2012

Reclaiming the borderlands : a relational and transnational feminist approach to the history and treatment of borderline personality disorder

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ABSTRACT

This paper utilizes transnational feminist theory to both deconstruct the history of borderline personality disorder and to contextualize treatment within a relational psychodynamic frame. Using transnational feminist understandings of the borderland and splintering self-states, the concept of borderline personality disorder is reframed and explored through a historical perspective. Relational psychodynamic theory is considered as a response to this deconstruction, offering a contemporary perspective, which acknowledges the structural oppressions intrinsic in mental illness. Additionally this paper argues that this perspective highlights a path to engage authentically with intersections of self-states rather than at the poles of binary constructions of identity and self.

RECLAIMING THE BORDERLANDS: A RELATIONAL AND TRANSNATIONAL FEMINIST APPROACH TO THE HISTORY AND TREATMENT OF BORDERLINE PERSONALITY DISORDER

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work

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2012

ACKNOWLEDGEMENTS

For my clients, my true teachers--the bravery in connection that could never be translated through the written word—thank you.

Cara Segal, I am so grateful for your presence and multiplicity through out my experience at Smith. This thesis speaks to what I have learned from you and with you. Thank you for bearing witness to this process and your enduring belief in my abilities even before I had discovered them for myself.

My deep appreciation to the UMass Amherst Women, Gender and Sexuality Studies Department with special gratitude to Professor Alexandrina Deschamps: I have continued to try to "not to throw the baby out with the bath water" and cherish this insistence on complexity and praxis.

With love and gratitude to my parents especially my mother for always encouraging my voice and making space to question everything—to subvert the dominant paradigm.

Finally, because every brick needs the mortar as the mortar needs the brick: Neil, thank you for believing I could do this from before I began, to the day I am done and every day in-between.

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CHAPTER I

Introduction

The borderland as a concept has historically held many distinct social and political meanings. This paper argues that these concepts are inherently tied to the current understanding and treatment of borderline personality disorder. Through an exploration of the relevant literature and application of transnational feminist perspectives as well as a relational psychodynamic lens, this historical narrative points to gaps in the current understanding of borderline personality disorder's political context and to areas for potential healing and treatment.

CHAPTER II

Methodology

This study proposes to explore the borderland concept as it has been entrenched in the understanding of borderline personality disorder. By utilizing transnational feminist theory and relational psychodynamic theory the history of borderline personality disorder will be explored with the intent to propose new paths in historical conceptualization as well as opportunities in treatment. The initial chapter will explore transnational feminist theory and narrow its area of focus to better understand its applicability to the field of psychodynamic theory and practice. The following chapter will flesh out the history of borderline personality disorder as it stands alongside transnational political movements and social concepts. The third chapter will review relational theory, and propose its connections to a feminist clinical stance. Finally, these two theories will be used to examine both the conceptualization of borderline personality disorder and the current modality of treatment by means of an exploration of clinical case examples, with a focus on the clinicians' use of self as well as personal clinical development within supervision/advising. Additionally, in respect to notions of visibility and invisibility, the social location of the author of this paper will not be excluded from analysis and critique. Such avoidance seems both incomplete and compliant to notions of truth that in fact obscure experience and selfhood. In an attempt to address the inconsistency between the demands of authenticity in treatment and the sparseness of self in traditional academic research, particular

case studies will be utilized to better explore how these theories might be utilized in practice including the experience and selfhood of the therapist.

CHAPTER III

Transnational Feminist Theory

Transnational feminism stems from the exploration and critique of feminism as it has been historically tied to paradigms of colonialism, racism, and imperialism. This theory reflects on the needs to identify the dynamics between structures of power on a global level and to understand the constructions of individual selfhood and connections between and across difference. A transnational feminist perspective argues that white, western feminist thought is not a distinct archetype for understanding sexism but rather a problematic frame that extinguishes opportunities to address difference as well as connection. Mohanty's "comparative feminist studies" theory (2003) espouses the framework of "common differences" enabling border-crossing, which avoids the academic tourist model or the western academic tendency to commodify knowledge. This tendency to want to learn *about* rather than *from* the "other" prevents the equitable sharing of knowledge as well as denying the common space at the intersections of experience. This fluidity and intersection, or what has been described as the third space (Anzaldua, 1987; Nnaemeka, 2004), identifies the point at which common difference may be utilized in the creation of knowledge and the articulation of selfhood. Gloria Anzaladúa's concept of the *mestiza consciousness* represents the ability to weave in and out of cultures, creating a fluid self-state that holds the awareness of multiple identities and cultures. This sort of transference occurs while creating new spaces outside of the binary constructions of identity and uses these spaces as locations of autonomy, agency, and articulation. Such a shift in

conceptualization of the marginalized self to the frontier of understanding and articulation of self (Philip, 1990) highlights the notions within transitional feminism that selfhood is both expansive as well as connected to larger global and cultural systems of oppression. Additionally, it helps to deconstruct the borders of nationhood as well as borders created between individual identities. Transnational feminist thought posits that we neither create a melting pot nor celebrate the retention of fixed identities. National borders have been translated and compared to borders between identities (as constructed within identity politics) which in and of itself makes the building of dynamic and curative relationships extremely difficult as we grasp to identify ourselves within categories of sameness or difference.

One way that this dilemma might be understood best is through the narratives of selfhood originating from the Diaspora: The experience of shifting the self and community between nations. This experience has been described as a fracturing and splintering of selfhood (Mehta, 2004) in that the constructions of identity held are ruptured in the process of dislocating the self from nation and home. Interestingly this has been identified as a point primed to create new and revolutionary constructions of selfhood outside patriarchal notions of femininity, individuality, and nation. Brinda Mehta states in her book *Diasporic Dislocations: Indo-Caribbean Women Writers Negotiate the Kala Pani* (2004):

> The dynamic complexities of space in transformation upset the structural dissymmetry maintained by hetero-patriarchy through the process of fusion in which un-differentiation favors the mutuality of experience. Un-differentiation eliminates the principle of otherness that is located within binary polarities by celebrating the notion of multiple internal heterogeneity or expansion. Like the process of osmosis, un-differentiation permeates the very fabric of society to

liquidate self imposed and culturally imposed boundaries. (p. 134)

This example richly highlights the ways in which attunement to relationship actually creates libratory space through which to expand and explore selfhood outside the constraints of rigid notions of identity.

