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Women's Narratives of Their Experiences with the Diagnosis of Borderline Personality Disorder (BPD)

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WOMEN'S NARRATIVES OF THEIR EXPERIENCES WITH THE DIAGNOSIS OF
BORDERLINE PERSONALITY DISORDER (BPD)

by

JENNIE LAMBERT

Under the Direction of Dr. Susan Talburt, PhD

ABSTRACT

Seventy-five percent of people diagnosed with borderline personality disorder are women; however, these women have only infrequently represented how they experience BPD. I interviewed three women with BPD and their narratives were transformed into vignettes using techniques from ethnographic fiction and affect theory. Salient themes from the vignettes were embodiment, trauma, and internal turmoil. This thesis represents how my participants experience BPD and demonstrates that their trauma needs more attention.

INDEX WORDS: Borderline personality disorder, Gender bias, Medical discrimination, Affect theory, Ethnographic fiction, Feminism

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A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

Master of Arts

in the College of Arts and Sciences

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2018

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DEDICATION

I would like to thank my partner, Danny, for supporting me in getting my Master of Arts degree and encouraging me when my thesis work was difficult.

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LIST OF ABBREVIATIONS

BPD: Borderline Personality Disorder

DBT: Dialectical Behavioral Therapy

DSM: Diagnostic Statistical Manual of Mental Disorders

DSM-III: Diagnostic Statistical Manual of Mental Disorders, third version

DSM-V: Diagnostic Statistical Manual of Mental Disorders, fifth version

APA: American Psychiatric Association

PTSD: Post-Traumatic Stress Disorder

INTRODUCTION

Janet Wirth-Cauchon's book, *Women and Borderline Personality Disorder: Symptoms and Stories*, details the narrative of Ms. V is detailed. Ms. V is introduced to us through the perspective of her psychiatrist Martin Stein, who wrote about his therapeutic encounters with Ms. V in 1989. Wirth-Cauchon critiques Stein because he frequently victim-blames and believes Ms. V is a "dark daughter," who is primitive, anti-social, aggressive, perverse and wears makeup to mask her inner sense of emptiness (2001, p. 122-123, 126). Stein believed that Ms. V used makeup as a metaphorical mask because she applied makeup when she felt alone and confessed that she rarely washed her face. Stein concluded that makeup "helps her avoid possible loss of identity, depersonalization, or even transient psychosis" (p. 125-126). However, Ms. V made a direct connection between her makeup ritual to gender relations and how she performed heterosexualized femininity to attract men because otherwise she felt invisible (p. 126). Stein did not listen to Ms. V and deduced that she was self-destructive by inviting men to treat her in a sadistic and abusive manner because all she craved was sex (p. 124). After two years of therapy together, Ms. V terminated her therapy with Stein. His first conclusion was that Ms. V must have been sexually abused, instead of being attentive to Ms. V's request to see a female therapist (p. 124, 127).

I discuss Ms. V's story because it highlights issues of how women are treated by psychiatrists and therapists as there has been a long history of mistrust between women and their clinicians. In this thesis, I argue for a critical examination of the diagnosis of borderline personality disorder (BPD) through the lens of the narratives of women with BPD. I claim that we have something to learn from women with BPD about their knowledge of their mental illness,

emotions, and attachments. My thesis recontextualizes and repoliticizes my participants' experiences of their BPD diagnosis.

I chose to interview women to investigate if their clinicians have harmed them by adopting sexist bias, invalidating their trauma, stereotyping, or refusing to treat. Feminist scholars and some psychologists agree that there is a *gender bias* in the diagnosis of BPD because 75% of individuals diagnosed are women (Howard, 2015, p. 68). Clare Shaw, an expert in self-harm, and Gillian Proctor, a clinical psychologist, think that labeling women with BPD instead of recognizing their trauma decontextualizes and depoliticizes the experiences of women and instead pathologizes them (2005, p. 487-488). Nadine Nehls, an academic in the field of population health sciences, explored the stereotypes related to BPD and claims that angry and promiscuous females are more likely to receive the diagnosis of BPD (1998, p. 98).

Some clinicians refuse to treat women post-BPD diagnosis because of stereotyping and negative assumptions. The voices of women with a BPD diagnosis have not been included in much literature because the embodied knowledge, experiences, and emotional make-up of these individuals are often presented as subordinate to the greater interpreting scientific knowledge of the "expert." I want to take the narratives of these women, utilizing affect theory and ethnographic fiction, to provide awareness of these issues surrounding BPD.

BPD was adopted by the *Diagnostic Statistic Manual of Mental Disorders III* in 1980. The diagnosis of borderline affected women long before its inclusion in the DSM, as it was used as a placeholder for women who "bordered" schizophrenia and neurosis. Currently, the American Psychological Association (APA) uses the DSM-V to define BPD. The DSM-V characterizes BPD by impairments in identity, self-direction, empathy, intimacy, emotional liability, anxiousness, separation insecurity, depressivity, impulsivity, risk-taking and hostility

(2012). These criteria must be consistent over time, not understood in relation to a patient's developmental stage or environment, and not linked to drug abuse or a medical condition (APA, 2012). The DSM stipulates that BPD is not connected to the socio-cultural environment, which is why many feminists argue that BPD decontextualizes women's lives. The DSM says, "The impairments in personality functioning and the individual's personality trait expression are not better understood as normative for the individual's developmental stage or socio-cultural environment" (APA, 2015). Many women have experienced gender-related trauma, which I define as a trauma occurring based on a women's social, environmental, political, historical, or economical position within society. For example, domestic violence cases generally affect women more so than men because of women's assumed gender-role in a household. While trauma is not a part of the criteria for BPD, it might be recognized; however, the fact that the trauma is gendered is usually overlooked and so women's lives are not contextualized appropriately (APA, 2012; Shaw, 2005, p. 487).

In addition to the neglect of gender-related trauma, the DSM's construction of BPD is also harmful to women because of its *criterion sex bias*, which is when the criteria for a disorder are selected in ways in which the disorder is seen as either male or female (Becker, 1997, p. 44). According to the DSM-V, BPD individuals must have issues with *interpersonal functioning*, with either *empathy*, meaning they cannot recognize the feelings and needs of others, and/or *intimacy*, having intense, unstable relationships alternating between idealization and devaluation. It is problematic for the DSM to focus on empathy and intimacy because in American culture women are expected to be more empathetic and cultivate more intimate relationships than men (Klein, 2001; Strauss, 2004). For example, if a man does not have many friends, know how to interact with his coworkers, or have long-term intimate relationship/s, he is

just thought of “a man being a man” or an idealized life-long bachelor. However, when a woman does not have many friends and has several short-lived intimate partners, she is believed to be dysfunctional. When the DSM fixates on issues of empathy and intimacy, it targets more traits seen as feminine to be pathologized.

The DSM also constructs the BPD individual as displaying pathological personality traits of *negative affectivity*, the most problematic being *separation insecurity*, similar to fear of rejection (APA, 2012). It is worrisome that the DSM concentrates on *separation insecurity*, which it defines as excessive dependency and a lack of autonomy (APA, 2012). Historically, in American culture, women have been put into positions of dependency with their partners and families by not having individual rights and not having the means of financially supporting themselves. In the past several decades, more women are entering the workforce and being more independent (DeLauro, 2010). This transition from being dependent to independent is a struggle for many women particularly because their female gender-role implies submissiveness, reliance on men, and fear of rejection. The DSM is again targeting more women to be diagnosed with BPD by focusing on separation insecurity.

In my literature review, I explore how women with BPD can be erased, misunderstood, and harmed by the disciplines of psychiatry and psychology. I discuss the critiques of psychiatry from feminist standpoints and disability studies that argue that psychiatry’s methods of engaging with BPD women are detrimental. I also explore the methods and ideals of ethnographic fiction as a tool to evaluate my interviews. I argue that these vignettes recontextualize and repoliticizes the BPD diagnosis.

1.1 Literature Review

1.1.1 BPD Women's Erasure

Merri Lisa Johnson, a queer borderline woman and an academic in women's and gender studies, uses her memoir, *Girl in Need of a Tourniquet: Memoir of a Borderline Personality*, as a method to situate herself as a maker of knowledge about BPD (2010). Johnson's memoir is in direct opposition to research being done about individuals with BPD because Johnson has the power to present herself as she chooses. Johnson complicates the typical understanding of a memoir by developing her own creative academic memoir that uses vignettes, quotes, poems, and performative text to blur the lines of what academics should reveal. Johnson's memoir is "academic" because she has higher education and access to archives and knowledges, which the typical person does not, and she uses her academic training to build a strong argument against the medical model that claims it knows women with BPD more than they know themselves. Johnson uses her authority to tell her story of how her disorganized romantic attachment patterns led her to feel rage, fear, depression, pain, and chaos (p. 35).

In her memoir, Johnson discusses her interaction with psychologists, therapists, and clinicians. Johnson discusses her self-harm, which is a prevalent "symptom" of BPD, by stating, "Psychologists call it perseveration. I call it emotional self-cutting" (p. 110).

Perseveration is a clinical term used by psychiatrists to talk about repetitive, pathological behaviors in their clients. Johnson claims that her self-harm is indeed not pathological, but an emotional experience that she engages with to deal with her trauma. Simply put, Johnson self-harms as a coping mechanism. Johnson's clinicians tried to remove Johnson's self-harm as a way of erasing her coping options, to convince her to comply with their prescribed treatment. Johnson uses her memoir as a way to push back against this form of erasure as she continues to explain

how she cuts to ease her tension, as it can be a biochemical relief. Justin Healey, who edited *Self Harm and Young People*, claims that self-harm is a behavior and not a mental illness, but BPD is the only mental illness in which self-harm is a diagnostic feature (2012, p. 57). Healey defines self-harm as a “behavior that is used to cope with difficult or painful feelings” (p. 58). Healey also mentions that usually more women self-harm compared to men and around 50% of self-harmers have been abused (p. 57). Healey’s work aligns with Johnson’s knowledge and contrasts with that of some clinicians who still believe that self-harm is connected to suicidality. While Johnson claims self-cutting as a coping mechanism, her actions are not innocent, but can be quite dangerous. It is important for clinicians to not conflate suicidality with self-harm, but a clinician’s focus on either seems medically ethical, as both acts can be deadly.

Johnson had the academic privilege to write a memoir to prevent herself from being erased, but most women with BPD do not have this luxury. I already mentioned that 75% of individuals diagnosed with BPD are women, and this statistic should be investigated as I think it contributes to BPD women’s erasure through stereotyping and refusal to treat. Dana Becker, a psychotherapist and professor of social work, created the only study that investigated the gender bias in BPD. In 1994, Becker gave over a thousand clinicians a case study of a patient who exhibited BPD and PTSD (post-traumatic stress disorder) behaviors in equal amounts, and the only difference in the case studies were the pronouns, he or she. Becker found that the female pronouns elicited more clinicians to diagnose the client as BPD (p. 46). Becker’s study highlights the female gender bias that occurs in the diagnosing process and also points out how men are more often given the diagnosis of PTSD. Johnson did not list the percentage of male-pronoun case studies that elicited a PTSD diagnosis, but she did explain that PTSD was adopted by the DSM-III in 1980 as a response to the Vietnam War (p. 72). The premise of PTSD is to aid a

client in healing from a traumatic experience or chronic trauma, such as combat memories (National Institute of Mental Health, 2016). It could be said that PTSD and BPD are quite similar, with the differences being that PTSD attends to trauma and is treatable while BPD attends to pathologized behaviors and is considered a life-long disorder. Becker's study suggests that women's trauma is not recognized as much as men's trauma, but men's trauma is more attended to when they receive the PTSD diagnosis.

Not only can the trauma of women with BPD neglected, but the type of treatment they want can be dismissed as well. Some clinicians refuse to treat women with BPD mainly because of stigmatization and stereotypes. Nadine Nehls explored the stereotypes, stigma, and care systems related to BPD (1998). She claimed that angry and promiscuous females are more likely to receive the diagnosis of BPD (p. 98). This stigmatization connects to *criterion sex bias* (see page 3) because the DSM-V codes the stereotype of "angry" as the symptom *hostility*, which the DSM defines as persistent angry and irritable feelings. The DSM also codes the stereotype of "promiscuous" as *impulsivity*, acting on the spur of the moment, and *risk-taking*, engaging in dangerous activities, which includes sexual behavior (APA, 2012). These stereotypes progress from angry, promiscuous women to women who are *not sick, manipulative, more difficult, noncompliant, and hateful* (p. 101). Lastly Nehls states that around one-third of women with BPD are labeled "system misfits" and "treatment resistant," due to the intense circumstances surrounding women with BPD, such as their trauma, suicidality, and nonresponsiveness to medication (p. 102). When clinicians think women with BPD are treatment-resistant, more difficult to treat, and manipulative, this belief can prevent BPD women from receiving the care they need or want. Most women with BPD want to be treated, as long as they get to give input.

The refusal to treat is also connected to clinicians prioritizing their own feelings over the feelings and experiences of their clients. Bodner et al., professionals in the fields of social science, music, mental health, and social work, sent out surveys about attitudes towards suicide, BPD clients and fear of death to two hundred psychiatrists (2015, p. 963-964). They discovered that psychiatrists' *fear of professional impotence* as well as their *fear of feeling negative emotions* could contribute to unstable relationships with their clients (p. 963). Bodner et al. define *professional impotence* as clients not complying with their psychiatrist's prescribed treatment as well as clients' attempted and completed suicides (p. 963). The negative emotions clinicians feel are anger, indifference, impatience, embarrassment, helplessness, emotional exhaustion and parental emotions (Bodner, 2011, p. 551). Psychologists' refusal to feel negative emotions and process those feelings leads them to become overwhelmed by their BPD clients. This overwhelming experience throws psychologists off track because they do not know how to handle the hostility in their therapy sessions, clients dropping out of therapy, or clients committing/attempting suicide (2015, p. 965). When clinicians refuse to treat borderline women because they do not want to address their own feelings and experiences, BPD women's feelings are disregarded, and the clinician's feelings are prioritized.

1.1.2 Feminist Critiques of Psychiatry

Now that we see that BPD women's experiences, coping strategies, trauma and feelings are often invalidated and misinterpreted by psychiatrists, I will discuss how feminist criticisms detail the repercussions of gender roles, gender and sampling bias, and cultural influences on mental illness. Phyllis Chesler, a psychotherapist and professor of psychology and women's studies, argues that women have fewer acceptable behaviors compared to men because they are more confined to their *gender role*; thus, non-conforming women are seen as "annoying,

inconvenient, stubborn, childish, and tyrannical” (1997, p. 78). Chesler explains that this phenomenon stems from childhood: boys tend to have aggressive, destructive, and competitive behavioral problems, while girls have personality problems such as shyness, timidity, and inferiority. Chesler reveals that women are seen as “sick” if they act outside of or reject the female role (p. 148-149).

