on 747 adult inpatients found that of the BPD symptoms, impulsivity and anger were endorsed in men whilst the same traits when displayed in women were seen as evidence of pathology (p.231). Although women may demonstrate lower levels of anger and impulsivity than men, women's anger was treated as symptomatic of BPD. Frye (1983) points out, "It is a tiresome truth of women's experience that our anger is generally not well received" (p.84). Women's anger has been readily treated as evidence of mental instability.

Frye (1983) highlights two important points on the functions of anger, firstly anger is a response "to being thwarted, frustrated, or harmed". Frye writes, "The frustrating situations which generate anger, as opposed those which merely make you displeased or depressed, are those in which you see yourself not simply obstructed or hindered, but as wronged" (1983, p.85). In responding to women's anger the focus is often not the cause but the expression of anger, thereby denying or disregarding the initial wrongdoing or harm. This leads us to Frye's (1983) second point, that anger requires "uptake". Without uptake, anger remains a "burst of expression of individual feeling" (p.89).

The significance of uptake can be better understood when we consider the role of anger in orienting persons in the world, and in relation to one another. Anger is communicative, it not only depends on its expression, but also its reception. The diagnosis of BPD describes "inappropriate" or "intense" anger as a symptom of underlying pathology (Zimmerman, 2013, p.116). When anger fails to achieve uptake the person's response is decontextualized and treated as an individual outburst or described as irrational. Instead of acknowledging the wrongdoing that took place that led to the person's anger, the initial harm is denied recognition.

Psychiatric knowledge has discursively constructed women's anger as a threat to their selfhood. Wirth-Cauchon writes, in psychiatric case narratives "women's anger … is constructed as out of control and beyond the borders of reason, the mere primitive eruptions of a fragmented and unstable self" (p.173). Anger is translated into a form of "emotional illness" to be "cured" through psychiatric knowledge (Chesler, 1972, p.108). The angry woman is thus treated as mentally

unstable, as opposed to being wronged, enabling that which caused her distress to continue. As a symptom of mental pathology, the use of anger to diagnose BPD builds upon a history in which women are denied validation of their anger, which is instead interpreted as evidence of their biological inferiority.

As I discussed in the first chapter, the feminization of madness in the nineteenth century was rooted in a belief that women's biology made them vulnerable to madness and thus would readily locate the origins of women's psychic distress in their reproductive function. They are cast as victims of their biology, at the whim of their uterus which pushes them beyond reason and beyond sanity. This association of women with madness has functioned to delegitimize and depoliticize their distress. Whilst their suffering may be recognized, historically it has been decontextualized and ascribed to women's fragility. Contemporary psy discourses have further perpetuated this belief (see Eisenlohr-Moul, Dewall, Girdler and Segerstrom, 2015; Eisenlohr-Moul, Schmalenberger, Owens, Peters, Dawson and Girdler, 2018).

Mary Pipher's (1994) *Reviving Ophelia: Saving the Selves of Adolescent Girls* became a bestseller as it garnered public awareness of a supposed crisis of girlhood. The Shakespearean character Ophelia has been readily deployed as a metaphor for the feminization of madness and the female malady. Ophelia is the hysteric who is driven mad by love sickness which ultimately leads to her death. In examining the pathologization of dependency in chapter five, I discussed how historically depictions of women's madness have been characterized by this loss of love, that the woman who cannot achieve the heteronormative dream faces dissolution of the self.

Drawing on the character Ophelia, Pipher continues to emphasize in her work the fragility of young women, referring to them as "saplings", "they are young and vulnerable trees that the winds blow with gale strength" (Pipher, 1996, p.22). Pipher argues that young girls early in their development are forced to create split or false selves thereby denying their "authentic selves". According to Pipher (1996), girls experience psychic distress as they go through puberty and during this vulnerable stage of their biological development, are subject to a hostile culture that leads to the development of false selves. In doing so, Pipher (1996) reproduces the hysteric writing,

> "Girls become fragmented, their selves split into mysterious contradictions. They are sensitive and tender hearted, mean and competitive, superficial and idealistic. They are confident in the morning and overwhelmed with anxiety by nightfall. They rush through their days with wild energy and then collapse into lethargy. They try on new roles every week - this week the good student, next week the delinquent and the next, the artist. And they expect their families to keep up with these changes" (p.20).

This portrait of adolescent girls strongly resembles the characterizations of hysterical young women such as Charcot's patient Augustine, described as "sweet, capricious, willful", attention seeking and temperamental (see chapter two). These romantic depictions of girlhood were also reflected in the work of early psychoanalysts with Breuer (2004) describing hysterical women as "the flower of humanity, a sterile, admittedly, but also as beautiful as forced blooms" (p.241). Metaphorical descriptions of girls experiencing psychological distress have emphasized their vulnerability in turn reproduced the association between femininity and pathology. Ehrenreich and English (2005) discuss how historically women's fragility was taken as evidence of her femininity.