For psychotherapists, the importance of feminist construction of the splintered self lies in negotiating our current understandings of self-states, diagnosis, and treatment. Without understanding the context and history of this diagnosis, it might seem irrelevant to apply social and structural theories that address political oppression to intra-psychic experience and relationship. In order to begin to understand the connection and intersection of transnational feminist theory and relational psychodynamic theory, it is necessary to explore the occurrence of social and political constructions of splintered self states; more specifically, the diagnosis of borderline personality disorder.

CHAPTER IV

The History of Borderline Personality Disorder

The Borderlands.

Borderline personality disorder's history within the scientific community may be best understood in the context of the social movements of its time. The empirical model science, now considered by postmodernists to be a social historical construct, has been used to validate or ascertain "truth" since the 18th century. Empiricism's normative idealization of the scientist's objective position as the condition for scientific veracity masks the social and political disciplinary effects of scientific knowledge (Foucault, 1979). The initial concept of this disorder was originally entitled the "borderland" (Rosse, 1890) between the psychosis and neurosis. Rosse identified this term in the context of a narrative of case studies in which he felt perplexed by the chaotic nature of his client's behaviors and affect states. This term, borderland, held the danger and chaos Rosse felt in finding himself presented with self-states that did not conform to previous notions of mental illness.

Interestingly this period in the late 19th century also marked the movement of women into the professional scientific and medical fields. As with most transitions and exchanges of power, what women gave up to be part of the medical field was both their individual agency and intra-connectivity. The practice of healing (prior to the conceptualization of allopathic medicine) for many years had been co-opted into a masculine profession. With the rise of feminism, women's entrance into professional medical schools challenged the gendered power structure within the

field influencing both medical treatment as well as the conceptualization of the female physicians' identity (Ehrenreich & English, 1989). Despite this seemingly spontaneous progress, due to the financial expense of the school system and racial segregation only wealthy, western, white women were allowed entrance at the expense of their less socially privileged counterparts (Ehrenreich & English, 1989). The few women allowed to enter the sciences were then forced to comply with even stricter gendered norms in order to compensate for their choice of entering a masculine professional field. The nature of this transition, or gate keeping, that occurs through the concept of scientific knowledge highlights the shattering of the communal self in favor of localized identities, which are branded and allocated social positions. Individual's grappled with their inner sense of self and other while the social world imprinted it's own order of identities, which carried the brutal realities of oppression and invisibility.

Contextually, it is important to understand the experience of being divided into multiple selves so as to comply with social standards that impede individual self-determination. In order to be a part of the medical field women were required to comply strictly with all standards of femininity in order to balance the socially constructed masculine nature of the medical field. In order to accomplish this, women were then forced to deny their own sense of self-identity as containing both masculine and feminine characteristics as well as severing the ties between women through divisions of race, class, and national identity. From this narrative space, we return to the concept of the borderland, that space between psychosis (the engagement with the unconscious so as to be out of touch with reality) and the neurosis (to be in touch with reality to the point of ego inflexibility) (McWilliams, 1994). In many ways, the term borderland reiterates that this phenomenon can occur both socially as well as inter-psychically. Although the construction of this borderland state was perhaps a casual choice in title, there are historical

connections to other paradigms of social imperialism. The borderland has also been the location of the metaphoric and actual maintenance of the western colonial powers. Further, the constructions of these borders, both of identity and nation, have served to maintain generalizations of experience, in place of inner and communal subjectivity (Mohanty, 2003). Similarly, the continued construction of identifiers of pathology served to highlight characteristics that are attached to aspects of social identity such as gender, race, class, and nationality. Holding the meaning of these constructions begs the question: what did Rosse mean by borderland? One might argue that the implicit danger to western colonialism inferred by the term borderland was consciously or unconsciously connected to his case narrative observations.

It is important to create space for previous constructions of women's mental health within this history. From early seventeenth century witch burnings to nineteenth century Victorian hysteria, there are many ready examples of the constructions of women's behavioral deviance that were defined within the scientific community as pathos (Becker, 1997). As the diagnosis of hysteria slowly transformed into the borderline diagnosis familiar today, the attitude of clinician's towards their patients has changed very little. Since only women were afflicted with hysteria, familiar gendered stereotypes were amassed in association with the disorder. Women diagnosed with hysteria were viewed as lacking the necessary docility and subservience to conform to norms of femininity (Becker, 1997). Physicians' complaints that their patient's were unable to conform to gender roles is not very different from the current dilemma clinician's find themselves in when utilizing this particular personality disorder diagnosis.

In addition to the construction of female mental illness, women's bodies have been historically utilized for scientific and medical experimentation. One of the most notable of these cases was the founder of gynecology, who conducted surgeries without anesthesia to correct

vaginal fistulas on his female slaves. After the surgery, if they survived, he would recreate the fistula in order to practice the surgery again (Roberts, 1999). This sort of disregard for human suffering and "ethical" treatment was only possible because of the strength of racialized constructions of personhood. We see these same constructions impact the current mental health field, and yet it somehow seems inconceivable that our therapies are not created on objective empirical evidence. The nineteenth century scientific obsession with Sarah Baartman (the "Hottentot Venus") is a horrific example of racism and sexism impacting the construction of the "objective" diagnosis and a racialized and gendered pathology (Hammonds, 1997). The difference and divisions in scientific diagnosis and experimentation historically and currently follows lines of race, class, and nationhood. The diagnosis of hysteria in wealthy, white Victorian women did contribute to reinforcing stereotypes about women's inherent subservient nature, however the physical torture and public spectacles were distinctly appointed to the bodies of women of color. This distinction is an important factor in understanding borderline personality disorder's use in the field. It has been, for the most part, a diagnosis with the face of white women, which both serves to reinforce notions of true womanhood as well as maintain the invisibility of women of color.

