What Does Borderline Do? An Ethology

by

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ABSTRACT

This thesis grapples with the discourse and materiality of 'borderline personality disorder (BPD),' a highly stigmatized psychiatric label for a cluster of relational and affective patterns with several unresolved clinical and theoretical debates. While feminists have long critiqued the diagnosis as inherently misogynistic, Mad-affirmative scholars have called for more nuanced accounts of the borderline concept and experiences. For example, the borderline diagnosis can be resonant and relieving for some, and borderline affects and worldviews can be insightful: ontologically, epistemologically, and ethically. Alongside Mad scholarship, there has been an increase in mainstream awareness-raising and activism surrounding 'BPD,' situated within the lens of psychiatry and pathology. These psychocentric and Mad-affirmative efforts to destigmatize borderline are very different from each other, and yet both seem to be located in white, globally elite spaces. We can thus learn from other reclamation movements that, co-opted by the colonial state and neoliberal market, have mainly benefited globally elite populations. Similarly, then, any universalizing attempt to reclaim, recategorize, or reconceptualize borderline risks benefiting "acceptable" (white, cisgender, affluent, globally elite) borderlines, while continuing to criminalize, pathologize, and neglect structurally precaritized people that present as or are labeled as borderline. Intersectional oppression patterns experiences and perceptions of borderline: who gets diagnosed and how, and what the borderline label then does for them.

Thus, rather than unpacking what borderline really *is* or *should mean*, this thesis asks what borderline *does,* for whom, and in which socio-political contexts. To do so, I use French philosopher Gilles Deleuze's analytical method of ethology, which moves us from asking ontological questions (what something is) to ethological questions (what something does). To introduce my ethology, I draw on Deleuze as well as transnational queer theorist and disability scholar Jasbir Puar, who integrates Deleuzian theory with intersectionality. Importantly, this thesis

asks not only what borderline does and in which contexts, but what it does and *towards what ends.* Following Deleuze and Puar, this question necessitates an ethical and political analysis of not only borderline's differential effects, but what systems various uses of borderline are serving. In other words, this thesis acknowledges borderline's socio-political patterns, as well as the broader agendas we might be inadvertently serving in our clinical practice, activism, and societal discourse about borderline.

After introducing the appropriate literature, theoretical, and methodological background, I present my argument over two chapters, drawing on theory-based methods to analyze my own auto-ethnographic writing, borderline scholarship, popular discourse, social media posts, and clinical literature. I first analyze what (else) borderline affects and worldviews can do, beyond what psychiatry says about 'BPD.' This section has several clinical and micro-political implications. I then trace what various destigmatizing discourses about borderline and 'BPD,' from both Mad-affirmative and psychocentric perspectives, do, for whom, and towards which macro-political ends. Drawing on Jasbir Puar's work on the geopolitics of disability, I show how much of our seemingly progressive work on borderline and 'BPD' is likely serving Euro-American empire, whiteness, capital, and (settler) colonialism, and thus perpetuating health disparities that no reclamation of 'BPD' can ameliorate. I conclude this thesis with several implications for clinical practice and research, mental health advocacy and reclamation movements, and Mad scholarship and activism.

PREFACE

This thesis is an original work by Erin Tichenor. The methodological use of an 'advisory group' (see Chapter Two), which contributed to all chapters in the thesis, received research ethics approval from the University of Alberta Research Ethics Board, Project Name "What does borderline do? An advisory group," No. Pro00131750, on August 24, 2023.

Chapter Three of this thesis represents a version of an article that is currently under review for publication; it has not been accepted or published anywhere. The article, entitled, "What does borderline do? A Deleuzian ethology of 'borderline personality,' is a collaborative piece written by me (Erin Tichenor), Dr. Tim Barlott, and Eduan Breedt. For this paper, Tim and I led the conceptualization and theoretical framing of the manuscript. I wrote the initial draft of the manuscript, with Tim contributing to various sections and reviewing iterations of the draft. Eduan supported further theoretical development and writing after the initial draft, and both Tim and Eduan provided editorial support in the final versions of the draft. In Chapter Three, I outline how I have modified the manuscript for the thesis. That is, I have not replicated the manuscript that is under review for publication, but many of the elements are the same. I have added and removed context in order for the chapter to flow with the broader thesis, and I have added empirical sections that we excluded from the submitted manuscript due to word count requirements.

Chapter Four of this thesis somewhat resembles a commentary piece that has been accepted and is undergoing its final revisions for publication with *Atlantis: Critical Studies in Gender, Culture, and Social Justice.* I am the author of the article, which is entitled, "Reflections from 'Revisioning Feminist Engagements with Madness:' Borderline, Futurity, and Debility." The short commentary piece offers some theoretical and methodological background, which may slightly resemble small portions of Chapters One and Two. The commentary piece has a few focused paragraphs on some of the theory and concepts used in Chapter Four, but only small sections are replicated. In Chapter Four, I have expanded the arguments, incorporated empirical data, and furthered the theoretical analysis. Tim offered supervisory support to this article, and to all components of the thesis project.

DEDICATION

He aha te mea nui o te ao? He tangata! He tangata! He tangata!
What is the most important thing in the world? It is the people, the people, the people.

Ka warea te ware
Ka area te Rangatira
Hongihongi te whewheia
Hongihongi te manehurangi
Kei au te Rangatiratanga

Ignorance is the oppressor
Vigilance is the liberator
Know the enemy
Know the destiny
Determine our own Destiny

(Māori Whakataukī or proverbs)

This thesis is dedicated to whānau in Tāmaki Makaurau who are experiencing or have experienced houselessness, engaged with ‘mental health,’ substance use, or other social services, in particular, tāngata whenua who are experiencing the ongoing effects of settler colonialism in Aotearoa on taha tinana, taha hinengaro, taha whānau, taha wairua, mana motukahe, and whenua tapu. E iti noa ana nā te aroha.

ACKNOWLEDGMENTS

I would like to thank all those who supported this 'small thing given with love.' I first want to acknowledge and thank my ancestors, parents, and all the work and sacrifice they put into raising me and Sean, and in supporting us through the ups and downs of the past several years.

Several generations ago, my ancestors came from England, France, and Ireland to what is called the United States. They have mainly settled in the states of Kentucky and Michigan. They experienced hardship, but also likely benefited from federal policies that supported White, Northwestern European immigrants, at the expense of enslaved African people, Native Americans, European ethnic minorities, and Latin American, African, and Southeast Asian migrants (Brodkin, 1998; Glenn 2011; Katznelson 2006; Lee 1993). Various systems such as white supremacy, settler colonialism, and American empire, have thus greatly shaped my being here, and writing this project.

I also want to thank the lands and waters that have nourished me throughout my life. Though I have never connected with the rivers and lands in England, I have learned much from Māori, and more recently, nêhiyawak, about the importance of knowing where we come from and who calls us home. (Settler) colonialism, chattel slavery, and imperialism have squandered this opportunity for so many Black and Indigenous people, as well as forced migrants around the world. As an aside, then, I want to highlight the harms done by the erasure of Black and Indigenous histories, stories, knowledge, lands, and communities, while reflecting on the consideration that colonialism is harmful to white folks (though in much different ways); desire has been assembled to convince us otherwise (Buchanan 2020; DuBois [1935] 1988). As white settlers, we stripped ourselves of our specific cultural identities, knowledges, and traditions to assimilate into the project of white supremacy, nationhood, and wealth accumulation, supported by federal policies meant to bolster the white nation-state (Brodkin 1998). Whiteness has been made to be an identity based on lack (based on not being not white); based on the oppression of other people (see Baldwin 1962; Morrison 1993, in Hyman 2019). Part of my commitment, then is, to challenge these systems, respect and honor Indigenous cosmologies and worldviews, *and* to learn who I am. I have not done this journey, but this thesis has pushed me to realize the importance of this work for my own well-being and for speaking back to white institutions and violence (Hesse, in Rico and Sargent 2021).

For now, I want to thank and acknowledge the stolen lands upon which I was raised: the lands of the Anishinaabek (The Three Fire Confederacy of the Odawa, Ojibwe, and Bode'wadmi), the Wyandot and Meswaki nations, and the waters of Giwitatigweiasibi (Huron River), and the Great Lakes that I played in and drank from. I received by education, and am still greatly influenced by the people I met, on the lands of the Wampanoag and Massachusett people. In 2018 and 2020-2022, I was nourished by the lands of and waters surrounding Aotearoa, in particular, the Waitematā and Manukau harbors and the freshwater stored in the Waitākere and Hūnua ranges. I was also supported, fed, housed, challenged, taught, and cared for by various mana whenua (people of the land) and manuhiri (visitors) of Tāmaki Makaurau, all of whom I am grateful for. I want to thank every person that I worked with in Aotearoa. I would not be aware of so many of the harms of our social service and health systems if it was not for the lessons that you have taught me. I now live and work in amiskwaciwâskahikan, the homelands and gathering grounds of the nêhiyaw, Dené, Anishinaabe, Nakota Isga, Niitsitapi, and Iroquois peoples, as well as the Inuit and the Métis Nation of Alberta. I am grateful to play along and drink from kisiskâciwanisîpiy, the North Saskatchewan River, and for the hospitality of the guardians of these lands. While I learn more about where I come from and commit to supporting Indigenous people and their knowledges, my main intentions with this thesis is to call out various forms of white and colonial violence.

I also want to thank the various clinicians that have and continue to support me. Thank you to my committee members and examiners, Gayla Grinde, Pier-Luc Turcotte, Lindsay Eales, and Tim Barlott, for holding me accountable, guiding me, challenging me, and supporting me. Thank you especially to my supervisor, Tim Barlott, for generously supporting me over the past few years. I appreciate your guidance, encouragement, wisdom, approachability, theoretical and methodological insight, and respect for students. I also want to thank Angela Libutti for all of the support that you continuously provide to me and all students in the Faculty of Rehabilitation. Thank you to my advisory group for all your care, time, and thoughtfulness: Verity Armstrong, Karlene Schwencke (Mamea), Stephanie Dixon, Kim Smith, Sarah Redikopp, Francesca Lewis, Nathan Fawaz, and Tiffany Sostar (see Chapter Two).

Finally, thank you Eduan. Thank you for loving, learning, living, and growing with me and alongside me. Thank you for being my partner in life and in scholarship, in reading and in pointing at things, in writing and in music, in conversation and in silence. Thank you for encouraging this work, and for all the insight you have offered for it. Thank you for everything.

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CONTENT NOTE

This thesis includes discussion of mental distress, including and beyond those specific to ‘borderline personality disorder’ symptom criteria. This includes reference to self-injury, suicidal ideation, suicidal planning, and suicide attempts, as well as anger, impulsivity, and paranoia. In addition, there is significant discussion about psychiatric harm, as well as other forms of colonial violence. In terms of psychiatric harm, I discuss or mention some specifics, but do not go into much detail: institutional labels, medication, discrimination, neglect, and restraint. Some of this includes my own experiences, and much references other people’s experiences or writing about the experiences. There is the odd reference to sexual assault or abuse, not in detail, but in terms of politics and discourse and in relation to psychiatry. Harm, violence, and distress come in many forms, not just those typically covered in content notes. In terms of colonial violence, I do not go into graphic detail because it is not my place to do so; I do, however, call out and mention forms of violence that often get glossed over, such as anti-black police violence, racialized psychiatric violence, the violence of the criminal justice system, Israel’s genocide against Palestine, and the intergenerational effects of Euro-American colonialism. Some of these references are political and theoretical, to emphasize my points, and others are with specific reference to the ways that psychiatric practices as well as destigmatizing efforts can perpetuate colonial violence. I do not flag all the instances these topics come up, though some may be obvious by way of heading or section title. I leave it up to the reader and their communities to discern whether and how they read, skip, or modify their reading of various sections.

CHAPTER ONE: WHAT SHOULD WE DO ABOUT BORDERLINE?

1.1 Meta-narrative

This thesis is, in part, a storytelling of itself, or rather, of the process of conducting this project. While these chapters make an argument about "what borderline does," they also narrate an epistemological journey about my changing relationships to 'borderline personality disorder (BPD),' Deleuzo-Guattarian theory, intersectionality, and various forms of borderline activism.[1] In contrast to many academic works, I want to start where I started, rather than where I ended – to value the learning process and not only the outcome. Although I cannot really 'go back' to 2022, neither can I pretend to have simply 'arrived' at the concluding chapter. It is my hope that by documenting some of the shifts involved with this project, I can affirm that we can change our minds, and that inductive work is not always about discovering the empirical. Induction can also be about our encounters in the world, with social theory, with books, with our gut feelings, with being challenged, with paradox, and with the political world. In this meta-narrative, I provide an overview of this story, starting with my entry points to asking what borderline does or can do (of course, nothing 'started' there). I hope this meta-narrative provides an incomplete, yet somewhat overarching narrative of the thesis, which itself spends significant time tracing why the questions and analyses generated in the literature review are not quite the questions and analyses generated in Chapters Four and Five. Many of the differences can be attributed to a political shift in my orientation to madness[2] and Mad mobilizing, but much was also caught up in onto-epistemological

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[1]Later in this chapter, I describe the distinctions I make between borderline and 'BPD.' I use 'borderline' colloquially throughout this thesis, particularly with regards to the question I started with: what does borderline do? For much of my research, I clumped various aspects of borderline discourse together into the unstable concept of 'borderline.' However, as I make clear in Chapters Two, Three, and Four, I gradually teased out the various assemblages of borderline and 'BPD,' how they are distinct, and what they each do. Briefly, I tend to refer to 'BPD' to denote the labeling of and/or identification with 'BPD' as a "personality disorder," as defined by psychiatry. I use borderline, specifically borderline 'knowing' or 'experiences' to refer to borderline as a cluster of unique experiences and worldviews, conceptualized by Mad scholars in critical opposition to psychiatry's pathologization of these experiences as "personality disorders."

[2] I use madness to refer to mental, spiritual, emotional, neurological, cognitive differences from the supposed 'norm,' imposed by Western psychiatry and its correlates in European humanist notions of the body and mind (Liegghio 2013; Rashed 2019). This conceptualization is taken from Mad Studies, which, along with various Mad activist movements, has reclaimed the derogatory notion of being 'mad' and politicized it (LeFrancois, Menzies, and Reaume 2013). I thus capitalize Mad to refer to this politicization of being psychiatrized or otherwise deemed as 'insane' in order to call out the harms of psychiatry, including how it labels what (and who) is abnormal/normal, and health/unhealthy, and its punitive and biomedical responses to mental distress and mental difference. I discuss Mad Studies more later in Chapter One.

shifts enabled by reading the work of transnational queer theorist and disability scholar Jasbir Puar, which I detail more in Chapter Two.

January 24, 2024: Autotheoretical note on epistemological process
The journey through this thesis – the movement through Mad Studies, affirming borderline, Deleuzo-Guattarian analyses, and uses of Deleuzo-Guattarian theory and critical race theory in the context of empire – is all epistemologically interesting. Or at least, is interesting to me, and has been helpful for my own distress and I think, ability to apprehend how power shapes and is shaped by borderline and 'BPD' discourses. If I were to start this MSc again, I might start straight from Puar's analyses in the context of madness and disability (Chapter Four). I only want to write Chapter Four, but I also want to value the shifts that the former chapters offer – the various things that borderline, theory, and the world have done to me. How silly (and colonial) to think or hope that I could restart or skip steps as if these journeys – affective, theoretical, political, relational, embodied, emotional – are not the work itself. Scholarship, or whatever, is not about the outcome, but the process, as much as we like to focus on the output.

Throughout this thesis, I have included a few footnotes, dated text boxes, and images, all of which denote a break or deviation from the main flow of text. Although I have not made hard and fast rules about what to present in a footnote and what to present in a text box, the two formats have served very different functions for me throughout the thesis. I have used footnotes in order to clarify concepts for myself during the writing and editing process, as well as to provide clarity for readers. I use footnotes for clarification, definitional coherence, reference to broader theories, acknowledgment of the shortcomings of my argument, and (often retrospective) caveats to what I am writing. Footnotes thus contain more academic writing, references to other scholars and theorists, and serve as nods to the larger web of theories and disciplines that I am drawing from and connecting to. The textboxes, on the other hand, purposefully stand alongside and in disruption of the main flow of text, valuing the viscerality of this autotheoretical project; I have selected them from a larger range of autotheoretical reflections that informed this thesis. I did not write these text boxes – and those reflectsions I have not included – while writing this thesis (in Spring 2024), but prior to it, and as part of a separate process in Fall 2023 (what one might call my 'data collection;' see Chapter Two). That is, the writing in these text boxes made the thesis possible; they contain w*hat I needed to write in order to write this thesis.* They include auto-ethnographic description or poetry about various encounters with borderline, autotheoretical writing about borderline, and general theoretical reflections; I denote the type of entry in each heading. They include a range of formal and informal writing styles, but they all contain elements of the visceral and raw, rather

than edited and formalized. I am grateful for Nathan Viktor Fawaz, who pointed out these distinctions and the value of not just visceral imagery or autoethnography, but visceral theorizing.[3] I have included these text boxes in part to value the less formal writing that is still theorizing, as well as to show and value my methodological process of working through this topic, theoretically and affectively. Rather than converting all analysis into palatable academic language, I want to value the abject and 'incoherent' for their theoretical insight and methodological value (on valuing the abject, see Redikopp 2018; on autotheory, see Fournier 2021, Zwartjes 2019a, b; on research creation, see Chapman and Sawchuk 2012, 2015). Finally, these various forms of reflections also highlight my reliance on chronological thinking, and the tension that arises when I am faced with the reality that ideas, knowledge, and even time itself, do not work in such a linear fashion. Although I have not put too much thought or intention into my relationship to chronicity in this thesis, I want to thank Nathan again for asking about this elision.[4] Briefly, I note that I have only made sense of this thesis by way of organizing when "I thought this, and did that," and when "this changed and then I did something else," as shown by my distinction between what I wrote before, during, and after the drafting process. These distinctions perhaps help me story the process for myself, but notably, they also reify a linear, Western, and settler colonial view of time, rather than valuing and sitting with the contradictions inherent in my (and our collective) work; these contradictions and paradoxes are not indicative of disruptions of a linear process, but rather, of the constant tensions inherent to something like a thesis, an opinion, or a piece of autotheoretical work – tensions that bring past, present, and future together into one.

1.1.1. Entry points and the story of this thesis

I was first introduced to the concept of 'borderline' in 2020 while working at a social services organization in Tāmaki Makaurau (Auckland), Aotearoa New Zealand. I worked as a kaitohutohu (key worker) in their transitional housing facilities, both co-ed and for those who identify as women. The latter was supposedly a therapeutic housing service, though the Covid-19 pandemic (among other things) made group and individual therapy quite difficult if not impossible. After all, the psychotherapists and psychologists were working from home and trying to do phone appointments; I will not go into the details of why this did not work. Throughout my few years at this organization, there were massive shifts in the level of therapeutic discussion and influence

[3] Personal communication, April 25, 2024.
[4] Personal communication, April 25, 2024.

over our practice as case managers, shift leaders, support staff, and incident responders. I highlight these shifts through discussion of 'borderline personality organization,'[5] with a note that all approaches to borderline held similar underlying stigma, cloaked with various degrees of palatable psychotherapeutic language. Notably, people I worked with that were labeled as borderline all experienced extreme forms of structural inequality, and experiences caught up with inequality such as polysubstance use, inpatient institutionalization, criminal justice system involvement, Oranga Tamariki (Ministry for Children) care or removal of their children, racialization, transphobia and misogyny, poverty, rough sleeping, and transient housing. Several of the people referred to as borderline were racialized migrants or wāhine Māori (Indigenous women), which adds to the layers of harm done by pathologizing and dismissive accounts of their experiences.

In the co-ed house, we were first taught to 'handle borderlines' with pretty punitive approaches; some staff referred to people with frequent 'borderline behaviors' as 'actors' and 'manipulators;' this ultimately led to someone's near-fatal overdose being dismissed for hours. Two years later, we had reached a point where our in-house psychologist wrote up an information sheet about 'BPD' for staff so that we could better understand its presentation and how to respond. Perhaps because of their limitations as a registered psychologist, from upper management, or otherwise, this info sheet was not all that much more therapeutic or non-Western than the mainstream conceptualization of borderline (as I expected it to be, given the kaupapa Māori therapeutic approach we were supposedly taking). People called borderlines' anger was described as "inappropriate; they behave recklessly; they have irrational fears." At least, however, the info sheet suggested that we be empathetic and listen.

In the years between these two extremes, the punitive lesson and the therapeutic lesson, the invocation of 'borderline,' 'borderline traits, or 'being a borderline' – officially diagnosed by the mental health system or suggested by our psychotherapy team – warranted serious discussion at clinical meetings. At both facilities, some psychotherapists normalized that borderline service users, or tāngata whaiora[6], were 'the most difficult ones,' given the 'emotional roller coasters' they bring staff members on. We, as staff, were taught about borderline mood swings, suicidal tendencies, attachment issues, and the importance of non-reactivity and 'firm boundaries.' Having

[5] Originally introduced by Kernberg (1967), used by many therapists and scholars to highlight the organization of one's personality, or sense of the self and of others; many use this in contrast to the language of a 'disorder.'
[6] In te reo Māori, "people seeking health;" often used to refer to people that use mental health services.

boundaries, which is often invoked in 'mental health' settings, meant that we were to share little or nothing about ourselves with people, that we should not let our emotions get shaped by the emotions of tāngata whaiora, nor let them guide our actions; we were also taught to be firm, assertive, and confident with shutting down any attempt to 'push our buttons,' 'break the rules,' or 'manipulate' us in any way (see Barlott and Setchell 2023; Shevellar and Barringham 2016). When someone who even resembled a borderline was angry, we were supposed to 'teach them to regulate' and that's it – even if their anger was rightfully directed at the organization's harmful policies. Amidst this, the public mental health system's staff perpetuated the idea that we should be suspicious of borderlines. For example, a mental health nurse once said to me something along the lines of, "it's all behavioral. They know their court date is coming up. They're acting so they can get under the mental health act again.[7] They don't really have mental health [sic]" – this is, despite their multiple suicide attempts. This invocation of 'BPD' as a 'behavioral issue' and therefore 'chosen' is common, and justifies the need for non-response from practitioners, lest we/they 'reinforce bad behavior' by providing support during a crisis (Aves 2023, cited in Jones and Lomani 2023:98). With the advice of these various practitioners, we were left with few tools other than to 'not give in' to the emotional crises of the women, femmes, and non-binary people that came through our services with various degrees of borderline 'organizations.'

As the years went on, I became increasingly frustrated with these approaches. I was confused about why we were pathologizing borderline sensitivity and insights, given how justified their anger or other behaviors were. I wondered if there were more affirmative approaches out there. Perhaps unsurprisingly, I ended up having a distressing depressive episode of my own, leading to my first psychiatry visit in three years, a diagnosis of borderline traits, the realization that my therapist had been using borderline-targeted therapy for two years, and later, to this "diagnosis-that-must-not-be-named," followed by other diagnoses (Cannon and Gould 2022). I note that my diagnos(es) are still provisional, in-process, and up for contestation by my treatment team, and that I 1) did not have the 'BPD' diagnosis brashly and immediately applied to my file,

[7] Similar to being 'formed' in Canada (O'Reilly and Gray 2014). Being 'formed,' 'sectioned,' or 'put under the mental health act' refers to the use of legal policy to limit or restrict the rights of people based on their supposed mental capacity, based on a psychiatric evaluation (Changing Minds 2021). These policies, accompanied at times by police force, can be used to force people to take medications, to engage with outpatient services, and/or to be involuntarily committed to inpatient treatment. In this context, getting 'under the act' refers to the role that being sectioned has in determining legal culpability or responsibility for an action, and whether or not someone will face legal consequences such as imprisonment or deportation, will be forced to undergo 'mental health' treatment, or both.

and 2) I have had several clinicians contest my diagnoses. In contrast, many people (including those I worked with) get the label without question or further deliberation; these differences in experiences with the diagnosis will become important throughout this thesis.