Biological theories of women's madness provided ideological support for a sexuo-economic relation by justifying women's seclusion within the home. Too excitable for the public domain, the white woman was encouraged to avoid any mental stimulus or physical exertion, as evidenced by Silas Weir's *rest cure* (Showalter, 1985, p.138). Darwinian psychiatrists such as Maudsley were explicit regarding their views that women should be excluded from the spheres of men (Collie, 1988, p.50-2), Maudsley having actively challenged the inclusion of women in medical school (Appignanesi, 2010, p.110).

Psychoanalysts developed a different but corresponding narrative in which, by romanticizing young women and emphasizing their fragility, they uphold a view of the female malady and thus young women's need for protection. This emphasis upon vulnerability and call for protection provides ideological support for heteronormativity by re-establishing women's place in the private domain. The work of Pipher continues to obscure the systems that cause distress, reinforcing the view of young girls as voiceless victims and treating the origins of their distress as stemming from an innate sensitivity. This view of the hysterical woman was based on Ophelia, and importantly, not only is she gendered but also racialized. She embodies the character traits that were culturally

sanctioned in white women, fragility, dependency, vulnerability. These not only uphold heteronormativity but also, as the work of Patricia Hill Collins (2000) has demonstrated, the binary thinking that defines Western thought has constructed white womanhood in opposition to black women.

Patricia Hill Collins (2000) writes,

> "According to the cult of true womanhood that accompanied the traditional family ideal, 'true' women possessed four cardinal virtues: piety, purity, submissiveness, and domesticity. Propertied White women and those of the emerging middle class were encouraged to aspire to these virtues. African-American women encountered a different set of controlling images" (p.72).

By nature of their whiteness, white women are diverted from the prison industrial complex. They are considered sick but deemed worthy of saving. Black women have not had this privilege. Their suffering has not been recognized in the same way as white women. Instead their anguish has been denied; moreover, to express this anguish would put themselves in danger of a punitive system that erases black bodies, to show pain and to express this pain would pose a great risk to their immediate safety.

Sapphire

"Every Black woman in America lives her life somewhere along a wide curve of ancient and unexpressed angers" (p.146)

—Audre Lorde, *Sister Outsider*

Judd (2019) discusses how anger functions as a force demanding recognition. In a world that denies black women the space to live as dignified human beings, black women are forced to navigate systems that deny their humanity. They exist in a precarious position where their silence cannot ensure their safety and their anger is a direct challenge to white supremacist power. Challenging this power invites, as Audre Lorde (1984) describes, a "societal death wish" (p.146). In discussing

the murder of Sandra Bland while in police custody, Judd (2019) illustrates how a black woman challenging white supremacist power through the simple assertion of her human rights, her right to be, her right to exist, is met with a violence that may lead to her death.

On July 10, 2015, Texas state trooper Brian Encinia pulled over Sandra Bland and asked her a series of seemingly benign questions to which Bland responded, but her replies agitated Encinia. Choosing to maintain her dignity, Bland did not try to appease Encinia by partaking in his power play. To which he responded by asserting his dominance and placing Bland under arrest. Judd writes, "It is the moment in which Bland's annoyance and frustration articulated through speech and silence are read as a threat and when Brian Encinia exerts force in order to put *an angry Black woman* in her place" (p.203, emphasis in original). Three days later, after Bland had attempted to post bail, she was found dead in her cell (Judd, 2019, p.203). The racial trope "angry black women" codifies black women as dangerous. Cast in the role of the Other, they are treated as a threat to the moral and social order (Hill Collins, 2000, p.70).

When we think of the trope "angry black women" this is not to say that black women are any angrier than any other group of persons. This is to say that *anger*, particularly the reception of anger, is racially coded, and that this code, in a system of white supremacy that denies the humanity of black women, means that their anger is not tolerated by such a system. White supremacy has delegitimized black women's anger by creating controlling images that depict them as irrational, uncontrollable, and dangerous. Where Ophelia serves as the iconic white woman, Black women are cast as Sapphire. Judd (2019) writes, "Sapphire, the angry Black woman, explains me to myself through television, through everyday interactions; she renders my adult inner life a caricature animated by white supremacist fears and patriarchal mores" (p.178). This racist trope has functioned as ideological support for the continued violence against black women. Sapphire is accused of unwarranted anger making her difficult or beyond "reason" (Judd, 2019, p.179).

Genna and Feske (2015) suggest that black women have been underdiagnosed with BPD because they present their symptoms differently. They argue,

> "African-American women with BPD may present with more severe symptoms of lack of anger control and fewer suicidal behaviors than those of white women with BPD, raising

> the possibility that they are misdiagnosed and receive treatments that are not optimal for BPD" (p.1027).