Recantation of the seduction theory.

As borderline personality disorder has come to be causally linked to childhood sexual abuse and incest (Kluft, 1990), it seems relevant to understand the ways in which childhood sexual abuse has been constructed historically through frames of patriarchy, hetero-normativity and nationhood. This is best highlighted by Freud's seduction theory, which was initially presented in 1886 as a paper entitled *The Aetiology of Hysteria* (Moussaieff Masson, 1984). Freud's theory postulated that hysterical symptoms stemmed both from current experiences as

well as the triggering off earlier experiences that merited the identified symptomatic response. He identified sexuality as being part of human life from birth however that traumatic experiences of sexual assault would leave lasting (conscious or unconscious) memory that was triggered in adult experiences interpreted as explicitly or implicitly sexual. He asserted that the shame surrounding these events was so profound that to assume that these "memories" were anything but true went against the individual's own desire to avoid shame and guilt in the reporting of their own experiences (Freud, 1886). Freud went on to recant this theory after much negative feedback and social hostility reporting in his autobiography that the pressure of his "technical procedure" encouraged his clients to report certain memories and that he had erred in believing these narratives of incest to be truths rather than wishful fantasies (Freud, 1950). This shift in his theoretical stance effectively silenced the reports his patients had given of their own trauma experiences.

As both oppression and trauma entail the use of power in pursuing the course of silence and subjugation, these two areas understandably overlap in the intra-psychic and social fields. Freud's exploration of childhood sexual assault in his seduction theory demonstrates this connection through the social movements to suppress narratives of individual psychological trauma. This silencing demonstrates the ways in which individual traumas are connected to larger social oppressions and therefore any theory that attempts to validate the experience of individual disempowerment threatens the overall power of systems that perpetuate systemic oppressions.

Freud's research occurred during a time of conflict around nationality/borders as well as ideas of race and purity. Within this context his theory of hysteria stemming from early childhood incest inserts itself directly in the cross fire of these social discourses. Conflicts of

nationhood themselves are often directly connected to notions of racial purity (Mohanty, 2003) and the political upheaval in Europe during the late 1800's heightened the social focus on racial purity.

This concern was identified by Jeffery Moussaieff Masson's (1984) in his interpretation of Freud's abandonment of the theory, in which he argues that Freud had known of the prevalence of childhood sexual assault and incest prior to hearing of the statements of his patients. Masson argued that this knowledge led Freud to believe the reports his clients gave him to be memories of childhood trauma rather than fantasies. This was in contrast to formulation by Freud's peers and students that his work had actually progressed towards the more accurate assessment of childhood sexuality explained by the Oedipal complex (Lothane, 2001). Interestingly, both Masson and Freud were Jewish and this overlap in their racial and cultural identities holds a piece of the fundamental importance of the relational enactment their work creates. Freud abandons his theory of hysteria stemming from childhood sexual trauma after intense social pressures during a time of political and social anti-Semitism. As noted earlier, his theory although focused on the individual experience was also profoundly challenging norms of gender, hetero-normativity and human sexuality. As this unfolded he was attacked on both the basis of his work's scientific merit and on the implication of his racial impurity (Masson, 1985).

Masson's work, revealed the many social and political pressures that Freud experienced as a result of challenging these social norms, however his assessment of these actions was that Freud lacked the necessary personal courage to stick with the truth of his initial theoretical pinning's (Masson, 1985). However, in light of their similar ethnic identities, this attack on Freud's character might be understood as a projection of Masson's unconscious or conscious fears of his own work being attacked and discredited. He himself had developed professionally

in the psychoanalytic community. By challenging the field's understanding of Freud's seduction theory he risked alienating himself in the same way he claimed Freud had been. Systems of oppression continued to influence social thought and scientific "knowledge" and this environment would have impacted Masson just as it had impacted Freud.

Masson's attack on Freud's courage demonstrates both the strength of social systems of oppression as well as the ways in which these occur through relational projections and enactments. This example also serves to demonstrate the continued prevalence of avoidance and fear triggered within the field surrounding the numerous and profound results of childhood sexual abuse. As Freud and then Masson demonstrate, the ability to address the individual experiences of social oppression and sexual violence necessitate an attuned focus rather than avoidance on the current social and political systems that work to silence and subjugate these experiences. Without this consciousness the relational experience pulls both client and therapist towards avoidance and further perpetuation if the same methods of oppression that caused the trauma in it's own aetiology.

The Second Wave of the Borderland/Borderline.

The second surge of interest in the "borderland" state occurred through the 1950's into the late 1960's and early 70's (Maleval, 2000) in conjunction with social unrest and the second wave of feminism. The definition of more concrete borderline characteristics was established as well as the attachment of the disorder to the sexually deviant female body. Kernberg and other object relations theorists identified borderline personality features as existing primarily within the conflict between self and external object. This was seen as the problematic shift between the libidinal and aggressive drives rather than an integration of the two (Kernberg, 1975). Again, we find dualistic constructs and the deviant movement between these two poles. Binary

constructions have been the hallmark of repressive notions of identity and this phenomenon has permeated the psychological diagnosis. Jonathan Metzel (2009) identifies the movement of paranoid schizophrenia from disorder to threat as it came to signify a disease inhabited by black men. Similarly, borderline personality disorder became associated with women who were displaying behavior that was deemed gender nonconforming, including sexual deviance and anger. The borderline diagnosis continued to hold the implicit meaning of the frontier or territory of the unknown (Wirth-Cauchon, 2001).