For example, many BPD women self-harm and have suicidal ideations and attempts. Chesler points out that males are more successful in completing suicide while women have higher rates of attempts (p. 86). Chesler states, “female suicide attempts constitute an essential act of resignation and helplessness” because females are conditioned to experience physicality at “male hands” rather than their own or female hands (p. 87). Not only is Chesler explaining that some BPD women self-harm or attempt suicide as a means of feeling in control, but she is also providing evidence that BPD women’s self-harm is tied up in gender roles. It is rarely discussed that men have more access to lethal means of suicide such as firearms, whereas women do not, and men’s access to more lethal weapons contributes to their success rate of suicide. In 2016 in the United States, over nineteen thousand men committed suicide by firearms compared to three thousand women (CDC, 2017). My point is that when men commit or attempt suicide, they are not pathologized, whereas when women self-harm because they lack access to lethal weapons, they are pathologized.

Clare Shaw, an expert in self-harm, and Gillian Proctor, a clinical psychologist, draw on Chesler as they conclude that BPD is a *double-bind diagnosis*: “Chesler coined the term ‘double-bind’ to describe the processes by which women can be pathologized both for conforming to, and for failing to conform to, expectations of feminine passivity” (2005, p. 485). Shaw and Proctor argue that BPD is a double-bind diagnosis because it is given to women who

do not conform to their female gender role by being aggressive and independent as well as women who strictly conform to their female gender role by internalizing their feelings (p. 485). To illustrate, a woman who is not committed to one man, lives on her own, makes her own income, intimidates men and women alike at her job because she has a commanding presence, expresses her irritation and anger regularly and has fleeting friendships, would be more vulnerable to being diagnosed with BPD. On the flip side, a woman who is a devoted housewife, lives to please her family, financially relies on her husband, has a passive personality, never truly expresses her feelings and struggles with self mutilation would be more susceptible to being diagnosed with BPD.

However, Shaw and Proctor go a step further by saying that instead of recognizing their trauma, labeling women with BPD decontextualizes and depoliticizes the experiences of women and instead pathologizes them (2005, p. 487-488). Today women with BPD are silenced and disempowered by psychiatrists who deem BPD women's feelings as inappropriate compared to the "norm." Shaw and Proctor argue that the abuse and harassment within our "normal" culture are concealed by labeling survivors with BPD (p. 488). They explain this argument by stating that the diagnosis of BPD "pathologizes women for their responses to oppression, because of its fundamental failure to locate and understand distress within its social context" (p. 483). They use the feminist concepts of *social constructionism*, looking at how BPD was developed and how it is utilized as a diagnosis, and *social causation*, looking at how women cope in the world with less access to resources and more vulnerability to violence. They demonstrate that the diagnosis of BPD has been socially constructed as the newest way to "explain away the strategies which some women use to survive and resist oppression and abuse" (p. 484). They explain the psychiatric preoccupation with rationality: women are on the side of

irrationality, silence, nature, and their body, while men are on the side of reason, discourse, culture, and mind (p. 485).

Jacqueline Simon Gunn, a clinical psychologist who specializes in trauma, and Brent Potter, a licensed psychotherapist, also argue that the diagnosis of BPD is “untreated trauma” (2015, p. 112). Gunn and Potter do not define “untreated trauma,” but explain that trauma should be treated, which to them means “to manage, handle, deal with, conduct oneself towards [it]” (p. 112). They claim that psychiatrists are concerned with reducing symptoms and curing BPD instead of focusing on helping their clients live an enjoyable and fulfilling life. Gunn and Potter seem to speak in broad strokes, but essentially they are asking psychiatrists to stop treating women with BPD like an equation that needs to be solved and to “discontinue demonizing what they have not taken the time to understand” (p. 112). Gunn and Potter are placing the work on psychiatrists, not BPD women, because they argue that the DSM criteria for BPD diminish the human struggle to a list of symptoms (p. 112). Women’s suffering can be alleviated when psychiatrists and therapists respect the humanity of these women, open up conversations about trauma, and focus on the day-to-day.

1.1.3 Disability Studies’ Critiques of Psychiatry

The feminist critique of psychiatry illuminates how gender roles and unrecognized trauma lead more women to be diagnosed with BPD. Disability studies add to this critique of psychiatry by highlighting that some people may want to claim their mental illness as a disability and get treatment. Historically, disability studies flourished in the 1980’s and 1990’s with the founding of the Society for Disability Studies and the creation of the journal *Disability Studies Quarterly*, which is invested in examining disability as a social construct (Conner, 2005). The meanings of “disability,” “impairment,” and “disabled” have been the main controversy within

the discipline of disability studies (Kafer, 2013, p. 10). One branch of disability studies wants to move away from the medical (individual) model of disability to a collective identification of disability (p. 13). Disability studies wonders what type of *impairments*, cognitive, psychiatric, sensory, physical, should determine who is *disabled* and question whether the *disabled* have to have a definable *disability* or diagnosis (Kafer, p. 11). Recently, there has been a shift to understanding *disability* as a “collective affinity” instead of a fixed definition. “Collective affinity” asserts that disability is not linked to a diagnosis, but a collective “we” of folks who are labeled “disabled” by experts and discriminated against as a result (p. 11). “Collective affinities in terms of disability could encompass everyone from people with learning disabilities to those with chronic illness, from people with mobility impairments to those with HIV/AIDS, from people with sensory impairments to those with mental illness” (p. 11).

With the understanding of collective affinity, disability studies provides a disability politics that offers disabled folks an opportunity to claim their mental illness as a disability. I use the terminology “mental illness” because saying “suffering” does not encompass the variety of experiences the way “mental illness” does. Mental illness is tied to the terminology of diagnosis, and, as I said earlier, diagnoses can be enabling to the client by explaining their differentiated experiences. For example, Katie Aubrecht, a researcher in sociology and social justice who analyzes mental illness through disability studies, says, “My being named mentally ill led me to view myself as a problem, my histories and experiences as deficient, defective, and the products of an unfortunate chain of events, and my perceptions as delusional. My being named this way also brought me to disability studies, which has in turn brought me to a more critical awareness of myself as an embodied being, and has helped me to realize that my experiences, histories and perceptions are both valid and valuable” (2014, p. 1). Aubrecht

demonstrates how her psychiatric diagnosis was problematic for her because her symptoms became individualized, and she internalized her mental illness, whereas disability studies offered her a way to view her mental illness as a way to understand herself. Aubrecht backs her assertion that disability studies offer value to the disabled by explaining how disability studies view disability “not as a problem, but a social and political project” (p. 2).

One way disability studies assembles disability as a political project is by reclaiming the self and community, where psychiatry locates disability in the individual and wants the individual to be the site of intervention (Aubrecht, 2014, p. 5). For example, Rod Michalko, a professor of sociology, recounts his experience of realizing at the age of nine that he was blind. Michalko says, “This is a story of something gone wrong and a story of how wrongness is given life through the recognition that a life must be lived within the paradoxical awareness of the necessity and desire for life itself” (1998, p. 37). Michalko’s story reclaims his life as valuable and offers him new possibilities of resistance and rebellion against medical models that want to maintain that Michalko’s blindness is a “problem.” Disability studies run up against psychiatry because psychiatry “objectifies disability as a negative value and locates it in the individual” (p. 3).

Disability studies pushes against psychiatry as a site for reclamation and is also in opposition to the *individualism* psychiatry promotes. In Bradley Lewis’s article, “A Mad Fight: Psychiatry and Disability Activism,” he defines individualism as someone’s disability being viewed as a personal failure, pathological, and problem-oriented (Davis, 2012, p. 340). Disability studies aims to characterize mental illness as a neoliberalization of the psychological condition that is located in families, communities, and society instead of blaming and punishing disabled folks (p. 340). By situating mental disability as a structural problem, disability studies creates an

epistemological critique of psychiatry where “survivors” and “ex-patients” organized their own space (p. 344). Survivors and ex-patients engaged in alternative, creative, and artistic practices to deal with their emotional suffering instead of psychiatric treatments of “forced or manipulated hospitalizations, restraints, seclusions, and medications” (p. 342, 339).

Last, disability studies opposes psychiatry’s approach to treatment where the former wants consumers to be a part of their own treatment, and the latter wants to exclude consumers from their treatment plan. Treatment, for clinicians, includes step-by-step, evidence-based techniques, such as dialectical behavioral therapy (DBT) for women with BPD. Treatment, for consumers, might focus on healing from trauma, spiritual wellbeing, or identity exploration; treatment, in this regard, might not have “tangible” results. Many consumers, who pay for therapy, have the common experience of being treated with “disrespect, disregard, and discrimination at the hands of psychiatry” and have suffered from needless confinement, verbal and physical abuse, and complete exclusion from their own treatment plan (Davis, 2012, p. 341). Disability studies have fought for no forced treatments or denial of treatment in the mental health sector (p. 348). Disability studies promotes empowerment and choice so disabled folks, such as women with BPD, can choose their own doctors, medications, and locations of care (p. 348).

1.1.4 Ethnographic Fiction

Disability studies provides women with BPD a way to claim their mental illness as a way to get better treatment, but ethnographic fiction takes this advocacy further by using people’s narratives as a tool to bring a broader awareness and understanding. Matt Jacobson and Soren Larsen, geographers, argue that *ethnographic fiction* is a form of writing that “aims to evoke cultural experience and sense of place using literary techniques to craft conventional ethnographic materials - interviews, participant observation, field notes, photography - into a

compelling story” (2014, p. 179). They refer to Norman Denzin’s term “evocative epistemology,” where readers can “imaginatively feel their way into the experiences that are described by the author” (p. 184). Kirin Narayan, an anthropologist, states that ethnographic fiction began in 1890 when anthropologists, such as Adolph Bandelier, Elsie Clews Parson, Franz Boas, and Zora Neale Hurston, began to write fiction based on their fieldwork (1999, p. 136). Narayan discusses how ethnography opens with a clear, structured argument, whereas fiction withholds arch plots to intentionally create suspense (p. 139). Ethnographic fiction generally poses ideological questions that are answered throughout the text (p. 139). Narayan argues that the border between ethnography and fiction is not fixed, but rather shifting, and crossing borders between the two can enrich each writing style (p. 143).

Considering the fluctuating border of ethnographic fiction, Narayan discusses four “orienting landmarks” to help authors navigate this border: disclosure of process, generalization, subjectivity, and accountability (p. 139-143). Narayan asserts that the author should be upfront about their argument, stray from using universal statements, pull from the participants’ personal experiences, and be committed to the participants who appear in the narrative (p. 139-143). Jacobson and Larsen apply Narayan’s work to negotiate the intersection of fiction and nonfiction by employing four literary elements that help authors transform their field notes into ethnographic fiction: characterization, verisimilitude, kinesis and scene-setting (2014, p. 185-187). *Characterization* advances the story by showcasing the engagement between characters such as creating dialogue that reveals qualities about the character. This can include interjections, hesitations, everyday talk, imperfect grammar and colloquial phrases (p. 185). *Verisimilitude*, or believability, places the reader in the narrative where the reader can think within the story instead of think about the story. Verisimilitude utilizes imagery, sound, smell, touch, and physical and

emotional movement to produce a flow of the story as natural and real (p. 186). *Kinesis* refers to how meaning is conveyed through the narrative and how the reader is touched by the story. *Kinesis* uses transformation and mystery to help propel the narrative with plot arcs and ambiguities (p. 186). Last, *scene-setting* conveys the historical, political and environmental world without cluttering the presentation. The creation of a scene should not simply be the backdrop to the plot, but a perspective that includes tone, mood, and motivation (p. 187).

Ethnographic fiction's use of evocative writing is different from the standard academic ethnography because ethnographic fiction's goal is to produce an experience for the reader instead of documenting facts. Cameron Awkward-Rich, a writer, poet, and academic, argues that Charlotte Perkins Gillman, the author of *The Yellow Wallpaper*, should be an interlocutor of the genealogy of social theory (2016, p. 332). Awkward-Rich states that the turn-of-the-century social theory is traced back to Lewis Henry Morgan, Karl Marx, Emile Durkheim, Max Weber, and Michel Foucault, while no one seems to know how to engage with Gilman's production of social theory (p. 332). Awkward-Rich demonstrates how Gilman's utopian fiction makes the reader question their cultural assumptions of male domination and normative female gender roles (p. 331, 333, 339). Morgan, Marx, Durkheim, Weber, and Foucault hold a privileged position within feminist social theory because they draw from the respected and established disciplines of anthropology, economics, sociology, and philosophy, while Gilman utilizes science fiction. Awkward-Rich envisions that ethnographic fiction can be a useful method of interacting with feminist theory and should be recognized as such.

The debate about "truth" has been brought up when readers are unable to tease out which part of the plot line derived from field notes or research. Glenn Allen Phillips uses ethnographic history and fiction to let documented facts and imagined truths coexist in his poetry

about Barbara Rose Johns, a civil rights activist (2013, p. 451). Phillips states, “in all instances the voice(s) is/are a delicate braiding of truth, my understanding of truth, and my created biographical fiction” (p. 457). Phillips draws on Norman Denzin, a sociologist, to complicate the notion of “truth.” Denzin thinks the goal of an author should be to balance verisimilitude with the original text while resolving tension between readers’ assumptions and the author’s story (p. 457). Phillips so eloquently explains, “A real danger of traditional texts is that they are too often read as infallible truth. The *truth* is that all authors fall short of truth as truth is a constructed and subjective entity” (p. 458). To Phillips, the goal of ethnographic fiction is not to argue for “truth” or “prove” something, but rather to resonate and engage with his audience.

An example of the power of fictionalized accounts of “truth” can be seen in Gilman’s *The Yellow Wallpaper*, a first-person short-story narrative of a woman’s descent into madness (1980). This woman, who is unnamed, is diagnosed with nervous depression as well as hysteria and a doctor recommends that she rest and not work at all. She and her husband, John, move to a mansion for the summer so this woman can get some “fresh air and relax.” They rent a nursery room, in a mansion, that is covered with an ugly yellow wallpaper. With no other stimulus besides the wallpaper, this woman starts to see things in the wallpaper that irritate her and drive her mad. In order to free herself and the other women trapped in the wallpaper, she begins to rip it off the walls. The main character is left nameless so that any woman can imagine herself in this position, while the husband, John, is named, hinting that he is the character who has power. This fictional short story evokes readers to question female gender roles, psychiatric power, and women’s mental illness. Gilman stated that this piece stemmed from her own experiences as a patient. While the plot didn’t actually occur, for her it was a way to explore women’s roles and push back against her doctor.

In my literature review, I have argued that the diagnosis of BPD can be harmful to women's claims to their experiences, coping strategies, trauma, disability, and feelings. Women with BPD have internal suffering that is not addressed adequately by the prescribed treatment of psychiatrists. Feminist critiques of psychiatry place fault in the systematic oppression produced from gender roles, culture, and untreated trauma, but have offered few options of reparation. However, disability studies provide a way for women with BPD to claim their illness as a disability to take control of the treatment they receive. I will use ethnographic fiction as a tool to take women's stories and experiences to bring awareness and understanding.

1.2 Research Questions

I interviewed three women with BPD to address the following research questions:

1. How do women describe being diagnosed with BPD?
2. How do women describe the impact of the diagnosis of BPD?
3. How do women describe their relations to clinicians?
4. What affects and attachments do BPD women express?