Genna and Feske justify a lack of medical treatment by using the seasoned stereotype of black women as angry. This fails to critically assess how dominant racial tropes have reinforced the treatment of black women in particular as unworthy of "victimhood". Black feminist psychologists Angela Mitchell and Kennise Herring have argued that the strong black women role was created by the African American community as a self-affirming image of black womanhood (Beauboeuf-Lafontant, 2005, p.113). It should also be recognized that the strength of black women has historically been used to deny their humanity. In referring to the strength of black women in the nineteenth century Dr. Sylvanus Stall writes, "Her square sister will endure effort, exposure, and hardship that would kill the white women" (cited in Ehrenreich & English, 2005, p.126). The racial trope "strong black woman" diminishes outrage for the injustice black women are subjected to, reinforcing an expectation that black women will endure dehumanization in silence (Beauboeuf-Lafontant, 2005, p.108).

This belief has enabled the treatment of black women as both subhuman and superhuman. They have been denied recognition as human beings with their own needs and desires, instead being expected to serve others selflessly and bear the weight of social inequality. The trope of strong black women has not permitted black women the space to be vulnerable. As one white woman expressed to Danquah (1998), "when black women start going on prozac you know the whole world is falling apart" (Danquah, 1998, p.21).

The notion of victimhood is imbued with a heteronormative and racialized view of who attains the status of victim. White women have been cast in this role of victim, which is to say that they have been deemed by the system as worthy (and in need) of saving. Importantly, such views of victimhood are codified in the diagnosis BPD. Whilst white women may stray from what is deemed socially acceptable morality, i.e. the "castrating medusa", she is ultimately given the opportunity for salvation or moral redemption through psychiatric knowledge. Black women have not been afforded this opportunity for salvation but have been expected to endure and to survive.

Patricia Hill Collins (2000), in discussing controlling images of black women highlights racial tropes such as the *mammy*, the *matriarch*, and the *welfare mother*. These tropes emerge as ideological justification for the subjugation of black women under capitalism and the receding of welfare under neoliberal governance. Racialized tropes such as the welfare queen targets black women as morally responsible for broad social issues produced by rising inequality. Hill Collins (2000) also highlights how these images not only serve to control black women, but also serve as a reminder to other women, influencing their construction of gender by dictating how a woman ought not to behave. In discussing the characterization of the welfare queen, Hill Collins (2000) writes,

> "Typically portrayed as an unwed mother, she violates one cardinal tenet of White, male dominated ideology: She is a woman alone. As a result, her treatment reinforces the dominant gender ideology positing that a woman's true worth and financial security should occur through heterosexual marriage" (p.79).

Hill Collins (2000) highlights how gender, heteronormativity, and white supremacy are interwoven with one another, each one providing support for the other. The racial tropes *welfare mother* and *welfare queen* not only blame black women by accusing them of exploiting the welfare system, but also attribute her dependence on the state to her inability to keep a man. As such, this racial trope corresponds with *the matriarch*, accusing black women of being emasculating and assertive, and therefore "unfeminine". These racist characterizations silence black women by defining the terms in which their anger is received.

Why Pathologize Women's Anger?

Following from my previous discussion on the desire to achieve recognition, we can see how racial tropes such as the *angry black woman* and the *strong black woman* have shaped the lived experience of black women, functioning to both delegitimize and depoliticize their anger and in turn their struggle against the matrix of oppression. In writing on the hatred she experienced from white people, Audre Lorde (1984) explains that "we still live our lives outside of the recognition of what that hatred really is and how it functions" (p.146). Racism has been upheld by such hatred and disguised by it.

This has important implications for how we think of anger because, as mentioned earlier, anger stems from harm or wrongdoing. BPD locates the problem within the individual thereby denying the wrongdoing and thus the hatred black women experience from white systems and white people. To diagnose black women, or any women for that matter, with BPD is to conceal the structures that enable such hatred. To expand BPD and include black women in a diagnosis that is predicated on "irrational" and unjustified anger is dangerous for it further distorts their experience and thereby protects systems of white supremacy and patriarchy.

If the hallmark of BPD is emotionality and in particular anger then we need to question why is such emotionality or anger not tolerated in some, whilst being accepted in others, and what purpose does the delegitimization of this anger serve? As Lorde makes plain, "For it is not the anger of Black women which is dripping down over this globe like a diseased liquid" (Audre Lorde, 1984, p.133). Showalter (1985) argued that to medicalize women's suffering is to contain it (p.249). The reception of anger expressed by black women and white women is racially coded, meaning that it is interpreted on the basis of a racialized view of acceptable personhood. Through binary thinking this ideology demarcates acceptable personhood in which to be insane is to be labeled a threat, it is to be diagnosed as *being* the problem. This serves to shore up a status quo in which women's experience of injustice is treated as a personality flaw. Women's anger has not been recognized but instead it has been treated as primitive eruptions that are taken as evidence of their flawed nature. By containing women's anger, psychiatric diagnoses prevent us from challenging the systems that privilege selfhood according to whiteness, gender, and heteronormativity.

Anger is a force for change, hence the medicalization of women's and in particular of black women's anger is of political significance. Marilyn Frye (1983) writes,

> "To expand the scope of one's intelligible anger is to change one's place in the universe, to change another's concept of what one is, to become something different in that social and collective scheme which determines the limits of the intelligible" (p.92).