Looking back, I do not necessarily disagree with some of the advice given about boundaries (with several caveats), and about trying to provide a sense of stability for people in extreme distress. What I, and many other borderlines might take issue with (besides the whole notion of a 'disordered personality;' see the literature review) is the dismissive nature with which psychiatric professionals talk about and respond to borderlines and our behavior. That our anger is inappropriate, and we should be taught that it affects other people. Seldom was it acknowledged why we might be angry, or what that might say about the environment. Seldom was there validation, empathy, or curiosity. In Deleuzo-Guattarian terms, seldom were our actions seen as outcomes of the productive nature of desire, rather than desire-as-lack. Borderline behaviors were merely projections of our Oedipal complexes – our "daddy-mommy-me" triangles – onto the socio-political world, rather than the other way around, or both (Deleuze and Guattari [1972] 1980:23).

As is perhaps obvious from the above reference, I was reading Deleuze and Guattari's two volume book, *Capitalism and Schizophrenia,* during my last few months at this organization. In *Anti-Oedipus* and *A Thousand Plateaus,* Deleuze and Guattari introduce a new theory of desire, taking into account Karl Marx's analysis of the capitalist political economy and Sigmund Freud's analysis of the libidinal economy. To do so, they offer an affirmative, though highly conceptual, reading of schizophrenia (and madness more broadly). They interrogate what 'psychotic' experiences can indicate, produce, initiate, and transform, beyond psychoanalysis' Oedipalizing interpretations of neurosis, or its claim that psychotic experiences are simply 'unanalyzable' (Lewis 2023ba). In short, Deleuze and Guattari's work, as well as Māori conceptualizations of emotional distress and difference, informed my clinical practice and offered new ways for me to conceptualize madness, and the ways that we respond to pathologized behaviors (see Kopua, Kopua, and Bracken 2020; Ngata 2014; NiaNia, Bush, and Epston 2016, 2019; Taitimu, Read, and McIntosh 2018).

Early in my Master's program, I was thus conceptually interested in the productive nature of borderline, as well as clinical approaches that affirm and validate borderline insights (for example, into injustice). As I navigated my own diagnoses, relationship to psychiatry, and potential

thesis projects here in Canada, I came across the few pieces out there that do just that. Mad and Mad-affirmative scholars like Rebecca Lester (2013), Merri Lisa Johnson (2015, 2021, 2024), Sarah Redikopp (2018), and Francesca Lewis (2023a, b) have pushed back against the rampant stigmatization of borderlines, as well as those that reject the validity of the concept all together. They remind us that the 'borderline' concept can be uniquely resonant and relieving, despite the harmful terminology of 'personality disorders.' Furthermore, what are called borderline 'traits,' like other forms of madness, can be valuable and insightful: ethically, politically, and onto-epistemologically. Following lived experience scholars Johnson, Redikopp, and Lewis, I also draw a messy distinction between psychiatry's conceptualization of 'BPD,' psychocentric[8] approaches to reclaiming 'BPD,' and Mad approaches to affirming 'borderline knowing' (for a discussion of how I conceptualize these distinct assemblages,[9] see Chapter Two). While acknowledging that "the relationship between BPD and borderline" is "one of contention [and] negotiation" (Redikopp 2018:78), throughout this thesis, I refer to *'BPD'* as the often-harmful psychiatric label that is (supposedly) diagnosed based on having at least 5/9 'borderline traits,' as per the Diagnostic and Statistical Manual of Mental Disorders (DSM). Many psychocentric influencers and advocates are mobilizing around 'BPD,' and I ultimately argue that this form of destigmatization and reclamation participates in the reification of psychiatry and its harms. In contrast, *borderline* is a subjective experience or "constellation"[10] of affects and worldviews that can be painful, but that can also be

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[8] Psychocentrism refers to the mainstream view of mental distress and difference, as headed by psychiatry and related fields: the "view of human problems as pathologies rooted in the mind and/or body of the 'pathological individual'" i.e. by your genetics, brain chemistry, neurobiology, how *you* think/behave (LeFrancois, Menzies, and Reaume 2013:63; see Rimke and Brock 2012; Rimke 2016)

[9] I define assemblages in Chapter Two, but briefly, they refer to evolving arrangements of matter (such as borderline discourse, people, 'BPD' diagnoses, medications, policies, feelings, etc.). As I discuss in Chapter Two, I do not define borderline assemblages only by the components they consist of, but how and why these components come into relation with one another to then produce certain micro- and macro- political outcomes.

[10] I want to thank Sarah Redikopp (personal communication, December 20, 2023) for providing this language of a "constellation" of borderline, which she used to describe the amorphous, yet somewhat coherent, cluster of affects and worldviews that compose what many people call borderline experiences (see also Johnson 2015:653; Redikopp 2018). Sarah, as well as Francesca Lewis (personal communication, November 10, 2023), also helped me to delineate the differences between approaches to 'BPD' and borderline reclamation in my thesis, given the vast and important distinctions between reclaiming these experiences within, or outside of, hegemonic psychiatric frames. At the same time, while I make these distinctions, I acknowledge that I use 'borderline' throughout the thesis without necessarily only referring to the constellation of borderline experiences. This is in part because much of this thesis, particularly Chapters One and Two, is a narrative account of my exploration of borderline, where in my early questions, I did not draw such clear distinctions between borderline and 'BPD.' For example, Chapter Two will focus on the broad question of "what does borderline do," before introducing how I came to delineate the different sub-assemblages of the 'borderline personality' phenomenon, which I analyze more distinctly in Chapters Three and Four. I thus use borderline as the most shorthand way to describe my questions about what I had previously lumped together, that I

epistemologically, ontologically, and ethically valuable (Lewis 2023b). Borderline is often not separate from 'BPD,' but troubles psychiatry's pathologization of these traits as rooted in a "disordered personality." Throughout this thesis, I try to distinguish psychocentric reclamation and Mad affirmation efforts, while highlighting where they overlap, particularly in terms of whiteness, eliteness,[11] and what that means for geopolitics (see Chapter Four).

As I read the Mad scholarship on borderline, I learned more about Mad Studies (thanks also to my committee and coursework) and was interested in its potential for (and history of) de-pathologizing, destigmatizing, and affirming the affects, behaviors, and worldviews that have been so pathologized by Western psychiatry and the systems it is embedded in. To briefly situate us, Mad Studies is a field built upon the activism of people with lived experience of mental distress, who have been pathologized for their mental and emotional differences, or who otherwise have experiences as service users in the psychiatric system (Ingram 2016; LeFrancois, Menzies, and Reaume 2013). Mad Studies is now an international and multidisciplinary field that, like various Mad movements, challenges the assumed 'truths' of psychiatry and other dominant professions that diagnose and treat mental distress and difference (the distinction of which is central to Mad Studies) (White and Pike 2013). Both Mad Studies and Mad activism position themselves as affirming the experiences, identity, politics, and culture of madness, which refers to mental, spiritual, emotional, neurological, cognitive differences from the supposed 'norm' (Liegghio 2013; Rashed 2019). They thus challenge common notions of what is insane and sane, normal, and abnormal, as determined by Western psychiatry, as well as hetero-patriarchy, racism, homophobia, transphobia, and capitalism. They push back against the biomedical model that suggests that mental distress is caused by individual neurobiological and/or chemical deficits, rather than broader socio-political determinants. Mad Studies centers lived experience, as well as allies who

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have now, thanks to Sarah Redikopp, Francesca Lewis, Stephanie Dixon, and Eduan Breedt, have decided to make distinctions between for the purposes of argument.

[11] I use elite to refer to fluctuating positions in relation to the global "ascendency of whiteness" and capital accumulation, where whiteness and socioeconomic advantage definitely do not always co-exist but are highly related to one another in terms of global domination and imaginaries. I draw from Olúfẹ́mi O. Táíwò's (2022) notion of elite in his book, *Elite Capture*. He writes that whiteness and eliteness are not the same but are highly connected. Still, being elite is a constantly changing and contextual relationship with global power: "Sometimes you're an elite because of how people have decided (or been forced) to relate to some aspect of your social identity. Sometimes you're an elite because of some more contingent advantage: your level of education, wealth, or social prestige. Sometimes you're an elite just because you happen to be the only one of your group who's in a particular room" (Táíwò 2022:22). He continues, writing that "The status of elite is not "a stable identity – it's a relationship, in a particular context, between a smaller group of people and a larger group of people" (Táíwò 2022:22).

call out the harms of the psychiatric system, including, but not limited to over-medicating, institutionalization, iatrogenic diagnoses, and the paternalistic, individualistic, and often punitive nature of this supposed 'care.' While Mad Studies is a body of critical scholarship, it also has a practical aim to come up with alternative ways of responding to distress that do not involve state power, state violence, or nonconsensual pathologization (LeFrancois, Menzies, and Reaume 2013). Mad Studies also allies itself with other anti-oppressive movements, particularly "with people who also have complex, ongoing experiences of legislative, institutional, and carceral oppression" (Gorman 2013:269). However, Mad scholars and activists have varying approaches to Mad identity, identity politics, and the relationship between madness and other axes of oppression (i.e. racism, sexism, ableism, classism, and criminalization/incarceration) (see Gorman 2013; Tam 2013). I return to different ways of conceptualizing the solidarity between the Mad movement and anti-racist, decolonizing, and anti-imperial movements throughout this thesis.

Originally compelled by my personal and professional experiences to destigmatize borderline with a socio-political and Mad analysis, I had a deep unease in my gut about any move to reclaim or even reconceptualize borderline. I recalled learning about the co-option of queer liberation, as one example, and worried about the number of white people reclaiming 'mental illness,' or madness, respectively, in psychocentric discourses online and in Mad Studies (Ferguson 2018; Puar 2007; see Chapter Four). I worried about these things, as much as my subjectivity is also caught up in desiring the "mutual aid" of social media influencers and Mad scholars (Johnson 2024). In Deleuzo-Guattarian terms, my interests, given my situatedness in the social field, are shaped in such a way to ignore the demographic makeup of this seeming progress; my politics, however, push me to question why it is that white, elite women are the ones reclaiming borderline from both Mad and psychocentric perspectives. I digress. I began to focus more on how much Mad Studies can learn from how other reclamation and rights-based movements have either lacked socio-political analysis, and/or gotten co-opted by powerful systems, turning into not only watered-down and white-washed, but dangerous versions of themselves. For example, several scholars and activists have traced the ways in which intersectional queer liberation (and thus parts of queer theory) have been co-opted into neoliberal reforms that benefit the imperial state, corporate profit, and by proxy, white elite people, to the neglect *and* expense of everyone else (Connell 2016; Conrad 2013; Ferguson 2018; Jackson 2021; Johnson 2010; Puar 2007). As I have learned, both Mad Studies and Critical Disability Studies have been critiqued for these very

reasons; I outline these critiques later in this chapter, as well as the small, but important work emerging on the intersectional patterning of borderline.

The risk with borderline, for me, had not only to do with what we can learn from queer and disability pride, but with what I had already seen in practice, and what we already know about health disparities, racial inequality, and structural oppression more broadly – both of which teach us how any liberation project, particularly white-led ones, might go. For example, I have largely been protected from psychiatric violence, given the variety of geopolitical, intersectional, and socioeconomic advantages I have, as well as the fact that I have not needed inpatient or involuntary treatment. Yes, borderline has helped me make sense of my experiences with myself, my family, and my therapists, but I have also been sheltered from the stigma of the 'BPD' label, as evidenced by various clinicians' hesitancy to put it on my health record, because I am considered 'one of the good borderlines' (a crisis nurse told me this in 2024), and more trenchantly, my various forms of social advantage. Another nurse told me that "I have a lot of potential [for recovery], because I have gotten all the way to graduate school." What does this same nurse say to a depressed borderline without any higher education? Do they have "potential" or "hope?" What about borderlines who are not white, affluent, and familiar with the health system? Do they just get the diagnosis on their files, with little back-and-forth conversation about the pros and cons of being diagnosed, or less confidence to call in advance to cancel their appointments (one of the reasons I am both a 'bad patient' for canceling, and a 'good borderline' because at least I call in advance)?

All of this is also to say that the main reason I ever share my lived experience in this thesis is *not* to amplify my knowledge of the borderline topic matter in order to give more "credibility" to what I think is happening (though I do have some insight into borderline experiences, and to how borderline operates through various institutions, as both a service user and frontline case manager working with people labeled as borderline). I do appreciate and value the importance of representation and learning from people who have first-hand experiences of psychiatric harm; however, just because I have certain labels does not mean that I have much insight to offer. In fact, sharing the part of my social location that could be considered subjugated, or holding subjugated knowledge, risks exactly what I just highlighted: the prioritization of white, cisgender, elite 'voices,' not to mention a furthering of the assumption that simply learning more about marginalization will change how powerful institutions operate (Tuck 2009). How then do I reconcile the importance of subject positioning, representation, and lived experience, with an

intersectional analysis that necessitates me to acknowledge my plethora of structural advantages that I would argue 'outweigh' any harms I have experienced? How do I speak back to psychiatric harm *and* to white supremacy and its vectors, in order to prioritize an intersectional and geopolitical analysis of what borderline does, rather than an inevitably whitewashed and universalizing account? As I have grappled with these questions, I have decided to share small pieces of my experiences as a service user in the mental health system not in order to "represent" what borderline "is like," but in order to *highlight* that I have had much different experiences compared to the tāngata whaiora I worked with (Hedva 2016). This thesis is about that: what borderline does, for whom, and in which sociopolitical contexts. I share some of my experiences to highlight the ways in which 'BPD' and borderline can not only differentially debilitate people, but can capacitate white elite people through neoliberal rights, discourses, consumerism, and identity politics, thus calling out universalizing narratives about psychiatric harm that do not adequately account for how power operates through psychiatric labels much differently than it did even twenty years ago. I thus start with my implication in systems of harm – as both a frontline worker and as a white, globally elite service user – as a site through which to analyze borderline's patterns and to emphasize the responsibility that white elite borderlines (and people in general) have in responding to imperial violence that goes well beyond the lenses of oppression we have or might think we have. I am hesitant to call myself a Mad scholar, not only because of the limitations of identitarian frames based on "self-subalternization," injury, and innocence (Puar, in CLAGS 2013), but because this thesis has mainly become a response not only to psychiatry and empire, but to white borderlines: What we are focusing on, where we are building solidarity, and where we are putting our energy?

To summarize, affirmation without intersectional analysis risks uplifting socially advantaged 'borderlines,' while criminalizing, pathologizing, and neglecting equity-denied populations with the same behaviors and/or diagnosis (Gorman 2013). However, as I outline throughout this thesis, merely 'adding in' intersectional analysis is unlikely to mitigate these harms (Tam 2012). As we learn from Jasbir Puar (2007, 2017), we live in a system wherein the rights and progress of certain populations do not just obscure or neglect, but are made possible through, the systematic debilitation of disenfranchised communities around the world. Merely conducting more and more research, wherein we prove that diagnoses or reclamation movements have differential effects, might assume that these disparities are simply flukes of the system or results

of bias, not built-in to the "economy of injury that claims and promotes disability empowerment at the same time that it maintains the precarity of certain bodies and populations" (Puar 2017:xvii). Learning from Puar, along with Eve Tuck and K. Wayne Yang's (2014) work on theories of change, I am not sure that empirical research that confirms what we already know is the intervention that is needed. The observations I make thus are not indicative of some profound insight into borderline's intersectional patterns, but are unsurprising symptoms of racial capitalism,[12], Euro-American empire[13] and how they manifest both in the mental health system and in Mad critiques of it. Further to this, I do not make these observations to provide "proof" or "evidence." This is because, while empirically proving the inequitable patterns of borderline and 'BPD' can be important, I am more interested in asking what it does to apply certain theoretical perspectives, even if I cannot make concrete claims about what borderline is doing. For example, I learn from Deleuze's guidance against consuming empirical evidence at face-value, and to instead employ a critical analysis of the unconscious desires (inseparable from the political economy and social field) that produce 'BPD' and borderline in their various forms. Taking intersectional oppression as a given, I thus make claims, or rather, describe my observations, that borderline and 'BPD' are inequitably deployed across intersectional lines, *and* that borderline

[12] I use the term racial capitalism to note the intricate relationships between capitalist exploitation and inequality, chattel slavery, (settler) colonialism, and anti-Blackness. Critical race scholars from across the world use this concept to refer to how white supremacy and elitism work to keep racial and class inequality widespread and intertwined. For this thesis, I draw from Andy Clarno's (2017) definitional work on racial capitalism, a term that he traces to the Black Consciousness movement, as well as scholars across the world who have built theory and activism based on the analysis that "industrial capitalism was built on a foundation of colonialism and slavery" (Clarno 2018:9; see DuBois [1935] 1998; Gilmore 2007; Ralph and Singhal 2019; Robinson [1982] 2000). Drawing from these scholars, Clarno (2017:9) defines racial capitalism as "the recognition that racialization and capital accumulation are mutually constitutive processes that combine in dynamic, context-specific formations." An important point is that "racism cannot be reduced to an effect of capitalism," because "processes of racial formation are relatively autonomous from and constitutive of capital accumulation" (p. 9); after all, there continues to be "gratuitous anti-Black violence" (Wang 2012:n.p.) unexplained by theories of exploitation alone. Racial capitalism does not only operate through exploitation and "coercive labor regimes," but through the dispossession of land, people, and life for the "security of the white population" and nation (Clarno 2017:12). Finally, increasing, racial capitalism is increasingly being neoliberalism, operating less through overtly racist techniques, and more through insidious regimes that can make ongoing inequalities appear to result from "individual choices" (rather than built-in to the logics of the market, state, and their control over everyday life) (P. 12).

[13] I use the term "empire" to denote this historical period's particular nexus of control, shaped by the histories and present of British colonization and U.S. imperialism over the past four+ centuries. Empire critiques Euro-American domination and their ongoing enmeshment with the logics of settler colonialism, chattel slavery, cis-heteronormativity, neoliberalism, European humanism, and racial capitalism. Ultimately, this thesis critiques the role of the United States (and its allies) in perpetuating and maintaining vast inequalities between the 'North' and 'South,' and within the 'North,' through mechanisms such as resource extraction, unregulated corporate growth, Islamophobia, anti-Blackness, the dispossession of Indigenous land, ethnic cleansing and genocide, white nationalism, neoliberalism, and racialized poverty.

discourse could be contributing to the proliferation of empire in its various forms. This thesis then theorizes what borderline has done, is doing, or might do, and explores what this theorizing may open up or foreclose in our theory and practice. For example, what might it be doing to affirm and destigmatize borderline, within and outside of psychiatric frames, when the message of who can be crazy, who should get help, and who should be dismissed is continuously imprinted within the geo-socio-political field?

Another approach to understanding borderline's movements around the world, beyond empirically proving this, could be at the level of our concepts and how we are using them. Before continuing with this thesis then, I was compelled to decide what exactly I was analyzing. Is borderline *really* a misogynistic social construction, or *really* a unique set of worldviews that can provide insight into trauma and injustice? If only we have an adequate understanding of the concept, will our movement be anti-oppressive? Or, as I mentioned above, is it that what borderline *does*, how it is conceptualized, and what that conceptualization does, differs and will continue to differ across populations in our current socio-political field? In thinking through borderline, the socio-political field, and the risks of reclaiming that which probably should be reclaimed, I became frustrated with all the commentary on what borderline really is, should be, or should mean. In the name of destigmatization, both psychiatric and psy-critical professionals have long argued about the borderline concept, given how uniquely harmful it is. There are ongoing conversations about whether we should reject, recategorize, reconceptualize, or reclaim borderline. I go into these debates more in the literature review but want to note that many of these arguments seem to be trying to universalize an answer or approach to borderline. Assuming that there is a true or correct approach to borderline – whether as a personality disorder, a misogynist construction, or a form of neurodiversity – flattens the different ways that borderline moves. The problem for me, and for many theorists who have unpacked the differential effects of various progressive movements, is that borderline will still have differential effects, no matter what we do with it (see Puar 2017; Tichenor 2019). For example, being diagnosed and identifying with the diagnosis is modulated by which country we are, which room we are in and with whom, as well as our access to healthcare, the internet, racial and economic privilege, and so on. See, for example, the difference between Cannon and Gould's (2022) call for 'BPD' to be more readily diagnosed, in order for people like their daughters to get adequate care before it is too late, and Gary H's (2018) story about their diagnosis being given hastily and violently, a difference that echoes how my experience compares

with those of the tāngata whaiora I worked with. So how, then, can we both affirm pathologized ways of knowing, being, feeling, and behaving, with the acknowledgment that their pathologization is caught up in European humanism, *and* stave off what Olúfẹ́mi O. Táíwò (2022) calls "elite capture," wherein only an elite few benefit, and us elite perpetuate systems that harm our peers in the movement? How can we both value borderline affects while interrogating how axes of geopolitical power interact with borderline, its conceptualization, and what it does, for whom, and in which contexts?

Frustrated by these various approaches to "what to do with borderline," given its social patterns, I was interested in how Deleuzo-Guattarian ontology could unsettle the idea that borderline is or should be a static concept that can be known and pinned down (see Johnson 2015:254 on not getting caught up in the "competition for status as ultimate 'truth' of BPD"). Deleuze's ontology of immanence, for example, helps us to give up reaching for the 'truth' or the 'correct approach,' because it acknowledges that whatever truth is, it is only built upon the assumptions, presuppositions, and material reality immanent to the world and our very thinking (Buchanan 2020). That is, rather than getting caught up on what borderline *is,* why don't we ask what borderline *does* – how it comes in and out of relation with the world*?* In an attempt to make room for more socio-political nuance in our advocacy, I integrated Deleuze's immanence with intersectionality as 'epi-ontology,' or that which we can layer onto our assumptions about truth; just because everything is immanent to the world does not mean it is not material, and thus, with material consequences.

In late 2023, I revisited Jasbir Puar's work after reading parts of *Terrorist Assemblages* during my undergraduate degree and having no idea what assemblages meant. Already halfway through this project, I had done my best to reconcile the value of Deleuzo-Guattarian ontology with an analysis of the importance of intersectionality. However, reading Puar's ([2012] 2020) chapter "I'd rather be a cyborg than a goddess," thanks to a suggestion by Kim Smith, was extremely useful for this project because of how she integrates Deleuzian theory with intersectionality (the Black Feminist lineage), as well as geopolitical analyses of transnational feminists and postcolonial scholars. As Chapters Two and Four outline, Puar also helped me to add another question: what does borderline do, for whom, in which contexts, and *towards what ends?* That is, how can we analyze not only borderline's ontological (in)stability via its social patterns, but what broader systems are being amplified through how borderline is being used for

different populations? Like Puar (2017) asks of disability rights movements in *The Right to Maim,* these shifts include questions that rely on Deleuze's use of desire (see Chapter Two): What wills or produces Mad Pride, the white nature of Mad Pride, Mad Studies, reclaiming borderline, destigmatizing borderline, replacing borderline with Complex-PTSD, differentiating borderline with C-PTSD, and raising awareness about borderline? Again, I make more discrete distinctions between these movements in Chapter Two when I discuss assemblages of 'borderline personality.' These distinctions did not become clear until more recently, and thus I started with broader questions, such as, why do certain people, groups, and institutions desire these approaches? We need to treat 'borderlines' differently, and yet we must ask what wills questions solely about its stigma, what is obscured by them, and what systems – not just who – they benefit. What systems are we serving in reclamatory or destigmatizing movements, and how are they captured towards oppressive ends like state and corporate power? These questions allow us to more adequately comprehend how power operates, and to trace how borderline does different things across individuals, populations, and contexts, regardless of how much work has been done to destigmatize it, because of the workings of racial capitalism and Euro-American empire.

Puar (and Deleuze) also helped me move beyond an intersectional analysis of discrete individuals, as if we can always predict exactly what borderline will do based on individual intersections of social oppression (though we can do this to an extent). Puar's integration of Deleuzian assemblage theory with intersectionality helped me move towards an analysis of dividuals, populations, assemblages, affect, modulation, and control (see Chapter Two). That is, what borderline does is not just differential, based on levels of social oppression; rather, because of the ends we are made to serve (Deleuze [1990] 1992:7), borderline capacitates some populations *at the expense* of others. 'BPD' does not harm us all to different extents, and its reclamation will not benefit us all to different extents, in some linear, graduated fashion. Rather, we are caught up in a political economy wherein what borderline does is continuously "modulated and tweaked," based on calculations that benefit capital and the colonial state, to the finely tuned benefit and detriment of dividuals, individuals, and populations (Puar 2017:20). Thus, even though I use individuals as examples at times, I want us to continue to look beyond the individual neoliberal actor, and consider what systems they/we are caught up in. I detail more of these theoretical shifts in Chapter Two, and hope they are clear by the conclusion of this thesis.

