"Citizens of Nowhere": Diffractive Engagements with Borderline Personality Disorder

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Citizens of Nowhere: Diffractive Engagements with Borderline Personality Disorder

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PhD Interdisciplinary Humanities, Concordia University 2017

This thesis examines lived experiences with Borderline Personality Disorder through arts-based qualitative research and 'friendship as method'. Rather than treat social experience as distinct from material, or biological realities, the thesis builds on a feminist, new materialist position that resists a division between matter and meaning. A diffractive approach is used to work through problems of representation that divide vision into self/other and to facilitate the emergence of stories along different patterns of relating. Intra-action implies the emergence of experience through and within our entanglements, rather than inter-action, which presupposes the object prior to its relations. Given that women with the diagnosis of Borderline Personality Disorder (or those with the same grouping of symptoms) are incarcerated at a disproportionately higher rate than those who do not, the thesis also works to move beyond some of the limitations of prison abolitionism and mad studies scholarship, whose social constructionist frame marginalizes emotional experience and fails to reflect the needs or lived experiences of women with the diagnosis of Borderline Personality Disorder. By diffractively working through the lived experiences of collaborators, the author presents three 'friendship' stories with fictional characters that represent contributions from all participants in the project. These stories help us to imagine ways in which prison abolitionism and mental health advocacy movements can dismantle harmful institutions without relying on discursive structures that marginalize those who are most vulnerable. This thesis seeks to expand abolitionist theorizing, by holding space for critical attention to suffering that emerges intra-actively between and within us.

dedications

For Camille. I'm so sorry.

For KJ. Building emotional literacy is a matter of survival. You should still be here.

It feels wrong to claim authorship to a project such as this. I am deeply grateful for the friendship and insights offered to me by my collaborators. I wish the world was kinder, so I could name you. Thank you for persisting. And resisting. And showing me the stars in your bellies and the scars on your hearts. I have tried my best to inscribe them into some kind of official record. Again, we will keep the stories going. We paint the cave walls together. This is what we do.

For the kids that are 'hiding in closets with sharpies, covering their skins'.

For the parents and loved ones that are banging on the doors of the ER and being turned away.

For Ria Mae.

Especially, for my sister. You work the frontline. You know.

For all of you who work in transformative justice; who build cultures of indispensability; who build containers. For the pincushion starfish.

For the women who write poems with me in jail.

For Family. For the resistance. For the Girl Gang. Ride or Die.

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These pages exist, largely because of the physical and emotional labour of my (chosen) family. I was able to complete this project because of my dad, who followed behind me, tending to the creatures I collected along the way- my dogs, my horse and the ducks I raised in my living room while I wrote Chapter Three. I was able to complete this project

because of my brothers, who fixed things that were broken and kept me laughing even when things were at their worst. My sister, who was an unwavering ally as we both worked within the institutionalized mental health care system. Grace and Wayne, your lion hearts prevail. Stella, Laura, Kim, Rosa, Bonnie, Mark, Ryan C., Margaret and other dear friends who put up with me through all the selfishness that this kind of work requires. It is hard to face the darkness of the world- making kin keeps the fires burning.

And, mom, who demonstrates the power of emotional literacy. She taught me that 'validation' and a 'willingness to feel' are acts of deep resistance against the alienation of these terrible times. She was/is the original point of reference for this work.

Prologue

October 19th, 2007

Ashley is in a tiny segregation cell with beige-painted walls and a metal cot bolted to the floor. She is wedged between a corner of the cot and the wall, slumped face down on the floor, gasping for air with a strip of fabric tied around her neck, while a prison guard films her from outside the cell door.

She tied a ligature around her neck and tightened it until she could barely breathe.

A male correctional officer calls into her:

"Ashley- Ashley. I need you to get up."

Ashley's body becomes still, her chest and neck wrapped around the metal leg of the cot. She does not respond.

He continues to stand- outside the cell- with a camera pointed at her now motionless body.

Nine minutes later, a group of guards enter the cell. The camera, continues filming her motionless body as the uniformed legs of correctional officers, pace, confused, around her face. They debate whether or not Ashley might be faking.

They leave the cell.

They continue to film her body.

Three minutes later they return- realizing there is no visible movement of breath in her chest or upper body.

"ASHLEY! ASHLEY:" a female guard yells.

A male guard kneels down towards Ashley's body. "Oh my god, you guys..."

The female guard responds: "Is she awake? Is she breathing? WHAT!?!"

Silence.

They continue to film her.

The grainy footage shows panic and urgency in the footsteps of the correctional officers around Ashley's ashen face, her dark curly hair pulled up in a loose bun, her body: motionless on the prison floor.

The female correctional officer panics: "Jesus Christ I haven't had fucking CPR training in 11 years, gimme a break. Get the nurse"

Paramedics arrive 24 minutes later. They attempt CPR for a long period of time, to no avail.

Ashley is later taken to hospital where she is pronounced dead.

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Ashley was incarcerated as a teenager in New Brunswick for throwing crab apples at a postal worker. She was diagnosed with learning disabilities and borderline personality disorder. She often 'acted out' in school and, later, inside correctional facilities. She accrued more charges as a result of her 'disordered' behaviour inside these facilities. She was eventually transferred to an adult prison. During her time in Federal custody, Ashley spent a total of 4 years in solitary confinement and was transferred 17 times between 8 prisons in 4 different provinces. Ashley repeatedly attempted to harm herself, prompting ' use of force' incidents, as guards fought with her to stop her from self-strangulating or cutting. Management eventually gave the order that 'no one was to enter her cell while *she was still breathing'. They believed that she was just 'attention seeking' and did not want to enable further 'incidents' that would require extensive paperwork to be completed as a result. Guards complied. Ashley died by self-strangulation in Grand Valley Institution on October 19th, 2007 while prison staff watched via surveillance cameras from outside the cell. In December 2013, a coroner's inquest ruled her death to be a homicide.*[1].

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I began working in prisons as a poetry teacher just a few short months after Ashley's death. I was hired to work directly with a young woman who also spent extended periods in solitary confinement. She was just like Ashley. She would yell and scream for hours until she was placed back into solitary confinement. She would bang her head against the wall repeatedly until she bled. Management hired me in an attempt to provide some sort of programming for her because she was not allowed in General Population where the majority of programs take place..

After a few months working inside the prison, I began to notice that many of the women in the maximum-security unit had the same behaviours. They had raw, purple scars like tiger stripes from their wrists to their elbows. They were emotionally 'dysregulated'. They were in constant emotional pain. They had trauma histories. They 'acted out' of fears of abandonment and had high conflict relationships- in their intimate lives and also with friends, medical staff and guards.

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[1] Ashley's experiences with the Federal prison system were far more complicated and often more violent

When I began this work, I was firmly rooted in social activism. I accepted the contract with Correctional Services of Canada out of financial need, but felt conflicted about it. In the tradition of post-Foucauldian activism, I believed that prisons and asylums were the architectural manifestation of state violence. They represented problematic social power structures. I believed (and still do) believe in de-carceration. Prisons, asylums and other total institutions - like the ones that Erving Goffman wrote about- symbolized oppression and violence. They were the antithesis of 'autonomy' and freedom.

I became interested in Ashley's story. And the stories of all of the women like her I met through my work in Federal prisons, and later, in community-based mental health facilities. I was curious about the diagnosis that they all seemed to share; 'borderline personality disorder'. I began talking about it with friends and colleagues. Young women I had known for years as a youth worker began to confide in me that they had the same diagnosis. I began to see this diagnosis on the margins of every organization I had been involved in. "Borderline" was a word that was whispered. It was like a dirty secret.

This project began in the prison, but as I worked backwards to trace the pathways that drew women with BPD into disproportionate rates of incarceration, I realized that the prison was everywhere- at every stage of their lives. Although I continued to work as a poetry teacher in Federal prisons throughout this project, my research collaborators took me far outside the prison to show me how deep the roots of carceral violence extend into our communities. This project is about the prison outside the prison.

My doctoral research with women diagnosed with borderline personality disorder has forced me to question the foundations upon which I understand violence, subjectivity and the role of secure - and total- institutions in contemporary life. Ashley's story- and, indeed- all of the stories I have heard since I began this research, have drastically changed my understanding of what 'social justice' means.

Introduction

"Borders are set up to define the places that are safe and unsafe, to distinguish us from them. A border is a dividing line, a narrow strip along a steep edge. A borderland is a vague and undetermined place created by the emotional residue of an unnatural boundary. It is in a constant state of transition. The prohibited and forbidden are its inhabitants."

Gloria Anzaldúa

"There are reasons for emotional dysregulation.
There are reasons for drinking and cutting, for smoking meth and lighting fires. There is a story that makes sense of all this. Nerve damage and nightmare and nostalgia"

Lisa Merri Johnson

This is a dissertation about borders. It is about borderline personality disorder and those who fall through the gaps between our mental health and prison systems. It is about what can be done to hold space for them and how to imagine interventions that account for (and hopefully repair) the harms done to them. In the pages that follow, I explore what the 'borderline experience' means in contemporary life through the stories and creative work of women with direct experience with the diagnosis and secure care in carceral institutions. This work begins with the carceral problem; that of the prison and the asylum as institutions that consolidate and reproduce particular social power relations and particular subjectivities. It is accepted that our contemporary nation state is a carceral dystopia, a version of the carceral archipelago as envisioned by Michel Foucault in *Discipline and Punish*, a state that is built and maintained by systems of punishment, surveillance and control. A carceral state is one in which social problems are scapegoated by responsibilizing individuals and the most marginalized subjects are surveilled, punished and warehoused instead of given access to resources and support with which to untangle and heal problems of addiction, violence, crime and poverty.

The borderline experience is one that lies on the fringes of social institutions in the carceral state. Although many Foucauldian scholars and anti-psychiatry activists view these institutions, including the disciplinary practices of the human sciences, including psychology, law and medicine as forces of oppression, the borderline experience is often one of seeking out and being *turned away* from such disciplinary practices and their respective institutions. From this position it becomes very difficult to ideologically critique services and systems that one has been denied access to. Indeed, from the borders, the defining feature of state violence becomes *neglect* rather than forced intervention. In this way, this project is about how certain forms of social constructionist critique work to alienate those on the borders of social institutions and perpetuate the same violence they claim to resist. The borderline experience is one of being refused entry to a mental health ward when you are suicidal because 'inpatient treatment is contra-indicated'. The borderline clings to the edges of those institutions and structures that contain everyday life. This project seeks to disrupt critiques of the carceral state by collaborating with those it refuses, expels and marginalizes most persistently. Women like Ashley Smith are drastically over-represented in our prison systems, and, since the deinstitutionalization movement in the 1960s, they are also the most likely to be denied mental health care. Ashley's death in custody represents the end of a borderline journey, but it also represents the beginning of this story as we work backwards to determine the ways in which the borderline experience is constructed, articulated and reproduced in contemporary life, and how borderline subjectivities are co-constituted with those considered 'sane' or legitimately 'mentally ill'.

The term ‘borderline’ was first coined in 1938 to describe patients who were too ill for treatment by psychoanalysis, but not clearly psychotic (Wirth-Cauchon, 2000). Those in the liminal zone of being ‘borderline’ were clearly disturbed but not in ways that fit common conceptions of a psychotic patient who has completely lost touch with our shared notion of 'reality'. The diagnosis of borderline personality disorder signifies a confounding of categories- a disruption to the tidy taxonomic systems that western medicine works to organize in diagnostic and statistical manuals. The 4th Edition of the American Psychiatric Association Diagnostic and Statistical Manual describes borderline personality disorder as being characterized by: extreme mood swings and volatile emotional dysregulation, fear of abandonment and rejection, impulsivity, chronic aggressive, anxious or depressive states and behaviours of self-harm including suicidal ideation and attempts at suicide. There is no pharmaceutical solution. The symptoms are difficult to treat and require extensive (and costly) talk therapy. Personality disorders are relational- they rest in the space between us, the place where we show our 'selves' to each other. Personality disorders are a sickness of the 'self' but cannot be traced easily back to the brain. They are not easily understood using western notions of the 'individual' as an 'autonomous machine'. There is no conclusive evidence to point to a problem in 'brain chemistry' as being responsible for these symptoms. Just as the symptoms border upon but do not tidily fit within other categories of mental illness, borderline personality disorder manifests itself just *outside* of us- on our edges, where we form relationships with each other. The border is the place where we spill over.

Borderline subjectivities are, in many ways, produced by the very categories they touch upon, but are expelled from. The violence experienced by borderline women is the violence of being situated at the fulcrum- at the point at which juxtapositional identities sit side by side. Understanding borderline subjectivity in the carceral state, positions us *just outside of* the social power structures we seek to dismantle and shows us a landscape of violence, where the taxonomic processes of Western medicine and the colonial state draw lines in the sand between their respective disciplinary and political domains. The result of this process is that of neglect and de-legitimation of their claim that they are suffering. Most women with borderline personality disorder have trauma histories and, as such, confound the traditional separation of mental illness pathology from that which is broken 'inside' us, such as a malfunction of brain chemistry, and that which happens ' to us'. Yet, unlike physical trauma from a car accident, emotional wounds cannot be healed using current medical technologies that were designed to intervene in tissue and blood. Understanding the lived experience of the diagnosis places us at the point at which nature/culture collide in a messy articulation of suffering that is rendered alien to the domains of biomedical psychiatry and traditional talk therapy. Thus, understanding and articulating the borderline experience requires us to forego the language and conceptual structures of Eurocentric philosophies that rest upon binary notions of subject/object; nature/culture; good/bad. It requires a commitment to work from theoretical and conceptual landscapes that *hold space for both sides; simultaneously* because the borderline is about entanglement- not sovereignty. Critical theorizing about psychiatry has often rested upon social constructionist critiques of western 'objectivism' but, in situating itself in the domain of the 'social' in opposition to the disciplinary power regimes of the human sciences, this critique has *perpetuated* those same binary oppositions that have enacted that same violence we seek to resist. Sustained attention to the lived experience of the borderline will provide a stark contrast against the positions of those 'within' the circle of care, or those who have received psychiatric care and, are now positioned to critique it from the *privileged* position of having received medical attention.

The conventional format for a PhD dissertation is structured by an introduction (which includes a thesis statement), a literature review (which demonstrates the student's mastery of relevant literature in their field) and two separate chapters outlining the theoretical framework and the methodological procedures. This is usually followed by discussion and analysis of resulting data. In this traditional format, the narrative tone is impersonal, disinterested and consistently objectifies the 'data' as something that the author has mastered and then 'reveals' to a scholarly audience. This traditional structure of academic work is dominated by Eurocentric notions of positivism and Cartesian dualism, which posit 'theory' and 'matter' as separate and distinct domains. Contemporary ethnographic practices and other qualitative approaches to social research have attempted to disrupt these structures and practices of knowledge creation, yet relics of modern positivism and Cartesianism remain in bureaucratic practices and policies that govern rituals such as a PhD defense and research ethics protocols. However, the goal of this project was to explore and understand the spaces where official protocols, procedures and policies enact upon and marginalize particular forms of experience. Particular forms of violence and marginalization experienced by borderline women come from practices which seek to exclude or ignore their suffering because is it not 'relevant' or 'tidy' enough to fit within official institutional or social protocols. Archaic ideas about the distinct nature of 'mind' and 'matter' permeate the health sciences and, indeed, much of the carceral state. It is this very set of archaic ideas about individual autonomy and a separation of mind and matter that have created the conditions for continued violence and neglect of women who are called 'borderline'. Their suffering is created by systems that were built with this ontological framework- one which de-legitimates emotion and emotional experience. Therefore, this dissertation is structured in such a way that the 'mess' and the detritus at the edges of a 'neatly designed' study will be allowed to remain. To understand the borderline experience, we must be willing to *sit in the mess* and see value in what is discarded and cast out of the institutional system of our carceral state. In this sense, the format depicts the *struggle* of this research, which is ultimately the most honest and ethical place from which I can invite an audience of strangers into the project. At times, the narrative may feel disjointed- the parts may not fit neatly together and the reader may struggle, moving between the stories of collaborators and sections that engage with scholarly discourse. As I writer, I struggled deeply to integrate the mess and dissensus of my field experience with scholarly discourse. I began to realize that my struggle was an ethical one- it simply did not feel ethical to knit together a cohesive narrative that would feel pleasing to a reader.

The following chapters will present qualitative data gathered through auto-ethnographic and arts-based inquiry with women living with borderline personality disorder. The format I have chosen to use in the preceding pages will expose the reader to my own experiences, as I worked to navigate the painful disjuncture between traditional academic practices and ethnographic immersion in the mess and dis/order that is created at the borders of social institutions and taxonomic categories. I will draw upon feminist, new materialist frameworks and seek to resist the binary opposition of matter/meaning to hold space for borderline narratives to emerge. Data from semi-structured interviews and arts-based inquiry will be presented through three 'case studies' that are based on real life accounts but, 'collaged' into fictional characters in order to protect the identities of my collaborators. Direct quotations and auto-ethnographic description of events will be presented verbatim, with only names and identifying characteristics changed. Data will be analyzed using feminist materialist frameworks such as agential realism (Barad, 2007) and presented according to feminist principles of diffraction (Haraway, 1997; Barad

2007; 2014) that support multiple and contradictory narratives to emerge simultaneously. A diffractive approach ultimately allows for the author, collaborators and readers of the work to understand the women's stories in such a way that does not position them as pawns in larger debates between scientific objectivism or social constructionist critique. I will not be constructing a singular, meta-narrative about the social construction of 'mental illness', but more simply, working to trace the embodied moments of violence that stem from the agential cuts of everyday life in the carceral state as it exists outside the walls of the prison.

While this thesis represents a period of intentional field-work with project collaborators, it would be disingenuous to ignore my previous decade of experience within the community-based mental health community. For the past fifteen years, I have worked as an arts-facilitator in both clinical and non-profit community-based spaces with young people who have experienced mental health challenges. My period of engagement in this PhD research brought many of my previous experiences into sharp focus. Engagement in this research shifted and re-framed my position as a Foucauldian scholar, but also prompted me to re-examine many of my past experiences as an advocate and 'professional' in the mental health community. In this sense, this thesis is auto-ethnographic as much as it is based on deliberate and sustained qualitative field-work. To ignore the role of my past experiences in structuring my interpretation of data, would be to erase from the frame many of the 'normalizing' forces of discipline in the mental health community, which is the very process that I seek to disrupt. In this sense, the story is both backward-looking and forward-oriented, and in no way chronological.

Disruption of linear chronology is part of a diffractive approach (Haraway, 1997), which attempts to move beyond problems of representation by moving beyond a metaphor of 'reflection' to one that invokes disruption, dissensus and multiple lines of seeing, simultaneously. Feminist new materialist approaches claim to break down problematic binary structures, by refusing to take up oppositional 'social constructionist' positions with which to critique biological 'objectivism' in psychiatry, for example. Feminist anti-psychiatry (Burstow, 2005) and other social constructionist approaches to borderline personality disorder (Becker, 1997) have focussed on the diagnostic category of BPD as an example of 'medicalization' (Conrad and Schneider, 1992) and critiqued the practice of psychiatry as an oppressive force, embedded with patriarchal ideologies that invalidate women's experiences. As Lester (2013) has pointed out these constructionist critiques are *also* deeply invalidating for women with severe experiences of emotional dysregulation. To be told that your diagnostic category is an artefact of your oppression, does nothing to heal your wounds. Even if suffering is caused by experiences in everyday life (such as experiences with oppressive systems), the emotional experience of suffering is real and healing cannot be achieved by simply removing oneself from conditions of oppression. It is much more complex. As Johnson (2010) and Pershall (2011) note, these simplistic and abstract forms of feminist and social constructionist critique can undermine a very real and pressing need for women to access treatment in existing medical systems- even if the treatment is imperfect and oppressive. The feminist new materialist position attempts to carve out space to critically work through pressing issues of justice and inequality In the context of this project, the onto-epistemological commitment to a feminist new materialist position is demonstrated by untangling and refusing the binary oppositions that are set up by adopting 'social critique' against 'medical objectivism'. The new materialist position, although difficult to achieve in academic *practice*- as existing discourse in the field is heavily structured by disciplinary divisions between 'social theory' and 'medical knowledge'- makes space to refuse binary oppositions throughout the collaborative research process and place emphasis on the emergence of experience through and within our entanglements. Ultimately, taking up a feminist new materialist position provides the most rich and open context in which to explore and disrupt how and where suffering emerges in the lives of women who are affected.

The stories presented here point to the importance of moving beyond Eurocentric binaries of matter and meaning in order to account for and resist the violence enacted upon those who fall victim to being 'less than human', or are cleaved from subject status into the grey zone of objectified, liminal experience. Intentional commitments to vulnerability and intimacy in the research process will position this project outside of the tradition of 'reflexivity' in qualitative research, which relies upon binary conceptions of self/other in the research process. This thesis will examine social life as an emotional landscape in which patterns of relating; or affective choreography, works within patterns that are shaped by, through and sometimes in spite of, the structures of the carceral state. Analysis of the findings will make a case for sociological attention to 'attachments' and push for a relational understanding of suffering and 'illness' that moves beyond critiques of biomedicine and into collaborative negotiation with the disciplinary practices of psychiatry in order to re-pattern social relations in transformative ways. The experiences of borderline women bring us to the point at which we must form intra-subjective ways of accounting for suffering and the disciplined practice of medicine in everyday life. This dissertation speaks to all of those who grieved for Ashley Smith, for others like her, and seeks to make space for a different kind of collaborative world-making between activist, academic and community spaces, where decarceration can become an active project- not just in opposition to architectural spaces- but performative projects that unfold in emotional territories and the spaces between us.

Chapter One: Against the Carceral State

A review of the literature in critical prison studies, mad studies and sociology of psychiatry

they said we were animals

that WE had lost OUR reason

what kind of reason does a person have

for chaining another to a wall?

for tying them down and performing

frontal lobotomies?

using ice and insulin to shock their bodies?

Hitler's idea for his famous gas chambers

came from the euthanasia program at the local

Berlin psychiatric hospitals

(Excerpt from a poem by LB)

Introduction

In the preceding chapter, I offer a somewhat disjointed pathway through relevant literature in my field; work that I believed would help me to understand both the diagnosis of borderline personality disorder and its overwhelming presence in the prison system. Although these foundational texts and concepts were pivotal to my development as a scholar, I found myself increasingly frustrated with my own growing sense of a disjuncture between social theory and the lives of the women I was working with in my research. The following section contains snippets of the work of many brilliant and important scholars who have shaped my thinking on 'self', 'subjectivity' and 'carceral state', however, the literature review will be occasionally disrupted by my own increasingly fraught relationship with these bodies of work.

Michel Foucault

In 1954, Michel Foucault published his first book, *Mental Illness and Personality* (Mahon, 2001). Young Foucault, who received his license in psychology in 1952, was deeply critical of the discipline. He argued that psychology could not possibly be as 'scientific' as biological medicine because: 'the human personality cannot be grasped as an organic totality" (Mahon, 2001 p. 181). He later abandoned his first book and re-released a revised version which concluded that mental illness is a cultural construct and argued that our notions of 'pathology' tell us much about our normative notions of what it means to be human. His doctoral dissertation, which was later published as *Madness &*

Civilization in 1960, remained critical of the human sciences (Foucault, 1965). Foucault's transformation in thought between his first book and *Madness & Civilization* signified a shift from Marxist realism to a position that abandoned notions of 'objectivity' as anything other than a cultural invention.

Foucault's preoccupation with psychology and madness was influenced by his position both as a student and scholar within the discipline and through his own battles with suicidal depression, self-harm and experiences as a patient (Miller, 1993). During his time at the École Normale Supérieure, he was assessed by the school doctor who concluded that his persistent depression and attempts to self harm were the result of repressed homosexual feelings, which were not accepted in France at the time (Miller, 1993). Foucault's own position, both as an 'expert' in the field of psychology, and a patient whose suffering was constituted by and through social forces- the combined effects of homophobia and a Roman Catholic upbringing in mid 20th Century France- cannot be ignored. It must also be asserted that the young Michel Foucault had *access* to psychiatric care and was positioned within the elite academic system in France at the time.

Madness, Prisons, Punishment

In *Madness & Civilization* (1965), Foucault traces the evolution of 'madness' from the Renaissance to the modern period. If we follow Foucault's archaeological (and later genealogical) treatment of madness, medicine and punishment, it becomes clear that the history of madness and the history of the penal system cannot be separated. Practices of confinement and segregation of 'undesirables' are deeply intertwined as political tactics of rule and governance throughout the history of the west. For Foucault: "[t]he Middle Ages has given madness, or folly, a place in the hierarchy of vices" (1965, p. 24) and thus, the practice of institutional confinement became a means to execute discipline over such 'vices' in this period of Western rationalism. The period of the 'Great Confinement': "seemed to assign the same homeland to the poor, to the unemployed, to prisoners and to the insane" (Foucault, 1965 p. 39).

Where institutions that previously housed leper colonies became emptied by the gradual retreat of the disease, the practice of incarcerating those guilty of 'madness' or 'folly'- prostitutes, unemployed persons, epileptics and mentally ill -filled them up again: “poor vagabonds, criminals, and ‘deranged minds’ would take the part played by the leper” (1965, p. 7). During the plague of leprosy, the traditional Christian practice of lending a helping hand to the poor and the sick was reversed. To discourage spreading of the disease, a new religious value was instilled: that of being saved through *exclusion*. Foucault notes that lepers: “are saved by the hand that is not stretched out” (1965, p. 7). Thus, the earlier Christian value of inclusion as moral salvation, was replaced with the penance of exclusion.

As Foucault argues, the end of the Great Confinement began with the birth of the asylum; at the point at which Philippe Pinel, the father of contemporary psychiatry, becomes the benevolent champion of the madman, securing a more civilized and humane facility to treat them, where there are: "[n]o bars, no grilles on the windows" (Foucault, 1965 p. 242). Thus the birth of the asylum symbolizes the transition from architectural confinement to the less tangible process of governmental power in which the madman is now ruled through the practice of contemporary psychiatry.

Fifteen years after the first publication of *Madness & Civilization*, *Discipline & Punish* (Foucault, 1995) brings us to a similar, pivotal moment in which the founding of the Mettray Penal Colony in 1840 becomes the point at which the penal system secures itself as the dominant system for the organization of power in contemporary life. Foucault writes: "[w]hy Mettray? Because it is disciplinary form at its most extreme, the model in which are concentrated all the coercive technologies of behaviour" (Foucault, 1995 p. 293). Mettray Penal Colony holds historical significance as a landmark shift from architectural confinement, to a space *without walls* where juvenile 'delinquents' were free to roam, but now subject to the disciplinary powers of the human sciences. Thus, the point at which the logic of confinement became disseminated into the logic of visibility and surveillance by disciplinary norms was intertwined with: "the birth of scientific psychology" (Foucault, 1995 p. 295). Foucault argues: "it was the emergence or rather the institutional specification, the baptism, as it were, of a new type of supervision- both knowledge and power- over individuals who resisted disciplinary normalization" (1995 p. 296).

The Mettray Penal Colony was: "the most famous of a whole serious of institutions which, well beyond the frontiers of criminal law, constituted what one might call the carceral archipelago" (1995, p. 297). Foucault (1965; 1995) begs us to consider that the *removal* of our chains might actually be the point at which we become *more* subject to the political tactics of rule; where criminal law and diagnostic and statistical manuals become the architectures of confinement, surveillance and discipline. Psychiatry and the carceral system become the logics in which governmental power expresses itself and their respective disciplinary institutions become factories to reproduce and consolidate power in the carceral state, through the shaping of human subjectivity.

The Antipsychiatry Movement

Foucault's critiques of psychiatry are often referenced as part of the broader anti-psychiatry movement of the 1960s. At roughly the same time that Foucault was publishing his first book and beginning work in mental hospitals as a psychologist, sociologist Erving Goffman was conducting ethnographic fieldwork in an asylum. It should be noted that: "[t[he highest rate of aggregated institutionalization during the entire twentieth century occurred in 1955 when almost 640 persons per 100,000 adults over age fifteen were institutionalized in asylums, mental hospitals, and state and federal prisons"(Harcourt, 2005 p. 1754). Thus, the period in which Goffman, Foucault and other scholars in the antipsychiatry movement were most active, was during a time in which large numbers of the population were institutionalized in asylums.

In 1961, Goffman published *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, in which he put forth his concept of a 'total institution' and traced its effects on inhabitants. Whereas Foucault's archaeological and later, genealogical approach helped us to critically understand the discursive construction of social structures of ‘madness’ and the birth of the asylum, Goffman locates us more firmly inside the relationship between individual actors and the social structures and normative practices around them. Foucault also looked for patterns, symbols and addressed the construction of meaning and used archival historical documents as his ‘data’. Goffman’s work was completed using qualitative fieldwork, specifically, participant observation inside the asylum. The four essays contained in the book explore the role of everyday rituals and practices inside the institution and their power to humiliate and erode the identity of inmates, thereby erasing their sense of 'self'. Goffman's notion of a total institution, is similar to Foucault's notion of a 'complete and austere institution (1995).

For Goffman (1961), a total institution is a "social hybrid; part residential community, part formal organization" (p. 12) that is, a self-contained space in which a strict separation between staff and inmates is maintained and all facets of daily life for inmates is restricted by the bureaucratic procedures of the institution. Total institutions have a profound impact on the self-identity, or subjectivity, of the inmate. Goffman's critical work on the asylum argued that total institutions erode the inmate's identity in ways that make healing impossible. It erodes the ‘self’ through systematic control over the patient’s ability to protect oneself from contaminating forces. The practices involved in this process include forced social relationships with people the patient wouldn’t otherwise associate with, unwanted medical intervention or replacement of the patient’s belongings with institutional materials that contain the traces of others, such as soiled shirts or dishes.

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You can get there using any of the elevators, but only one of them brings you right to the security door with the doorbell that you need to ring to get in. The youth inpatient unit is 'secure' meaning that a nurse has to buzz you in and out. You need an i.d. card for entry or to be listed as a visitor for a young patient. The outdoor rec yard is surrounded on all four sides with 10 feet of chain link and there is barbed wire at the top. It's on a rooftop. And covered in pigeon shit. There is a basketball net out there- just the rim. No net, actually. It is possibly the most depressing and lonely place on Earth. But it's chaotic inside. The walls in the activity room are painted with whiteboard paint and covered in colorful scribbling. There is graffiti everywhere. There are kids' paintings on the walls. The nurse at the desk is watching YouTube videos of a baby rhino making friends with a baby hippo at an animal sanctuary. Everyone is talking about Terry- the senior Psychiatrist- and how he tried to sing a song from Frozen during the karaoke lunch jam. I already know what has been happening that day because some of the kids texted me. I pop my head into the nursing station to say hi- "Did you hear that Terry tried to sing Elsa's song from Frozen!?!" I laugh. The girl I was hoping to see won't be coming to the poetry session. She is in TQ.

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Where Foucault (1995) put forth the idea of the carceral continuum to explain the ways in which carceral logics of discipline and punishment become part of everyday life, Goffman focused more closely on the role of strict enclosure as a tactic of rule and saw total institutions as very separate structures from that found in everyday life[2]. Goffman's work gives insight into the role of personal boundaries and the relationship between self and other in defining the moral experience of the patient inside the asylum: "in total institutions, the boundary that the individual places between his being and the environment is invaded and the embodiments of self profaned" (Goffman, 1961 p. 23).

The final section in *Asylums* on *The Moral Career of the Mental Patient* illustrates how the psychiatric gaze and even the most mundane practices, such as the creation of a medical file all contribute to the process of moralizing the patient's sense of self to align with the institutional mandate to create a uniform and predictable population of compliant patients. His critical ethnography of the asylum was a crucial text in the history of anti-psychiatry and has been frequently cited in support of the deinstitutionalization movement of the 1960s.

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I got a message from a parent today. Their daughter has been self harming and suicidal for almost 8 weeks and they won't admit her when she goes to the ER. I hardly ever check my messages on my desk phone. Most of the kids just text my cell. It was from last week. I hear a woman's voice- cold and distant like she is on autopilot.

"I am not sure if this is the right office to be calling. My daughter has been cutting herself all summer. It's been getting worse. I can't control her. I have been to the ER at this hospital 5 times. They will NOT admit her. She is 19. She is still young enough for the

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[2] Foucault also addressed the importance of enclosure in institutional disciplinary practices, but placed greater emphasis on the transition of disciplinary power outside of the institution along a 'carceral continuum'

kids' ER but they won't see her there either. We have been sent to the other ER twice now and when we get there they won't do anything. I need to speak with someone who can explain to me what I can do. Please, I don't know what to do. We don't have the money for a private psychiatrist and I am worried I won't be able to stop her if she tries again. I don't even know if we are on the waitlist. No one will tell me what is happening"

Civil Libertarian Critique of Psychiatry

During this same period, psychoanalyst Thomas Szasz published a letter in the *American Psychologist* in which he argued against what he called ' the myth of mental illness'. He argued that: "belief in mental illness, as something other than man's trouble in getting along with his fellow man, is the proper heir to the belief in demonology and witchcraft. Mental illness exists or is "real" in exactly the same sense in which witches existed or were "real." (1960, n.p.).

Szasz is widely regarded as a founding father in the antipsychiatry movement, and was arguably one of the most radical. He argued against the diagnosis of mental 'illness' and suggested that we abandon notions of 'illness' in favour of seeing the symptoms as part of the human struggle over how to live together (2011). He was staunchly against any medicalization of the 'mind' and posited a strict dualism between mind and matter: "I use the word "psychiatry" here to refer to that contemporary discipline which is concerned with *problems in living* (and not with diseases of the brain, which are problems for neurology)" (Szasz, 1960 n.p.).

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I am taking time out of editing a Moodle page for my students by checking notifications on the Mad Studies page on facebook. It's moderated by mental health consumers and some high profile Canadian and British scholars in the field. Someone has posted a newspaper article about a protest in Montreal against the use of ECT- or electroconvulsive therapy. I feel prickly. I text a couple of my collaborators:

"Hey-- remember that chat we had about ECT when you were an inpatient? There is a group protesting it in Montreal. Check the Mad Studies fb."

One responds right away: "that's fucking bullshit. meds did nothing for me. i would be dead right now if wasn't for ect. fuck inpatient care but omfg i don't know what ect did but it did something. like we talked about. ect some magic shit."

The other responds later: "Sometimes it feels like with this mad studies stuff.. It's like how second wave feminists always want to tell sex workers that prostitution is 100% wrong. But, what they should really be doing is listening to those of us who keep doing what we want to do. And just help us make it safer. Stop judging me for wanting psych meds. Or ect."

I smile. Yes. Sometimes Mad Studies feels like second wave feminism, finger-wagging at pro-sex youngsters. Sometimes it does.

I notice later that day, that in the comments under the post, someone is quoting Thomas Szasz with reverence. I feel my skin crawl again. 'He was a fucking libertarian, for chrissake. Good luck getting his help when you are bawling your eyes out at 2am and staring down the dark hole of a pill bottle'.

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At the same time, Szasz was a civil libertarian who vehemently opposed institutionalization and argued that the diagnostic and treatment process was an inhumane assault on human dignity (Szasz, 2011). He also opposed any notion of 'not criminally responsible' in the criminal justice system and argued that psychiatrists were colluding with criminals in order to ensure that they were not held accountable in a court of law. He believed that 'diminished responsibility' was a fraudulent construct used in the defense of unconscionable criminals (1961).

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I want to tell you how angry I am about the way that scholars and activists use anti-psychiatry texts. I want to say that it is because things are SO different from the 1960s and that we need NEW forms of critique to account for neglect. I want to rant about structural adjustment and the World Bank and the 1980s... How in the absence of asylums we have a new monster on our hands- silence. And a refusal to fund anything. But sometimes, this anger comes, because they make me feel lonely. In Psychiatric spaces I feel like I am undercover. Like I am sitting in the lap of Empire and pretending to like it. Often I stumble trying to tell my collaborators how frustrated and confused I am- how *hearing their stories - and then trying to make sense of everything in social theory and medicalization literature- is the loneliest thing in the world. How I have stacks and stacks of notes on sexual assault, child sexual abuse, the different ways that wrists have been slit, about schoolyard bullying that makes me nauseous in the depths of my ribcage... And how Mad Studies scholars and Foucault and Goffman are the friends I want to call and cry to. But there just isn't a place for these ugly things, there. Except Laing. Except Bateson. They are like those psychiatrists in the unit who don't have egos- the ones who have cool glasses but don't wear flashy watches or designer shoes. Laing and Bateson feel like those allied psychiatrists who send you private fb messages and texts to vent about a lack of funding. The allies. The ones who understand the complicated dance between broken systems, empire and wounding.*

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Cybernetic Ontology & Anti-psychiatry

Although they are considered to be colleagues in the early anti-psychiatry movement, R.D. Laing was not a libertarian nor did he hold the same social values as Thomas Szasz. Laing, a Scottish psychiatrist in the 1960s, stressed the role of the social environment and argued against the trend to posit all mental distress as a result of neurochemical imbalances that have yet to be definitively proven. Although Laing did not argue against psychotherapy or psychiatric treatment, his contribution to the antipsychiatry movement served to validate the experiences of patients with psychosis. Similar to Gregory Bateson (1973), he believed that psychosis was a valid expression of distress in response to particular types of environments (Laing, 1988).

Later, in *The Cybernetic Brain*, Andrew Pickering traces the historical rise of the cybernetics movement in the 1960s, which was an important thread in critiques of psychiatry during this period. Pickering (2011) argues that the cybernetics movement was both ontologically and epistemologically distinct from the oppositional camps of positivism and social constructionism. Although the book is not expressly about the history of psychiatric critique, Pickering reviews the work of Laing and Bateson as pivotal in both the cybernetics and anti-psychiatry movements.

Married to Margaret Mead and making many notable contributions to the field of anthropology in the twentieth century (Pickering, 2011), for Bateson, psychosis was a highly complex system of adaptation to the environment that served to transform the self. His critique of clinical psychiatry rested on the cybernetic belief that we cannot simply ‘control’ things through the scientific method. Cyberneticians believed that notions of the scientific method, or cause and effect were far too simple to be applied to the complexity of life: “we do not live in the sort of universe in which simple linear control is possible” (Bateson as quoted in Pickering, 2011 p. 179). For Bateson (1973), the psychiatrist is one half of what should be a *symmetrical* relationship. The normative gaze is made visible and considered a symmetrical part of a system of exchange, negotiation and adaptation.

Similarly, Laing argued that the problem with biomedical psychiatry was an epistemological one. Mental illness is *socially* diagnosed (using normative ideas of conduct and behaviour) but treated ‘biologically’. In *Self and Others* (1988), RD Laing writes: “the most significant theoretical and methodological development in the psychiatry of the last two decades is, in my view, the growing dissatisfaction with any theory or study of the individual which isolates him from his context” (Laing, 1988 p.