Anger challenges the systems that establish social hierarchies; it can therefore be used to reclaim one's humanity and to call out injustice. To treat anger as evidence of one's pathological selfhood

is to remove this anger from the context in which it is made manifest, concealing the wrongdoing and harm, thereby protecting the social hierarchies that codify and manage acceptable modes of selfhood.

In *Wretched of the Earth*, Frantz Fanon discussed how white supremacy forces black, indigenous, and people of color (BIPOC) into a space of ontological insecurity, removing their ways of knowing, and concealing their way of being. Fanon (2001) writes,

> "Because it is a systematic negation of the other person and a furious determination to deny the other person all attributes of humanity, colonialism forces the people it dominates to ask themselves the question constantly: 'In reality, who am I?'" (p.200).

White supremacy and patriarchy have negated the humanity of black women. In response, black women have had to cultivate the strength to overcome adversity and to survive. Historically racial tropes have served to deny black women their humanity and continue a status quo in which they have been expected to endure inequality and persevere at the service of others. Christine Pungong (2017) discusses the violence inflicted upon black women through the expectation that they will sacrifice themselves and suffer in silence, fetishizing their strength to justify their subjugation.

Whiteness as Universalism

In examining the power imbued in psychiatric knowledge systems, we can see how BPD encodes a relation to the self that is predicated on whiteness and the "universal subject". As the work of Rose and Kalathil (2019) highlights, this universal subject is rooted in a white epistemology thereby upholding the supremacy of white knowledge under the guise of objectivity. This pretense of objectivity has been described by Donna Haraway (1988) as "the God trick". In her work on feminist standpoint epistemology, Haraway discusses how the belief in the "universal knower" upholds knowledge hierarchies that privilege a particular way of being.

BPD is encoded with a particular construction of selfhood and relation to the self that is predicated on white middle class femininity. As discussed in chapter five, the rise of neoliberalism placed new constraints on the self, leading to the pathologization of dependency in women. As Jimenez

(1997) noted, earlier in the 20th century it was not seen as pathological for women to be dependent on a man for their financial security and sense of self. It was not until after the 1960s that dependency in women was treated as a symptom of mental pathology, becoming a hallmark feature of hysteria. Jimenez (1997) writes, "The relatively recent identification of dependence-linked behavior as a symptom of mental disorders in women demonstrates how responsive psychiatric thought is to shifting social values" (p.160). As hysteria diminished in salience, BPD took its place as the metaphor for pathological femininity and retained dependency as a symptom of pathology.

Moreton-Robinson (2006) discusses how the boundaries of humanity are constituted through knowledge of the self. Robin DiAngelo (2010) describes individualism and universalism as the two master discourses of psy knowledge in the industrialized West, and these two master discourses obscure and thereby uphold the privileging of white knowledge and securing of white power. Whiteness is codified into the borderline diagnosis itself. That is to say that it has been created on the basis of the Western construction of personhood, which is rooted in the construction of the racialized and gendered *Other*. Persons diagnosed as BPD are positioned outside of the boundaries of acceptable personhood. Diagnosing black women with BPD re-codes their anger without legitimizing it.

Access to Care

Racism has functioned as a significant barrier preventing BIPOC from accessing the help that they need. The intersection of racism with gender bias and the stereotyping of BIPOC has meant that those who manage to gain access to psychiatry have experienced the disregard for their distress or the delegitimization of their anguish. It is for this reason that scholars examining racism within psychiatry, such as Suman Fernando (2017), have argued for addressing this racism so that BIPOC may receive care and support. It is telling, however, that psychiatry has located this lack of adequate care not in the racism that is imbued within psychiatric practice, but instead within the suffering persons themselves and how they present their symptoms. In doing so, psychiatrists such as De Genna & Feske (2013) reinforce the trope of the "angry black women".

In chapter four, on trauma, I highlighted the work of Swartz (2013) in describing the dangers of being misdiagnosed, that such a misdiagnosis can result in worsened distress and even lead to

death. This is an important point because there has been a call for inclusion, a call to reexamine the application of these diagnostic categories, but these diagnostic categories prevent critical reflection of the systemic inequality by treating psychological distress as individual sickness. Further, the biomedical model has located this sickness in the physical body without acknowledging how the physical body is produced through social relations/power.

BPD reinforces a psychiatric relation to the self and in doing so treats black women as individuals and denies their shared experience of systemic violence. Pathologizing black women's anger does not recognize their experience of surviving a violent system that is in many ways predicated on their destruction. The diagnosis BPD is coded with whiteness and therefore does not encompass the lived experience of surviving a racist society and the psychological distress that this produces. This is not to say that all black women's distress stems from their experience of racism, but their experience of being is shaped by surviving a racist society.