Finally, the assumption that knowledge (or concepts) can liberate us is not only limited to a critique of positivist theories of change; even the provision of new theoretical and conceptual language for our research, activism, community efforts, and theories of change, is limited. Sharing and analyzing my observations, of my own and others' encounters with borderline, is limited to my lens, which is shaped by the political economy we are all caught up in. As I have reflected (and tried to understand Deleuze's notion of desire), I have had to admit to myself that my interests – conscious and unconscious – regarding borderline were and are shaped by the socio-political field. Although I could do with some more self-trust, I can also acknowledge the ways in which my own subjectivity (and performance of it) is caught up with the desires of late-stage capitalism, with neoliberal "piecing", the "ascendency of whiteness," and "moves towards innocence" (see Chapter Four). I am thus interested in what we can learn from analyzing borderline discourse in various ways, what that can teach us about our activism and scholarship, and how it can expose my own conscious and unconscious investments in a certain depiction of borderline, a limitation that will continue to be apparent throughout this thesis.

1.1.2 Roadmap

I present the rest of this thesis by way of storying through my engagements with borderline through social theory, disability studies, Mad Studies, social media, popular culture, geopolitical events, and my lived experience as a privileged service user and as a frontline worker supporting people (who, not to negate their agency, but are systematically targeted by the settler colonial state). The rest of this chapter serves as a literature review based on the above entry points. It also presents the important work done on race, empire, and madness, which although I did not adequately grapple with while first asking questions about borderline, has ended up informing much of this work.

Engagements with these theories and discourses, and my writing about them, form what I at one point called an "auto-ethology," combining feminist autotheory (Fournier 2021; Zwartjes 2019a, b) with Deleuze's ([1970] 1988) ethology. I now just call it an ethology, for various reasons that I outline in Chapter Two. Chapter Two also stories my workings through Deleuzo-Guattarian theory, and how it animated much of the early pieces of this project. This story includes a near rejection of Deleuze and Guattari, questions about intersectionality and immanence, and the normative ethical possibilities of their theories, which too often get used in white-washed, apolitical, and seemingly relativist ways. In Chapter Two, I also introduce how I am

conceptualizing the 'borderline personality' assemblage, and its *sub*-assemblages of the 'BPD' diagnosis, 'BPD' reclamation, and borderline affirmation – distinctions that become useful for Chapters Three and Four.

Chapter Three engages more with the micro-politics of borderline, specifically, having or presenting what might be understood as borderline 'traits.' I use ethology to explore how else we understand and respond to these experiences, affects, and worldviews as clinicians, friends, family members, and in popular discourse. This chapter has more resonance with the assemblage of affirming borderline from a Mad Studies lens.

Chapter Four focuses more on the macro-politics of 'BPD' and borderline – how they get used, avoided, deployed, taken up, or reclaimed in popular discourse, and what this does in terms of Euro-American empire and corporate control. Although I highlight where the assemblages of the 'BPD' diagnosis, psychocentric reclamation of 'BPD,' and Mad affirmation of borderline diverge in what they do socio-politically, I conclude the chapter with their similarities and affinities. I ultimately bring a skepticism around empowerment-based rhetoric surrounding the 'borderline personality' assemblage, *particularly but not only* those that replicate psychiatric frames of 'BPD,' because empire often proliferates through rhetoric of pride, rights, reclamation, and acceptance – regardless of how critical of biomedicine these discourses are (Puar 2007, 2017).

I conclude in Chapter Five with considerations about what borderline can galvanize (that is, how we can affirm borderline subjectivities and mobilize them as socio-political forces), followed by a query if we should abandon borderline and madness as sites to mobilize around. Drawing on Jasbir Puar's (in Adler-Bolton and Gill-Peterson 2022) question "what can debility galvanize" I query if I am ready to "give up on Mad Studies" (Redikopp 2021) based on this ethological analysis of one aspect of madness (borderline). Throughout this thesis, I hope that there are useful implications for more affirming and contextual clinical practice, for theoretical uses of Deleuze and Guattari, and for critical interrogations of our activist movements: what we mobilize around, and what ends they are serving. I use Chapter Five to summarize and pull together these potential implications.

1.2 Literature Review

This section expands what I alluded to in the meta-narrative. I mainly introduce the background necessary to continue on with the thesis. That is, what is it that we are talking about, even if we are about to question some of the points of stability around borderline, and perhaps reinforce

others? My first questions had to do with affirming borderline worldviews, with tāngata whaiora in mind. This made me wonder about the stability of the concept overall, given its differential effects and opinions about it. Turns out, borderline is a quite unstable concept (which is ironic), both between feminist and Mad scholars, but also amongst clinicians and researchers themselves – those who we seem to think of as having the most set-in-stone view of 'BPD.'[14] There are ongoing debates about what to do with borderline (and borderlines), clinically, and these debates seem important to highlight. Next, I trace arguments "what should be done about borderline" from outside of the medical field. I introduce the feminist and Mad-affirmative scholars I mentioned in the meta-narrative, whose work was so validating for me, and for reconsidering how we might respond differently to tāngata whaiora. I do not exhaustively introduce Mad-affirmative conceptualizations, because their work is so present in Chapter Three. In reading Mad-affirmative scholars, I had started wondering about the universalizability of reclaiming borderline and sought work that unpacks identity politics and whiteness in Mad Studies. At the end of this chapter, I outline this work, which, along with the other key concepts and debates that I introduce in this chapter, I will return to throughout the thesis.

1.2.1 What 'is' 'BPD'?

Although this thesis does not necessarily respond to clinical literature, it seems necessary to situate the discussion within the mental health field's current understanding of 'BPD,' the psychiatric label with the highest suicide rate (Oldham 2006; Paris 2019). During the first half of the twentieth century, borderline was conceptualized psychoanalytically, initially coined by Adolph Stern in 1938 for people who seemed to be frustratingly on the 'borderline' between the Freudian poles of psychosis and neurosis, or otherwise uncategorizable (Lewis 2023b; NICE 2009). By 1975, Otto Kernberg had identified 'BPD' as a distinct and unique way of presenting and seeing the world, particularly characterized by extreme shifts in identity and relationships marked by shifting views of the self or others as 'all good' or 'all bad;' this is also known as 'black and white thinking' or 'splitting' (Leichsenring et al. 2024). While Kernberg's conceptualization of borderline as a personality 'organization' still focused on psychoanalytic concepts such as "primitive defense

[14] As will become clear throughout this thesis, I am less interested in invalidating the notion of 'borderline,' just because the diagnosis is unstable, socially constructed and remains contested. Even though there are debates internal and external to psychiatry, these experiences (such as those described as bipolar, psychosis, autism, or borderline) do exist and can be distressing. Brushing these terms aside because they are debated, constructed, or harmfully rooted in Western epistemes can miss important analyses about diversity, distress, intersectional patterns of distress, and the prevention of undue and unjust predisposition to distress (see Chapter Four).

mechanisms, projective identification, identity diffusion, and severely disturbed object relations," the focus in the DSM-III and onwards has been on borderline behaviors – 'what it looks like' (Leichsenring et al., 2024:4; see also Gunderson 2009). In other words, with psychiatry and psychology's turn away from psychoanalysis and towards statistical analysis, neuroscience, and behavior, 'BPD' is more frequently classified in clinical settings based on externally observable behaviors, as opposed to inner views of the self and other (see Lewis 2023b for a history and discussion). Kernberg's work formed the basis for the DSM-V's current description of a 'BPD' as a "pervasive pattern of instability and interpersonal relationships, self-image and affects, and marked impulsivity, emerging in early adulthood and present in a variety of contents, as indicated by five or more of a set of nine criteria," including: chronic feelings of emptiness, affective instability, frantic efforts to avoid abandonment, unstable self-image, impulsivity, extreme or inappropriate anger, patterns of intense and unstable interpersonal relationships characterized by extreme idealization then devaluation, suicidal behavior and ideation, and stress-related paranoia and/or dissociative symptoms (American Psychiatric Association 2013:663). Notably, after much controversy over whether to remove 'personality disorders' from the International Classification of Diseases (ICD), borderline remained as the only one in the ICD-11. These criteria are similar to the DSM, with additional presentations such as a "view of the self as inadequate; an experience of the self as profoundly different and isolated from other people; and proneness to rejection hypersensitivity" (Leichsenring et al. 2024:5). 'BPD' is now a diagnosis that comprises about one to three percent of the U.S. population (Ellison et al. 2018). 'BPD' has similar prevalence worldwide, with higher rates (up to 22 percent) in community and inpatient clinical samples (Duff et al. 2020; Ellison et al. 2018; Leichsenring et al. 2024). Where 'BPD' and other 'personality disorders' used to only be able to be diagnosed after age eighteen, to avoid diagnosing teenagers with stable and pervasive 'personality disorders,' it is now fairly accepted by advocates and researchers alike to diagnose 'BPD' early in order to reduce "individual suffering and societal costs" (Leichsenring et al. 2024:19). As I revisit throughout the thesis, little about the diagnosis can be said to be objective, given our situatedness in an economy wherein people and corporations profit from early intervention and treatment; in fact, one of the reasons that the ICD retained the 'borderline' category is that "several academic careers have been built upon its research and treatment" (Leichsenring et al., 2024:18).

Despite 'BPD's relatively stagnant nature in psychiatric classifications, and the fact that it is the most widely researched 'personality disorder,' there is little consensus amongst clinicians, service users, and researchers about the diagnostic validity of 'BPD,' its etiology, and relationship to trauma (Duff et al. 2020). To add onto the variety of clinical practices in diagnosis, some researchers argue that 'BPD' has "poor construct validity, high rates of diagnostic co-occurrence, poor clinical specificity, and a lack of clarity regarding its underlying neurobiology" (Duff et al. 2020:6; see Carcone et al. 2015; McKay et al. 2022; Pilgrim 2017; Tyrer 2009; Vanwoerden and Stepp 2022; Zimmerman and Balling 2021). In fact, 'BPD' has long been referred to as a "wastebasket" (Horn et al. 2007) or "dustbin" (James and Cowan 2007) diagnosis, because of the way in which it can be resorted to for patients considered 'unable to be helped,' or otherwise uncategorizable (Duff et al. 2020). 'BPD' is also frequently said to be 'misdiagnosed' – or a 'misdiagnosis' of depression, bipolar, attention-deficit hyperactivity 'disorder', autism, psychosis, antisocial 'personality disorder' (particularly among men), and other experiences that overlap: "it is an excellent demonstration of a failed classification system" (Tyrer et al. 2003:136; see: Beatson et al., 2019; Frías, Baltasar, and Birmaher 2016). Philosopher Nancy Nyquist Potter (2009) contends that this diagnostic sloppiness occurs alongside symptomatic sloppiness, particularly regarding conceptualizations of anger, aggression, impulsivity, and manipulation. At the same time, 'BPD' seldom occurs without the addition of other co-occurring psychiatric diagnoses, including those mentioned above, as well as substance use 'disorder' and eating 'disorders.' People diagnosed with 'BPD' also experience higher rates of morbidity and mortality compared to control groups, which could speak to the nature of the condition, but could also speak to which populations more readily meet the criteria for the diagnosis, get the diagnosis, and/or are less considered when it comes to the diagnosis' iatrogenic nature (Hastrup et al. 2024; Leichsenring et al. 2024; Sadek 2024). Finally, Potter and others critique the idea that 'BPD' indicates an "underlying personality structure," given the high rates of 'remission' experienced by people over time and with treatment, as well as its etiological links in early childhood trauma (see also Duff et al. 2020).

The jury is out over what model most accurately accounts for all of 'BPD's' genetic, neurophysiological, environmental, and psychosocial causes – that is, if it should be considered a diagnosis in its own right (Ahluwalia, Calderwood, and McMurphy 2019; Duff et al. 2020). 'BPD's' psychoanalytic and epidemiological links to abandonment, abuse, sexual abuse, emotional neglect, invalidating environments, and other forms of trauma are increasingly accepted,

perhaps in part to disrupt the notion that one's personality is at fault (Duff et al. 2020; Leichsenring et al. 2024; Linehan 1993). Some researchers and clinicians even think that 'BPD' should be re-classified as a form of post-traumatic stress disorder (PTSD) or relabeled as Complex-PTSD (C-PTSD) (Amad et al., 2019; Becker 1997; Bujak 2022; Fernández-Guerrero 2023; Frías and Palma, 2015; Jowett, Karatzias, and Albert 2020; MacIntosh, Godbout, and Dubash 2015; Shaw and Proctor 2005; Yuan et al. 2023). This distinction was central to the debate over the ICD-11, though for now, psychiatry and psychology seem to be set on a clear distinction between C-PTSD and 'BPD' (Leichsenring et al. 2024). Other researchers are focusing on neurobiological markers and treatments for 'BPD,' though Leichsenring et al.'s (2024:10) review notes that "most neuroimaging studies are severely underpowered."

As intersectional scholars point out, even trauma-informed accounts of 'BPD' often focus on childhood trauma and fail to consider systemic trauma, such as the impact of racial discrimination and transphobia on borderline 'symptoms' (Leibel 2019; Paris and Lis 2013). To my knowledge, few clinical studies have robustly accounted for differences in 'BPD' experiences and treatment across social positions like race, ethnicity, and socioeconomic status, despite a swath of evidence about the social determinants of health (Duff et al. 2020; see Leichsenring et al. 2024 for a connection between 'allostatic load' and 'BPD'). It has long been established that about 75 percent of 'BPD' diagnoses are given to ciswomen, though its prevalence in the general population is estimated to be more equal between males and females (Leichsenring et al. 2024). There is growing research, however, on the disproportionate diagnosis of transgender and non-binary people with 'BPD,' which may signal how the diagnostic criteria, for example, of an "unstable sense of self," are being used to pathologize people who do not conform to the gender binary (see Leibel 2019; Porter 2023; Rodriguez-Seijas, Morgan, and Zimmerman 2023). In terms of race and ethnicity, I first note that most of the research done on 'BPD' is in the West; however, the diagnosis is increasingly being used and advocated for across the world, perhaps due to financial incentives and neocolonial constructs of mental distress (Beresford and Rose 2023; Tyrer et al. 2010). Within the U.S., a recent study (Becker et al. 2023; see also Castaneda and Franco 1985) suggested that there was no difference in rates of 'BPD' diagnoses for white and non-white individuals, though it is widely documented that African Americans and Latina/o people are diagnosed with psychiatric conditions such as schizophrenia at much higher rates than white Americans; there is a violent racial history to this (Metzl 2011; Schwartz and Blankenship 2014; similar racial

disparities can be seen in other settler colonial contexts, Lee, Duck, and Sibley 2017). One factor influencing this study could be the 'help-seeking' behaviors common in 'BPD,' which may be less likely for populations who have a rightful distrust of the healthcare system (and its criminal justice arms), and thus may be less likely to present to the emergency room, family doctor, or psychiatrist (see Redikopp 2023). Another reason could be the close relationship between 'BPD' and 'antisocial personality disorder,' a diagnosis that is rampant amongst people involved with the criminal justice system, an experience highly patterned by racial inequality across the Western world (Simes 2021). Other debates in the U.S. have been regarding rates of diagnosis amongst immigrant populations, wherein researchers have argued for more culturally appropriate analyses that take into account the ways in which immigration experiences can produce distress that resemble 'BPD,' but should not be responded to as such (see Nielson, Ziegenbein, Sieberer's 2014 response to Pascual et al. 2008; see also Jani et a. 2016; Ziegenbein et al. 2008 on cross-cultural bias in diagnosis). Surprisingly, or perhaps unsurprisingly in the context of Chapter Four, recent qualitative studies on 'BPD' include *some* demographic characteristics of participants, but not race or ethnicity (see Harris, Jones, and Borovica 2024; van Schie et al. 2024; I wonder if all participants were white, and if so, this should be disclosed). For pieces that have discussed racial, ethnic, and cultural factors in 'BPD' presentation and treatment, see Beckstead et al. (2015), De Genna & Feske (2013), Fromene and Guerin (2014), Fromene et al., (2014), Gaztambide (2018, 2019),[15] Johnson (2021), Newhill, Eack, and Conner (2009), Paris and Lis (2013), and Scheidell et al. (2016).

All these debates pattern how 'borderline' experiences are responded to across the world (Duff et al., 2020). Although this stigma seems to have improved in recent years, it is widespread: Mulder and Tyrer (2023:148) write that "the diagnosis of borderline often reflects the clinician's affective state rather than careful assessment," referring to the ways in which the 'BPD' label can get used to describe patients that are deemed 'too difficult.' At the same time, other clinicians are unwilling to diagnose 'BPD' due to its stigmatization, and instead diagnose people with bipolar

[15] As I finish up the typographical edits on this thesis, I realize my lack of attention to Gaztambide's important work, both for theory and praxis. I recently read Gaztambide's work on race, class, identity, and 'BPD' more closely, having previously overlooked it as a purely clinical evaluation only relevant to psychoanalysis. His work, however, highlights many of the themes in thesis about how 'BPD' debilitates and capacitates along racial and class lines (for example, how in the United States, African American and Latinx populations with 'BPD' are more likely to be funneled into the criminal justice system, whereas white women with 'BPD' are more likely to receive 'care' in the mental health system). Gaztambide's work on 'BPD' and psychoanalysis more broadly is important for any clinician to engage with.

(often a 'misdiagnosis' of 'BPD'), depression and anxiety (quite common), or some form of post-traumatic stress disorder. Not diagnosing 'BPD,' while perhaps protecting someone from unwarranted stigma, can mean that clinicians are often treating people for other conditions and thus prescribing unnecessary psychotropic medication (such as antidepressants, antipsychotics, and mood stabilizers; see Cannon and Gould 2022; NICE 2009). On the other hand, many clinicians find 'BPD' to be a clinically useful classification and necessitate that it be differentiated from other conditions; after all, therapy is the first-line treatment for 'BPD,' and no medications have been approved for 'BPD,' a statement that cannot be said for most other common psychiatric diagnosis (NICE 2009). These debates also pattern how people think 'BPD' should be treated. Although dialectical behavioral therapy (DBT) is widely considered the gold-standard (and most studied) treatment for 'BPD,' there remain debates about its efficacy, as well as how to respond to borderline presentations in more acute settings like emergency departments (see Crotty et al. 2024; Leichsenring et al. 2024; Lundh, Petersson, and Wolgast 2016; Setkowski et al. 2023). In general, treatment experiences for borderline often involve 1) high use of emergency and acute inpatient services due to impulsive self-harm and suicidality (Gunderson et al. 2018), 2) encouragement of DBT and other psychotherapies, which, if accessible, can be effective and lead to 'symptom remission' (Barnicot et al. 2012; Bloom et al. 2012; Gillespie et al. 2022; Hernandez-Bustamante et al. 2024; Kliem et al., 2010; Linehan et al. 2015; Rudge et al. 2020), 3) high use of psychotropic medication and polypharmacy, despite little evidence indicating its efficacy (Gartlehner et al. 2021; Hancock-Johnson et al. 2017; Poloczek and Szczerba 2024), and 4) stigmatizing experiences with healthcare systems and practitioners (Duff et al. 2020; see below).

Some of the reasons that psychotherapy remains debated regarding 'BPD' include high rates of drop-out (up to 30 percent), its inaccessibility, and its lack of attention to the "psychosocial supports" and "social contexts" for people diagnosed with 'BPD' (see Duff et al. 2020:2; Iliakis, Ilagan, and Choi-Kain 2021). For example, many public health services do not provide full DBT programs due to their financial and personnel costs. Committing to DBT programs is also very difficult, given the barriers to access, rules upon starting, and inability to again, address the social, as well as financial and interpersonal, contexts within which people are also situated. From my experiences, DBT and other Western psychotherapies are highly individualistic, appropriate certain aspects of Eastern religions without adequate acknowledgment, and cannot adequately attend to the socio-political circumstances that 'BPD' 'symptoms' are in response or resistance to

(see Chapters Three and Four; Linehan 2020). In an outpatient treatment program I was in, for example, therapists lauded Marsha Linehan for all her insight on mindfulness, sometimes referencing her training as a Zen Buddhist. At the same time, the therapists kept citing all of the science and evidence behind mindfulness and its effects on brain chemistry, without a nuanced conversation about the differences between Buddhist religion, Buddhist philosophy, and Western uses of mindfulness, or the fact that Buddhist teachings have been used – and successful – for thousands of years without needing Western empirical science to justify it (Linehan does, however, describe how the field of psychology dampened down how she built DBT from Zen Buddhist teachings). Furthermore, therapies are focused on individual meditative practices, lifestyle changes, and behavioral adjustments, without addressing the involvement of community and family, or the myriad of barriers that may make mindfulness practice difficult to incorporate or to accept, for example, if someone's primary concern is their disconnection from their Nation and land and how that shapes their sense of themselves (for more discussion on DBT, see Chapter Five).

One aspect of 'BPD' that is agreed upon is that the diagnosis renders one at high risk of stigmatization, invalidation, under- or over-treatment, confinement, and ridicule from practitioners (Carrotte et al. 2019; Donald et al., 2017b; Harris, Jones, and Borovica 2024; Miller et al. 2023; Duff et al., 2020; Klein et al. 2022; Lamont and Dickens, 2021; Stiles, Gumley, and Gajwani 2023).[16] Francesca Lewis (2023b) describes the diagnosis of 'BPD' as a form of "cruel optimism" (Berlant 2011), because while getting a formal diagnosis can promise treatment options and perhaps validation, the 'BPD' label ends up doing more harm than good. Early in their training, therapists are taught about the 'meat grinder sensation' – that "if you're talking to a patient and it feels as if your internal organs are turning into hamburger meat, the patient most likely has BPD" (Luhrmann 2001:113).[17] People labeled with 'BPD' are often deemed to be "attention seeking," "self-defeating" (van Schie et al. 2024), "difficult and disruptive" (Stapleton and Wright 2019:445), "chaotic, impulsive, and malicious" (Duff et al. 2020), "disingenuous, noncompliant,

[16] These references include patient experiences of stigmatization. For clinicians' experiences, see Baker and Beazley (2022), Donald et al. (2017a), James and Cowman (2007), Lester (2013), Lindell-Inness et al. (2023), McKenzie, Gregory, and Hogg (2022), and Ukwuoma et al. (2024).

[17] Karlene Schwencke (Mamea) shared that she had similar experiences in her psychotherapy training, where she felt that she was taught to fear borderlines so much so that she *felt* different (anxious, scared, defensive) when working with her first few borderline clients; the ingrained beliefs surrounding borderline, coming from psychotherapeutic dogma, are lessons that she has had to challenge throughout her career (personal communication, November 30, 2023).

annoying and undeserving of resources" (Lewis and Appleby 1988:47), "manipulative and attention-seeking" (H 2018:72), "needy, hostile, draining, manipulative, and 'not mentally ill'" (Redikopp 2018:85). These attitudes have enormous consequences. If the 'BPD' label is on one's electronic medical record, it can serve as an automatic filter through which clinicians may dismiss or overlook one's needs, psychiatric or otherwise: "It is almost as though the mere hint of borderline pathology devalues all other symptoms, not just psychiatric but also medical, on the grounds that they are exaggerated and distorted" (Mulder and Tyrer 2023:149). Reynolds (2023) writes that the 'BPD' label rendered her "everyday experiences [...] distorted through a clinical lens;" for example, her use of a dating application was written as "inappropriate flirtations with strangers," and notations on her experiences of sexual assault reeked of victim blaming. As I saw in my time in the social services, the borderline label can render one not only likely to be ignored because of our 'overreactions,' but because 'we cannot be helped.' 'BPD' was previously deemed 'untreatable,' but no longer is; still, the idea that "once a borderline, always a borderline" persists (Lester 2009:291). In pop-culture, borderline is often depicted through the trope of the "psycho" or "crazy (ex)girlfriend" (Johnson 2015; Love and Fillerup 2022). This stigma is largely discussed in terms of white, affluent, cisgender women, and neglect the – I would expect – disproportionate, institutionalization, criminalization, and neglect of structurally precaritized populations labeled with 'BPD' (see Johnson 2021).