I use ethnographic fiction to dramatize these women's narratives to evoke feelings in my audience as they grapple with the emotions, attachments, entanglements and movements surrounding BPD. I analyzed the interviews with the women through the lens of affect theory to understand how women with BPD are affected in their everyday lives through sensations, feelings and experiences.

1.3 Methodology

I epistemologically assume that women with BPD know a great deal about themselves and their clinicians can help them unlock this knowledge. Because women with BPD have important knowledge about BPD, I interviewed three women about their encounters with BPD.

As a research investigator, my role was to give women with BPD a platform to articulate their realities.

I am invested in this thesis because I personally struggle with a mental illness. I have experienced discrimination in my search for treatment and support. My internal turmoil attracted me to the discipline of psychology, but through years of studying this realm, I realized it often harmed the mentally ill, particularly women. I left psychology behind and centered women's, gender, and sexuality studies because it provided tools to examine power dynamics, discrimination, and gender bias. I decided to focus on BPD as it is a precarious diagnosis with little advocacy for women's narratives.

1.4 Methods

I interviewed three women-identified individuals who were professionally diagnosed with BPD who were over the age of eighteen and had a variety of demographics (i.e., age, sexual identity, race, ethnicity, nationality). I recruited my participants from a university Testing and Counseling Center and a mental health facility. I conducted all of my interviews on Skype so each woman could talk at her convenience. I spoke to my participants around two hours each in a semi-structured interview style. I opened the dialogue and debriefed each participant according to the IRB's guidelines. I asked each participant around fifteen questions about their diagnosis, clinicians, treatments, stigmatization and relationships (see Appendix A). Each participant was allowed to skip any question, but none of them did. In exchange for interviewing, I compensated each participant with a twenty-dollar gift card to Target.

1.4.1 Privacy and Informed Consent

To ensure each participant's privacy, they signed a consent form before the interview began. The consent form detailed that I would keep their identity concealed and that I would be recording the interview session.

1.4.2 Risks

I did put my participants at risk because discussing mental health struggles could become distressing. None of my participants seemed distressed during our interviews.

1.4.3 Evidence and Analysis

I turned these interviews into ethnographic fiction, specifically *affective vignettes*, which are short snippets that evoke emotions, such as disgust, anger, and sadness, while speaking to overarching issues with the diagnosis of BPD. I drew inspiration from Kathleen Stewart's work, *Ordinary Affects*, where she writes about Appalachian culture using affects to highlight the everyday and animate the ordinary (2007). Stewart opens her work by questioning monolithic terms that are widely used, but frequently misunderstood, such as *neoliberalism*. My vignettes unravel the monolithic terms of *diagnosis*, *treatment*, *mental illness*, and *emotions* by focusing on the messy assemblage of scenes they entail and not letting these terms obstruct everyday feelings. I write in dialogue, first-person and third-person omniscient voices that reflect the interviews.

I was also influenced by Claudia Rankine's work, *Citizen: An American Lyric*, where she writes poetry using affect to shine a light on acts of racist microaggressions (2014). Rankine's poetry evokes affects within the reader, particularly anger, as a tool to illuminate how people of color feel when they experience racial microaggressions. The goal of my vignettes is to

evoke feelings from my audience so they can become aware of the stigmatization, harm, erasure, and limited treatment options around BPD.

I used Eric Shouse's definition of *affect* as a "non-conscious experience of intensity; it is a moment of unformed and unstructured potential" to inform how I wrote my evocative vignettes and analyzed my interviews (2005, p. 2). Shouse defines *feelings* as "a sensation that has been checked against previous experiences and labeled" (p. 1). Then *emotions* are a social display of feelings, whose expressions can differ (p. 1). For example, the negative emotions psychiatrists experienced towards BPD clients manifested as anger, impatience, and helplessness (Bodner, 2011, p. 551). I want my affective vignettes to unlock the potential to impact my readers where they feel between the lines instead of merely grasping the content of my interviews.

When I created my vignettes, it helped to be able to listen to my interviews retrospectively because I too could feel between the lines. I used Jacobson's, Larsen's, and Narayan's guidelines of ethnographic fiction to write my vignettes. The interview "answers" that had the most detail were transformed into first-person vignettes. I used more direct quotes and infused more emotion into my first-person vignettes. I was able to employ *characterization* by using the first-person dialogue to reveal qualities about each participant. The answers that didn't have as much detail were reconstructed into third-person vignettes. The third-person vignettes reflected my personal voice as I understood parts of the interview. I filled in gaps of story lines as needed and embellished certain scenes to create intensity, but this was based on my own interpretation, knowledge and experiences. I tried to maintain *verisimilitude* in the third-person narratives to not stray from the integrity of each interview. The interview answers that heavily involved another person, such as a family member or a friend, were reassembled into dialogue-

style vignettes. My participants put voice to the other people they were talking about, sometimes by changing the pitch or tone of their voice, which made it easier to create dialogue. The dialogue-style vignettes didn't focus so much on scene-setting, but more on the interaction between each participant and someone they knew.

Each interview has its own chapter where several vignettes are written. Each vignettes switches scene and voice and can be disorienting for readers to experience. I choose to write this way because my interviews were quite chaotic, which is characteristic of BPD. I redefined the ideal of verisimilitude for some vignettes because I wanted to represent how my participants experienced certain events instead of coming across "believable." I let the interviews guide my vignettes and after the vignettes were written, I then could identify overarching themes. These salient themes are analyzed in my concluding chapter as I revisit my initial research questions.

2 Hannah's Story

“To me, BPD means that relationships scare me because I am afraid people will abandon me.” –
Hannah

Self-Image

Hannah introduces herself to people in a derogatory way. She might say, “Sorry I look like a really hot mess, I don’t even look hot, I just look a mess right now.” She is not comfortable in her skin and is self-conscious when meeting new people. To compensate for her insecurities around her appearance, she might comment to others about how she is not attractive. While Hannah may say these things to assuage her anxiety, many people respond with affirming messages like, “No, you look great!” The approving commentary gives Hannah positive attention, reinforcing her to self-deprecate. The cycle can become endless.

Hannah's Diagnosis

I have been diagnosed with anxiety and a host of other things. You know my Mother has bipolar disorder and for a long time, the psychiatrists thought I also had bipolar. I tried to tell them this didn’t fit me, but they didn’t listen. I saw my Mom’s manic episodes, and I knew I didn’t have those. The psychiatrists were getting mania confused with my intense anxiety. The psychiatrist at the time put me on a mood stabilizer, but the mood stabilizer made me feel like a zombie. I would fall asleep in class and meetings; I was exhausted. When I was in the hospital for cancer treatment, I had to meet with a psychologist. I guess it’s protocol, because, you know, cancer is a stressful thing to go through. I filled out all of these paper forms where I had to answer questions about myself. I didn’t mind because I was bored in the hospital. The psychologist came back with a sheet of paper that read “Borderline Personality Disorder.” I

didn't know what to think at first. I just listened to what she had to say. She went through the symptoms and it all seemed to click for me. Afterwards, I was feeling hopeful because I was already in a hospital setting and I thought I could get help.

Hannah's Reaction

I was relieved when I was diagnosed with BPD because I thought I could finally get help for my suicidal thoughts and angry outbursts. I was diagnosed with bipolar, anxiety, and depression, but none of them seemed to fit the way BPD did. I was hopeful, but at the same time, I kind of stigmatized myself. I had heard of borderline before in a college course and I knew what people thought about it. I thought to myself, "Great, people are going to think I'm looney tunes or something." I agree with the diagnosis because I will go from being completely happy and if something stressful happens, I will switch and feel overwhelmed to the point where I want to die.

The School-Friend Defend

Darrel and Hannah just got out of a class together and are walking down the hallway.

Darrel: "Hannah, why are you stressin'? That class wasn't that bad!"

Hannah: "Well, I'm just stressed about it, is all."

Darrel: "There's no need to be stressed. Try to relax; you are like the top of the class. Is something else going on?"

Hannah: "Yeah, I have borderline personality disorder..."

Darrel: "What?!? Does that mean you murdered someone?!?"

Hannah: "What? No! Of course not! It just means..."

Darrel interrupts Hannah.

Darrel: “Wait a second, does that mean you switch personalities?!?”

Hannah: “NOO! I don’t have multiple personality disorder, it is borderline personality disorder.”

Darrel: “I don’t get it...I heard on television that that means you switch from being normal to being all crazy and shit.”

Hannah: “No, that’s not right! I don’t turn into another person, it is just mood swings.”

Darrel: “Oh, okay, alright. Well I have to go this way to catch MARTA. I will see you next Thursday.”

Do You Really Care?

Jazmin: “Hey Hannah, how are you doing?”

-Hannah looks off and does not respond to Jazmin-

Jazmin: “Hannah, are you okay?”

-Hannah looks Jazmin dead in her eyes with a glaring expression-

Jazmin: “Hannah, what is going on?”

Hannah: “Don’t you know? Haven’t you seen my Facebook?”

Jazmin: “No... I haven’t been online today.”

Hannah: -sarcastically- “Why don’t you take a look?”

-Jazmin pulls out her smart phone to look at “acebook. She scrolls down the page to see

Hannah’s latest status, “I want to kill myself,” that has gotten over twenty concerning replies.-

Jazmin: “Oh... Hannah.... I thought you were past this.”

Hannah: “Keep up. I am not past this.”

Jazmin: “I don’t know what to say...”

Hannah: “What do you mean you don’t know what to say? God, what kind of friend are you?”

Jazmin: “You just caught me off guard is all....”

Hannah: “Well get it together!”

Jazmin: “I’m trying to. This is upsetting to me, you are my friend. I don’t know how to help you and it scares me to think you would want to do that.”

Hannah: “Do that? Oh, you mean kill myself? Are you too timid to even say it? God!”

Jazmin: “I am only human, death scares me, especially losing someone I care about.”

-Hannah glares at Jazmin again-

Jazmin: “What?”

Hannah: “Don’t lie to me.”

Jazmin: “What are you talking about?”

Hannah: “You don’t care about me. I just make you uncomfortable. You don’t want to deal with my suicidal thoughts. It’s always the same. Everyone is the same.”

Jazmin: “Hannah I do care about you and want to help. How can you even say that I don’t care? That is so insulting. I am speechless because I am terrified.”

Hannah: “I know you hate me! Don’t pretend like you care about me! You just feel guilty because I want to kill myself. Don’t lie to me!”

Jazmin: “Hannah, I’m not lying, I don’t want you to kill yourself. Listen to me!”

Hannah: “You don’t give a shit about me and won’t even miss me when I’m gone.”

The Phone Call

It was the week before Thanksgiving. Hannah was asleep in bed when her cell phone rang. She rolled over to see it was just past midnight. She didn’t think, she was too tired, so she just

answered the phone with a sleepy “hello?” It was bad news... her Dad had died unexpectedly. Her stepmother had found him dead. Hannah hung up the phone and started pacing around the bedroom. Her mind was racing. “Dad was supposed to come to my university tomorrow. I just spoke to him the other day. We planned everything out. We are going to get that award. He promised he would make it. Why is this happening? He was supposed to come down. He wasn’t sick at all. He is my Dad. He was my Dad. No! He is still my Dad. He wasn’t supposed to die! He was supposed to come see me. I have to call my Mom. Maybe she doesn’t know. I can’t remember if they called her. Why would she care if he’s dead, they aren’t together anymore. I should call someone. It is so late, the university won’t be open until 8am. What will happen at the award ceremony? He was supposed to come... He was supposed to come see me.”

Mother

I attempted suicide a while back, you know the lows were bad. I was terribly depressed. Hannah says she is going to kill herself and I get worried. I worry that I passed that on to her, that I was a bad example to her, a bad mother. Growing up, I was concerned for Hannah. She displayed hints of somethin’ weird, like OCD, I don’t know what you call it. She was a happy kid, but would have periods where she would be anxious or somethin’. I thought she was just a mamma’s and daddy’s girl. She always liked to be around us, she hated having a babysitter, you know? That was hard, because I felt uneasy leaving her alone. I thought most kids went through something like that, but Hannah has yelled at me, saying I didn’t take her issues seriously. I did take them seriously. I did the best I could. Hannah said she had panic attacks as a child, and I just shrugged it off. I guess I thought if I put too much on those times it would make it worse. So, yeah, maybe I did play it down because I wanted her to get better, to be more independent.

The First Round of Therapists

Hannah started reaching out to therapists because she knew something was off. She felt like no one liked her or wanted to be her friend. She was sick of having to try so hard in relationships. She thought to herself, “I must be doing something wrong.” Also, she couldn’t control her moods. She wouldn’t describe them as swings, but she would get upset and have these impulsive outbursts. “Why do you always have to tell me what to do?!” “You don’t understand me! I’m leaving!” “This is all your fault! You keep messing up everything between us! What is wrong with you?!” She couldn’t maintain a friendship or a romantic relationship, even though that is what she truly desired. A therapist received Hannah’s message and made an appointment with her; they started a therapist-client relationship, but it didn’t last. Hannah’s therapist was frustrated with Hannah, as they hadn’t been making significant progress. Hannah’s therapist terminated their relationship saying, “Nothing is working, and as a therapist, I feel I have nothing left to offer you. It is probably best if you find another therapist.” Hannah was devastated, distraught and lonely. Not only could she not maintain social relationships, but her therapist didn’t even want her.

Dialectical Behavioral Therapy

When Hannah was undergoing cancer treatment in California, the psychologist put her in contact with a therapist near the hospital who treated clients with BPD. This therapist used DBT, or dialectical behavioral therapy, the prescribed treatment for patients with BPD. Hannah enjoyed DBT and thought it was helpful because it provided tangible strategies. She read and wrote in a DBT workbook that supplied her with tangible strategies to use in stressful situations.

Hannah thought DBT was more effective than “talking about things from her past.” Hannah grew irritated when every therapist wanted to talk about her trauma of losing her father. DBT taught Hannah “distress tolerance,” which trained Hannah to accept the emotion she was feeling, instead of reacting to that emotion. DBT also coached Hannah to learn to react with the “opposite action.” When Hannah was distressed by school, she would say, “Oh my God! I need to drop out! I can’t do this anymore, it is too hard!” Opposite action guided Hannah to do the opposite of dropping out and help her understand that the idea of dropping out is an impulse she doesn’t have to act on.

Back Home

Receptionist 1: “Hello, thank you for calling Resorative Therapy, how may I help you?”

Hannah: “Hi, my name is Hannah and I was recently diagnosed with BPD and I am looking for a new therapist.”

Receptionist 1: “Oh, I’m sorry honey, we don’t treat ya’ll here.”

Hannah: “What do you mean?”

Receptionist 1: “All I know dear is that none of the therapists at our location work with that disorder.”

Hannah: “But why? I looked at your website and you have fifteen therapists here. None of them are available to see me?”

Receptionist 1: “Like I said before, we can’t help you here. You will have to find another location.”

Hannah: “Do you know of another clinic I can call?”