Diagnostic labels uphold a belief that we live in an equal society, that is a "post-racism" or "post-feminism" society. As discussed in previous chapters, not only does the diagnostic label individualize the distress and locate the disorder within the "disturbed personhood", rooted in the Western construction of selfhood, but the BPD label in particular has a highly stigmatizing effect. The response of doctors and clinicians continues to be shaped by the view of borderline persons as difficult, dramatic, and irksome. A study carried out by Bonnington and Rose (2014) found that upon being diagnosed with bipolar disorder or borderline personality disorder, persons experienced both physical and psychological violence within psy institutions (p.14).

Christine Pungong (2017) describes the experience of being a black woman diagnosed with BPD:

> "Little did I know of the stigma that would await me post-diagnosis. Hospital staff don't treat you with quite the same care or attentiveness as other patients, GPs refuse to offer you certain medication, nurses audibly sigh when they read your file. Despite being medical professionals, none of them even try to hide their distaste. The internet doesn't prove to be any more reassuring. The first time I Googled BPD I was bombarded with pages and pages of unwarranted stigma and abuse. Articles on how awful and manipulative those with BPD are, and forums with tips on how to avoid us."

The experience of stigma and unwarranted abuse has been characteristic of BPD. Therefore advocates for the expansion of the diagnosis, who want to broaden the criteria so that it may recognize more persons suffering from psychological distress, must contend with the fact that this expansion is also potentially dangerous. It risks obscuring a person's distress by preventing recognition of the source of that distress. Christine Pungong (2017) describes being denied recognition, denied a voice,

> "In a world that doesn't give me the space to be in pain, let alone listen to why or affirm it, surely the greatest thing I could do is deteriorate, and make a spectacle of it too — do it loudly and violently and in protest."

As discussed in chapter four on trauma, the diagnostic label recognizes a person's pain but only to the extent that it coheres with psychiatric knowledge.

Diagnosing black women and women of color with BPD projects a relation to the self that is constructed on the basis of a Western epistemology thereby invalidating their own knowledge of and relation to the self. The diagnosis produces an epistemic violence in which one's knowledge and experience is treated as evidence of a disordered personality. Recognition is therefore dependent on whether one's experience is consonant with a white subject position and the construction of selfhood in accordance with Western knowledge.

Moreton-Robinson (2006) writes:

> "Whiteness is a form of strategic essentialism that can silence and dismiss non-Western constructions, which do not define the self in the same way. Such silencing is enabled by the power of white Western knowledge and its ability to be the definitive measure of what it means to be human, and what does and what does not constitute knowledge" (p.248).

The privileging of white knowledge is, in itself, a form of white supremacy. By privileging psychiatric knowledge, the diagnosis BPD fails to acknowledge power structures thereby rendering the mad, and those "racialized mad" speechless (p.2). Rose & Kalathil (2019) argue that psy

knowledge privileges “reason” and whiteness. Jayasree Kalathil (2019) works in the community around mental health, she describes being asked to speak at a seminar on the subject of PD’s in 2013. Of those invited to speak, Kalathil was the only person of color and, as person who was diagnosed with BPD, one of two people with the experience of being labeled with a psychiatric diagnosis and subjected to psychiatric interventions. Kalathil (2019) writes:

> “I was being asked to speak about my personal experience alongside others who wrote about people like me as damaged human beings, with a corrupt morality and a disordered personality. These others contributed routinely to the very knowledge base that makes it possible for one group of people not only to pass medical and moral judgements on another group of people, but also to claim the possession of a ‘correct morality’ to fix them” (p.3).

Through the BPD diagnosis we can see how the Western conception of selfhood subjugates persons by conferring recognition to some and withholding recognition from others. The supremacy of the “rational” subject privileges a particular way of being in the world and thinking about the world, which is critical for establishing the boundary, or borderland, between the sane and insane. Whilst the boundaries of insanity expanded to include more persons, it did not diminish the notion of the enlightened subject but positioned it as a goal for which each of us must strive. The way in which we strive for this is prescribed on the basis of heteronormativity, neoliberal governance, and whiteness. The enlightened subject has been predicated on the racialized, gendered *Other*.

Social Control

There is extensive literature on the use of psychiatry as a mechanism of social control. Suman Fernando (2017) writes, “The history of psychiatry shows that the need to diagnose mental illness has been intimately tied up with the need to control populations and people—the exercise of power over the individual often by, or on behalf of, the state” (p.91). Psychiatry has been more than willing to advance knowledge in the interest of the state. This alliance extends back to the court rooms of the 19th century with alienists assessing the mental state of moral deviants and criminals.

By qualifying the boundaries of humanity, psy knowledge has rationalized violence against those persons deemed to be dangerous or disturbed. Ameil J. Joseph (2015) explains,

> "The effect of this Eurocentrism is that little attention has been paid to the influences of colonial and imperial projects of dehumanization, on the categorization of people as 'types', and on the establishment of human hierarchies to rationalize violence through racial ideologies" (p.1021).