Perhaps unsurprisingly, clinical research has rarely included the voices of people labeled as borderline, and/or their support systems. This appears troubling, given the discrimination that people labeled with 'BPD' often face from institutions, and the insight they could offer for improving care (Duff et al. 2020). This trend seems does seem to be reversing in recent years, however; for those that have included patient experiences, see: Barr et al. (2020) Chugani (2017); Donald et al. (2017a); Harris, Jones, and Borovica (2024); Horn et al. (2007); Jones and Lomani (2023); Koivisto, Melartin, and Lindeman et al. (2022); Lajoie (2019); Lester et al. (2020); Jørgensen and Bøye (2024); Ng et al. (2019); van Schie et al. (2024). Again, the social location of the majority of participants is unclear; Redikopp's forthcoming dissertation is one of the first that looks specifically at the experiences of racialized people who engage with self-injury, shedding light on the differentially ways the concept of 'self-harm' is taken up, understood, normalized, and responded to across different communities.

1.2.2 What should borderline be?

Given the recent uptick in research on 'BPD,' there has also been a broader movement to destigmatize 'BPD' (for example, see Kriss 2024). Social media and the advocacy of 'BPD' organizations seem to play a large role in increasing the understanding of 'BPD' as a health condition, rather than a personality flaw. Influencers are using social media to destigmatize, build awareness about, and even reclaim 'BPD,' through psychiatric frames that focus on childhood trauma and emphasize the need for greater access to proper diagnosis and treatment (see Chapter Four; Emotions Matter 2016; Johnson 2024; NEABPD 2024; Project Air 2024). This approach is notably different from the Mad approach to affirm borderline outside of the psychiatric frame of 'BPD,' but does seem to be the more dominant form of reclamation. Despite their differences, however, both the psychocentric and Mad approaches seem to be located in elite spaces. I discuss these relays more in Chapter Four, but wanted to introduce that there is a growing pop culture surrounding 'BPD' that, though destigmatizing, mainly reifies psychiatric hegemony. This contrasts with the feminist and Mad scholarship on borderline that I outline below.

The stigmatization of 'BPD' is one of the many reasons that mainstream (white, globally elite) feminist scholars have long called for the removal of the diagnosis. The other reason is the fact that women are given the 'BPD' diagnosis three times more frequently than men (Duff et al. 2020). Feminist scholars have thus denounced the entire concept of borderline due to its misogynistic psychoanalytic origins, gendered deployment, and pathologization of feminine emotionality and ways of knowing (see Becker, 1997, 2000; Becker and Lamb, 1994; Cahn 2014; Potter 2009; Shaw and Proctor 2005; Taylor 2022; Tseris 2013; Ussher 2013; Wirth-Cauchon 2001). These critiques tend to align with social constructivist views of psychiatry, seeing 'BPD' as a medicalization of trauma-responses, particularly amongst women and femmes, in a misogynist and violent world (Duff et al., 2020). Mainstream feminists that critique psychiatry as inherently misogynistic, however, miss several complexities about borderline experiences: 1) how intersectionality patterns experiences of and responses to borderline experiences, 2) the lifesaving relief the borderline concept can provide, 3) the possibility that people labeled as borderline and their communities might value borderline experiences as informative, not merely an unwanted pathology (see Johnson 2021; Redikopp 2018; Lester 2013; Lewis 2023b), and for me, the materiality of these so-called social constructions; just because a label or diagnosis is a fabricated concept, does not mean that it is not socially and materially *productive* (see Chapter Two; Deleuze

and Guattari [1972] 1980). In fact, Mad scholars have pointed out the contradictions in these feminist arguments, where 'BPD' is both a misogynistic construction (implying it is not real) and an experience caused by patriarchy (thus it is real). As Johnson writes, feminist critiques create "an illogical framework in which patriarchy harms women, but women cannot be damaged," and sometimes medicalization is a necessary argument for calling out structural harm (Johnson 2021:645; see Eromosele 2020; Puar 2017). Lewis (2023:28) also importantly calls out the feminists' plea that 'borderlines are not Mad, just traumatized,' as if being Mad is a bad thing: "to define selfhood in contrast with madness and make liberation from ableist pathologizing oppressions contingent on not being Mad is to fundamentally fail at undermining patriarchy." As I discuss in Chapter Four, there is nuance to this as well; mental difference is not bad, but we should be concerned about distress – particularly given that distress *does* discriminate, socio-politically, epigenetically, and environmentally. Furthermore, whereas Duff et al. (2020) suggest that more work needs to be done to understand why 'BPD' is still so gendered, I would suggest that feminist approaches to 'BPD' need to first account for the lack of intersectionality in their approaches. Which women and gender minorities are being diagnosed, how, why, and what does that diagnosis then do for or to them? As I suggest in Chapter Four, the 'BPD' diagnosis is not only validating and/or debilitating; it can *also* capacitate elite populations through financial, racial, and neoliberal streams of identification and empowerment; the three processes are not mutually exclusive. As I suggest in Chapter Four, postmodern critiques of 'BPD' are no longer adequate, given how what 'BPD' and borderline do is modulated across populations at highly granular levels based on their supposed benefit and/or threat to the nation and capital (see Deleuze [1993] 1995; Hardt and Negri 2000; Puar 2017). Nevertheless, the anti-oppressive and anti-sanist stance of Mad scholarship seems a useful place to start with our critiques of the white feminist denouncement of borderline.

In my reading, I found five recent articles that affirm the ways of being that are often called borderline. Rather than throwing the whole concept out like the feminists, these scholars acknowledge that borderline is a resonant concept for many people that can refer to a cluster of both distressing *and* valuable affective and onto-epistemological tendencies; they reject psychiatry's pathologizing frameworks, as well as mainstream feminist dismissals of these uniquely painful experiences that cannot be boiled down to 'feminine emotionality' (Johnson 2021). For psychotherapist and anthropologist Rebecca Lester (2013:72), 'BPD' is a form of

gendered social control but is not only that; the label can be lifesaving, and give insight into borderlines' "resilience, adaptation, creativity, and brilliant survival skills." Borderline scholars Sarah Redikopp, Merri Lisa Johnson, and Francesca Lewis also critique mainstream feminist approaches, instead drawing on Mad, Crip, and Queer theories to reconceptualize borderline as a valuable standpoint, as Redikopp (2018) outlines below:

> To be clear, I am highly critical of the diagnosis of BPD and hold that diagnostic categories more generally are epistemically unethical and violent. It is my assertion that BPD is a psychiatric construction embedded in mechanisms of power; however, I concede that borderline knowing is also a valid (and valuable) standpoint of knowledge (and emotion) production, and that some borderlines resonate with the diagnosis of BPD. (P. 83)

One of the first people to write a memoir about the borderline experience, Merri Lisa Johnson (2021:653, 656) uses a "critical realist" approach to "complicate-without-dismissing psychiatric labels" and "complicate-without dismissing critiques of those labels;" Johnson suggests that the 'BPD' label may be harmful, but borderline knowing, and the physical and emotional pain that comes with it, is an experience to value, learn from, and to take seriously (see Johnson 2024 on her recent conceptualization of 'BPD' as a chronic pain condition). Johnson (2021) introduces how Neuroqueer Feminism, which brings together intersectional feminism, Queer theory and Disability Studies, might help us "turn with tenderness towards borderline personality disorder" by destigmatizing neurodivergence and madness among women, racial and gender minorities, and psychiatrized people and valuing their expertise "on the psychiatric categories they inhabit, exceed, and critique" (Johnson 2021:635). Johnson (2021:642) hopes Neuroqueer Feminism will value the expose "what BPD distress feels like from the inside:" its debilitating pains, its relays with neurodivergence, its intersectionality, and its instructive affects. Johnson's article is one of the few pieces, to my knowledge, that prioritizes the voices of BIPOC people who identify as borderline; she calls for us to "parts of ableism we might otherwise miss," including "gendered and racialized ableism" (Mingus, in Talley 2013, cited in Johnson 2021:637).

Sarah Redikopp (2018:77) draws from lived experience, Feminist Standpoint Theory, Mad Studies, Johnson's Feminist Psychiatric Disability Theory, and Queer theory, to trouble the potentially harmful psychiatric label of 'BPD,' while, like Lester and Johnson, validating the borderline experience, thus "both recognizing the material reality of mental illness categories and contesting the epistemic violences and hierarchies which foster their construction and pathologization." Redikopp affirms the borderline "standpoint" as having useful insight into

trauma, injustice, and power dynamics from an "epistemic standpoint defiant of dominant Western knowledge frameworks" that erase "nonlinear" ways of knowing (Redikopp 2018:77-78). Experiences of 'dysregulation,' 'hypersensitivity,' 'impulsivity,' and suicidality, for Redikopp (2018:88), provide insight into "dynamics of power, causal trauma, madness, and the richness of intense emotionality" (see also H 2018). Rejecting the colonial silencing of affective, embodied, and locational knowledge, Redikopp (2018:86) recenters the wisdom of borderline (and other non-normative) forms of emotionality: "This is not to universalize the borderline experience, but to take up the 'borderline' as a strategic site of counter-knowledge production" that "while abject, can teach us something about trauma and subjugated knowing" (p. 85); borderline knowledge "can be held as valid, in spite, or perhaps because of, this abjection" (p. 86).

Redikopp and Smith's (2022) article on non-suicidal self-injury brings further nuance into discursive and clinical debates about the diagnosis and experience of self-injury, an experience closely related to borderline. Their notion of strategic dis/identification (drawn from Johnson 2015; Muñoz 1999) with diagnoses like 'BPD' and 'non-suicidal self-injury disorder' allows for 1) valuing what are often pathologized affects and behaviors, 2) validating the emotional and physical pain that comes with what are labeled as psychiatric disorders, and 3) moving towards an analysis of what a label *does,* which can change based on social location, and disparate, yet concurrent, desires for either diagnosis (to get validation, insurance coverage, and treatment) or no diagnosis (to avoid stigma and institutional harm) (see also Johnson 2021; Price 2015).

Francesca Lewis' (2023b) dissertation uses Neuroqueer feminism, new materialism, Deleuze, and related theorists, to flip borderline's relationship with psychiatry on its head; rather than viewing the borderline as a patient to be acted upon by psychiatry, she situates the borderline as someone who diagnoses the world, psychiatry, and the systems that promulgate injustice, trauma, and subjugation; borderlines become the 'diagnosticians,' rather than the diagnosed. While cautious about "romanticizing" or developing a new "essential" borderline, Lewis takes a closer look at the borderline onto-epistemology, a worldview that "seems to encourage ambiguity, change and flux, and yet at the same time demand binaries and boundaries" (Jones and Lomani 2023:99). Where Johnson and Redikopp focus on valuing the knowledge that comes from borderline emotionality and trauma responses, Lewis (2023b) looks at the lesser talked about experiences of

> uncategorizability (the effect of stigma, later theorized as becoming uncategorizable), instability (the identity diffusion or fragmented, unreal,

> incoherent self, later theorized as becoming indeterminate), and unreality (dissociation, or reality/unreality, later theorized as becoming unreal). (P. 32)

She theorizes "the borderline as someone who knows things, someone who can make meaning, and whose differences can have value beyond the clinical sphere" (Lewis 2023b:210). For Lewis, what are pathologized as borderline traits are real experiences; while certainly gendered, they are not fabricated out of thin air; furthermore, they are valuable and can be valued particularly when we move beyond the Western epistemes within which they are diagnosed: "I can be actually Mad and still not deserve the stigma around BPD. I do not have to possess a stable or coherent narrative selfhood to be freed from oppression, because the very idea of a self in those Cartesian terms ought to be dismantled" (Lewis 2023b:28; Redikopp 2018 makes a similar argument with regards to the epistemological shift that borderline emotional knowledge offers). Lewis' work is particularly relevant in Chapter Three, where I consider what else borderline 'traits' can do. The notion of an unstable sense of self, for example, is only pathological under a European humanist conceptualization of the self as a coherent mind, detached from the body and from the world.

1.2.3 Capture, co-option, and Mad nationalism

> "A Mad Studies that would remain relevant in contexts outside of Euro-American formulations, must itself be conscious of the diverse ways that people interpret their conditions and the limitations or possibilities they generate" (Eromosele 2020:16).

In response to the moves to reclaim psychiatric disabilities within disability and Mad Studies, and the relative lack of specific attention to borderline, Johnson (2015:263) writes, "when will it be the borderline's turn?" I wonder, however, what the risks of the borderline's turns are. Lester, Redikopp, and Johnson have emboldened an affirmative approach to the stigmatized label of 'borderline personality disorder.' Yet, if intersectional and decolonizing analyses are not foregrounded, reclamatory discourses can easily reproduce the "Western, 'normative,' white, middle-class, female" borderline or self-injuring subject (Redikopp and Smith 2022:5). That is, despite the differences in Mad-affirmative and psychocentric approaches to destigmatizing 'BPD,' both should maybe learn from other movements. Queer and disability rights movements, for example, have importantly shifted discourses about difference, and have pushed the state to grant rights and accommodations. Still, people have been incorporated along lines of racial, citizenship, class, and gender advantage, into colonial states and neoliberal markets that rely upon the mass disablement – or debilitation – of specific populations (Puar 2007, 2017). These contradictions

lead us to ask, can these movements really accomplish anti-oppression in all its forms, as they espouse in their solidarity statements (for more, see Chapter Four)?

This phenomenon of the "elite capture" *and* elite participation in the capture of queer pride is what transnational queer theorist and disability scholar Jasbir Puar (2007) calls "homonationalism." Homonationalism, perhaps the most comprehensive critique of rights-based movements, is an interpretive device that shows us that when we 'achieve equality,' white elites in the Global North[18] benefit the most, as do institutions like marriage, the corporation, the military, the consumer market, and thus Euro-American empire – which often espouses its progressivism while invading 'less progressive' [read: 'less civilized'] countries; in fact, rights-based movements are part of the contradictory workings of liberalism, settler colonialism, neoliberal capitalism, and U.S. imperialism. I discuss Puar's work and homonationalism more in Chapter Four but want to note that these are important critiques of rights-based and reclamatory movements for Mad Studies to contend with. We can see, for example, how online discourses about 'BPD' are likely going to benefit certain populations, as well as corporations and the psychiatric industrial complex, given the plethora of white women destigmatizing 'BPD' and advocating for proper treatment, medication, and diagnosis. However, we can also see white and elite capture occurring in Mad Studies and the Mad movement.[19] For the purposes of this introduction, I outline some of the critiques made about the whiteness of Mad Studies, so that we

[18] I use 'North/South' terminology for brevity but want to note its limitations. Helen Meekosha (2011:669) writes that the distinction broadly refers to a "complex of inequalities and dependencies" where 'Southern' countries (sometimes referred to as 'developing) or 'Third World' are "historically conquered or controlled by modern imperial powers, leaving a continuing legacy of poverty, economic exploitation and dependence." Of course, this distinction is not entirely geographic or spatial (Puar 2017:xxi). Terms like the Global North or 'Global center' include Southern colonial powers like Australia and New Zealand, and even places within the Global South or 'Global Periphery" that have not been colonized (such as Tonga) still geopolitically and economically hold a "peripheral position in global society, culture and economics" (Meekosha 2011:669; see Hardt and Negri 2000). The 'North/South' distinction also operates within these boundaries; for example, we may well use the Global South to refer to communities within rich, Western nations that have been and continue to be disenfranchised, exploited, and neglected (such as reservations, poor black communities, immigrant neighborhoods, etc.: "The United States displaces its production of debilitation through incarceration and racialization practices both 'here' and in the 'elsewhere,' temporally as well as spatially, creating objects of un-care—social pariahs" (Puar 2017:16; see also Hardt and Negri 2000). The critiques of Euro-American imperialism in this thesis, thus extend beyond and within the borders of these nations.

[19] Notably, most of my discussions will center around Mad Studies, not various forms of Mad activism. This is in part because I am mainly drawing on the extant literature and critiques of the whiteness of Mad Studies, and have not been involved with nor delved into the histories and ongoing conversations about race and Mad activism. I want to thank Sarah Redikopp (personal communication, June 2, 2024) for pointing out these distinctions and elisions, and for highlighting the important contributions of Mad scholars and activists of color, as well as the ongoing conversations going on in Mad activism with respect to race and identity politics (see Reaume 2021; Piepzna-Samarasinha 2018; Schalk 2022).

can return to them throughout the thesis. Notably, the points I outline below hold up for both Mad and psychocentric reclamations of borderline and 'BPD,' respectively, because they are critiques of whiteness, elitism, and Euro-American empire. I explore these arguments with specific regards to borderline and 'BPD' in Chapter Four, and in Chapter Five, I query if Mad Studies can be recuperated; perhaps its efforts would be more useful if put towards decolonization as a whole.

Mad Studies though it has importantly de-pathologized difference, has been called out for its elitism and whiteness – not dissimilar to critiques made of critical disability studies (see Bell 2016; Erevelles 2011; Meekosha 2011; Miles, Nishida, and Forber-Pratt 2017; Mollow 2004; Peers 2015; Puar 2017). First, Mad Studies has mostly contained white voices, thus "reproduc[ing] the white, Western Mad subject" (Gorman 2013:270). This does not mean that we should not affirm mental difference, but neither does it mean that we just need to include BIPOC voices; instead, we should question the foundations of the movement: Why is it that white voices are primary, why do white people feel more comfortable in Mad Studies or the Mad movement(s), and how are we conceptualizing the link between sanism and colonialism? As the Mad People of Colour Manifesto states, "[w]e don't want to be 'included' in a white movement: we want you to take responsibility for keeping your movement white" (Gorman et al. 2013:n.p.). Indeed, some Mad scholars have tried to equate sanism to being a form of colonialism or "like racism," as if someone cannot experience both, or experience sanism as a method of being racialized (for critiques, see Gorman 2013; Mollow 2006; Tam 2012, 2013). Jennifer Poole, in her (2014) TEDx Talk on sanism says "like racism, which is another oppression, sanism might come across as blatant discrimination" or "more likely in a thousand everyday insults." Lou Tam (2012:10) calls out how these scholars, such as Poole (2014) and White (2009), have theorized "colonialism as non-specific ideologies of sameness/otherness, normal/abnormal, and productive/unproductive;" these are certainly byproducts of European humanism and colonialism, but the crucial reasons behind this othering – genocide, eugenics, extraction, theft, and racialization – get ignored with such watered-down conceptualizations. When colonialism gets flattened to any form of othering, the very specific historical and material realities of European imperialism get obscured. While European humanism, an Enlightenment project, did create harmful binaries such as normal/abnormal (often for patriarchal and elite control) that were sanist, sanism was expanded

and cemented during European imperialism and its gendering and racializing projects.[20] Leaders in politics and the social and biological 'sciences' in the British Empire produced notions of sanity, among other measures of biological and cultural 'inferiority,' to justify the enslavement of African people and genocide against Indigenous populations (Menzies and Palys 2006; Myers 2014; Peers 2015).

The co-constitution of racism and sanism cannot be relegated only to the seventeenth and eighteenth century. Almost one hundred years after Native Americans were being institutionalized for "horse stealing mania," and people trying to escape slavery, with "drapetomania," psychiatry was and still is used as a form of racial control (Redikopp 2021). In the 1960s and 70s, black men engaged in activism during the Civil Rights and Black Panther Movements became increasingly diagnosed with schizophrenia, medicated with antipsychotics, and sometimes institutionalized for being "aggressive and belligerent" (a code for protesting the racist state) (Metzl 2011). During this time, the association between psychosis and danger/aggression grew, as well as with blackness. Schizophrenia became known as a "black disease," and black and Latino men are still about three to four times more likely to be diagnosed with schizophrenia or other psychotic 'disorders' than white men in America (Schwartz & Blankenship 2014). In our current age of neoliberalism, late stage capitalism, and more covert forms of automatic racial control, Tam (2012, 2017, 2023) shows how the language used on electronic records, practices in immigration detention, and the "palliative" mental healthcare for immigrants all participate in 1) normalizing distress and poverty amongst racialized immigrants in Canada, and 2) reinforcing their supposed threat to the system through various forms of indirect and direct racial violence, modulated by calculations of extractability and disposability. This is where reclaiming difference – and considerately including non-white folks into reclamation – falls short, because it does not call out how madness was created as madness in the first place, in our particular geopolitical and socio-historical milieu:

[20] Madness and cis-hetero-patriarchy also cannot be untangled, in that sanism has been a mechanism through which to further deem women and gender minorities as inferior. These realities, however, are so intricately bound up with race, and to the particular and specific demonization of women and men of color. For example, black women are often viewed to be "unable to experience depression" because of the trope of the "strong black woman," while also being easily deemed "too angry," the latter of which is also a widely spread and utilized stereotype, bias, and mechanism for controlling black men (Robinson-Brown and Keith 2003). While gender is an important dynamic to have at the forefront of our minds when considering borderline (particularly given that the 'BPD' diagnosis is disproportionately given to cisgender women, transgender men and women, and non-binary people), focusing on only this axis of oppression is often a white move that obscures our role, as psychiatrized white folks (particularly white cisgender women), in perpetuating and exacerbating violence against racialized and Indigenous people in these lands.

"Genealogies of madness and genealogies of race have infrequently been in dialogue with one another" (Tam 2012:13).

When Mad Studies places madness (or disability) as just another axis of intersectionality, it ignores the co-constitution of racism and sanism, and in particular, sanism as a racializing project. Madness is not 'equal to" to race or gender along the matrix of oppression, as we learn from Mad scholars of color, but they are so intricately connected under the project of colonialism that they cannot be talked about separately. In other words, madness and disability cannot just be added on to the axis of intersectionality because ableism and sanism have often become proxies for empire: "An intersectional approach need not mobilize the term 'disability' [or madness] itself, rather exposes the term for the racial elisions it relies upon" (Puar 2017:81; see also Tam 2012:8 on the shortcomings of this "additive" model of oppression). Sarah Redikopp's review on the neglect of race in Mad Studies also provides an overview of how racism and sanism cannot be equated, but that sanism exists through racism; they don't just intersect, but bolster each other up in relation to white supremacy and Euro-American empire:

> White madness and racialized madness are both organized through proximity to white supremacist norms and structures, and therefore, rigorous attention to the structurally organizing role of white supremacy in understandings of and responses to madness within contemporary settler colonial and white supremacist paradigms poses an urgent project of inquiry for Mad Studies scholars. (Redikopp 2021:113)

In short, all of this begs us to ask, which groups of Mad folks can demand that our health system improves, and which have always known that it was built to target them?

Given this intertwined relationship between sanism and colonialism, it is unsurprising that mostly white elite people can safely "reclaim" madness, and thus might be more able to participate in Mad Studies: **"**The possibility of Mad freedom [is restricted] to those who can reasonably 'run wild' without being murdered by police in the streets and slapped with the visceral materialities of racial violence" (Redikopp 2021:115, citing Waldron 2021). Gorman (2013:275-6) describes how some may benefit from the reclamation of stigmatized labels, while others still face serious carceral and migratory consequences. For example, white students are more likely to ask for and receive accommodations, while students of color may not feel safe to do so, given the simultaneous over-surveillance, violent stigmatization, and under-treatment of Mad and/or disabled people of color (Gorman 2012:272, 277-278; see also Jarman 2011; Muhammed 2010).

Next, Mad Studies does not focus enough on the *production* of distress by systems like racial poverty, discrimination, colonial occupation, and cultural erasure. That is, although notions of 'mental illness' have been constructed by psychiatry, acute and chronic mental distress does exist, and it is not sanist to say we should prevent this. Afro-Caribbean psychiatrist and theorist Frantz Fanon's observations and theories still resonate; that racism, poverty, state violence, and the various forms of precarity that come with living under settler colonial rule produce distress: "While the particular 'madness' of Black subjects can be conceptualized and understood as a result of white supremacist and colonial violence, it can also be a response *to* white supremacist and colonial violence" (Redikopp 2021:108). Mad scholars, as well as public health scholars (who use pathologizing terminology), do point to the socio-political causes of distress, but as Helen Meekosha (2011:667) writes with regards to disability studies, "the agendas of disability pride and celebration in the metropole may appear to stand in stark contrast to the need to *prevent* mass impairments in the global South" (italics added). As I revisit in Chapter Four, a Mad Studies that suggests it is sanist or ableist to say that we should prevent distress and debilitation cannot adequately ally itself with anti-racist and decolonizing movements (see also Meekosha 2011; Puar 2017, 2023).