Receptionist 1: “Unfortunately, I do not. I’m sorry hun, we can’t help you here. I have to get the other phone line.”

Hannah: “Alright.”

Receptionist 1: “Okay, goodbye!”

-phone hangs up-

Hannah: “Bye...”

Psychiatrist 1: “You have reached the confidential voicemail of Dr. Erin Smith. Please leave your name, phone number and a brief message and I will get back with you. If you are a current client, I will call you back within twenty-four hours. If you are inquiring about becoming a new patient, I will call you back in two to three business days. If this is a life-threatening emergency please call 911 or go to your nearest emergency room. Thank you for calling and have a nice day!” –beep-

Hannah: “Hi, my name is Hannah. My phone number is 658-226-7438. I am calling because I am interested in starting therapy with you. I was recently diagnosed with BPD. I saw your profile online and think we would be a good match together. Please call me back so we can set up an appointment!”

-several days later-

Psychiatrist 1: “Hello, I am calling for Hannah.”

Hannah: “Hi, this is she.”

Psychiatrist 1: “Hello Hannah, this is Dr. Erin Smith calling you back regarding your voice message about becoming a new client.”

Hannah: “Yes, thank you! I am so excited to speak to you, I think we would be a really good fit.”

Psychiatrist 1: "I'm sorry to inform you Hannah that I do not take on BPD cases. I mainly deal with mental disorders that are effectively treated with medication."

Hannah: "Oh, I thought that BPD could be treated with medication?"

Psychiatrist 1: "It can, I suppose, it just isn't as straightforward as other mental disorders. I'm sorry, I don't have much experience with BPD clients and couldn't ethically take you on as a new client."

Hannah: "Okay. Well can you recommend another psychiatrist who treats people with BPD?"

Psychiatrist 1: "I'm sorry, like I said, that isn't my specialty so I don't currently know of any psychiatrists accepting new BPD clients."

Hannah: "Alright."

Psychiatrist 1: "Okay, good luck!"

Hannah: "Thank you."

Psychiatrist 1: "Goodbye."

Hannah: "Bye."

Therapist 1: "Hello, this is Shamika White, may I ask who is calling?"

Hannah: "Hi, yes, my name is Hannah and I was looking to find a therapist."

Therapist 1: "Nice to meet you Hannah. Have you ever been in therapy?"

Hannah: "Uh, yes I have, when I was younger."

Therapist 1: "Okay. May I ask why you are seeking out therapy now?"

Hannah: "Yes, I was recently diagnosed with BPD and wanted to find a therapist to continue treatment with."

Therapist 1: “Hmm. Well Hannah, I personally don’t work with borderline patients because they generally are too clingy and needy. I have a heavy case load right now and don’t have the time to deal with such an involved case.”

Hannah: “Not to be rude, but you have never met me before, how do you know I will be clingy?”

Therapist 1: “I have been doing therapy for over ten years and in my experience that is generally how BPD patients respond once the therapist-client relationship begins. I’m sorry, but I don’t have the time right now to take you on as a new patient.”

Hannah: “So, do you know any other therapists who see people with BPD?”

Therapist 1: “Well, I don’t know anyone in particular who specializes in BPD, but Dr. Carl Wright has seen BPD patients before.

Hannah: “Okay, do you have his phone number?”

Therapist 1: “I don’t have it on hand, but you can search for him, he is in a nearby area.”

Hannah: “Alright.”

Therapist 1: “Okay, well it was a pleasure talking to you Hannah, I hope Dr. Wright can help.”

Hannah: “Yeah, me too.”

Therapist 1: “Have a nice rest of your day! Bye!”

Hannah: “Goodbye.”

Therapist 2: “Hello?”

Hannah: “Hi, I’m looking for Dr. Carl Wright?”

Therapist 2: “This is he.”

Hannah: “Hi, my name is Hannah. Dr. Shamika White referred me to you.”

Therapist 2: “Oh yes, Shamika! Why did she refer you to me?”

Hannah: “She said that you have counseled people with BPD before?”

Therapist 2: “Uh, yes I have, but only in mild cases. When were you diagnosed with BPD?”

Hannah: “Just recently at a hospital.”

Therapist 2: “Why were you in the hospital?”

Hannah: “Oh, for my cancer treatment.”

Therapist 2: “Oh, I’m sorry to hear that. Does your family have a history of any mental illnesses?”

Hannah: “Yes, my Mom has bipolar disorder and several family members have substance abuse issues.”

Therapist 2: “I see. It is very frequent for borderline patients to have some kind of addiction and that risk increases if it runs in the family. Maybe you should look into an addiction counselor?”

Hannah: “I don’t have an addiction, I just want to do behavioral therapy.”

Therapist 2: “Well Hannah, after speaking with you, I think your case is too severe for me. It is my professional opinion that you need higher-level care, maybe from an outpatient facility. I’m sorry but I cannot see you.”

Hannah: “I don’t need to go to outpatient treatment! I was in DBT training for a while and just need regular therapy now.”

Therapist 2: “I understand, but your case is too severe for me, I’m sorry.”

Hannah: “Okay, well do you know anyone else who I can call?”

Therapist 2: “I do not know anyone in this area who takes BPD patients, sorry.”

Hannah: “Alright.”

Therapist 2: “Okay, well I hope things work out. Bye bye now.”

Hannah: “Bye.”

Psychiatrist 2: “Alright Hannah, before we schedule you an appointment I need to run your insurance, otherwise you will have to pay out of pocket.”

Hannah: “How much is that?”

Psychiatrist 2: “For a thirty minute session, \$150, and for an hour session, \$250.”

Hannah: “Yeah, I can’t afford that. Um, hold on... Okay my insurance is with Humana. My group number is 12345678 and my I.D. number is 87654321.”

Psychiatrist 2: “Alright, thank you for that information. I am going to have to bill your session a little differently than normal, but that shouldn’t matter. So I will run your insurance and call you back once I hear from them.”

-Psychiatrist 2 never calls back.-

-Humana customer service agent calls Hannah instead.-

Humana Customer Service Agent: “Hello, this is Jane with Humana. May I speak to Hannah?”

Hannah: “Yes, this is she.”

Humana Customer Service Agent: “Hello Hannah, I am calling regarding your claim with Dr. Morris.”

Hannah: “Oh yeah, I haven’t heard from him in several days, but he said he was going to run my insurance before we scheduled an appointment.”

Humana Customer Service Agent: “Yes, that’s correct. I’m sorry to inform you that your claim has been denied. Your coverage does not cover the code 024.8.”

Hannah: “I don’t know what that means?”

Humana Customer Service Agent: "I'm sorry for the confusion. You can look up your policy benefits online by logging into your Humana account. You can also go online and find doctors within our network."

Hannah: "So you are saying Dr. Morris isn't in your network?"

Humana Customer Service Agent: "I am not sure if he is in network with your policy. You can look up your policy benefits online by logging into your Humana account and find doctors within our network."

Hannah: "You can't help me do that?"

Humana Customer Service Agent: "No, I'm in the claims department. You would have to call the benefits department to get that information. Would you like their phone number or for me to transfer you?"

Hannah: "Uh, no that's okay."

Humana Customer Service Agent: "Alright Hannah, is there anything else I can help you with today?"

Hannah: "No."

Humana Customer Service Agent: "Okay, great! I hope you have enjoyed your experience with Humana! Please stay on the line to fill out a short survey of this experience. Goodbye!"

Pre-recorded Voice: "Hello and thank you for calling Humana...."

-Hannah hangs up the phone-

Hannah: "Hello?"

Psychiatrist 3: "Is this Hannah?"

Hannah: "Yes it is."

Psychiatrist 3: “Hi Hannah, I am Dr. Gerard from the Center of Mental Health in Midtown. I know you called our office in regards to behavioral therapy, but you would be an excellent candidate for our experimental electroconvulsive therapy. Would you like to hear more about it?”

Hannah: “Um, no.”

Psychiatrist 3: “Oh, I’m sorry to hear that. May I ask why you are not interested?”

Hannah: “I just want to do regular therapy, not ECT.”

Psychiatrist 3: “I understand. Well if you change your mind, feel free to call me back at 629-123-4567.”

Hannah: “I won’t change my mind.”

Psychiatrist 3: “Just in case you do!”

Hannah: “Okay.”

Psychiatrist 3: “Well, it was a pleasure speaking with you today Hannah and I hope to hear from you soon. Have a nice day. B-bye.”

Thirty-six “No’s”

I have probably called about thirty-six doctors at this point, since my diagnosis, and been rejected by all of them. I mean, I was desperate to feel better once I got back home from California and called a Rolodex of doctors. The rejection makes me feel like a horrible person. I didn’t choose to have borderline, I’m not choosing to have it. I was born this way, it’s like there is something in my mind that needs help. Why won’t anyone help me? It’s like going to a family doctor with a stomach bug and they reject you because it’s a really bad stomach bug. Like no family doctor or emergency room would turn away a patient with a really bad stomach bug. And

psychiatrists help people with schizophrenia, a really terrible mental illness, but yet they won't help me? I just don't understand. This is why I can't trust anyone.

Dating

Josh is so amazing, I can't believe we have been together for over four months now. This is the longest I have been in a relationship, maybe it is a sign? I remember when I first met him, months ago. He was such a good friend, no wonder we started dating. A couple days ago we were kind of talking about engagement. I mean, I wouldn't seriously date anyone who I couldn't see myself marrying. Maybe he could be the one. I wonder if he thinks I am the one for him? I feel anchored by him. I just hope he doesn't leave me, that would kill me. I mean things have been going well and it helps that we knew each other before we started dating, but what if he doesn't think it's going well? What if he is leading me on? Was I the one who brought up engagement, or was it him? How did it all happen? I was so excited, I felt like I was in a whirlwind. Maybe I was the one who brought it up and he just went along with it? What if he thinks it is too soon? What if I scared him off?

Dating with Cancer

I got my cancer diagnosis today. All I can think about is Josh, not myself, but him. I'm afraid to tell him because what if he leaves me...?

I know Josh said he was going to support me through my cancer and treatment, but I don't believe him. He is only saying that now, but he is going to leave me when things get worse, I know it. He doesn't understand.

Josh: "Hey, I just wanted to call you and check up on you."

Hannah: "These steroids are making me gain weight. I know you don't think I'm pretty like this."

Josh: "You know I think you are beautiful. You need to stay on the steroids so you can start chemotherapy. It won't be like this forever. I am going to help you through this."

Hannah: "No, you're not! You say that now, but I know you are going to leave me. Once I get fat you will be repulsed by me and won't want to deal with a girlfriend who has cancer!"

Josh: "Slow down. None of that is true..."

Hannah: "Don't lie to me! I saw how you looked at me the other day. You noticed the weight I gained and you didn't like it! You probably are on the look-out for someone who is thinner than me!"

Josh: "Hannah, please, calm down. I care about you a lot. I know this is a stressful time for you, but I am glad we are dating. This is a curveball, but we can handle it."

Hannah: "I know you will cheat on me, if you already haven't! I am stuck in this hospital and you are probably off with another girl. How could you do that to me? I promise I will lose the weight, even if I don't have to eat! Please, just stay with me!"

Josh: "Hannah, you need to eat to stay healthy and beat this cancer. I am going to stay with you through this, you don't need to worry about that. You should focus on getting better."

Hannah: "Alright, well I'm tired."

Josh: "Okay, well you should rest. I will call you tomorrow, okay?"

Hannah: "'kay."

Josh: "Talk to you later, bye."

Hannah: "Bye."

I know Josh is cheating on me. He hates me, he is going to hate me forever. I'm not good enough for him, I'm not beautiful enough. He is with another girl who is thin, with a slim face and narrow nose, silky smooth hair. Someone who is more put together than me.

Hannah: "It will kill me when you leave me!"

Josh: "Hannah, I've told you before that I'm not leaving!"

Hannah: "I know you are cheating! I can't take it anymore! I'm going to kill myself before this gets any worse!"

Josh: "Hannah, no! Please! Please just listen. I care about you so much, please don't hurt yourself... I'm begging you."

Hannah: "Why do you even care if I'm dead, you're just going to leave me anyways?"

I knew Josh was going to leave me, just like everyone else.

Yoga

Hannah became a certified yoga instructor because the gym was her safe haven. Yoga has helped Hannah be mindful by concentrating on her body, the way she moves, and her breath. She has all these thoughts flooding her mind. She accepts them and lets them be. She lets the thoughts pass. She feels the ground, her body, the poses, the movement. She can now pay attention to the sensations the world has to offer her, like the calming scent of lavender. When Hannah does yoga, it is like nothing bad can happen and her worries melt away. Hannah's

anxiety decreases when she does yoga. She practices her breathing regularly to manage her anxiety and racing thoughts.

Art Therapy

When I get really anxious or really mad, I will take some old magazines I have around and rip them up and make collages. The ripping helps calm me, on top of smelling my essential oils. All my frustration can be let out by shredding apart these magazines, tearing someone's head off. Once I release the negative energy, I can create something insightful to hang on my wall.

Anxiety Mixed with Anger

Mom: "Hannah, I know you are upset, but you don't have to be angry at me this way. I know I was late showing up, but I am here now."

Hannah: "You don't understand how upset I am! I thought you weren't coming!"

Mom: "I tried to call you, but you didn't answer. Traffic was heavy and I was running fifteen minutes late. Everything is okay now."

Hannah: "Okay, fine, whatever. I'm still mad at you."

Mom: "Why? I apologized and I'm truly sorry."

Hannah: "I am all worked up about what happened! I can't just calm down that easily. I've told you before that when I get angry at you like this, it means that I care about you, more than anyone else. I mean, I worry that you will be gone one day, so when my anxiety flares up around you, that's why."

Mom: "I understand. I care about you too, but you don't have to lash out at me for being fifteen minutes late."

Death/Suicide

Sloan: "Hey Hannah, how are you doing?"

Hannah: "Yeah, I'm fine! What about you?"

Sloan: "Well... Actually I'm worried about you."

Hannah: "Huh? Why?"

Sloan: "I know that Peter died unexpectedly last week and I'm sure that upset you and I know you have struggled with suicidal thoughts and all, but please, please, just don't hurt yourself. I know you are hurting, but you don't have to take that path. You can get help. I can help you find someone on campus to talk to. I just... I don't know if I'm making sense, but I just want you to be okay."

Hannah: "I know how to grieve and I'm not some fragile person, Sloan. I plan on going to the funeral in a couple of days. I am going to be fine."

Sloan: "I worry that you are just saying what you think I want to hear. It's okay if you are feeling suicidal. You can trust me. If you don't want to talk to me about it, then please let me help you find someone who you feel more comfortable with. What about Josh?"

Hannah: "Josh and I haven't been together for a while now, I'm not going to bother him with this. Besides, I'm not telling you what you want to hear. I'm telling you the truth."

Sloan: "I'm not trying to call you out, but Mindy told me that you told her once that you were going to kill yourself. I just want you to be safe. We all do. You don't have to hide that part of yourself from us, we can handle it..."

Hannah: [under her breath] "I doubt it."

Sloan: "We just want what is best for you. If you need us to take notes for you, we totally can, you know, if you need to miss class to take care of yourself."