Psy knowledge has legitimized through "science" the state-sponsored terror of indigenous peoples and people of color, oppressing dissent and carrying out genocide (Cohen, 2016, p.173). One such infamous example is the diagnosis known as *drapetomania*, "or the disease causing slaves to run away" (Fernando, 2017, p.52).

In discussing the racial inequalities in clinical psychiatry in the UK, Fernando (2017) points out that Black and ethnic minorities are more likely to be "diagnosed as schizophrenic, sectioned under the mental health act, admitted as 'offender patients', held by police under MHA for observation, transferred to locked wards from open wards, [and] not referred for talking therapies" (p.94) than are white people. There is significant research demonstrating that black persons are more likely to be diagnosed with schizophrenia than their white counterparts (Fernando, 2017, p.103-105).

Schwartz and Blankenship (2014) found that in the U.S. African Americans are three to four times more likely to be diagnosed as psychotic than white persons, moreover "African Americans are almost five times more likely to be diagnosed with Schizophrenia compared with EuroAmericans admitted to state psychiatric hospitals" (p.134). There is a lack of research into the cause of this racial discrepancy, whether it stems from differences in the expression of psychic distress or differences in the interpretation of psychic distress (Schwartz and Blankenship, 2014, p.139).

Racial imagery has informed the boundaries of humanity leading to the popular association of black people with the dangerous and Schizophrenic *Other*. Cohen (2019) points out, the increase in diagnosing schizophrenia in BIPOC corresponds to increasing demands for civil rights in the 1960s (p.174-77). Controlling images such as *Ophelia* and *Sapphire* inform the basis of how your symptoms are interpreted and thus the diagnostic label that is applied. Whilst help is needed for BIPOC experiencing psychic distress, the help that is extended is embedded in a system of white supremacy, which categorizes them as a threat. The implication of these prevalent inequalities and extending the diagnosis of BPD to identify symptoms presented in the BIPOC community is that

the care that is extended fails to meet the person's needs and further exacerbates their psychic distress.

In particular, the historical role of psychiatry as a mechanism for social control can be seen more recently in UK government efforts to further delineate acceptable personhood through the implementation of the category *Dangerous and Severe Personality Disorder* (DSPD). This was to be carried out on the basis of a “risk assessment” to distinguish the merely disordered, or nearly normal, from the bad. Bourne (2011) discusses the dangers of this move towards risk assessment (p.82). Aitken & Logan (2004) observe, “The DSPD concept is linked to proposed legislative reforms to the Mental Health Act (1983), where more than two personality disorders or a high score on the Revised Psychopathy Checklist will be synonymous with high risk or dangerousness” (p.264).

Such legislative moves should give us pause to consider the role of diagnostic labels in further entrenching systems of inequality. Aitken & Logan (2004) expressed apprehension concerning the DSPD concept writing, “Our concern is that under existing systems, psychiatric comorbidity among women will be equated with severe personality disorder, and that self-injurious behavior will be used as a proxy for risk of harm to others” (p.265). The survivors of traumatic experiences thereby have their coping strategies pathologized and in turn used as rationale for their further disempowerment.

Access to life preserving services is desperately needed. At present, the diagnostic label is one of the few ways of accessing these services. But to access such services also places persons, particularly persons made vulnerable by inequality and the matrix of oppression, at risk of being subjected to further trauma by removing their self-determination and denying their self- knowledge and experiences of being in the world. There needs to be recognition of the psychic distress of BIPOC, but we must stand guard against the systems that produce this psychological distress. We therefore must be careful not to locate the origins of such distress within the individual's personality. To do so removes them from the context in which the distress is produced and conceals the systems that produce their distress, as with the individualizing and pathologizing of white women’s response to sexual abuse.

Challenging the Hegemony of White Supremacy

"*The Master's Tools Will Never Dismantle the Master's House*"

- Audre Lorde (1984)

If as Dr. Cornel West (2017) describes "the condition of truth is to allow suffering to speak", then we must recognize the way in which psychiatry and psy knowledge has rendered certain persons speechless. As the experience of Kalathil (2019) demonstrates, being diagnosed with BPD removed her voice. Even when given a platform to speak, her experience of being is only recognized to the extent it complies with psy knowledge and fits the Western worldview.

Psychiatric knowledge since its inception has been used to justify and uphold human hierarchies, the very hierarchies that cause suffering and lead persons to become distressed. The psychiatric labels thus cannot effectively liberate persons from such suffering. As I have tried to demonstrate, psychiatric knowledge is embedded with a particular view of personhood, and in establishing the boundaries of personhood has denied the humanity of those relegated to the status of *Other*. Psychiatry has used its knowledge of the self to deny persons of their humanity and through this epistemic violence has upheld a racial hierarchy thereby protecting white supremacy.

Fanon (2001) addresses the relation between mental pathology, material equality, and social transformation writing, "Independence is not a word which can be used as an exorcism, but an indispensable condition for the existence of men and women who are truly liberated, in other words who are truly masters of all the material means which make possible the radical transformation of society" (p.250). We cannot heal without a radical transformation that challenges the systems which produce psychological distress. These are the systems that recognize certain persons, whilst concealing *the Other*, and in doing so privilege a particular way of being in the world, reproducing and upholding the unequal distribution of power.