Finally, while Mad Studies can *obscure* all the above, white-led scholarship and activism can also *contribute to* further erasure and violence; this is true of neocolonial calls for globalizing mental 'healthcare,' but can also be true for Mad Studies. That is, it is perhaps obvious that calls for psychiatry's global expansion can act as a form of neocolonialism, so too can destigmatization movements (often caught up with expanding psychiatric treatment) and Mad Studies. As Femi Eromosele (2020:16) reminds us, when "madness becomes an imaginary nation whose citizens are homogenized across time, cultures and borders through their oppression by psychiatry and society in general," Mad Studies and activism can "simply impose an extra layer of (literal) neocolonialism – a Western response to its own problems with biomedical psychiatry, one that overlooks the resources in [low to middle income countries]" for responding to mental distress (Miller 2018:314). Fanon's "commitment to situation specific engagement" (Eromosele 2020:16), and Gorman's (2013:269) "hazard against the solidification of an 'essential' Mad identity" both caution any attempt to reclaim borderline, then impose that process elsewhere, devoid of history, locality, and geography. Thus, when affirming borderline ways of knowing, we should avoid treating it as a transcendent concept, bound to be whitened, rather than as an immanent and

necessarily intersectional concept that may only be of use to certain Western borderlines (see Chapter Two). We must ask what borderline (and 'BPD') will *do* in each moment, and how it changes based on time, place, and social positionality (see Puar 2017:55-56 on the importance of geopolitical analysis, not just intersections of identity). Regardless of our destigmatizing efforts, who is still more likely to be affirmed for their borderline affects? Medicalized or demedicalized (Cannon and Gould 2022)? Whose sense of injustice gets validated, who gets labeled as paranoid, and towards what ends? (H 2018; Klein 2022; Wang 2012; see Chapters Three and Four)?

These are some of the questions I started with in grappling with the tension between affirming borderline and taking seriously the risks of white, elite capture. I want to note, however, that reading Jasbir Puar's work and her analysis of elite capture (Táíwò's term, not hers) in the context of financial capitalism and increasingly insidious forms of state and corporate control, pushed my analysis further. As Chapter Two demonstrates, I moved beyond simply asking contextual questions about what borderline and 'BPD' do and for whom. Deleuzo-Guattarian theory – and Puar's use of it – helps me to conceptualize the shortcomings of reclaiming borderline and 'BPD' without reifying the "static epistemological categories" produced by "modernist colonial agendas and regimes of epistemic violence" (Puar [2012] 2020:408). Puar's use of assemblages helps us to move beyond just another static identity-based critique and towards one that analyzes the "constant ontological assembling of power" (Puar 2017:20).

In Chapter Two, I introduce thinking of borderline in assemblages, asking how borderline comes into assemblages, what 'borderline personality' assemblages do and *towards what ends.* That is, this thesis is not simply about the limitations of a universalizing reclamation of borderline, but about the ends that borderline (and its psychocentric counterpart, 'BPD') are serving. Both concepts and how they are mobilized can and are perpetuating the very systems that determine who will benefit and who will be neglected by reclamation movements. Moving from an analysis of intersectionality as the intersection of discrete individuals' identities to an analysis of how power operates through aggregates of data, calculations of risk, and assemblages of identity politics, corporate profiteering off identity politics, and ongoing state violence, helps us to see not only who these various 'borderline personality' assemblages are serving, but what systems. These shifts move us from simply having a more inclusive reclamation movement to questioning why and if we should be even focusing our attention on borderline or madness at all.

CHAPTER TWO: ETHOLOGY

> "But while we forget Deleuze we should also remember him. We should remember Deleuze the anti-fascist. We should remember Deleuze the thinker of materialism and immanence. We should remember Deleuze the communist" (Berry and Galloway 2016:158).

2.1 Introduction

As I alluded to in Chapter One, Deleuzo-Guattarian theory, borderline's intersectional patterns, and the risks of universalizing any approach to reclamation all pushed me to ask not what borderline essentially is, but what it does or can do. This assertion that we cannot know what something is, only what it does, is the foundation of Deleuze's ethology, which, at its most basic level, is an analysis of what something *does.* This chapter thus outlines my use of ethology to ask what borderline assemblages do, but it does so by way of storying through the theoretical priors needed to do an ethology. That is, while I ultimately outline my ethological method for analyzing borderline, I spend significant time tracing the paradigmatic underpinning of ethology, as well as the key concepts needed to understand it (namely, assemblage, desire, and affect). Part of the reason that I story my way through these theories and concepts before getting to the practical points about "what I did" is that, in this chapter, I am not simply explaining ethology; I am also showing it and doing it.[21] In other words, this chapter describes ethology, but it is also an example of one. Asking what borderline does – an ethological question – ultimately changed my theoretical commitments and methodological approaches, thus changing my ethology. I trace these changes throughout this chapter, starting with my workings through Deleuzo-Guattarian theory. I specifically discuss their ontology of immanence, which shapes how I introduce assemblages, desire, and affect. In introducing these concepts, I introduce the "borderline personality" assemblage, which outlines how I approach the relationship between 'BPD' and borderline for the rest of this thesis. This chapter also details my qualms with using Deleuze and Guattari, and how I consider intersectionality and ethics, given the widespread apolitical uses of their work (see Buchanan 2020; Galloway 2013; Puar 2017, 2020). While I value Deleuze and Guattari's important interventions into continental philosophy, I ultimately use their theories through the lens of social theorist Jasbir Puar, (2007, 2009, 2017) who mobilizes their work to call out Euro-

[21] This thesis project does not simply "apply" ethology but is an embodiment of ethology. By doing an ethology, ethology changed my thesis – changed my ethology. This becomes clear as I discuss the shifts, tensions, and differences between my empirical chapters (Three and Four). Each chapter conducts an ethology but is also a product of ethology.

American empire. Only in the final section of this chapter do I specifically describe my approach to ethology.

2.2 An Ontology of Immanence

> "There is no such thing as a borderline individual, only a set of conditions that create borderline experience" (Jones and Lomani 2023:100).

In this section, I introduce Deleuze's ontology of immanence in order to lay some groundwork for the pivot from questions about what something (like borderline) is, to what it does. I am compelled to write this section for multiple axiological and political reasons. First, if we do not ask what ontological presuppositions we are bringing into our movements, theorization, research, and practice, then we risk recreating fixed categories that do not attend to the (increasingly) diffuse operation of power and control in contemporary society, what Gilles Deleuze ([1990] 1992) referred to as a society of control.[22] Second, as I discussed in Chapter One, universalizing assertions about "what should be done" with the borderline concept neglect the fact that 'BPD' seems to be a swift mechanism of social control, an iatrogenic label, a pathway to care, a neoliberal identity, or a Mad worldview to be reclaimed outside of psychiatry (borderline); it can act as all of these things for some, but it can also lean more towards harm or benefit, distributed by racializing,

[22] Societies of control, and how they relate to disciplinary and sovereign societies, are beyond the scope of this thesis. However, I will reference control a few times, and want to give some brief context for what this means about power. Expanding on the work of Michel Foucault, Gilles Deleuze argued that we are leaving purely disciplinary regimes of power and have entered a society of control. Disciplinary societies exercised power through institutional enclosure, confinement, and normalization through internalized surveillance (think schools, prisons, hospitals, and factories). In a society of control, power permeates the entirety of society; the individual is set free from enclosed institutions while being perfectly controlled. Data and information are particularly useful components of control. Our age is characterized by instant communication, networks of information, data mining, and global network computing, thus participation in society requires one to be plugged in, where our data is harvested to produce aggregates of data to be sold, bought, and controlled. Rather than disciplining *individual* bodies in space, the body is fragmented into constellations of data aggregates to be controlled, producing what Deleuze calls "dividuals". The transnational corporations and state institutions that own our data determine our access to resources and information through risk and profit analyses, thereby determining and controlling one's access to particular futures. Although boundaries have become more porous, precarization, insecurity, and futures are modulated on a granular, dividual level. Where disciplinary power mainly operated through restricting and conforming people to a rigid norm, thus erasing difference, the "*positive power*" of control societies, however, focuses more on the resemblance of autonomy and freedom (Han 2014). We are encouraged to share, participate, engage, consume, and communicate our opinions, desires, and beliefs; more difference means more data and greater the intensity of control and the more ''target markets'' can be created (Hardt and Negri 2000:152). People are no longer punished or disciplined for not conforming to a norm; rather, rules automatically apply themselves, and access to possible futures are automatically cut off, for certain individuals and populations that are deemed fiscally risky. Finally, the passage to control societies does not mean the end of discipline, rather, its logics are exacerbated; some populations experience ongoing forms of discipline and even the sovereign right to kill, while others experience more perceived autonomy, while being infinitely controlled (Hardt and Negri 2000; Mbembe 2019; Puar 2017). As we see throughout this thesis, discipline, and control work in tandem, oscillating back and forth to segment and control individuals and populations through a variety of overt and covert, direct and indirect mechanisms. This footnote was adapted from a grant proposal (Barlott et al. 2024).

gendering, citizenship, and classed logics in diagnosis, psychosocial violence, mental health treatment, (de)stigmatization, and reclamation (Gorman 2013; Redikopp and Smith 2022; Puar 2017; Tam 2013).Whatever intended benefits that might come with Mad and psychocentric reclamation are likely to be co-opted, or at the very least, differentially accessed across geo-political and intersectional contexts (Gorman 2013; Tam 2013); therefore, asserting what borderline or 'BPD' are or should be without an analysis of how emotional distress, psychosocial disability and psychiatric labeling move disparately around the world can reinforce the futurity of acceptable (globally elite) borderlines while continuing to criminalize, pathologize, under-treat, and/or over-treat structurally precaritized borderlines. These nuances necessitate that we move beyond questions about what borderline really *is* – whether as a neurobiological structural difference (Noor et al. 2024), a misogynistic social construction,[23] a 'personality disorder,' or a form of neurodiversity (Johnson 2021; Lewis 2023b) – and towards what borderline *does,* for whom, in which contexts, and towards what ends.[24] This differentiation reflects an ontological shift from transcendence to immanence, and a move from ontological to ethological questions, both of which I highlight below.

Deleuze differentiates an ontology of immanence from an ontology of transcendence, where the latter refers to the exertion of 'truths' based on largely unquestioned presuppositions. As such, Deleuze critiques the transcendence embedded within much of Western continental philosophy and psychoanalysis: "The transcendent plan, according to Deleuze, is never given to us but must always be inferred from some authority" (Novak 2021:89). From a transcendent ontology, the borderline concept is a signifier for 'borderline personality disorder,' a tangible, material phenomenon that exists in the natural world, that psychoanalysis and psychology 'discovered,' and that science is constantly nearing a more 'accurate' understanding of. We can see transcendence playing out in both clinical and societal discourses about borderline, where the DSM attaches borderline to the found-in-nature 'borderline personality disorder.' Even if researchers decide it needs a different name, the idea that this phenomenon is an illness that exists is widespread (see below).

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[23] As if social constructions do not have material, physical, chemical, and neuro-biological affects. Simply 'doing away' with something that is a part of society and thus our bodies is not as simple as calling out its constructedness; we have to contend with the materiality of these so-called constructions.

[24] Tiffany Sostar has also noted the value of viewing borderline as a neurotype, personal communication, September 12, 2023.

May 17, 2023: Autoethnographic observations on borderline and 'BPD' being treated as transcendent

It's funny how the DSM-V is the 'Bible' for psychiatry. 'BPD' is a thing, even still in the ICD (as it changes other 'PD' diagnoses). 'BPD' is a thing, in clinical research, in popular psychoeducation, and on *some people's files.*
But there are so many rampant debates, amongst psychiatrists, amongst researchers. So how can we even talk about it as a thing/as truth? The transcendence of 'BPD' is often replaced by a new one - a trauma-informed approach, a feminist approach, a hesitant clinical approach, a neurodiversity approach, a Mad approach. "This is the way we should view it" - the it-ness being quite established (except by the feminists. *It* is just how psychiatry controls feminine trauma responses and emotionality). Is that all? Is it not many of these things? Should it not probably get thrown out, and yet it also retains a lot of resonance as a concept, something people have found community around? What ontological approach allows us to comprehend this and ask more useful questions about various assemblages of borderline?

In the psychiatric literature, 'BPD' is a thing, to be diagnosed based on meeting criteria.
In practice, more discretion seems to be used - at least for me.
"You really don't want that label."

And then, Dr. M is different. A new form of transcendence.
"I don't believe in diagnosing personality disorders when someone is unwell."
"Your traits will get better when you get better from your depression."
"It is over diagnosed."
I'm couscous (see Chapter Three's commentary on an "unstable sense of self"), and agree that it has issues, that I think there's probably racial bias in the diagnosis.
He said well, and a lot of gender bias (yes, and, the go-to white feminist argument. Have we not moved on?).

Another one, who makes constant psychoeducational videos about 'BPD,' says he doesn't like to think of it as a personality disorder, but a "maladaptive response to a stressor" (Fox 2022).
What is maladaptive? What are considered stressors, and which are legitimate? What are the legitimate ways to respond to what stressors?
What is maladaptive, and who decides?
Regardless of what he says, his profitable platform is based on the existence of 'BPD,' as well as other 'PDs.' He also must have vested interest in making personality disorders a thing. Folks make potentially useful points about distinguishing diagnoses, so as not to overmedicate or wrongly treat people (as if psychiatry is that benevolent). And yet how many of these folks are also the ones whose careers are based on expensive neuropsychiatric evaluations, treating adolescents for 'PDs,' and making videos based on 'PDs,' no matter how destigmatizing they are? Curious to think more about vested interests. Deleuze and Guattari on desire and interests is useful here, but I suppose I'm focusing on the borderline concept here.

Reading (Cohen 2023): "Choosing our terms: how diagnostic words can be harmful"
This reminds me of Dr. M and other Dr M not wanting to diagnose me because of stigma.

And Dr. K saying "well, it's not really about the diagnosis," when I was asking for validation and clarity. I wasn't asking for a diagnosis - no thank you - I was asking for a direction, a conceptualization, sharing a frustration with having so many vague things thrown at me, with no language to make sense of what I was experiencing. In the name of patient-centeredness and destigmatization, she said "It's more about finding things work for you to feel better." A new transcendence. A refusal. What don't you understand, Dr. K., about what I am asking? I have even proven to you that I'm aware of the issues with diagnosis. I repeat, that's not what I'm asking.

Here's more - let's see people's experiences on Reddit[25]
"My previous psychiatrist had refused to grant me an official diagnosis for some reason [...] but the next doctor I saw came to the conclusion that I had BPD like half an hour into our first session."

[Reflection: So frustrating who is willing and who isn't (and for whom, under which circumstances? Who does the institution need to control, and who does it need to protect? And how does that shape psychiatrists' 'objective' practice?). He doesn't want the stamp on my file. But the alternative (for him, as if there's not an in-between) is to treat me for depression, to give me unnecessary antidepressants, to discuss a major depression that I do not resonate with (and to later be fairly convinced that these anti-depressants are what induced hypomania, a well-documented occurrence in the clinical literature, but that's another story)].

"I've heard a lot of psychiatrists flat-out won't give BPD diagnoses because of the stigma surrounding it. Which is pretty messed up honestly. People need to understand themselves first to properly address their mental health."

"The initial psychiatrist I saw dead-ass told me she 'doesn't believe in borderline personality disorder as a diagnosis' and never said what I had. My current psychiatrist did give me an official."

[I am so curious about the demographics of this Reddit chain, and who feels safe to receive that label, and to seek validation from psychiatry (including me). This is to ask what allows this experience, not to invalidate the need for self-understanding. What wills some of us to seek understanding from the health system, and what populations know that the health system is not a safe place for them].

"I know that it doesn't feel that way, but this psychiatrist was doing you a favor by not diagnosing you. Even in countries with good protection, psychiatric records are not as entirely leakproof as it sometimes seems. If you haven't already, get yourself into DBT and do the work to get better, as much as you'd really like to have letters to put to it, try not to worry about the

[25] Ok_Bid_8789. 2023. "How many of you have a formal diagnosis?" Forum thread on Reddit. Retrieved from https://www.reddit.com/r/BPD/comments/15uyp93/how_many_of_you_have_a_formal_diagnosis/.

diagnosis."

"Some people need the diagnosis for funding and treatment and accommodations."

I could go down this Reddit trail forever. Okay, so give us C-PTSD. Fine. But do not tell us it's a mood disorder (is that any better, particularly given the pharmacological implications for mood disorders, compared to 'BPD'?). Tell us that there are issues with 'BPD,' but that we can discuss them, discuss the framing, and weigh the risks/benefits of diagnosis, official or unofficial.

Now I'm reading affirmations of borderline instability.
Very cool.
We are able to read the analyst. We exist in contrast with Cartesian and positivist dualisms.
But as the author discussed, we don't need a new essentialist narrative about borderline.[26]
Also, who will benefit from this framing?

In contrast, Deleuze's ontology of immanence (or ontology of difference) is useful for addressing the complexities about the borderline concept without creating new essentializing narratives. An ontology of immanence asserts that whatever we call 'truth' exists only in relation to the world, rather than being predetermined or fixed by a transcendent power, such as religion, psychoanalysis, capitalism, positivism, European humanism, or even empirical science. In other words, there are no higher Truths, Ideals, or Blueprints 'out there' to find or approximate. In an ontology of immanence, concepts like 'borderline' actualize only in relation to the world; borderline exists on the plane of immanence, where it emerges as a concept based on a set of social, political, economic, and material forces that will it to be: "Given a specific situation what kind of assemblage would be required to produce it?" (Buchanan 2021:22). The borderline concept changes meaning and implications in minute, contextual, and molecular ways, determined not only by historical shifts in psychiatry, psychoanalysis, and feminism, but by the mundane, everyday affects, relationships, interests, interactions, policies, and material realities that constitute borderline. As such, borderline's boundaries are constantly adjusting as it relates to the world: "It has both an internal limit and an external limit, that is, boundaries which cannot be crossed without it becoming something different from what it was [...] Analysis consists of bringing these limits to light" (Buchanan 2020:123). A question we might ask within the field of immanence is, at what point are certain presentations deemed to be 'borderline' or not, when are they borderline 'traits' versus

[26] Francesca Lewis, personal communication, November 10, 2023.

the full 'personality disorder,' when is borderline no longer considered to be 'borderline,' but 'complex trauma' or simply a concept to be rid of, and "how are these limits decided?" (Buchanan 2020:132; Campbell et al. 2020; Watts 2023)?

The various approaches about "what to do with borderline," such as those that assert it should be replaced with C-PTSD or those that suggest it should be reclaimed and reconceptualized, often assume some sort of 'correct' way to understand and deploy borderline, while at the same time being unable to account for how borderline and 'BPD' do different things, in different contexts, and across populations. This is not only because there has not been adequate attention to intersectionality and borderline, though there has not been, but because of the concept's ontological instability – its situatedness within the field of immanence (see Redikopp 2023; Johnson, 2021; Leibel, 2019).[27] An ontology of immanence thus helps us to see how concepts, categories, words, tools, goals, industries, and other forms of segmentation have been and are continuously introduced onto the plane of immanence, but are not ontologically primary in and of themselves.

2.2.1 Immanence and intersectionality

Deleuze's ontology of immanence has some clear implications – including intersectional implications – for how we view, study, and critically engage with borderline. However, immanence can also become an attractive reason for overriding critical engagements with identity positions, intersectionality, and socio-political categorization. Pure immanence can then easily and unknowingly be made into its own form of transcendence (Read 2022), where we disregard identity categories because they are seen as essentialist and antithetical to immanence (for a summary, see Galloway 2013; Puar [2012] 2020). After all, Deleuze ([1968] 1994) asserted that difference (immanence) is primary to identity. While ontologically everything *may* exist on the plane of immanence and thus be interconnected, in-flux, and dependent on its relations with the world, asserting this without attention to not only intersectionality, but geopolitics, runs the risk of what Jasbir Puar (2017:55-56) calls a "locationless ontology." This occurs when we assert our ontologies, however useful, while discounting "the productive force of geopolitics within [our]

[27] Of course, ontological assertions about what borderline or 'BPD' really are *can be* important, for example, when we are calling for the removal of 'BPD' (or all 'personality disorders') from the DSM or ICD (after all, the notion of a 'PD' *is* pretty harmful), or when we want to retain the value of borderline (as a resonant and lifesaving concept, a form of neurodiversity, or even a clinically useful category). That these assertions are important or useful, however, does not mean that they are inherently embedded in reality; they are only "true" or "truer" given the presuppositions made to come to these conclusions, and are only valuable based on what it does to treat them as true.

scholarly purview as well as [...] the geopolitical forces that enable theorizing." I have incorporated this caution against a locationless ontology with my other engagements with Puar's work on intersectionality and Deleuzian theory, namely, her ([2012] 2020) piece on "Becoming Intersectional in Assemblage Theory." In what follows, I discuss my grapplings with the value of both Deleuzian immanence and human-imposed intersectional and geopolitical categories, two approaches that some might contend are incompatible. I assert that intersectional categories must not be brushed aside due to their fabrication or dabblings in transcendence, but be critically contended with, if our work is to have any political or ethical value. [28]

The prioritization of fluidity, relations, and encounters in an ontology of immanence have been used to flatten differences or reject humanist notions like identity, subjectivity, and intersectionality – and how these all interact with and shape borderline (for critiques, see: Chen 2016; Puar 2017; Wang [2010] 2018). These approaches – often done by globally elite white men and women – ignore Deleuze and Guattari's politics, and their use of subject formations as important categories, even if ontologically in need of disruption. When a particular subjectivity or identity (i.e. white, elite, cisgender, heterosexual men) is not seen as a threat to the system, that group may be able to continuously assert that 'whiteness is made up' (it is), that our uses of intersectionality are too rigid (they can be), and thus that they should be ignored. Those of us in geopolitical and intersectional locations that are not deemed as threats to global power can also tend to romanticize "becoming-imperceptible," a fantasy that has political value (Deleuze and Guattari [1980] 1987) but is only desirable or possible given a particular relation to state power and the dangers of (often simultaneous) invisibility or hypervisibility (see Berry and Galloway 2015; see Chapter Three).

In contrast, I take seriously the importance that Deleuze and Guattari, and their contemporaries like Jasbir Puar ([2012] 2020), place on subjectivity (see also Chen 2012; Musser 2012; Weheliye 2014). Although Deleuze and Guattari critique signification, interpretation,

[28] Notably, this thesis references the importance of geopolitics, but does not adequately attend to them. This thesis mainly contends with a North American perspective of borderline, borderline activism, and Mad Studies, because this is the location and positionality from which I am watching these discourses occur. I have only worked in settler colonial nations derived from the British Empire, and I only speak English. Thus, while I attend to the importance of geopolitics (with specific reference to Palestine in Chapter Four, and to the effects of extractive colonialism, imperialism, and forced migration throughout the thesis), I mainly do so to caution against universalizing approaches to borderline, 'BPD,' and madness. I have not spent enough time considering these topics from non-Western perspectives (see also Chapters Three and Four). In other words, I acknowledge the importance of geopolitics, without really doing a geopolitical analysis.

subjectification, and organization, they critique the hegemonic and imposed nature of these phenomena, and do not make their critiques transcendent. Rather, an ontology of immanence requires utilizing what might be considered transcendent: analyzing the presuppositions that make certain concepts, assemblages, and 'truths' possible, and what these presuppositions then produce, in which contexts. They go so far as to say that for an assemblage – whether it's you, your organization, your family, an ecosystem, or a concept – to continue, you must "keep small supplies of significance and subjectification if only to turn them against their own systems when the circumstances demand it, when things, persons, even situations force you to" (Deleuze and Guattari [1980] 1987:160). The borderline concept, for example, is produced by, but can also reproduce or re-orient assemblages of (settler) colonialism, neoliberalism, and more; foregrounding intersectional analysis need not overpower notions of agency and resilience, nor should it be rendered a 'paranoid' and optional addition to our analyses (Butler, Gambetti, and Sambsay 2016; Hemmings 2005; Puar [2012] 2020).