By the 1990's the field had also highlighted the severe and persistent nature that both self-harm and histories of trauma (specifically incest) played in the characteristics of borderline personality disorder (McWilliams, 1994). Additional markers to diagnosis were the behaviors most often referred to as manipulation, turbulent relationships, and the defense of splitting (Stone, 1986). A borderline diagnosis is often highlighted by the identification of the individual's use of the splitting defense. This defense maintains the separateness of otherwise juxtaposing or ambiguous self-states or emotions. It is generally understood to simplify experiences, or eternal and internal objects onto one end of a spectrum or binary construction such as good/bad, love/hate, etc. The self and eternal objects become split and separated in that certain characteristics or elements of the self are accepted while others are latent or rejected by the consciousness (Goldstein, 1995).

Many transnational feminist and post-colonial discourses argue that binary oppositions inherently silence already marginalized voices and perpetuate systems of oppression. This is understood to occur within the constructed split relationship between two identities or concepts negating any complexity within the relationship. Within this frame, the fundamental binary opposition of good/bad is held in association with all other relationships so that particular

structures and identities are held as good and all outside/othered concepts are correlated with badness. As implied by the label borderline/borderland the dilemma inherent in this diagnosis is the exchange between otherwise distinct locations. The struggle to retain a cohesive self is central to multiple treatments for borderline personality disorder (Linehan, 1993 & Stone, 1986) however how this has been addressed has shifted historically.

Much of this shift in treatment has been directly tied to the connections identified between the disorder and multiple and complex traumas. As the chaotic nature of chronic and complex traumas were revealed, so increased the mental health field's deprecation and stigmatization of the disorder. Clients with the diagnosis were refused treatment by therapists who refused to work with borderlines, and others were subject to "treatments" that acted out the very power dynamic that they struggled to flee (Wirth-Cauchon, 2001). Despite awareness of this cycle of mistreatment, the clinical community continued to throw up its hands in the face of the diagnosis of the unknown: of the borderlands. In 1993 Marsha Linehan published her seminal research on working with highly suicidal clients diagnosed with borderline personality disorder, in which she proposed a treatment that was evidence based. Her approach utilized a combination of both teaching skills such as distress tolerance and mindfulness that individual's with borderline personality disorder were seen to lack. Additionally her therapeutic stance was that of both therapeutic support and consultation for the therapist as well as a focus on the "middle path" (Linehan, 1993). Her treatment utilized a behavioral framework for addressing problematic behaviors; however, the utilization of diary cards and chain analysis also served as tools for low level exposure therapy to clients' triggers and flashbacks. Her therapy model came to be increasingly popular, especially within community mental health centers that did not have the choice to turn away "problematic" clients, nor the resources to turn down insurances that

only paid for evidence based therapies. As the treatment became widespread, the diagnosis itself became increasingly common, in many ways the wastebasket for client's that trigged the feeling of the unknown or the perilous in a clinician's relational response.

Within all of this, the construct of the "borderland" continued to exist in the treatment and diagnosis of borderline clients. As Gloria Anzaldúa (1999) points out this framework for understanding otherness between social identities is not uncommon. She identifies the concept of the *mestiza consciousness* as the ability of the "other" to interpret both their own consciousness and the consciousness of the oppressor. This concept does not entail a dual consciousness, as identified within object relations as the existence betwixt two poles; it is rather a mix, a whole created by its parts (Anzaldúa, 1999). For Linehan, the middle path is also a form of consciousness, however the means to achieve this state is attempted through the utilization of skill building. Anzaldúa's theory articulates the need for a spiritual connection, to the breaking down of the identity politics that falsely generalize our experience into categories, and to identify the subjective experience within the larger, complex, human experience. This is not to over simplify what is not, by proposing a form of global sisterhood; this type of glazing over and silencing is understood as inherently oppressive (Mohanty, 2003). Rather, the experience of the oppressed gives rise to a dual consciousness, which offers the opportunity to call up the *mestiza consciousness* to resist, rather than to allow the self to batted back and forth between binary juxtapositions.

I will end this history by noting that even Rosse (1890) was aware, at least peripherally, of his client's ability to tap into alternate consciousnesses that provided healing and relief. In his case studies that initially described the borderland state he wrote,

> One of these letters tells me of a miracle that happened to her: That she was walking down the street feeling so depressed as to be nearly insane with wretchedness when suddenly she had a strange experience; the operation of natural law had stopped in her being; a beatific feeling came over her, followed by the most perfect peace and quiet, and a voice spoke to her words of consolation and good advice. (p. 680)

I would argue that this aspect of the borderland, what might be called the spiritual, the metaphysical, and most certainly the relational, has yet to be properly explored within the clinical and scientific community.

CHAPTER V

Relational Psychodynamic Theory

Relational theory argues that the mutuality of experience between therapist and client allows for the exploration and curative work to be processed within the therapeutic alliance. This theory stemmed out of both object relations theories and self psychology, in which an attempt to explore how the therapists inability to hold true objectivity actually plays a role in healing past relational dilemmas (Hadley, 2008). Relational work both addresses disruptions in formation of self in relationship and explores the socio-political dynamics within the therapeutic relationship. Part of this work involves the therapist's ability to both observe their own emotional and relational experience with their client and to notice and understand the enactments, which are seen as inevitable occurrences (Hadley, 2008).