Hannah: "I'm not missing any class. I already told you that I know how to grieve. I, I don't want to talk about this anymore."

Sloan: "Okay, sorry... If you change your mind you can call my cell phone anytime, even after midnight. Okay?"

Hannah: "Sure, yeah, thanks."

Cancelled Coffee Date

Marcel: "So, I was wondering why you freak out all the time about stuff?"

Hannah: "Uh, what do you mean?"

Marcel: "I mean, like you get upset over the homework and stuff. And just the other day you mentioned how your Mom was late and it hurt your feelings. Like, what's going on?"

Hannah: "Honestly?"

Marcel: "Yeah, of course. I want to know what's going on."

Hannah: "I have BPD. It stands for borderline personality disorder. I just get more anxious and afraid than other people."

Marcel: "Oh. Uh, well, I will have to look into that later."

Hannah: "Oh, don't worry about it! We can talk about it later today when we meet up for coffee."

Marcel: "Yeah, yeah, for sure."

Hannah: "Great! I will see you at 3pm!"

Marcel: "Yeah, see you then."

-30 minutes later, on the phone-

Hannah: "Hello?"

Marcel: "Hey Hannah, it's Marcel."

Hannah: "Oh hey Marcel! What's up?"

Marcel: "I'm sorry 'n' all, but something came up and I don't think I can make it to our coffee date later."

Hannah: "Oh, is everything okay?"

Marcel: "Yeah, yeah, everything's fine, just something I gotta do, you know?"

Hannah: "Yeah, sure. So uh, do you want to get coffee tomorrow?"

Marcel: "Um, tomorrow's not a good day. I have my chemistry lab and a test in bioethics."

Hannah: "Yeah, that's a lot to study for. Okay, well, I guess another time?"

Marcel: "Definitely! We can get together another time. Thanks for understandin."

Hannah: "No problem."

Marcel: "I will see you in class next week!"

Hannah: "Yeah, see you then. Bye."

Marcel: "Bye!"

-Marcel never went on a coffee date with Hannah-

"You're Fucking Crazy!"

Daniel: "I don't believe it! You are making up some shit again!"

Hannah: "No, I'm not. The lady at the hospital told me I have symptoms of BPD."

Daniel: "No you don't! God! Why do you have to make everything so damn chaotic?!?"

Hannah: "I'm not making things chaotic, I was just telling you what the lady said."

Daniel: "Bullshit! There was no lady that told you that! You're making it up! You just want attention and for Mom to 'oooo' and 'awww' over you like always. I'm tired of this, Hannah!"

Hannah: "Quit yelling at me, Daniel! You're my brother, can you be a little more understanding?"

Daniel: "No, I can't! You are fucking crazy! You are always messing shit up, like seriously just stop being so damn dramatic all the time. God!"

The Notorious DSM

The DSM just literally labels people. I was happy when they finally fixed the eating disorder criteria and got rid of the weight requirements. Like yeah, let's stop telling people who think they are fat that if they don't fall under a certain weight, they don't deserve to get help. And then on top of that, if someone wants to go to therapy because they just need to talk to someone, they have to be labeled with a diagnosis code so their insurance will pay for the sessions. It's messed up. The DSM promotes language that is not people first. Like I am a woman with borderline personality disorder, I am not a borderline woman. I am a person with anorexia, I'm not anorexic. When the DSM labels someone with a mental disorder, they are sentencing that person to a lifetime illness with no hope of getting better. That's just wrong.

Eating Disorder

My Mom, grandmother, aunt, and I have struggled with eating disorders. I was diagnosed with severe anorexia. At one point I weighed sixty pounds. I ended up in a coma. I gained weight when I had to take steroids for my cancer and that drove me to lose more. When I restrict, it

takes the edge off my anxiety, like I only feel the hunger. I also went through a bulimic phase where I would get impulsive and eat everything I could. My self-image was low and I thought if I fixed myself and became thin, then people would like me. I went to an eating disorder recovery center and my BPD started flaring up. I felt like I couldn't trust anyone and felt completely trapped. I could only call my family once a day for an hour, and I had new people coming in and out of my life. It was terrible. I started to bang on the walls because I wanted to get out! I had to get out of there! The cops came and they forced me to leave the treatment center.

The Counseling Center

Hannah reached out the counseling center at the university where she attends. The counseling center told Hannah that BPD was too severe of a diagnosis for them to take on and didn't provide her with any resources.

3 Caroline's Story

“BPD means an abundance of pain, self-hatred, and insecurity; on the up side BPD means creativity, self-awareness and self-care.” –Caroline

Psychiatrist One

Psychiatrist 1: “Caroline, come on back.”

-Caroline walks back into Dr. Harris's office; it is a relatively modern office that smells like a new car. Caroline dislikes the scent and it makes her tense-

Psychiatrist 1: “I know today is our last session before you move to another state, so I wanted to answer any questions you had.”

Caroline: “Well I have been coming here for several months and have been treated for my schizophrenia, but I wanted to ask if I had any other mental illnesses before I transition to my new psychiatrist?”

Psychiatrist 1: “Well, let's see.”

-Dr. Harris clicks on his iPad glossing over Caroline's online medical records; there is a long pause-

Psychiatrist 1: “About two months ago I made a note to myself to check into personality disorders. I forgot about that, but if you like, I could look at the DSM real quick to double check?”

Caroline: “Sure.”

-Dr. Harris walks over to his massive bookshelf and pulls out a thick glossy book. He flips through the pages as Caroline anxiously awaits his response-

Psychiatrist 1: “This is tricky, but I don’t think you fall into a specific personality disorder. I would say you have a personality disorder, not otherwise specified.”

Caroline: “Uh, I don’t know what that means...”

Psychiatrist 1: “It just means that you display significant problems in personality functioning that don’t fit into any of the other existing personality disorder categories. It’s nothing to be alarmed about. I’m sure you can discuss this further with your new psychiatrist after you move.”

Caroline: “Okay... But do I need medicine for this personality disorder?”

Psychiatrist 1: “Technically personality disorders don’t have a certain medication to treat them. We don’t really have the time to discuss your treatment for PD. Most personality disorders are treated with intensive talk therapy.”

Caroline: “Oh, okay...”

Psychiatrist 1: “Now, do you have enough of your Seroquel to get you through your move?”

Caroline: “Uh, yeah, I have a whole ‘nother refill left.”

Psychiatrist 1: “Alright, just make sure to transfer your prescription to your new pharmacy...”

-At this point Caroline isn’t paying much attention to Dr. Harris; his voice fades out as she sits with her thoughts, “What is wrong with me?”-

Psychiatrist Two

-Caroline has been in a residential mental health clinic for a couple of weeks and is in a session with her primary psychiatrist. Caroline and her psychiatrist are discussing Caroline’s experience in church-

Psychiatrist 2: “So you mentioned before you came here you were attending a church?”

Caroline: “Uh, yeah, they are a fundamentalist religious group. I liked going to that church, but they kicked me out because they had way too many rules to follow.”

Psychiatrist 2: “What do you mean, ‘kicked out’?”

Caroline: “Well, they were very strict about praying and asking for forgiveness for their sins. I got a letter in the mail saying that an elder in the church heard from God that I wasn’t cleansed. They asked me to not come back to their church and said that they had to break ties with me because of my sins.”

Psychiatrist 2: “I don’t understand, that doesn’t make sense. You must have done something wrong to get kicked out of a church.”

Caroline: “No, I didn’t do anything wrong. I liked that church, but I guess I wasn’t pure enough in their eyes.”

-Dr. Ford is on her cell phone and isn’t paying attention to what Caroline just said. Caroline waits thirty seconds and clears her throat.-

Psychiatrist 2: “I was reading an important email, what did you say?”

Caroline: “I said I didn’t do anything wrong to get kicked out of the church.”

Psychiatrist 2: “Caroline, I am going to be straight with you because I think you need some tough love. I have never heard of someone getting kicked out of a church before and I have seen clients for over ten years. This baffles me and I think you aren’t telling me what really happened to save face.”

Caroline: “I promise I didn’t do anything wrong. It is pretty easy to get kicked out of that church because they are so fundamentalist. I looked it up on Google and read about other people who got kicked out.”

-Dr. Ford is on her phone again. Caroline can see Dr. Ford's cell phone screen from across the room. Caroline notices that Dr. Ford is playing a video game and is not reading her emails.

Caroline feels ignored and unimportant-

-Dr. Ford finally looks up from her phone-

Psychiatrist 2: "Well, people don't just get kicked out of a religious group, so you must have done something."

Caroline: "I..."

-Dr. Ford interrupts Caroline-

Psychiatrist 2: "It is clear to me that you have borderline personality disorder. You are attention seeking and want people to see you as the martyr."

Caroline: "What?!"

Psychiatrist 2: "Don't act surprised. I saw the records from your previous psychiatrist. In his notes he mentioned that you had a personality disorder. After speaking to you today, I think it is apparent that you have BPD. I am going to sign you up for the DBT skills group."

Caroline: "DBT?"

Psychiatrist 2: "Yes, DBT is for people who have BPD. Now, I need to speak with your primary care doctor and therapist about this issue. You can go ahead to your next group."

Caroline: "Uh, alright..."

-As Caroline drags her feet out of Dr. Ford's office, she glances back to see Dr. Ford is playing the same game on her phone again-

Caroline: (under her breath) "Uninterested much?"

Judgment

I felt really judged by my therapist and primary care doctor at the residential facility. I was there for six months and not once during that time did my doctor or therapist make me feel like there was hope for me. My BPD was presented to me as if something was severely wrong with me and I couldn't change. They would say things like, "You don't get along with people," "You don't manage your emotions well," and "You just want attention." My doctor told the residential counselors not to talk to me. He said, "Caroline talks too much about her problems and that exacerbates her BPD, so if she tries to talk about her problems simply suggest that she try to use a skill she learned in DBT." That was so problematic because I really needed someone to talk to. Because I didn't have much access to the residential counselors, I started calling warm lines, which are basically people trained to talk to people about mental health issues. A warm line isn't a therapist, but someone who you can chat with about what you are going through. If I didn't have those warm lines, I don't know how I would have made it.

Opposing Psychiatric Opinions

The year before Caroline attended the residential facility, she had a major stint in the hospital. When she met with the psychiatrist at the hospital, he told her, "I don't know what disorder you have, it seems like a personality disorder, because you are very dependent on others and have unhealthy relationships." He told her she could get better after she left the hospital, but it would require work on her part. Then Caroline moved to another state the next year and got a new psychiatrist. This psychiatrist didn't think Caroline had a personality disorder. They said, "I just don't think this really matches up with your experience or where you are right now."

Psychiatrist Five

-Caroline had started a new medication and she was in a follow-up appointment with her psychiatrist so they could gauge how things were progressing-

Caroline: "I keep shaking in my bed, I try to stop, but I can't stop shaking."

Psychiatrist 5: "Caroline, I have reviewed all the potential symptoms for this medication and shaking or tremors isn't on the list."

Caroline: "I mean, I don't know what a seizure feels like, but the shaking is bad."

Psychiatrist 5: "Why do you think you are shaking?"

Caroline: "I don't know. I told the nurse and she told me to come see you. I came to you because I don't know what is going on."

Psychiatrist 5: "I wonder if you are causing yourself to shake so you can interact with your providers?"

Caroline: "What? We have an appointment planned next week, why would I want to come in earlier unless I needed to?"

Psychiatrist 5: "That is the question I am trying to figure out. Your therapist has informed me about your other attention-seeking behaviors and I think that this is probably what you are doing right now."

Caroline: "No, I'm not lying. When I lay down to go to sleep I start shaking."

Psychiatrist 5: "I find it curious that these tremors only happen at night. Why aren't they occurring throughout the day?"

-Caroline's eyes begin to well up with tears-

Psychiatrist 5: "Caroline, this isn't the time to cry. You and I both know that in the past you use crying as a way for people to feel sorry for you."

Caroline: "That's not why I am crying..."

Psychiatrist 5: “Okay, well why are you crying?”

Caroline: “Because you don’t believe me.”

Psychiatrist 5: “I am trying my best to believe you, but the circumstances don’t add up. I spent time researching this issue before you came in and I found nothing about tremors. I think it is best if we wait a few days to see if these shakes stop on their own.”

-Caroline returns to her room, sits on her bed, and stares at the wall-

-A few days later Caroline’s primary care doctor realized Caroline was not eating enough calories at dinner and that is why she would only shake at bedtime. She began eating more dinner, even though she didn’t have much appetite, and her symptoms improved.

Threatened

There was this man in my residential facility and he told me that he wanted to kill me. I was terrified and when I told someone about it, they said, “He has a mood disorder and is going through a manic phase, it is nothing to worry about.” I was disgusted. This man threatened me, but the counselors made an excuse for him because he had a mood disorder. However, when I said that I am going to kill myself, I was judged and placed under careful watch. It is absolutely ridiculous how mood disorders are treated with respect compared to personality disorders.

Marsha Linehan

I believed for a long time that I brought my BPD on myself and it was Marsha Linehan’s work that changed my perspective. Her work in DBT has helped many women with BPD. She is someone I can look up to because she openly stated that she has BPD and that altered how people look at BPD; well, at least some people. I was working with a wonderful therapist who

used Linehan's theories to help me heal and I discovered that my borderline was symptomatic of my trauma. I took on borderline behaviors because that was the only way my body knew how to deal with what happened to me.

BPD Mixed With Schizophrenia

When Caroline was diagnosed with BPD, she was not on an anti-psychotic for her schizophrenia. She hallucinated all the time and her providers thought she was making up crazy shit to get attention. In fact, her reality was distorted. It was hard for her to separate BPD from her schizophrenia; where did one begin and the other end? How were they connected? Did one intensify the other? Caroline wrestled with her BPD diagnosis; she knew deep down it fit her behavior, but she criticized herself because of it. "How can I be so stupid that I can't process my own emotions?" Her mind was on fire. Later on when she started taking medication for her schizophrenia, her hallucinations slowly went away. She could then focus on her BPD symptoms and begin the process of healing.

One of the Many Therapists

-Caroline and her therapist from the residential facility are half-way into their therapy session together-

Therapist: "Your doctor weighed you yesterday and said you have lost five pounds in the last week. What is that about?"

Caroline: "I don't know. I was talking to him about it and frankly it scares me."

Therapist: "Why does it scare you? I would kill to lose five pounds in a week."

Caroline: "It worries me because I have never lost weight that fast before."

Therapist: "It's probably either a medication, or the stress of being here, or the healthy-fit challenge we do here."

Caroline: "No, I really don't think it is one of those things. Something just doesn't feel right."

Therapist: "Your doctor will keep an eye on it. Seriously though, I have struggled with my weight and to start losing would be an answer to prayers."

Caroline: "Okay, I guess I won't worry too much about it..."

-Caroline desires for her therapist to like her so much that she puts aside her worries and agrees with her therapist-

Therapist: "Okay, moving right along. What else is on your mind?"

Caroline: "Well, one of my friends graduated from the program last week and I have been missing her a lot. I mean I have cried every night about it. I talked to the other group members about it, but they don't seem to understand my pain."