All of this is to say that viewing the borderline concept as immanent is not some relativist, white-washed claim about the fluctuating nature of concepts. Just because something is socially produced or fabricated on the plane of immanence, does not mean that there are no material and physiological consequences that "modulate and tweak" the hierarchization and distribution of life and death across populations and communities (Puar 2017:20); in fact, Deleuze's materialism necessitates that everything, including everything that is constructed or produced, is real, and thus has consequences (see Buchanan 2020; Latour 2004). As one example, race is a social construction, but very real in its consequences of racism; many critical race scholars speak of the racial ontology we live in, because of the primacy of anti-blackness and white supremacy that order our lives, institutions, and very notion of reality, consciously and unconsciously (Dixon-Román and Puar 2021; Ferber, 1998; Graves, 2005; Puar 2017). Similarly, the fact that borderline is this unstable and in-flux *ontologically*, does not mean that it does not have relatively rigid material, physical, and epistemological consequences, that I would argue, are patterned by the "ontological irreducibility" of the power relations created by (settler) colonialism and chattel slavery (Puar 2017:18). Micha Frazer-Carroll (2023:5) reminds us that "[l]ooking at mental illness as a 'social construct' does not mean that these experiences are not 'real' but rather that they do not constitute a fixed or objective category across time and space."

A more careful and political reading of Deleuze and Guattari's work, thus, would be to understand the importance of identity, while uprooting how identities get imposed, and the consequences of that imposition. As is perhaps clear from the above comments on borderline, I approach intersectionality and immanence through scholars that show how they need not be contradictory but used in tandem. I specifically draw on Jasbir Puar's work on the utility of supplementing intersectionality with Deleuzian theory, and vise versa. Puar, like many Deleuzians, critiques how categorical, rigid, and fixed notions of identity that have emerged since the Combahee River Collective's (1977) statement on black feminism have limited intersectionality's utility – politically, ontologically, and epistemologically (again, a problem with its institutionalization, not its original conceptualization). However, she goes beyond those that simply abandon intersectionality, and notes how thinking with immanence does require the analyses of power that the Black feminist lineage has made so clear (Collins, 1990; Crenshaw 1991; hooks, 1981; Lorde, 1984; Truth, 1851). Puar does not abandon intersectionality, but critiques how it has been taken up and modifies it, putting it in conversation with Deleuzian theory and geopolitics. Puar's first critique is that intersectionality has so often been used, particularly among Western elites, to analyze individuals as discrete and stagnant, where we sit at rigid intersections between *certain* identities: gender, race, and class are prioritized often over citizenship status, geopolitical location, and more. Increasingly, disability and madness are being 'added on' (often for globally elite folks) and ableism and sanism are being equivocated with racism, even though they are conduits of heteropatriarchy, capitalism, settler colonialism, and chattel slavery (Chapter One). For Puar, the Western reliance on intersectionality without critiquing its assumptions about identity formation retains a "Western, colonial epistemic regime," where not only is everything measured against a European masculinist norm but retains the presuppositions of European humanism and Cartesian dualism:

> Indeed, many of the cherished categories of the intersectional mantra, originally starting with race, class, gender, now including sexuality, nation, religion, age, and disability, are the product of modernist colonial agendas and regimes of epistemic violence, operative through a Western/Euro-American epistemological formation through which the whole notion of discrete identity has emerged. (Puar [2012] 2020:408)

Much of intersectional feminism (particularly its centers in the Global North) also ignores postcolonial feminist critiques of the nation-state that produced these demarcations and hierarchies of individual identities in the first place.

Puar's ([2012] 2020:411) second critique is ontological, where she remarks that intersectionality is "a much more porous paradigm than the standardization of method inherent to a discipline has allowed it to be." Bracketing an important discussion about humanism and which bodies are considered human, if humans are arrangements of matter composed of constantly shifting and fluctuating organs and if we change as we interact with oxygen molecules, people, institutions, and the environment, then what do we do with the notion of discrete identities? Can we account for the co-constitution of gender and race in isolation, without paying just as much attention to how passports, travel, autonomy at work, and parenting status also co-constitute these entities? Can we really analyze experiences based on the 'intersection' of someone or a group's race and gender, for example, when those experiences change each moment, based on what their gender and race do, in different moments and geopolitical spaces? There are, of course, several aspects of our identities that are more stable, and less changeable and maskable than others. Many identities are imposed; people are not given any option to 'come out' about how we are racialized, which country we are born in, or how much or little intergenerational wealth we have. Still, even these more fixed aspects of our subjectivities *do different things* as we move through different spaces and relate with different people. While Deleuzians have been critiqued for ignoring subject formation altogether – and rightfully so – Puar (2020:411) calls attention to how Deleuzian ontology may be useful to our understanding of intersectionality, because "identities are multicasual, multidirectional, liminal." Viewing categories like race, gender, and borderline as "events, actions, and encounters between bodies, rather than simply entities and attributes of subjects" (Puar [2012] 2020:411), allows us to analyze how they morph, ease up, and rigidify "across historical time, geopolitical space, institutional mandates, and discursive regimes" (Puar 2017:xiv). In the case of borderline, being diagnosed and identifying with the diagnosis is modulated by which country we're, which room we're in, and with whom, as well as our access to healthcare, the internet, racial and economic privilege, and so on:

> In fact, depending on where we live, what resources we have, what traumas we have endured, what color our skin is, what access we have to clean water, air, and decent food, what type of health care we have, what kind of work we do . . . we will not all be disabled [or be diagnosed a certain way]. Some of us will simply not live long enough. (Puar 2017:xiv)

In Chapter Four, I use Puar's work on disability to discuss how "categories privileged by intersectional analysis do not necessarily traverse national and regional boundaries" in the context of borderline and 'BPD' (Puar [2012] 2020:408).

Further to this, Puar's (2017:20) analysis is not just about individuals, but about addressing the "constant ontological assembling of power and its effects" – her reference to the oscillating modulation between discipline and control mechanisms based on specific calculations of profitability, extractability, and disposability: "My intervention is less wedded to the elaboration of subjects and identities—and attempting to determine what their contents or attributes are—than to the elaboration of bodies and their affective modalities as they are modulated in control societies" (Puar 2017:19-20; see footnote 4 on discipline and control). Capitalism feeds on every aspect of our fragmented identities – whether marginalized or not – to input into its data machine and output as a profitable commodity.

A central question of this thesis, particularly Chapter Four, is "[w]hat does an intersectional critique look like – or more to the point, what does it do – in an age of neoliberal pluralism, absorption and accommodation of difference, of all kinds of differences" (Puar [2012] 2020:408)? These useful questions point out how the focus on inclusion, acceptance, and diversity becomes fuel for the capitalist "absorption of difference" – but only differences that are profitable (see Chapter Four). For example, when queer liberation turns into rights within an imperial state and corporate appropriation of the pride flag for profit (Puar 2007). Madness and all our considerations about it needs to be intersectionalized, which is where Puar's view helps us to look beyond just individual intersections of identity – though important – and at what movements and discourses are doing, as well as how populations are controlled in immanent, contextual, and minute ways that go through, but beyond disciplinary categorization.

2.3 "We Know Nothing About a Body Until We Know What It Can Do:" Assemblages, Desire, and Affect

We cannot really know what borderline is; we can only see how it interacts with the world. That is, we can only see what the borderline concept, borderline experience, and the 'BPD' diagnosis do: how they are actualized, how they come into encounters, and what those encounters do. Informed by Deleuze and Guattari's ([1980] 1987:25) above comment on the body,[29] these

[29] When Deleuze discusses bodies, he is not referring only to physical bodies, but bodies of composition or "relationships of forces [...] whether chemical, biological, social, or political" (Deleuze [1983] 1986:40)

statements help to situate the borderline concept within the field of immanence and epi-ontology of intersectionality. This section further explores the question of what borderline can do, introducing Deleuzo-Guattarian concepts that can be used to contextually and provisionally 'answer' it. First, I discuss how viewing borderline as an *assemblage*, rather than a discrete identity, helps us to ask what it does across time, space, and geopolitics. Second, I introduce how we can ascertain how 'BPD' and borderline are assembled (through *desire*), and what those assemblages then do (through *affect*).

Thinking with assemblages, we are not required to produce a "coherent [borderline] subject" or "homogenize the unevenness of borderline" (Puar, in CLAGS 2013), but to think with "'variation to variation,' and hence the event-ness of identity" (Puar [2012] 2020:411, citing Deleuze and Guattari [1980] 1987). *Assemblages* are evolving arrangements of matter (people, places, memories, things, activities, etc.) defined not only by what these components of matter *are,* but the "patterns within which they are arranged with each other" (Puar [2012] 2020:412). For Ian Buchanan (2020), focusing on assemblages as "clusters of interrelated things," however, tells us nothing about how these clusters of things came together, what willed them to come together, and what they do – including what they do socio-politically: "[O]ne cannot look to the material itself to find the answer; instead, one has to examine the assemblage as a whole – what are its requirements? What expectations does it create? What are the tensions internal to it?" (Buchanan 2020:131-132). To reiterate Buchanan's point, Deleuze's invocation of materialism or the materiality of assemblages does not mean that we simply analyze what pieces of matter compose an assemblage, or that we apply a flat, or "monist," ontology to all forms of matter (Fox and Alldred 2022). Materialism cannot serve as a "get out of jail free card" (Chen 2016) on the material histories and presents of racism, empire, capitalism, and more:

> Materialism is taken to mean historical materialism, that is, the materialist philosophy of history found in Marx and subsequent Marxist theory. It should not be confused with the definition of materialism used in certain scientific and philosophical circles, for example that used by Harman [object-oriented ontology], which defines materialism essentially as a form of atomism through which small elements of matter are the foundations and ultimate arbiters of everything that exists. (Galloway 2013:fn18; see also Chen 2012; Puar 2017; Weheliye 2012)[30]

[30] This is where Deleuze's materialism differs from new materialism, a field that often cites assemblage theory and the importance of matter and more-than-human material (see Buchanan 2020). Discussing the relays and tensions between Deleuze's materialism, Marxist historical materialism, and new materialism is beyond the scope of this thesis. However, I want to point to the interventions made by Buchanan (2020), Weheliye (2014), Puar (2017), Chen (2012),

For Ian Buchanan, Deleuze and Guattari's political and materialist assemblage theory relies upon their intervention with *desire,* where desire is productive of reality, not based on the desire for something one is lacking. Desire is an unconscious force that does things: it turns "matter into material" (Buchanan 2020:131), brings matter into certain assemblages, breaks apart assemblages, is that which determines the boundaries and limits of certain assemblages, and how assemblages affect and are affected. For example, desire is what can turn a hammer into a weapon (a hammer-weapon-soldier-war assemblage) or into a tool (hammer-person-carpenter-project assemblage), where the assemblage is shaped by the desires – conscious and unconscious – bringing the various actors and objects into encounter (Buchanan 2020).

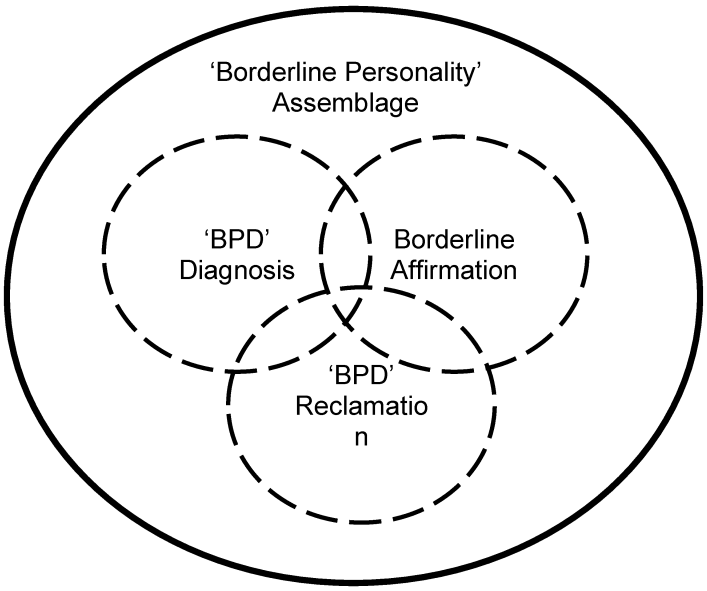
Deleuze's materialism shows us how to analyze not what borderline or 'BPD' *are* as identities or discrete signifiers, but as assemblages. That is, with regards to borderline diagnoses, identification, reclamation, and references in popular culture, where are the limits and edges of borderline: "Where and when does a particular thing happen, how does it happen, and so on?" (Deleuze [1993] 1995:25). For the purposes of this thesis, I treat 'borderline personality' as a broad assemblage brought together by interacting *sub*-assemblages of 'BPD,' the psychiatric label; 'BPD,' the (sort of) destigmatized identity largely taken up on social media; and 'borderline,' the experience or way of knowing as conceptualized by Mad scholars (see Figure 1). *The 'borderline personality' assemblage,* then, refers to the set of relationships between the 'BPD' label (whether the actual diagnosis, or the potential for diagnosis), the reclamation of the 'BPD' identity in psychocentric terms, and the affirmation of borderline knowledge from a Mad perspective and critique. This is a complex assemblage wherein each component relies upon the other, shaping what it does, why, and how. Reclaiming 'BPD' as a trauma-related pathology and becoming a 'BPD Baddie'[31] requires the material reality of 'BPD' as a label for distressing experiences *and* a

Galloway (2013), and more in foregrounding the political in materialist analysis. The risk with analyzing assemblages and their components, as opposed to solely using macro-political critical theory, is to remove any discussion of politics, responsibility, and agency (Buchanan 2020; Karera 2019). Thus, in thinking through assemblages and the productive force of desire, I want to remind that desire is productive, but that does not always mean it is good or affirmative. Desire is caught up and shaped by the political economy; how desire is organized is also determined by macro-political power structures. Furthermore, as Jasbir Puar (2017:56) notes, none of our micro-political or materialist theorizations can be removed from the "geopolitics of the racial ontology" that they inhabit; the question is whether we acknowledge the political nature of desire and material, or we bifurcate it through our critiques of the ways in which intersectionality has been institutionalized. For more reflections on my use of Deleuze, see the autotheoretical commentary at the end of the chapter.

[31] Margot (@margotsaywood). 2024. TikTok, May 2. https://www.tiktok.com/@margotsaywood/video/7364421864325795105.

pushback against the stigmatization that comes with the label. This 'BPD' reclamation interacts with assemblages of white supremacy and the ability to safely reclaim such a label and promote psychiatric and psychological responses to it (see Chapter Four). Affirming borderline from a Mad perspective necessitates a rejection of both the harmful history and present of 'BPD' and psychiatry, as well as its reclamation on social media, where the psychiatric industrial complex still gets foregrounded. However, the Mad critique of psychocentric destigmatization movements, while pointed, can also serve as a foil to distract from its own affirmative project, where borderline (and Mad identity more broadly) is valued as a unique and insightful subjectivity – an affirmation made possible by assemblages of racial, socioeconomic, and geopolitical advantage. Both the 'BPD' reclamation sub-assemblage *and* the borderline affirmation sub-assemblage compel a focus on pride rather than, say, the systems that produce not only psychiatric violence, but emotional distress and debilitation (some of which may get labeled as 'BPD'). On various levels, this 'borderline personality' assemblage as a whole ensnares white, global elites, through 1) material capacitation, and 2) affective capacitation, where we believe that we are advocating for liberating projects, even as this affirmative imaginary relies upon the pre-calculated debilitation of globally disenfranchised populations "whose major goal is survival" (Meekosha 2011:670; see Chapter Four). Throughout this thesis, in discussing 'borderline personality' as an assemblage, I discuss the differences and relationships of these three sub-assemblages: the psychiatric system's view of and deployment of the 'BPD' label and mainstream references to 'BPD' as pathology; the psychocentric approach to 'BPD' awareness; and the Mad-affirmative approach to borderline. I trace where they diverge and where they converge, often through the subject positioning of the two reclamation assemblages: how they may contrast with those most likely to be affected by the psychiatric assemblage of 'BPD,' and the shared systems they may be serving. As I alluded to in the preface, the two empirical chapters discuss different components of this assemblage. Chapter Three relays more with the Mad affirmation assemblage and attends to the micro-political possibilities of borderline experiences, based on the assumption that we cannot know if a borderline's behaviors are pathological until we analyze what they are doing or what they might do. While Chapter Three does not universally affirm borderline experiences, it does employ more of a Mad affirmative analysis. While I hope that Chapter Three will support clinicians, family members, service users, and more to reconsider what else borderline affects can do, given the violence that borderlines – particularly impoverished, gender diverse, and racialized borderlines –

face, I address the limitations of Chapter Three and its presuppositions in Chapter Four. Chapter Four analyzes each component of the 'borderline personality' assemblage, with specific focus on the white elite capture of both psychocentric 'BPD' reclamation and Mad-affirmative borderline reclamation, tracing not what they do for individuals, but what they do macro-politically. I now turn to a broader discussion of how I analyze these sub-assemblages, and the 'borderline personality' assemblage as a whole.



In each assemblage, clusters of things such as diagnoses, emotions, social location, medication, psychiatrists, discourse, pop culture, and more, are brought together by desire, and create borderline or 'BPD' assemblages that produce certain affective and relational capacities, where *affect* is a preconscious force that refers to a body's change in its power to act, or to affect or be affected by other bodies (or assemblages) (Deleuze [1968] 1992:225). Affect in this sense *can* materialize as emotion but does not only refer to the state often used in psychiatry to assess people's body language, facial expression, and other non-verbal cues. Rather, affect is any change in a body or assemblage's capacities or powers to act (powers to change and affect change). This change can be chemical, physical, emotional, or otherwise (Deleuze [1970] 1988:125). It could be large-scale and obvious, or subconscious or molecular: "[W]hen desire is productive [produces assemblages] it produces affects" (Buchanan 2023a:7). Affect is what is produced by desiring assemblages, where again, desire "is a process, as opposed to a structure or a genesis. It is an affect, as opposed to a feeling. [...] As opposed to a subjectivity, it is an event, not a thing or a person" (Deleuze [2003] 2006:130).

If the 'borderline personality' concept is actualized in assemblages, then studying what affective and relational capacities are produced by various 'borderline personality' assemblages requires an analysis of what they foreclose and open up (or, as Puar writes, debilitate and capacitate; see Chapter Four), not only for individuals, but for the socius. Analyzing with affect, and not just transcendent notions of choice, health, or other Cartesian measures, allows us to show

what something does while attending to diverse and diffuse operations of power that affect our individual and collective embodied, emotional, financial, affective, and otherwise capacities. These capacities are also not just what someone or something is doing or does because of the formation of an assemblage, but what they *might* do or *could* do – what is possible; affect is a "dispositional orientation to the world" (Duff 2014:44) that we can use to evaluate someone or something's potential, including what they think about that potential, what is said about that potential, what constrains and enhances that potential, and what ultimately happens. This query around affective capacities and changes in affect can include changes in assumptions about the future: changes in possibility, whether psychological, discursive, emotional, material, economic, and so on. Analyzing with affect helps us to see what assemblages do not in terms of only tangible material outcomes, but in terms of the translation of matter into material, where different types of matters (diagnoses or not, electronic records or not, hope or not, ability to be open about one's diagnosis or not, etc.) come to *matter* or not when it comes to different individual, population-level, and discursive relationships to borderline. Asking what assemblages of 'borderline personality' do in terms of affects and capacities helps us move beyond only disciplinary analyses about discrete bodies and identities (though important, and we will still do this), and to also include control analyses about data, affects, psyches, algorithms, dividuals, prognosis, and beliefs about and access to certain futures (Dixon-Román and Puar 2021; Puar 2009, 2017). In my analysis, then, I do not only have to highlight what 'BPD' actually does to an individual person – whether it denies or grants them access to certain forms of healthcare; we can also analyze what they do at the level of prognosis, imagination, ideas about futurity, messages about hope, and appeals to innocence, at the individual and population, where our units of analysis are not just individuals and their emotions, but population groups and their affective, political, epistemological, and ontological tendencies and presuppositions (Puar 2009).

Importantly, affect is not some apolitical force that marks out bodies' and assemblages' "endless capacity" to affected and be affected, and this is a particularly important point when it comes to questions about what borderline and 'BPD' do for the 'health' of populations (Puar 2017:12, 20; see Chapter Four). Though much of white affect theory seems to glamorize the assumed "reciprocity between the capacity to affect and be affected" (as if we always have both in equal amounts, and can always have more), this forecloses the ways in which very specific populations, macro-politically, are made to be affected and not to affect (and micro-politically, to

relate to time, future, and potential not through assumed capacity, but assumed foreclosure) (Puar, in Dixon-Román and Puar 2021; see also Gorman 2017).[32] Jasbir Puar (2017) reminds that studying affect is thus also about studying what foreclosures (debilitates) potential, through discourse, politics, direct violence, feelings, predispositions, neglect, siphoning, and other forms of population control; affect is then a differential relation of affecting and being affected that shifts based on power relations and their material consequences. This of course does not mean that ontologically we are not all continuously doing both in the material world, but that when we analyze with affect, we should be careful not to assume that all assemblages have the endless possibility or hope of increasing affective capacities; the capacity to affect and be affected is bifurcated by racial and economic violence, for example, and this is one of the utilities of studying with affect.

2.4 Deleuze's Ethology

The study of what affective and relational[33] capacities are produced by assemblages brought together by desire is what Deleuze refers to as *ethology*. In this section, I outline the theoretical assumptions embedded within ethology, before turning to the process of conducting an ethology in section 2.5. An ethology moves us from asking ontological questions about what something *is,* or if it is *good or bad* (transcendence), and towards immanent questions about what a given assemblage does, is doing, or might do, based on how it changes capacities to affect and be affected (Deleuze [1970] 1988:125). For borderline, an ethology would analyze what the formation of different 'borderline personality' assemblages produce, how, where, and for whom, and through what mechanisms. An ethology means inquiring about what certain arrangements (e.g. of diagnosis and/or behavior) do by "distinguishing between elements, forces or relations that promote the power of acting of a given assemblage of health, and those which decompose or frustrate this power" (Duff 2014:53). *Health,* from a Deleuzian perspective, would be based on an assemblage or body's capacities to affect and be affected. That is, health is not a transcendent definition to be reached: "In the absence of substantive definitions, and in the preponderance of the negative, health becomes a kind of 'empty signifier' into which all manner of normative judgements may be

[32] The "rupturing" of this assumed reciprocity is what Puar, in Dixon-Román and Puar (2021) calls racializing affect; see also Karera (2019) on anti-blackness and relationality; Gorman (2017) on race and affect.

[33] I briefly touch on relations only because they are central to ethology. Although "inseparable from the capacity to be affected," which "does not remain fixed at all times and from all viewpoints" (Deleuze [1968] 1992:218, 222, cited in Duff 2014:43), relations "contain the encounter [...] between subjects, bodies, and worlds," and the involved bodies' affective responses produced by the encounter (Duff 2014:37).

invested" (Duff 2014:65). Rather, health is immanent – a changing state based on if affective and relational capacities are increased or decreased by a particular action or assemblage (see Buchanan 1997; Duff 2014). To become healthy is to "advance in the provision of new affective sensitivities and new relational capacities" (Duff 2014:xiii) "such that our ability to affect and be affected is increased, rather than diminished" (Adkins 2015:96).