Closely related to interpersonal theory in many ways, relational theory parallels the desire for the therapist to stretch towards relational intimacy with their client. Ehrenberg (1974) refers to this as "the intimate edge" identifying the movement towards connectedness and contact at the intersections of selfhood rather than a fusion or domination on the part of the therapist or client. Similar to transnational feminist articulations of the opening up or transcendence that may occur when connection actually frees the participants from outside constructions of selfhood; similarly Ehrenberg's "intimate edge" facilitates the mutuality in the definition of the interpersonal space creating more room for clients to better understand their inner world and selfhood. Additionally, relational theory has identified the false constructions of individuality and rationality as

grounded in patriarchal systems of knowledge (Benjamin, 1988). This offers relational therapists the opportunity to deconstruct meanings of positionality, unity, and separateness within clinical practice. Most importantly is deconstructs the notions of public and private space both politically as well as intra-psychically, leaving room for the therapists use of self to facilitate growth within the mutuality of experience between client and therapist.

In identifying the existence of numerous self states that occur for individuals, it is interesting to note the push towards identifying the core true self state within which one might exist. As with the diagnosis of borderline personality disorder the treatment itself has often focused on the expense of splitting that can occur as the result of psychic trauma. In light of transnational feminist arguments that the subjective experience of structural oppression causes psychic splintering and yet this very splintering is the opportunity or frontier of articulation and authenticity. Philip Bromberg (1996) raises a similar question when exploring the multiplicity of self states, arguing that people are continuously splitting and unifying selves and that the process of this shift is itself the unity of the human psyche rather that the presumption that we are stagnantly singular. He quotes Vladamir Nabokov (1920) writing, "I had once been splintered into a million beings and objects. Today I am one; tomorrow I shall splinter again. . . *But I knew that all were notes of one and the same harmony*" (p. 77; italics added). Bromberg (1996) goes on to say,

> Some people can't "stand in the spaces" at all, and in these individuals we see the prototype of a psyche organized more centrally by dissociation than by repression. The key quality of a highly dissociated personality organization is its defensive dedication to retaining the protection afforded by the separateness of self-states (their discontinuity) and minimizing their potential for simultaneous accessibility to consciousness, so that

> each shifting “truth” can continue to play its own role without interference by the others, creating a personality structure that one of my patients described as “having a whim of iron.” (p. 513)

Relational theory would then argue that the experience of splitting itself is not problematic but rather that as therapists we fail to remain in authentic relationship with our clients multiplicity of self states, facilitating what transnational feminists might identify as “othering” or marginalizing clients multiplicity of experience rather than remaining present for notes of “the same harmony”.

CHAPTER VI

Discussion

The implications of this research identify the need for therapists to remain authentically attuned to their clients, allowing therapeutic engagement to raise and explore a multiplicity of self-states. The idea of a core self state is deconstructed since the use of multiplicity and authenticity within clinical work is understood to hold the opportunity for articulation of self and simultaneous resistance to oppressive binary systems of understanding personhood as well as nationhood. This highlights that the only thing clinicians can bring to their work, which is not inherently tainted by notions of imperialism, misogyny, and racism, is the relationship itself. In meeting our clients at a point of "un-differentiation" or the intersection of their and our splintering selves, we can find healing that does not demand our clients re-experience the trauma inflicted by patriarchal constructions of identity. Additionally, mutuality of experience allows us as therapists to border-cross with our clients rather than learning from them as academic or clinical tourists.

In treatment this means holding the complexity of experience of both client and therapist, identifying that the multiplicity of self states represents an intra-psychic awareness of the world and the self rather than an avoidance of it, as constructions of splitting often imply. Much of the pain that stems from the "splintering" occurs directly as a result of societies avoidance and silencing of the pain and trauma that has been experienced. The clinician's ability to bear witnesses to this experience without identifying it as other or marginal occurs when clinician's are able to bring their own human experience and authentic response to this interaction. This third space (Benjamin, 2004) between therapist and client is the space in which the two

splintered experiences (that of the therapist and that of the client) might meet—the intersections of this meeting are the place within which un-impinged healing might occur.

In the following case vignettes and analysis I attempt to navigate the use of relational theory and transnational feminism in treating borderline traits and explore the use of social identity as a tool for holding the complexity and multiplicity of self-states. I argue that relational psychodynamic theory in combination with a transnational feminist framework allows the clinician to explore the emotional and social experiences of individuals through the use of mutuality of experience and authenticity. As differences arise, so do opportunities for attunement, which allow for the exploration of both political as well as emotional meaning in the relationship.

Treatment took place in a rural outpatient community mental health center during my second year internship while working towards the completion of my MSW. The primary modalities of treatment at the clinic were individual, family, and group work.. These cases were reviewed during treatment in primary supervision, secondary supervision with the clinic director as well as case consultation with Smith College School for Social Work faculty. Due to the format of this discussion and the purpose, to explore a certain clinical stance in therapy, these cases will focus on my use of self with clients, rather then on their individual case material. Focusing this material around myself rather then my clients has been a challenging decision to come to. Ultimately this was chosen to protect my clients confidentiality, however it should be noted that within a transnational feminist framework this also serves to limit the role their own voice and agency play in these narratives. While I consciously struggled to address my own blind spots, this discussion should be read as my narrative and experience, rather then an objective tool with which to measure success or outcome of the experience of my clients.

Julia

Julia was one of my first Spanish speaking clients at my internship. This was her first time in therapy and she had recently moved to the area from Puetro Rico. My process of taking Julia on as a client was one of some anxiety. I had learned Spanish having lived in Argentina for two years and had used it professionally in my previous work as a Case Manager. This would be my first time using Spanish as a therapist and I worried that the stakes were higher. My concern was that somehow I might be doing my Spanish-speaking clients a disservice by my inability to understand them perfectly or to perhaps reflect my thoughts accurately as therapy seemed a profession primarily practiced through language. Ultimately, I decided to see Spanish-speaking clients as there were a shortage of Spanish-speaking clinicians at the agency and there were multiple clients on the waiting list that only spoke Spanish and otherwise would have seen an English speaking clinician with an interpreter. Although I discussed these fears in supervision (my supervisor was the only other Spanish speaking clinician at the agency), I continued to feel particularly nervous about my abilities as a therapist when I took on new Spanish speaking clients.