Therapist: "Caroline, you should be happy your friend got better and went back home. You are acting as if she died or something. This shouldn't be a grieving period, this should be a joyful time to know your friend is on track to being healthy."

Caroline: "Oh course I am happy for her, but I miss her. It is hard getting to know someone and then have them leave, move to another state and not see them again."

Therapist: "What have we talked about before? Your issues of abandonment fuel your borderline tendencies. You are becoming overdramatic about this girl. Everyone who comes to this treatment center will eventually leave. You know that. You need to learn how to move on."

Caroline: "I have been trying to move on, but she was my closest friend here. We ate lunch together everyday and were in the same support group. She told me things about herself and I told her my secrets. I can't..."

-Caroline's therapist stands up rapidly while Caroline was in mid-sentence. This startles Caroline and she jumps a little in her seat. Caroline's therapist comes very close to Caroline and lowers her face in front of Caroline's face. Caroline's heart begins to race-

Therapist: -yelling- "Caroline, for the sake of my own sanity, stop being so dramatic! I cannot help you get better for your borderline if you don't do as I say. You need to move on from your friend. She is gone and is not coming back here! We are no longer discussing this issue because it feeds into your bad behaviors."

-Caroline's therapist takes a step back-

Therapist: "Now. Our session is over and you should go. When we meet in two days, I don't want to hear about this girl. I will touch base with the residential counselors asking if you have mentioned her."

-Caroline stares at her therapist and doesn't say a word. She is frightened-

Therapist: "Good. It is better you don't say anything than to ramble on about your long-lost friend."

-Caroline gets up from the couch and walks out of her therapist's office-

-Caroline thinks to herself-

Caroline: "My pain is so real. I feel it in my chest, in my body. It isn't real to her at all..."

Giving a Diagnosis

It took me years to find a therapist who validated my trauma and my anguish. All those years I was not believed. I received no comfort, no support. I was talked down to; I was diminished into nothing. It was like they wanted to strip me of everything, so I became nothing, a woman without experiences, a woman without agony. I was shamed. I have had to handle the

torment of my providers and believe in myself to heal from my past. All I needed was a compassionate therapist who knew how to comfort me. I believe that anytime a professional gives a borderline diagnosis, they need to be prepared to provide a lot of hope, insight and validation.

The Rest of the Therapists

Most therapists didn't know how to interact with Caroline because she had a non-verbal learning disability, dyspraxia. Dyspraxia affects Caroline's motor functions, interferes with her speech, and sometimes comes across as autistic characteristics. Many of Caroline's therapists didn't know how to carry out treatment with her because they weren't well versed in dealing with a client who displayed autistic traits. Therapists who deal with developmental disabilities are specialized and most common therapists do not have this type of training. Some therapists told Caroline she was too complicated of a case for them. One therapist continued to see Caroline but was dismissive of her experiences. One therapist was quite impersonal because Caroline's dyspraxia threw him off; he chopped up Caroline's issues, which dehumanized her. A residential counselor took advantage of Caroline's disability and made up stories about her. The residential therapist told Caroline's providers that Caroline had asked her to shave Caroline's legs. It is hard to pin down the intentions of lying about Caroline. One day Caroline was with a residential counselor and they were walking into a building. Caroline attempted to open the door, but her motor function was off and she couldn't. The residential counselor was standing behind Caroline becoming annoyed, thinking to himself that Caroline was simply being dramatic to gain attention. He was fed up. He said, "It's not rocket science! Just open the door!" Caroline stepped out of the way and the residential counselor opened the door. Caroline immediately went into the

bathroom and started sobbing. Her emotional reaction put her in a tail spin and she called her psychiatrist and told her she was going to kill herself. Caroline stayed in the bathroom, trying to calm down, when all of a sudden four police officers showed up along with two paramedics. All of this because a residential counselor was a dick.

Hospitals

I've been hospitalized about eight times. It was more related to my BPD because I had chronic suicidality for years. I would go from zero to a hundred, from feeling okay to feeling suicidal. The hopelessness took over like a disease, slowly infecting my body with the mind-frame that life wasn't worth it. There was a really sweet nurse in one hospital and she helped me understand how my suicidal reactions were related to my BPD. She advocated for me and I felt like she was on my side. Another time I was in an all-women's hospital and almost every woman there had a dual diagnosis of BPD and PTSD and had some sort of traumatic history. I really healed in that setting because I got close to several women and I still keep in contact with some of them. It was a nurturing community, where these women were hurting just like me and we all came together to talk and share. I was hospitalized when I was in college as well. The doctor from that hospital would call and check up on me weeks after I left. There are some good eggs out there, but I won't talk about the bad experiences I had in hospitals.

The Diamond in the Rough

My current therapist, Cynthia, is specially trained in DBT. I started seeing her because she was the most affordable therapist in the area I lived; she used a sliding scale based on my income. Another therapist charged over a hundred dollars a session and that wouldn't work out

for me because I only make ten dollars an hour! The most important thing about Cynthia is that she has taught me to like myself; she has believed in me and been my cheerleader. She has also helped me give myself a break. You know our society tells us to constantly stay busy with work and family, to maintain your beauty, exercise, and eat right, all the while being an upstanding citizen. Cynthia guided me to operate at my own pace, what is best for me, not society's standards. I work part-time, attend physical therapy and therapy with Cynthia, meet with my social worker, and go to exercise classes. I don't plan things every evening because it is good for me to take it easy. In the past I wanted to stay busy because it distracted me from my pain, but Cynthia has encouraged me to experience my pain because it allows me to be more in tune with myself. That's why my BPD symptoms would creep up on me, because I didn't take the time to check in with how I was feeling. It would be like something unexpected would happen and I would fall apart because I had all these unresolved issues. I know Cynthia likes me and genuinely cares about me and I cannot tell you the impact that has had on my well-being.

Insurance

Caroline is currently on Medicaid because she has a disability and her income is so low due to the fact that she can only manage to work part-time. Her dad has private health insurance and would allow Caroline to be on his plan, but the deductible is four thousand dollars, a price Caroline cannot afford. So Caroline stays on Medicaid even though it limits the providers she has access to. She goes to a psychiatrist that takes her insurance. He sees her for five minutes, but bills her for a fifty-minute session. Caroline doesn't understand this, but is happy that he only circles "schizophrenia" on her invoice. She only sees this psychiatrist for medication, but on the invoice she is charged for a fifty-minute psychotherapy session. Caroline doesn't receive

psychotherapy from him, but is simply glad he gives her medication that keeps her hallucinations in check.

Caroline's Job

There are two of my co-workers that hate each other and the old me would have gotten involved in that scene. But now, whenever one comes to me with a complaint I just say, "That sounds really hard. I'm sorry you feel that way." Sometimes I have the urge to say, "You know, don't you think some of those things don't matter much at the end of the day?" But part of surviving trauma is trying to enjoy as much as I can since I have been through shit. Avoiding the melodrama of my job is part of me living a life of joy. For instance, there was this one co-worker who didn't like me. Several people came up to me and told me that this co-worker thought I mopped too slowly. Like, what the heck? I told those people, "I mop the best I can, so if she doesn't like the way I mop, she can do it." And that's what happened, she mops now and I wash the dishes. I would rather wash the dishes anyways. The ironic thing is that now this co-worker is a dear friend of mine. The old me would have probably started sobbing about the whole mopping situation, but now she is my friend because I didn't let that petty situation get to me.

Boyfriend

Caroline had never had a boyfriend before, but she has been dating Derek for two months now. They are quite sweet on each other, but take intimacy slow and only hold hands and hug because of Caroline's past. Derek's last relationship was abusive. For several years Derek's girlfriend would forbid him to leave the house without her permission and he felt trapped. They

met on an online dating website and have a healthy relationship thus far. They take turns paying for meals and respect each other's boundaries.

-One day Derek texted Caroline-

Derek: "Hey Caroline, do you want to go to a Mexican restaurant tonight?"

Caroline: "Yeah, sure! That sounds great! Do you want to pick me up or should I meet you there?"

Derek: "Uh, well... There usually is a lot of traffic after work, so it would be better if we met there."

Caroline: "Oh yeah, that makes sense! I will meet you there, say like 6pm?"

Derek: "6pm it is ☺"

-They both arrive at the restaurant and are sitting across from one another at a table-

Caroline: "This is one of my favorite places to eat, they have great fajitas. What are you going to get?"

Derek: "Uh, I'm not sure yet... Um, are you mad at me?"

Caroline: "What? No, I'm not mad at you."

Derek: -panicked- "I should have picked you up, you wanted me to pick you up and I didn't."

Caroline: "No, it made sense what you said about the traffic after work. It's totally fine."

-That's when Derek opened up about the abuse of his last partner-

Caroline: "Derek, first off, I have never been mad at you. Second of all, if we hurt one another's feelings, we should talk to each other about it. If I were upset you didn't pick me up, I would have told you. I want you to feel comfortable to do the same."

-Later on in their relationship they got together for another date-

Derek: "I need you to know something..."

Caroline: "What is it?"

Derek: "I need you to know that I am kind of crazy."

Caroline: "Really? Well you don't have to worry about that, because I am kind of crazy, too."

Derek: "What do you mean?"

Caroline: "Well I have schizophrenia."

Derek: "Oh, well that's okay. I have had my fair share of mental health issues."

Caroline: "Whew, I'm glad you're okay with it because I thought you would be really freaked out."

Family

For the most part my family is pretty supportive of my mental health. Sometimes my mom gets upset. I think she feels guilty, like she could have prevented some of the trauma I went through. When I was first diagnosed with BPD, my Mom filtered my experiences with the nine criteria. I was limited because sometimes what I was going through didn't precisely connect to one of those criteria. One day I screamed that I hated her and she told me, with a straight face, that I was being dramatic. Some days I just wanted my Mom to listen to what I was saying and validate my pain, but she always had to bring it back around to my BPD diagnosis. Things have gotten better over time, but the first year was really difficult to navigate with her. She hated hearing about all the people I met in residential and hospital settings. Looking back at those times, I laugh at all my experiences, but my Mom just tenses up and I can tell she is uncomfortable. I don't tell her stories anymore because she can't handle them; I wish she could.

But my brother and sister, who both live out of state, are super supportive. I talk to them every week. I know I can call them whenever I need them. My older brother lent me some books about BPD because at one point in his life his therapist thought he might have BPD. I consider them both to be my friends, which I am grateful for. I can talk to them about things I can't with my Mom and Dad. I still live with my parents and younger brother, but it's a good set up because they live on the bottom floor, my brother lives on the middle floor, and I live on the top floor. My parents make a point of us all having our own interests, hobbies and friends to not smother one another. I like spending time with my parents, but I enjoy having my own space and being independent. My Dad is mostly a practical parent who likes to strategize, he supports me, like offering me his health insurance plan, but is not someone who I can really talk to. As for my brother who lives below me, he tries to be supportive, but because he is autistic, he has a hard time being empathetic. We have similar neurological issues and our own ways of relating, like I will take him out to dinner once a month and we talk. I will tell him when I feel depressed, but I can't talk as freely to him as my other siblings. I wish my younger brother could understand me better, since we live in the same house, but I have accepted his limits. Instead I just call my other brother to chat about deeper things.

Bible Study

The people in my bible study, which is pretty liberal-minded, know about my mental health issues. I tell them when I am depressed and they are encouraging. I do censor myself with them sometimes because I don't want to say something that is triggering to someone else like, "I think about killing myself." Some other people in the church found out that I have schizophrenia and when I wanted to teach Sunday School, they wouldn't let me. I talked to my doctor about it and

he said I could teach Sunday School if someone else was in the room with me. Then later on as I got better he said I could teach on my own. I guess the church folks were afraid of me. I mean, I'm not a danger to other people; I'm not homicidal or anything. In the past I was a danger to myself, but I would never hurt anyone else.

Getting Fired

Before I was diagnosed with BPD and schizophrenia, I was diagnosed with bipolar disorder, which wasn't the correct diagnosis. Anyways, I was struggling a lot at one of the first jobs I had and I went to the nurse they had at this job. We were just talking and I thought things were confidential between us and she asked me, "What's wrong?" I told her I had bipolar disorder, thinking nothing about it. Well apparently she told my boss and a week later I was fired. It was a very clear case of medical discrimination, but I didn't pursue it because the idea of getting a lawyer was too daunting for me. I did well at that job and it was wrong of them to fire me, that's why I never tell anyone I work with about my mental health struggles.

4 Ariyanna's Story

“Borderline means to me that I struggle with defining who I am, the foundation of who I am is rocky.” –Ariyanna

My One and Only Relationship

We met in high school. I was trying to figure out my sexuality and was increasingly attracted to her. We finally started dating and it was great. We saw each other everyday, talked all the time, and were practically inseparable. The summer before college was amazing, but I kept worrying about how our transition to college would be. I was going to a university in the South and she wasn't. We said our goodbyes and we decided to stay together. The first couple of months were really hard; we went from seeing each other everyday, to only seeing each other every two to three months. It was unbearable. We began arguing a lot. I was in a LGBT+ support group at the time and that helped me, but things escalated. We got together one weekend and started arguing...and then she hit me. I didn't know what to think. I was in shock. I cared about her so much that I put the incident behind me, but over time she became more abusive. I began to manipulate her because I thought that is the only way she would stay with me. Later on I found out she cheated on me. I was devastated.

The Hospital

It was a traumatic experience for Ariyanna when her girlfriend cheated on her. She opened up to her support group about it and the group facilitators recommended that Ariyanna try individual therapy. At that point she was willing to try anything. Individual therapy provided Ariyanna with the support she needed at the time. However, Ariyanna got in a heated argument

with her girlfriend and later that day attempted suicide. She was admitted to General Hospital on the thirteen floor, where she stayed for about a week. She was stabilized and discharged. She returned to school and went back to her therapist at her university's counseling center. Ariyanna opened up about her suicide attempt and her therapist rummaged through some papers and handed Ariyanna a sheet that read "Borderline Personality Disorder." They read through the handout together and Ariyanna felt a light bulb go on; she was on the path to understand herself.

Her Reaction

I have a personality disorder. I have BPD. It is long-lasting, pervasive. It's my personality. Sometimes I feel hopeless. What if I am always in therapy? What if therapy doesn't work? What if I never get better? What if I don't find love? What if I make an impulsive decision that fucks everything up? What if I don't make it...? I feel self-conscious, like people know I'm messed up, that I can't find a stable romantic relationship. I feel inadequate for love. But at the same time, I feel encouraged that I can get help. I know deep down I deserve help and I constantly have to remind myself of that. I know in my head I can work really hard and try my best, even if my emotions tell me otherwise.

Friendships

Before I knew about my BPD, it was really hard for me to make friends and keep friends. I thought it was because I was shy or just unpopular, but I didn't get it until now. Since my diagnosis I am aware that I am afraid of abandonment. My therapist told me it could be either real or imagined abandonment. Like I fear that all my friends will leave me, even if they actually won't. So I don't commit too much to a friendship too fast. I will go slow in getting to know

someone and pace myself. Before I would dive head first and things would implode. I would try to emotionally manipulate my friends into staying my friends through guilt or something. Now if someone doesn't want to be my friend anymore, I let them go. Of course it hurts, but I try to accept it and over time it hurts less. I tell myself that this won't be my only friend, that I will have others. That makes me feel less alone.