We must return to the Other in order to understand how power is re-inscribed upon the material body. Fanon (2001) captured this in writing, "Let us reconsider the question of [humankind]. Let us reconsider the question of cerebral reality and of the cerebral mass of all humanity, whose

connexions must be increased, whose channels must be diversified and whose messages must be re-humanized" (p.253). In pursuing biology, psychiatry looks to the material body to uphold its claims to objective knowledge and pure science. To establish more deeply and thoroughly human difference, thereby reinscribing *the Other* without "re-humanizing."

This inclusion is done under the pretense of recognition: that upon the inscription of the psychiatric label one's suffering will be recognized and the promise that through this acknowledgment they will be given the space and means to heal. The fulfillment of this promise can only elude us in a system that functions to re-establish the norm, and through this normalization deny persons of the opportunity to challenge systemic inequality. We see this in the response to the borderline person's rage. The use of anger to diagnose damaged personhood serves to delegitimize the experience that led to such anger and thereby conceal the systems that continue to produce these experiences.

Biology as Destiny

Theodore Beauchaine, a professor of psychology, maintained that "when we can show that something is going on in the brain, people take psychiatric issues, mental-health issues, more seriously" (cited Viviano, 2018). The hegemony of the biomedical model has meant that in order to have one's distress "taken seriously" it must be located in the material body. This poses a problem for considering the expansion of BPD. This genealogy has endeavored to denaturalize our assumptions around the self and demonstrate how this conception of selfhood has been shaped over time through a number of historical processes.

Whilst BPD was predominantly applied to white women, there is now a growing interest in diagnosing BPD in black women and women of color, noting how the symptoms may present differently and, according to psychiatrists such as De Genna & Feske (2013), have thus been overlooked. Deploying a biological lens to scientifically quantify the differences between personalities serves to reify the social construction of race and more deeply entrench the very systems that privilege a particular way of being on the basis of race. This disguises the history of the borderline diagnosis, and in calling for more investigative technologies to explore the biology of the disorder, takes the disorder and its biological origins as a given.

The hegemony of the biomedical model leads to conclusions that psychic distress is the product of faulty biology. In the case of PDs, the pursuit of biological markers has the potential to reproduce trauma by locating the disease within the person, rendering the person a disease. Psychiatry determines the basis upon which their experience is understood and thus renders the person voiceless, that is to say, psychiatry removes their voice by treating their experience of being as an individual pathology, or a sickness stemming from their biology. Robin J DiAngelo (2010) discusses how the *Discourse of Individualism* has functioned to uphold inequality and in particular, has bolstered white supremacy by giving the pretense of equality and denying the impact of racism in shaping one's life opportunities. This *Discourse of Individualism* hides the systems that recognize particular ways of being and deny others. Biological determinism serves to disguise the uneven distribution of power and the interaction between power and knowledge. By locating the problem within the person's biology, the person themself becomes a problem and, as was discussed using Foucault's concept of biopolitics, this problem is that which the state seeks to regulate, manage and ultimately solve as illustrated by the diagnosis *Dangerous and Severe Personality Disorder* (DSPD).

Conclusion

Madness is a lens through which we can better understand how systems of gender, heteronormativity, and whiteness operate to inform our conception of personhood. I began our genealogy looking at the borderland because it highlights how the development of knowledge and the formation of a Western construction of personhood was part of a political project. This project entailed manufacturing human taxonomies to carve up the social world. The creation of the borderland and the concept of degeneration enabled the state to secure its power by disqualifying certain persons as human beings. Madness played a critical role in establishing the boundaries of citizenship, which the emerging discipline of psychiatry could police.

The development of personality disorders emerges from this borderland whereby those considered abnormal, but perhaps not criminal, can still be disciplined and regulated. The concept *borderline* morphed throughout history, but as it developed it continued to center around a concern with delimiting acceptable personhood. The borderland and the character pathology BPD carved out an insecure ontological space for categorizing persons who fail to accomplish successful personhood according to prevailing social norms. The highly subjective nature of these concepts enabled them to shift according to the demands of governing systems. The borderland/borderline is a slippery space without clear or distinct boundaries. Healthy or *normal* personhood in one age may become pathological in the next.

Critical feminist scholarship discussed hysteria as a precursor to BPD with scholars such as Jimenez (1997) employing Faludi's theory of *Backlash* (1991) to suggest that psychiatry responded to shifting gender norms by producing knowledge that continued to treat women as predisposed to mental disorder. Both hysteria and borderline personality disorder have been conceptualized in psy literature and the popular imagination as female maladies, reflecting the archetypal femininity and historical shifts in what we consider pathological femininity. Hysteria and BPD, while bearing significant similarities to one another, have important distinctions, which highlight not only the shifting demands on personhood but, more specifically, the shifting demands placed on the feminine subject.