On the micro-political level, one question could be, what (else) might borderlining[34] affects do? As I explore in Chapter Three, borderlining affects need not signal pathology, but be evaluated based on what they are doing, and in which contexts. This perspective neither demonizes nor overlooks substance use, paranoia, mental distress, self-harm, or violence; instead, Deleuze and Guattari invite an explicit conversation about what they can enable and foreclose. Cameron Duff (2014) similarly explores not whether substances are good or bad, but how and when substance use, or lack thereof modulates and mediates our affective and relational encounters. Drugs must be evaluated based on what they do, for whom, in which amounts, and in which contexts: "[There]

[34] I want to note that early on in this work, I conceptualized 'borderlining' and 'borderliners,' along with Tim Barlott (in writing the paper that Chapter Three is based off). I find this intervention in terminology useful because they remind us that borderline is a process, not an identity, as I outline below. However, I have not stayed with nor relied on these concepts, because I do not necessarily think that asserting that more or 'better' concepts, particularly ones that are still embedded in the Western conceptualization of 'borderline,' will support people who identify as borderline in any meaningful way; as Sarah Redikopp (personal communication, 2023, December 20) reminded me, there are potential consequences of destabilizing or reconceptualizing a concept that so many people resonate with and rely upon. Despite this departure from asserting a new concept, I still leave in some instances of 'borderlining' and 'borderliners' throughout this thesis for stylistic purposes and theoretical interventions. These terms come from the following conceptualization in the manuscript that Chapter Three is based off of: Building upon the work of affirmative borderline scholars like Sarah Redikopp (2018, 2022, 2023), Merri Lisa Johnson (2010, 2015, 2021), and Francesca Lewis (2023b), I want to hesitantly introduce, but not impose, *borderlining* as a necessary ethical gesture, while acknowledging the unique forms of distress that accompany it. Conceptualizing borderline in this way necessitates an ontological shift from treating borderline as a categorical truth (as it is in many clinical and societal contexts) to a fluctuating and highly contextual concept or, in Jasbir Puar's terms, a "constellation" of concepts (Puar 2017; Redikopp, personal communication, December 20, 2023). *Borderlining* can refer to the affective, relational, cognitive, embodied, and emotional processes encountered and maneuvered by those who identify as borderline or who are labeled as such. Borderlining thus also involves moving through the world with a label of 'BPD' or 'borderline traits.' I find 'borderlining' to be conceptually useful, in that it shifts the focus from borderline as a fixed identity towards borderlining as a process or in-process subjectivity. *Borderliners*, those who identify as borderline or are labeled as such, cannot be universalized as a fixed identity group, because "[borderline] is not a fixed state or attribute but exists in relation to assemblages of capacity and debility, modulated across historical time, geopolitical space, institutional mandates, and discursive regimes" (Puar 2017:xiv). Affects that could be called borderline exist across the world but are 1) not responded to or conceptualized universally (Fromene, Guerin, and Kraig 2014; Jani et al. 2016), and 2) the associated mental distress will be shaped by specific relationships to various forms of oppression and trauma (Armstrong 2016; Giacaman 2018; Haami 2024; Redikopp 2021). Relationships to borderline, whether chosen or imposed, will not move evenly across and within borders (Eromosele 2020; Gorman 2013; Rodriguez-Seijas, Morgan, and Zimmerman 2023). This terminology may come back in Chapter Three, which focuses more on the micro-politics of borderlining and borderliners, and less so on the macro-political implications of 'BPD.'

is a fascist use of drugs, or a suicidal use, but is there also a possible use that would be in conformity with the plane of consistency?" (Deleuze and Guattari [1980] 1987:165). In addition, if an ethology is an "empirical study of bodies in order to know their relations and how they are combined" (Deleuze [1968] 31992:212), it is so "that they might be recombined otherwise" (Duff 2014:80). For example, rather than hearing that someone self-injures and jumping immediately to intervention because self-injury indicates pathology, we could consider what the self-injury might be doing. Self-injury is a prevention of suicide for many people, rather than a gateway to it, and thus, temporarily increases one's capacity to act and form new affective and relational assemblages (see Chapter Three; Redikopp and Smith 2022). We might then ask what other actions could be taken towards similar goals or to validate these desires. Further to the political use of affect is the question of not only individual and population health, but health in what context, and towards what macro-political ends? I turn to this question next, where I discuss the final element of ethological analysis in this thesis.

2.4.1 The ethics and politics of ethology

> "It's their job to discover whose ends these serve, just as older people discovered, with considerable difficulty, who was benefiting from disciplines" (Deleuze [1993] 1995:182).

Determining that something is healthy only tells us so much. Activities associated with capital accumulation increase affective and relational capacities, or health, but for whom, for which populations, and at what costs (see Culp 2016)? We often forget that Deleuze was concerned with not only what assemblages do, but what ends they serve. That is, is something healthy for participation in the accumulation of capital? Or for one's relationship to mutual aid networks? I would thus like to follow those that assert the importance of asking not only 'when, where, and for whom,' but 'towards what ends' in our ethologies (Deleuze 1993/1995; Galloway 2013; Puar 2017). Adding this qualifier to our ethologies isn't about evaluating what something does in relation to predetermined, transcendent, or imposed morals, where morals "rely on a set of constraining rules that judge actions and intentions by considering them in relation to transcendent values;" rather, "ethics are immanent to each context" (Braidotti 2013:343). Immanent *ethics* thus refers to "*a set of practices* governing action that, when observed and put into play, may tend toward certain ends (moral or not)" (Galloway 2013:365, italics added). For Deleuze, "transcendence … prevents ethics from taking place" because actions are already predetermined by a moral code about what is right or wrong, rather than by an immanent guide in the service of

which we then determine the best course of action (Smith 2007:68).

So how do we evaluate the ethics of an assemblage, or what ethical practices might come from our ethologies? This requires asking towards what ends are we evaluating and learning from to determine ethical practices from our ethologies. That is, ethical practice is not about rejecting all morality and sliding into relativism, but about determining what specific moral principle will guide us in ethical practice; here, the morals we choose are immanent, and not taken as transcendently ordained. This is what Alexander Galloway (2013:365) refers to as having an aligned politics: "a politics tethered to a moral yardstick and equipped with an ethical mechanic able to pursue it." He continues, stating that an aligned politics is when the vectors of ethical action aim directly at a specific moral outcome" (P. 366). These ends are for us to determine in our work. The ends I am concerned about in this work are the demise of Euro-American empire, (settler) colonialism, racial capitalism, and their various vectors and conduits. Only asking what borderline or 'BPD' does for whom, and in which contexts, does invite an intersectional and ethological analysis, but I want to ask specifically what 'BPD' and borderline do, given these differential effects, to disrupt, cope with, subvert, prop-up, distribute, and/or justify the ever-expanding reach of Euro-American empire and corporate control. This ethology thus asks: ***What does borderline and 'BPD' do, for whom, in which contexts, and towards what ends?*** Specifically, what do they do in relation to Euro-American empire, in terms of both discourse and other realms of the material (Buchanan 2020). Following my main guiding question above, this ethology specifically interrogates: ***How is desire assembling different 'borderline personality' assemblages, what do these sub-assemblages produce, micro- and macro- politically, and what do they obscure?*** In the following section, I highlight how I specifically attend to each sub-assemblage in the empirical chapters (Three and Four).

2.5 Doing an Ethology

> "Rather than documenting the flow of a river flow from a fixed point on the bank, take to a boat and become part of the flow" (Fox and Alldred 2022:627, referring to Deleuze & Guattari 1988:372).

2.5.1 Methodological inspiration

Deleuze never laid out a method for ethology, and many would likely doubt that is something he would do (on post-qualitative inquiry and theory-informed methods, see: Law 2004; Mazzei 2017; St. Pierre 2023; on methodological refusal, see Puar 2007; Sircar 2020). I thus take methodological inspiration from theoretical, rather than empirical, uses of Deleuze and Guattari (Buchanan 1997;

Gatens and Lloyd 1999; Puar [2012] 2020; Reyes 2017), as well as those that have conducted highly intersectional and geopolitical ethologies without necessarily naming their work as such (e.g., Puar 2017).[35] After introducing how Jasbir Puar ([2012] 2020:415) approaches the mapping of what is "prior to and beyond what gets established" in various assemblages, I use the last few sections of this chapter to explain what I specifically did, through two interrelated processes: 1) how I conceptualized and then conducted an ethology of borderline, both during my 'data collection' and in my analysis for Chapter Three and Four, and 2) what ethology did to this project, where this project is an application, deployment, example, and product of ethology.[36]

Though Jasbir Puar (2007, 2009, 2017, 2022) never calls her work ethological, she precisely asks what assemblages do, a line of inquiry she brings into conversation with queer theory, transnational feminism, critical race theory, and settler colonial studies. In her piece on assemblages and intersectionality that I referenced earlier, she responds to Brian Massumi's (2002) analysis of a setting wherein a man is watching the Superbowl on TV and then strikes his partner; Massumi analyzes this setting in relation to the increase in domestic violence on Superbowl Sunday. I am interested in how Puar ([2012] 2020) secondarily analyzes this setting, which gives me pointers for analyzing the 'borderline personality' assemblage and its sub-assemblages. She starts by writing:

> So what do we have here? First, an intensification of the body's relation to itself (one definition of affect), produced not only by the significance of the game, Superbowl Sunday, but by the bodily force and energy given over to this significance [...] Second, a focus on the patterns of relations—not the entities themselves, but the patterns within which they are arranged with each other. (P. 412)

Here, Puar pieces apart the assemblage, or the event of the man watching television, and asks what systems produce it (the various forces that make Superbowl Sunday significant, patriarchy and how masculinity is inscribed and internalized by this person, how technology directly and indirectly modulates affect and embodiment). She also identifies the potential boundaries of the assemblage – the moment when something changes, when desire deterritorializes the assemblage,

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[35] Fox and Alldred (2022) do have a methodological article on the Spinozo-Deleuzian "ethological toolkit," wherein they outline practical steps to ethological analysis. However, I do not use affect in the same way that Fox and Alldred do, and also take issue with their lack of discussion of desire in their paper; identifying affects and relations tells us nothing about why things form certain assemblages the way that they do (Buchanan 2020).

[36] For example, I did not conceptualize borderline in three distinct sub-assemblages that come together to form a broader assemblage during any of my 'data collection' period. These categorizations came as a result of analysis; they are a result of doing an ethology, *and* they help to facilitate my ethological analysis.

then reterritorializes: What is produced? While she analyzes various components of the assemblage, looking to happenings as small as a television advertisement or as big as the cultural weight of Superbowl Sunday, embedded within her analysis is an analysis of power and intersectionality; rather than flattening everything to an interaction between pieces of matter with equal ontological weight, she builds into her analysis that which we know plays a role in the opening up and "closing off of becoming" (Puar [2012] 2020:412), or the formation or rearrangement of assemblages. In bringing these analyses together to understand how and why an assemblage was formed, Puar notes that "[t]he focus here is not on whether there is a crime taking place, nor determining who is at fault, but rather asking what are the affective conditions necessary for the event-space to unfold" (Puar [2012] 2020:413). That "there is no straight line of causality" (Buchanan 2020:126) between various material, discursive, and affect realms of an assemblage is one of Deleuze's main interventions with ethology, where Deleuzian research is less concerned with determining what something is or is definitively caused by, but what might cause a phenomenon, and what it does to analyze a phenomenon from a certain perspective, to ask how might we prevent it, and how might we do otherwise (Puar [2012] 2020413).

> Being right or wrong is not compelling terrain for me. I am more interested in what thought is, where it moves, and how it can be otherwise. Regardless of whether I agree or am aligned with that line or body of thought, I am curious about the force of it, the gospel of it, how it attracts and repels. What gets to be said that wasn't said before. (Puar, in Sircar 2020:344)

This is the type of analysis I sought to do in Chapters Three and Four, wherein I care less about proof and statistical significance, and more about what our discourses and concepts are doing, and what analyzing them from a certain perspective may teach us. I learn from these theoretical approaches that analyzing assemblages is less about exactly what they look like (i.e., what specific pieces form each 'borderline personality' assemblage), and more about what micro- and macro-political forces desire, or produce, these assemblages or event-spaces. Notably, acknowledging the multifactorial nature of causality does not mean that we remove any discussion of culpability, agency, or responsibility, but that we use a variety of tools to analyze how, where, when, and why desire is assembling in a certain way, and where and with whom we might make an intervention. For example, I instead wonder why some populations, but not others, seem to be drawn into or have vested interests in certain borderline sub-assemblages, and what those sub-assemblages produce in terms of social inequality. When I discuss various components of each sub-assemblage

in Chapter Three and Four, I do not exhaust their various components, but analyze that which may indicate or tell us something about how desire is operating through and surrounding borderline and 'BPD,' as these concepts interact with individuals, affect, emotions, embodied feelings, politics, populations, policies, notions of futurity, and so on, often contributing to various forms of inequity: "A concept is oriented by the path it draws forth [...] it is less ours to claim than ours to follow" (Manning 2020:11). Now that I have highlighted the theoretical underpinnings and implications of ethology, I turn to discussing what exactly I did during my data 'collection' and 'analysis,' noting that each process - including writing and editing – continuously shaped and where shaped by ethological analysis.

2.5.2 What I did

> "This academic essay brings together select theoretical and empirical perspectives [...] Instead of a causal model (e.g. this person was influenced by that person or event), it constitutes a constellation of events, a spatial arrangement with no starting or ending point, where specific links can be apparent or concealed depending on the observers' viewpoint" (Turcotte and Holmes 2023:2).

As I have alluded to, my methodological approach to ethology changed throughout the course of this project; doing an ethology changed my ethology. I start this section by explaining what I did: how and when I wrote my autoethnographic and autotheoretical reflections, how I analyzed them, and how I worked with an advisory group. I then discuss how this process was not as neat and tidy as it might sound; I describe the qualms I came up with after my initial proposal of doing an auto-ethology using affect-as-method, tracing how doing this ethology led me to use affect in certain ways, changed my relationship to studying borderline and my subject location, and helped to solidify the ends towards which this thesis aims – the validation of that which is pathologized as 'borderline' (or other 'mental disorders'), through and as a result of a more pressing critique of how borderline discourses – both Mad and psychocentric – seem to debilitate and capacitate populations based on the logics of Euro-American empire, racial capitalism, and (settler) colonialism. It is against these ends that my ethology has moved and morphed towards. Instead of simply explaining these shifts, I mainly *show* them by way of autotheoretical reflection – the writing I needed to do in order to come to a new understanding of ethology.

Between April and November 2023, I wrote almost every day. I wrote about the affective and embodied experiences I had about borderline and 'BPD,' in relation to social theory and the political. After I was saturated with autotheoretical and autoethnographic writing (i.e. I had 600+

pages of writing, ranting, passages, social media posts, and observations by the end of October 2023), and thus began 'analyzing' these texts. This consisted of drawing out common elements, themes, and focal points that I deduced from reading theory and from being immersed in the socio-politics (and lived experience) of borderline for several months, if not years: "Analysis was writing and thinking with the scholars I was reading, not coding words from interview transcripts and field notes, and watching themes somehow miraculously 'emerge'" (St. Pierre 2023:3). By the end of October, I had an idea of what general chapters I wanted to write and began color-coding my documents into different categories (see below).

Autotheoretical notes on "themes" used in analysis
Ethology as both method and intervention INTERVENTION 1 - how we conceptualize borderline (mainly Chapter Two) Borderline as ontologically immanent Borderline as necessarily intersectional INTERVENTION 2 - micro-political (Chapter Three) Affirming borderline onto-epistemologies (Lewis 2023b) What borderline affects can do INTERVENTION 3 - more macro-political (Chapter Four) Geopolitical analysis - debility, capacity, empire (what borderline does and for whom, and also towards what ends)

I went through this process several times until I created an outline of my argument, supported by theory, literature, lived experience, and other cultural observations about borderline. Preparing a presentation for a conference in February helped me solidify my arguments and is probably the reason I can write this thesis now.

Finally, before I show what doing this *did* in order to write Chapters Three and Four, I'd like to draw attention to my advisory group. I formed an advisory group to value that my thoughts are not my own, but an articulation of my encounters and relations with my friends, colleagues, clinicians, books, pop culture, and more. I was also drawn to having a 'sounding board' with whom I can discuss the resonance (or dissonance) of my ideas, with people who all have unique insights about the discourse, practices, labels, and theories surrounding borderline and/or related topics of psychiatrization and disability. I sought an advisory group with multiple perspectives to hold me accountable, to nudge me towards alternative perspectives, to provide greater insight into the topic,

and to help me ascertain: *What is this thesis doing? What are its potential uses and dangers?*[37] *What might it do? What else could it do?"*[38] Using this advisory group not only helped prevent this autotheoretical work from only being about my worldview (though I still ultimately decided what to write) but pushed me to value and recognize the importance of relationality in scholarship, as well as living while doing scholarship. My advisory group provided much more than insight and accountability; they provided support, encouragement, and comradery for my time in graduate school, for my various struggles with the 'mental health' system, and for solidarity in the writing process. Finally, as Sarah Redikopp noted to me, having an advisory group therapeutically and theoretically pushed me to work through my own challenges with interpersonal relationships (a diagnostic criteria), as well as the predominant view that borderlines cannot have, value, learn from, and contribute to interpersonal relationships.[39]

I selected my eight[40] advisory group members based on previous relationships, theoretical or political resonance, and trust in their ability to hold me accountable while supporting my process and any deterritorializing affect that may come up in the process. Given this, their experience is not meant to be generalizable in terms of the geopolitics and intersections of borderline, but to provide relational accountability and insight into a highly autotheoretical project. Advisory group members come from a variety of disciplines (social work, occupational therapy, psychotherapy, women's and gender studies, sociology, Mad Studies, and kinesiology) and are practitioners, graduate students, professors, and/or service users in the mental health system (none mutually exclusive). In alphabetical order, I share the following ways in which I relate to each of them, in order to provide context about the various methodological, theoretical, axiological, ethical, and political commitments that bring us together (or that drew me to them), without siphoning them based on individual axes of identity for the academy to further piece apart and exploit.[41]

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[37] "Uses and dangers" has been articulated by Danielle Peers.

[38] Although much of the work on advisory groups is within a community-based participatory context (Cousins and Chouinard 2012; Miller et al. 2021; Wallerstein et al. 2018), I draw from the principles of participatory evaluation (Brisolara 1998; Springett and Wallerstein 2008; Zukoski and Luluquisen 2002), as well as the transdisciplinary theoretical collaboration shown by Abrams et al. (2019), Fadyl et al. (2020), and Setchell et al. (2021).

[39] Personal communication, December 20, 2023.

[40] I originally had nine people in my advisory group, but one person had to drop out before starting participation due to time constraints and other life commitments.

[41] My advisory group was composed of, in alphabetical order: Verity Armstrong, Stephanie Dixon, Nathan Viktor Fawaz, Francesca Lewis, Sarah Redikopp, Karlene Schwencke (Mamea), Kim Smith, and Tiffany Sostar.

I reached out to Verity Armstrong because of her embeddedness within both kaupapa Māori and Western perspectives of psychotherapy and social work, specifically with regards to trauma. Verity was one of my clinical supervisors in Tāmaki Makaurau, and one of the first people with whom I spoke with about the stigma faced by people labeled with 'BPD,' specifically the tāngata whaiora I worked with, the relationship between 'BPD' and complex trauma, and the importance of Indigenous frameworks for describing and responding to these forms of distress.

Stephanie Dixon was my peer in a trauma-informed course, taught by Lindsay Eales and Nathan Fawaz, and became a methodological, theoretical, and political companion during this work. I called on Stephanie because of her impressive reflectiveness about her own workings through various discourses and politics surrounding disability, ableism, madness, sanism, trauma, and emergent methodology, and I have so appreciated their encouragement and support through this project.

I have had the honor of learning from and with Nathan Fawaz in this same course, as well as in a variety of other research settings at the University of Alberta. Nathan brings a highly nuanced set of skills, knowledge, and thoughtful approaches to trauma and madness (broadly speaking) that I knew would be valuable for my process. Nathan's work specifically invites me to ground myself more in my own bodymind (see Price 2015), to engage with lineages and knowledges that have been ostracized from the academic purview, and to keep crafting methodolog(ies) that align with my axiological and epistemological commitments.

I am also grateful to have met and connected with Francesca Lewis, whose insightful work on borderline onto-epistemologies was and continues to be inspiring. I cold-emailed Francesca after reading her work and am very appreciative that she responded. I appreciate the degree of nuance she brings to any discussion of borderline, neurodivergence, madness, race, gender, and more – nuance that has shaped this work profoundly. Each conversation we have had about the politics, history, theories, and experiences surrounding borderline have been invaluable; they leave me feeling grounded in the complexities of these topics.

Much earlier in my Master's program, I also cold-emailed Sarah Redikopp, whose work was the first I ever read on the value of borderline (counter) knowledge. I would not be here, in so many ways, if it were not for Sarah's pointed, political, affirmative, and nuanced account of borderline knowing and other forms of subjugated knowledges that have a lot to teach the world because of their abjectness. Since reading her work, Sarah has pushed me conceptually, politically,

and ideologically, and I am grateful for and excited about her more recent work on the various namings of self-injury and what that says about intersectional harm.

Karlene Schwencke (Mamea) is a trusted friend and colleague from Tāmaki Makaurau, who made my time in frontline work more survivable, and who continues to bring a nuanced, complex, compassionate, culturally sensitive, and strategically political approach to her work with people most affected by various forms of colonial harm in Aotearoa. I always appreciate Karlene's insight, because she brings psychotherapeutic knowledge on experiences like borderline, alongside a sociological and lived experience understanding and acknowledgment of the harms and shortcomings of these Western frameworks and the systems they're embedded within. Karlene brings me back to the complexities of clinical practice, engagements with the system, and has taught me heaps – to use a kiwi phrase – about the politics of 'BPD' within the field of psychotherapy.

I met Kim Smith almost two years ago while working together on a research project here in Edmonton. Kim has become a close friend, theoretical buddy, and mentor in so many realms of theory, methodology, axiology, and politics (and I am not sure that she knows the extent to which she helps me think more complexly). I have so appreciated Kim's difficult questions, the variety of sociological, theoretical, and community-based tidbits she introduces me to, and the nuance she brings to all things implications and 'what we think are the right approaches.'

Finally, I am grateful to have been inadvertently connected with Tiffany Sostar through a variety of people here in Alberta. I first knew I wanted Tiffany on my advisory board because of their community narrative work on the "BPD Superpowers" (Sostar, Thomas, and Nault 2020). Upon getting to know Tiffany further, I learned more about narrative therapy and narrative methods that, although I do not use these in this thesis, provide enormous political and axiological insight for any work that involves or has implications for community (which is all work). Through their various professional, academic, and community experiences, Tiffany also brings a nuance to conversations about borderline, trauma, neurodivergence, and related topics, that I greatly appreciate; they understand the complex ways in which personal experience, discourse, divergent access needs, and competing political implications can all come together to make any discussion of something like borderline much more complicated.

Notably, I had similar meetings with and am similarly grateful for my supervisor, Tim Barlott, and received input from Gayla Grinde, Lindsay Eales, and Eduan Breedt as well. I did not

include their input as official advisory group members because of their positions as my academic supervisors, and in the case of Eduan, his situatedness as my romantic partner. After receiving ethical clearance (University of Alberta Research Ethics Board, Pro00131750), I reached out to advisory group members in early Fall 2023 and met with seven of them in November and December 2023, and one in February 2024. Based on their individual preferences, I shared an outline of my thesis arguments, and/or a recorded presentation of my preliminary thesis arguments with them prior to our meeting. In April and May 2024, I met with six of them to discuss a draft of my thesis, which I shared a few weeks prior to our meeting. In each meeting, we spoke for about an hour, sometimes more if we were both interested in doing so, and discussed theoretical, political, methodological, and sociological matters about my current work. I took hand-written notes and shared them on a locked Google Drive with each member. Advisory group members were compensated for their time in the form of an honorarium, funded by my supervisor's discretionary research funds. As I discussed in the acknowledgments, each person provided unique questions, insights, suggestions, perspectives, and feedback that contributed to this project. Even if I did not have time to finish all the readings they suggested, our conversations, their work, and that which I did read (or skim), has greatly shaped my thinking and this work. Several advisory group members have been acknowledged and/or referenced in papers (see Tichenor, under review; Tichenor, Barlott, and Breedt, under review). If I end up publishing more papers that come from this thesis, I plan to invite advisory group members who may have theoretical and topical interest to co-author or be acknowledged in the publication.

2.5.3 What (asking what) borderline (does) did to me, or, what doing an ethology did to my ethology

> "I am not a representative for a specific kind of experience; I am presentative of it. That is, I'm doing it right now, in front of you, and in front of myself. I am a proponent of aporia: thinking with holes in it, thinking that contradicts itself, that circles back, that reveals the knotting and fraying and re-weaving of an argument so that it contains all of its mistakes so that you can see them, and so that I won't forget how I got here. [...] So here I am, in transit" (Hedva 2016:n.p.).