65). Here, Laing explores the process of identity co-creation between individuals and argues for a practice of psychiatry that is rooted in notions of *sociality* and resists the fragmentation of mind and body. He writes: “one does not wish to sever ‘mind’ and ‘body’, ‘psychic’ and ‘physical’. One must not treat persons as ‘animals’ or ‘things’, but one would be foolish to try and disrupt man from his relation to other creatures” (Laing, 1988 p. 65).

Laing views the ‘self’ as something that is not contained within an individual. The notion of complementarity is: “the function of personal relations whereby the other fulfills or completes self” (Laing, 1988 p. 66). The idea that: “other people become a sort of identity kit, whereby one piece together a picture of *oneself*” (Laing, 1988 p. 70) relates very much to Goffman’s notion of the *mortification of self* inside the *total institution* which points to the ways in which the environment - and all its rituals and choreography- shapes the 'self'. Laing’s views on psychosis, specifically that of patients suffering from schizophrenia, were counter to the traditional assumption in clinical psychiatry that the patient’s brain was broken and suffering ‘false’ sensations. Instead, he believed that psychotic experiences were, in themselves, a valid and real experience and resisted the authoritarian practice of clinical psychiatry that attempted to regulate and coerce patients into a normative view of reality.

Laing’s thoughts on complementary identity challenge not only the individualist view of selfhood in clinical psychiatry, but also point to the importance of the social network or institution in shaping and providing meaning to the development of the singular ‘self’. As Pickering (2011) notes in the introduction to *The Cybernetic Brain*, Laing put into practice cybernetic ideals of *mutualism* and horizontal relationships. In many ways, Laing also put into practice what have emerged as contemporary ideas in sociology and feminist theory, such as intersubjectivity. Both Laing and Bateson's notions of the 'self' were thus close to Foucault's understanding of subjectivity.

More importantly, however, Pickering's history of Cybernetics points to an emerging paradigm that was not positioned as a social constructionist critique of positivism in psychiatry. RD Laing suggests that the 'anti-psychiatry' movement of the 1960s was not, in fact, against psychiatry, but a cybernetic version of the previous medical and psychoanalytic models in the earlier half of the twentieth century. Cybernetics *grew out of* psychiatry and, as Pickering (2011) argues, that is an entirely different paradigm from the dominant biological approaches of the time. It rose in popularity after the Second World War but was never disciplined into an expert field or specific discipline. Pickering writes of it as: "an attitude, a way of life" (Pickering, 2011 p. 9). Critiques of psychiatry in the 1960s, espoused by Laing and Bateson, were based on cybernetic principles, or "nonmodern ontology as [Pickering] call[s] it, goes with a performative understanding of the brain, mind and self, and which undoes the familiar Western dualism of mind and matter, resonating instead with many Eastern traditions" (Pickering, 2011 p. 13). The cybernetic paradigm asks us thus to shift our sociological and anthropological gaze from viewing hierarchical structures of power inequality to understand the world as horizontal, complex systems of interactions between human and non-human agents.

Broadly speaking, the work of Foucault (1965; 1995), Goffman (1961) and other scholars in the anti-psychiatry movement (Szasz, 1961; Laing, 1988; Bateson, 1973;

Cooper; 1967) argued for the autonomy of the 'madman' and an abolishment of inhumane treatments (such as shock therapy or ECT), coercive treatment and hierarchical power structures in the practice of psychiatry that placed the 'expert gaze' at the top and the patient at the bottom. However, their epistemological and ontological commitments were not always the same. Whereas Szasz founded his critique of psychiatry on libertarian principles of individualism and 'free will', Laing (1988), Bateson (1973), Foucault (1965, 1995) and to some extent, Goffman (1961) critiqued the practice of institutional confinement as a tactic designed to shape human subjectivity, which was constructed through time and space and within particular socio-historical contexts.

More importantly for this project are the earlier assertions of Foucault (1965, 1995) and Goffman (1961) who urge us to look at institutionalization as a political tactic of rule- where both asylums and prisons represent the organization of power through discipline in everyday life. In the following section, I will review relevant texts in critical prison studies and mad studies; two fields that critique institutionalization, but work in different disciplinary domains. In order to understand and contextualize the borderline experience, we must synthesize and bring together all the critical work on medicalization and institutionalization; tactics of rule that most affect the experiences of women with borderline personality disorder. The following section represents the pathway through which I navigated relevant texts in an attempt to provide a conceptual background for my field research.

The political economy approach: medicalization --> biomedicalization

Medical sociology arose from earlier critiques of the treatment of deviance. Inspired by Howard Becker's labelling theory (1997), Conrad and Schneider (1992) wrote extensively about the 'medicalization' of everyday life, specifically, about the ways in which deviance was increasingly framed in medical terms. Sociological critiques of medicalization were attentive to the ways in which social problems increasingly fell under the gaze of the medical expertise. Critique of the medicalization of social problems in the 1970s and 1980s (Conrad and Schneider, 1992) can be traced back to Foucauldian critiques of expert knowledge and earlier sociological theorists such as Talcott Parsons (1951).

Later, Nikolas Rose (2006, 2006 ii) put forth the idea of 'biomedicalization', or the ways in which bio-knowledge becomes the organizing structure for citizens in contemporary life, where we become increasingly responsibilized for maintaining optimal health in ways that reduce the risk of disease. Whereas earlier critiques of psychiatry, and medicalization in a broader sense, focussed on power imbalances between expert clinicians and patients, Nikolas Rose urges us to the consider the ways that neoliberalism has downloaded the responsibility for maintaining health and vitality to patients, who increasingly face a barrage of complicated decisions about dieting, reproductive choices and engage in activities like body scans in order to surveil not only our present health, but our future health as well. Bioicitizenship (Rose, 2006), is contingent upon our ability to secure biocapital, in a society where deviance is now strictly framed in bio-medical terms.

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In 2013 I attended the 4S Annual Meeting in San Diego, California. I was presenting a paper on art creation as 'messy method' with a colleague, but was eager to attend all of the sessions on or about medicine, as it related to my PhD research. Joseph Schneider, one of the authors of "Deviance and Medicalization: From Badness to Sickness" (1987) was presenting a paper that was a 30 year retrospective on the concept of medicalization. My palms were sweaty. I got there early to get a seat. But as he began so speak, I grew anxious. The longer he spoke, the more my heart sank. Perhaps my expectations were too high. I could feel my face getting blotchy and red. I could feel myself sweating. His argument was largely that 'medicalization' had become 'biomedicalization' and he focussed exclusively on cultural shifts in the practice of scientific 'claims-making' over the previous 3 decades. He seemed to be a very kind and gentle person. I raised my hand after his paper and explained that I work with women in a maximum-security unit of a prison and that I was going graduate research on mental health. I talked about cutting and head-banging and how they tried to drink toilet cleaner to kill themselves. And how it seemed to be getting worse. How everything I read about self harm in prisons told me that it was getting worse every year. I asked him if he had hoped that his concept of 'medicalization' would have somehow alleviated this kind of suffering... Or if it could someday offer something to these women who were all on wait lists to see psychologists... He seemed genuinely sad to hear these things. He shook his head. "No" he replied, "I suppose it doesn't offer much to those who want care or might need it". I felt embarrassed. I left quickly at the break. One of those days when you realize you are 'feeling' too much and making everyone else uncomfortable.

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Earlier sociological scholarship on medicalization (Conrad and Schneider, 1992) and later critiques of bio-medicalization (Rose 2006, Rimke, 2011) also take up a political economy framework in a critique against capitalism and its expression in 'big pharma'. Critique of the biomedicalization of social problems points to the ways in which pharmaceutical companies profit from the construction of new diagnoses that can be treated with expensive medication. However these critiques often retain an element of Foucauldian constructionism, which attends to the ways in which knowledge and power-through the human sciences of psychology (Rose, 1990), medicine (Rose, 2006) and law (Hunt, 1999) structure social power in less tangible ways[3].

Psychocentrism and the Neurochemical Self

Nikolas Rose (1990; 2006) outlines how the relationship between psychiatry and culture was greatly impacted by developments in technology that allowed scientists to *see* the human brain. Whereas the psychoanalytic tradition had turned to the memory and childhood experience to explain mental disorder, the biologization of psychiatry through advances in neuroscientific experimentation began to dominate as the sphere in which the key to the 'self' resided. He writes: "while our desires, our moods, and discontents might

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[3] It should be noted that there is a strong tradition of scholarship on biomedicalization, including Adele Clark's work, which provides feminist intervention and works to strengthen and further develop the term beyond what Rose and earlier scholars have put forth.

previously have been mapped onto a psychological space, they are now mapped upon the body itself, or one particular organ of the body- the brain" (Rose, 2006 p. 187).

Indeed, a distinguishing feature of contemporary life is the tendency to explain things in neuroscientific terms. This mapping of the contemporary subject onto the murky grey matter of the brain and development of new apparatuses of truth, such as Diagnostic and Statistical Manuals and randomized control trials in clinical medicine have transformed how we see ourselves. In the past 50 years, the mind has become simply what the brain does, which creates new ways to be governed and to govern our selves. As we come to know our 'selves' as residing within the brain, thus we look for causes of abnormality in our brains (Rose, 2006).

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I have been teaching a third year Sociology Health & Illness course at my university. We spend en entire month working through Nikolas Rose' work. It's a late point in the term- they start to rebel a little bit. They've all grown comfortable with each other. They are no longer afraid of me. I have stopped wearing suits to work- just band t-shirts and sneakers and they are no longer handing in assignments on time. March is the cruelest, month, actually. Forget April. They are frustrated with Rose. I am frustrated with them. I pause a lecture and ask them directly.

"Why all the attitude about the Rose book? What is going on, here? Don't you see how much it applies to EVERYTHING we have talked about?"

They don't disagree with me. That isn't really their issue.

One of my students pipes up "it's not WHAT he says. It's, like, it's like I just don't know what he really believes in. Why does he even care?"

We turn to the introduction and prologue to the book. I ask them to re-read the section where he explicitly states that his goal is to 'map' what he sees unfolding. I explain that his project is to DESCRIBE things that are hard to describe because we are so immersed in them. I talk about how social norms become invisible as a function of their power and how it is not until we violate those norms that things become visible. They are not convinced. They don't trust him. They want to know what his politics are. They want to know where his allegiances lie.

"But how can he write about these things and stay so neutral, though? What is the point? If we can't care about disability rights and the health care system then why bother? What are we supposed to do with this?"

I can't disagree. I recall meeting Joseph Schneider. I recall my frustration at feeling like social theory was an empty promise, devoid of blood and guts and frontline struggle. I tell them that it's their job to do something with Nik Rose' work. I can't help but feel like that was a cop out. I don't know what else to say.

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Today, our notion of good, neoliberal citizenship is measured according to our ability to fine-tune ourselves to stay *productive* and consume pharmaceuticals in a way that allows us to study, work and function as productive, responsible and ‘healthy’ neurochemical citizens. Rimke and Brock (2011) expand on this notion of neurochemical citizenship to look at how *psychocentrism* has become a part of everyday life. Psychocentrism is: “the outlook that all human problems are innate pathologies of the individual mind and/or body, with the individual held responsible for health and illness, success and failure” (Rimke and Brock, 2011 p. 183). Drawing upon Rose, Foucault and Hacking, the authors explore how particular power regimes are produced through the formation of expert knowledge and how this impacts racialized and gendered communities in specific and often troubling ways.

Morality, Surveillance and Regulation

Alan Hunt and Heidi Rimke (2002) expand on some of the ideas introduced by Goffman (1961) in *the Moral Career of the Mental Patient* and explore how madness is connected to moral campaigns, thus bringing us back to Foucault's assertion that madness became part of the "hierarchy of vices" during this period in history (1995). Hunt (1999) provides a theoretical historical framework for understanding how popular moral campaigns have been used a way to regulate and police the values of others. Hunt (1999) shifts a focus away from the looming normative power structures discussed by Foucault to address how large groups of people, specifically the middle classes, have historically worked to build these normative power structures. Rimke and Hunt (2002) provide a case history of Victorian notions of ‘moral insanity’ and how this concept was mobilized in later movements for moral hygiene. Notions of contagion, morality, hygiene and madness are tied to the genealogical history provided by Foucault and to contemporary issues of institutional segregation and the socio-cultural experience of madness.

Horwitz and Wakefield (2007) address the ways in which moralized subjectivities are surveilled and policed within the clinical encounter. In *The Surveillance of Sadness*, Horwitz and Wakefield (2007) critique the pathologization of sadness and discuss specific marketing strategies used to further the notion that anyone, at any time could be affected by depression and not know they were affected. This notion is intended to encourage self- governance and voluntary submission to the truth apparatus of depression screening. In this sense, Horwitz and Wakefield (2007) are taking up the notion of responsibilization discussed by Rose (2006) and Brock and Rimke (2011) by looking at the various political strategies employed by the pharmaceutical industrial complex.

Harper (2008) takes up constructionist perspectives on madness, with a focus on how these constructions are facilitated by mass media. Burr and Butt (2000) explore the relationship between postmodernity and the pathologization of everyday life, a common thread in contemporary sociology of psychiatry (Rose, 2006; Rimke and Brock, 2011, Littlewood, 2002; Horwitz and Wakefield, 2007). Kendall (2005) and Warner (2008) introduce themes of gender and deviance. Kendall (2005) deconstructs the ways in which female offenders are framed as (dis)ordered with attention to the shift in late modern capitalism to an industry of psy-products (Rose, 2006, 2007; Rimke and Brock, 2011) and how our continued fascination with women's psychological deviance continues to ignore the body on one hand, yet perpetuate the biological medicalization of behaviour on the other.

Madness as a Sociocultural Experience

Fee (2000) explores how divisions between formal social and biological knowledge perpetuate the expert power of neuroscience and clinical psychiatry. In *Making Up People*, Ian Hacking (2002) describes the process by which something people *do* or feel, becomes moralized into a ‘kind’ or type of person. This process of labeling and diagnosis illustrates how specific social processes or states become absorbed and produced into a historically specific subject. Hacking continues the Foucauldian tradition of looking at how discourse and the structures of truth and power that they produce, constitute subjects. He also frames ideas about labeling, socio-historical context and the production of subjectivity.

Littlewood and Lispedge (1997) confront racism in psychiatry, and make links between social forces that cast immigrants and the mentally ill as ‘alien’ to normative ideals. In *Medicine and Racism*, Littlewood and Lipsedge (1997) provide a theoretical foundation for understanding the relationship between the treatment of racialized communities and those with mental (dis)order. In *Against Pathology*, (2002) Littlewood argues against the very notion of pathology as anything other than a relative term. Although other proponents of the anti- psychiatry movement argued that a pathological approach to medicine was inherently inhumane (Szasz 1960; 2011, Cooper, 1967), Littlewood’s argument is slightly different. He argues that any anthropological study of psychiatry and mental (dis)order contains its own cultural assumptions about the meaning of social power and thus, concepts of pathology cannot be universally applied. He writes:

"[b]iology is a discipline, a social procedure, a way of examining what is going on in the field in which organic forms are located" (Littlewood, 2002 p. 34). Thus, psychiatry and its meta-concepts of pathology and normality are culturally- relative constructs that are founded in Eurocentrism.

Postmodern Epidemics / Postmodern Subjects

Gottschalk (In Fee 2000) asks: "[w]hich types of mental disorder are we most likely to find in the postmodern moment?" (p. 18). Both Gottschalk (In Fee 2000) and Ehrenberg (2010) move beyond the critique of medicalization approach to address the pathologization of everyday life. Instead of focusing on how certain experts and knowledge systems increase their power through the medicalization of the contemporary subject, Ehrenberg (2010) and Gottschalk (2000) explore how culture shapes the very fabric of who we are- producing pathologies that are historically and culturally specific.

Continuing with some of the ideas introduced in the work of Laing (1988), they explore subjectivity as the product of culture- something that is collectively produced. Gottschalk calls for a need to understand the pathologization of mental (dis)order in the context of postmodern selfhood and critiques the assumption that everyday society is 'sane'. Gottschalk links an upsurge in diagnosis of anxiety disorders with a critical politics of fear, drawing in the work of Freud and risk theorists such as Anthony Giddens. He also discusses the prevalence of 'schizoid' tendencies using R.D. Laing and others. He concludes by calling for an ecologically-grounded psychological theory that articulates yet another way of understanding inter-subjectivity or the inter- connectedness of social and material life.

Shifting slightly from how the postmodern experience shapes the psyche of the postmodern subject, Ehrenberg (2010) asks whether our so-called contemporary epidemic of depression represents a shift in the fundamental ways that we understand and know ourselves as autonomous, sovereign individuals. For Ehrenberg, the major changes between modernism and postmodernism can be understood as a shift in how we come to experience the relationship between self and society. In this way, depression has become part of the language with which we describe and *know ourselves* as subjects today. Speaking to theme of what it *means* to be an ‘individual’ subject in contemporary society, Ehrenberg provides a critical understanding of what 'individual autonomy' means today and how the Western experience of endless opportunities for self-realization in the post-modern moment sets up failures, experienced as depression.

“Is it Real?” Materiality, Social Construction and Knowing

Hacking (1999) goes beyond looking at illness as historically-specific or transient and beyond those diagnoses that are presumably tied to increasing the disciplinary power of the medical profession by expanding its professional gaze into everyday practices. He looks specifically at schizophrenia and to a lesser extent, cognitive disability or autism. He has chosen to discuss these incarnations of mental (dis)order because it is commonly accepted that they have existed in some form, for many centuries. Instead, he takes up the question of whether or not (dis)orders of the mind are ‘real’ or socially-constructed. He discusses some of his earlier work on the distinction between *interactive* and *indifferent* kinds as well as concepts of *‘looping’* which is how a person reacts and responds to being classified and how this, in turn, affects the construct of the classification. He concludes by semantically proving how an illness can be *both* interactive (or constructed) and indifferent (materially ‘real’). It is the performative process of looping between the diagnosis and the person who is diagnosed through time, that demonstrates the complexity of defining what is real and what is constructed. Williams (2000) also provides an overview of broader debates about the relationship between pervasive European concepts such as ‘mind’ and ‘body’; ‘biology’ and ‘society’ and the role of emotion as performative and material.

Feminist Critiques of Psychiatry

Ussher (in Fee, 2000) provides a gendered analysis on the relationship between materiality and madness, arguing that social construction on its own is not a way out of the positivist ideology of contemporary science. She also suggests a blending of categories to take into account the *material* body as well as the *critical* potential of social constructionism, which has largely failed to make a difference in the gendered medicalization of women’s madness, despite decades of critique from social and gender theorists.

Warner (2008) points to the gendered of use of fear and constructions of risk

(Gottschalk, in Fee 2000) in the reorganization of social power and self- governance. Drawing upon the work of anthropologist Mary Douglas, Warner (2008) provides critical discourse analysis of the forensic psychiatry, where the criminal justice system and the medical model intersect in ways that frame mental distress and suffering as threats to public safety. Rimke and Brock (2011), Hunt (1999), Kendall (2005) and Ussher (In Fee 2000) take up notions of materiality and subjectivity for a contemporary consideration of how feminist theory may lead us forward with interdisciplinary, critical analysis on the role of psychiatry, gender and social power.

Wirth-Cauchon (2000) draws upon Foucault's analysis of institutionalized discourses and also feminist literature on how many mental 'disorders' represent embodiments of gender non-conformity. Reflecting on the symbolic and social meaning of women's symptoms, and drawing from personal case accounts as her data, she focusses on the intersectional relationship between gender, psychiatric discourses and power in modernity and post-modernity and how they affects women's subjectivity. Burstow (2005) outlines a history of feminist presence within anti-psychiatry and survivor movements, which will be discussed in the subsequent section.

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One of my collaborators has posted a long, difficult piece on facebook tonight. She is feeling disenfranchised and fed up with the short-term length of the treatment program she has been in. She is feeling tired of relapsing back into depression again. Tired of people telling her things will 'get better'. Tired of how uncomfortable her sadness names everyone around her. Tired of everything. Feeling weighted and heavy. And not wanting *to feel guilty for her depression but also wanting someone to step up and save her from it. It was beautiful. And honest. I posted a few hearts underneath and thanked her for her honest words. Under my comment, another comment appeared. A local feminist counsellor- a woman in her late 60s, a well known feminist activist who has been engaged in work against sexual violence for decades posted this: "the label of 'borderline' was designed to make you feel this way. It's the way that the system blames you for your suffering. Things will improve once you stop trying to get help from a system that is not designed to help you. Together we can overthrow these conditions and overcome. Much love. Here for you."*

I was stunned.

It was that thing- again- where anti-psychiatry activism is positioned in a way that judges any attempt at seeking care in the traditional medical system- that thing that turns my fists into hot coals. That thing that can get me in trouble because sometimes I cry and sometimes I want to pull out my cross-bow. I want to yell and pound my fists on the table and say every name of every young person I know who has been fighting to get into care and been denied in the past six months.

I waited for my collaborator to respond to the counsellor's post... Nothing. I began typing. I explained that experiences in the system were varied... And that dismissiveness, cruelty and victim-blaming take place in the workplace, social settings and also in activist spaces. I argued that the medical system is not the only place that this violence *takes place. I passionately urged this woman to re-consider posting judgemental statements about accessing care in the provincial system because many women have described it as 'life-saving'. I explained that my PhD research demonstrated that, despite the problems in medicine, ALL of my participants wanted more treatment programs. Across the board.*

She responded by chastising me. "Well, it appears as if we have different goals. You are intent on reforming or working inside a system that is fundamentally oppressive to all women. I am concerned with the collective liberation of all women. On this front we differ."

I remember what L. said about anti-psych activism feeling like militant second wave feminism.

Maybe I sound like a reformer. Maybe I do. Maybe I sound distant or disinterested like Nik Rose and anyone invested in changing the system would feel exasperated by what I have to say. Maybe other activists feel like I am devoid of blood and guts and struggle with all the 'careful nuance'. I don't feel like a moderate.

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Mad Studies

The field of Mad Studies: "is an area of education, scholarship, and analysis about the experiences, history, culture, political organising, narratives, writings and most importantly, the PEOPLE who identify as: Mad"[4] (Costa, 2014). Canada has been identified as a hot bed of critical activism and scholarship that is critical of psychiatry and connected to, and in support of, patient's rights and advocacy networks. It is: "based on a simple idea: listen to mad people and look at madness from their points of view" (Gillis, 2015 n.p.). The emergence of the field has been credited to Ryerson's school of disability studies and allied scholars at York University who offer "a series of courses that deconstructs medical models of "schizophrenia," "psychosis" and madness in general and puts them in historical context" (Gills, 2015 n.d.). In the introduction to *Mad Matters: a critical reader in Canadian Mad Studies* (LeFrançois, Menzies and Reaume, 2013) the editors state that their collection represents:

> [T]*he radical reclaiming of psychic spaces of resistance against the psychiatric domination of Mad people as a collection of chemical imbalances needing to be corrected in a capitalist system that prizes bourgeois conformity and medical model "fixes" above all. This book, in contrast, prizes the decades-long resistance of activists and allies in Canada who have sought to provide an*

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[4] https://madstudies2014.wordpress.com/2014/10/15/mad-studies-what-it-is-and-why-you-should-care-2/

> *alternative to Big Pharma and profiteers in the psychiatric system and academy who make a living labelling and medicating that which they cannot imagine or tolerate*. (p. 2)

A 2014 Conference on Disability Studies in the UK (Gillis, 2015) was organized around the theme of Mad Studies, where connections between disability studies and critical scholarly attention to 'madness' were firmly made. Scholars in this field position their work as a continuation of work that psychiatric survivors and former patients have been doing since the 1940s to self advocate and speak out against coercive and often abusive treatment in psychiatric care (Costa, 2014; LeFrançois et. al. 2013).

Similarities in the two fields can be seen through the ways in which disability studies scholars work to reveal 'ableism' and its effects (LeFrançois, et. al; Burstow, 2005) and mad studies scholars reveal 'sanism' as the basis behind discrimination and abuse of 'mad people' in psychiatry. Sanism, defined as "the systematic subjugation of people who have received mental health diagnoses or treatment" (LeFrançois, et. al. 2013, Glossary p. 339), becomes the basis on which normative notions of 'neurochemical citizenship' (Rose, 2006) are positioned as superior to that of a 'mad' person.

Mad studies places the knowledge and experiences of mad people as central to the project of envisioning a different kind of future; addresses the epistemic violence (Liegghio, 2013 in LeFrançois et. al) of psychiatric research that fails to consider the experiences of psychiatric patients as legitimate knowledge and where: "DSM categories become the social texts that speak for, on behalf of, and in place of the individual" (Liegghio, in LeFrançois et. al. 2013 p. 125). Liegghio, in *Mad Matters*, asserts that the pathologization of mental illness can often work to dismiss and invalidate the subject to the point where they are de-legitimated as a subject. Thus, Mad Studies has emerged as a way in which to move forward with critical activism and scholarship that supports the 'liberation' of mad people (Gillis, 2015; LeFrançois et. al, 2013; Beresford, 2014). As Burstow (2013 in LeFrançois et. al.) points out, the movement is intentionally aligned with the struggle for rights in the same way that feminist studies was with women's liberation and queer theory, with the struggle for gay rights.

'Mad Studies' as Psychosis Studies?

However, foundational critiques in the emerging field of Mad Studies rest strongly on the experiences of those who see 'madness' through the lens of *psychosis*. Much of the earlier critiques of psychiatry in the 1960s rested on visions of 'madness' that were based on working with patients diagnosed with schizophrenia (Laing, 1988; Bateson, 1973; Szasz, 2011). Much emphasis is placed on calling out and speaking against what is perceived as coercion- either in the form of pharmaceutical intervention or the use of ECT, or electroconvulsive therapy (Weitz in LeFrançois, et. al). Those who experience psychosis (or unshared experiences), tend to suffer a high rate of coercive intervention in institutional care (LeFrançois, et. al 2013).

Moreover, much of the work of Mad Studies scholars stems from a Foucauldian, or social constructionist tradition, which fit well with a critical study of psychosis. As Reville (in LeFrançois et. al) suggests, you can spot a Mad Studies ally or advocate as such: "in the room they come and go / talking of Michel Foucault" (p. 170).

Psychosis is a non-hegemonic reality. It is an experience that differs from normative perceptions. A social constructionist reading of psychiatric intervention for those experience psychosis would see it as hegemonic violence- or the imposition of normative values on an 'othered' subjectivity. Thus, intervention in the health care system that seeks to pathologize an 'unshared experience' is viewed as a form of state violence. Many forms of psychosis are considered to be a lifelong, chronic 'disease'. Thus, critical attention to 'sanism' as a discriminatory regime and allyship with disability studies makes sense if one considers that many of those who experience psychosis will continue to have 'unshared' experiences for much of their life. Narratives of 'recovery' remain suspect as being implicated in sanist visions of the world and structured by biomedical determinism supported by 'brain disease' discourse (Morrow in LeFrançois et. al, 2013)). As Beresford (2014) points out: " “Recovery” was meant to be the bright new idea of mental health policy. For many service users, however, it has become code for cutting support and trying to push people off benefits and into employment" (n.p.).

Patients with psychosis have been some of the most mistreated and stigmatized members of the survivor community. Essayist Esme Weijun Wang writes about the hierarchy of stigma within mad communities and in clinical spaces:

> *A natural hierarchy arose in the hospital, guided by both our own sense of functionality and the functionality perceived by the doctors, nurses, and social workers that treated us. Depressives, who constituted most of the ward’s*

> *population, were at the top of the chain [...] The ones with schizophrenia, on the other hand, landed at the rock bottom — excluded from group therapy, seen as lunatic and raving, and incapable of fitting into the requirements of normalcy.*(Wang, 2016 n.p.)

Wang writes about her own shifting diagnoses of bipolar with borderline traits to schizoaffective disorder, with bipolar features and how stigma of schizophrenia resulted in internalized stigma of her new diagnosis and fear of being around others with psychosis. Burstow (2005, 2013 in LeFrançois et. a.), a feminist academic and long time member of the antipsychiatry movement in Canada, asserts the importance of using conscious language as a way to re-frame experience and refuse the power regime of psychiatry that is based on a system of language that names, classifies and 'rules' our experiences. She reminds us of the ways in which psychiatrized language tends to structure our own thoughts and values, even when we consciously seek to resist it.

However, it must be noted that the term 'mad' has been historically deployed in relation to those who are in the grips of a *psychotic* experience; the 'lunatic'; the archetypal 'madman'. The use of 'mad' in 'mad pride' movements (Diamond in LeFrançois et. al, 2013) reflects a *particular* history of discrimination and institutionalization. The borderline experience is one that has been defined in Psychiatric discourses by its *failure* to meet the criteria of *madness* (Becker, 1997, Wirth-Cauchon, 2000; Lester, 2013). The borderline experience is one that faces a different type of epistemic violence (Liegghio 2013 in LeFrançois et. a.), that of being dismissed as a 'legitimate mental illness' and positioned as a 'bad person' who is not deserving of treatment at all (Becker, 1997; Nehis, 1998). If, as Weijung Wang (2016) points out, there is a hierarchy of discrimination within the mad community, then the diagnosis of BPD is positioned as an outsider, all together.

As outsiders, those with a BPD diagnosis do not see their experiences reflected in the current composition of mad activism and scholarship in Canada. Uncritical adoption of 'madness' as a term of pride (Starkman and Diamond in LeFrançois, et. al) and refusal of psychiatric power regimes (Burstow in LeFrançois, et. al 2013) does not take into account those who are excluded from any form of care or intervention as a result of their failure to meet historical and contemporary depictions of 'madness'. Mad studies scholarship that continues to promote anti-psychiatry ideology - which historically originated during a time in which a large proportion of the population was in secure care- fails to address the ways in which 'neglect' - rather than forced confinement- is now a defining feature of many contemporary mad experiences.

Cartesian Dualism in Critiques of Psychiatry

Mad studies scholarship, as well as sociological critiques of biomedicalization (Rose, 2006; Rimke, 2011) that stem from social constructionist analyses of power are problematic for the ways in which they seek to critique western society, but stay firmly rooted in dualistic, or binary conceptions of the world that stem from Cartesian dualism (Barad, 2007; 2012; 2014). Where the borderline experience already rests in the uncertain territory between long-established academic traditions (Lester, 2013) that take up a dualistic understanding of matter and meaning, the borderline experience becomes erased from the conversation. Foucault's work has been critiqued for ignoring the role of agency in the subject- for sketching out a landscape of rule, in which we are powerless to resist and find our feeble attempts at resistance inevitably shaped by the very forces it seeks to disrupt.

A similar tendency to view subjects as passive victims of power, whose agency is only expressed through acts of resistance against it, can be seen in the work of LeFrançois (LeFrançois et. al, 2013; LeFrançois, 2013) who has written extensively about 'psychiatrized' children. This language evokes a sense that psychiatry is something that is done 'to' them, rather than something that was sought in response to periods of distress or pain prior to hospitalization. Although she does assert that we must be attentive to the agency of children (LeFrançois, 2008), the experiences of psychiatric survivors who *support* interventions like ECT, coercive antipsychotics for some patients, or those who have experienced healing within psychiatric institutions is largely absent from the discussion.

In *Social Economies of Fear and Desire* (2011), de Courville Nicol asserts a need to: "move beyond the common approach to fear as an undifferentiated emotion tied to irrational, morally or ideologically suspect effects that thwart the exercise of autonomy" (p. 1). She calls for more complex interrogations of the terrain of emotional experience and socialization, in which fear and desire operate in ways that impact the exercise of our agency. To conceptualize agency in abstract terms, while ignoring emotional experience, is to perpetuate a form of Cartesian dualism that positions the social constructionist critic in opposition to biologically deterministic psychiatry, with little sincere attention paid to lived, emotional experience.

Eurocentric philosophical values in the field of Mad Studies are also seen in the way in which notions of 'autonomy' and freedom are deployed in ways that echo the libertarianism of Thomas Szasz (1960; 2011). Ehrenberg (2010) points to the way in which 'depression' is intrinsically linked to neoliberal conceptions of 'autonomy' and individual freedom- where a failure to thrive or meet these goal posts of normative success can cause suffering. Outside of the work of Laing (1988) there is little attention paid within Mad Studies to the role of therapeutic *containment*, care, or intersubjective (or intra-subjective) interpretations of healing outside of western individualism. In this sense, all therapeutics are inherently 'bad'. In the tradition of antipsychiatry, psychiatric 'care' is at best; dubious and at it's worst; violence.

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She had to break the door down. She had to hold her down- kicking and screaming. Her fingers furiously tearing at the strip of fabric around her throat. She held her down on the closet floor, ripping the fabric off her neck. Breath. Fingernails scratching. Tears. Blood. This. This is what comes to my mind when I read the word 'autonomy'. I think of this. And also of all the times they spoke of rape. Of how autonomy feels like abandonment when you've never been held - or you've been held by the wrong people- how 'autonomy' is a deep nightmare when all we want is to be held together. How they sell special 'anxiety blankets' that are weighted to feel heavy and hard against *you when you sleep. How institutions become the last refuge for those who can't hold themselves together. How cold they are. How utterly fucking impenetrable.*

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Furthermore, critiques of medicalization since the 1960s have not been taken up with similar fervour with regard to pharmaceuticals used in the treatment of common ailments such as diabetes or heart conditions. In this sense, activist critiques of 'big pharma' have become a form of ableism, as many psychiatric survivors actively choose and rely on the use of pharmaceutical treatments to stay healthy. Camila Laurentine, a disabled artist and activist argues that critiques of the medical system (and the common suggestion to rely on social support and holistic approaches) are deeply ableist. She argues that these critiques are: "hyper-focusing on one part of a much larger problem when you use the term “Big Pharma,” and to put it bluntly, you’re using a term that is steeped in ableism" (Laurentine, 2016 n.p.).

Indeed activist scholars are not usually referring to diabetic insulin injections or their grandmother's nitroglycerin pills when they critique the medical system or its tendency to rely too heavily on pharmaceuticals. This kind of critique is dismissive and de-legitimating to those who have had to overcome stigma in order to receive care in the first place. It also ignores real evidence that some forms of suffering are impacted by naturally present and/or synthetic chemicals. Sometimes brains can be broken in tangible or tactile ways. When we critique the pharmaceutical industry solely through the lens of social constructionism (which views matter and meaning as separate fields of existence) and particular 'mad experiences (and not all)', we are perpetuating the very idea that emotional or psychological suffering is not 'real' or valid because it is not 'biological'.

To shift the conversation around suffering to an abstract critique of the pharmaceutical industry is to invalidate and dismiss those who are in deep psychological or emotional suffering. In giving critical attention to psychiatry, we must be cautious not to perpetuate forms of Cartesian dualism that are responsible for stigma and violence in the first place. Not all suffering comes from anomalies in brain structure, but not all suffering is 'social'. It is more complex than this. When we respond to human suffering by suggesting that 'suffering is a normal part of human experience', we are deeply invalidating people in ways that are harmful, and represent the same forms of 'epistemic violence' critiqued by antipsychiatry scholars (Legghio, in LeFrançois et. al, 2013). Laurentide responds to the activist tendency to view suffering as 'emotionally-rooted AS IF everyone is capable of just 'feeling different' on their own: "chronically ill people have developed emotional problems because they are constantly being told there is nothing wrong with them. Some chronically ill people do have mental health issues, because they’ve gone years upon years without a diagnosis or being diagnosed incorrectly" (Laurentide, 2016 n.p.).

As Ian Hacking reminds us, social constructionist critiques can "confuse more complex types of interactions, which make some people think of antique dualisms between mind and body. These come out most clearly when we turn to the very habitus of mind and body, psychopathology"(1999, p. 101). Social constructionist critiques of psychiatry from the mid-twentieth century arose from a particular sociohistorical context; that of high numbers of institutionalized people and the emergence of social constructionism in response to the emerging hegemony of medical 'objectivism', but they have not meaningfully engaged the heterogeneous experiences of those who have lived experience in such institutions.

Critical Prison Studies

Critical prison studies, or study of the carceral state from an abolitionist position, emerged from the same Foucauldian critiques of institutionalization in the 1960s. Prison abolitionism is the belief that prisons should be abolished as a legitimate tactic of rule in the state. In *Are Prisons Obsolete* (2003), a landmark text in the prison abolitionist movement, Angela Davis argues that prisons should be abolished in the same way that slavery was abolished in the United States. She points to the growing problem of the incarceration of black Americans and traces the connection between private corporations and the emergence of the 'prison industrial complex'.

Davis argues that incarceration represents an inhumane and racist tactic of widespread social oppression and calls for a social movement to organize against it. Prison abolitionism is distinct from 'prison reform movements' that seek to improve conditions for prisoners, but do not question the validity of incarceration as a practice. Abolitionist scholars are positioned across the fields of critical criminology and American studies, where a special critical prison studies caucus brings together scholars from cultural studies, philosophy, gender studies and queer and trans studies to generate critical attention to incarceration in the United States. Davis writes, that an: “attempt to create a new conceptual terrain for imagining alternatives to imprisonment involves the ideological work of questioning why " criminals" have been constituted as a class and, indeed, a class of human beings undeserving of the civil and human rights accorded to others" (Davis, 2003 p. 112).

Critical scholarship that seeks to disrupt the penal order of the contemporary state has, in many ways, taken up a political economy approach to critiquing the 'prison industrial complex' and its relationship to social crises created by neoliberal capitalism (Davis, 2003, Wacquant, 2009, Wilson Gilmore, 2007, Pratt, 2005, Clarke in West and Morris 2000, Alexander, 2012, Loyd, Mitchelson, Burridge, 2012). Angela Davis writes: "the term "prison industrial complex" was introduced by activists and scholars to contest prevailing beliefs that increased levels of crime were the root cause of mounting prison populations. Instead, they argued, prison construction and the attendant drive to fill these new structures with human bodies have been driven by ideologies of racism and the pursuit of profit" (Davis, 2003 p. 84).

Clark (in Morris and West, 2000) writes: "[t[hat prison constitutes the ultimate sanction of our legal code and that these institutions are de facto warehousing for the poor and homeless people is an assertion that no one can credibly deny" (p. 77). In neoliberal capitalism, the failure of the state to provide protection from hunger (Wacquant, 2009, Davis, 2003) and violence (Cheliotis, 2009, Brown, 2010) is deeply implicated in prison expansion in the United States (Wilson Gilmore, 2007) and in Canada (Clarke in West and Morris, 2000). In neoliberal ideology, poverty is depicted as a fault of the individual rather than the failure of the state (Clarke in Morris and West, 2009, Davis, 2003 and Alexander, 2012). Thus, the relationship between unemployment and prison expansion remains unquestioned.