Group of Friends

Shelly: "Hey, Ariyanna, it's so good to see you!"

Ariyanna: "Same girl! How're you?"

Shelly: "Doin' good, doin' good. What about yourself?"

Ariyanna: "I have been better..."

Shelly: "Aww no... what's goin' on?"

Ariyanna: "I don't want to make you uncomfortable or anythin', but it's about Charlene."

Shelly: "You know you can talk to me about anything girl! What about Charlene?"

Ariyanna: "Well, we aren't close anymore... We aren't friends and I don't know why. I just wanted to let you know because she is in our circle."

Shelly: "Oh gosh, I didn't know. What happened?"

Ariyanna: "I don't really know. She just said she couldn't handle our friendship anymore in a text and I tried reaching out to her and she never replied. I feel upset about it and want to tell you in case you noticed any tension between us."

Shelly: "No, I haven't noticed any tension. The only thing I have noticed is that Charlene doesn't really talk to the group much anymore. She literally only talks to Brittany."

Ariyanna: “Yeah, I have realized that too. She only hangs out with us if Brittany is there.

Remember when we went to see *Get Out* in the theater and neither of them showed up? But then when we went ice skating at Piedmont Park, they both were there?”

Shelly: “Oh, yeah! Now that you say that, I have only seen them together as a pair when we go out.”

Ariyanna: “I’m just really hurt and angry that she would end our friendship without talking with me about it. You know?”

Shelly: “Yeah, I can understand that. Honestly, I don’t get why Charlene did that and I personally don’t think you did anything wrong.”

Ariyanna: “Really? Because it feels like all my fault and I keep second-guessing myself. Like maybe I should text her again or go to her dorm or somethin’.”

Shelly: “No, I mean if you reached out to her and she didn’t reply, then the ball is in her court. You did everything you could to work it out with her.”

Ariyanna: “It means a lot that you would say that. I have been angry and feeling invalidated because I told Cindy about Charlene ‘n’ stuff and she said she didn’t want to get in the middle of our fight. I told her it wasn’t a fight, but she didn’t listen to me.”

Shelly: “I’m sorry Cindy was being like that, she tends to avoid conflict. But I am here for you if you need to talk about all of this. You know that, right?”

Ariyanna: “Yeah, I do. Thanks for that.”

DBT

Ariyanna’s therapist referred her to a psychologist in the area to begin dialectical behavioral therapy. DBT was created by Marsha Linehan specifically for individuals with BPD

and helps them work on mindfulness. Ariyanna struggled with mindfulness and would get bored, but now she has learned to find something valuable in those moments. When she is sitting in traffic and is annoyed, she will sing to the radio, a rare opportunity since she lives in the dorm. DBT has guided Ariyanna to regulate her emotions by recognizing her feelings and not automatically reacting to them. She uses breathing techniques to calm her urges and tries to be aware of her urges. Ariyanna has improved her interpersonal effectiveness by asking for what she wants instead of avoiding her needs. In the past she thought others should perceive her needs and when they didn't, she would explode and yell at them. Now she knows how to be assertive and ask for what she wants.

Avoidance

My group of friends were getting together for a dinner and I was tempted to decline. Charlene was going to be there and I wanted to avoid her because I was pissed at how she treated me like shit. I wanted to say, "Oh, I'm really busy with school and can't make it this time, but thanks for inviting me," but I didn't. I was free that night and could go to dinner. I wanted to go and see my friends. I recognized that if I didn't go, I would be letting Charlene control my decisions and that wasn't fair to me. Those other girls are just as much my friends as they are hers and it's not my fault that Charlene is treating me like I don't exist. So I'm going to go. I know I can handle it.

Distress Tolerance

Therapist: "I want to recommend some note cards that have phrases that will encourage you to use your distress tolerance skills."

Ariyanna: "Okay, sure."

Therapist: "I will read some to you and then we can talk about them. The first card says, 'Observe. Just Notice.' When do you think you could use this card?"

Ariyanna: "Um, I'm not sure."

Therapist: "What about when you were at Olive Garden with your friends?"

Ariyanna: "Yeah. I felt really angry when I got there, but I paid attention to my other friends instead of Charlene."

Therapist: "Yes, exactly. You were just noticing Charlene and not allowing your anger to stand in the way of you enjoying the night with the rest of your friends."

Ariyanna: "I just don't know in that situation where I could read those cards. I would be embarrassed to pull them out at the dinner table where everyone could see them."

Therapist: "Can you think of a more private place to read over them?"

Ariyanna: "Uh, I guess I could have gone to the bathroom."

Therapist: "Yeah, that is a good idea. You could excuse yourself to the restroom and look over the cards if your anger got out of hand."

Ariyanna: "That would definitely work and no one would know about it."

Therapist: "Another card reads, 'Stay in the moment.' Can you think of when this card would be relevant?"

Ariyanna: "Yeah, sometimes in group therapy I daydream and don't listen to what other people are saying. It's not that I don't care, I just have other things on my mind and they can take over."

Therapist: "Yes, we have discussed your racing thoughts and it could help you if you try not to get caught up in those thoughts. If you try to focus on what is happening in the moment, where you are, like in group therapy or class, you can stay present."

Ariyanna: “It just seems so impossible some times to stay in the moment. I don’t want my thoughts to control my feelings, but I can’t help it. Even if I read that card, I don’t know if I will have the will to be present.”

Therapist: “It is definitely a skill to practice. The cards are only a reminder of the skills you have. You can read these cards and remember what options you have in moments of distress.”

Ariyanna: “Okay, I see what you are saying. I was feeling a lot of pressure to always be able to follow the card’s instructions, but you are saying they are only reminders. I like that.”

Therapist: “I’m glad you think they could benefit you. The next card says, “Imagine you are in a relaxing place.” When do you think this card could apply?”

Ariyanna: “Hmm, I am stressed out when I have an exam, so maybe before the exam starts I could imagine being on a beach?”

Therapist: “That is an excellent example. Can you tell me things about the beach you would imagine?”

Ariyanna: “I guess the sounds of the waves going back and forth. The warmth of the sun shining against my back. The soft breeze against my skin. The sand between my toes. The scent of sunscreen.”

Therapist: “How do you feel now, imagining the beach?”

Ariyanna: “It is pretty soothing actually. I didn’t realize how I could calm myself so quickly just by focusing on the sensations of being at the beach.”

Therapist: “You can imagine the beach wherever you are and that is the power of imagination. I want you to have this pack of cards and I hope you will keep them with you at all times, in case you need them.”

Ariyanna: “Oh okay. They are small enough to go in my bag, so I will keep them in there.”

Therapist: “That’s wonderful. We are out of time for today, but I look forward to seeing you next week.”

Ariyanna: “Yeah, I will be here next Tuesday at eleven.”

Therapist: “Sounds good. See you then, Ariyanna.”

Psychiatry

Psychiatrist: “Hi Ariyanna, it’s a pleasure to meet you!”

Ariyanna: “Nice to meet you too.”

Psychiatrist: “My name is Dr. Jones and your therapist, Mary, referred you to me?”

Ariyanna: “Yes, she thought it could be useful to try medication in conjunction with my therapy.”

Psychiatrist: “I have worked with Mary for many years and she does her job well. We can absolutely explore medication options based on your needs. I have the depression inventory and anxiety scale you filled out while you were in the waiting room. It looks like you have both mild anxiety and depression.”

Ariyanna: “I agree with that assessment. It’s not like I can’t function or anything, but the anxiety and the lows get in my way sometimes and I can’t do the things I want.”

Psychiatrist: “That makes perfect sense. I think an anti-depressant would boost your lows and it can also reduce your anxiety. The most common anti-depressants are called SSRIs, which stand for selective serotonin reuptake inhibitors. SSRIs help the brain get more serotonin, a neurotransmitter that contributes to wellbeing and happiness. These include Prozac, Paxil, Lexapro, Celexa, Zoloft, etc.”

Ariyanna: “Okay.”

Psychiatrist: “If you are willing, I think we should start off with an SSRI to see if your body responds to one.”

Ariyanna: “Yeah, sure, okay.”

Psychiatrist: “I would recommend Zoloft for you because it helps with depression, but is also known to help with general anxiety and social anxiety. We could start you off with 50mg daily and then work our way up in 25mg increments and see how it affects you. How does that sound?”

Ariyanna: “That sounds fine. When should I take it?”

Psychiatrist: “It is really up to you. Some people take it in the morning and others like to take it at night. If it makes you feel sleepy, I would recommend to take it in the evening with your dinner.”

Ariyanna: “Oh okay, I will just take it in the evening then.”

Psychiatrist: “That should be fine. There are some common side effects with Zoloft that include dizziness, drowsiness, upset stomach, sleep fluctuations as well as weight fluctuations, and possibly decreased sexual drive. If you experience these side effects feel free to contact me so I can help you address them. More than likely the side effects will go away in about two weeks. If you have a severe reaction like vomiting, fever, rash, or increased suicidal thoughts, please call 9-1-1 or go to your nearest emergency room. They can immediately help you, but please also give me a call so I know what is going on and can also advise you during that process. Most people don’t have severe reactions, so don’t worry about that. Do you have any other questions?”

Ariyanna: “Uh... not right now. I just hope this can help me feel better.”

Psychiatrist: "I hope that it can as well. Alright then, I would like to see you back in two weeks to see how the progression goes. You can schedule a follow-up appointment with Courtney in the lobby."

Ariyanna: "Thanks, I will."

-two months later-

Psychiatrist: "Ariyanna, you can come back now."

-they walk into Dr. Jones's office-

Psychiatrist: "How are things going?"

Ariyanna: "They are fine, I guess."

Psychiatrist: "Good. So I see here in your chart that you have been on 100mg of Zoloft for about three weeks now. How is that going?"

Ariyanna: "It's alright. I mean, I don't feel happy or anything, but I feel more stable, if that makes sense?"

Psychiatrist: "Yes, that makes sense. I am glad that you feel more stable, that is a positive response. Have you experienced a depressive phase since on the 100mg dose?"

Ariyanna: "Uh, not really. I mean I feel low some days, but it isn't as bad as it was before and it doesn't seem to last as long."

Psychiatrist: "I am glad to hear that. What about your anxiety?"

Ariyanna: "That has only eased up a little bit. I still have racing thoughts and what not. I have been working with Mary every week to try to make it better."

Psychiatrist: "Of course. We can always raise the dose of your Zoloft and see if it helps the anxiety. Would you like to try that?"

Ariyanna: "Yeah, sure. I mean, if you think it would help."

Psychiatrist: “I cannot guarantee that it will help reduce the anxiety, but I would rather bump up the dose of your Zoloft than add another medication into the mix.”

Ariyanna: “I am not ready to try another medication, so bumping up my Zoloft is a better alternative.”

Psychiatrist: “Super. I will write you a new prescription for 125mg. Why don’t you come back in about three to four weeks so we can see how things are going?”

Ariyanna: “Alright, I will.”

Nondiscriminatory

Ariyanna sought out the help of a therapist when she was fifteen because she was grappling with her sexuality. She wanted to explore and discover this part of herself because she was feeling confused. When she started attending Georgia State University she joined the LGBT+ support group and this opened the door for her to start individual therapy. During her time in individual therapy she attempted suicide. When she returned to her therapist at her university and discussed her attempt, her therapist diagnosed Ariyanna with BPD. Ariyanna has never felt discriminated against and has felt supported by the clinicians in her life. Ariyanna graduated with her undergraduate degree and took some time off from school. A few years later, she returned the same university to pursue a higher degree. She went back to the same university counseling center to start up individual therapy to deal with the stress of her mother being diagnosed with a chronic illness. She was welcomed by the counseling center and in time started seeing a psychiatrist at her university. When approaching the counseling center, Ariyanna did not disclose that she had BPD, she simply said she wanted to do individual therapy to deal with stress. Maybe if she had disclosed she had BPD, she would have been turned away. Who knows? Ariyanna

thinks her BPD isn't as extreme as some women's and that she is relatively compliant in therapy and wonders if this is why she has always been supported by her clinicians.

Therapist Recommendations

Ariyanna's therapist has recommended that she always get enough sleep and exercise regularly. Ariyanna thinks that exercising helps her release negative energy and feelings such as anger, anxiety, and sadness. Being in a routine also provides stability in Ariyanna's life and reduces her stress. She has done extensive research on BPD and depression and takes Omega 3 fatty acids to improve her mood. She also will take melatonin at night to help her sleep better. Ariyanna is aware of the substances she puts in her body and is mindful about being as natural as she can. She takes omega 3 fatty acids and melatonin because her body produces them both naturally. Ariyanna's therapist has recommended that she should plan social engagements to keep her surrounded by supportive friends and family. Ariyanna likes to read and write and has joined book clubs and participated in poetry contests. Because she likes to write, she journals a lot to put her ruminations on paper and get them out of her head, which decreases their intensity.

Being a Minority

Being a minority with a mental illness is something that is generally not accepted in minority communities. When I have tried to bring up my depression, especially to older generations, they always say things like, "Well, you're just sad. You need to get over it" and "You can pray it away." While I am a Christian and attend church, my spirituality is not the only piece of my recovery. My friends who are minorities, who also struggle with mental illness, are

usually more supportive than the church or older generations. But it has been hard to break the stigma and have a place where I can talk about these things in a community I identify with.

Internal Family

My parents have always been supportive about my mental illness by getting me the help I need. I may have not shared all the details with them, but I know they are there for me if I need to talk. I remember when I was going to a DBT class, my Dad would drive me there, wait for me, and drive me home. That was really nice of him. On the way home he would talk with me about the class, if I wanted. I don't think my diagnosis has brought us closer as a family, I think it was when my Mom was diagnosed with a chronic illness. She has had multiple strokes and many setbacks in her health. We all had to deal with that stress and sadness and that made us a stronger family unit. Our communication has gotten better and now we can be open about things that upset or irritate us. My sister doesn't agree with my diagnosis. She told me that she doesn't think I have borderline personality disorder, but rather depression and anxiety. While it hurts that she doesn't want to accept that part of me, she has continually been a support for me. She is a shoulder I can lean on even though she doesn't agree.

Disclosure

I will only tell a friend about my BPD or previous suicide attempt if they are compassionate and haven't made insensitive comments about mental health before. It is just a feeling I have, but I look for compassion, empathy, and a non-judgmental stance. Most of the friends I have told have also struggled with a mental illness, like depression. The friends that I haven't told, I get the vibe that they wouldn't take me seriously or have an open mind. I am usually cautious around the

friends I haven't told and try to observe how they behave. I never want to feel ashamed about my diagnosis because I think that perpetuates the stigma, so I trust my gut in regards to who I tell. There have been people who have made me feel ashamed of my BPD and I have learned from that experience.