The diagnosis BPD has upheld the association between femininity and madness by maintaining that something unique to women renders them predisposed to mental disorder. The psychoanalytic tradition appeared to challenge this prevalent ideology by recognizing the social and cultural context within which women constructed a sense of self. However, listening to women was usurped by a desire to develop universal narratives of the human psyche and the unconscious. The preoccupation with creating grand meta-narratives undermined women's self-knowledge. Psychiatry used that knowledge as evidence of pathology, labelling it fallacy and phantasy.

The emergence of ego psychology helped inform the Westernized conception of selfhood working in tandem with neoliberalism to create new pathologies of the self. Through the ego concept and the medicalization of the personality, a new individual project emerged in which one had to cultivate their *self*. Personhood was judged in terms of its authenticity. This re-conceptualization of the subject led psychotherapists to maintain that women who failed to perform femininity convincingly lacked authenticity. Psy literature claimed that persons diagnosed as BPD had a false self or no self at all. Femininity's association with pathology placed women in a precarious position whereby their performance of gender was intimately linked to their perceived psychic stability.

Using Bordo's (2003) analysis of the *crystallization of culture*, I considered the BPD symptom self- injurious behavior and the desire to achieve recognition. Bordo is useful in theorizing the relationship between the expression of psychic distress and the contradictory demands placed on personhood, as well as how these contradictions produce social pathologies. Drawing upon Bordo's work on the subject of anorexia, we were able to see how the mind/body dualism in the Western philosophical tradition has produced a view of the body as an obstacle and deceiver. The body is that which obstructs the self and is also the means to liberate oneself. I argued that women's historical association with the body hindered the conception of authentic personhood demanded by neoliberal governance. In failing to accomplish authentic selfhood, Women remain the Othered subject, along with those subjectivities that do not adhere to the white heteronormativity.

I have endeavored to denaturalize the pathologizing of individual personhood and the association of femininity with pathology by demonstrating the socio-historical and cultural contingency of the authentic self. I suggest that a neoliberal conception of autonomy has produced an intolerance towards psychic distress, thereby individualizing and pathologizing persons in need of recognition

and connection. When the knowledge available for making sense of one's experience fails to account for that experience, persons must grapple with psychic distress as they try to navigate an epistemic space that denies their personhood and conceals or distorts their experience. Of those persons who receive the diagnosis BPD, an overwhelming majority have experienced trauma during their childhood. The response has been to individualize their suffering and treat their coping strategies as evidence of disturbed personhood. Rather than evidence of a false self, I posit that BPD symptoms are a set of behaviors that we choose to individualize, pathologize, and ultimately deny space because they counteract normative personhood constructed upon the masculine, heteronormative, and white subject.

The treatment of trauma as individual pathology provides ideological protection for structural inequality and the systems of governance that are heteronormativity, patriarchy, and white supremacy. BPD relocates the sickness from society to the self. Much in the same respect as the early formation of the concept – the borderland – BPD upholds human taxonomies and seeks justifications for social hierarchies by locating fault within the individual. It promotes a culture of victim-blaming because it denies recognition of the violence of social systems heteronormativity, patriarchy, and white supremacy. It is not enough to re-label BPD as PTSD or C-PTSD because the diagnosis is constructed upon a white, gendered, and heteronormative subject and thus provides ideological support for these systems.

In order to deconstruct this process, we must challenge the view of personhood as bounded and distinct from others, the creation of the authentic subject, for behind this delusion of authenticity lies a masculine, white, heteronormative subject that conceals alternative constructions of personhood. Instead of treating symptoms of psychic distress as though they are individual failings or maladies, I suggest that we challenge the knowledge systems that function to obscure and deny personhood. We do this by acknowledging that our self is constructed in relation to others, resisting the attraction of binary thinking and the creation of universal truths, and by creating space for the alternative modes of understanding. In order to avoid the epistemic violence of the mad label we must look into the borderland, the “vague and undetermined place created by the emotional residue of an unnatural boundary” (Anzaldua, 2007, p.3).

The knowledge for withstanding and challenging the violence that is intrinsic to heteronormativity, patriarchy, white supremacy systems resides in those subjectivities that are denied space, “the squint eye, the perverse, the queer, the troublesome, the mongrel, the mulato, the half-breed, the half dead; in short those who cross over, pass over, or go through the confines of the ‘normal’” (Anzaldua, 2007, p.3). By delving into the multiplicity of selves that reside within each of us and exploring those tensions, we can challenge the violence imbued in our systems of governance. Within the borderland, we have the opportunity to shape the systems that enable and constrain personhood. By undermining the unification of the self and knowledge stabilizing practices and looking to contradictions, tensions, and uncertainties we are able to create space. This project does not aim to solve a riddle, as Freud had set out to, but to allow for new imaginative ways of thinking and being, outside of heteronormativity, patriarchy and white supremacy, thus enabling the formation of new subjectivities and recognize the potential for the humanity of these alternative ways of being.

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