One very important element to examine within this particular dynamic is the issue of the translation of experience through language. Of course this becomes particularly salient when there is a language difference between client and therapist as in Julia's case, however our sense that language is the primary avenue for accurate communication is often a crutch, at best, in our struggle towards connection. Seen as the primary form of communication, if not the only, language is an incredibly powerful and often overlooked tool for recreating oppression within relationships. As described by Rosario Castellaños (2003)

> Things, as Garcia Marquez says, happened in Macondo, are pointed to with a finger, not by any name that defines, illuminates, or locates them. The usufructors of language perverted it over three or four centuries, they sacked it. It is not worth the trouble to appeal to the local court because the treasure, the treasure is irrecoverable…Word is the incarnation of truth because language has meaning. (p.75-76)

By using language we are agreeing to comply with the constructed idea that language is truth whereas experience is subjective. That we are communicating with our clients in relationship forces us to acknowledge the truth resides both in the articulation of experience through language as well as through the relationship between client and therapist and their individual and mutual experience of this relationship.

In working with Julia there were often moments where I needed to correct my wording, check in with her about a sense of mutual understanding, and at times ask her for help in finding the right phrasing or translation of her experience. These moments were the very ones I had feared from the beginning. At times I felt absurdly inept and despite her and my supervisors reassurance that my Spanish was more then sufficient, I felt totally ungrounded in my practice. The connections between my training (all in English) and my practice in Spanish were so tenuous that I often found myself taking longer pauses to actually allow psychodynamic theory to percolate through my English speaking brain, until it could land somewhat worse for wear in the Spanish speaking present. It was through this process I began to notice an important distinction in my work with Julia. Mainly, that a binary construction of therapist and client were fundamentally challenged by a dynamic in which Julia was “expert” of our narrative experience despite the fact that I maintained the power/privilege within multiple other aspects of our relationship.

Ultimately, Julia and I held different truths about language as we struggled to translate our words into an authentic relationship based on bearing witness to the subjective truths of the past and the present. As I struggled with my own shortcomings as a Spanish speaker, I both unconsciously and consciously positioned Julia as expert, expert of her own experience as well as the language that helped facilitate our relationship. Although this shift occurred, which I would argue facilitated a moving into the spaces, articulating the juxtaposition of the borderlands, many of the fundamental social and political binary oppositions remained. It is interesting now to notice my choice to navigate this narrative in English. Although we can share histories, genders, and languages, the systemic oppressions we do not share work to push us apart, to maintain the superiority of nations and classes.

"Because differences are relational, our ability to understand an "other" depends largely on our willingness to examine our "self" (Moya, 1997).

As I sat with Julia, my own self states were often splintering, pulling me back to my experience of living in Argentina before I had a handle on speaking Spanish. One experience in particular held my attention, of when I was ill with a kidney infection and had gone to the doctor after a week of feeling incredibly sick. When she found out I was from the States she turned to me and said in faltering English, that she would do my exam in English as she had just returned from a conference in New York. Terrified that she would misunderstand my symptoms I urgently looked to my boyfriend and asked that he translate what I said to her back into Spanish. Remembering my own terror in that moment, I reflected on the bravery it took for Julia to trust that I could really understand her despite our language difference. I held this memory as I also

held my fears, my fears of being a middle class white clinician, unsure that my own intuition wasn't speaking from a place of destructive and oppressive idioms—terrified that I would misappropriate her symptoms and stigmatize her experience and identity.

The concept of splintering self states inherently implies that individual's experience of splintering is not only common it is a necessary part of holding a central self; as the self is met with multiple contexts and narratives of selfhood. As Julia and I struggled through the translation and interpretation of language and inevitably shifted the structure of what "truth" was defined as, we created space for new realms of relational connection as well as individual understanding of selfhood.

Additionally, transnational feminists would highlight the themes of diaspora that were evoked through our work. Julia and I shared the individual experience of shifting our sense of self as we navigated movement between national and cultural contexts. Brinda Mehta (2004) writes,

> …the exploration of exile that exemplifies the very politics of othering provides the framework for an alternative positioning of female subjectivity, whereby the de-figuration of the female self becomes a precursor to its reconstruction in an attempt to break the mold of gender and racially based typecasting. Indo-Caribbean female authorship and, by implication, readership of the female exile script bears testimony to women's efforts to speak (out) their own texts through a concerted contestation of otherness. (p. 158)

If we hold the interpretation of mental illness specifically borderline personality disorder as a very specific type of social exile then the construction of this experience as holding opportunities for reconfiguration and self-definition is quite eschewed from current treatment agendas.

Interestingly, Marsha Linehan's "coming out" with her own history of being diagnosed with borderline personality disorder speaks clearly to her own reconfiguration of mental illness and female subjectivity (Carey, 2011). As the diagnosis of borderline prior to Dialectical Behavioral therapy had been that the disorder was essentially a permanent personality structure, she first transformed the definition of the diagnosis and then owned her own subjectivity within it. Clearly, the experience of othering within this context allowed Linehan to reconfigure not only her own connection to a fragmented self but also the social and political meaning of otherness. What is problematic is that her process of reconfiguration is not attainable through the maintenance of her methods; rather that it was the process of exile and reconfiguration itself which allowed for movement away from rigid identity structures. Between Julia and I the process of her own diaspora as well as the fluid holding of expertise in our relationship allowed for her to experience multiple self states in relationship with me as well as to redefine her own self concept with her family of origin. Through this particular interpretation, Julia's "voice" in therapy represented a political reconfiguration of gender and cultural archetypes, a notion that stretches beyond a "strength based perspective" into the field of political action as well as personal empowerment. The capacity to ground treatment in political histories allows us, as therapists, to view our clients as actors within their own political narratives as well as to facilitate authentic exchanges of love and compassion across political and interpersonal difference.