Cavender (2004) notes that in the nineteen sixties and nineteen seventies, penal welfarism dominated crime and prison policy in the United States. During this period, notions of rehabilitation as a process of positive reinforcement drove prison policy. Cavender (2004) reconsiders Garland's work insofar as both attempt to trace the shift in the nineteen eighties into a 'tough on crime' approach to punitive deterrence. Both Wilson Gilmore (2007) and Wacquant (2009) link the rise of neoliberal strategies of punitive deterrence with the political economy of the United States during the nineteen seventies and nineteen eighties. A global recession, increasing rates of unemployment and rising popularity of austerity and structural adjustment (or reduction) of state welfare programs were the backdrop upon which tough on crime approaches to criminal justice sparked an unprecedented period of mass incarceration. Wilson Gilmore (2009) notes that: "the California State prisoner population grew nearly 500 percent between 1982 and 2000, even though the crime rate peaked in 1980 and declined, unevenly but decisively, thereafter" (p. 7).

In Canada, racialized bodies are also incarcerated in vastly higher numbers. The Canadian Correctional Investigator's 2012 annual report[5] noted that the number of aboriginal women in prison has increased 85% in the past five years. Approximately 25 % of inmates in Federal custody in Canada are of aboriginal descent, yet aboriginal peoples account for only 4% of the Canadian population. However, the emergence of a carceral 'identity' through the caging of specific bodies is a process that is both historically and culturally contingent. At different points in history, large numbers of 'undesirable' citizens have been incarcerated in mass numbers (Combessie, 2012,

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[5] http://www.oci-bec.gc.ca/cnt/rpt/annrpt/annrpt20112012-eng.aspx

Wacquant, 2009, Davis 2003) and the racial, political, religious and class identity of these groups is not always homogenous.

But the framing of the carceral body in Canada (and the United States to some extent) cannot be explained only in terms of racial ‘othering’ (Butler, 2010, Brown, 2010, Jackson, 1983). The Canadian Correctional Investigator’s office has noted that 30% of the carceral population in Federal custody meet the diagnostic criteria for a major mental disorder. Morris (in Morris and West, 2000) notes that Canadian penal policy is driven by a pervasive social fear of the “dangerous few” or, archeytpe of a sadistic serial killer. The prevalence of “infotainment” (Kohm, 2009) and emergence of numerous primetime television dramas about serial killing (Young, 2010 in Hayward and Presdee) has served to deflect engagement with the precarious suffering of the poor, addicted and mentally ill in favour of hardlined approaches tailored for the sadistic killer archetype. Morris argues that: “the greatest fraud perpetrated by our retributive justice system is that it exists to protect us from a dangerous few” (p. 101).

As recession and rising unemployed rates continued to affect communities across the United States and Canada during the nineteen eighties, increasing public concern about immigration policy became part of the ever-expanding net of ‘control’ that David Garland (as cited in Cavender, 2004) sought to describe. Illegal immigrants became a new folk devil by the 1990s in both Canada (Walia in Loyd, Mitchelson, Burridge 2012) and the United States (Koskela, 2011). Borderlands Autonomous Collective argues that national border zones have become new sites of the formation of nationhood and identity. They note: “from 1992 to 2006, the Border Patrol tripled its number of agents” (In Loyd, Mitchelson and Burridge, 2012). Pratt (2005) notes: “Canadian immigration law and policy emerged in the 1990s as a critical and necessary instrument of crime control to an extent unprecedented in Canadian history" (Pratt, 2005, p. 104).

Loyd (in Loyd, Mitchelson and Burridge 2012) argues that: "walls and cages share common economic and political histories at the global scale" (p. 5) and that there are notable interconnections: "between contemporary migration and penal policies" (p. 3). She goes on to suggest that immigration and immigration detention, penal policies and the project of war are deeply tied to the processes of state maintenance and formation in the contemporary world. Thus, careful analysis of how social and cultural changes brought about by economic and political contexts since the nineteen seventies must also account for how the lives of migrants, criminals and those depicted as terrorists are rendered ungrievable. In this way, frames seek to "naturalize the abandonment of increasing numbers of people who have been placed into categories of "illegal" and "criminal" (Loyd in Loyd, Mitchelson and Burridge, 2012 p. 3).

Contemporary political discourse crime policy consists over a panic raised over: "the need for more and harsher imprisonment, whilst the imagery of human suffering so caused is either blocked or neutralized" (Cheliotis, 2010 p. 170). In this sense, the visibility of carceral bodies becomes a way in risk and danger that can be reinscribed upon bodies that are not seen as grievable; lives whose precarity remains un-representable in frames of law and justice. The disturbing realization that the state cannot protect us is made easier by projecting this failure onto marginalized bodies. Michelle Alexander (2012) argues that the criminal justice system in the United States functions as a new system of social cleavage that creates a racial caste system, similar to that seen in the Jim Crow era. She argues that racism continues to persist, despite notions that the

United States is now in a ‘colorblind’ era, following the election of Barack Obama. Racialized identities, within which ‘blackness’ becomes framed as inherently dangerous and deviant, become the frame in which harsher penalties are executed, specific communities are political disenfranchisement is justified. She writes: “[r]acial segregation rendered black experiences largely invisible to whites, making it easier for whites to maintain racial stereotypes about black values and culture. It also made it easier to deny or ignore their suffering” (p. 195).

She goes onto link the process of racialization in the United States to the criminal justice system, which, for Alexander (2012) serves to mask Black cultural values and reproduce racial stereotypes: “rather than merely shunting black people to the other side of town or corralling them in ghettoes, mass incarceration locks them in cages. Bars and walls keep hundreds of thousands of black and brown people away from mainstream society” (p. 195). Davis (2003) writes that relief from the failure of the state: is the ideological work that the prison performs-it relieves us of the responsibility of seriously engaging with the problems of our society, especially those produced by racism and, increasingly, global capitalism” (p. 16), thus the carceral system becomes the tool in which an unjust state maintains itself, despite widespread alienation and oppression of the majority of it's voting public.

Mad Studies & Prison Abolitionism

Although Mad Studies and Critical Prison Studies are separate and distinct fields, they stem from similar critical traditions that take aim at organized structures of power and the ways in which practices of discipline and institutionalization function to organize power and disenfranchise large groups of people who already face many intersecting forces of oppression in their lives. These fields directly intersect, most recently, on considerations of deinstitutionalization in the United States and Canada since the 1950s. The antipsychiatry movement of the 1960s was part of a broader social movement toward deinstitutionalization of mental health care after World War II. As Morrow, Dagg and Pedesrson (2008) point out, deinstitutionalization: "was, and continues to be, driven by a number of interconnected forces including developments in psychopharmacology, new psychosocial rehabilitation practices, studies of the negative impact of institutional life, concerns about the civil rights of people with mental illnesses and cost-containment" (2008, p. 2). The story of deinstitutionalization in Canada and the United States has been framed as a move from the oppressive residential asylums described by Goffman (1961) to a system of community based mental health care treatment options. The Canadian Prison ombudsman, Howard Sapers, echoes what many researchers have claimed; that the deinstitutionalization movement led to a corresponding increase in the number of mentally ill people being incarcerated in correctional facilities (Sapers, 2014). Many high profile organizations, such as the Canadian Mental Health Association, have called prisons 'the asylums of the 21st Century'. Attention to the relationship between deinstitutionalization and subsequent increase in the incarceration of mentally ill people in prisons has affirmed what Harcourt (2005, 2011) asserts is a *continuity* of incarceration in the west. Harcourt (2011) notes that critical criminologists tend to refer to the 1980s and 1990s as a period characterized by a boom in mass incarceration, however, when he aggregated the data on confinement in both types of institutions (2005), it showed that, with the exception of a slight drop in the 1970s (corresponding with the oil crisis and subsequent recession), numbers of state incarcerated people in the United States has remained the same, although the *type* of secure institution has shifted. As Howard Sapers (2014), CMHA (2009) and NIMH (2001) would suggest, it appears as if mentally ill people have simply been moved from hospitals to prisons. However, Harcourt (2011) reviews studies that show that the relationship is more complicated, but that: "mental hospitalization rate has a statistically significant and robust negative effect on prison rates" (Harcourt, 2011 p. 1780). He concludes that, rather than allowing the data to bring us back to accepting institutionalization as a tactic of rule, that, since social factors such as poverty, racism and shifting public conceptions of deviance tend to also influence rates of confinement, our: "real challenge is to deconstruct *both* the categories of the "insane" *and* of the "criminal" *simultaneously"*(Harcourt, 2011 p. 1781).

Rembis (2008) argues that critiques of mass incarceration must take up a mad studies approach and lend an ear to the lived experiences of those who were held in asylums in the former part of the twentieth century. It is here, with a backward glance to the deinstitutionalization movement, and a commitment to critique practices of confinement that we find the work of Liat Ben-Moshe (2014). Ben-Moshe is a disability studies and critical prison studies scholar who argues that the deinstitutionalization movement- advocated for by many of the founders of the antipsychiatry movement- should stand as a case study in decarceration. She argues (2014) against interpretations of deinstitutionalization that show a relationship with a rise in prison populations. She disagrees with:

> *the public outcry following deinstitutionalization (heard by sociologists, activists, and the media) that most people, particularly those labelled as mentally ill, became homeless and were increasingly re-incarcerated in jails and prisons in urban areas in the U.S. I believe this narrative reduces a much more complex process and puts the blame on an easy target—deinstitutionalization—instead of neoliberal policies that led simultaneously to the growth of the prison system and to the lack of financial support for disabled and poor people to live in affordable and accessible community housing. (Ben-Moshe, 2014 p. 19)*

She points out that there are demographic differences in previously institutionalized populations and those who found themselves incarcerated during the 'incarceration boom' of the latter part of the twentieth century. She concludes that "deinstitutionalization could be characterized not only as a process or an exodus of oppressed people outside the walls of institutions and into community living, but as a radical anti-segregationist philosophy" (Ben-Moshe, 2014 p. 22). However, in a 2008 issue of the *journal of Ethics in Mental Health,* the authors reflect upon deinstitutionalization using British Columbia as a case study. They argue that focussing on deinstitutionalization as a case study often obscures the most important issue; that of shifting social values and the ways in which communities will, or will not tolerate someone who 'deviates from the norm'. They call upon clinicians to take greater responsibility for supporting community inclusion and improving the ways in which community based services are delivered so that community-based care can succeed in partnership with broader social change for better health outcomes (Morrow, Dagg, Pederson 2008). In this sense, it is clear that many clinicians (rather than being the villains in the antipsychiatry movement) are frustrated with the slow rate of acceptance of neurodiverse people outside the hospital and do not feel that *communities* have always been allies to the process of deinstitutionalization.

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ICOPA is the international Conference on Penal Abolition annual general meeting. It's a conference for prison abolitionists and radicals who are invested in dismantling the carceral state and abolishing prisons. And police. I attended the 15th Annual meeting in Ottawa in June, 2015. I was presenting a paper that discussed self harm intervention and concepts of autonomy. I never did present the paper. Shortly before my own panel, I attended a panel of authors from a recently released book 'Disability Incarcerated'. It's an incredible collection that explores the intersections between critical disability politics and carceral spaces. Liat-Ben Moshe, one of the editors of the collection, presented a paper that used the deinstitutionalization movement as an inspirational case study for prison abolitionists. She argued that deinstitutionalization of asylums was a success from a prison abolitionist standpoint and expanded on ways in which prison abolitionists could learn from this historical case study. In years previous, this argument would have excited me a great deal. Social movement research- sharing of tactics- consideration of social movement successes? These. These are important projects.

Until this very moment I had not yet been able to process the incoherence between what I was hearing in my field research - what my collaborators were telling me- and my own abolitionist leanings.

Cognitive dissonance. I think I was surprised at how intense my reaction was to the arguments Ben-Moshe presented. I didn't know where to begin- or to laugh or cry or storm out. I FELT SO INCOHERENT AND FUCKING ANGRY.

I asked one question. It was about her statistics. "Did you draw solely upon US statistics in making an argument intended to apply to abolitionist projects in other colonial countries?" She nodded. I mumbled about American imperialism and tried to rebut her paper by drawing on Canadian statistics that showed clearly that deinstitutionalization of asylums DID lead to an increase in homelessness for those experiencing addiction and mental illness. I came off like a jerk.

When it was my turn to present my paper later that afternoon, I threw everything out the window. Instead, I recounted- over and over again- the experiences of my collaborators in trying to access care, being turned away and the tragic consequences this had for them. I delivered an impromptu argument (or, perhaps, an incoherent, rambling rant) on why deinstitutionalization of asylums represented a total failure of a social movement. I think I called everyone an 'ableist' at some point. I remember ending it by giving an inappropriately graphic description of self harm which was recounted to me by a woman *who was turned away from an ER because of her borderline diagnosis and ended up maiming herself- horrifically.*

It was a train wreck. I remember three or four heads nodding furiously while I spoke. The rest of the room just stared- at a train wreck. A disaster. I was a disaster.

Hearing Liat Ben-Moshe speak was when I realized that the abolitionist project - as a sister project to the anti-psych activism in Mad Studies- could not be an ally to my collaborators. It could not be an answer to the problem of neglect. It was too pure and too focussed on the perfect devil of the institution. It gave us no weapons with which to fight the devil of relational suffering. It scoffed at our need for containment.

It is also the reason that I now read every conference paper - WORD FOR WORD- off the page and NEVER deviate from the plan. If I am going to be this emotional about my research, clearly I can't be trusted to go off script.

(Clearly the abolitionists had secure attachments. They don't need a weighted blanket to sleep at night.)

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Biocitizenship, Privilege and Exclusion from Advocacy

Ben-Moshe (2014) reminds us that the goal of abolition is: "to fundamentally change the ways we interact with each other, the ways we respond to difference or harm, the ways normalcy is defined, and the ways resources are distributed and accessed" (p. 22). The goal of mad studies and sociological critiques of psychiatry are to reveal power imbalances and account for harms that are normalized (and thus rendered invisible) in clinical treatment of mental illness. However, sustained attention to these projects in historical context does not paint a convincing picture of success. While they may have created space for some 'mad' people to find voice in self-advocacy and contribute to scholarly critique, these movements have not contributed much to the alleviation of suffering for those most vulnerable. Both prison abolitionism and contemporary revivals of the antipsychiatry movement have given us tools with which to trace how patriarchy, racism and colonialism shape practices of institutional confinement. The antipsychiatry movement has popularized critiques of 'big pharma' in ways that have led to public scepticism of the 'pill cures all' approach to psychiatry. Attention to saneism has called communities to account for the ways in which they create harm by imposing narrow visions of 'neurochemical citizenship' that profits industry, while ignoring the ways in which neurodiverse or mad people could contribute to shaping communities in different or better ways.

However, none of these movements have allowed for sustained engagement with and for those with complex experiences of trauma, addiction and self -harm, even though the overwhelming majority of incarcerated people have had these lived experiences. Mass incarceration of the most vulnerable members of our society is a social problem that is not going away. In 2012, Canada had the highest number of prisoners in its history, while the United States- although it has only 5 % of the world's population- accounts for 22 % of the world's prison population. Prisoners have disproportionately high rates of trauma, addiction, suicidality and mental health conditions- especially personality disorders but critiques of mass incarceration that look to deinstitutionalization as a successful approach to social justice (LeFrancois, 2013; Ben-Moshe, 2014), ignore the ways that deinstitutionalization has done little to reduce stigma and improve care (Morrow, Dagg, Pederson, 2008).

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She set herself on fire.

She survived.

She set herself on fire. Her burns were unimaginable.

Staff were traumatized. Security protocols changed. An investigation.

The women were haunted by the smell.

***

The most recent Ombudsman's report on the Federal prison system in Canada notes that 75% of female offenders require mental health treatment while in prison, while 30 % of all female federal inmates were hospitalized for mental health treatment prior to incarceration (Sapers, 2014). Mental health problems are three times more prevalent in prisons than in the Canadian population at large (Sapers, 2014 report). Although the Correctional Services of Canada does not collect data on trauma, it is clear that trauma is considered part of a broad range of mental health issues experienced by offenders and is often a root cause of addiction (Sapers, 2014; Mate, 2009).

Approximately 70 % of the federal prison population has a substance abuse issue (Sapers, 2014). Self-harming behaviours, a characteristic of the borderline diagnosis is now a major issue in the Federal prison system. Prison Ombudsman, Howard Sapers reports that:"there were more than 1,000 self-inflicted injuries involving 295 offenders recorded in federal facilities, a rate that has more than tripled in the last five years" (Sapers, 2014 p. 2). In order to understand the effects of mass incarceration, and to be accountable to those who are most impacted by the carceral state and contemporary structures of law and psychiatry, we must respond to those who self-harm and find themselves excluded from society and segregated in prisons.

How do we respond to a lack of critical and compassionate attention to women with lived experiences like that of Ashley Smith in the mental health and prison systems? Their stories allow us to explore biomedicine in the carceral state from the lived experiences of those who have been *refused* institutionalization- those who return, time and time again to the emergency room and beg to be admitted. Their stories are often rendered incoherent within anti-psychiatry and abolitionist projects because they have little to offer in the debates between biomedicine and social constructionism and because their needs complicate notions of individualism, autonomy and what 'care' could or should look like.

The data presented in this dissertation will question the Euroentric assumption that all containment is oppressive and suggest that notions of 'autonomy' stemming from Foucauldian constructionism are, in many ways, a form of ableism that ignores the experiences of those who *actively seek containment and attachment* at the borderlines of social institutions. If we return to Foucault's suggestion that it is only when the institutional chains are *removed*, that we truly become subjects to disciplinary power, then we must commit to more sustained attention to *the performative space of relationships* within structures of disciplinary power, rather than the architectural structures that house them. If power operates at the level of our subjectivity, then it is *here*, at the production of subjectivities- rather than the symbolic nature of physical confinement- that we remain attentive to *how* power operates in the classification systems of the DSM and the territories of social institutions.

Chapter 2: Borderlines & Borderlands

Contextualizing the literature on BPD

"the madmen's *liminal* position on the horizon of medieval concern- a position symbolized and made real at the same time by the madman's privilege of being *confined* within city *gates*: his exclusion must enclose him; if he cannot and must not have another *prison* than the *threshold* itself, he is kept at the point of passage. He is put in the interior of the exterior, and inversely"

(Foucault, 1965 p. 11)

"a class of persons standing in the twilight of right reason and despair- a vast army of whose units, consisting of individuals with minds trembling in the balance between reason and madness, are not so sane as to be able to control themselves, nor yet so insane as to require restraint or seclusion"

(Rosse, 1886 in Stone p. 32)

"We hardly know that we have built. No one is in control of the intrastructure; no one has the power to centrally change it. To the extent that we live in, on, and around this new infrastructure, it helps form the shape of our moral, scientific, and esthetic choices. Infrastructure is now the great inner space"

(Bowker and Leigh Star, 2000 p. 319)

Although acknowledgement of those who have a diagnosis of borderline personality disorder may be scarce in the fields of mad studies and critical prison studies, there is some sociological and anthropological literature on borderline personality disorder. In order to understand the women's stories and to provide a background for their experiences as relative to their diagnosis, the following section will review literature on BPD from the fields of biomedical and psychoanalytic psychiatry, alongside the work of sociologists, anthropologists and three well-known BPD memoirs. This section will conclude with a contextualization of BPD that takes up strands of RD Laing's work on cybernetics, with consideration of BPD in the field of Science and Technology Studies and the notion of 'boundary objects'.

Historical Discourse on the 'Borderline States'

In the 1800s and prior to the rise of psychoanalysis made popular by Sigmund Freud, psychiatric classification rested on: "two nebulous concepts about psychosis and neurosis, (the latter a catchall phrase for any mild nervous condition" (Stone,1986 p. 5). In the introduction to a large, edited volume containing all of the original, historical papers (from the 1800s to the 1980s) on 'borderline conditions'; Stone (1986) points out that the notion of the 'borderline condition' was frequently used to describe anything that did not fit established theories about mental sickness. This included the notion of a *criminal*, who was, perhaps, *morally* insane, but not psychotic, thus occupying a position of deviance that differed from established archetypes of madness. Stone (1986) also notes that conditions made popular in the period of psychiatry in the late 1800s- such as hysteria, a diagnosis given largely to women who did not fit gender norms and/or displayed 'extreme contradictoriness' (Stone, 1986 p. 6)- described many of the same features that are listed in current DSM criteria for the diagnosis of borderline personality disorder.

Stone credits early psychiatrists, Janet and Kraepelin for sketching out some of the earliest, and in his view, most accurate descriptions of what is now called borderline personality disorder. Pritchard (1835 in Stone, 1986) describes what he calls 'moral insanity' as a condition where moral or emotional function is impaired, yet psychotic delusions are not present, thus emphasizing the notion of criminality as a feature of the 'borderlands' of psychiatric conditions. For much of the twentieth century, 'borderline' features were referred to as 'pre-schizoid' or schizotypal, however, the period of psychoanalytic theory which became fashionable in the mid twentieth century, psychiatrists began to use: "the term 'borderline' in ways that had *less* to do with the classic psychoses and *more* to do with particular patterns of dynamics and defense mechanisms" (Stone, 1986 p. 13).

In the late 1880s, Irving C. Rosse wrote a treatise entitled; *Clinical Evidence of Borderland Insanity*, where he argued that everyone: "knows of positive and negative electricity; of black and white; of health and disease; of high spirits and mental depression, but our knowledge of the imperceptible difference in their intermediate conditions is extremely limited" (Rosse, in Stone, 1986 p. 32). In describing a series of cases that Rosse claimed to be "borderland insanity", he argues that such patients exist: "on a sort of neutral ground that is neither Spain nor Gibraltar" (Rosse, in Stone 1986 pm. 43). Stone (1986) cites a paper written in 1941 by a psychiatrist named Dr. Greenacre, who identified an element of hypersensitivity in borderline patients, whom she believed were predisposed for severe anxiety as a result of their: "genuine physiological sensitivity, a kind of increased indelibility of reaction" (Greenacre, 1941 in Stone, 1986 p. 53).

Greenacre's identification of hypersensitivity differed from that of Dr. Otto Kernberg, who suggested that they simply had a lowered *tolerance* for anxiety, a less validating approach that resonates more closely with contemporary biomedical constructions of the disorder. Dr. Kernberg has been credited with some of the earliest attempts to consolidate 'borderline states' into a sovereign category of their own as a '*borderline personality.* In the paper he claims to: "attempt a systematic description of the symptomatic, structural, and genetic-dynamic aspect of the so-called "borderline-personality" disorders (Kernberg, in Stone, 1986 p. 279).

"How does a human become a borderline?"

Controversy remained throughout the nineteen sixties and seventies, over whether or not 'borderline states' were connected to the development of schizophrenia, with increased interest over whether or not biological evidence of the disorder could be established. Further complicating the development of the 'borderline state' as an identifiable category in itself, was growing acknowledgement that there were at least four distinct 'types' of borderline state. This territory- which was neither Spain nor Gibraltar- was not homogeneous, nor were any of its forms responding well to established psychoanalytic treatments. Discussions around the role of Freud's 'ego' and the libido took place in psychoanalytic circles, but, once again, treatment with these practices did not lead to recovery for those who were remained in the grey zone of diagnostic taxonomy.

Controversy about the classification and nature of the disorder was structured between the disciplines of psychoanalysis and psychiatry, the former suggesting that such borderline states could be explained through an understanding of the role of the ego and the latter suggesting that there could be other hereditary or physiological causes. In 1968, Dr. Grinker and colleagues published a paper in which they asked; *what is the border?"* and why, although those who appear to be sick with such 'borderline syndrome' have been appearing more frequently in clinical practice, they are not being treated with any success (Grinker, 1968 in Stone, 1986).

The Grinker study postulated a structure in which the four emerging clusters of 'borderline types' were defined by and through the symptoms of *other* pathologies that they border upon. Although this study was instrumental in providing the 'cluster' types of borderline symptoms later seen in the DSM in subsequent decades, they concluded that many of their broader research questions remained unanswered. They were able to describe a pattern of phenomena in relation to existing typologies, yet: "[t]he question *Why is the borderline?"* remains unanswered except by vague philosophical approaches to the relationships between modern urban civilization and culture. The 'Why' becomes a humanistic rather than a scientific question" (Grinker, et. al, 1968 in Stone, 1986 p. 353). Stone (1986) concludes that in the nineteen-seventies and eighties: "'Borderline' begins to fill in the space between existing and more sharply discernable entities like schizophrenia and manic depression" (p. 411). This latter period of the twentieth century was dominated by Dr. Otto Kernberg's notions of the 'borderline personality', which, given the nature of Dr. Kernberg's formulation, also included alcoholism and sociopathy (Kernberg, 1975).

Diagnostic Classification of BPD

Borderline Personality Disorder first appeared in the third edition Diagnostic and Statistical Manual of Mental Disorders in 1980. DSM III represented a turning point in western psychiatric practice, whereby psychoanalytic models and assumptions about the etiology of misunderstood diseases were abandoned in favour of a more strictly 'categorical' approach that classified mental illness by symptoms (Mayes and Horwitz, 2005). Mayes and Horwitz (2005) argue that DSM III represented a major paradigm shift in psychiatric practice, but that it cannot be simply explained neither as increased medicalization, nor of increased scientific knowledge about mental disorder.

The release of DSM III was a result of increased political and administrative pressures to standardize diagnoses in ways that were continuous across various administrative and therapeutic contexts. The new taxonomic structures of mental 'disease' represented a push for standardization and professionalization in the practice of psychiatry and responded to public and corporate pressure for greater research and knowledge about the etiology of disease (Hayes and Horwitz, 2005). The placement and categorization of borderline personality disorders has shifted between DSM III (1980), and, later DSM IV (1994) and 5 (2012)[6]. DSM IV (1994) listed 9 diagnostic characteristics, whereby the presence of five or more of these symptoms warranted a diagnosis of BPD. The diagnostic criteria from DSM IV are as follows:

> *(1) frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.*
>
> *(2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation*
>
> *(3) identity disturbance: markedly and persistently unstable self image or sense of self*

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[6] The fifth edition of the

> *(4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.*
>
> *(5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior*
>
> *(6) affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)*
>
> *(7) chronic feelings of emptiness*
>
> *(8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)*
>
> *(9) transient, stress-related paranoid ideation or severe dissociative symptoms (DSM IV, 2000)*

DSM 5 describes each characteristic in more detail, with less direct emphasis on "relational patterns" and greater focus on the patient's 'response to stimuli'. DSM 5, while more clear and descriptive in its language about BPD, contextualizes the symptoms in a more individualistic manner, locating the dysfunction in the patient's 'response' patterns, which impair their ability function and thrive. DSM 5 lists different levels of 'personality impairment' in addition to impairments in an ability to form and maintain stable relationships.

The APA working group responsible for making changes in personality disorder classification from DSM IV to DSM 5, rationalize the changes as follows: "greater emphasis on personality functioning and trait-based criteria increases the stability and empirical bases of the disorders" (APA, 2012 p. 17). The authors emphasize that: "[p]ersonality functioning and personality traits also can be assessed whether or not an individual has a personality disorder, providing clinically useful information about all patients" (APA, 2012 p. 17). Although some scholars would argue that this claim demonstrates an expanding scope of the biomedicalization of everyday life (Rose, 2006; Rimke, 2011), those with lived experience of BPD (Johnson, 2010; Pershall, 2011) assert that BPD should be seen on a *spectrum*, where everyone can experience the symptoms to some degree at different points in their life, but a BPD experience is very far on the most severe end of experiencing these 'impairments' with greater frequency and severity.

Canada's most well known clinical expert on borderline personality disorder is Dr. Joel Paris, who holds a faculty appointment in the Department of Psychiatry at McGill University. In a 2007 paper outlining current best evidence in the treatment and etiology of BPD, Paris responds to controversies around whether it should be a classified disorder at all (Paris, 2007). Given how stigmatized the label is within medical institutions and the broader community, some have argued against the usefulness of the diagnosis at all. Paris asserts: "[a]voiding the diagnosis of BPD has not made the clinical problem go away. We can call patients by a different name but still be in a quandary about what to do with them". (2005 p. 435). In a casual interview with *Wise Counsel,* Dr. Paris describes borderline patients as follows:

> *"these patients are best known for two things. One is that they cut themselves quite often to relieve tension, and the second is when things go bad for them, they'll take overdoses of pills, and although they occasionally do commit suicide, the usual result is they end up in the emergency room having to get their stomach pumped"* (Joel Paris, as cited in Van Nuys, n.p. n.d.)

He challenges the myth that BPD patients are not treatable and refers to evidence that shows that BPD can often reside naturally throughout the life course: "[t]reatment can be seen as speeding up a natural process of recovery. In long-term follow-up studies, about 90% of BPD patients diagnosed in their 20s no longer met criteria by middle age" (Paris, 2005 p. 435). He emphasizes the effectiveness of dialectical behavioural therapy, which: "emphasizes empathic responses to distress that provide validation for the patient's inner experience" (Paris, 2005 p. 436) and argues that the problem with treating BPD is related to economics, where the: "most difficult problem is that DBT is resource-intensive and expensive. For this reason, more than a decade after its introduction, its implementation has been spotty. Where it is available, there are usually long waiting lists—not surprising for a treatment whose initial phase lasts a full year". (Paris, 2006 p. 436).

Paris (2015) and others (Gillard et. al. 2015; Pershall, 2011; Johnson, 2010) have emphasized the importance of a recovery model for BPD that acknowledges the role of supportive community relationships and psychotherapy approaches that develop skills for mindfulness and distress tolerance. This emphasis on recovery remains in stark contrast to contemporary critiques in Mad Studies and the antipsychiatry movement that contextualizes 'recovery' as the biomedical imposition of 'saneism' (Morrow in LeFrançois et. al, 2013).

Dialectics of Radical Acceptance

Dr. Marsha Linehan, the world's leading expert on borderline personality disorder is the founder of the Linehan Institute and has made a career out of the development of a pioneering treatment for suicidality and BPD that is based on principles of mindfulness, radical acceptance, compassion and emotional validation. Her treatments are the only widespread, evidence-based treatment for BPD (Linehan, 1993; Paris, 2005; Johnson, 2010).

Dr. Linehan has first-hand, personal experiences that were similar to those of Ashley Smith and others, who have languished in punitive seclusion wards in hospitals and prisons as a result of persistent self-harming behaviours (Carey, 2011). At age 17, Marsha Linehan was hospitalized in an asylum in the 1960s, where she: "quickly became the sole occupant of the seclusion room on the unit known as Thompson Two, for the most severely ill patients"(Carey, 2011 n.p.). Marsha Linehan's institutional confinement was similar to Ashley's experiences in both juvenile detention and, later, in Federal prisons, whereby: "staff saw no alternative: The girl attacked herself habitually, burning her wrists with cigarettes, slashing her arms, her legs, her midsection, using any sharp object she could get her hands on" (Carey, 2011 n.p.).

Dialectical behavioural therapy differs from other cognitive behavioural therapy approaches that attempt to 'rationalize' or 'think' differently in order to influence emotions. In DBT, all emotional experiences- no matter how dysregulated or 'disordered' they are, *make sense* in the context of our environment and our upbringing. The therapeutic experience begins from a place of radically accepting how the patient *feels*, rather than starting from a place that asserts an inherent 'irrational' deviance of the patient from established social norms.

Countertransference & BPD stigma

Despite the proven effectiveness of DBT treatment, its use and availability are limited, largely due to the 'cost concerns' voiced by Paris (2005). Failure to provide the resources required to treat BPD can be partly attributed to the tremendous stigma attached to the diagnosis within the medical community. A 2006 study (Aviram, et. al.) identified widespread negative attitudes amongst health professionals for patients with BPD. Researchers identified that stigma contributes to distancing and self-protective behaviours by clinicians, which, in turn, creates pain for the patient and invokes a self-fulfilling cycle whereby the stigma contributes to treatment which creates the conditions for the patient's negative behaviours to emerge.

In other words, patients with BPD are often invalidated and don't receive compassionate care, which causes them to feel greater distress and anger in health care settings, which further constructs the stereotype of a 'difficult patient'. Nehis (1998) and

Becker (1997) argue that misogynistic gender stereotypes are often grafted onto the diagnostic criteria, which leads to further marginalization and denial of care for women with BPD. One factor that leads to stigmatizing attitudes amongst health care practitioners is that of 'countertransference' or the emotional reaction of the therapist to their relationship with the patient (Hunt, 2003; Becker, 1997). Kernberg (1975) posited that countertransference was a hindrance to the therapeutic process, thus upholding the position of a clinician as a 'rational' and autonomous subject that must at all times remain distant from his object of study and experimentation.

More recent considerations of countertransference resonate more strongly with the radical work of Laing (1988) and others during the cybernetics movement, who envisioned the therapeutic relationship as one that is not hierarchical, or 'controlled' by rational, positivist epistemologies (Gabbard, 1993). Countertransference has been described as a 'meat grinder' sensation (Lester, 2013) where an emerging relationship with a BPD patient leaves the clinician feeling disrupted and uncomfortable. Stigma within health care settings extends beyond clinical institutions to the greater landscape of community-based institutions and patient advocacy groups.

It is here that I find it prudent to share an anecdote from the first time I heard the term 'borderline personality disorder'. In my early twenties, I was a youth worker in a non-profit organization that did arts-based engagement with youth who were either victims or perpetrators of violence. One of the youth in my caseload was going through a period of severe suicidal ideation and, while waiting for a referral to see a psychologist, I was scrambling to get him into other community programs that were better geared toward peer support for depression. I phoned a very reputable organization, a charity that was nationally renowned for running peer support programs for youth suffering from psychosis or mood disorders.

While on the phone with the executive director, she explained that they could not conduct an intake with a youth until they had a firm diagnosis. I explained that this young man had already been seen by a family doctor who diagnosed him with depression- but that he might be waiting for months to see a psychologist in the public health care system. She empathized with our situation but, ultimately declined to accept him for intake because, as, she explained, there was a slight chance he could have borderline personality disorder and, if that was the case, then he presented a risk to their entire program- both staff and program users. She explained that someone with BPD would upset everyone and put everyone else's health in jeopardy, including staff. Despite his suicidality, he would not be accepted for intake until a BPD diagnosis was ruled out.

Although this anecdote is nothing than a single experience, it also represents the experience of many young women with BPD who find themselves to be the pariahs of the community-based self advocacy movement, an issue that will be discussed at length in subsequent chapters. The needs and voices of those with BPD are not heard within the mad studies or critical prison studies movement, even though they are, by many accounts, the most highly impacted by problems in secure care in both prisons and hospitals. As Lester points out: "those who resist working with these clients therepeutically, or deny their existence epistemologically elide the incredible strength, resilience, creativity and integrity of many of these people" (p. 76).

Research shows that BPD patients are those who are most stigmatized in health care settings (Paris, 2007), denied care (Becker, 1997; Johnson, 2010) and, although they represent approximately 2 % of the general population, they are drastically over-represented in the prison system. In a comprehensive review of the literature, Sansone and Sansone suggest: "[c]ollectively, these studies— all using specific measures for personality disorder assessment— suggest that approximately 25 to 50 percent of prisoners suffer from BPD" (n.p.).

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When I accepted my first position as a part time lecturer in a sociology and criminology department, I was excited to work alongside a criminologist who had made a research career out of evaluating anti-stigma programs. I had recently read his paper that outlined the benefits of using theatre as a means of reducing stigma in health care settings and I gushed when he invited me to his office to chat about my doctoral research. After graciously showing me his selection of books on stigma and mental illness and offering to loan me anything I needed, he asked about my field research. "I am working with young women who have been diagnosed with borderline.". He leaned back against his desk and crossed his arms across his chest. "Well, that must be challenging. Why would you ever decide to do that?" I was confused. "What do you mean?" I asked. He looked at me, almost incredulous and responded with "Well, nothing they are going to say to you will be true. They are just going lie to you. How could anyone validate your research?" Nowhere in the diagnostic criteria for BPS is 'pathological lying'. His comments were ignorant- but he is certainly not the only person in the field to uphold such stigmatizing and discriminatory beliefs.

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Critical Feminist Engagement with BPD

Therapist and feminist scholar Dana Becker (1997) draws upon a critical history of women's madness and explores fairy tale archetypes and gender socialization of girls to understand the ways in which BPD takes shape- both as a lived experience *and* as a social construct that is made visible by the ways in which borderline women resist gender norms through expressions of anger and wounded dependency. For Becker, the BPD experience is the 'new female malady', which can be traced through historical patterns in the persecution of 'witchcraft' and institutionalization for hysteria (1997).

However, more recent feminist work on BPD, including a series of first-voice memoirs (Johnson, 2010, Pershall, 2011, Kayson, 1993) has shifted the discussion about BPD between 'expert' clinicians and critical social scientists, to a space that is more clearly defined by lived experience. The most famous of these memoirs being *Girl Interrupted* (Kayson, 1993), a screenplay written by a woman who was institutionalized in the 1960s for symptoms related to a BPD diagnosis, which was later made into a movie starring Winona Ryder and Angelina Jolie.

From a 'first-voice' perspective, the BPD existence is one, more accurately, of 'non-existence' (Lester, 2013; Johnson, 2010; Pershall, 2011). It is developed in reaction to persistent experiences that invalidate their very *existence* as a subject (Kreisman and Strauss, 2010; Johnson, 2010; Becker; 1997, Paris, 2005). BPD 'symptoms' can be seen as adaptive ways of coping with being told that you are not allowed to exist, either through chronic abuse, neglect or repeated experiences with violence or mistreatment outside the home (Kreisman and Strauss, 2010; Johnson, 2010; Becker; 1997, Paris, 2005). Psychiatrists often misunderstand these adaptive strategies as being 'manipulative', yet, a person with BPD: "fares little better in the world of academic critique where her struggles are deconstructed as artifacts of psychiatric discourse" (Lester, 2013 p. 75).

Anthropologist and feminist counsellor, Dr. Rebecca Lester identifies the ways in which *both* social constructionist critique and biomedical discourse on BPD invalidate and ignore the suffering of women who experience the symptoms firsthand. She writes: "I understand BPD somewhat differently than my clinical colleagues who see it as a dysfunction of personality and my academic colleagues who see it as a mechanism of social regulation (Lester, 2013 p. 74). She asserts that: "BPD does not reside within the individual person [...] if we eliminated BPD from the DSM, people would still struggle with the cluster of issues captured in the diagnosis. Rather, BPD resides - and only resides- in *relationship* (Rebecca Lester, 2013 p. 74).

Lester argues that we must see BPD from the "*underside"* where it becomes easier to understand the meaning and significance of BPD symptoms when we are not focussed on critiquing power from the top-down, whilst inadvertently ignoring the lived experiences of those women whose relationship with diagnostic criteria might challenge our social constructionist interpretations of 'biomedicalization'. The relational nature of BPD, suggested by Lester (2013) is echoed by Johnson (2010), a scholar of both feminism and English literature, who wrote a brilliant memoir of her experiences living with BPD in *Girl In Need of Tourniquet* (2010). Johnson (2010) underscores the argument that activist critiques of psychiatry pose very real dangers to the lives of women who require life-saving forms of therapeutic support: "[p]roposing that the borderline personality label is INACCURATE or ARTIFICIAL, or that borderlines are NOT

CLEARLY DIFFERENT FROM HEALTHY PEOPLE may further undermine the very real needs for therapeutic support" (caps in original. p 201).