Abnormal Psychology

Dr. Johnson: "Okay class, today we are going to go over personality disorders. We are on chapter 14 in your textbooks. There are several personality disorders, but I am going to start with borderline personality disorder. Is anyone familiar with BPD?"

-Ariyanna sits uncomfortably in her desk as no one raises their hand-

Dr. Johnson: "Alright, since no one is familiar with BPD I think it is best if we watch a short YouTube clip about what it feels like to have BPD."

-Dr. Johnson pulls up the YouTube clip. The woman with BPD is describing her symptoms and how they affect her life-

-A student that Ariyanna has causally gotten to know is clearly bored while watching this video-

Paul: "Oh my god... when is this going to be over?"

-Ariyanna's cheeks begin to feel flushed-

Paul (continued): "I just want to go so I can slit my wrists!" –snickers-

-Ariyanna feels conflicted, like she should laugh with the rest of the class at Paul's comment, but the urge to speak out and be an advocate-

-Ariyanna doesn't laugh. She sits uncomfortably in her desk. Her heartbeat is racing-

Ariyanna (thinking to herself): "What should I do? Should I tell Paul that was insensitive? Or should I say, 'Hey, that's not okay, I have BPD?' I feel so lousy. I just want class to be over..."

First Impressions

Everyone thinks I am so put together and that my life is together. Sure, I have a 4.0, I am in the Honor's college, and I receive a scholarship. I know I excel professionally and academically, but socially I am struggling. I hide my BPD from others quite well, but I wish sometimes I didn't feel the need to conceal it. Some of my friends know, but most people think I am little miss perfect. It hurts to hold all of this inside. You never know what someone is actually going through...

The Fine Arts

I like to draw. I may not be the best drawer, but I like it. I also like to sing and act. I want to get back into performing, but school keeps me busy. The arts bring me happiness and are calming. I also feel a sense of community, by getting to know people who have similar interests, so I don't feel isolated and lonely. I have always loved music, listening to it and creating it. I play the piano and used to play the French horn in band. I think music and art are beneficial when I can't articulate my feelings or I may not be comfortable putting my emotions into words. Using art as a medium, whether it is a sketch, monologue, or song, is a constructive way for me to express myself.

Eating Disorder

I have struggled with my body image since high school. I grew up in a whitewashed world where white-beauty was put on a pedestal. I would see magazines and television shows where models would be so thin and barely have any body fat. They were idolized as the epitome of beauty. I went to high school with many white, skinny girls who constantly got attention from

guys. I felt I didn't measure up and the only way to get that kind of attention was to change my body. I remember it was around lent and in church I was taught that during the first lent Christians would fast from sun up to sundown. I decided I wasn't going to eat for the entire season of lent to lose weight. That was the beginning of my struggle with an eating disorder. I still wrestle with it and I am trying to love my body and the skin that I am in, but it is difficult. Nowadays it manifests in excess exercising or too much dieting. I try to be aware whether I am exercising to be healthy or with the goal of losing weight. It is something I have to continually be cognizant of.

BPD is Sexist!

More women are diagnosed with BPD and I think that is sexist! I think many men behave in borderline ways, but it is more acceptable. I am reminded of the film Fifty Shades of Grey. Anastasia's life is completely controlled by Christian. He decides where Anastasia lives, whom she sees, and where she goes. He is constantly manipulating her with his bouts of anger, seduction, and phrases like, "Don't leave me, I love you." I think in our society that controlling and manipulative men are thought to be appealing and sexy. So when men have symptoms of BPD, they are just thought of being romantic because they have intense emotionality and are afraid of abandonment. I suppose some women are attracted to men who worry about losing love, but it is twisted and biased because then more women are getting diagnosed with BPD.

5 CONCLUSION

5.1 Affect and Emotions

Now that you have read the vignettes from my three participants, I bet you feel something about each woman. You can sense that Hannah's life is chaotic and that she feels insecure and struggles with her anxiety, depression and rejection. You probably realize that Caroline is more optimistic and assertive than she was in the past, wrestling with loneliness, anxiety and being hesitant. Lastly, you perceive Ariyanna as open, liberated and inquisitive, but she is critical of herself and desires to be accepted. In this concluding chapter I touch on the disjuncture between my literature review and my vignettes. I will discuss the salient themes of my interviews, answer my initial research questions and circle back to my literature review. I reflect on the process and meanings of these interviews and how it informs the significance of my thesis, essentially why this work matters.

My research questions are as follows:

1. How do women describe being diagnosed with BPD?
2. How do women describe the impact of the diagnosis of BPD?
3. How do women describe their relations to clinicians?
4. What affects and attachments do BPD women share?

5.2 Disjuncture

I went into my interviews thinking that my participants would be stigmatized, denied treatment, and discriminated against based on their gender and BPD diagnosis. My vignettes do not support my initial assumptions and showcased the variety of lived experiences of my participants. Hannah was the most discriminated against, but also the most chaotic. Caroline had trouble getting access to treatment for her BPD, but not her schizophrenia; however, later on in

her journey, through the help of the women's hospital, Caroline found a more feminist therapist. Arianna, the only woman of color, had the most access to treatment, which is ironic since historically women of color have been invalidated for their mental suffering.

5.2.1 Gender Bias

I came into this thesis thinking that BPD was a gendered diagnosis, but we don't see gendered issues in my vignettes. Gender is not central to my participants' narratives, but their behavior was hyper-feminine. Shaw and Proctor argued that BPD is usually given to women who strictly conform to their female gender role (p. 485). I claim that BPD is a gendered diagnosis because two of my participants had limited access to the treatment they desired.

Up until this point, Caroline was moving around frequently and having trouble finding a therapist she could see weekly. She was easily treated for her schizophrenia, but after she got her BPD diagnosis, she had more trouble. When Caroline went to the women's hospital, most of the women had a dual diagnosis of BPD and PTSD. Caroline's experience in an all-women's hospital touches on Alison Kafer's idea of *collective affinity*. In that hospital, it seemed that these women banded together and claimed their trauma as a gendered experience by taking on the diagnosis of PTSD.

5.2.2 Verisimilitude

In my literature review I examine Narayan, Jacobson, and Larsen's work on ethnographic fiction. A main point for all three of them is to write in a believable manner. Some of my vignettes do not read as plausible and I wrestled with this. I decided it was more important to stay true to how my participants experienced an event than to tweak the vignette to make it more reasonable.

5.3 Salient Themes

5.3.1 Embodiment

Interviewing my participants humanized them in a way that much previous literature has not. These women are real beings who struggle. Up until this point, women with BPD have been stereotyped to a degree where they become a monster of sort, the “fuck up.” Their personality has been ripped from their body and studied as a commodity to become “evidence.” My vignettes portray each woman as human as a way to press against their previous representations. My participants embody pain, struggle, instability, neediness, anxiety, fear, hopelessness, and impulsivity. These women carry around knowledge and truth about their existence that should be valued.

5.3.2 Trauma

I am not surprised to uncover that each participant has experienced some sort of trauma. For Hannah, it was the loss of her father in conjunction with having cancer. For Caroline, it was the sexual abuse that she endured. For Ariyanna, it was the physically and emotionally abusive relationship she was in. Shaw and Proctor’s argument, that labeling women with BPD instead of recognizing their trauma decontextualizes and depoliticizes the experiences of women and instead pathologizes them, comes into question for my narrative (2005, p. 487-488). The trauma my participants have endured needs to be attended to more than it has been. With that being said, my participants did not give much detail about their traumatic experiences and at least for Hannah, she shied away from talking about the loss of her father. Trauma should be coded for in the DSM’s criteria for BPD, and clinicians should be more mindful of trauma. However, it is not the clinicians’ fault if their client does not want to dig deeper into their trauma. None of my participants went very far in discussing their trauma. It could be because I set boundaries in our

interview sessions, but it could also be because my participants push back on the idea of trauma. My vignettes did recontextualize my participants' experiences of trauma within the realm of society's rape culture, sexist attitudes, and mental health discrimination, but my assumption that clinicians ignore their clients' trauma is unsustainable.

5.3.3 *Internal Turmoil*

Internal turmoil is an essential sensation that women with BPD feel. This turmoil can be expressed as anxiety, depression, suicidality, chaos and fear. All three of my participants had internal struggles that hindered them from living the life they wanted. I wrote my vignettes in a way to disorient readers in an effort to approach the intensities of the everyday lives of women with BPD. Most vignettes do not have closure or even seek it because the unpredictability reflects the frayed edges and loose ends of these women's emotional journey. Merri Lisa Johnson's memoir, *Girl in Need of a Tourniquet: Memoir of a Borderline Personality*, concentrates on her internal pain. Johnson did not rely on clinicians to substantiate her anguish, but it is important for clinicians to recognize their clients' suffering. Clinicians needn't attempt to "tie" up these loose ends, but perhaps try to grasp at the authenticity of each woman's lived experiences. As we saw in Hannah and Caroline's narratives, Nadine Nehls points out how clinicians construe these feelings of internal turmoil as women being treatment-resistant and manipulative, which can prevent BPD women from receiving the care they need or want.

5.3.3.1 *Fear*

All of my participants were confronted with feelings of fear, whether it was of abandonment or rejection. This fear bubbled inside of each of them, contributing to their internal turmoil. This fear presented itself as apprehension, mistrust, and unstable relationships, but also as neediness and dependency. My participants oscillated between pushing people away to relying

on their support systems, with little in between. This back and forth is distressing for them to go through.

5.3.3.2 *Self-Hatred*

My participants' internal turmoil was often accompanied by their own self-hatred. They expressed to me that they didn't fancy being diagnosed with BPD even though they agreed that the diagnosis was representative of their behavior. I can recall several instances in each interview where my participants said something negative about themselves. I never countered how they viewed themselves because I didn't want to disqualify how they felt. Many clinicians and support systems might react to self-hatred with positive messages, but what really matters is that these women hate who they are. Their self-hatred should be centered and explored rather than dismissed. My participants' self-hatred was closely connected to their self-esteem, as all of them, at one point in their life, felt unworthy of affection and attention. They wrestled with internal feelings of desiring attention, but believing they were undeserving of it.

5.3.3.3 *Eating Disorders*

Two out of three of my participants have and still do battle with disordered eating. Hannah and Ariyanna expressed that they restricted their eating because they were unhappy with their body and they wanted to escape their emotional pain. Their disordered eating was and is a corporeal manifestation of their internal turmoil. To escape their anguish they starved themselves, much like how Merri Lisa Johnson cut her body (2005). Phyllis Chester defended how males are more successful in completing suicide while women have higher rates of attempts (1997, p. 86). Restricting food may be a more accessible way for these women to inflict pain on their bodies as a way to drown out their emotional pain. Justin Healey poignantly reveals that BPD is the only mental illness in which self-harm is a diagnostic feature (2012, p. 57).

Pathologizing self-harm is an issue, but so is having tunnel vision around cutting and suicidality. Disordered eating can be a co-morbid issue with BPD and should be identified as such.

5.3.3.4 Suicidality

Suicidality, including suicidal thoughts, ideations, and attempts, were discussed in all of my interviews. While the details of each woman's experience with suicidality were not touched on, I could feel it weighed on them. Suicidality is connected to the intense manifestation of BPD. My participants' array of sensations was overwhelming to the point that they began to choke on their life and wanted to end it. Their sensations should be allowed to reside even if it makes clinicians and support systems feel uncomfortable.

5.4 Reflection

Going in to this thesis I knew that my relationship with my participants wouldn't be a reciprocal one. As much as I wanted things to be equal between me and them, it wasn't. I had control of the interviews and I did extract data from my participants. While participation in my interviews was voluntary and each participant could skip any question they wanted, I still had the upper hand. All three participants warmed up to me very quickly and I felt a connection with each of them. I wonder if my personality made them open up in ways they wouldn't otherwise have. There was no intent of manipulation on my part, but I can recognize that I might have presented an illusion of reciprocity.

At the end of each of my interviews, every woman took the time to thank me for investing my time, energy and thesis to this topic. They were excited that my research would represent them in an accurate way and educate others about women with BPD. I am truly overwhelmed by the grace and support that each of these women gave me as we said our goodbyes. I saw a piece of myself in each woman, but I did not let them personally know that. I

withheld my story and my experiences from them because I did not want them to have to hold on to that. My decision not to disclose to them was, as I thought, in their best interest.

Retrospectively, I wonder if giving them the option to hear my story would have made the interview process more reciprocal.

Hannah was particularly torn that I would no longer have communication with her even though she told me she understood the IRB's restrictions. Hannah said that I should be careful interviewing women with BPD because they do have issues with abandonment. She worried that other women would become attached to me as a friend and would feel as if I left them after our interview. While Hannah was talking about these "other women," it felt to me as if she were really talking about herself. Hannah did reach out to me after our interview, and although I won't get into specifics, I definitely sensed that she had a hard time letting go. This interaction with Hannah got me thinking that women with borderline are a vulnerable population to interview even if IRB doesn't consider them so. It is hard to reconcile the boundaries between a researcher and women with borderline, especially when these women need better representation.

5.5 Significance

My thesis is significant because it values women's borderline narratives in a way that has not been previously done before. Psychiatrists through cold, clinical calculations have often dehumanized these women to where they have become a commodity to be studied. We all should be outraged by how women with disabilities and mental health issues don't matter in the eyes of some clinicians. My interviews showcased the humanity of these women and how they struggle so we can empathize with them in their pain and neglect.

I only interviewed women because their stories have been overlooked and I hoped to discover a gendered element to the diagnosis of BPD; however, I did not specifically ask about gender bias, thus not opening a door for this exploration. In the future, I hope to be able to address the possible gender bias around BPD.

Even though I was not able to broach the topic of gender bias, I think my research has broken barriers around gender to open a dialogue. BPD has long been a category to dump women into who do not conform to their gender role. This thesis shows that some psychiatrists diminish women's truths, specifically around trauma, simply because they are women. These women are more than just a category, a diagnosis, their trauma or their suicide attempt. Some psychiatrists use diagnosis-first language, meaning they can only see these women through the lens of their diagnosis. These vignettes push back against that notion and demonstrate that BPD is an aspect of these women's lives, but not their whole being.

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APPENDICES

Appendix A

Interview Questions

1. When were you diagnosed with BPD?
2. How did you feel when you were diagnosed?
3. What do you remember thinking when you were diagnosed?
4. Do you agree with your diagnosis? Why or why not?
5. How has your life changed, if in any way, now that you have this diagnosis?
6. What led you to seek out the help of (therapist/psychiatrist/psychologist)?
7. What have been your experiences with your clinician/s?
8. Has a therapist, clinician, psychologist or psychiatrist ever discriminated against you? If so, what happened?
9. What recommendations were you given based on your diagnosis?
10. Did you follow through with those recommendations? Why or why not?
11. How do you manage your borderline?
12. Do you tell people about your diagnosis, if so, who? Why?
13. Does this diagnosis affect your life in any way?
14. What meanings does the BPD “label” have for you?
15. Anything helpful or good about a BPD diagnosis?
16. What stigma or stereotypes have you encountered with BPD, if any?
17. How did that experience make you feel?
18. How do you feel at this moment?