Kelly

I was transferred Kelly's case midway through my internship. During our work together, which focused mainly on her recovery from substance abuse as well as a complicated trauma history, we established a speedy and emotionally rich rapport. Shortly into our work together Kelly didn't show up for an appointment and when she called to reschedule she told me she had

gone on vacation and then hadn't been able to get back home in time for our appointment because her ride home had left her there. This moment was a turning point for us clinically, but also raises an issue that comes up often in treatment: how to we as therapists manage our clients desire to push us away and/or avoid therapy?

One aspect of this exchange that seems particularly salient to both relational as well as transnational feminist perspectives would be the underlying enactment of the roles of "tourism" and "nativism' in our encounter. Jamaica Kincaid identifies the dynamics of oppression inherent within tourism in her article, *A Small Place*. She highlights the ways in which wealthy, white tourists exotify the people and country of Antigua in the Caribbean in order to maintain notions of race and national superiority for both monetary as well as interpersonal ends. She writes,

> They do not like me! That thought never actually occurs to you. Still you feel uneasy. Still you feel a little foolish. Still you feel a little out of place. But the banality of your own life is very real to you; it drove you to this extreme, spending your days and your nights in the company of people who despise you, people you do not like really, people you would not want to have as your neighbor…That the native does not like the tourist is not hard to explain. For every native of every place is a potential tourist, and every tourist is a native of somewhere.…Every native would like to find a way out, every native would like a rest, every native would like a tour. But some natives—most natives in the world—cannot go anywhere. They are too poor. They are too poor to go anywhere. They are too poor to escape the reality of their lives; and they are too poor to live properly in the place where they live, which is the very place you, the tourist want to go—so when the native sees you, the tourist, they envy you, they envy your ability to

> leave your own banality and boredom, they envy your ability to turn their own banality and boredom into a source of pleasure for yourself. (156)

Kelly's history of trauma and addiction appeared strongly linked to not only her working class background but also her life as situated within rural poverty. By contrast, I had grown up in the same county going to different schools, living in different neighborhoods, experiencing life within the context of a white middle class family. Despite overlaps in our families histories of addiction and mental illness our experiences of these histories was quite different as mine had never being threatened with homelessness, or experienced the interference of social services such as the Department of Child Protective Services. In many ways our class difference created an enormous divide for us to overcome as I could easily be identified as a "tourist" of Kelly's life—choosing a profession where I regularly interact with people with lives that my profession has exotified and categorized—using their lives to not only build a profession that financially supports a highly educated workforce but also enables the wealthy to "visit" the lives of the poor and examine their every move and thought in extraordinary detail. That I was a tourist in Kelly's life was heightened by the fact that I was to meet with her for a very brief four sessions and additionally that I was leaving to return to my elite college due to my unpaid internship was coming to an end.

The beauty of our enactment is that Kelly managed to flip the tables within this dynamic, if briefly, long enough for her resistance to the pejorative and classist structural and interpersonal forces to be highlighted. In other words, Kelly didn't show up for therapy because she went on vacation. Yes, her ride bailed on her, and she had planned to come, and this of course only further highlights how her class background impacts her inability to escape the banality of her own life. However, Kelly became the tourist, triggering in me if only briefly the experience of

envying her. What is powerful and interesting about the use of social identity within unconscious enactments is that it allows for the complexity within the social and the political as well as the deeply interpersonal connections to be explored. By not showing up for our appointment Kelly didn't erase the cultural oppression the held us captive relationally, however she effectively vibrated what had previously been rigid binary roles of tourist and native enough for my conscious and unconscious relational take on her "resistance" to be held in a more supportive rather than paternalistic frame.

As in Benjamin's (1988) articulation of the dynamics of dependence and independence in the master/slave dynamic, Kelly's unconscious resistance to showing up for therapy created an enactment which forced me to acknowledge both my dependence on her (financial) and separateness from her (emotional) which ultimately heightened my ability to authentically love her. As both Kincaid and Benjamin attest the invisibility of the class/race divide is what creates the possibility for oppression to exist without the oppressor having to acknowledge that their experience is based on the suffering and enslavement (monetary and relational) of the very subjects of the oppressors deepest desires and relationships. In other words, if my love and acceptance of Kelly's actions were based solely on her docility in treatment, then my ability to actually "see" her would have been compromised. Kelly's avoidance of treatment in this frame can be understood as not only understandable, but necessary in order for an authentic and mutual relationship to unfold.

What I find to be the most beautiful and ultimately spiritually intoxicating about this perspective of unwrapping the relational and political enactments within the therapeutic dynamic is that it allows the understanding of each moment to exist outside *and* within current binary constructions of relationship and context. As transnational feminist theorists such as Gloria

Anzaldúa (1987) have attested, resistance to binary constructions is not about finding their opposite but about finding the third space, the space within and between. To highlight the importance of our contextual differences I have noted the many ways that Kelly and I are different however there were many ways in which our authentic connection developed out of our similarities as well. Although I can look back at this process and notice the multitude of "flaws" in my ability to transcend structural and relational oppression in my role as therapist, I think that ultimately it is about recognizing the ways in which this language of oppression becomes a metaphor utilized by the unconscious in order to communicate and enact interpersonal emotional dilemmas. As therapists we must hold ourselves accountable not to be "perfect" in each moment but rather to challenge ourselves to become fluent in the metaphoric expressions of oppression so that we might recognize our clients and our own use of these metaphors within the clinical relationship.

Two important things to note: In contrast to a cultural competency model (Hays, 2008) I do not argue that knowledge of specific cultural differences is "fluency" in the language of oppression rather that oppression is constructed and maintained in similar avenues and patterns structurally and that these same principles may be used to understand individuals interpersonal enactments. Secondly, I am positing that client's resistance and avoidance of therapy, especially with clients who are victims of both social and relational oppression, actually indicates both a communication to the therapist about the structural oppressions being enacted within the therapeutic relationship *as well* as a political act of resistance to structural oppressions as a whole. This step towards differentiation should not be pathologized as this only further strengthens notions of superiority based on race, class, gender, sexuality and nationhood.