For Johnson, BPD is: "a pattern of cognition and reaction that impairs the capacity to be productive, happy and generally at ease. It is a fractured sense of self giving way to the weight of stressful interpersonal dynamics" (2010, p. 203). Work such as that of Kilty (2009), which traces the ways in which the "psy-carceral complex" of forensic mental health treatment for Ashley Smith, tend to focus on the abstract (and pharmaceutical) means of social control, with little attention to the ways in which other forms of compassionate care could have impacted Ashley's life in very different ways.

As Becker (1997) suggests; "we must look at the social elements of madness from within a perspective that does not deny its reality" (p. 28) and attend to the experiences of women who are afflicted, whether or not the patterns are clearly cultural and rooted in social constructions of gender norms. As Lester points out: "many women really *do* struggle with the behaviours and experiences associated with BPD, and that [acknowledging] *this* can be as much a source of feminist critique as dismantling the diagnostic encrustations around it" (Lester, 2013 p. 73).

Boundary Objects and Critiques from the Exterior

Michel Foucault, and many of his contemporaries, structured their critiques of psychiatry from the *interior* of the psychiatric power/knowledge matrix. Foucault himself, was able to receive treatment by doctors who determined that his suffering was a result of homophobia - both in social context and from an internal lack of self acceptance (Miller, 1994), thus giving him first hand experience of the 'socially-constructed' nature of *some* forms of suffering. Historic images of the horrors of the asylum from documentaries such as Frederick Wiseman's Titicut Follies (1967) and the works of Erving Goffman (1961) have depicted a brutal history of psychiatric confinement, and condemnation of such spaces could only be made by those who had *access* to them; either as a clinician (Laing, 1988; Bateson, 1973, Szasz, 2011) or a patient.

However, as Lincoln (2006) points out, the contemporary mental health care system has completely transformed and *denial of access* to inpatient treatment is now the norm for the most marginalized members of our communities: "[p]revious policies led to disproportionate rates of involuntary hospitalization among marginalized and powerless groups; these same groups are disproportionately denied access to psychiatric inpatient treatment" (p. 622 - 623). Indeed, current clinical 'best practice' for borderline patients is *not* to admit them as inpatients when they are suicidal (Paris, 2004).

Citing many of the 'negative consequences' of institutionalization first discussed by Goffman (1961), clinical psychiatrists are hesitant to admit borderline patients where there is evidence of improvement in inpatient settings. Outpatient treatment is recommended (Paris, 2004) but rarely available and where it is, the wait lists are so long you could be waiting for many years to get any kind of treatment (Paris, 2005). In order to account for and understand the experiences of those with a diagnosis of borderline personality disorder (and others with complex diagnoses such as trauma, addiction or comorbid conditions), we must re-structure our critiques to account for the ways in which *refusal to confine* or *care* for patients is the predominant form of violence experienced in health care settings. In order to dismantle the oppositional and dualistic nature of the debates between biomedical objectivism and social constructionist critiques, it is necessary to find a neutral territory- a borderland- a space where one is not forced to choose a side in such tired debates about the etiology of the disease and the social power implications of the treatment regime.

While Borderline personality disorder is largely ignored in critical theorizing about psychiatry and confinement, biomedical clinicians remain in controversy over the cause of this form of suffering. Although lived experience with symptomology remains consistent, decades of research defy any attempt to anchor the experience in the singular terrain of the 'neurological', nor simply in childhood experiences. As Paris suggests:

> *some of them come from terrible families with alcoholic fathers - this is fairly common - but not all of them. Some of them have histories of physical and sexual abuse, but many of them don't. Now, there are genetic studies, which suggest that there's something, some heritable vulnerability for this disorder, and we know that people who suffer very traumatic life experiences don't always get sick. (Paris, as cited in Van Nuys, n.d., n.p.)*

To move into a space where borderline subjectivities can emerge, one must take up a position where the separation between mind/meaning: brain/experience no longer matter, where the borderline is contextualized as part of a broader system of classifications, and where institutional responses to borderline subjects come to co-shape their subjectivities and produce particular forms of suffering.

Jutel (2009) argues that there is a need for a clear and cohesive 'sociology of diagnosis'. Given the tremendous power of classificatory regimes in the health sciences, the project of understanding classification and diagnosis is necessary to understand how such regimes arise within and entangle with everyday experiences. French and Smith (2016) explore the role of surveillance upon the body and argue for a need to consider the ontological and epistemological consequences of such 'surveillant dispotifs'. Thus, without writing off a classificatory regime such as the Diagnostic and Statistical Manual as a tool of oppression, we must take up the project of interrogating classification and diagnosis as powerful process of entanglement and emergence.

The fields of science and technology studies (STS) and feminist new materialism present spaces in which matter/meaning are not dualistically opposed to each other and where all actants, (human and non-human) become positioned in entangled networks, or mangles (Pickering, 1995). Whilst side-stepping any attempt to position attention to culture *against* that of science, Susan Leigh Star and Geoffrey Bowker turn their attention to the study of classifications, which: "are powerful technologies. Embedded in working infrastructures they become relatively invisible without losing any of that power" (Bowker and Leigh Star, 2000 p. 319). Leigh Star (2010) puts forth the idea of 'boundary object' or concept that allows for interpretive flexibility, but also: "are a sort of arrangement that allow different groups to work together without consensus"(p. 602). Boundary objects emerge from residual categories, which: "have their own texture that operates like the silences in a symphony to pattern the visible categories and their boundaries" (Bowker and Leigh Star, 2000 p. 325).

For Leigh Star (2010) a 'boundary' object does not draw its meaning and significance from the interiority of the concept that it bounds or contains, but: "it is used to mean a shared space, where exactly that sense of here and there are confounded" (Leigh Star, 2010 p. 602). Residual categories in scientific practice and their resulting 'boundary objects' are performative, they are "the stuff of action" (Leigh Star, 2010 p. 602). For the purposes of this dissertation, borderline personality disorder is understood as a 'boundary object', one that operates through time and space, in ways that are implicitly connected to 'matter'; the stuff of segregation cells and skin and scars; 'meaning'; that of the disciplinary power of the human sciences; and the affective and emotional sensations that are elicited by and through lived experience as a product of the residual categories of psychiatry.

Chapter 3: Everything is method.

Diffractive practice and its onto-epistemological commitments

"The truth came slowly, like a story told by people interrupting each other"

Paula Fox

"You proclaim two natures? Indeed, tomorrow, depending on how many declare themselves to belong to the one or the other.. You'll make one, perhaps involuntarily, predominate over the other, and soon we'll have a bad and good nature, an original sin… You shall be the God and I shall be the devil."

Claire Démar

"Quantum entanglements are not the intertwining of two (or more) states/ entities/events, but a calling into question of the very nature of two- ness, and ultimately of one-ness as well. Duality, unity, multiplicity, being are undone"

Karen Barad, 2007 p. 177

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I need you to know that this is where I found the space where borderline stories made sense on their own terms. It began with Donna Haraway. It intensified when I read the first few pages of Karen Barad's book on Agential Realism.

It was like flipping through radio stations- all static - until you find something that rings true and clear and feels like it is speaking directly to you.

Many of the previous conversations in my field made me feel like I had to justify or interpret my collaborators' stories inside a broader project of dismantling a large institutional or conceptual structure- but inside these projects my collaborators were constantly being ignored or invalidated. They became collateral damage in these big, conceptual projects, rooted in dualism and disciplinary structures. It was inconvenient to talk about neglect in Mad Studies- because they want to argue against medical intervention. It was inconvenient to talk about desire for containment in prison abolitionist spaces because it went against normative desires for 'autonomy'. We were traitors. Because we needed things we weren't supposed to need.

In new materialist feminism, it no longer mattered whether 'the material brain' or 'social experience' caused suffering. Whether or not prisons or asylums were the 'evil monsters' of the state did not matter. The focus of the conversation was on the performative entanglement of agencies- the focus was on understanding moving targets and no one *cared whether or not the women wanted medical care... Or if they wanted containment and attachment. The focus was on performative unfoldings of justice that emerged through our entanglements in everyday life. The stakes were different. And this mattered to us a great deal.*

DOING new materialist feminism, however, proved challenging. It was not a practice I was used to... I always felt like I was getting it wrong. There were few examples to follow. This was both exciting and terrifying. And fitting this practice into the expectations of scholarship made me feel deeply vulnerable- I was much safer inside the projects I had so recently moved away from. But at least, here, in this space, we felt coherent in linking our practice to justice // as a moving target // as a series of changing, imperfect, moments.

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It is customary in research-driven scholarship, to provide intricate details on both the theoretical framework and methodological procedures of a given study. The challenge of taking up a position that does split matter from meaning, is to work through ontology and epistemology, *simultaneously*. To separate the 'theory' from the 'method' would be to draw a distinction based on Cartesian dualism and ignore the performative effects of theory *as* action. Dualism, a concept deeply rooted in the history of European thought, was reiterated through Descartes as an opposition between the abstract *mind* and the material body, with the former being positioned as superior. The following section contains details that support the forging of an onto-epistemological space for the research, with attention to vulnerability, participation, risk and consent. I detail how a *diffractive ethnography of a boundary object* might take place collaboratively; working through intentional commitments to qualitative field research and acknowledging the many and multiple ethnographic experiences of the author within the 'psy-carceral' landscape of psychiatry and incarceration.

More specifically, this section will outline how 'reflexivity' as a research tradition will be partially abandoned in favour of collaborative, diffractive approaches where 'subjects' become collaborators and the threads of each story become multiple, entangled, and part of a broader project that articulates *from* the borderline, without reinforcing the dualistic posturing of previous discourse that has excluded these experiences into residual categories as the pariahs of the mental health community. The larger question guiding this inquiry thus is how feminist new materialist frameworks can provide a space outside of the debates sketched out in social theory and critical literature aligned with anti-psychiatry and prison abolitionist projects, which ultimately did not reflect the needs or experiences of those on the borderlines of our social institutions.

Taxonomy as process?

To be accountable to the borderline and its subjects, one must be attentive to the way that traditional scholarship supports Cartesian dualisms that separate matter from meaning, and taxonomic approaches to naming and classifying the world. To gain perspective on the ways in which such classification systems (such as the DSM) lead to forms of violence, I make an intentional commitment to move toward the 'mess' of social emotional experience, without resorting to methodological habits that seek to sort, categorize and 'order' the stories that were shared with me. In 2004, sociologist and STS theorist, John Law wrote *After Method*: *mess in social science research*. He argued that *our world is 'messy'* and suggested that method, as a practice of following established protocols intended to create orderly taxonomies, might actually obscure the very messy and indefinite processes we wish to uncover. He writes;

> *If much of the world is vague, diffuse or unspecific, slippery, emotional, ephemeral, elusive or indistinct, changes like a kaleidoscope, or doesn't really have much of a pattern at all, then where does this leave social science? How might we catch some of the realities we are currently missing?* (2004, p. 2)

He argues that we need to revise and transform our framing assumptions about what it means to 'know' and explore other creative practices in order to do so. Thus, this project has employed a collage of both creative and more traditional methods, including auto-ethnographic practices, arts-based collaborative research and semi-structured interviewing.

Attention to 'realities we are currently missing' is the imperative of this research. In an attempt to make space for critical intervention into mass incarceration and psy-carceral power, we must make the concerns and experiences of the most marginalized people at the heart of those systems; the women like Ashley, the women who self-harm in prisons and are persistently denied mental health care. Barad (2007) writes:

> *The point of challenging traditional epistemologies is not merely to welcome females, slaves, children, animals and other dispossessed Others (exiled from the land of knowers by Aristotle more than two millennia ago) into the field of knowers, but to better account for the ontology of knowing* (p. 378)

Accounting for the ontology of knowing requires more than reflexivity. Frustration with the limits of critique (See Latour, 2004) and the practice of reflexive posturing are echoed by Karen Barad: *"*of course the mirror image of that is that Science mirrors Culture, so we have a kind of scientific realism versus social constructivism, which are of course both about mirroring"[7]. She goes onto note that: "social constructivist approaches get caught up in the geometrical optics of reflection where, much like the infinite play of images between two facing mirrors, the epistemological gets bounced back and forth, but nothing more is seen" (2003, p. 803).

Feminist scholars, increasingly concerned with a (post)human future where critical attention is paid to "how matter comes to matter" (Romer Chistenson and Hauge, 2012), argued for an alternate metaphor in research to replace that of 'reflexivity'. Haraway (1997) suggested that the metaphor of *diffraction* might offer more expansive possibilities. The metaphor of diffraction: "aims at the multiplication and dissemination of differential powers in order to produce other, unexpected, and (hopefully) less violent

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[7] (Karen Barad in http://quod.lib.umich.edu/o/ohp/11515701.0001.001/1:4.3/--new-materialism-interviews-cartographies?rgn=div2;view=fulltext)

interference patterns" (Thiele, 2014 p. 204). The feminist materialist position distances itself from the genealogical methods of Michel Foucault as well as Judith Butler's concept of the 'performative' as they both fail to account for how 'matter' and the body are implicitly connected to/with workings of power.

Barad (2003) argues that Foucault's "implicit reinscription of matter's passivity" (p. 809) works to reinforce the binaries of matter/meaning (or subject/object) that are so foundational to the ontologies that critical theory works to undo. She continues: "Foucault and Butler's theories fail to provide an adequate account of the relationship between discursive practices and material phenomena" (Barad, 2007 p. 146). If it is true, then, that the world is messy, dynamic, slippery and constantly in flux (Law, 2004; Barad, 2003, 2007) and that critique on its own is limited in its ability to move us beyond that which we are seeking to transform, then how do we account for the "ontology of knowing" in *practice*?

Everything is method: posthuman performativity

To operate outside of a world defined by a proposed dualism between subject and object, we must also resist the binary of ontology/epistemology. To escape this, Karen Barad (2003) proposes what she calls a "posthumanist performativity". Performativity, in a more general sense: "is arguing that *realities* (including objects and subjects) and *representations* of those realities are being enacted or performed simultaneously" (Law, 2008 p. 635) For Barad (2003), a "posthumanist formulation of performativity makes evident the importance of taking account of "human," "nonhuman," and "cyborgian" forms of agency" (p. 826). In what she labels "agential realism" "agency is cut loose from its traditional humanist orbit. Agency is not aligned with human intentionality or subjectivity" (2003, p. 826).

Ontology is, itself, performative and not "given in the order of things, but that, instead, ontologies are brought into being, sustained or allowed to wither away in common, day-to-day sociomaterial practices." (Mol, 2002 p. 6) In the following pages, I will outline the onto-epistemological commitments of this project, including detailed explanations of diffractive ethnography (Schneider, 2002), vulnerability as practice, witnessing (Haraway, 1997) and felt experience (Shotter, 2014), and how the apparatus of this text has been deliberately crafted with attention to the politics of citation and the 'boundary-making practices' of discipline, language and frame.

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"talk to me about what it feels like"

"It feels like getting a lot of information from everything. Like making eye contact, you get a whole rush of all… It's like all that information, all of what people are feeling, like everything, you're getting tons and tons of information all the time. And you feel it very strongly. And so it feels very raw. Very raw. And it's… It's hard because with all that chaos that is…that most people can kind of wander through life, and they get chaos but they don't feel it as much as we do. And it's really difficult to kind of just manage day-to-day at a level of other people not giving off all this feeling of emotion and then… So it's very hard to find a place to like ground yourself and come back because it's kind of like, I don't know, the world of expectations of you are designed for people who don't have the

sensitivity, kind of. So yeah, so it's very chaotic. It's kind of like every moment is a crisis. "

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Radical imagining and Diffractive Ethnography

As a professional arts facilitator and youth worker in clinical, carceral and community-based spaces, my positionality within the mental health and criminal justice community has allowed me to engage in auto-ethnographic observation without the significant challenge of gaining access and acceptance within these spaces. This practice provides consideration of my own role as an insider within these systems, but also of some of the more subtle, non-linguistic interactions between subjects and actors around me. AnneMarie Mol (2003) suggests that ethnographic inquiry offers us a way forward from the tyranny of the scientific method: "epistemological normativity is prescriptive: it tells how to know properly.

The normativity of ethnographic descriptions is of a different kind. It suggests what must be taken into account when it comes to appreciating practices" (p. 5). The promise of ethnography, then, is in the way it permits immersion, rather than privileging distant observation. Thus, a move to ethnography that "works the ruins" (Lather, 2001) of the literary turn validates notions of 'the performative' (Law, 2008) and can intervene in ontological politics: "attending to the multiplicity of reality is also an act. It is something that may be done- or left undone. It is an intervention" (Mol, p. 5).

Haraway (1997) and Barad (2007, 2014) offer diffraction as an onto-epistemological practice that refuses a binary distinction between epistemology and ontology. A diffractive approach to ethnography (Schneider 2002; Davies 2014) requires a firm commitment to a possible future that operates outside of (or transits through and between) disciplined knowledge. This: "diffractive approach allows for multiplicity and openness to critique because the researcher is entwined in knowledge production rather than being a detached witness searching for aperspectivical objectivity" (Nikoleyczik, 2012. p. 237).

Schneider asserts that not all ethnographic inquiry is diffractive: "Instrumental ethnographies-although yielding findings that might challenge dominant (and, it is often assumed, flawed) understandings of the object-are those that necessarily keep the analysts' own world-making practices in the shadows" (Schneider, 2002 p. 468). Rather than engaging in the "geometric optics" that Karen Barad (2003) desires us to move beyond, diffractive ethnographic practice requires an obvious and transparent commitment to a possible future- an unabashed desire for change, for an expansion of the possible (Haraway, 1997). This; "requires caring about the worlds or possible worlds that your own work, your own kind of work, helps create and/or sustain" (Schneider, 2002 p. 470).

Insomuch as Simpson (2007) urges us to engage in ethnographic refusal as we negotiate the traps of empire in our academic pursuits, diffractive 'witnessing' (1997) positions itself in service of a collectively imagined future that is informed by "marks on bodies" (Barad, 2007) but not limited to serving grand narratives of discipline or progress. Diffractive practice moves us outside the reactionary position of critique to an acceptance of contradiction, which is, in itself an intervention: “the way we understand contradiction itself usually implies an opposing dualism, a dichotomy in the face of which one must choose one or the other; not both, and” (Schneider, 2002 p. 474).

Further, Haraway (1997) reminds us that to work in a feminist diffractive practice is to engage the contradictions of analytic realism and speculative fiction. Such practice is rooted in an “analytic and imaginative standpoint” (Haraway, 1997 p. 198). This ‘Radical Imagination’ is required in order to move beyond reflection as a reaction to what can be seen as the current workings of power. Khasnabish and Haiven (2010) remind us that “the ability to imagine the world, social institutions and human (and non-human) relationships otherwise is vital to any radical project” (n.p.). Diffractive engagement posits an ‘and’ or addition rather than a cancelling out of that which is ‘successfully’ critiqued and thus we are able to imagine from these sites of contradiction.

The agential cut (Barad, 2007, 2014) of subject/object is revealed when contradiction is welcomed and a refusal of the Eurocentric practice of dualism is refused. Thus, the commitment of diffractive ethnography is one that welcomes and accepts the mess (Law, 2004), complexity and contradiction (Schneider, 2002) of the socio-material world. It is a desire to transform this mess not into the taxonomic order so characteristic of the western tradition (Foucault, 1966), but into a reimagined landscape. To be diffractively mapped: “is not to fit in the taxon, to be dislocated from the available maps specifying kinds of actors and kinds of narratives, not to be originally fixed by difference” (Haraway, promises of monsters p. 69).

In diffractive ethnography, desiring a different world “means asking ourselves how our work, our ethnographies, offer more than reflection and self-visibility; it means asking how they tell altered, material, and semiotic stories aimed at making better worlds for living things. It means doing ethnographies that seeks to effect diffractions or diffractive analysis" (Schneider, 2002 pp 470 – 471). In this project, we have envisioned our engagement with both text and memory that is both backward looking in its analysis and forward-looking in its imaginative aspects.

Agential cuts as felt experience

One of the challenges in conducting this research was negotiating the role of 'felt experience' and emotional processes as part of the landscapes of matter/meaning discussed in feminist agential realism. Communication theorist John Shotter (2014) sought to explore: "not only people's *performative understandings* of each other's communicative or *performative* expressions, but also the kind of agential *doings* that go into the "shaping" of such expressions" (p. 309). As early as 2004, Feminist writer, Kirsten Campbell noted that Haraway's (1988, 1997) initial visions of diffraction were lacking in respect to acknowledging the emotional aspects of situated knowledge (Haraway, 1988). She argued that Haraway's proposed subject "produces a knowledge that is not shot through with affect, emotion, and fantasy-that is, with irrationality. Its practices and its standpoint are the outcomes of rational decisions" (p. 176).

Barad's landmark work on agential realism (2007) also largely failed in acknowledgement of emotional experience as both an agential force and contingency of the agential cuts between subject and object. Violence is acknowledged as "marks on bodies" (Barad, 207) but left largely unexplored outside of it being a consequence of the agential cut she seeks to define. Barad writes:

> *Knowing requires differential accountability to what matters and is excluded from mattering. That is, what is required is differential responsiveness that is accountable to marks on bodies as part of a topologically dynamic complex of performances* (2007 p. 380).

But, what does it mean to *feel* in this "on-going intra-action" that is the world? Shotter (2014) argues that acknowledgement of 'felt experience is pivotal to such 'differential responsiveness' (Barad, 2007). Shotter engages notions of performativity and communication and argues that awareness of affect and emotion is exactly what is required if we are to take seriously the project of interrogating "how matter comes to matter" (Barad, 2007) in the cleavage between what is rendered subject/object. He asserts that: "in line with the task of re-situating ourselves as spontaneously responsive, embodied beings, immersed within a somewhat "fluid" reality, is the turn to a study of our *felt* experiences" (Shotter, 2014 p. 308). Drawing upon Gergen (2009), Shotter (2014) reminds us that emotions are always relational performances.

Shotter's notion of 'felt experience' does not clearly differentiate between thought and feeling, thus employing that which Barbalet (1998) describes as a radical approach to emotion that views both thought and feeling as aspects of a continuum of felt experience. By re-visiting notions of the Cartesian split (or subject/object divide) and reminding us that all previously deemed 'subjective' internal experiences (such as our thoughts and desires) are directly connected and unfolding in response with on-going, performative intra-actions with the world, Shotter is demonstrating that 'felt experience' is the terrain in which agential cuts are made and that the moral implications of these cuts are determined by what is felt at any given moment. This project takes literal interest in "marks on bodies" as the embodied experience of ontological and epistemological violence. The onto-epistemological commitments made in this practice of diffractive ethnography, also acknowledge "felt experience" (Shotter, 2014) as a *morally* orienting force (de Courville Nicol, 2011) that drives our accountability to and through agential cuts. Radical vulnerability, as a practice of orienting oneself at the borderland (Anzaldúa, 1987) of the agential cut (Barad, 2007) to stand with (Tallbear, 2014) research collaborators will be discussed below.

This is not Participatory Action Research

STS Scholar Kim Tallbear (2014) is critical of the ways in which participatory action research is framed as an answer to the problems of authority and power in research with vulnerable communities. In a 2013 keynote address at the Society for Social Studies in Science (4S), she reflected on the emotional tensions she experienced while 'studying up' as an ethnographer of the human genome diversity project that was collecting and categorizing indigenous DNA. She spoke of the importance of 'standing with' colleagues (subjects) rather than 'studying up' as a critique the construction of scientific knowledge about indigenous peoples:

> *[i]In addition to enacting an oppositional politics of returning the gaze, I had chosen to study scientists in order to avoid the personal discomfort and social*

> *challenges of doing anthropology at home. In studying up, however, I found another sort of discomfort. I could not shake that feminist ethical imperative to study a community in whose projects I could be invested*" (Tallbear, 2014 PAGE?).

Tallbear addressed the binary of research 'subject' and 'objective researcher' as an ever-present legacy in how participatory action research has been employed in institutions of higher learning. She writes: "the goal of "giving back" to research subjects seems to target a key symptom of a major disease in knowledge production, but not the crippling disease itself. That is the binary between researcher and researched" (2014, n.p.). Instead of exchanging 'data' for service, she describes her work as 'standing with' her colleagues (not subjects) in the research process. Drawing from post-colonial anthropological texts and the work of Donna Haraway who, in her words: "lives with" the dog world (Haraway, 2003) rather than outside of it, Tallbear insists that notions of 'feminist objectivity' resonate with (and helped shape) her approach to indigenous feminist inquiry; an approach that prioritizes investment into shared projects over professional commitments on one's disciplinary home. Echoing a call for diffractive transdisciplinarity (Nikoleyczik, 2012), standing *with* your research collaborators means serving the trajectory of the project rather than your disciplinary or institutional affiliation:

> *A researcher who is willing to learn how to "stand with" a community of subjects is willing to be altered, to revise her stakes in the knowledge to be produced. I*

> *should say up front, a multi-disciplinarian or someone eager to challenge disciplinary norms and someone with a varied professional background will see many more opportunities to do this and is more likely to have the skills to carry it off* (Tallbear, 2014 n.p.)

Tallbear admits that her experiences as an insider in indigenous communities has made it easier for her to achieve the aims she has set out for herself, but the act of standing with is not entirely contingent on a fixed aspect of identity. Standing with is an act of loyalty to the imagining of a more just future that aims “to seek out and articulate overlapping respective intellectual, ethical, and institution building projects” (2014 n.p.) and “share goals and desires while staying engaged in critical conversation and producing new knowledge and insights” (Tallbear, 2014 n.p.).

Vulnerable Subjects

What does it mean to do research about trauma and violence with young, highly-stigmatized people who identify as women? Is it ethical to engage in a long term creative project about pain, identity and memory with collaborators who teeter on the edge of suicidality, who may still be bleeding from the wounds of self harm? The most recent Tri-Council Policy Statement on research ethics, which governs all Federally-funded research in Canada defines vulnerability as:

> *A diminished ability to fully safeguard one's own interests in the context of a specific research project. This may be caused by limited decision-making capacity or limited access to social goods, such as rights, opportunities and power. Individuals or groups may experience vulnerability to different degrees and at different times, depending on their circumstances* (TCPS 2, Glossary)

While this formal definition represents a significant improvement from earlier notions of 'vulnerable persons' which collapsed one's condition and one's identity into a single category, notions of vulnerability as contingent are not always fully reflected in the ways in which institutional review boards govern how research happens. American scholar, Amy Ritterbusch (2012) argues for "grounded care ethics" as a way to bridge the disconnect between research ethics requirements and the contingencies of the field, where notions of vulnerability and protection are: "blurred and unsettled" (p. 17).

Ritterbusch supports the use of participatory action research as transformative activism, and locates its failures- like those identified by Tallbear (2014)- as a disconnect between an "abstract ethical standpoint underpinning written guidelines" (p. 17) and the complexities and dangers of the field. Ritterbusch did her PhD research with street girls in Bogota, many of whom were 'vulnerable' to sexual abuse, violence and murder by police. The stark contrast between "bureaucratic discourse" of IRB protocols and vulnerability as it is managed and experienced by street girls "positions researchers in a structural role of protection, thereby widening the social field separating researcher and participant" (Ritterbusch, 2012 p. 18).

More importantly, she reminds us that: "to effectively convey the principles of consent, prospective participants must first recognize value in themselves" (p. 18), something that traumatized and exploited youth may struggle to do. As Lather (2001) wrote about the desire for intimacy as part of the ethnographer's project, Ritterbusch (2012) asserts that she "achieved this level of intimacy and trust with the girls by allowing everyday human expressions of constancy and care to drive the research process rather than by starting research relations instrumentally vis-a` -vis institutional requirements such as informed consent" (p. 19). Ritterbusch argues that in order to fully realize the goals of institutional ethics protocols, one must maintain consistency and develop trust in authentic ways that are legible and meaningful to all participants. She points out that consent is a process that unfolds over the span of the research collaboration and is contingent upon the strength and character of participant relationships.

Although Ritterbusch makes a strong case for being consistent in 'caring' for research subjects through negotiations over consent and vulnerability in the field, Tallbear's notion of 'standing with' presents a less custodial metaphor for locating oneself in proximity through consistent acts of loyalty toward a goal shared with research participants. All of the collaborators in this project have been 'cared for' in custodial institutions such as inpatient facilities, secure treatment programs or police holding cells. Their memories of being held and cared for are tangled up in other feelings about being denied, ignored or harmed by those same kin or institutional spaces that symbolize 'care'. In both text and everyday practice, I have chosen to invoke the notion of intentional proximity and engage *vulnerability as diffractive practice*.

Consent as 'on-going intra-action'

The procedural requirement of written informed consent was an awkward and seemingly alien intrusion into our casual coffee dates. Many of the participants in this project were youth I had come to know after years of working for youth advocacy organizations and in community-based mental health programs. I had seen many of them come and go through inpatient care, various experimental hair colours, forensic assessments, turbulent relationships, and day treatment programs. I'd heard their poetry about cutting. I'd been there when they punched their mom in the face and clapped enthusiastically when they played their first song on stage after getting out of the hospital. We dreamed up this project together. When I first announced publicly at a monthly mental health coffeehouse event that I would be organizing a creative project for youth over 18 who have been diagnosed with BPD, I had 11 participants within the week. I made one announcement and put up one poster in the classroom of the local DBT treatment program for Borderline. Knowing that intense stigma about BPD means that many hide their diagnosis, I said:

> *"I am doing a creative arts project for folks who have had BPD on their charts. It's free and for anyone over 18. We are going to hold an art show- hopefully to reduce stigma- and you can be anonymous and submit to our project under a fake name. The stuff you share will be part of the research for my thesis. If you <u>have a friend</u> who might be interested, come see me after the show and i'll give you info to pass onto them"*

I was passed notes that read:

"this is for me. not my friend. i'm not bipolar- i'm borderline. i don't tell people my real

diagnosis."

There were whispers, looks were exchanged, names and numbers and email addresses were scribbled in my notebooks. I told them all that I would meet them for a coffee in that same café to tell them about the project and see if they were still interested. We met one on one at first, both the youth that I knew and those I had seen around but didn't know very well.

I received emails that read:

> *"I am 22, diagnosed with BPD. I've been living with it knowingly for a number of years, and have been in the BPD treatment program for 6 months now. I would really like to contribute to the project"*

I quickly found myself with more participants than I could possibly interview. At our largest, we were 16. The swinging door of inpatient units and the ups and downs of emotional dysregulation meant that at any given time, only 8 or 9 were active in meeting for coffee dates to chat and making art for the project.

In our first 'official' meeting to chat about the direction of the project, I went over the official ethics form required by my institutional ethics review board. I went over it with them line by line. I told them stories about the Tuskegee experiments and explained how forms like this are supposed to prevent people from being taken advantage of by researchers. I told them that this form gave them a number to call if I ever hurt them or if they felt uncomfortable with the project. Some participants had taken bioethics classes as part of an undergraduate university program, while others had never been exposed to research before in such a way. They all signed the form. They all expressed how awkward it was to install a formalized structure between us when, up until the point at which consent forms were signed, we had been allied collaborators towards a common goal. In this sense, we begin to see the role that conventional method (as a formalized process) works to impose a particular (and limiting) frame on the relationship between the researcher and the 'researched'. By participating in these bureaucratic processes, the messy, dynamic entanglement of collaborators becomes obscured. As highlighted by Law (2004) and emphasized by Barad (2007), the world itself becomes artificially cast in Eurocentric terms that superimpose static boundaries on the identities of the agents/agencies involved in the creation of knowledge. By formalizing these processes, it is easy to miss the hesitations, the re-negotiations and collaborative shifts that take place between myself and my collaborators. The world-making gestures within each entanglement slip outside the frame- we lose the ability to develop language for articulating the spaces between us. The designation of researcher /'research subject' insinuated in this document and our ritualized performance of signing it together and agreeing to these roles created distance between us. We worked to overcome this and return to a place of friendship, to a place where expressions of loyalty, empathy and shared frustrations built a different set of relations than those outlined in the official documents. Consent, as it was negotiated in our project, was something that we developed through trust. Although I had known many of the participants for some time, in our first official meeting I made it very clear;

> "*if you are having a bad day and don't feel like talking. Don't come. I am not going to take that personally. If you are having a bad day and DO want to come,*

> *then come. Cry, I will bring Kleenex. We can sit and watch cat videos on the internet. It's fine. You don't have to speak, you don't have to be chipper or happy or 'professional' or articulate or in a good mood. I need you to promise me that you'll never feel guilty or sad for me if you don't feel like participating. Ok? I need you to take care of yourself because you are worth it and this project has to be about how we support each other. All feelings are ok. What you need is ok. I am okay with what you bring to the table"*

This mini-lecture was my way of acknowledging the dangerous possibility that their 'consent' to participate would be mediated by a desire to not let me down, or impress me. This was, in fact, our only rule. Your participation on any given day had to be about what YOU felt like doing. We emphasised this to each other and throughout the process. Often participants would leave early if they were too anxious to continue, or they would not show up at all and, instead, send a text that read something like: *"I'm sorry I can't come. need to stay in my room today"*.

Smith (2004) calls upon researchers to acknowledge that research ethics require: " study of how societies, institutions, disciplines, and individuals authorize, describe, settle, and rule" (p. 134 - 135). In this project, universal concepts of 'vulnerability' and 'consent' were replaced with negotiated sets of community standards that acknowledged the emotional experiences of our members as being both personal and co-constituted through the practice of working together.

Vulnerability as a condition of the borderline

Marsha Linehan describes those with BPD as: "[l]acking emotional skin, they feel agony at the slightest touch or movement" [8]. Lived experience of with the symptoms of BPD as outlined in the DSM reads like a case study in 'too much vulnerability'. The concept of 'emotional dysregulation' is a way of implying that these women simply 'feel too much' in response to phenomena that the broader world does not deem worthy of such intense emotional reactions.

High sensitivity, tendencies to self-harm and the feeling of being raw and un-contained are hallmarks of the 'borderline' experience. The themes explored in this project wade into waters that third wave feminists would call deeply 'triggering'[9]. Complex webs of vulnerability, trauma, memory and emotion were ever-present. To be borderline is to suffer from "emotional hemophilia" (Kreisman and Straus, 2010). Feminist scholar and author, Lisa Merri Johnson interviewed Stacy Pershall, a performance artist and author who also wrote a memoir about her struggles as a teen girl with BPD and anorexia. Pershall explained the need to confront triggering issues on her own terms and without reservation:

> *You have to. BPD is a crisis. Especially in small towns where there's no DBT or decent pharmacologist for miles. People are dying. Teenagers are killing themselves and each other, and I'm up against assault weapons and pro-ana websites and cutting communities on LJ where they compare pictures of*

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[8] http://blogs.psychcentral.com/wellness/2012/04/emotional-dysregulation-in-partners-with-borderline-personality-disorder/

[9] I usually avoid using this term as it is a metaphor that draws on the technology of war to describe the effects of violence. I am using it here to directly reference a body of feminist writing, largely in popular culture blogs such as Jezebel and Feministing, that have made popular the a practice of 'trigger warnings' which will be discussed in a later chapter. This use of 'trigger warning's serves to 'fragilize' the recipient of such harms while underwriting a lack of responsibility on the part of the author to communicate about violence in ways that reduce the impacts of brushing against traumatic memories in the viewer.

> *themselves slashed and bleeding, so I have to be equally loud.*
>
> (http://borderlinephd.blogspot.ca/)

The importance of being 'equally loud' with Tumblrs full of cutting videos and websites encouraging (and swapping tips on) anorexia is something that is not lost on our collaborators. They know first hand the "crisis" of BPD and their desire to engage with the project stemmed from a desire to share a different kind of story- a different kind of character- to expand what a young person might feel is possible for their future after receiving a devastating diagnosis. For this reason, I resisted the temptation to be afraid of the trauma and difficult content. I allowed my participants to choose how deep they wanted to wade into these difficult issues. It was only after those conversations closed that I would suggest a care plan for afterwards, in case they were left carrying the heavy weight of traumatic memory.

During one of my first meetings with a collaborator, I broached the topic of vulnerability and 'triggering'. She told me about a particularly devastating experience where, after recovering somewhat from a long period of persistent self-harm and suicidal thoughts, she was sent in for an assessment with a well-known psychiatrist who specialized in personality disorders. Although this particular clinician had done very progressive work in forensics and advocated strongly for better access to treatment for patients with BPD, his engagement with her was deeply harmful. She explained:

> *He just wanted to pull up like every little trauma I had been through. And unfortunately at that time in my life, I had been doing much better. It had been like a good 2 ½ years since I had been in hospital. Like I was barely cutting*

> *anymore. Like it was rare. Like I quit smoking for a couple of months. I was barely drinking. Like I was off of all the hard drugs. And unfortunately this like… I was assessed in February for something that was supposed to start in September. And he even told me when we were done, "Like that's it, like there's nothing in place for you. Good luck in September," kind of thing. And then like a couple of days later, I ended up having a huge freak-out. Like took a hammer to a bunch of walls in my apt. I put my head and my fist and my feet through a bunch of walls in my apartment. Like freaked right out. Overdosed on the Valium and the Clonazepam I was prescribed at the time. I had to go to the hospital. Was admitted again. And that just started like a good couple of years of stuff that took me a long time to get back over.*

I asked her if it was the re-counting of the traumatic experiences that caused her to spiral, or if it was the lack of a care plan. She explained that it was both- and that she felt it was because she had been asked to recall tiny and graphic details about every traumatic experience. I asked a similar question to another participant, about what whether we should 'set boundaries' to what we talked about. She replied by saying: "setting boundaries is just asking for what you need, to continue the relationship".

With another participant, I broached the topic of boundaries and triggering and asked her what she needed to feel comfortable in the research process. She replied: "Well, I think you need a safe container in order to do some… [...] Well, maybe you need a safe container to try to do constructive work to make change". This idea of containment and safety – and how it is built and maintained through a practice of radical vulnerability- will be explored in the final chapter of this work.

Radical Vulnerability and 'Modest' witnessing

So how do we go about feeling without skins and walking through the violence of the borderlands of trauma, mental illness, madness and sanity, thought and emotion without causing greater pain and suffering in the name of ‘research’? Staci Marshall points out that safe spaces are hard to come by: “kids nowadays have no escape from their bullies; the bullies can come into their bedrooms through their phones and Facebook and email”.

Enclosure, as suggested by Wendy Brown (2010) is a myth of modernity. ‘Safe spaces’, while they are a worthy goal to strive for, they are few and far between and proponents of the term often do not engage intersectional analysis about the ways that these spaces are constructed and for whom. In a previous life, I coordinated a storytelling program for a local non-profit advocacy centre for youth recovering from severe mental illness. Youth who had progressed far enough in their recovery to speak publicly, would be invited to talk to local community groups about their experience in the hopes of reducing stigma.

At one such event, I took a young woman with a BPD diagnosis to speak to a group of university level administrators to discuss disability accommodation and mental illness at a large research university. This young woman did not publicly disclose her diagnosis of BPD and, instead, alluded to having an ‘anxiety disorder’. After speaking at length about the micro-violences and mistreatments she endured in an institution of ‘intellect’ when her ‘*brain* was broken’, she was asked by a member of the audience how it was possible that she came to recover and return to post-secondary education after everything she had been through. She said;

> *“For me, it was a practice of radical vulnerability. Things are always going to affect me more- hurt more... So I embrace my vulnerability as a way to stay open to the world and remind myself that I am resilient. It allows me to build relationships with others that become a source of healing when I need support”*

Vulnerability, then, becomes a realm of *possibility* in which we can envision a world different from the one we have right now. It is relational and in this relational space of imagining, we can engage in diffractive (Haraway, 1997, Barad 2007), committed, feminist work and stand with (Tallbear, 2014) each other. Although Haraway (1997) did not directly address the role of felt experience (as highlighted by Shotter, 2014) in the diffractive practice of ‘modest witnessing’, she did emphasize the role that vulnerability must play: “[w}itnessing is seeing; attesting; standing publicly accountable for, and psychically vulnerable to, one’s visions and representations. (p 267).

Witnessing (Haraway, 1997) as a felt experience (Shotter, 2014) is something that one participant identified as a transformative and healing experience. She was speaking one day about her numerous experiences with the mobile mental health crisis unit and how she always felt more suicidal and worse after calling them. I asked her why. She explained how they would always try and ‘*talk her out of*’ her feelings. I asked her if she ever had experiences with emergency mental health treatment that didn’t make her feel worse. She thought about it for a moment and said:

> *What I really needed was a witness. […] I don't know her name. But I was in like the psych assessment room, and she kind of like asked about… This was before I talked about trauma and stuff. But she kind of asked about growing up. And I kind of shared a little bit of what I shared with you. Not specific incidents but just like generally being really sensitive and feeling like I had to hide, and then that sort of thing. And she told me… Well, first she cried. Like she sat and she cried. And I'm sure a lot of like clinicians would frown upon that. But that's what I needed. I needed someone to see that like my suffering was real. […] That was bearing witness.*

In a practice of diffractive ethnography, we envision vulnerability is the pause *before/during* the agential cut- it is a temporal moment of witnessing (Haraway, 1997) as *felt* experience (Shotter, 2014) in ways that strengthen our resolve toward possible futures (Schneider, 2002) as we performatively intra-act with the world.

Friendship as Method

At the 5th Annual 'Collide, Create, Connect 'Conference in 2012, disability rights activist, Mia Mingus delivered a keynote address that emphasized the importance of *relationship building* and emotional investment in each other as a radical space in which our power relations can be reconfigured in ways that shift broader society. She writes:

> *The best analysis in the world is useless if we don't treat each other well. If we don't invest our time and energy in learning how to love each other better, if we*

> *can't build relationships that can last more than 2-5 years. If we can't commit to practicing working out hard dynamics in our relationships or if we are recreating the very conditions we are fighting against inside of our collectives, organizations, and movements*[10].

Tillman-Healy (2003) has asserted similar sentiments in her notion of 'friendship' as a site of fieldwork. Friendship as method requires an obligation toward mutual reciprocity and building intersubjective meaning: **"**we employ traditional forms of data gathering (e.g., participant observation, systematic notetaking, and informal and formal interviewing), our primary procedures are those we use to build and sustain friendship: conversation, everyday involvement, compassion, giving, and vulnerability" (Tillman-Healy, 2003 p. 734). She echoes many of the sentiments toward ethical witnessing (Haraway, 1997) and the importance of consistency in performances of care (Ritterbusch, 2011).

Friendship 'as' method means that: "[w]e lay ourselves on the line, going virtually anywhere, doing almost anything, pushing to the furthest reaches of our being. We never ask more of participants than we are willing to give. Friendship as method demands radical reciprocity" (2003 p. 735). She identifies that the intimacy and closeness of a friendship method brings with it the peril of trauma, ethical complexity and occasionally, violence. Vulnerability is something that is negotiated in the space-between collaborators. Vulnerability becomes our yellow brick road as we seek the wizard of

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[10] (https://leavingevidence.wordpress.com/2012/08/03/on-collaboration-starting-with-each-other/)

BPD, or, put another way, the; "unfolding path of the relationships becomes the path of the project" (Tillman-Healy, 2003. p. 735).

To 'stand with' each other (Tallbear, 2014) is to remain in a place of vulnerability that is open to imagining, together. It means that we have the capacity to hurt each other- much like the well-intentioned psychiatrist who unknowingly triggered a vulnerable, addicted young woman struggling with BPD and no access to treatment. It also means that we have the capacity to transform our relationships through performances of care and accountability to those practices between us that leave 'marks on bodies' (Barad, 2007). The old trope of insider/outsider no longer applies. Although I can wear these hats at different times in our collaborative work, this binary is something we must resist in the interests of building a world that is not marked so severely by the Cartesian split between the material and immaterial world. As Wendy Brown reminds us: "[s]overeign power carries the fantasy of an absolute and enforceable distinction between inside and outside" (2010, p. 119). Vulnerability means that I, as 'researcher', have to open myself up, to share, to avoid playing the character of 'caretaker' and, instead, let them care for me by giving them an honest answer when they ask me how I am doing. It means resisting my own tendencies to perform these caretaking roles in one-sided ways, something I learned in a household with an addicted parent and have continued to do in every other human relationship. It is maintained by practicing: "radical reciprocity" (Tillman-Healy, 2003 p. 735). Radical vulnerability is both being open to 'felt experience' (Shotter, 2014) but also being accountable to the ways in which these experiences shift, draw, erase and re-draw the boundaries between us in the on-going intra-active negotiation of our relationality.

Agential cut as borderland

The agential cut between subject/object, the site at which: "[b]oundaries don't hold; times, places, beings bleed through one another" (Barad, 2014 p. 179) is a *borderland* (Anzaldúa, 1987). In her landmark feminist work, Gloria Anzaldúa put forth the idea of *mestiza consciousness* as the experience of surviving in the space in which two cultures collide. She writes that *mestiza consciousness*: "It is work the soul performs. That focal point, the fulcrum, that juncture where the *mestiza* stands, is where phenomena tend to collide. It is where the possibility of uniting all that is separate occurs" (1987, p. 101).

In a 2014 paper that serves as the introduction for a special issue of *Parallax* on diffraction (Barad, 2007), Karen Barad (2014) diffractively reads Anzaldúa (1987) with the work of quantum physicists and feminist scholars such as Trinh T. Minh-ha and Haraway (1992). Anzaldúa explains: "[t]he work of *mestiza* consciousness is to break down the subject-object duality that keeps her a prisoner and to show in flesh and through images in her work how duality is transcended"(1987, p. 102).

For Barad (2007) the practice of diffraction achieves a similar end: *"*[d]iffraction queers binaries and calls out for a rethinking of the notions of identity and difference" (2014 p. 171). Subject/Object; Madness/Sanity; Thought/Emotion; Male/Female; Mind/Body; these are the cuts at which our collaborators have experienced marks on their bodies- often at their own hand- as their complicated lived experiences defy the tidy categories of 'brain disease' and 'trauma victim'. The borderline between psychosis (the disease of perception) and mood disorders (disease of emotional response) is where they find themselves rendered invalid as subjects and depicted as monstrous objects of disdain[11]. To stand with them at the borderline is to move toward being accountable for the ways in which these cuts are made. Our *proximity* as collaborators is both affective and spatial. Vulnerability allows me to expand my *felt* experience (Shotter, 2014) as a form of knowing, and, as Barad suggests “knowing is not a bounded or closed practice, but an ongoing performance of the world” (2007 pp 149).

Art and 'the Mess' of it all

As discussed above, I met regularly in one-on-one coffee dates with all of the collaborators, which ranged in the format from casual chats (with no recording) to a more formal, semi-structured interview that was recorded on an iPhone. It took five months of meeting individually before they expressed comfort with coming together as a group.

Many of them were in the same treatment program and, although they may have known each well from the treatment program, they were forbidden to hang out as friends while in the program[12]. We were lucky to have the support of the local DBT day-treatment program who supported our work together by assisting with recruitment and inviting me in to give poetry workshops to their clients. They supported the participation

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[11] See *Fatal Attraction*, the 1987 thriller featuring Glenn Close as a ‘borderline woman’ who is shot dead by the love interest she has been stalking for the duration of the film

[12] The local DBT program- the only treatment exclusively for adults with Borderline Personality Disorder in the span of three provinces- has this rule to protect the participants from possible confidentiality issues from socially connecting outside of the treatment space. The treatment is five days a week, 8 hours per day and involves intensive sharing of traumatic memories, personal secrets and struggles within the group. The ‘no hang-out rule’ is to ensure that they have a social space outside of program that gives them a break from the intense intimacy of group treatment. It also ensures that treatment is not compromised by participants dating each other and having these relationships (and their associated conflicts) spill over into the structured group activities in the program.

of many of their clients in our project and encouraged them to get involved in making art with me as part of the process.

We met for the first time in a community room of a local grocery store and set a schedule of art workshops based on their interests. I taught the poetry workshop and the remaining workshops were facilitated by participants – many of whom had professional training and experience with art-making. We drew, painted, wrote and imagined together, using semi-structured activities that explored issues of identity, stigma, institutionalization and a range of emotional landscapes. This creative work formed part of their stories. It was a form of knowledge that they offered alongside interviews and the occasional Facebook or text message they would send with an idea about BPD. Our end goal (aside from the creation of text to serve as my PhD dissertation) was to have a public art show of their work and host a discussion about BPD that was participant-driven, fiercely honest and hopefully attended by health care workers and medical students.

In our first session, I asked;

How should we go about deciding which work gets submitted to the art show? Some of the things we wrote about today are very personal I want to give you the space to decide about your own work so you are ok with what is submitted for public viewing… But at the same time, I know that most of you won't recognize or admit when your work is awesome and you'll be all, like 'this kind of sucks' or 'this painting is really crappy, but….'. So, if I leave it entirely up to you, you might throw your brilliant work in the garbage at the end of the night.

They laughed. Guilty as charged.

One participant piped up; *"What if we nominate each other's work? If there is a poem someone writes that really works for me, can I say; ' I want this one to be recorded for the project'? And then you can say no if you really don't want to….?"*

I nodded. "*Can I trust you guys to say no if someone nominates you? That you won't say yes just because you feel guilty saying no, even if you really don't want it shared?"*They all nodded. We had consensus. Thus, we developed a collective process for curating the creative work that was shared both in this ethnographic text and our eventual art show.

Leavy (2013) has noted that arts-based research, in its transgressive, boundary-crossing of disciplines and blurring of the rules of method and analysis, is an authentic transdisciplinary approach to world-making that draws no clear lines between data collection, analysis, presentation (to a peer-reviewed audience) and subsequent 'translation' for knowledge communication to the public (See, CIHR's knowledge translation model). My own background as a poet and performance artist made it tempting to conceptualize our process as a collaborative 'research-creation', however, in the interests of engaging in diffractive practice that is attentive to the cuts made between subject and object (and other such dualisms) in the on-going performance of the world, "the term research/creation is in danger of upholding the very binaries that it purports to undo; the slash between research and creation begins to look like an either/or" (in Riley and Hunter 2009 p. 62). The truth is, that our project was all of these- ethnographic, arts-based, qualitative, collaborative research-creation practices -and none of these practices at the same time.

Ethnography as text

Attention to diffractive commitments and a refusal to engage in binary dualisms in the production of this work must also stand in relation to the drafting of the *dissertation as text.* In the midst of the literary turn in the social sciences, Marcus and Cushman (1982) wrote a landmark paper, exploring the emergent possibilities of ethnography as *text*. Postmodern crises of representation and realism (Lather, 2001; Lynch, 2000) generated new experimental ethnographic practices, with attention to the implicit values (Ellis, 2004) and standpoint (Haraway, 1988) of the researcher and how these, in turn, shape the knowledge that is produced.

This "crisis of confidence" in critical social sciences (Ellis, Adams, Bochner 2011) in the ontological possibilities of positivism flipped the lens onto the researcher, herself. The practice of reflexivity became a sustained means with which to make visible the contingencies of power structures in disciplined knowledge (Foucault, 1994). Marcus and Cushman (1982) trace the historical shift in the intrusion of the "authorial first person" (1982, p. 39) into the stories told in ethnographic writing and in the organizational frames into which these stories are given meaning.

Experimental ethnographies within this new ‘post-modern turn’ were often caught between an ethical imperative toward deconstructive un-doing of disciplinary authority and a need to maintain some authority in which the author must: “tie its own ends together in a systematic analysis” (Marcus and Cushman, 1982 p. 46). These early ethnographic texts tended to: “operate with both kinds of rhetoric in the same text, while persuading readers to shift criteria by which they trust in and accord the text authority” (1982, p. 46). Reflexivity was limited in its ability to distance the researcher from the disciplinary power structures, in which differences are originally produced, thus: “aside from preparing readers epistemologically for radical differences, self-reflection serves to sharpen the separation between ethnographer and his representation of difference, thus achieving the effect that native worlds are authentically different from his (and our) own” (Marcus and Cushman, 1982 p. 48).

Although reflexivity can make visible the standpoint and biases of the researcher, when the intended readers of the text possess the same socio-cultural privileges awarded by power/knowledge structures, these rhetorical approaches do little to reduce the authority of the researcher. Reflexivity, in this case, simply nurtures a relationship of familiarity and sameness between reader and researcher, who, in many cases are academic audiences, or outsiders to the ‘object’ of culture within the text. Later critiques of reflexivity as an academic virtue (Lynch, 2000) and feminist practice (Haraway, 1988, 1997 and Barad, 2003, 2007) has given way to a call for ‘diffraction’ as a metaphor for feminist engagement in the socio-material (Haraway, 1988, Latour, 2005) world.

“Working the Ruins” of voice and text

After decades of field work with women living with HIV/AIDS, Patty Lather (2001) reflected upon the practice of feminist ethnography in the postmodern turn as 'working the ruins' and situated the tension identified by Marcus and Cushman (1984) as being "within/against" the "noninnocent space" of ethnographic methodology (2001, p. 200). Lather depicts this tension as: "a doubled epistemology, where the text becomes a site of the failures of representation and textual experiments are not so much about solving the crisis of representation as about troubling the very claims to represent" (2001 p. 201).

To accept this crisis, this failure of language, is to wander in the ruins in search of intimacy with the object of knowledge as we simultaneously fight the urge to 'objectify' as such. Closeness is found in: "the moment of loss where much is refused, including abandoning the project to such a moment" (2001 p. 202). To engage in ethnography is to always, already, be foregrounded by its failures to disrupt the practices of power it both reinforces and seeks to disrupt. Drawing Derrida and Butler into an account of ethnographic space, Lather suggests that: "ethnography becomes a self-wounding laboratory for discovering the rules by which truth is produced" (p. 202). Lather discusses her own attempts to grapple with her postmodernist awareness of the inherent failures of 'realist voice' through a splintered presentation of voice and temporality in her published book:

> *As an intervention in the machinery of mimesis, most pages combine a top two-thirds that appears to be an unmediated interview transcript that foregrounds insider stories and a bottom underwriting that both decenters and constructs*

> *authorial presence through a kind of temporal disturbance* (2001, p. 207)

This "interruptive" approach to the presentation of ethnographic text is an example of an emergent feminist strategy of 'diffraction' (Haraway, 1997) that foregoes the closed loop of self-referential reflexivity in favour of a more multi-sited and temporally dispersed presentation of knowledge.

Equally important to the emergence of experimental ethnographic practices that resist a single authorial voice, is a consideration of the absences and silences of research informants. Lather (2001) is critical of the ways in which notions of 'voice' have obscured the reinscription of authorial expertise and largely failed in Liberal feminism's attempt to 'give voice' to 'the other'. Audra Simpson (2007) reminds us that the practice of "[k]nowing and representing the "voices"" of indigenous peoples in colonialism "required the methods and modalities of knowing, in particular: categorisation, ethnological comparison, linguistic translation and ethnography" (p. 67).

Ethnographic practice, then, is a dance of refusal and negotiation between empire (Simpson, 2007) and the borderlands of what is rendered unknowable in disciplined knowledge. 'Knowing' by and through ethnographic voice persists in the ruins of representationalism, master narrative, empire. Simpson reminds us that ""voice" is coupled with sovereignty that is evident at the level of interlocution, at the level of method and at the level of textualisation" (2007 p. 68). In this sense, ethnographic practice is shaped by the possibilities (and limitations) of voice, but also to silences, to curation, to the processes of editing and refusal and the setting of boundaries that make up the organizational frames (Marcus and Cushman, 1982) of the project.

Simpson argues for an understanding of ethnographic refusal that sees generative potential in the *boundaries* of what we can achieve as qualitative researchers. She charts her own experience as an ethnographer 'of the familiar' and the ways in which she chose to re-direct her anthropological analysis when the data no longer served the community she worked with. She asks: "What is theoretically generative about these refusals?" and asserts that moments of ethnographic refusal- the setting of boundaries on our own terms:

> *[T]ell us something about the way we cradle or embed our representations and notions of sovereignty and nationhood; and they critique and move us away from statist forms of recognition. In listening and shutting off the tape recorder, in situating each subject within their own shifting historical context of the present, these refusals speak volumes, because they tell us when to stop* (Simpson, 2007 p. 78).

Thus, to refuse a question in an interview, to deliberately stay silent during an ethnographic encounter is, for Simpson (2007), an "exercise of dominion" over the "representational territory".

"like the silences in a symphony to pattern the visible categories and their boundaries"

In this stuttering process of world-making we committed to, together, the story is as much framed by what was offered as what was held back. This is to say, we have shared secrets and not all of those secrets will be told in the final narrative. The narratives offered within this text are punctuated by the deliberate turning on and off of the iPhone recorder, the stops and starts, the days when they don't show up at all. The text messages that just say "I'm sorry". The days I spent alone at our table, writing poems in their absence, knowing that speaking is a privilege for those who already believe that they have something valuable to say. Knowing that self- care sometimes means refusing to speak.

Together, we set the bar at *radical vulnerability* and often come up short. Narratives have been given, erased, re-offered, and erased again. Solidarity has been built in the keeping of secrets, in the silences. Ethnographic refusal, in the context of friendship, in the context of trauma, is more than the exercise of dominion over the territory of representation (Simpson, 2007), it is also a language in which we are able to care for each other. Intentional silences became part of a practice of "modest witnessing" (Haraway, 1997). Often we would be interrupted by the slow creep of a panic attack, sometimes by the persistent ring of a needy partner on the phone, sometimes by ugly tears- the ones that tell us to stop, re-group and stitch up the wounds before we can take a breath and continue. These moments oriented us *within* our vulnerability- they told us we were invested in the project and showed us the contours and boundaries between and within us. Silence, in our encounters and in this text, is a way in which we honour the labours and limits of vulnerability and acknowledge the violence of representation in everyday life.

Text as apparatus

Text is an apparatus of knowledge. Language does not signify an already existing reality that was ‘discovered’ through appropriate methods and signified in language. Apparatuses: “*are boundary-making practices*” (2007, p. 148 emphasis in original). This project is a practice of world-making in a performative intra-action with the world, as we go. To read diffractively, to make cuts between what is and is not, to frame or curate in ways that are accountable to such ‘agential cuts’ requires thoughtfulness and deliberate intention in the telling of these stories.

In *Body Multiple*, Annemarie Mol explains the format of her ethnographic exploration of the construction of atherosclerosis in two different hospital sites: “I deal with the literature in a series of separate texts that resonate, run along, interfere with, alienate from, and give and extra dimension to the main text. In a subtext, so to speak” (2002, p. 3). If it is true that; “ “apparatuses are the material conditions of possibility and impossibility of mattering” and that they “enact what matters and what is excluded from mattering” (Barad, 2007 p .148), then this the format of this text must be ethically examined. In Lather’s (1995) work that depicted life for women living with HIV/AIDS, she was careful to put the women’s narratives on the top of each page and relegated the author’s analysis and engagement with the literature of their respective disciplinary canons to the bottom: “we try not to position ourselves as knowing more about these women than they know about themselves. Placing their voices above ours on the pages and their poems in boxes, seemingly out of control of authorial judgement” (Lather, 2001 p. 216). Thus, the politics of citation weigh heavily when collaborators are invited to tell their own stories. Texts that rely heavily on theories of the sub-conscious or that posit social theory through the explanatory constructions of psychoanalytic narratives are thereby excluded from our bibliography. This was an ethical choice and a deliberate move away from a tendency to position the “mentally ill” as in need of the explanatory authority of an ‘expert’.

Laura Maria Agustin, an anthropologist who has spend decades in the field interviewing migrant sex workers has long been critiqued for refusing to psychoanalyse or pathologize the choices of migrant sex workers she interviews. She explains: “ I give a lot of weight to what people say about themselves. I suppose that’s some kind of bottom line”[13] Thus, the exclusion of certain texts and the spatial presentation of women’s narratives in this text are deliberate in their respect for ensuring that ‘everything goes equally’ rather than using the meta-theories of my discipline a framing apparatus for how and in what ways, these stories are interpreted.

I imagine ‘myself’, as a facilitator in a community meeting, and each text, each story, each creative work is an attendee at the meeting. It is my job, to use anti-oppressive principles (Bishop, 2002) in balancing the discussion. A choice to diffractively read a deliberate selection of texts through and within each other is performative in its unfolding, but in the writing of this text, becomes, itself, an apparatus. The agency of the texts is material-discursive, as such: “boundary-making practices, that is, discursive practices, are fully implicated in the dynamics of intra-activity through which phenomena come to matter” (Barad, 2003 p. 822). The importance of this will become clear as complex intra-actions of blood, emotion, MRI scan images, diagnostic apparatuses, Instagram hashtags and ‘marks on bodies” (Barad, 2007) will be explored in later chapters.

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[13] https://www.youtube.com/watch?v=e_i_zBkoh68

Historically, the messy texts of ethnography (Marcus and Cushman, 1983)) and use of thick description (Geertz, 1973) have signified the awareness that the apparatus of the text can produce or re-produce a particular kind of world. However, as Ritterbusch (2011) notes, thick description is not an act of justice on its own. It can actually serve to romanticize particular forms of suffering and essentialize the experience of her participants. In 1998, Michael Angrosino published *Opportunity House: ethnographic stories of mental retardation*. After many years of volunteering for a forensic residential facility that housed men with concurrent labels of 'mentally retarded' and 'psychiatrically disordered', he wrote a series of 'fictional' short stories based in his time with the men inside. He does this as a way to protect their identities and protect their vulnerabilities as highly-stigmatized men who are living in secure care.

In the introduction to the book, Carolyn Ellis and Arthur Bochner write that Angrosino's stories are: "fictional but ultimately true" (1998 p. 14). Patricia Leavy reminds us that: "perhaps more than anything else, fiction-based research practice challenges the fact/fiction dichotomy that has historically dominated our understanding of what is and is not considered research" (2013 p. 24). John Law suggest that, perhaps, we need to erase the lines between literature and 'research' all together and questions the ontological repercussions that could occur:

> "*Poetry and novels wrestle with the materials of language to make things, things that are said to be imaginary. It is the making, the process or the effect of making, that is important. The textures along the way cannot be dissociated from whatever is being made, word by word, whereas academic volumes hasten to describe, to*

> *refer to, a reality that lies outside them. They are referential, ostensive. They tell us how it is out there. How, then, might we imagine an academic way of writing that concerns itself with the quality of its own writing? With the creativity of writing? What would this do to the referent, the out-thereness*? " (Law, 2004 p. 12)

Thus, if "everything goes" equally (Feyerabend, 1993) and diffractive practices have the potential to transform the agential cuts between what is/is not and trace the differences created in the on-going entanglement of the world, fiction not only serves to protect the vulnerability of participants, but is also a way to radically imagine ourselves to another possible world.

Chapter 4: Findings

The following three stories are 'fictional but ultimately true (Ellis and Bochner in Angrosino, 1998)' in the sense that they are collaged from the experiences of 16 different collaborators on this project.

Names and details have been changed to ensure absolute protection for all collaborators.

The stories were written over a 48 hour period, with audio recordings of the interviews played on an iPad as an immersive soundscape and the artwork of collaborators lined the walls and was strewn across a large dining room table where I sat with my laptop.

The stories were not 'planned' following ordered analysis of data. They were written creatively while immersed in the data. In this sense, the research findings fulfill the definition of the research-creation. The process was a creative one. I focussed on my own emotional responses to the women's stories as I worked to weave them together.

However, once written, they were cross-checked against each interview transcript and field notes to ensure that they reflected the data, accurately. In some cases, the stories *highlighted aspects of the data that I did not see until after it emerged in the story and I went back into the archive to find it. In this sense, the stories also represent structured data analysis, even though the analysis took place after initial creation.*

These stories emerged from my own interpretations of the 'data' but also interfered with my conscious interpretation of the data by reflecting dimensions that I missed during initial analysis.

Anna

It is deep winter. We are sitting in the nook of a bay window on the second floor of a cafe next to the medical school. It's a converted Victorian home that still feels like one. We are in a small room at the top of the stairs. Both of us, with our knees pulled up to our chins in bistro chairs at a wooden table covered in notebooks, ceramic mugs full of tea and colourful markers.

She is wearing a floral cardigan with tiny pearl buttons and her hair is pulled back in a braid. She fiddles with a keychain full of baubles and a tiny, framed photo of a golden retriever. She borrowed her mom's car to come meet me at the Cafe. She has freckles.

"I always knew something was wrong. I mean, my teacher - my junior high teacher- he noticed that I wasn't eating... He called my parents and that's how they found out I had an eating disorder... But even before that. I was really depressed. And really sensitive. And the eating disorder treatment when I was in high school wasn't working.

I just felt like it wasn't going to get better. I ended up at the ER the first time because I was trying to kill myself and my mom couldn't keep me safe."

"Talk to me about that-" I said. "Talk to me about when you started trying to get help from doctors after the eating disorder treatment ended..."

***

Anna was 18 when her mom took her to the adult emergency room for the first time. They had a disagreement over whether or not she was going to return to her old school after taking a year off for treatment for anorexia. Anna did not want to return and she was frustrated that her parents weren't listening to her. She locked herself in her room, sobbing. She didn't feel better. She was still restricting her food intake and was deeply depressed. She tried to hang herself in her closet with the belt from her housecoat, but her mom broke through the door in time to stop her. Anna fought back, her hands curled into tiny fists, sobbing and yelling at her mom as they struggled on the floor of her bedroom. Her mom called 911 and paramedics eventually transported them both to the ER because they could not calm her down. She waited for close to 9 hours before receiving an assessment from an ER doctor who consulted her chart, spoke to her for less than ten minutes and then left her again for another 2 hours.

After her initial -and short- assessment with a doctor, Anna became frustrated and acted out by kicking a garbage can and screaming at her mom to take her home. Nurses and security staff entered her room and warned her that if she didn't calm down, she would be sent home. They offered to restrain her, but her mom promised to try and keep her under control. Nursing staff told Anna that yelling and screaming would not be tolerated in the ER. She eventually cried herself to sleep on the bed until she was awoken by the return of the on call ER physician, who asked to speak to her mom outside.

The ER physician asked Anna's mother if she was familiar with 'borderline'. She said yes, it was a diagnosis they had considered when Anna was hospitalized for her eating disorder at 16. At the time, she had been told that Anna was too young for the diagnosis and that she didn't meet all the criteria- she didn't cut or burn herself- and she had not attempted suicide. The ER physician explained that Anna's other doctors had listed 'borderline' on her chart and he recommended that she be admitted to the youth inpatient ward (which sees patients until age 19) for another assessment.

Anna's mother returned to the room and explained that they were waiting to be transferred to the youth inpatient unit Anna was familiar with- the one she had spent some time in previously. Anna refused. She asked to go home.

When the ER physician returned, he explained that there were no beds in the inpatient unit and suggested a follow up with her psychiatrist on another day. Anna agreed. She wanted to go home.

***

Anna is a part-time student completing a Bachelor of Science degree. She wants to become a psychologist. When she is not studying, she spends time in a local peer support program for youth who are diagnosed with mood disorders and psychosis. Her diagnosis is borderline personality disorder- which is not what the program is intended for. She is not 'out' about her diagnosis in this community-based mental health program. She tells everyone that her diagnosis is 'anxiety' and anorexia. Her 'borderline' status is a secret. When I ask her why she keeps her diagnosis a secret, she replies:

"It's hard. When I found out my doctors had borderline on my chart and didn't tell me... That was hard. I didn't want to be the same as all of the worst people I knew. I mean- the worst people to me. The meanest girls in the hospital had borderline. I guess, now I know some who are not like that- but back then, I hated people with borderline. And if I tell people I have it now- even though we're all, like, anti-stigma and everything... They just, they wouldn't want me around. No one would trust me."

***

Anna was in and out of the adult ER many more times over the next couple of years. She received a formal diagnosis of borderline personality disorder when she was 18 and was placed on a waiting list for dialectical behavioural therapy- the only effective treatment for her diagnosis. She spent the next two years without treatment as she waited for a spot to open up in the program. She grew increasingly more suicidal and attempted to end her life many more times. When you have been diagnosed with BPD, the ER is a holding cell of heartbreak. There is nothing more cruel than triage; where the wounds of each suffering visitor are ranked in hierarchical order, and the most urgent ones are placed at the top of the list. When you have BPD on your chart, you always end up at the bottom- if they'll even see you at all. Anna was never admitted as an inpatient during these visits. On one visit, a nurse told her that her 'attention-seeking' behaviour was 'selfish' and she was repeatedly told by ER nurses and medical residents to 'calm down' when she was panicked, suicidal and in severe distress. It was always assumed that she was lying- or exaggerating her symptoms. Her distress was invalidated and, in turn, she would sometimes get angry and yell at medical staff. This resulted in punitive responses from staff and further prevented them from being able to empathize with her. They call it 'compassion fatigue' in the official literature, but for someone with BPD, it's just part of the typical ER experience.

***

We are colouring in notebooks with markers. She is drawing flowers and I am trying - ineffectively- to draw a picture of my dog. Anna has the day off of classes because of a university holiday and we've already been through two refills of tea at the cafe. I ask her what it felt like- being in the ER. Being without treatment. She tells me: "I felt like a nowhere person. There was nowhere for me. No treatment. No one would take me. Psychiatrists said they couldn't handle my case and the ER kept kicking me out. Like, where was I supposed to go?"

I run downstairs to get us some fresh tea. Anna is in no rush to leave- she has studying to do and doesn't feel like going home.

When I return, with a steaming mug of strawberry rooibos tea in each hand, I say "you know; I would be so angry. I would feel so angry and frustrated if I was hurting all the time and every time I went to get help, doctors pretended I was faking... Or acted like it wasn't serious. I think I would want to burn the whole place down". Anna laughs. "Yes, it's hard. Hard not to get angry, but if I show them how I really feel they'll call security and I'll get kicked out, so... Yeah. Glad not to go to the ER anymore."

***

DBT helped Anna a great deal. She still struggles with depression and self-harm, but after a six month day treatment program, she was able to become a volunteer in the local animal shelter, join community programs and go back to school. When Anna was 11, she was sexually abused by a friend of the family. The abuse went on for many years and when she was first admitted as an inpatient as a teenager, she refused to talk to her family because they reported him to the police after her clinicians told them of her disclosure. She thought she was in love with her abuser. Through years of therapy, she also realized that she was angry with her family for not protecting her from him. It is constantly complicated; constantly shifting. It took Anna many years to come to see herself as the victim of sexual abuse. Sometimes she wants her abuser to stay in prison forever; other times she misses him. She sees a psychiatrist regularly about the issue, Dr. Kendall, but he is not trained in DBT. Not all victims of sexual abuse have the same severe symptoms of emotional dysregulation that Anna suffers from; and not everyone with Anna's diagnosis has experienced sexual abuse, so it's difficult for her to find a specialist who can respond to her needs. Her abuser is still serving a prison sentence. She is slowly learning how to emotionally regulate herself and stay out of the rabbit hole of 'black and white' thinking that plunges her into extremes. In one of our first coffee meetings, I asked her what it was about DBT that helped the most. She explained, "DBT really teaches you that you have value. Like, breaks it down so you learn all the parts about loving yourself. Like, it's one thing to 'say' you have value, but it's different to try and put that into all your thoughts and reactions."

***

A few seasons have passed since my last coffee date with Anna. She became busy with school and I have been away in another province, teaching. It's summer now. I am home, entertaining a houseguest and making a pot of spicy peanut soup. I receive a text from Anna.

“Are you busy? Are you in Halifax?”

I reply: “Yes, I am home making soup, but my brother is coming over in 20 minutes to talk about a seating plan for his wedding. Are you ok? ☺”

***

I have known Anna for many years, through work in community-based mental health organizations and later through this research. I consider her to be a friend. She has told me that she considers me to be an older sister. She doesn't have any sisters, so she jokes about how she's adopted me. Anna has never reached out to me when she was in distress, before. We speak regularly, but it is always scheduled in advance.

On that particular day, Anna expressed that she felt guilty for messaging me, apologized and finally admitted that she was in the ER. She had a panic attack at work and it had escalated into severe suicidal impulses and outbursts of anger and tears. Her mom, frustrated by yet again another period of 'emotional dysregulation' dropped her off at the ER and continued on to a lunch date with a friend. She texted me, because we had spoken most recently about the ER and she knew that I would understand what she was going through.

She explained: "They are refusing to see me. They are not listening. I'm done. I'm really done. I can't do this. They offer assisted suicide to people with terminal illness. It's not fair that they can't do this for me?"

I turned off the stove and debated whether I should drive down to the ER to sit with her.

She continued: “I want to die. I can’t do it. It never gets better. They aren’t listening to me, Ardath. They know I have BPD and they are refusing to listen to me. They just stuck me in this room and said it will be awhile to find a psychiatrist and it is freezing in here and they wouldn’t even give me a blanket. I am so cold. I am so angry. They don’t care about me. They don’t even care.”

I respond: “That must be really frustrating. Listen-I know this is hard. The ER is the worst place. It is terrible, I know. It must be really, really hard to feel like they don’t care. But I do. And lot’s of us care about you and believe you. I would be angry, too.”

She sobbed into the phone, taking long, sucking breaths as she tried not to choke on the tears she was holding back. I asked her to describe the room for me. I asked her if the walls were that ugly grayish-pink colour and if the floors were clean or dirty. I told her that she had been through so much and that anyone who had experienced what she experienced would struggle in the same way. I told her I was here and that we would talk or text every couple of hours until she was home safe and not feeling suicidal any more. I told her that I believed what she said. Every word of it.

After 14 hours the ER staff had finally agreed to admit Annie. By then she was tired and frustrated and opted to just go home. We spoke the next morning and set up a time for a coffee date the following Monday after her appointment with her regular psychiatrist. She said she still felt suicidal but didn't believe the hospital had much to offer her.

***

A few days later, we meet again at our favourite Café. They greet us both by name. This is a safe and familiar place for us. They make Anna a hot chocolate and pour me a decaf, laughing, as I often order a decaf and then return for a refill of caffeinated coffee afterwards. This tall, Victorian house is the place where we have all our meetings, in the tiny room upstairs with the bay window and a door that can close for privacy when we talk about things like suicide and cutting. The café is full, mostly with tables of university students having lively conversations and faculty members hunched over stacks of papers.

Anna doesn't look good. She hasn't been sleeping she told me. I ask her why she had such a bad weekend after she had been doing so well for so many months."I don't know" she says "I just feel done".

I ask again; "Why do you think you got so upset this weekend?". She shrugs.

"My manager scheduled me when I had to be at my other job. I told her. I emailed her. She forgot- it was her mistake but she was such a bitch about it. She was, like, Anna- it's

your responsibility to read the schedule and I was, like, it's YOUR responsibility to read emails. Then I had a panic attack in the back room. And they called my mom"

"That must have been super frustrating". I remind her that she just finished exams and how stressful it must be to work two jobs when your managers won't cooperate on scheduling. "Yeah", she says. I switch topics. I remind her that lots of young women like her have terrible experiences in the ER, hoping that she wouldn't feel so alone. Anna has never made it to our group art-making sessions. She always finds a reason not to attend at the last minute. We only meet one-on-one.

She stares down into her hot chocolate for a few moments, then reaches down to pick up her purse from under her chair, rifling through it and finally pulling out a folded piece of lined paper. She slides it across the table towards me.

"What is this?" I ask, carefully unfolding the paper. Bold letters in pencil, read:

"I AM NOT TELLING <u>ANYONE</u> HERE MY PERSONAL BUSINESS. I THINK I MIGHT BE PREGNANT AND NOW I'M NOT SURE. IT IS NONE OF YOUR BUSINESS TO KNOW MY PERSONAL INFORMATION OR ANYTHING ABOUT ME. I WILL ONLY TALK TO <u>DR. KENDALL</u>"

"Anna…." I mumble, holding back tears. I had met her boyfriend a month earlier at an event for Psychology Week. He looked like Harry Potter and he held her hand the whole time.

"Anna, did you have sex with your boyfriend? Is it the first time, since...?"

She nods, her eyes welling up with tears. "Oh my god, Anna. That is so brave. That is so, so, so very brave. And it must have been a really big step and then really stressful thinking that you were pregnant". She keeps staring down at her hot chocolate. "That's what Dr. Kendall said". I asked her if she had told her parents. She hadn't. She didn't want to upset them. She was embarrassed.

"Did you give this note to the people in the ER?". She nods. "Did they give you a pregnancy test?". She shakes her head.

Cheyenne

Cheyenne's living room is packed full of paintings. We sit on the floor- carpet splattered in acrylic paint, drinking Tim Horton's tea. Her dog is laying on the floor next to me, demanding a belly rub. There is a ginger tomcat that comes and goes from a rip in the window screen. It's late afternoon. We are meeting at her place so we can look through her paintings and be there when her daughter returns from school. Cheyenne lives in the projects, a single mom with a tween-age daughter, a dog, a cat and a room full of art work. She shows me one piece, with an excerpt from a poem on one side. "I don't usually show my writing to anyone- it's private. Like, journalling stuff. But I made this one in DBT and I thought it would be fun to layer it- like, multimedia- which isn't my style, really, but it was fun to do it. Plus we got bonus points for including our DBT journals in our work". I laugh.

Cheyenne looks a lot younger than she is- appearing more like a teenager than her actual age which is closer to mine. She has curly, dark hair in a short bob- like the French film character, Amelie- and is equally as cute. She is self-conscious about her weight and compulsively tugs her tie-dyed tank top down over tummy as she reaches in behind stacks of paintings to find the older ones. She has an eyebrow ring with a rainbow stone on it, and a green and purple tattoo of a hummingbird on her right arm.