Supervision

As I have grappled with describing moments of emotional connection and distance within my own clinical practice one fundamental relationship has thus far been omitted. Throughout this process of reflection and practice, my work has been connected and in many ways guided by my relationship with my thesis advisor and clinical mentor who for the purposes of this case I will describe as my supervisor, although she inhabited this role relationally, rather then professionally, as the title of her role in my academic experience was as both instructor as well as advisor. It is interesting to me that many clinical case studies omit supervisory relationships, in whatever their manifestation, from the analysis given the importance supervision and case consultation has been given in the field. Internally, I can understand the avoidance of this subject, as discussing my own supervision especially within an academic context forces me to step back from the "knowing" stance and become more vulnerable within the context of this narrative. It seems the Benjamin's hypothesis of relationships of domination (1988) suits the context of this dilemma as I continue to struggle with my own desire to internalize and recreate the masters' texts. Audre Lorde (1984) pointed out that "the masters tools will never dismantle the masters house," yet therapists are charged to perform this clinical "knowing;" perhaps we can manage this dilemma by engaging in a reflexive practice in our own understanding of relationships with clients as well as in supervision (Hawes, 1998).

At the center of this story is the insecurity and ambivalence that rises out of any learning experience and it was at this moment, weeks before I was to start my first clinical internship, that I met advisor and our supervisor/supervisee relationship of sorts began. She held a relational psychodynamic stance and through our clinical discussions, I came to feel closer and closer to this form of understanding my work. In part this was due to the theory itself although it was also tied to my deep respect and admiration towards her as a person and clinician. I felt that she saw

me, for who I was, and also that she supported me and saw the very best in me. This experience of being "known" is a very intimate experience, although this intimacy was really an intimacy with and between my own subjective selves. Although my supervisor and I have worked together throughout my process in school we have not spent a great deal of time together. Really, the development of intellectual intimacy was in many ways similar to with our clients, where my ideas were the object of out mutual exploration and as such I grew to trust her as I also grew to trust my self—to recognize the notes of my own harmony.

As described in the previous case vignettes this experience of closeness and intimacy is only initially possible through the experience of one self state not multiple. The growth of relationship and self develops out of the connection that allows for individual movement between self-states—between connection and differentiation. If she and I were to remain within the prescribed script of masculinized domination within relationships, it would require that one of us attempt to destroy the other. Interestingly, as the process of writing my thesis was nearing it's close and my continued relationship with my supervisor hung in the balance (what next? where from here?) I had a startling dream. I dreamt that she and I met to discuss my thesis and when we met she was wearing roller blades. She skated circles around me and then she took my arm and we skated off to our destination together, as friends and equals. Initially, I wasn't sure how to hold this dream, unsure if I should be ashamed that I had hopes of being her peer however unconsciously they were buried. After this dream, I couldn't stop thinking about our process and its connection to "my" work in developing my own clinical stance. How could I write about mutuality and rejoicing in our clients' multiplicity and differentiation without discussing the very relationship that fostered my own multiplicity and growth as a clinician? At our next meeting as I described these thoughts to her, she looked at me startled and asked if I had

received her email. I hadn't read it yet and I asked her what she had said. She told me that the evening before she had written me asking if I would be interested in participating in a peer supervision group she was formulating. She described how she had hesitated, knowing it required a certain shift in our relationship from advisee to peer.

This level of attunement to relationship, both with clients as well as within supervision, is truly the foundation for mutual and autonomous growth, as my supervisor and I rejected the script of domination and destruction in favor of mutual and equal subjectivity (Benjamin, 1988). It was in this moment that I was able to understand not only that she was aware on some level of my need to shift our relationship so as not to destroy it (figuratively) and also that she was another person, someone who was impacted by me as I had been impacted by her. As she allowed this shift, she hesitated, and I can only assume that in that moment there must have been some level of fear. The very scripts we hoped to avoid are the ones we know best. They are the structures of our enslavement and therefore the objects of our own deepest fears and desires. They represent individualized sovereignty and dominion (Benjamin, 1988); to step outside these scripts means rejecting the alluring mirage of individualized power at the loss of inter-communal connection and social equality. For my supervisor to choose mutuality over individualized subjectivity would cause some anxiety because it is both an inter-subjective choice as well as a political act of resistance that recognized mutuality as the largest threat to structural systems of oppression which laud the rugged individual.

This example highlights my own growth through the allowance and exploration of differentiation and mutuality of experience and serves to bridge the false divide between my self as clinician and myself as client. This bridge serves to reinforce feminist notions of transnational

discourse (Moraga & Anzaldúa, 2002) as well as to address the relational frames reflexivity towards self as mutually entangled in our clients dilemmas.

Conclusion

This paper has outlined a historical framework for understanding the construction of the borderline personality disorder diagnosis in its political and social contexts. Primarily, the usefulness of this analysis rests in the intersection of feminist and relational theories as they address the history presented as well as implications for future treatment. The exploration of a topic that rests in histories of both social oppression as well as inter-personal violence and trauma, demands that attention continually be paid to highlighting avenues for resistance, resilience and healing. From this stance, and the exploration of multiple and reflexive case examples has served to highlight the complexity of holding multiple self states within the clinical relationship. These case examples have also identified narratives of structural oppression within relational enactments and described how these enactments both serve to differentiate from a prescriptive and oppressive script of relationship as well as acts of political resistance to structural and relational oppression. As the clinical field struggles to understand the connection between individual relationships and political processes this research hopes to add to that dialogue through this contribution to the collective consciousness.

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