***

Cheyenne lives on social assistance through the Provincial Disability Support Program. She paints full time and sells her work at the Farmer's Market as part of the Healthy Minds Cooperative, community art-preneurship program. She was diagnosed with BPD as a teenager, but she did not receive treatment until her mid-30s. Cheyenne has challenges with mobility- she walks with a pronounced limp. She was born with a spinal cord and hip defect that makes it difficult for her to walk without the use of a cane. She refuses to use one, preferring instead to shuffle and move on her own, using walls or furniture for support- or she won't go out at all if she can't get around on her own two feet. Winter is hard for her, but now that her daughter is older, she can help with getting groceries and running errands in the neighbourhood. Cheyenne never had any formal training as a painter, but she tried abstract painting at a music festival when she was in her 20s and has been painting every day since. She paints less often now, as the Dollar Store has raised the price of canvasses and paints to $3 each, which is prohibitive when you are a single parent on social assistance.

***

"So, were you into art class in high school? She shakes her head. "I don't remember ever even going to art class". She doesn't like to talk about high school. "What about in

elementary school- you must have painted then?". She nods. She has been telling me about how hard DBT has been lately.

"It makes me angry- like, it shouldn't make me angry- but for some reason when they ask us to 'affirm' our value and all that stuff- it pisses me off. I know we're not supposed to go all borderliney on staff and freak out, but this module is the worst. I can't handle it."

I turn my attention back to her paintings. There is one with a skull- a big one, right in the centre of the canvas- it reminds me of images you often see of Dia de los Muertos celebrations in Latin America. I ask her about it. "Yeah, that one is done with glow in the dark paint. I was reading a lot about Frida Kahlo when I made that one." I am quiet for a few moments, recalling Frida Kahlo's crippled leg from Polio and stories I had heard about her depression and the tragic accident that ended her medical career.

"What was it about Frida Kahlo that interested you?"

"She refused to smile in her portraits. I guess- I guess I just liked her... She was real- like a weirdo. She never smiled"

I ask Cheyenne if she has ever painted a self-portrait of herself- she laughs- as if I have asked her if she has ever flown through the sky using only her arms as wings.

"No. No. I haven't. I don't paint myself. Or people, really."

I ask her what it is about a self portrait that would feel so difficult.

She responds "I don't even know what I am supposed look like"

***

Cheyenne has a boyfriend now. She makes it very clear that she is NOT straight, but she hasn't dated a woman in many years. She separated from the father of her daughter when she was still an infant.

Cheyenne had run away from home and dropped out of high school in her rural hometown when she was in grade 11. She was deeply depressed in junior high and began using drugs. She was later raped by the older man that her friends would buy drugs from. She was bullied intensely following the rape, as rumours spread throughout the town and her peers, teachers and older adults began to treat her as if she was 'bad news'. She was 'that girl' and the 'good kids' avoided her. When she does talk about high school, she describes it as a 'Christian school' even though it is in the public school system. The principal was a woman with very conservative values and she regularly asked Cheyenne into her office to reprimand her for wearing eye shadow, or to put a sweater on over her tank top- even though other girls also wore eye shadow and tank tops. They never seemed to get into trouble.

She once told me that she had experienced depression since puberty. She used to ugly cry at the World Vision commercials of starving children when she was a child and her acute sensitivity became more of a pervasive numbness and sadness as she became a teenager. She had sleeping problems and her parents grew increasingly exasperated with her crying fits and the weekends she spent sleeping up to 20 hours a day, staying in her room and listening to music. They did the best they could- they sent her to their family doctor who suggested that it was normal 'teenage stuff'.

After the bullying became too much, she ran away at the beginning of grade 11 and met the father of her daughter at a music festival. They did drugs, fell in love and she got pregnant. They moved to the city together- he tried to find work to support them- and she began to navigate the bureaucracy of the social service system as she found herself living independently, with a physical disability and severe (untreated) depression. They pan-handled to get them through the rough patches. She miscarried at 6 months. Although her pregnancy was not planned and they were struggling financially, they were devastated when they lost the baby and began to try again. Cheyenne's disability made pregnancy difficult and, against the advice of doctors, they kept trying. Two years later, Cheyenne gave birth to her daughter. She said that being pregnant was the happiest she has ever been.

She struggled with post-partum anxiety following the birth of her daughter, which put a strain on her relationship and, on top of the other pressures they faced, it ultimately ended their relationship.

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"This is the third time I've been through DBT. I mean, I didn't have any treatment for 20 years, so I find my own ways through some of this stuff. Like the mindfulness- I read about Zen Buddhism when I was pregnant and I found it helped me. Now they are teaching it to me as if I don't know anything."

I tell her she is my hero. I explain that there is NO WAY I could have handled being a single mother, with mobility challenges and depression on top of all the bureaucratic frustrations of dealing with community services. I am honest when I tell her that I can't fathom how she does it- and stays creative enough to make art on top of everything. I am the same age as Cheyenne and we have known each other for many years through art and music communities. For most of our friendship I had no idea she had BPD or was struggling with self harm and suicidal thoughts. She always seemed sweet, and kind and shy... I just never knew.

She tugs her shirt down again. I realize that she has a C-section scar, that she is hiding.

"Let's talk about DBT. The last time we talked you were really happy about it. Now it seems like it's kind of a let down for you. What's changed?"

She sighs. "I guess it's because I am getting to the end of the program again. It's hard not anticipating what it's going to be like after- like, you go from a supportive environment every day, build your skills and everything... And then all of a sudden you go right back to your old life. And all the things that hurt you are still there. And I didn't learn that much this time- I just have to keep doing the program over and over again otherwise I will lose my social assistance."

I ask her if there are any weekly support sessions available, or peer support programs for BPD. She shakes her head. 'There is nothing. You go from day treatment all day, every day for six months... To nothing. Just meetings with your psychologist if you need to change your meds and that's it."

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Cheyenne always sends me a message after our meetings to say thank you and she will often express anxiety or fear that she may have said or done something wrong. She is always afraid of hurting my feelings. She is sensitive. And very sweet. And very anxious- something she alleviates once awhile with sarcasm, which is the only thing that gives away her age. Most of the time she comes across like a shy, 18 year old. I met with her regularly during the time that my dog was dying. I had found an orphaned pup on the street when I lived in Cuba 15 years earlier and I brought her back home with me. She was a nervous and antisocial dog- but I loved her dearly and we were inseparable for all 15 years of her life. She was infamous in the city as the "Cuban puppy" I would take to work with me in various non-profit organizations. Cheyenne had met her once many years ago and she laughs about how she growled at her. I would talk with Cheyenne about my puppy's cancer treatment and how I couldn't sleep through the night because I kept waking up to check and see if she was still breathing. Cheyenne made me a custom blend of herbal tea to help me sleep- valerian root and chamomile- and she would share stories with me about her old cat, who used to sleep in the crib with her daughter. I always found myself confiding the most in Cheyenne, because if I was tired or anxious, she would always notice and think it was her fault. I confided in her to reduce her anxiety and let her know that I was carrying my own baggage with me that day. I couldn't hide anything from her.

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I am driving one day to a meeting and I receive a text from Cheyenne. She asks if I have any free time that day. Cheyenne doesn't usually ask for meetings- she is too shy to assert herself when she wants to hang out. I pull the car over and call her.

"Everything ok?"

"Yes, I just have some news and wanted to share it with you"

I tell her I'll come by after my meeting.

"I'm pregnant :)"

....

I reply " !!!" and then send her a dozen smiley face emoticons in response.

"I'll be over soon! What can I get you at Tim Hortons? Gimme two hours."

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Cheyenne has been struggling since the end of her DBT program. At the completion of her last round in the program, she was offered a part time job as a secretary in a mental health advocacy organization. The organization is a charity that seeks to 'reduce stigma' by putting on high profile public galas and engaging local celebrities to speak on their behalf. Their current spokesperson is a former news anchorwoman. Cheyenne is paid minimum wage to answer phones on behalf of the organization, however, as the organization gets closer to the date of their annual fundraising gala, she has been asked to stay late numerous times and to assist with other aspects of the organization. She was initially excited to take on more responsibility, but the restrictions of her work contract limits her pay to only 17.5 hours per week. This means that Cheyenne is not being compensated for any additional time- time that usually requires her to find a babysitter for her daughter who can stay home on her own, but is not yet allowed to use the oven or make her own meals.

Cheyenne's boyfriend works long hours and does not live with them so he is not able to help. If he moved in with her, Cheyenne's social assistance payments would be drastically reduced and it could jeopardize her housing. She becomes increasingly more anxious and frustrated as the demands of her employment begin to erode the work she had done in therapy. All of her emotional energy was being spent on trying not to cry or get angry at her boss who didn't think it was a big deal that Cheyenne wasn't getting paid for any additional hours. In fact, her boss even suggested that she should be excited about a chance to 'build her CV' with the additional responsibilities (on a voluntary basis). Cheyenne eventually quit. She gathered her things on a Friday afternoon and left a note that said "I am going into relapse with my anxiety and depression and I am no longer able to work". Cheyenne never told them her diagnosis was BPD. Her boss followed up with a note that said "We hope you have a speedy road to recovery. Hope you have lot's of time for self care!".

***

I am up late one night, drinking valerian root tea and scrolling through Facebook. I come across a status update from Cheyenne:

" I want to let everyone know that we lost the baby. This is not the first time I had a miscarriage, but it is still very hard. Please don't ask me about the baby boy or my pregnancy because it's gone now and I can't do this again. Thank you for everyone who helped us. I have not been able get around much lately because of my hip, but it would be nice to see some of you this weekend if you want to come by. I guess it is for the best as the depression has been hard on the family. It feels like it will never get better. Thank you for all the support and I love all of you."

I feel sick to my stomach. I remember how happy she was when she told me she was pregnant. I had brought her a box of Ferrero Rochers (her favourite) and we drank Tim Horton's tea on the front stoop of her housing complex together. Her daughter had just won a debate competition at school and she didn't want to tell her until after the weekend so she didn't overshadow her daughter's celebration with word of the pregnancy. I thought about her determination- walking tightly up against walls and hanging onto furniture to move from one room to the next- her stubborn refusal to give up, despite more than a dozen suicide attempts before she turned 30.

I find myself typing Frida Kahlo's name into Google. It's late. I stay up, wrapped in a quilt in a dining room chair and read articles about Frida's tragedies, her wit, her fierce feminism.... I read about how much of an asshole Diego Rivera was.

I look at thumbnails of her paintings.

I stop- pausing on her" Self-portrait on the Borderline of Mexico and the United States". Frida stands, in a pink dress, holding a Mexican flag between an industrial landscape of smoke and industry and depictions of an ancient Agrarian Mexico. On the right; skyscrapers, Ford, smog. On her left, a skull, ancient fertility idols and the sun and the moon. Here; on the interface between the rubble of Mexico's ruins and the imperial architecture of American industry, she stands; her face stoic, her eyes looking directly at the viewer, holding a cigarette.

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Lorelei

We are sitting in the bay window of our favourite cafe. Lorelei will only sit in the room with the door that closes- as she is not 'out' about her diagnosis and is well known in the community. She is wearing a deep purple sweater with a lime coloured t-shirt underneath. Her short-cropped pixie cut is bleached blonde and her glasses are a deep red colour. She always has a great sense of colour and style. Today she is all jewel tones- a nice contrast against the greyscale spring landscape of asphalt and overcast skies. We are both drinking Americanos. The hard stuff. No herbal teas today. It is too dark and too cold and we both need something to boost our energy.

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I have known Lorelei for six years. We were colleagues at a mental health organization where I ran an arts-based youth engagement project for youth with mental illness. Lorelei was a peer support worker in the program and used to help me organize art shows as a way to engage the local community on issues faced by youth with lived experience of the mental health care system. She is currently attending a graduate training program in Occupational Therapy, but her undergraduate degree is in English literature.

She has won awards for her creative writing- she is a tremendously gifted writer. Despite her talents, creative writing is not known for being lucrative, and she knows that the stress of life *without* a living wage would compromise her mental health.

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"It's like Goffman. No one reads Goffman. But it's not like we don't know how bad inpatient units can be for your self-identity. It's not fucking rocket science".

I laugh in protest "Hey! I read Goffman!"

She smiles. "Yeah, but you are not the usual health care person".

I laugh again. "Yes. I guess not. Like I don't really belong there, but for some reason no one has asked me to leave yet. I think it's because they need someone around who is literate in qualitative research so they can qualify for all the funding"

Lorelei runs her hands through her short, spiky blonde hair and sighs. She knows what I am talking about. Our previous employment together was funded by a CIHR knowledge translation program grant and we were supervised by psychiatrists who believed that 'randomized control trials' were the only form of legitimate research.

"That was a shit show."

I nod in agreement. We are both happy to have moved on from that particular project. She takes a long sip of her coffee, "I am grateful for the opportunities that Dr. MacKay gave me, but I think it wasn't the best place for me back then."

***

When I first met Lorelei she was 'out' as having a diagnosis of Bipolar II, which is the less severe manifestation of a mood disorder that involves cyclic periods of depression and mania. She was in recovery from an eating disorder and had recently graduated with her Bachelor of Arts and was looking for work where she could be creative and use her degree. She met Dr. MacKay when she was an inpatient in the youth mental health unit for a period of severe suicidal depression. He hired her, years later, to be the 'poster child' for recovery in a mental health literacy project he had been running, to educate communities about the importance of early intervention for severe mental illness. Lorelei would travel with him on speaking engagements and occasionally 'tell her story' of successful treatment and recovery for bipolar disorder. At the time, she had pink dreadlocks and facial piercings and was grateful for the opportunity to have meaningful employment where she could be open about her history with hospitalization.

When I was hired, I was asked to work with Lorelei to consult youth service users to find out what their needs and interests were- it was our job to make sure that our team of researchers was engaging the broader community on issues of adolescent mental health that were relevant to our youth community. At the time, our supervisors were only interested in building community literacy on schizophrenia, bipolar disorder, clinical depression and anxiety disorders- the 'SMIs' or 'serious mental illnesses'. It became clear that youth needed more support on understanding non-suicidal self injury (cutting, burning, self-strangulation) and situational suicide (suicide related to bullying or sexual assault). Our supervisors did not want to talk about trauma or personality disorders or cutting.

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"Did you know the whole time that I was borderline?"

I shook my head. "Not at first. When you wrote that piece 'living with Bipolar disorder' for the blog, I thought it was amazing. It felt really real. It wasn't until you took time off and I visited you in the hospital. I think that's when I got it."

Lorelei flips through her notebook and finds an old excerpt from a poem.

"Here- this is what I wrote when I was in the hospital that time."

She slides the notebook over to me. I skim the page, smiling.

"I had no idea you were so angry at MacKay. You hid it well."

Lorelei snort-laughs and shakes her head. "I'm going to run to the washroom. You can read more of those poems if you want"

I nod, flipping through her notebook.

***

Lorelei became quite sick after three years of working in the project with Dr. MacKay. I noticed that she was slipping first, as we worked the most closely together. It was the kind of work environment where everyone worked long hours. The Psychiatrists worked 12 hour days and the residents worked even harder. Even our administrative assistant stayed later than 5pm on most days. We had a lot of flexibility and little supervision, but this resulted in a sense that we had to work *even harder* to 'make up for' the leeway we were given in other ways.

Lorelei started missing meetings and her attitude changed. She became pessimistic and irritable. When our supervisors declined to honour the work that we had done, collecting information on youth to see what they wanted from the project, we were both frustrated and angry. They had promised to listen to what our group of youth wanted, but, in the end, they decided that the research was too 'unclear' on issues of self injury and trauma to be included in the project. "More RCT studies were needed" to determine what types of interventions were most effective and, in the mean time, we could only focus on the 'SMIs' (serious mental illnesses), which responded to pharmaceutical therapies and had established treatment protocols. Lorelei was devastated. The issue of self harm and how it is handled in schools was very important to her.

I received calls regularly from parents whose children were asked to leave school if they didn't cover up their self harm scars. One girl in grade 7 was made to wear a long sleeve t-shirt even during gym class and she was suspended on a hot day in early June when she refused to wear long sleeves. Some students were not allowed to return to school at all after a suicide attempt as administrators didn't want to 'upset' the other students with their presence. They were punished if their scars were visible to other students.

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"I think I felt like I was reading too much into you... Like I saw you as having borderline maybe because by then I was already interested in the diagnosis and had started my PhD research. Also- we were surrounded by the best psychiatrists in the city. If they didn't notice, then why did I think I had it right, you know?"

Lorelei nods in agreement. "Yeah. But they saw what they wanted to see. Once I said I was Bipolar I couldn't turn back. And then when they started asking me to speak... What could I say?"

I ask her if she thought she would compromise her employment by admitting that her actual diagnosis was borderline personality disorder. "Oh my god yes." She looks at me as if I am crazy. "What do you think??? You know what they were like. Borderline was bad. Plus, it wasn't a 'serious' issue - they wouldn't even put it on the blog even after all those kids were like, 'we need info on cutting and dysregulation'. They didn't want to touch it."

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When Lorelei was admitted to the adult inpatient unit, she texted me around 11 pm.

She said "I won't be into work tomorrow. I am in the hospital".

I waited a day before visiting her. The adult hospital is on the ocean, between a community college and the oil refinery. It smells like sulfur and at low tide, it smells like sulfur and seaweed and sewage. It was around 8 pm when I pulled into the deserted parking lot. It was deadly quiet, save for the foghorns and occasional police siren far off in the distance. There was a man in a hospital gown under an orange streetlight, smoking a cigarette. I say hello to him as I walk towards the main door. He nods.

I couldn't get the door open. "It's locked" the man says, now directly behind me, his hair standing on end, his eyes tired. "It's locked after 8. The other door is around back".

The hospital was built in the 1960s and not much has been updated since then. The previous provincial government promised to renovate and improve the facility, but all work stopped after the government changed in the last election. The first three floors of the building are completely deserted. They had begun work on the first few floors of the building, but sealed them off when the funding dried up and it wasn't clear when or if the renovation would begin again.

I find the after hours entrance at the back of the building. It's very dark and there are two dumpsters at the side with kitchen waste. The glass on the back door is embedded with cage wire and the floors are yellow and brown asphalt tile. I press the elevator button and the light doesn't come on. I press it again. There is no one around to ask if it is even working. The elevator did come, eventually. The doors were panelled in fake wooden plastic panels, and slid open so slowly that I wondered if it was safe to get in. The elevator walls are draped in quilted fabric and, luckily, the button for the 7th floor lights up when I press it.

When I arrived on the 7th floor, I heard the first sounds of life in the building. There was a locked hallway door, with the same security glass and a doorbell with a handwritten note taped above it: "Ring for Entry."

Lorelei's room is tiny- barely big enough for the cot and bedside table that are bolted to the floor. There is no window in her room. All of the windows on the unit have the same cage-wire security glass and are drilled shut anyway.

She tells me that her psychiatrist doesn't want her to work for MacKay anymore. She tells me it is unhealthy and that she may not return. She also says that meds aren't working and they are going to try ECT in a couple days if nothing else is working by then.

That was the first time that I saw her in a t-shirt. It was the first time I saw her tiger-striped forearm- purple scars from wrist to elbow on both arms. I told her I'd return the next day with some VHS tapes that she could watch in the common room- two seasons of the Office and a National Lampoon movie. That is what I promise her.

***

"Talk to me about the Mad Pride stuff" I say. Lorelei is finished her OT program now and has moved to a bigger city to take a job as a peer support worker in a large mental health hospital. She now works with youth who are hospitalized for eating disorders. She is back for a few weeks to visit her parents and we meet up for ice cream and lemonades at a local hipster joint.

"It's nice- being in a bigger place where we can be more critical about psych stuff without feeling like we'll hurt our doctor's feelings."

"Do you find it helpful- I mean- the space to be critical about psychiatry- does it help you stay well... Does it feel healthier for you?

"Not really. I went to a few Mad Pride events and it was like the Oppression Olympics. They didn't have anyone there doing well- like only people who are really sick and haven't recovered at all. It was depressing. I mostly like their stuff on Facebook. A few activists there, I mean. They post good stuff"

"Have you seen MacKay, since you've been back?"

She nods. I can tell she doesn't want to talk about it. Some days she hates him- for being so stigmatizing about borderline stuff- for never noticing that she wasn't 'bipolar'... Other days he is her hero. Other days she feels like he saved her life by giving her that job.

She knows that I have been very critical of him and, although sometimes she appreciates that, other times she feels protective over him. We've laughed about it before. 'Disorganized attachment.'

She seems happier to me. More confident. "How have you been lately? I was wondering if the hospital was going to be like working with MacKay- like overworking and martyrdom stuff that would be stressful"

She shakes her head. "I feel so much better now. I am off my meds. I just think about myself as having emotional dysregulation and I am taking better care of what I need to stay balanced. Like, asking for things."

"So you don't consider yourself 'borderline' anymore?"

"No." Lorelei wipes a big smear of ice cream off the front of her neon, graphic tee shirt and smiles. "I just see myself as having been through some shit. And now I'm fighting harder for myself so it doesn't happen again."

She licks the ice cream off her finger.

***

I haven't seen Lorelei as much now that she has left the city. But I did receive a text from her a few weeks after our ice cream date. One of her patients died when she returned back to work. It was a patient who had been struggling with self harm, but had moved back with her parents and was only returning for psychiatric appointments once a week. This patient had been asked to visit her old junior high as a special guest to talk to the students about her depression. Lorelei had coached her through writing her speech. The girl had been having trouble sleeping because she was so nervous/excited/anxious about an opportunity to speak to students at her old school. She died by accidental overdose on sleeping pills. It was unclear whether it was a suicide attempt or an accident- but Lorelei swears that it was an accident.

"She didn't want to kill herself anymore. She was just reaching out for help. She was excited about doing that speech- it meant everything to her"

I asked Lorelei if she was going to take any time off to grieve.

"We don't do that in the hospital" she said. "They give me two days but no one else is taking it, so I'm just going to go in. The funeral is on Saturday."

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Chapter 5: Analysis

On the Quiet Violence of Neglect

In an agential realist (Barad, 2007) account, the world consists of the intra-action of agential forces, or phenomena, which cannot be cleaved from each other to form separate, distinct and bounded forms that pre-exist each other. In this sense, the world is an ongoing performance of agential intra-actions and the agential *cuts*: those engagements that define that which is 'matter' in ways that matter to ethics and politics, unfold across space and time. Positions of 'expert' and 'patient', 'victim' and 'offender' and concepts of 'violence', 'harm', 'security' and 'care' cannot be separated from the tangled mess of agential intra-actions from which they arise. Entanglement, in this sense, does not separate agency or identity as stable, pre-existing concepts. There is no split between an 'immaterial' agency and a 'material' object.

From here, there is no stable position from which to critique systems- yet, the contributions of my collaborators, through their stories, art and poetry, present a diffractive landscape of experiences, from which we can find *embodied moments* (Zabrodska et. al 2011) that resonate and interfere with common narratives about mental illness, harm and the carceral state. In the following section, I will analyze specific intra-actions between the forces of neoliberal ideology and institutional systems (both material and discursive) on the emotional subjectivity of my collaborators.

In a 2011 paper, Zabrodska et. al. provided a diffractive case study of bullying as a set of intra-acting forces inside the neoliberal university, by sharing, reading and re-reading stories of collaborators against each other to find resonance and interference. In a similar way, this chapter seeks to draw out 'embodied moments' of violence in ways that disrupt normative notions of what violence is and how it is experienced, ultimately questioning the way in which prisons and mental health hospitals come to be scapegoated as manifestations of state violence, while many of the logics and forces that come to structure their operations also permeate our social movements, kinship networks and school systems.

Analysis of the intra-actions between neoliberal value systems and the socio-material structures of each institution will offer a different iteration of what we know as 'violence' and provide interference from the position of the *borderland*, or the space at which agential cuts are made in institutional value systems that mark those with 'borderline personality disorder' as matter that does not 'matter' in their respective jurisdictions. The following sections will outline the places at which emotional and physical harm is experienced and responded to by those living with the diagnosis of borderline personality disorder. In this sense, borderline personality disorder emerges as an agential boundary object (Leigh Star 2010) which does not pre-exist its relation to socio-material life. These moments also reveal the performativity of what Orr (2006) would call 'psychopower', which "can work somewhat psychotically to actively re-fuse and confuse the boundaries between the real and the unreal. Between deadly terror and its (potentially fatal) simulation" (p. 13). Much like the tragic choreography between Ashley Smith and the socio-material forces of the prison, borderline personality disorder and its 'symptoms' emerge through intra-action with classification systems, kinship relations and the agential forces, which seek to define and patrol the 'borderlines' of everyday life. Finally, I will extend this analysis to offer an interpretation of 'borderline personality disorder' as a *language* in which these lived experiences with *harm* in the carceral state are agentially expressed and *responded to*, across space and time and explore the implications for how this might also help us to understand addiction, trauma, incarceration and care.

Medical Spaces and Systems

"Cries for help go unanswered.

I scream until my lungs are sore.

They would help me if I had cancer.

But dealing with me is such a chore.

I'm not trying to seek attention." [SD]

The defining 'borderline' experience in the medical system is that of invalidation and refusal. Where much of the critique in Mad Studies and Critical Prison Studies has taken aim at manifestations of power that seek to reduce bodily autonomy by subjecting us to incarceration and forced treatment, the borderline experience is one of returning time and time again in times of crisis and being denied inpatient care, talk therapy or effective intervention. It is an experience of wanting desperately to be held- to be kept safe - and being turned away. It is an experience of wanting someone else to take the reins, but being told it's 'their job' to refuse the suicidal impulse on their own. It is an experience of neglect and abandonment.

As one collaborator explains:

"I have kind of like an internal war that goes back and forth between, you know, you should kill yourself versus, you know, I really don't want to kill myself, I just need help. And sometimes the 'you should kill yourself' side gets the better of me, which is why like I've done certain things like that or I've done that more than once. And I… It's not to like say that when I feel like that that I really don't want to but there is a part of me that just wishes that I could get help like any other mental illness because… Well, it's gotten to the point where I started to have panic attacks about feeling like I wasn't safe with myself. And I went to the hospital and they just told me, "Well, it's your responsibility to be safe. And we can't help you with that."

Being denied and refused care in emergency rooms echoes previous experiences of childhood abuse or neglect. Experiences of sexual assault, where they were not believed, or neglect from a parent who refused to respond to their childhood needs becomes played out time and time again with clinicians who refuse to diagnose them, refuse to admit them, or simply do not have the skills or training to provide the right kind of care. The repetition of experiences of abandonment and neglect, intensify feelings of hopelessness, which fuels even more suicidal impulses:

"I was like is there any hope? Like I don't know. Like everyone keeps telling me like I have to deal with this alone because no one is believing me. So I ended up going back to the hospital."

Another collaborator noted that visits to the ER ultimately made her feel worse and caused her self harm impulses to escalate:

"hospitalization did not get me anywhere. They admitted me, discharged me, let me go. I went home that night, took a 3 month supply of Seroquel, known as Quetiapine and Lorazepam, and chase it down with vodka. And I ended up in Short Stay 4 days later after being in a coma."

Inpatient units use solitary confinement rooms to punish patients for acting out, and to reduce risk when a patient is violent or insistent on attempting suicide. These rooms are referred to as 'therapeutic quiet' or TQ rooms. In the same way that solitary confinement is used in prison environments to surveil subjects who self harm and, also, to punish subjects who break rules, borderline patients are subjected to stays in TQ with greater frequency, where the line between punishment and 'care' becomes blurred to the point where they feel that they are being punished for feeling suicidal.

" the thing I did notice when I was hospitalized a number of times was if I started crying, like even if I wasn't screaming or freaking out, it would be isolation room. Like almost immediately. Not "Are you okay? What's going on?" But then other girls, like I'd hear walking around the unit screaming or like throwing stuff or freaking out, and people would kind of be like, "Well, what's wrong? Are you okay, sweetie?"

The use of TQ rooms as a form of punitive solitary confinement echoes the experiences of Ashley Smith in the Federal prison system:

" Well, I mean there was the first time I was at the Abbie Lane after overdosing on a valium and the Clonazepam after that meeting with Dr. Fraser. And like I ended up getting in there kind of late, and came out crying with a glass of water in my hand, and saying I just want to go home. And all of a sudden the nurse looked at the security guards and told them to put me in the isolation room. And I didn't understand because I hadn't done anything wrong. So I like started freaking out and like kind of pushing them away. Like tell me what I did and I will walk in there. And they would not tell me. They just would not tell me. So it took 3 big guys to get me in there because I was freaking out so bad. And they wouldn't tell me how long they were keeping me in there or anything

like that. So I was just freaking out. I punched walls a bunch, hit my head a bunch. And unfortunately the isolation room…"

"And I had 2 guys holding me down on either side on the mattress, which freaked me out because I had some stuff happen that way before. And like the girl like pulling down my pants partway to like inject me with more sedatives."

Neoliberal ideologies that idealize rationalism and deny the validity of emotional experience, permeate the medical system, where psychosis (a disease of the rational mind) becomes much easier to view as pathological, where emotional dysregulation is seen as outside the jurisdiction of what is considered a legitimate illness (Becker, 1997; Johnson, 2010):

"I just felt like they weren't taking me seriously. And I was crying and screaming, and they would tell me to be quiet when I couldn't. I just was in so much pain, like emotional pain. And it didn't really hurt when I cut. I mean it stung but it got rid of all my anxiety. I could just focus on that instead of what's going on in my head."

All participants in the project identified the 'emotional' nature of their distress to be a barrier to treatment because it was seen as an illegitimate form of suffering. They expressed that they were told to exercise rational autonomy over their emotions- as if they were capable of healing on their own. This was evidenced by numerous ER encounters where they were told to exercise greater 'control' over their emotional expressions. De Courville Nicol (2011) distinguishes between emotional regulation as a habitual and often unconscious practice of aligning oneself socially with broader moral discourses, and emotion 'management' as a conscious strategy to cope with emotional frictions and predicaments felt by the subject. Dr. Stuart Shanker (2016), a psychologist and philosopher who specializes in working with youth who experience emotional dysregulation, also differentiates between the socialized emotional response and the ability of the subject to 'manage' themselves accordingly. Those who experience distress and pain - and are chronically invalidated and de-legitimated for expressing this pain - cannot be expected to 'self-regulate'. In this way, it is clear that the claim made by participants that their emotional distress cannot be 'managed' on its own, is accurate. Their need for treatment is legitimate and clear.

The intra-action of ideologies of 'madness' as being oppositional to 'sanity' with other binary oppositions (such as that of the rational male versus the emotional female) create persistent experiences of dismissal and chronic neglect in both the emergency room and in inpatient units. Emotional distress is seen as inconsequential and they are told to 'calm down' or 'handle it' on their own. The 'realness' of emotional experience is undermined by patriarchal notions that young female patients 'lie' and 'manipulate' for attention, which works to excise any notion of real pain that they may be feeling and position their behaviour as being rational and calculated. Critical sociological work has analyzed the relationship between gender and emotion (Petersen, 2004), specifically, the ways in which emotion is positioned inside a gender a binary system to associate 'irrational', feminine and 'natural' impulses as a lesser form of knowledge than what is deemed as superior in the Cartesian divide; that of the intellect, which is associated with masculinized social norms. Becker (1997); Ussher (In Fee, 2000) and other feminist scholars who have written about Borderline Personality disorder (Lester, 2013; Johnson, 2010) have identified the role of patriarchal ideologies in western medicine as being central to the ways in which women with BPD have been delegitimized and refused appropriate care. Kenney and Craig (2004) and Kenney and Slowey (2010) have put forth the concept of 'illegitimate pain' to refer to the ways in which particular emotional experiences of distress are connected to broader systems of social oppression. Illegitimate pain is what is felt- but not acknowledged as a legitimate form of suffering. Kenney and Craig (2004) provide the example of shame and fear associated with 'coming out' as an LGBTQ person a homophobic society and link the concept to other concepts in the sociology of emotion that seeks to understand and trace affective wounds in social life. One strategy in which the emotion distress of borderline women is dismissed is to suggest that it is a 'manipulation' of the patient to try and seek attention and care, thus suggesting that it is an inauthentic performance with malevolent intention.

"there's so much assumption that like someone is trying to manipulate and that it's just like there isn't really… There's such fear. And I had a… I was at a party, and I talked to a friend of mine who was a psychiatry resident a couple of years ago. I don't know if she still is or if she's graduated. But she said, "You know, you've got to make sure the clients don't manipulate you. You know, you've got to like have your game face on. You've got

to…" And that's what they're taught. And they're taught that the borderline people that they see are the worst manipulators."

"I've been told when the police had to bring me down before, one person said, "Oh, well, borderline personality disorder isn't a serious mental illness."

Clinicians work from the framework of diagnostic taxonomies, which intra-act with political and economic forces that determine the ways in which each category is 'treated', materially, socially and in which disciplinary jurisdiction. Under-funded health care systems place temporal constraints on clinicians who find themselves struggling to see as many patients as possible in increasingly smaller chunks of time. Diagnostic manuals, hospital protocols and treatment protocols shape the ways in which interventions are made, thus reducing the ability of the clinician to make decisions based on previous training or instincts (Mayes and Horwitz, 2005).

"they seem to make up their mind… And this happens a lot in medicine as well as psychiatry where it's just kind of like they read a chart and then they just decide what you have without talking to you or getting all the details. So regardless of what you say, they're looking for specific diagnosis so they can easily tie it all in and dismiss the stuff that doesn't fit instead of just looking for a diagnosis out of nowhere and not having a preconceived notion."

Parents and caregivers of those with the diagnosis are cautioned not to 'give in' to what is ultimately framed as a 'rational' manipulation rather than a real experience of severe emotional pain.

"this nurse talked to my mom privately. My mom's a nurse and she knew her. And she was like, "Don't worry, I think she's borderline. That means you shouldn't trust anything she has to say. It means she's manipulative. So don't even worry about following up with… Like she's not… It's not real what she's saying."

All of my collaborators expressed that their first contact with the medical system for self harm was between 13 and 19. The difficult transition between being a 'child' and an 'adult' locates them on another borderline between two distinct 'identities' with different socio-political expectations- even though they are at once *both*, and *neither*. The age that they find themselves when they first have suicidal ideation intra-acts with discourses around teens as 'incompetent adults' and their agency is ignored in favour of speaking directly to parental or authority figures who may be in the ER with them.

One collaborator reflected on what it was like being in the ER at age 25 with her mom:

"Like everyone was talking to my parents. No one was talking to me. Like nobody talked to me about what they thought was going on. Like they were just like, "Hmm, yeah, no, that's not happening." And they would like go and talk to my parents"

The refusal to believe them and patronizing ways in which they were denied an opportunity to be actors in their own treatment further compounds internal feelings of low self worth, which plunges them further into depression and anxiety.

One collaborator with borderline personality disorder who worked as a peer support worker for youth with mental illness recalled a situation:

"there was one young woman who went to the ER with the staff, and they threw her out and mocked her because they said she didn't look sad enough to be depressed. Like it was just some weird like, "Well, you don't seem so sad. You seem angry. That doesn't seem like depression to me."

All collaborators spoke about the ways in which their diagnosis felt like a scarlet letter- or a warning to clinicians to keep away from them.

"It was around the point where like I was realizing that I was being dismissed for some reason. And I was like trying to find out why. And then someone like was honest with me, and was like, "Well, like sometimes it's a useful diagnosis but a lot of the time it's just a way of labelling your chart so that people avoid it." I don't remember the exact context

but yeah, it's also just… So it’s wastebasket also in the sense that it’s the people that you don't want to deal with."

Experiences of neglect are intensified by the material conditions of the hospital, where mental health units are some of the most under-funded and under-resourced areas in the hospital, with run down amenities and broken equipment, something that many participants commented on during interviews.

"Like it’s just very like blah coloured walls, like really grey, depressing. And like it’s just, you know, there's not much artwork up or anything. And there's just the day room there with a broken piano and a TV. And it’s just very, very depressing. Like if you’re depressed, it makes you a hundred times more depressed, I find."

The inherent high sensitivity and intuitiveness of the borderline condition creates the conditions where minor passive aggression or dismissal (through body language and other non-verbal cues) is experienced in an intense way.

"when someone tries to make you change and you’re highly sensitive and you’re fucked up, and like you feel…like you’ve been told you’re fucked up and that’s way… I mean that’s highly invalidating."

All of our collaborators remarked on the difficult conditions in which clinicians have to work. They remarked on the cruel culture of medicine- the ways in which it stresses them for time and discourages them from having emotional responses to their patients and their work. Doctors can only feel effective if they have a pharmaceutical solution as there is no time for talk therapy- a quandary that has been acknowledged in critical work on biomedicalization (2006) and mad studies scholarship (Burstow, 2005)

One collaborator remarked on the pervasiveness of 'neurobiological' notions of mental illness where early intervention with medications can save you from a life of chronic pain: "*You can't sell that with borderline because there is no pill for borderline."*

Doctors assume: *"they're not fixable because I can't fix them in 5 minutes,"*

One spoke of the ways in which they could see their own unhealthy relational patterns played out in how psychiatrists work with patients.

"it's like reflected in also how therapists often act, not just in our program but across the board, in terms of like sacrificing self-respect to get the work done. It's kind of like we often throw ourselves in and like don't take care of ourselves enough. And so there's the same with our clients. You know, there's the same level of like trying to often meet whatever that person's need is in order to keep them around, even if it means sacrificing their own health and wellbeing and safety."

They remarked that their needs in the ER were often very simple- that of needing recognition and validation for extreme emotional distress. Many of them had no hope of recovery, they simply wanted someone to see what they were feeling and acknowledge it with kindness.

One collaborator explained her daily experiences as: *"Just lots of chaos and darkness. I didn't necessarily want to kill myself, I just wanted the pain to go away."*

Another explained:

"as borderlines, we have a reputation for wanting to find rescuers, someone to fix our problems. And that may be so sometimes but I think really we just want someone to actually see you and, you know, sit with you."

One experience stands out as being the only affirming, helpful experience in the emergency room of the adult hospital. When a 22 year old woman with a borderline diagnosis was brought in by police after a suicide attempt in a youth shelter, the attending medical resident cried when she heard the young woman's story.

"she cried. Like she sat and she cried. And I'm sure a lot of like clinicians would frown upon that. But that's what I needed. I needed someone to see that like my suffering was real."

"What I really wanted was a witness."

Educational Institutions

In many of the same ways that the medical system intra-acts with emotional distress with punitive impulses, schools have many of the same bureaucratic approaches to emotional distress that stem from neoliberal ideologies of rationalism that erase lived experiences with neglect, trauma and emotional pain. In this ideological system, emotions are not 'real' or valid, therefore the emotional impacts of trauma and neglect do not exist. Karaba (2016) argues that the prevalence of Cartesian dualism in the public school system, which supports an idea of the 'self' that is distinct from social context and predominantly 'rational' rather than emotional is directly linked to an erosion of social justice initiatives and perpetuation of neoliberal capitalism. In a competitive school environment where students are ranked individually with quantified grades and groomed to become future 'professionals' in the global marketplace, expressions of pain are framed as 'acting out' and interpreted as a disruption to institutional order, thus privileging the sanctity over the administrative environment over the lived experience of the student.

'Bullying' is one form in which the intra-action between these ideologies and the desire of students to 'belong' in the institutional environment (Davies, 2014) creates tremendous wounding and harm for children who are affected. The harm is dismissed through use of terms like 'bullying' which is seen as somehow less serious than what normative discourse would call 'abuse'. Thus, the harms children inflict upon each other are seen as less harmful, or normalized as 'normal childhood stuff'.

"when I was 11 and I was really being bullied really badly, I had my first time sitting with a razor blade in my bathroom"

"I used to get thrown up against my locker. And I used to have boys just kind of tease me. It wasn't like anything too bad. But some girls were quite mean and name calling and just making fun of my appearance because I liked to dress a little bit different. The kind of like Emo style, if you will. So a lot of people made fun of that because it was different."

Youth who experience family abuse experience disorientation and confusion in a social world where security and love are positioned as synonymous with 'family', yet their experiences with 'care' are the opposite. Care becomes linked with experiences of 'neglect' and they experience loneliness and confusion. Children who develop emotional disregulation or depression at an early age can be further ostracized:

"the children, they were very nasty to me. And they all sided with each other and kind of outcasted me. Even younger children that didn't know hated me just because that was the cool thing to do. And I told them, you know, like this is why. It's like a form of brain damage, like you know. And they just said, "Oh, well, you're retarded then." And it just got worse from there. And I had one person say, "Like you're a freak of nature. You should go kill yourself." I've had people say lots of nasty things. And I just… I feel that's where my inferiority complex stems from because I always feel like they got me for something that I couldn't change as a person."

Peers in schools often spread rumours and intensified the violence of a sexual assault by responding with gossip or further bullying. Peers intra-act with the competitive neoliberal environment of the school and with each other by exposing each other's weaknesses and refusing to acknowledge the ways in which they harm other and are harmed by other agential forces within and outside of the school. Harm from sexual assault is rendered invisible in favour of negotiating socio-material spaces by scoring points through established value systems that are drawn from patriarchal, colonial and racist histories. Students who become public victims to sexual assault often become bullied relentlessly, as their vulnerability becomes a space in which other students can demonstrate power over them by mocking, criticizing and making of them[14].

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[14] The Rehtaeh Parsons case in Nova Scotia in 2013 is an example of how a sexual assault can turn into cyberbullying from a large group of other students who were not implicated in the original assault. http://www.cbc.ca/ns/features/rehtaeh-parsons/

"Like I ended up being sexually assaulted when I was younger for like the first time when I was 13. And the problem is in a lot of Christian environments, they'll preach and preach and preach that like if you aren't a virgin, you're somehow damaged goods"

One collaborator describes school as feeling:

"Very lonely. Very isolated and judged and lonely. Because when I was, yeah, in grade 8 or grade 9, my principal ended up calling the parents of everyone in my class, telling them not to let their kids hang out with me because I was such a horrible influence. Like I wasn't drinking at the time, I wasn't smoking, I was still a virgin. Like I wasn't doing anything all that bad, except for coping really poorly with my mental illness. So that was not a good environment at all."

Children and youth who already feel outcast or different because their emotional experiences in the world do not line up with normative expectations, take on identities of being 'goth' or 'emo' or 'slutty' as a way to control and own their alienation (Wilkins, 2008).

"around 12 was when the eating disorder and the cutting and all that started. I don't know, it was unfortunate because at my school when I started getting depressed, they all of a sudden started pegging me as being a Satanist even though I had never looked into it, it wasn't on my mind at all. And unfortunately being told again and again that I'm like

this sort of horrible demon child. And I eventually looked into it because what are they accusing you of."

Self harm becomes a way in which to make such pain visible, to distract from the painful sensations of misrecognition and to control the pain that is inflicted upon you - rather than to receive it passively each day at recess. Numerous participants talked about their use of self harm rituals in order to assert their own agency over their pain. Johnson (2010) echoes this sentiment, suggesting that self harm is a way to defy trauma by asserting yourself as the primary agent of your own feelings.

"I would go into the bathroom at school, and staff did not realize that I had razors on me, and I would cut in the bathroom. And my best friend caught me one day. So that was a bit of a shock for her."

Acting out becomes a way to replicate the choreography of punishment or neglect that they may be experiencing at home. Fears of abandonment cause behaviours that create abandonment through punishments such as suspensions or being kicked out of school altogether:

"So I started kind of skipping and getting high and stuff. Or just… Yeah. I ended up missing so many classes in grade 11 that I got kicked out. But even then I'd be like

leaving to go up there just to get high with people during the day and stuff because I didn’t want to be at home."

"there was a lot of very strict rules at school, and it felt like no matter what, at home or at school, there was something I wasn’t doing right."

Students who self harm through cutting, burning or self strangulation are often punished and those with scars are treated as if their scars were contagious and could 'infect' other students. One student used to hide her scars underneath wristbands until:

"They made a rule that we weren’t allowed to wear wristbands"

Peer bullying and punitive (rather than therapeutic) responses from teachers and school administrators has lasting effects, yet none of the collaborators in this project identified school bullying as a 'traumatic event'. None of them discussed experiences with persistent school bullying with their care team or individual psychiatrists when receiving treatment years later. They internalized the notion that 'bullying' wasn't a serious issue, even while admitting that it caused them to feel suicidal as children and continued to have lasting effects into adulthood.

"I'm almost 23 years old now. It [elementary school bullying] still affects me as a person. I still have times where I feel like, you know, like a waste of time and space. And you know, like I have too many problems. And you know, like I don't deserve anything and I just feel like things are not authentic. Like I almost feel like worse than human, like sub-human or like just something that doesn't even deserve to have that title just because… No reason really. It's just because I just don't feel good enough."

Family Networks and Intimate Partner Relationships

Not everyone with a diagnosis of borderline personality disorder grew up in an abusive home. The one consistent experience in family and intimate partner relationships is that of chronic invalidation. Occasionally parents would find themselves exasperated with a tween-age child who is acting out and self-harming, but they would be unaware that the child was keeping a secret about an assault. The behaviour would appear to have no direct cause, as the child would keep something secret for fear of upsetting their parents. In some cases, a teen might not even be able to identify that something that happened to them was an assault and therefore would not seek help from parents:

"is it really rape if like I kind of liked the person and I took drugs willingly, and all that stuff?"

One collaborator wrote about a childhood experience where she was abused by a woman who was a friend of her mom. One day when her mom stopped into this person's place for a cup of tea, her daughter refused to join her and go inside. Thinking nothing of it, she went in and left her daughter in the car. Once alone in the car she found a pen and: *"then I just started like writing all over my body. Like writing and drawing. And it was like… I feel like it was kind of like claiming my body as mine. And when she came back, she was there with Mrs. Leech. And it was like, "You have to come in." And I was like, "Okay." And they didn't comment on the pen everywhere, and they sent me to play with her children."*

The use of the pen to make her pain visible later became chronic food restriction (which received a diagnosis of anorexia) and finally, cutting with razor blades and progressed to suicide attempts in first year university.

Highly sensitive children are difficult to understand and their reactions can be difficult to interpret:

"the highly sensitive stuff became more invalidated and more like I felt like just completely out of control inside because it was like I had no…you know. And when I was bullied a lot when I was like, you know, late elementary school, I like would come home and I would cry in my room, and I wouldn't tell anyone because what are my parents going to do? You know, like I don't… You know. And I wasn't really engaging with them. So I was kind of like alone for a couple of years. Which is hard for a developing kid."

"It was like I would cry really easily. Like I was super sensitive to like my siblings teasing me and stuff like that. Like anything. And then I'd be kind of dismissed for like having too much feeling."

Every collaborator on this project has experienced sexual assault. Many of them kept it secret for years and all of them had their first experience with sexual assault when they were still living in their parent's home.

"I was too afraid to tell anyone. I felt disgusting. Like I got to the point where I would go party with guys and let them take advantage of me because I felt like my body wasn't worth anything anymore. And yeah, it really sucked. Like honestly, it was just like a guy would be, "Yeah, like I want to hook up with you," and I'm like, "Yeah, go ahead." "

In some cases, sibling violence or mistreatment would take place in ways that parents and teachers were unaware of. One wrote about how her sister's older boyfriend raped her at age 12 and her sister blamed her:

"after I kind of dealt with some sexual assault stuff, she started just calling me a whore and stuff, and wanted nothing to do with me."

Verbal and emotional forms of abuse seemed to have an equally strong (if not stronger) impact than physical violence, likely because emotional forms of abuse are the most unrecognized and invalidated, thus compounding feelings of disorientation and denial of the 'self' and its emotional sensations.

"An adult in my life hurt me and told me I was bad. Bad as in demons swimming in my soul and sirens singing from my skin. My body was filthy. My neediness was nothing but manipulation and seductive deceit. I was 3 years old and already so full of sin that I was headed straight for hell."

Children and youth feared telling clinicians about family abuse because they didn't feel that they had confidentiality in clinical spaces

"what they don't tell you is when you're under 18, there is no confidentiality. Regardless of what they tell you, that it's only if you hurt yourself or whatever, there's none. There is absolutely none. And that's really unfortunate when you're in a home where one of the parents is abusive. "

Many of these experiences took place in homes with rigid Christian value systems, which intra-acted with an inability of parents to provide love and care because of their own untreated emotional wounds and mental health care needs. Stein (2001) has argued that shame and invalidation of emotional experience plays an important role in shaping conservative Christian family values, thus attaching a sense of illegitimate pain (Kenney and Craig, 2004) to many children raised in such environments.

Experiences with family abuse, sexual assault or abuse from peers in the school system created non-normative notions of what 'love', 'care' and 'security' mean. When children are taught that families and partners are there to 'love' you, and that 'love' means name-calling, physical violence and neglect, it creates a very different set of intra-actions with the socio-material world.

"I had a pretty rough childhood and I have extreme fear of abandonment, whether that's like a partner or a friend or a family member. I feel empty and sometimes I don't really have a sense of who I am exactly. I went through periods of not even feeling like I'm alive."

"when people are really afraid to sit with their emotions and they don't know how to regulate, they'll sometimes distract with like chaotic relationships and things like that. And that can feel safe automatically. And that also has elements of love in it and it has elements of care. And like there's both things there."

Their future terms of engagement with all social institutions and peer groups become structured according to expectations of neglect and violence and the objects of 'safety', 'self care' and 'rational autonomy' become structured in ways that are unrecognizable in mainstream social life. 'Care' and 'violence' become blended together in a single unit and 'self care' becomes cutting; intimate relationships become abusive and engagements with medical, educational and professional institutions become structured through chaotic, punitive and neglectful intra-actions. Consideration of the role of attachment theory and sociology of emotion in providing a framework for understanding these experiences will be discussed in the subsequent chapter.

"the care and the violence, yeah. It's like they're both… I don't know where. And they meet somewhere in the middle and they're both sort of true. Like it is violence and it is also care."

"I think different things feel different levels of safe. I think there's like an emotion mind safe or a rational mind safe"

In psychology, these persistent re-engagements in adult life (that recreate childhood experiences of neglect) are often explained through 'attachment theory', which theorizes that adults seek to re-create the types of relationships they had with early caregivers (Bowlby, 1988). Our 'attachment style' is said to come from our earliest interactions, usually with a nursing mother. This body of theory largely ignores other forms of attachments - such as those with and through social institutions other than the family- and the ways in which trauma intra-acts with our own emotional landscape across the life course.

"my trauma, a lot of it didn't come from my parents. It came from other people. It came from like a school system. It came from a lot of things. And so when someone asks you like, "Oh, have you experienced trauma or abuse," like probably half of them would say no, especially if… Even if it would be considered emotional abuse, it's like somehow emotional abuse is less valid than physical or sexual."

"it's like I think when people can feel safe and set boundaries, and know… And I don't want to pathologize like the relationships that people do have because they're complex but they're also… I mean typically anyway when people are in the midst of chaos, there's beauty in the midst of all of it but there's also like some poor choices"

In many cases, abusive relationships felt more safe and secure than family spaces:

"Like I was kind of used to it almost. Like through the stuff with my dad and then him, like it was… It wasn't even really scary. Like he never, you know, pulled guns on me or tried to like hit me with anything super hard. It was just kind of him. But part of me was just kind of like so like angry or went to another place. I don't really know but like scared wouldn't be the right term. Like I think that was just I think because it wasn't as scary as my dad. Because I mean I was much smaller then and like he would…you know. And so that's a lot scarier being like a fifth the size of someone than it is when you're closer to their size. But I don't know."

" And then at 17, I moved out for good with my boyfriend at the time. Who a couple of months down the road turned out to be extremely abusive. Yeah. And unfortunately I felt like I couldn't go home"

For all my collaborators, experiences with family neglect shaped their later experiences outside the family:

"just found I was going back again and again and again to get love from people that didn't know how or want to give it, you know."

Workplaces

In neoliberal ideology, the entirety of the subject becomes occupied by, and with 'occupation' as the defining feature of one's value and purpose. We exist by and for the market as labourers or surplus labour and, as such, our value as political subjects is weighed according to our value within the marketplace (Rose, 2006). These values, which prioritize the subject's value to the global capitalist system, over their own sense of happiness and fulfillment, intra-act with a subject's desire to belong, and to 'succeed' in ways that secure their survival and value to others. The participant's creative work and thoughts and opinions expressed during interviews shows that *these* forces, coupled with a predisposition to hyper-sensitivity to unhealthy environments, emotional invalidation and other forms of subtle de-legitimation, creates workplace violence in the form of de-valuing of labour and unreasonable expectations that cause relapses, suicide and self harm.

"I was working at the Department of National Defence as a temp clerk. And every day it was like I was so depressed. I just… Like I'd sit there and think about wanting to hurt myself. I'd start scratching and I'd scratch really deeply to draw blood."

Often, those with a history of 'mental illness' fear discrimination in the workplace and guard their diagnoses closely so that they can secure employment.

"How am I supposed to explain my resume? I spent two years hospitalized and with my parents- like, should I make something up?"

Most of my collaborators took employment within mental health advocacy communities, where occupational opportunities were provided through non-profit programs aimed at getting 'mentally ill' people back into the workforce. However, many of them felt discriminated against even *within anti-stigma organizations* for having a diagnosis of borderline personality disorder. They would often lie and say their diagnosis was bipolar or anxiety-related, so as to be eligible for these work re-entry programs.

"I don't think I was the only one hiding my diagnosis in the team. One of the part time psychiatrists- I am pretty sure she was borderline, too. She was super sensitive and she, like, refused to work more than a half time position."

Often they would get employment as the token 'person with lived experience' in a mental health advocacy organization or clinical research team, but these spaces were rife with stigma and persistently de-valued their contributions in patronizing and belittling ways.

"Like, they weren't even paying me for the extra stuff. But it's like 'oh- you have a mental illness so you should be grateful we even let you do anything for free'"

"I was the only 'lived experience' person on the whole team- and I was the only without health insurance. Like, my fucking meds are expensive and I don't have Blue Cross. Or sick days."

"being like now they have like… It's like token mental health consumer thing where it's like, "Okay, come talk," and you know, "be wonderful, articulate, beautiful self, and then be quiet when us real professionals talk."

Recovery was 'objectified' as one type of particular experience and any deviation from the status of 'recovered' was seen as a failure:

"this kind of paradox that you get stuck in when you're doing well, where people want you to be this like model of like recovered wellness and this like poster child for whatever. But not necessarily this space to not be okay, for this to be a rocky sort of thing"

All collaborators commented on the misery of work, in general. As highly sensitive people, they are skilled at reading non-verbal cues and tuning into the emotions of those around them. They knew when others were unhappy- and acknowledged that general society was rife with misery and invalidation of emotional experience.

"It's not like, I can be, like, "the stress levels here are unhealthy for me". Everyone is stressed. No one wants to get fired."

"No one there was happy. No one. So, why should I complain? We were all fucking miserable."

The same cold culture of neglect that is experienced in health care and educational settings is pervasive in the workplace. Notions of 'professionalism' deny and discourage emotional expression and employees must intra-act with these workplace expectations by denying anything other than their 'rational' relationship to their socio-material workspaces.

One collaborator described her workplace using the metaphor of a factory farm, where chickens held in small spaces would peck at each other, maiming and causing injury:

"Just look at what the chickens do to each other in those circumstances"

Non-profit Organizations & Social Movements

Many of my collaborators worked in non-profit social justice organizations or were part of community-based social justice movements. Many of them spoke about the ways in which social justice-oriented spaces were able-ist and invalidating to people with lived experience of the mental health care system. Having a diagnosis of 'borderline' further de-legitimated them from having valid responses to conflict within these organizations.

"Like it’s having the wrong diagnosis. There's many different institutions that won’t take you in or offer you help because your diagnosis is this. Like many places, if you’re going for PTSD help, they won’t accept you because you’re borderline on your chart."

"It’s like something has come up and you feel strongly about it. But then they’re like, “Well, your emotions are strong so are you sure it’s even like happened? Are you sure it’s even…” you know. [...] It's kind of like you get angry and it’s like, well, is this… It’s like the possibility of having legitimate anger is like gone."

While many of these organizations and movements guarded the legitimacy of their political anger (against racism, sexism, capitalism, police & the prison system), those who tried to address saneism within these movements were not listened to, or validated in the same ways. Activist spaces that foster emotional ecologies based in anger and shame were hostile and damaging for those who were sensitive and had trauma histories.

"I know individuals who I think can identify as having had trauma and are very sensitive. And I think it becomes… You can use a lot of social justice language to like beat each other over the head with more, and to call out, call out, call out until like you’re alone on an island and there’s no one around you who hasn’t been oppressed in some way. And it’s really… No, I don’t find they’re safe from my experience. I find they’re very… I find there’s a lot of woundedness, and I think there’s a lot of absolute rejection of the system sometimes which is sometimes useful.

Rigid, oppositional movements that seek to define themselves by what they are 'against' replicate some of the same problematic binary oppositions that cast 'borderline' subjects to liminal spaces of neglect and violence. Much of the emotional dysregulation that is experienced, stems from intense oscillations between black and white patterns of thinking where subjects are in constant flux between thinking they are 'bad' and self harming and thinking they are 'good' and getting angry about their mistreatment. They are quick to recognize the harm that comes from rigid, oppositional approaches to justice, that makes monsters out of that which they seek to change (Whittier, 2001):

"But it's also like it's very one-sided and very black and white. And the black and white rigidity of people that have experienced trauma and are highly sensitive, that rigid holding on type of behaviour that gets accumulated stays there and it gets masked in all these other nice language – the social justice language. And so the rigidity is the problem. It's not the content of what you're expressing really."

The use of shame to frame social justice issues and force change was harmful for those who live in an emotional ecology where shame underpins many of the intra-actions that continue to harm them.

"But it can often get quite aggressive. So it basically… There's a big problem with shaming people for being wrong or shaming people… Shame is not very helpful. Like it can be helpful for a moment. But the thing is is people feel shame all on their own. You don't need to like shove it down their throats. So it's like when you call someone out… Like there's been a shift in calling people in sort of thing."

Critique of 'medicalization' of mental illness serves to de-legitimate the concerns of those who actively seek and desire medical care after many years of being neglected in families, schools, workplaces and the social movements they dedicate their time to.

"So I felt when I finally knew what was wrong with me and I went and I looked it up, I felt like I was reading something about myself. I could really relate. And you know, like it felt…it felt…it felt a little bit empowering to just finally know what was wrong. I knew that there was something wrong and I would have to try to deal with that. But it felt really good to just know that there was something actually wrong with me and I wasn't making it up."

'Call out' cultures of identifying 'triggering' language or topics were identified as harmful, as it created a culture of fear and paralyzed communities who feared making a mistake and being shamed in public.

"like someone says something that like really feels wrong to someone. Like it could be something like being mis-gendered or it could be use of a particular word or something. Instead of being like, "That's the wrong word," and like, "You and your sis, white, privileged, like your other sort of… You're the bad guy," right. Instead of turning people into bad guys, it's like it's working from the premise that like people don't want to be bad guys. So it's like yes, sometimes you need to call people out, and I actively like to do that.

But you also do it in a measured way. And it's like you don't… You want to be able to keep a conversation going, right."

Many of them expressed the potential- and also the pitfalls- of anger as a driving force behind implementing social justice principles in everyday life.

"I think there's a danger in… Like especially working with like social justice, things don't change quickly and it gets really frustrating and people get jaded, and just like chronically angry."

Collaborators identified a lack of compassion and a tolerance for the 'grey zones' in social justice movements to be short-sighted and harmful.

'by insisting on using like particular vocabulary or models of like feminist theory or whatever, and claiming that people are ignorant and like lazy or something for not knowing, is completely unhelpful. I think what gets forgotten is compassion in there – compassion for yourself that you... Like you're not going to win many battles in social justice. You really aren't. You're not going to… It's all going to be really, really difficult and slow going."

Feminist spaces that seek to protect women from 'men's violence' often marginalized those who identified as queer or non-binary and erased the experiences of women in violent, same sex partnerships (Walters, et. al 2013). Furthermore, the 'demonization' of a violent partner left them feeling alienated, as they truly did feel love for partners who assaulted them, regularly.

"They would want to focus on my relationship and how I should not be in it. And I wanted to focus on my behaviours and working on them so that I could do things like be in a relationship and not just have to cop out. I didn't want just to cop out. I wanted to work on things. And they just wanted me to cop out."

"Like a) they want people to leave, they want people to press charges, they want people to feel like they can do that. They're so scared people are going to go back that they just like fear monger them into hating that person. Like sometimes they feel the need to swing to the other side as opposed to like seeing a more complex view and teaching that."

Neoliberalism as a landscape of neglect

Embodied moments of violence and harm across a landscape of social institutions demonstrate the ways in which forces of psychiatric discourse, funding constraints, moral codes tied to binary oppositional constructs (which are deeply gendered and tied to Cartesian dualism) and legal frameworks around consent and autonomy of minors all serve to exclude women diagnosed with borderline personality disorder from any sort of secure attachment to these institutions. In this way, the 'symptoms' emerge as agential responses to violence experienced in the emotional self and the pattern echoes itself, over and over, in a similar fashion as the chronic invalidation of emotional experience becomes the defining feature of professionalized discourse in schools, hospitals, workplaces and social movements; de-legitimating those who have experienced trauma (either through physical or emotional abuse) or because of a predisposition to intense sensitivity.

This 'looping effect' as discussed by Hacking (1999) points to the deep entanglement between the subject and its environment. Impacts that are traumatic for an earthworm might go unnoticed by a shellfish. De-legitimation works to erase distress and the effects of such violence, thus, working to erase any claim to meaningful social identity. The intra-action of various forces of exclusion and emotional de-legitimation shape ways that borderline women view the world, as they come to experience what one participant described as a 'zombie apocalypse', where you exist in constant crisis, running from one dark space to another, fighting to survive amidst chaos and violence. Experiences of neglect come to shape their relationship to objects of 'security' and 'care', thus creating a choreography of seeking containment (in inpatient spaces or violent relationships) and provoking punitive and physically-forceful responses from those around them when they are trying to harm themselves. In this way, the dance of distress, self-harm, punishment, exclusion and distress becomes the way in which borderline women seek to negotiate worlds that are familiar; where their sense of emptiness and alienation makes sense; and where the object of 'care' provokes familiar sensations of being neglected by those who should have cared for them.

Conclusion

(the prison is everywhere)

"Justice, which entails acknowledgement, recognition and loving attention, is not a state that can be achieved once and for all. There are no solutions; there is only the ongoing practice of being open and alive to each meeting, each intra-action, so that we might use our ability to respond, our responsibility to help awaken, to breathe life into ever new possibilities for living justly"

(Karen Barad, 2007 p. x)

"If unhealthy attachment styles, personality disorders and affective dysfunction were recognized as PRODUCTS OF A WIDESPREAD SOCIAL DEFICIT IN EMOTIONAL LITERACY the headline news that shocks and baffles the public would no longer be met with surprise"

(Merri Lisa Johnson, 2010 p. 203 emphasis in original)

'marks on bodies'

This project began with the death of Ashley Smith in Federal custody. It began with the familiar sensation of anger at the carceral state- the sense that when we view the surveillance footage of her death in a segregation room- we are witnessing the cruelty of state violence. It began with the awareness that Ashley's diagnosis and experiences were reflected across the Canadian prison system; where words like 'personality disorder', 'self-harm' and 'trauma' resonate across the prison demographic, where the highest number of prisoners in Canadian history represents a population of Canadians who have been turned away from mental health programs, educational systems, their families and places of employment, before becoming warehoused in carceral space.

Initially, this project was intended to be a critique of the carceral state from an abolitionist, mad studies perspective. After hearing the stories and experiences of my collaborators, however, I had a growing feeling of discomfort with critical scholarly literature in my field- a sense that the position from which these critiques were being made was part of an apparatus of violence- a violence that I was beginning to recognize after learning more what it felt like to be on the borderline between a legitimate 'mental illness' and archetypes of a 'bad person'.

Moreover, the original intention of this project was to critique the ways in which the prison system responded to suicide and self harm, yet we found the prison *at every turn* when recalling experiences in schools, hospitals, workplaces and even our homes. By refusing to adopt a practice that forced a distinction between immaterial agency (power) and embodied experience, we were able to turn our attention more distinctly to the performative effects of everyday entanglements. In other words, it became possible to speak of violence as 'moments' that emerged in trends and patterns related to Eurocentric practices. We could speak of carceral violence as a series of engagements and intra-actions throughout community spaces- rather than turning the 'prison' or the 'hospital' into a firmly bounded concept that became responsible for particular and narrow forms of violence, thus leaving the traces and roots of the violence in everyday life, unaccounted for. By taking up a position that allowed us to articulate violence as embodied moments of intra-action, we are able to account for all relational spaces where the carceral state continually emerges and acknowledge the wounds that are created by making distinctive cuts between matters and doesn't 'matter' in projects for justice. By accounting for 'psychiatry' as an agency, with which we are continually entangled, it is no longer seen as a structure that is separate from its effects throughout social life.

Every story that was told about engagements with social services, employers, doctors, teachers and intimate partners elicited the same cold sensation of watching the correctional officers in surveillance footage with Ashley. It became clear that the violence of the carceral state lies not only in the socio-material forces of the criminal justice system, but also in the ways in which all of our foundational belief systems, institutions and apparatuses operate. New materialist feminism became the only ethical place with which to account for the 'marks on bodies' left by the agential forces of the carceral state at every level of its operation. In this sense; the carceral state is not a stable concept that pre-exists its intra-action with all of the agential forces at work in the community landscape. The carceral state is an 'action'. There is no 'bad guy' that pre-exists intra-action with apparatuses of diagnosis, policy manuals, employment expectations and religious codes.

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At the most recent 4S meeting in Barcelona, I wanted to read a poem I wrote with my collaborators about another woman who died in prison. I chose not to. I wrote a paper about emotions. And agency. And theory. I read it off the page.

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"Yes, and things have been so tense in the prison since X. died. They are under a lot of pressure from management"

"X. is dead? You mean she set herself on fire. She survived though. She didn't die. I just saw her a month ago."

".. No, honey. No. She tried again. She died this time. I think she swallowed some chemicals. I can't recall. Oh, I'm so sorry. I thought you knew.

***

When I was in Barcelona, I realized that I simply could not read a poem about burning flesh to a room of strangers in 12 minutes (with 3 additional minutes for questions). What were they to do with that? How were they supposed to carry traces of that story for the rest of their day? Were their handbags big enough to carry what I *would leave them with? How would that kind of engagement - with the rituals of professionalism, the 300 page program neatly organized into blocks of time with coded systems to tell you where your colleagues were most likely to be found- a room full of strangers- one simply can't make that kind of mess in that kind of space. How were we to build a different world out of that? How?*

There were not enough tourniquets.

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The stories of my collaborators detailed the precariousness *of in-between-ness* and the ways in which their failure to fit into pre-defined categories painted a landscape of neglect, exclusion, denial and de-legitimation. All of them occupied multiple non-binary spaces, either through their sexual orientation, their position as a 'youth', or through slippery disorientations in family structures that rendered them as child-age caregivers to mentally ill or addicted parents who behaved in childlike ways. Their stories interfered with interpretations of Ashley's mistreatment in prison as a manifestation of top-down, hierarchical violence. Their stories underscored the ways in which those who have *never been 'contained' in social spaces*, seek containment through pushing boundaries, 'acting out' and self-harming in order to come hard up against a familiar form of social contact. 'Standing with' those who feel the cuts of taxonomic systems and the boundaries of institutional jurisdiction nurtures an awareness that there is no stable object of 'violence' or 'care' that pre-exists intra-action with other forces, such as the socio-material context of neoliberalism. A new materialist position allows us to see agential cuts that are made on the terrain of the emotional self, in ways that validate and acknowledge the distress that is felt by those living with what is called 'borderline personality disorder' represents a an emergence of specific forms of of socio-material life,. Borderline personality disorder', becomes a language for speaking the pain of the borders, the pain of existing in a non-binary, non-categorical reality and experiencing wounds that are unrecognizable in neoliberal iterations of the rational autonomous self.

Interference

The stories and ideas shared by my collaborators interfere with anti-psychiatry narratives that argue against psychiatric treatment. They also interfere with notions of decarceration and prison abolition that seek to abolish institutions of 'secure care'. Critical interpretations of psychiatry and detention assume that all non-consensual 'containment' represents a violation of the autonomy of the subject. It is recognized as the antithesis of 'freedom' and compared to forms of modern day slavery.

However, the assumption that all forms of 'secure' care represent a form of 'violence', de-legitimates the very real experiences of those who *desire to be contained* for fears of their own safety or because they are a familiar sensation that, to them, represents *love* as much as it represents violence. 'Secure care' in prisons and hospitals is mobilized in critical, post-Foucauldian literature in ways that evoke an image of a militarized state, turning on its own people to maintain order and regulate the behaviour of the population. However, this critique is one that can only be made from the interior- where 'security' is already given through *containment of those who critique it*. It is a critique borne of the privilege of being included *inside* the jurisdiction of existing socio-material systems. In the mid 20th Century, when the highest number of people in North America were institutionalized in both prisons and asylums, this critique resonated strongly with the hundreds of thousands of people living in residential facilities at the insistence of the state.

Since the 1970s, however, neoliberal capitalist globalization has brought about drastic changes in the availability of residential facilities. Asylums have faded from the landscape, medical treatment has become downloaded to the sick individual through pharmaceutical prescriptions and those who fail to become 'well' on their own, become disenfranchised and are forcibly admitted to prisons, where care is sparse and the solitary confinement unit becomes another mechanism of *abandonment*. In this sense, solitary confinement units (and TQ in hospitals) are a way to exclude, rather than to forcibly contain. It is a way to alienate a subject and sever all meaningful social ties with others inside the facility.

For some, such as those with experiences of childhood neglect, sexual assault and those who are given a diagnosis of borderline personality disorder, the notion of *security* is an object of desire, where experiences of de-legitimation and exclusion have left them feeling vulnerable on the margins of social institutions, including their own families. To argue that all spaces of secure care must be abolished in the interests of 'justice', is to deeply invalidate and ignore the experiences of those who have experienced the highest rates of neglect in our current system. Borderline narratives challenge the assumption that all incarcerated subjects are beating on the walls of the institution to escape; some, in fact, are banging on the door *asking to get in*, and instead of pathologizing this impulse, we must radically accept it. Accepting this, requires foregoing the ways in which the 'carceral state' has been positioned as a moral anathema and seeing it as an intra-active system that responds to agential forces- operating at all levels, including that of the emotional self. Critical movements must begin to account for the ways in which *neoliberalism is experienced as chronic neglect* and consider that the closure of prisons and mental health treatment facilities might do little to reduce the violence that is experienced by those who are most impacted by these systems. If we accept that prisons have an epidemic of suicide and self harm, we must, too, accept that *junior high schools* are equally as fraught with violence, abuse and self-harm.

If we return to Michel Foucault and accept that the removal of bars from the windows of our carceral institutions signifies the point at which we become enslaved to new governmental technologies of self, then the relics of our institutions become symbols of the much larger and more disturbing patterns that emerge in everyday entanglements. We can shut down the prisons and asylums, but will we still be neglecting and harming our must vulnerable in ways that produce the same forms of deep suffering and pain? The very pain we sought to end by waging war against the oppressive 'structures' of the carceral state would still emerge in the spaces between us.

Canaries in the Coal Mine?

The inherent hypersensitivity of those with a borderline diagnosis allows them to experience agential forces at work in everyday life in ways that others cannot. They are tuned into the ways in which agential forces of neoliberalism intra-act with our emotional agencies and create harm. By positioning emotion as an agential force that does not pre-exist its intra-action with socio-material forces, we are able to understand it not as subservient to (or in opposition of) the rational self. Instead, we are able to see it as a site of violence, where agential cuts serve to render emotion as matter that does not matter in daily life. Borderline narratives help us develop language for the *emotional worlds* emerging from neoliberalism. When we acknowledge the particular ways in which colonial constructs, binary oppositions, material structures, and the de-legitimation of emotional experience make *marks on bodies*. It becomes possible to account for the ways in which the carceral state continually emerges in everyday intra-actions. Instead of continuing to position ourselves critically in opposition to the 'carceral', perhaps we could follow the call from the borderline to see emotional suffering on a *spectrum* (Johnson, 2010) where our symptoms are not 'artifacts of social regulation' or indicative of 'neurological pathology', but rather patterns of relating that arise in relation to the social environment.

As Merri Lisa Johnson writes: "ATTACHMENT DISORDERS ARE COMMON AS DIRT. They should not be relegated to the speechless realm of the ineffable" (2010, p. 203 emphasis in original). In this way, borderline narratives become the audible frequency at which we are able to tune into harms we may be already experiencing, yet lack the language to communicate in systems that function to erase and de-legitimate this violence at every turn. New forms of critique that validate emotional experience as matters that *matter* can " be built from materials retrieved from the black holes between words and feelings, past and present, lover and beloved, mental patient and the people who feel perfectly fine" (Johnson, 2010 p. 203).

Emotion as Intra-Subjectivity

Borderline personality disorder- or the pattern of experience that emerges from the intra-action of diagnostic categories, abusive forms of kinship and intimacy and neoliberal institutional practice- is described and understood by my collaborators as emotional dysregulation. It is described and understood as *relational* and these experiences of 'dysregulation', including pain, anger, suicidal thoughts, intense fears of abandonment and hopelessness arise from particular attachment patterns and relationships.

Although critical consideration of 'emotion' is not as common in feminist new materialism than it is in affect theory[15] or cultural studies, emotion can be understood within feminist new materialism as both a landscape and an agential force. In embodied in/capacity theory (de Courville Nicol, 2011) seemingly 'irrational' or problematic attempts at seeking security (such as banging one's head against a wall in a solitary confinement room or throwing a tantrum in the ER) can be understood as stemming from unconscious forms of emotional regulation that are socially produced and deeply

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[15] This thesis has deliberately excluded consideration of 'affect theory'; or the Deleuzian trajectory of social theory which considers 'affect' as: "a prepersonal intensity corresponding to the passage from one experiential state of the body to another and implying an augmentation or diminution in that body's capacity to act" (Massumi in Deleuze and Guattari, 2004 p. xvii). This project has centred new materialist feminisms as a deliberate and political tactic to make space for borderline subjectivities to be understood and articulated on the terms negotiated by and with my collaborators. The work of Sarah Ahmed, although deeply important in feminist cultural studies and affect theory, was also excluded because of her political position on biologism in social constructionism ("Some Preliminary Remarks on the Founding of Gestures of the "New Materialism" in 2008 issue of European Journal of Women's Studies). In analyzing my data; I chose not to use theorists whose work undermines or de-legitimates the ways in which my collaborators describe their experiences.

embedded in embodied action. Brennan (2004) has argued that 'affect' is contagious. She questions how: "the taken-for-grantedness of the emotionally contained subject is a residual bastion of Eurocentrism in critical thinking, the last outpost of the subject's belief in the superiority of its own worldview over that of other cultures" (Brennan, 2004 p. 2).

Brennan's ideas about the transmission of affect call into question the notion of an 'affectively contained subject', a notion that is taken for granted in contemporary psychology. For Brennan, affect is *both* material and abstract and has what she calls an 'energetic dimension' (2004). Brennan argues that notions of 'self-containment' are a fantasy of Eurocentric social and political thought. This 'fantasy' of self-containment structures "the Western psyche in such a way as to give a person the sense that their affects and feeling are their own" (2004, p. 25).

Brennan draws upon notions of 'countertransference' as proof that clinicians 'feel' affective energies from their patients, something that other clinicians have referred to as the 'meat grinder' sensation of working with a borderline patient (Lester, 2013) whose suffering spills over and contaminates the 'rational' clinician. Borderline personality disorder has been described as "emotional hemophilia" (Kreisman and Straus, 2010) or likened to being an "emotional burn victim"[16] lacking in resilient emotional skin. The persistent marginalization of those with emotional dysregulation can be attributed to the ways in which their porousness calls into question notions of an affectively contained subject. Borderline experiences force us to consider *emotion as intra-subjectivity*; as the space where affective transmission (Brennan, 2004) brushes up against the slippery, tenderness of their 'selves'.

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[16] Linehan, n.p. http://blogs.psychcentral.com/wellness/2012/04/emotional-dysregulation-in-partners-with-borderline-personality-disorder/

Painful Attachments?

Attachment theory, pioneered by John Bowlby (1988) and Mary Ainsworth (2016) connects our earliest childhood experiences with caregivers to relationship patterns in adult life. Bowlby had worked as a psychiatrist with children suffering from maladaptive behaviours following their experiences in World War II. He noted that children's early feelings of security with the nursing mother came to greatly influence their social behaviour later in life. Infant experiences of security and insecurity and the patterns provided by the early caregiver appeared to shape their intimate relationship patterns throughout their life course.

In the 1960s and 70s, developmental psychologist Mary Ainsworth, pioneered a landmark study called 'the strange situation' experiment. She intended to study infant reactions to stress. Stress was induced by the introduction and removal of the caregiver during scheduled intervals. The experiment demonstrated marked patterns in infant responses to loss of security from a caregiver, which led Ainsworth and later, Bowlby (1988), to posit four main types of attachment style; anxious-avoidant insecure attachment, secure attachment, anxious-resistant insecure attachment and disorganized/disoriented attachment. These attachment styles have been linked to pervasive patterns of abusive or unhealthy relationships later in life.

Attachment theory focuses primarily on the nature of the care provided by the parent (usually the mother) early in life as the sole cause for these relational problems. However, it is known that abusive relationships in teen years or adult life can sometimes cause someone to go from a secure attachment style to an anxious attachment style as a result of the abuse (Manson, 2011). Although attachment theory is popular in self help literature and some forms of talk therapy, specifically couples counselling, critical sociological attention has not been paid to attachment theory.

But, what if our relationship to social institutions, peer groups and our entire kinship network were acknowledged as forces that shape our attachments to each other? What if attachment theory was broadened to consider the ways in which *neglect* in contemporary neoliberalism- experienced through denial of care, extensive wait lists, punitive responses to emotional distress- served to create anxious or insecure attachment patterns on a broader level? Attachment theory, considered as a lens in which to interrogate our *institutional* relationships, could then serve as a framework for understanding how the carceral state both creates harm and forges particular types of attachments with the most vulnerable.

Attachment theory, applied to institutional relationships, serves to explain and account for how experiences in schools, families, workplaces and social movements create punitive and neglectful social-emotional structures. Although some affect theorists (Berlant, 1998, Blackman, 2008, Clough, 2010) and sociologists of emotion (Petersen, 2004; de Courville Nicol 2010, Ehrenberg, 2010) have taken up consideration of the social/emotional self as a means with which to understand the effects and organization of power, there is little discussion between progressive psychiatrists and social theorists.

Critical attention to emotional intra-subjectivity with consideration of attachment theory can explain how it is that so many young women in hospitals and prisons are caught up in similar abusive choreography with clinicians, correctional officers and, outside the prison, with abusive intimate partners. Consideration of emotional intra-subjectivity and attachment theory could also help understand our *intimate attachments to the carceral state* and why it is what we stubbornly cling to a system that punishes and harms us. Emotional intra-subjectivity and attachment theory can provide the language to acknowledge the emotional terrain of the carceral state and the ways we become relationally dependent upon it.

Decarceration as compassionate containment?

What sort of post-carceral world could we imagine from the borderlands? If the call to abolish prisons and mental hospitals inevitably reinforces preexisting processes of neglect and exclusion of those who desire containment, how, then, do we respond differently to these intra-active processes that leave marks on bodies of the most vulnerable? In *Rebellion is the Circle of a Lover's Hands*, Martín Espada writes:

"But Rebellion
is the circle of a lover's hands
that must keep moving,
always weaving."

His poem gestures to the way in which a family experiences police violence in multiple sites and locations, in different countries and, how, despite precarity and vulnerability at the hands of police, the mother keeps weaving and mending their clothes. Her hands continue to circle, a needle in each hand, sewing and mending cloth, as she thinks of her son; and of riots; and of billy clubs and cracked skulls. Borderline personality disorder has been described as a form of "emotional hemophilia" (Kreisman and Straus, 2010) or living as an 'emotional burn victim' (Linehan N.Y.) where the slightest touch or movement within the emotional self, elicits tremendous pain and distress. It has been described as the persistent and painful absence of a compassionate embrace.

These descriptions underscore the ways in which persistent experiences of neglect across the community, create a sense of being perpetually *un-contained* or lacking the thick skin, which is characteristic of the *ideal* neoliberal subject, who denies their personal misery in favour of maintaining secure relations with the capitalist system. Those who suffer from pain which is deemed 'illegitimate' are forced to cope on their own, without supports (Lincoln, 2006). Borderline personality disorder, if it is seen as a pattern that arises intra-actively within our contemporary world, begs us to acknowledge the many levels on which the carceral state operates, and continues to persist, despite our own internal unhappiness, or terrible tragedies such as Ashley's death in custody. If we are able to focus specifically on the intra-active harms which arise relationally in every given moment rather than making a monster of the state, which is depicted as a stable object that symbolizes all that is wrong with the world, decarceration then becomes a practice of accounting for our own emotional selves intra-actively with each other. Many of the harms experienced by those who contributed to this project were communicated subtly, through body language, dismissal or non-violent forms of punishment in the context of our institutional relationships.

"when you're really sensitive, like instinct is to like close up and put on your armour and survive. But if we lived in a culture that valued that sensitivity, maybe you wouldn't have to. And then who would you be?"

Decarceration, in this context, then becomes a practice of radical acceptance of our current world, and a gesture to *intentional vulnerability.* Decarceration impulses that engage intra-actively with the emotional self- despite the discomfort and vulnerability this may bring- locates the project of justice at the agential cut inside of us, rather than in the dismantling of architectural spaces of confinement. Decarceration work that attends to neglect, becomes attentive to the *in-between-ness* of our kinship bonds, our institutional relationships and collegial networks. Desire for the containment of kinship can be a place from which trauma and exclusion can be mended. Practices of intentional vulnerability and compassionate containment are emerging in transformative justice circles. The Bay Area Transformative Justice Collective (Mingus, 2014), has offered the notion of 'pods' as intentional circles of care, to be drawn upon in difficult times:

> *We needed a term to describe the kind of relationship between people who would turn to each other for support around violent, harmful and abusive experiences, whether as survivors, bystanders or people who have harmed. These would be the people in our lives that we would call on to support us with things such as our immediate and on-going safety, accountability and transformation of behaviors, or individual and collective healing and resiliency. (*Mingus, 2014 n.p.)

Groups such as Generation Five[17] and The Gatehouse[18] offer adult peer support for survivors of child sexual abuse. Both of these organizations are survivor-led and survivor-run and promote a transformative justice approach to educating communities about sexual abuse, rather than engaging in an oppositional system with a victim/offender model that does little to prevent abuse, rehabilitate 'offender's or heal 'victims'.

The stories offered by all of the collaborators in this project point to the presence of a real and deep desire for a better world. They all spoke of something like 'stars' in the belly, or a deep belief in the possibility for a better world. Honouring this radically imaginative and hopeful impulse, we must ask how, even during times of great suffering, those diagnosed with borderline personality disorder show us the possibilities of *resilience* as resistance to the conditions of our current world.

" there was something that was somehow keeping me alive over the years. And there was a number of times where I'd be really close, sitting with maybe like a knife or something a little more violent attempt, and not being able to completely go through with it or whatever. And just like crying with like a knife for a really good hour, just not being able to push it into myself kind of thing. So I don't know, it's really weird. Like despite all those like super lonely, hurt, empty feelings, there's like somehow this need and desire in me for something more"

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[17] http://www.generationfive.org/

[18] http://www.thegatehouse.org/

Honouring the impulse for a radically different future often means intervening in times of suicidality and hopefulness. Indeed, when someone we love is suicidal, we don't respect their rational autonomy- we grab ahold of them, we wrestle away the knife, *we hold them down* - albeit- against their will. The stories shared by all the collaborators on this project, point to the transformative potential of the *circle of a lover's hands* and beckon us to intervene.

Epilogue

Summer, 2001.

Webcam girl; Staci Pershall, is freaking out on camera. Her boyfriend cheated on her and broke up with her via email.

She looks into the camera and explains:

"i've been in love twice. both times i've been told at the end that i was not enough. this is it. i'm not going to do it again. i'm in a world where people aren't even kind to each other. i think it's just time to check out…skutch knows i'm going. he's meowing at me. sweet kitty."

She is covered in tattoos. And scars. She is wearing shorts and a t-shirt. Staci is an artist. And an adjunct professor at an art school.

She pops pill after pill, staring into the bathroom mirror, before she sits down between a kitty litter box and the edge of the toilet. She passes out; cross-legged with her arms in her lap and her head slumped over the toilet bowl.

Rapt onlookers take screenshots before the webcam shuts off.

The blogosphere quickly lit up with accusations of her suicide being a hoax. One site, Daign.com, explodes with comments:

"This has to be staged, no one is that pathetic"

"I don't care either way. if they're that farked up, it may be a good thing they off themselves before they can reproduce!"

"Ugh, what a farking UGLY biatch…love the commentary tho… if she wanted to kill herself she would've done it right"

"Daign rules. Those attention needing cam-whores deserve no respect, nor do the wankers who fawn over them and think of them as their net-girlfriends or something. Sad bastards, the lot of 'em."[19]

A feminist researcher who was doing a project on webcam girls happened to be watching- she called an ambulance. She knew Staci. She drove to her house, frantically, hoping that she was still breathing.

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[19] http://www.labusas.org/forum/showthread.php?19844-first-online-suicide-attempt

ER staff managed to revive her, pumping her stomach and keeping her on IV fluids while she lay for days in a coma, covered in bruises from the seizures she sustained, thrashing around on her bathroom floor before paramedics arrived.

In the 10 year period following her suicide attempt on a webcam, Staci published a memoir- 'Loud in the House of Myself"- and went through her first DBT program. She sat down with Merri Lisa Johnson to talk about the difficult work of writing a BPD memoir and the struggle of writing about yourself as a sympathetic character. They talked about the cruelty of online comments and callous reviewers. Staci responded by emphasizing that her memoir was not for them. It was not for everyone with lived experience of mental illness. It was an anthem for the outcasts, the strange kids, the "atheist" teens, the "queer" the "hyperintelligent" kids who don't fit in the world that has been laid out for them. She explained: "They're in the closet with me covering their skin with Sharpies"

Johnson asked her about her choices in revealing the difficult and intense details of her hospitalizations and suicide attempts. Staci replied:

"everything's relative when you've tried to kill yourself on the internet. I finally had a chance to tell my side of the story and let other strange girls realize they weren't alone"

Bibliography

Agustin, Laura Maria (2007) *Sex at the Margins: Migration, Labour Markets and the Rescue Industry*. London: Zone Books.

Ainsworth, Mary; et. a.l (2016) *Patterns of Attachment: a psychological study of the strange situation*. Psychology Press.

Alexander, Michelle (2012) *The New Jim Crow; Mass Incarceration in the Age of Colorblindness.* New York: The New Press.

Angrosino, Michael (1998) *Opportunity House: Ethnographic Stories of Mental Retardation*. AltaMira Press.

Angermeyer, Matthias C., Holzinger, Anita, Carta, Mauro G. and Schomerus, Georg (2011) "Biogenetic explanations and public acceptance of mental illness: systematic review of population studies" *The British Journal of Psychiatry*: 199, 367–372.

Anzaldúa, Gloria (1987) *Borderlands / La Frontera; The New Mestiza*. San Francisco: Aunt Lute Book.

American Psychiatric Association (2011) "Highlights of Changes from DSM IV TR to DSM 5." http://www.dsm5.org/Documents/changes%20from%20dsm-iv-tr%20to%20dsm-5.pdf

American Psychiatric Association (1980). *Diagnostic and Statistical Manual of Mental Disorders*: DSM III. 3rd ed. Arlington: American Psychiatric Association. Print.

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders*: DSM 4. 4th ed. Arlington: American Psychiatric Association. Web.

American Psychiatric Association (2012). *Diagnostic and Statistical Manual of Mental Disorders*: DSM 5. 5th ed. Arlington: American Psychiatric Association. Web.

Aviram, Ron B; Brodsky, Beth; Stanley, Barbara (2006) " Borderline Personality Disorder, Stigma, and Treatment Implications" In *Harvard Review of Psychiatry*. 14:5.

Balfour, Gillian; Comack, Elizabeth (2014) *Criminalizing Women; Gender and (in)Justice in Neoliberal Times.* Black Point: Fernwood Books.

Barad, Karen (2003) “Posthumanist Performativity: Toward an Understanding of How Matter Comes to Matter” In *Signs.* 28:3.

Barad, Karen (2007) *Meeting the Universe Halfway*. Durham: Duke University Press.

Barad, Karen (2014) “Diffracting Diffraction: Cutting Together-Apart” In *Parallax.* 20:3, 168 – 187.

Barad, Karen (2012) “Nature's Queer Performativity (the authorized version)," in Kvinder, Køn og forskning/ Women, Gender and Research (Copenhagen, 2012), No. 1-2, pp. 25-53.

Barbalet, J.M. (1998) *Emotion, Social Theory and Social Structure*. Cambridge University Press.

Barry, Andrew; Born, Georgina and Weszkalnys, Gisa (2008)” Logics of Interdisciplinarity” In *Economy and Society* 37:1. 20 – 49.

Bateson, Gregory. (1973) *Steps To An Ecology of the Mind*, New York: Palladin Books.

Becker, Dana (1997) *Through the Looking Glass: Women and Borderline Personality Disorder.* Boulder: Westview Press.

Becker, Howard (1997) *Outsiders: Studies in the Sociology of Deviance*. New York: Simon & Schuster.

Ben-Moshe, Liat (2014) "Deinstitutionalization: a case study in carceral abolition" In *Scapegoat 07.*

Ben-Moshe, Liat; Chapman, Chris; Carey, Allison C. (2014) *Disability Incarcerated: Imprisonment and Disability in the United States and Canada*. New York: Palgrave MacMillan.

Beresford, Peter (2014) "Mad Studies Brings a Voice of Sanity to Psychiatry" In *The Guardian.*

Berlant, Lauren (1998) "Intimacy: a special issue" in *Critical Inquiry.* 24:2. 281 – 288.

Bishop, Anne (2002) *Becoming an Ally: Breaking the Cycle of Oppression in People*. Zed Books.

Blackman, Lisa (2008)"Affect, Relationality and the `Problem of Personality" In Theory, Culture & Society 25: 23-47.

Brennan, Teresa (2004) *The Transmission of Affect*. New York: Cornell University Press.

Brown, Wendy (2010) *Walled States: Waning Sovereignty*. Zone Books.

Born, G., & Barry, A. (2010). Art-science: from public understanding to public experiment. *Journal of Cultural Economy*, *3*(1), 103-119.

Bowker, Geoffrey C. and Leigh Star (2000) Susan *Sorting Things Out; Classification and it's Consequences*. Cambridge: MIT Press.

Bowlby, John (1988) A *Secure Base: Parent-child attachment and healthy human development*. Perseus Books.

Burstow, Bonnie (2005) "Feminist Anti-Psychiatry Praxis- Women and the Movement(s); a Canadian Perspective" in Chann, Chunn and Menzies (Eds) *Women, Madness and the Law*. London: Glasshouse, pp- 245 – 258.

Butler, Judith (date unknown) "Precarious Life; Indefinite Detention" In *Guantanomo Bay Museum of Art and History*.
<http://www.guantanamobaymuseum.org/?url=butlertext>

Butler, Judith (2010) *Frames of War*. London: Verso Books.

Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada (2014) *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans,* December 2014, version 2.

Canadian Mental Health Association (CMHA) (2009). "News Release" http://www.cmha.ca/news/canadian-mental-health-association-urges-governments-to-develop-more-appropriate-solutions-for-the-mentally-ill-housed-in-today%E2%80%99s-prisons/.

Campbell, Kirsten (2004) “The Promise of Feminist Reflexivities: Developing Donna Haraway’s Project to Feminist Science Studies “ In *Hypatia*. 19:1.

Carey, Benedict (2011) http://www.nytimes.com/2011/06/23/health/23lives.html?pagewanted=all

Chann, Chunn and Menzies (Eds) (2005) *Women, Madness and the Law.* London: Glasshouse.

Choudhury, S., Nagel, S. K., & Slaby, J. (2009). Critical neuroscience: Linking neuroscience and society through critical practice. *BioSocieties*, *4*(1), 61-77.

Choudhury, S., McKinney, K. A., & Merten, M. (2012). Rebelling against the brain: Public engagement with the ‘neurological adolescent’. *Social Science & Medicine*, *74*(4), 565-573.

Clough, Patricia T. (2010 “The Affective Turn: Political Economy, Biomedia and Bodies:

In Gregg and Seigworth (Eds.) *The Affect Theory Reader*. Durham: Duke University Press.

Colombetti, Giovanna (2009) “From affect programs to dynamical discrete emotions” In *Philosophical Psychology*, vol. 22: 4. 407-425

Colombetti, Giovanna and Thompson, E. (2008) “The feeling body: towards an enactive approach to emotion” In Overton WF,Muller U,Newman JL (eds) *Developmental Perspectives on Embodiment and Consciousness*, New York: Lawrence Erlbaum Ass.. 45-68

Combessi, Philippe. “Marking the Carceral Boundary: Penal Stigma in the Long Shadow of the Prison” In *Ethnography* December 2002 3: 535-555,

Conrad, Peter and Schneider, Joseph (1992) *Deviance and Medicalization: From Badness to Sickness*. Philadelphia: Temple University Press.

Cooper, David (1967) *Psychiatry and Anti-Psychiatry*, New York: Palladin Books.

Davies, Bronwyn (2014) *Listening to Children: Being and Becoming*. Routledge.

Davis, Angela (2012) *The Meaning of Freedom and Other Difficult Dialogues.* San Francisco: City Lights Books.

Davis, Angela (2003) *Are Prisons Obsolete?* New York: Seven Stories Press.

De Courville Nicol, Valérie (2011) “Social Economies of Fear and Desire: emotional regulation, emotion management and embodied autonomy”. Palgrave MacMillan.

Ehrenberg, Alain (2010) *The Weariness of the Self: Diagnosing the History of Depression in the Contemporary Age*. Montreal: McGill-Queen’s University Press.

Ellis, Carolyn and Bochner. Arthur (2000) "Autoethnography, Personal Narrative, Reflexivity: Researcher as Subject" *The Handbook of Qualitative Research*. Ed. Norman Denzin and Yvonna Lincoln.. 733-768.

Ellis, Adams and Bochner (2011) “Autoethnography: an overview” in *FQS Forum: qualitative social research*. 12:1, article 10.

Elwood Martin, Ruth; Korchinski, Mo; Fels, Lynn and Leggo, Carl (2014) *Arresting Hope: Women Taking Action in Prison Health Inside Out.* Toronto: Inanna Press.

Fee, Dwight (Ed) (2000) *Pathology and the Postmodern: Mental Illness as Discourse and Experience*. London: Sage Publications.

Feyerabend, Paul (1993) *Against Method*. Verso Press.

French, Martin and Smith, Gavin JD (2016) "Surveillance and Embodiment: Dispotifs of Capture" in *Body & Society*. 22:2 .

Foucault, Michel (1970) *The Order of Things: an archaeology of the human sciences*. Vintage Books.

Foucault, Michel (1965) *Madness and Civilization*. London: Routledge.

Foucault, Michel (1995) *Discipline and Punish*. New York: Vintage Books

Freud, Sigmund (1989) “Chapters 3 - 4” In *Civilization and Its Discontents* New York: W. W. Norton & Company

Gabbard, Glen O. (1993) "An Overview of Countertransference with Borderline Patients" In *Journal of Psychotherapy Practice and Research* 2:1.

Geertz, Clifford (1973) *The Interpretation of Cultures: selected essays*. Basic Books.

Gillis, Alex (2015) "The Rise of Mad Studies" In *University Affairs.*

Gillard et. al. (2015) " Understanding recovery in the context of lived experience of personality disorders: a collaborative, qualitative research study" In *BMC Psychiatry*. 15.

Goffman, Erving (1961) *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. London: Anchor Books.

Gordon West, W.; Morris, Ruth (2000) *The Case for Penal Abolition*. Toronto: Canadian Scholar's Press.

Gosselin, Luc (1982) *Prisons in Canada*. Montreal: Black Rose Books.

Hacking, Ian (1995) *Rewriting the Soul*. New Jersey: Princeton University Press.

Hacking, Ian (2002) "Making Up People" In *Historical Ontology*. Boston: Harvard University Press. pp 99 – 115.

Hacking, Ian (1999) *The Social Construction of What*? Boston: Harvard University Press.

Hacking, Ian (2004) "Between Michel Foucault and Erving Goffman: between discourse in the abstract and face-to-face interaction" In *Economy and Society* Volume 33 Number 3 August 2004: 277–302

Hancock, Black Hawk and Garner, Roberta (2011) "Toward a Philosophy of Containment; Reading Goffman in the 21st Century" In *The American Sociologist*. 42:4.

Haraway, Donna (1997) *Modest_Witness@Second_Millennium. FemaleMan_Meets_OncoMouse: Feminism and Technoscience*. Routledge.

Haraway (2007) *When Species Meet*: *Posthumanities, Vol 3*. Minneapolis: University of Minnesota Press.

Haraway, Donna (1988) “Situated Knowledges: The Science Question in Feminism and the Privilege of the Partial Perspective” In *Feminist Studies* 14:3. 575 – 599.

Harcourt, Bernard E. (2011) "Reducing Mass Incarceration: Lessons from the Deinstitutionalization of Mental Hospitals in the 1960s" In *Ohio State Journal of Criminal Law* 53.

Harcourt, Bernard E. (2005) "From the Asylum to the Prison: Rethinking the Incarceration Revolution," In *Texas Law Review*. 84.

Harding, Sandra “Beyond Postcolonial Theory: Two Undertheorized Perspectives on Science and Technology” In In Harding, Sandra Ed. (2011) *The Postcolonial Science and Technology Studies Reader*. Duke University Press.

Harper, Stephen (2009) *Madness, Power and the Media: Class, Gender and Race in Popular Representations of Mental Distress*. New York: Palgrave MacMillan.

Hernandez-Wolfe, Pilar (2013) *A Borderlands View On Latinos, Latin Americans and Decolonization; Rethinking Mental Health.* Plymouth: Jason Aronson, Inc.

Horwitz and Wakefield (2007) *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder* Oxford: Oxford University Press.

Hunt, Alan (1999) *Governing Morals: A Social History of Moral Regulation*. Cambridge: Cambridge University Press.

Illouz, Eva (2008) "Freud: A Cultural Innovator" In *Saving the Modern Soul; Therapy, Emotions and Culture of Self-help*. Berkeley: University of California Press. Pp. 22 – 58.

Johnson, Merri Lisa (2010) *Girl in Need of a Tourniquet; a memoir of borderline personality disorder*. Seal Press.

Jutel, Annemarie (2009) "Sociology of Diagnosis; A Preliminary Review" In *Sociology of Health & Illness*. 31:2.

Karaba, R. (2016). Challenging Freedom: Neoliberalism and the Erosion of Democratic Education. *Democracy and Education*, 24 (1), Article 1.

Karp, David A. and Sisson, Gretchen E. (2010) *Voices from the Inside: Readings on the Experience of Mental Illness.* Oxford: Oxford University Press.

Kayson, Susanna (1993) *Girl Interrupted.* Turtle Bay Books.

Kernberg MD, Otto (1975) *Borderline Conditions and Pathological Narcissism*. New York: JA Incorporated.

Kendall, Kathleen (2005) "Beyond reason: social constructions of mentally disordered female offenders". In, Chan, Wendy, Chunn, Dorothy E. and Menzies, Robert (eds.) *Women, Madness and the Law. A Feminist Reader.* , Routledge-Cavendish .

Kenney, Scott J. and Craig, Ailsa (2004) "Illegitimate Pain*" In Emotions Matter: A Relational Approach to Emotions* Eds: Alan Hunt, Dale Spencer, Kevin Walby. Toronto: University of Toronto Press.

Kenney, Scott J. and Slowey, Jacqueline (2010) " Illegitimate Pain: Dimensions, Dynamics, and Implications" In *Deviant Behaviour*. 31:6.

Khasnabish, Alex and Haiven, Max (2010) "What is the Radical Imagination? A Special Issue. In *Affinities Journal*. 573.

Kilty, Jennifer M. (2014) “Examining the Psy-carceral Complex in the Death of Ashley Smith” In Balfour, Gillian and Cormack, Elizabeth (Eds) *Criminalizing Women: gender and (in)justice in neoliberal times*. Fernwood Press. Pp: 236 – 254.

King, Katie (2011) “Toward a Feminist Transdisciplinary Posthumanities” In *Networked Reenactments: Stories Transdisciplinary Knowledges Tell*. Duke University Press.

Kreisman and Straus (2010) *I Hate You Don't Leave Me*: understanding the borderline personality. Penguin Books.

Kuhn, Thomas S. (2011) *The Structure of Scientific Revolutions*. The University of Chicago Press.

Laing, R.D. (1988) *Self and Others: Selected works of RD Laing*. London: Routledge.

Lather, Patty and Smithies, Christine (1995) *Troubling The Angels: Women Living With Hiv/aids*. Westview Press.

Lather, Patty (2001) "Working the Ruins of Feminist Ethnography " In *Signs* 27:1. 199 – 227.

Latour, Bruno (2004) "Why has critique run out of steam? From matters of fact to matters of concern" in *Critical Inquiry*. 30.

Latour, Bruno. (1993) *We Have Never Been Modern.* Boston: Harvard University Press.

Latour, Bruno and (2005) *Reassembling the Social; an introduction to actor-network theory*. Oxford University Press.

Law, John (2004) *After Method: Mess in Social Science Research.* New York: Routledge.

Law, John (2008). "On sociology and STS" In *The Sociological Review*, 56:4. 623–649.

Laurentine, Camilla (2015) " "Big Pharma" & Privilege: Or Why I Wish Allies Would Stop Using This Phrase" In *Foxglove & Firmitas*.

Leavy, Patricia (2007) *Method Meets Art, Second Edition: Arts-Based Research.* New York: Guilford Press.

Leavy, Patricia (2013) *Fiction as Research Practice: Short Stories, Novellas, and Novels.* San Francisco: Left Coast Press.

LeFrancois, Brenda (2008) "It's like mental torture": Participation and Mental Health Services" In *International Journal of Children's Rights*. 16.

LeFrancois, Brenda (2013) " The psychiatrization of our children, or, an autoethnographic narrative of perpetuating First Nations genocide through 'benevolent' institutions" in *Decolonization: Indigeneity, Education & Society*. 2:1.

LeFrancois, Brenda A.; Menzies, Robert; Reaume, Geoffrey (2013) *Mad Matters: A critical reader in Canadian Mad Studies.* Toronto: Canadian Scholar's Press.

Lester, Rebecca J. (2013) "Lessons from the borderline: Anthropology, psychiatry, and the risks of being human" *Feminism & Psychology* 23: 70.

Leigh-Star, Susan (2010) "This is Not a Boundary Object: Reflections on the Origin of a Concept" In *Science, Technology and Human Values. 35.*

Lincoln, Alisa (2006) "Psychiatric emergency room decision-making, social control and the 'undeserving sick"" In *Sociology of Health and Illness*. 28:54-75.

Linehan, Marsha (1993) *Skills Manual for Treating Borderline Personality Disorder*. Guilford Press.

Littlewood, Roland (2002) *Pathologies of the West: The Anthropology of Mental Illness in Europe and America.* New York: Cornell University Press.

Littlewood, Roland and Lipsedge, Maurice (1997) *Aliens and Alienists: Ethnic Minorities and Psychiatry*. Third Edition. Tayler and Francis E-library Edition.

Loyd, Jenna M; Mitchelson, Matt; Burridge, Andrew (2012) *Beyond Walls and Cages; Prisons, Borders, and Global Crisis*. Goergia: University of Georgia Press: Georgia.

Lynch. Michael (2000) "Against Reflexivity as an Academic Virtue and a Source of Privileged Knowledge " *Theory ,Culture & Society* 17:3. 26 – 54.

Mahon, Michael (2013) "Revisiting Foucault's Earliest Madness Writings" In *Budhi: A Journal of Ideas and Culture* 5:2.

Manson, Mark (2011) *Personal Website*. < https://markmanson.net/attachment-theory>

Marcus, George E. and Cushman, Dick (1982) “Ethnographies as Texts” In *Annual Review of Anthropology*. 11. 25-69.

Mayes, George and Horwitz, Allan (2005) "DSM III and the Revolution in the Classification of Mental Illness" in *Journal of the History of the Behavioural Sciences*. 4:3.

Mate, Gabor (2009) *In the Realm of Hungry Ghosts: Close Encounters with Addiction*. Toronto: Vintage Canada.

Menzies, Robert (2002) “Historical profiles of criminal insanity.” *International Journal of Law and Psychiatry* 25 (2002): 379-404.

Meisner, 1982 http://www.ncbi.nlm.nih.gov/pubmed/6759438

Miller, James (1994) *The Passion of Michel Foucault*. New York: Anchor Books.

Mingus, Mia (2014) "Pods and Pod Mapping Worksheet" for *The Bay Area Transformative Justice Collective Website*. < https://batjc.wordpress.com/pods-and-pod-mapping-worksheet/>

Mol, Annemarie (2003) *The Body Multiple: Ontology in Medical Practice*. Durham: Duke University Press.

Morris, Ruth (1995) *Penal Abolition: the practical choice.* Toronto: Canadian Scholar's Press.

Morrow, Marina; Dagg, Paul; Pederson, Ann (2008) "Is Deinstitutionalization a Failed Experiment" in *Journal of Ethics in Mental Health*. 3:2.

National Institute for Mental Health (2007) "NIMH Special Symposium: Mental Illness, the Person, the Prison" On http://www.nimh.nih.gov/research-priorities/scientific-meetings/2007/nimh-special-symposium-mental-illness-the-person-and-prison.shtml

Nehis, Nadine (1998) "Borderline Personality Disorder: Gender Stereotypes Stigma, and Limited Systems of Care" In *Journal of Mental Health Nursing*. 19:2.

Niemimaa, Marko (2014) "Sociomaterial Ethnography: Taking the Matter Seriously" In *MCIS Proceedings.* Paper 45.

Nikoleyczik, Katrin (2012) “Towards Diffractive Transdisciplinarity: Integrating Gender Knowledge into the Practice of Neuroscientific Research “ In *Neuroethics* 5. 231–245.

Orr, Jackie. (2006) *Panic Diaries: A Genealogy of Panic Disorder* Durham: Duke University Press.

Paris MD, Joel (2005) "Recent Advances in the Treatment of Borderline Personality Disorder" In *Canadian Journal of Psychiatry*. 50:8.

Paris, Joel MD (2004) "Is Hospitalization Useful for Suicidal Patients with Borderline Personality Disorder?" In *Journal of Personality Disorders*. 18:3.

Paris MD, Joel (2007) "Why Psychiatrists are Reluctant to Diagnose Borderline Personality Disorder" In *Psychiatry* 4:1.

Paris MD, Joel (2015) "The Natural History of Personality Disorders: Recovery and Residual Symptoms" In *Canadian Journal of Psychiatry*. 60:7.

Parsons, Talcott (1951) *The Social System*. New York: Routledge.

Papadopoulos, Dimitris (2010) “Insurgent Posthumanism” In *ephemera: theory & politics in organization*. 10:2. 134 – 151.

Pershall, Stacy (2011) *Loud in the House of Myself; memoir of a strange girl.* WW Norton.

Petersen, Alan (2004) *Engendering Emotions*. Palgrave MacMillan. http://www.palgrave.com/us/book/9780333997376

Pickersing, Andrew (1995) *The Mangle of Practice, Time, Agency, Science*. Chicago: University of Chicago Press.

Pickering, Andrew (2011) *The Cybernetic Brain: Sketches of Another Future*. Chicago: University of Chicago Press.

Pickersgill, Martyn (2010) "Psyche, soma, and science studies: New directions in the sociology of mental health and illness" In *Journal of Mental Health,* August; 19(4): 382–392

Pickersgill, M., van Keulen, I. (Eds.), *Sociological Reflections on the Neurosciences*. Advances in Medical Sociology, Vol. 13. Bingley: Emerald

Pols, Jeanette. (2014) Knowing Patients, Turning Patient Knowledge Into Science. *Science, Technology & Human Values*. 39(1), 73 – 97.

Pratt, Anna (2005) *Securing Borders: Detention and Deportation in Canada*. Vancouver: UBC Press.

Reddy, William. (1997). “Against Constructionism: The Historical Ethnography of Emotions” In *Current Anthropology* 38:3.

Rembis, Michael (2014) “Chapter 8: The New Asylums: Madness and Mass Incarceration in the Neoliberal Era” in Ben-Moshe, Liat; Chapman, Chris and Carey, Allison C. (Eds) *Disability Incarcerated: Imprisonment and Disability in The United States and* Canada. Pp: 139 – 157.

Rimke, Heidi and Brock, Deborah (2011) “Chapter 9: The Culture of Therapy: Psychocentrism in Every Day Life” In Brock, Deborah; Thomas, Mark and Raby, Rebecca (eds) *Power and Everyday Practices* Nelson.

Rimke, Heidi and Hunt, Alan (2002) “From sinners to degenerates: the medicalization of morality in the 19th century” in *History of the Human Sciences*. 15:1.

Ritterbusch, Amy (2012) “Bridging Guidelines and Practice: Toward a Grounded Care Ethics in Youth Participatory Action Research” In *The Professional Geographer*, 64:1, 16-24.

RØmer Christensen, Hilda and Hauge, Bettina (2012) *Feminist Materialisms.21: Kvinder kon og forskning.* ISSN 0907-6182

Rose, Nikolas (1990) Governing the Soul : Technologies of Human Subjectivity, New York: Routledge.

Rose, Nikolas. (2006ii) “Disorders Without Borders? The Expanding Scope of Psychiatric Practice” In *BioSocieties*.

Rose, Nikolas (2006) *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty- First Century.* Princeton: Princeton University Press.

Sansone and Sansone (2009) "Borderline Personality and Criminality" in *Psychiatry* 6:10.

Sapers, Howard (2008) *A Preventable Death: Report into the death of Ashley Smith in Custody*. Office of the Correctional Investigator, Government of Canada.

Sapers, Howard (2014) "Annual Report of the Office of the Correctional Investigator 2013 - 2014" by the *Office of the Federal Correctional Investigator, Government of Canada.*

Saxon Hunt, Michelle (2003) "Understanding Countertransference with Patients Diagnosed with Borderline Personality Disorder: a Exploratory Qualitative Investigation" in *Philadelphia College of Osteopathic Medicine.* PhD Dissertation.

Schneider, Joseph (2002) “Reflexive/Diffractive Ethnography” In *Cultural Studies* < - > *Critical Methodologies*, 2:4. 460 – 482.

Shanker, Stuart (2016) *Self-Reg :How to Help Your Child (and You) Break the Stress Cycle and Successfully Engage with Life*. Toronto: Viking Press.

Shaw, Claire and Proctor, Gillian (2005) “Women at the Margins: A Critique of the Diagnosis of Borderline Personality Disorder” In *Feminism & Psychology* 15: 483.

Shotter, John (2014) “Agential realism, social constructionism, and our living relations to our surroundings: Sensing similarities rather than seeing patterns “In *Theory & Psychology.* 24:3. 305 – 325.

Sim, Joe (2005) “At the Centre of a New Professional Gaze: Women, Medicine and Confinement” in Chann, Chunn and Menzies (Eds) *Women, Madness and the Law.* London: Glasshouse, pp 211 – 226.

Skolbekken, John-Arne (2008) “Unlimited Medicalization? Risk, and the Pathologization of Normality” In Peterson, Alan and Wilkinson, Iain (Eds) *Health, Risk and Vulnerability*. London: Routledge

Smith, Caleb (2009) *The Prison & The American Imagination*. New Haven: Yale University Press.

Smith, Linda Tuhiwai (2005) “Chapter 4—On Tricky Ground: Researching the Native in the Age of Uncertainty”. In Norman Denzin and Yvonna Lincoln (eds), The Sage Handbook of Qualitative Research, Third Edition. Thousand Oaks, CA: Sage, pp. 85-107

Stein, Arlene (2001) "Revenge of the Shamed" In *Passionate Politics: Emotions and Social Movements* Eds: Jeff Goodwin, James M. Jasper, and Francesca Polletta. University of Chicago Press.

Stone MD, Michael (1986) *Essential Papers on the Borderline Disorders*. New York: NYU Press.

Szasz, Thomas S. (1960) "The Myth of Mental Illness" In *American Psychologist*, *15*, 113-118.

Szasz, Thomas S. (2011) *The Myth of Mental Illness: Foundations of Theory of Personal Conduct*. HarperCollins.

TallBear, Kim (2014). “Standing with and speaking as faith: A feminist-indigenous approach to inquiry” [Research note]. *Journal of Research Practice*, *1*0:2, Article N17.

Tillmann-Healy, L. (2003) “Friendship as Method.” *Qualitative Inquiry* 9:5. 729–49.

Thiele, Kathrin (2014) “Ethos of Diffraction: New Paradigms for a (Post)humanist Ethics” In *Parallax* Vol. 20, No. 3, 202–216.

Van der Tuin, Iris (2014) “Diffraction as a Methodology for Feminist Onto-Epistemology: On Encountering Chantal Chawaf and Posthuman Interpellation” In *Parallax* 20:3. 231-244.

Van Nuys, Vincent (n.d.) *An Interview with Dr. Joel Paris on the Treatment of Borderline Personality Disorder.* Wise Counsel; An interview series by Mental Health Services of Southern Oklahoma.<http://www.mhsso.org/poc/view_ doc.php?type=doc&id=33799>

Wacquant Loic (2009) *Punishing the Poor: The Neoliberal Government of Social Insecurity*. Durham: Duke University Press.

Wacquant, Loic (2005) “Carnal Connections: On Embodiment, Apprenticeship, and Membership“ In *Qualitative Sociology*, Vol. 28, No. 4, Winter.

Walia, Harsha (2013) *Undoing Border Imperialism*. Oakland: AK Press.

Walters, Mikel L., Jieru Chen and Matthew J. Breiding (2013)*The National Intimate Partner and Sexual Violence Survey: 2010 Findings on Victimization by Sexual Orientation*. National Center for Injury Prevention and Control for Disease Control and Prevention.

Warner, Joanne (2008) “Community Care, Danger and the Shifting Locus of Danger and

Vulnerability in Mental Health" In Peterson, Alan and Wilkinson, Iain (Eds) *Health, Risk and Vulnerability*. London: Routledge. Williams, Simon J. (2000) "Reason, emotion, embodiment: is 'mental health' a contradiction in terms?" In *Sociology of Health and Illness*. 22:5.

Weijun Wang, Esmé (2016) "Who Gets to be the 'Good Schizophrenic'?" in Buzzfeed News.

West, Gordon and Morris, Ruth Eds (2000) *The Case for Penal Abolition*. Canadian Scholars Press

Whittier, Nancy. "Emotional Strategies: The Collective Reconstruction and Display of Oppositional Emotions in the Movement Against Child Sexual Abuse." *Passionate Politics: Emotions and Social Movements.* Eds. Jeff Goodwin, James M. Jasper, and Francesca Polletta. Chicago: The University of Chicago Press, 2001. 233-250

Wilkins, Amy (2008) *Wannabes, Goths and Christians: the boundaries of sex, style and status.* Chicago: University of Chigago Press.

Williams, Simon J. (2000) "Reason, emotion, embodiment: is 'mental health' a contradiction in terms?" In *Sociology of Health and Illness*. 22:5.

Williams, Simon J. (2001) "Why Emotions, Why Now?" In *Emotion and Social Theory: Corporeal Reflections on the (ir)rational*. London: Sage Books.

Wilson Gilmore, Ruth (2007) *Golden Gulag: Prisons, Surplus, Crisis and Opposition in Globalizing Califormia.* Berkeley: University of California Press.

Wirth-Cauchon, Janet (2000) *Women and Borderline Personality Disorder: Symptoms and Stories*. Rutgers University Press.

Wiseman, Frederick. (1967) *Titicut Follies*.

Zabrodska et. al. (2011) " Bullying as Intra-active Process in Neoliberal Universities" In *Qualitative Inquiry. 17:8.*