What did borderline do? On the one hand, what did my being borderline do to my work and this project? Several things, particularly surrounding my "stability in my instability" (Kernberg 1967). However, I am not here to essentialize anything as being 'because of borderline' or quintessentially 'borderline.' So rather, I'm asking *what has it done to analyze borderline?* What has borderline done, through its relationships with me, my body, the theorists I've encountered, and the events

going on in the world? What have 'borderline personality' assemblage(s), in their various arrangements with the world produced?

I started with an "auto-ethology" (adapted from Fournier's 2021 review of feminist autotheory) using feminist "affect-as-method,"[42] where I more readily conflated affect with emotion and was interested in what my affective responses to borderline encounters (with myself, my psychiatrist, on social media, in the news, in clinical practice memories, etc.) did, and what they might say about the socio-political. Early on, I ran into affective dissonance about writing about my own affects, about doing an "auto" ethology, about how valid my borderline diagnosis was and therefore if I could write about this topic, about the extent to which I was producing or gathering enough data, and if I was proving my arguments properly (my arguments, which came from reading and more reading, observing and more observing). I discuss these changes more by way of reflection – showing what asking, "what does borderline do?" did to me, and thus to my 'data' and 'analysis.'

January 16, 2024: Autotheoretical reflections on affect and the "auto"
I picked this reflection up using Google Docs on my phone while in the emergency room, where I went as a last resort for what ended up being indicative of another psychiatric

[42] This shift highlights my shift in thinking about affect, from something akin to emotion or feeling that one can possess, to an ontological tool that helps us analyze debility and capacity (as I discussed earlier in the chapter). I pivoted from my previous prioritization of intersectional feminist affect theory in my prospectus, over Brian Massumi's (2002:27-28) suggestions that affect is autonomous, pre-conscious, non-subjective, pre-personal, pre- and post-political, thus of a "different order" than "recognized, owned, and qualified" emotion (see: Massumi 2002:3, 12). Feminist critics contend that Massumi's use removes the political from inquiry, missing important questions about how affect operates on, though, and against social power (Åhäll 2018; Hemmings, 2005; 2015; Tyler et al. 2008). Even if it has an unconscious or surprising element, we must ask: who is holding what affect, whose affect transfers to whom and how, and what does affect teach us about politics, inequality, and injustice? (Ahmed 2004:89; Tyler et al., 2008). Importantly, Massumi and Sedgwick also fail to cite the lineage of post-colonial, feminist, and queer scholars who have engaged with affect and its politics (Hemmings 2005:558; Dixon-Román and Puar 2021). In solidifying my ontological commitments to analyze borderline broadly in terms of debility and capacity – enabling and foreclosing affective capacities – I slowly shifted by orientation towards affect as indeed a preconscious force distinct from feeling and emotion. Although I have not taken up Massumi's work, I have shifted towards relying upon Jasbir Puar's (2017) interventions with affect. As Puar argues, that Deleuze and Guattari used affect in terms of power to act does not make it devoid of political analysis, but rather, necessitates political analysis of how capacities to affect and be affected are modulated. While acknowledging feminist theorist's important work about how affect and emotion "slide into one another" (Ahmed 2010:32), I use affect now to refer to changes in "dispositional orientation to the world" (Duff 2014:44) that can be constituted by a variety of forms of matter, and that often "elude the grasp of language" (Buchanan 2023a:6; see Pellegrini and Puar 2009). I am greatly influenced by and appreciate theorists like Clare Hemmings and Sara Ahmed, and yet, I am not interested in the affective states or moods produced by borderline, or that produce the image of borderline. I am particularly not interested in my own (borderline affects), while I acknowledge that everything written here is written through my own lens. Rather, my work uses a political methodology that looks specifically and contextually at what borderline capacitates and debilitates, which requires a broader ontological conceptualization of affect as a modality through which to analyze power and control (Puar 2017).

diagnosis. I wrote: "I am really not wanting to talk about this struggle right now." My own affects about borderline in popular discourse and clinical settings *could* tell us something about the socio-political. However, if I am writing about borderline and the socio-political, my analysis should certainly not be limited to my interpretation of my own affect. In fact, I am not interested in writing about my affect as a borderline, or even about borderline (though they are both caught up with my analysis).

I so much do not want to discuss my borderline crises or my emerging other crises because this thesis is not about presenting 'borderline' to you (Hedva 2016). I cannot show or tell what borderline or depression or hypomania or whatever is like because I would only be describing my specific experience and the language that I am putting to them right now. Borderline exists – it exists in that many of us resonate with it, in that the concept describes a "constellation" of experiences, worldviews, and affects that may be useful to lump together – even if there should arguably be no basis for treating these through psychiatric frames, perspectives, therapies, or medications.[43] The borderline concept can be a harmful thing and a resonate one, but we cannot really know what it is or is like until we examine what it does – what these affects and worldviews do, and most importantly, what does it do to describe them as borderline and/or 'BPD,' and in which settings. Here is why I do not have much interest in describing my experiences, except to call out the differential patterns of experiences based on empire (see next excerpt). My diagnoses do not necessarily amplify my knowledge of these subjects, but do highlight the much different experiences I have had with diagnosis and the mental health system compared to the structurally precaritized women and femmes that I worked with.

So that is where I have ended up, here, on January 16th. When I say I, I mean we – all of this comes from reading all of these people, and talking with Ed, Tim, my advisory group, Jessica Simes, Cati Connell, and more.

At the same time that I want to decenter this work from myself, "let us not pretend that we can understand what our dogs think." This is a paraphrased quote from Ian Buchanan, in response to a question posed at his keynote lecture at the In Sickness and In Health conference in February 2024 (see also Novak 2020 on Deleuze, humanity, subjectivity, and desire). In response to the posthumanist theory that urges we go beyond the anthropocentric perspective, let us not obscure that I am still the author through which this writing is occurring (and through which all writing and theorizing occurs). Regardless of my politics or preferences or ontology, it should not be thought that we can actually go beyond the human or our social location because *we* are writing (see Breedt et al., forthcoming). No, I am not a self-contained, coherent, rational, neoliberal self. *I* does not mean my autonomous, rational, agentic mind. That I am writing this means that the words are coming from my fingertips, but through and from and with the authors I have read, my parents and community who raised me, my ancestors, my interactions with the environment, conversations with my partner, my friends, and my colleagues, and and and.... The *I* in writing is not to reify the European humanist, neoliberal subject but to ensure we do not obscure that this is a specific account of socio-political phenomena that can only be incomplete and should not be universalized.

[43] Sarah Redikopp, personal communication, December 20, 2023.

January 8, 2024: Autotheoretical reflections on borderline and empire

Encountering borderline, borderline in our world, borderline and theory has produced affective dissonance. My 'borderline' affective dissonance and distress, both related and unrelated to this project, have produced new questions. Borderline and my encounters with theory and the world, or perhaps my encounters with theory and the world (while 'being borderline') have led me to ask more questions about borderline in relation to geopolitics (this was particularly enabled through Puar's work). 'Borderline personality' assemblages, particularly with reading, have produced methodological and theoretical qualms, changes, frustrations, and modifications. Borderline has shifted my attention to questions of global mental health and the use of 'BPD' in the context of control societies. Borderline has produced affective dissonance when my understanding of inequality (statistics, history, writers, theorists, listening, witnessing, social work) plays out in real time, in how I see people being treated based on their diagnosis, and how that compares to my own. However, it has also occurred with "affect-as-method," and with the differences between Mad affirmations of borderline and widespread changes in 'BPD' discourse in pop culture.

One thing that asking these questions about borderline *did* is open up borderline to the point where this thesis is not really about borderline any more, perhaps even *against* doing work on borderline. What started as a problem with the organization I worked for, psychotherapy, and a storytelling of my own relationship to borderline and whiteness (and the vectors of white supremacy) has transmuted into a big problem with not only white-washed reclamation movements but the broader neoliberal, neocolonial logics that underlie so many mental health discourses, research, approaches, and campaigns – even Mad Studies. Not that this thesis was not about those things, but I did not know the extent to which more could and should be written about empire and borderline, beyond just affirming borderline knowledge and asking who has access to that affirmation. I will say that it is a very white epistemological journey, in that the 'difference' between my starting questions and my concluding suggestions would quite likely not be able to be differentiated in the first place from different geopolitical perspectives; my whiteness allowed me to ask questions first about borderline, and then about empire. What I understand now as the inseparable conversation about madness and empire (as in, why don't we just talk about empire? Or, we cannot talk about madness without talking about empire) is not some 'epiphany' for many people around the world but is lived.

I, Erin, am writing through borderline, because it is a lens through which I am currently considering other things. This thesis is more about the ongoingness of settler colonial and Capitalist violence - in Michigan, in Aotearoa, in Canada/across Turtle Island, in Palestine, in South Africa, in ...I want to write about these – about these violences – and about where I have "ended up" in my thinking about borderline. I want to write about these violences, and yet they are so obvious; I am also quite interested in how seemingly liberating movements or positive things obscure empire or are conduits of its logics. What 'BPD' is currently doing is one of those conduits. This is where I am, in January 2024, that the use of 'BPD' is desired by empire and reproduced empire in various ways, and that borderline and other subjugated knowledges can be useful, valuable, often distressing tools against empire that unfortunately can also reproduce empire.

More succinctly, what started about borderline (and the sociopolitical field) ended up being about empire, in the context of borderline and madness. Or rather, it's about empire, but viewed through the lens of borderline. This thesis thus ponders various reconceptualizations of borderline, including as a sociopolitical force, but it also ponders the potentials of giving up any mobilization around borderline or madness at all. Still, having written through this – and needing to have written through this – it is okay to use something, i.e. borderline, or disability (Puar) or migrant mental health strategies (Tam) or physiotherapy (Breedt) to analyze and highlight empire. My partner, Eduan, helped me talk through this and brought up the analogy of a light beam being shown through a prism. How we look through empire, through different angles, always diffracts and changes what it looks like, but it's still empire. Even when we think we are looking at the thing – empire – we can only really perceive it through the perspectives we already know or are learning about. Landing on a plateau in our scholarship and activism can expose different aspects of empire when we analyze it from different angles. There is of course much that I do not perceive. The problem is when we do not call out empire, and/or we do not acknowledge that things are obscured. Something is always erased when we write, and the question is what are we erasing, and obscuring? What are we saying, and what are we not saying? When I focus on affirming borderline ways of knowing, feeling, and acting, I obscure the creation of psychological debilitation through imperial trauma. We/I cannot attend to all the things, and perhaps that is the tension I am working through. What this is all exposing is the rationalist perspective I am holding in my body that tells me I need to address everything, to know everything, to leave no rock unturned, to do justice to everything, to show everything. This is an impossible task, and a task that colonization, capitalism and European humanism ask of us. Instead, might I just highlight, channel, maneuver, focus, and be okay with contradiction?

Lastly, on repetition (thanks to a comment from Eduan). Some things need to be said again, and again, and again, and again. Simply repeating Sarah Redikopp, or Louise Tam, or Rachel Gorman, or Femi Eromosele, or Jasbir Puar is okay. Some things need to be repeated, over and over and over again: "Difference, is in-itself already Repetition" (Deleuze 1994:129).

As these reflections show, doing an ethology changed my ethology; engaging with borderline and the socio-political field changed how I approached affect and autotheory, how I situated borderline, and how I am situating this thesis – as a thesis not simply about borderline, as if it operates in a vacuum, but about borderline as it relates to empire. To return to Puar's invocation of a geopolitical ontology (and caution against a locationless ontology), conducting an ethology about borderline, as it moves through my own lens and the socio-political field, has also pushed me to reflect on the role of the "auto" in this thesis. I have attempted to acknowledge the importance of positioning (insofar that we as academics cannot purport to offer universal accounts of any topic), while distancing this thesis from myself enough to avoid an analysis that is solely based on my own injury (read: innocence) or the assumption that the one subaltern aspect of my identity means that I have generalizable and unproblematic insight into this topic.

2.5.4 Overview of the empirical chapters

Kim Smith put words to this idea of "starting from implications:" What are the implications, not just for individuals, but for society?[44] Implications beyond neoliberal individuals, while including the importance of differential subjective experiences. This helps us to ascertain not just what things are doing intersectionally, but what they are doing for our systems (reifying and bolstering up, or tearing down), which ultimately has deeply intersectional implications.

This thesis engages with the micro, but ultimately asks questions about macro-political ends, and is thus a writing through that which felt irreconcilable for so long (and that still feels irreconcilable): affirming borderline knowledge and madness, while still taking a staunch intersectional critique of who benefits from reclamation or affirmative movements, who and what experiences are excluded, and how pride and rights are made possible by the exploitation of disenfranchised populations (Puar 2017). At times, my empirical chapters (Three and Four) feel in tension, and yet, I think the question of "what is this doing, for whom, in which contexts, and towards what ends" helps to bring the chapters into conversation – to think with "and" (Barlott and Setchell 2023). We can both ask what 'borderline' affects and worldviews are doing – without jumping to conclusions about them (Chapter Three) – *and* what calling them borderline or 'BPD' does (Chapter Four). We can ask what borderline affects are doing micro-politically (Chapter Three), as well as what they might do on a macro-political scale (Chapter Four). We can ask what desires or wills these affects as well, and what desires or wills the label of 'BPD' or its potential replacements. As a reminder, the main research question I am exploring in relation to "what does borderline do" is:

1. ***How is desire assembling different 'borderline personality' assemblages, what do these sub-assemblages produce, micro- and macro- politically, and what do they obscure?***

Chapter Three addresses this question by specifically asking:

   a. ***What can the Mad-affirmative sub-assemblage of borderline do? Employing the Mad-affirmative conceptualization of borderline, what can borderline (affects, worldviews, and experiences) do (debilitate and capacitate), micro- and macro-politically?*** (Chapter Three)

To explore this, Chapter Three discusses the micro-politics of borderline and reconsiders the 'traits' that European humanism and its institutions, like psychiatry, so often pathologize.

[44] Personal communication, December 8, 2023.

Chapter Four then asks:

> **b.** ***Macro-politically, what do the sub-assemblages of 'BPD' diagnoses, psychocentric 'BPD' reclamation, and borderline affirmation do (debilitate and capacitate) for whom, and in which contexts, and towards what ends?*** (Chapter Four)

To do so, I analyze that which is obscured by affirming borderline 'traits' in Chapter Three, and focus more on the macro-politics of what destigmatizing and reclaiming borderline and 'BPD' are doing, for whom, and towards what ends.

To conclude this chapter, I have inserted an autotheoretical reflection on the use of Deleuze. I have placed this here so as to avoid disrupting the flow of the rest of the chapter, while emphasizing my evolving approaches to Deleuze (or more accurately, uses of Deleuze) within the main body of this thesis, rather than in the appendices.

January 22, 2023: Autotheoretical note on Deleuze and Deleuzianism

There are a few (of many) more caveats I'd like to discuss about using Deleuze's ontology, and with how his ontology is used. First and foremost, scholars like Deleuze are often credited for viewing the world based on flux and relations, even though "for hundreds and thousands of years, interconnectedness [...] has been the mainstay in many Indigenous frameworks, both tribal and diasporic" (Tuck 2010:646). Deleuzo-Guattarian theory - particularly as it appears in the affective, new materialist, and posthuman "turns" - risks further epistemic violence against non-Western knowledge, both when it is equivocated with it, and when it pretends to be saying something novel (Puar 2017; Sexton, in Barber 2017; Todd 2016; Watts 2013). Much of what Deleuze and Guattari were critiquing were the very problems with Western notions of humans, the self, and the world, particularly in psychoanalysis, priesthood, the state, capital, and the military: "Deleuze's writings were often aggressively mounted against all the perversions of power that saturate daily life: the ego, the father, repression, the state, even the dialectic. Nevertheless, Deleuzianism has become unaligned in recent decades, adrift from its original political goals" (Galloway 2013:365). Before I get to Deleuzian*ism,* I note that despite the alignment between Deleuze and Guattari's and other important anti-oppressive politics, relying solely on them and their worldview may not be the best approach going forward. French philosophy cannot account for everything, *and* they were by no means the first to critique these power structures – epistemologically or ontologically. Second, relying on Deleuze obscures and covers over what our work should be prioritizing - decolonization and Indigenous sovereignty, not the reinvention of the wheel of European dominance over thinking (capture), however liberatory from most other forms of European philosophy and politics (McLeod and Fullager 2021).

What started with an introduction to Deleuze and Guattari in 2021 (from my partner, Eduan Breedt, and then Tim, and then reading, and wondering why their work was not taught in my sociology program) has become an appreciation for their interventions, an acknowledgement of their shortcomings, an icky feeling about how they are used and who they cover up and

how they are used to cover up, and a deep appreciation for scholars like Puar who say "assemblages no longer have to belong to Deleuze!" (Puar, in Sircar 2020:346).

Does this mean moving on from Deleuze? For me, this means moving on from Deleuze without really moving on, and it means asking questions about what my role is as a white settler researcher, colleague, community member, teacher, writer, and (former) practitioner. Where and when do I speak back to whiteness, call out empire, and trace state violence (Puar, in Sircar 202?)? Where and when do I learn about, use, uplift, or share Indigenous knowledge in the specific places I call home (currently, the traditional gathering grounds of the nomadic plains nations of the Cree, Blackfoot, Dene, Iroquois, Anishinaabe, Métis, as well as the largest Inuit population outside of Nunavut)? Where do we critique, where and how do we build alternative practices and find spots for resistance within our colonial and capitalist systems, and when do we do completely otherwise? These are all personal (and thus communal and political) questions for me, but questions that the past few years have pushed me to contemplate). For now, I'm sitting in: based on my skills, interests, and responsibility to expose the harms of whiteness, empire, and racial capitalism, I want my academic work to focus on that. Particularly given that if anyone will be exploited in my data extraction and my benefitting from academic publications, it will be white institutions, not sacred knowledge and communities. This also means that I will not really forget Deleuze, but be continuously informed by the important questions and types of questions he pushes us to ask, and how he provides tools - yes, within my Western frameworks - for understanding the "constant ontological assembling of power" in control societies (Puar 2017:20). Still, I do not want my scholarship to stop at Deleuze, even if I stay with Deleuzian questions, and even perhaps theories of change (Tuck and Yang 2014). I want to follow scholars like Jasbir Puar, Mel Chen, Alexander Weheliye, Loic Wacquant, Jackie Wang, and more, who have taken Deleuze's and others' tools, mobilized them politically, and addressed power and empire as they are operating now.

I am much more than a hopeful academic, however, and am also a community member, friend, partner, colleague, peer, student potential mentor, potential educator, potential parent, family member. And what is my role there? Yes, to call out empire and its conduits. I think community work is also where I would like to shift my gaze from intense analysis, that yes, is informed by my Western views and comprehension of French philosophy, but not only by these. I want to support colleagues, peers, and community members to prioritize Indigenous sovereignty. At the moment, I do not think it is my role to become completely "culturally competent" in a way that makes me innocent (though I do agree with cultural safety, and to learning from and valuing Indigenous worldviews and having them influence and change me). These are not my worldviews to share without permission/co-opt, but they are for me to uplift, fund, support, and direct my community attention and teaching and advocacy towards. That is, I do not want to write a book on Indigenous ways of knowing, but I do want to write one on empire as it operates through the health system. I do want to, however, advocate within my faculty, at the University of Alberta, within Alberta Health Services, and in broader Edmonton - to learn, support, be an extra set of hands, prioritize sovereignty (a not great translation for what is meant - see on rangatiratanga v. kāwanatanga), treaty, treaty relations, adherence to treaty, and embedded with this, an end to imperial violence and genocide

globally. Not that I am or will or can do all of this. I am simply trying to work through and articulate where I would like my priorities to be in the coming years, in my life and scholarship, with my capacities and limitations. All of this is to say, that for this thesis, I am dealing with the very Western-created, used, and imposed concept of 'borderline.' I seek to affirm what is called borderline, or at least trouble the immediate and transcendent ways in which these experiences are responded to. I seek to call out how BPD specifically is and can be used as a conduit for empire and the ascendency of whiteness (Chow 2002; Puar 2007). Still, I could have taken a different approach, specifically for the former. In Chapter Three, I largely use Deleuze to ontologically trouble how borderline is treated/responded to while relying on this category of 'borderline' because of its resonance for many (mainly in the West) and to contribute to how it has been reconceptualized outside of the gaze of psychiatry (Lewis 2023b; Johnson 2021; Redikopp 2018). I also discuss, but do not pretend to have the knowledge or wisdom to share, how what we might call borderline is conceptualized and viewed differently in non-Western cultures. I'll admit that I have not found much, using my limited literature review techniques (and as if Google or academic journals are where all things are found), aside from Fromene and colleagues' discussion about Indigenous service users in Australia, and from the teachings and resources I have received from Māori and Pasifika practitioners, scholars, and tohunga; this could have been the focus of the first chapter, but it unfortunately was not. I encourage, however, to how these types of experiences might be viewed and responded to in Te Ao Māori, and what that teaches us about the limitations of our Western frames, even when we go beyond the largely harmful DSM.

Second, is the problem with how Deleuze has been used, co-opted, taken up for what my partner and colleague, Ed Breedt, calls "capitalism speak," or as Alexander Galloway (2013:352) aptly critiques: "What should we do so that our understanding of the world does not purely and simply coincide with the spirit of capitalism?" (see also: Culp 2016). This is a long discussion to have, and outside of the scope of this thesis. I will note a few things. First, "new materialism," as well as "post-humanism" or "post-anthropocentrism" are largely white academic fields, and fields that have used Deleuzian metaphysics to go for such a monist ontology that it becomes only about white biopolitics, only about a critique of capitalism *or* complicit in its adapting logics of connection and generativity, and only about certain types of humanisms that only certain humans have been granted humanity within (Jackson 2015; Karera 2019; McLeod and Fullager 2021; Puar 2017; Weheliye 2014). As pointed out by several scholars, and more in Ed's work, these fields obscure, erase, cover over, and neglect a lot; they are complicit in and participate in late-stage capitalism and control societies (not only biopolitical control, but necropolitical violence); they de-politicize almost everything, which is particularly interesting, given how political, and specifically political, Deleuze (and Guattari) were (see: Breedt 2024; Buchanan 2020; Galloway 2013; McLeod and Fullager 2021; McLeod 2024; Puar 2017; Sexton, in Barber 2017).

CHAPTER THREE: WE DO NOT EVEN KNOW WHAT A BORDERLINE MIGHT DO

*Note: This chapter largely resembles an article, entitled "We do not even know what a borderline can do: A Deleuzian ethology of 'borderline personality;" (Tichenor, Barlott, and Breedt, under review). This article has been submitted for consideration for publication in a journal, but it has not been accepted or published yet. Please refer to the following adjustments made for this thesis.

3.1 Introduction

3.1.1 Adjustments made to the manuscript for this thesis

Many parts of this chapter are replications of the paper mentioned above, and the 'we' used throughout refers to the authors of the paper: myself, Dr. Tim Barlott, and Eduan Breedt. However, much of the paper has been amended for use in this thesis. First, given that Chapter Two covered the theoretical and methodological background included in the publication, I do not repeat it here. After introducing the concept of the body-without-organs, as we do in the paper, the main body of this chapter consists of seven mini-ethologies of borderline 'traits.' Whereas the paper only included four ethologies, I have added ethologies of "a pattern of unstable and intense interpersonal relationships," "impulsivity," and "stress-related paranoia or dissociative symptoms" back into this version for the thesis. In this thesis, I chose not to include the traits of "chronic emptiness" and "affective instability," because these experiences, for me, are so caught up with other experiences that writing their own section proved redundant. For example, I discuss what else "affective instability" (and borderline "instability" more broadly) can do in relation to the "unstable sense of self," as well as "inappropriate anger." I relate "chronic emptiness" to the "unstable sense of self," and "unstable pattern of relationships." In terms of the final diagnostic traits, "stress-related paranoia and/or dissociative symptoms," I focus on the former, given my limited experience with dissociation and psychosis; instead, I point to other scholars who have offered critical analyses of these experiences, both within and beyond Western conceptualizations. I have removed the implications – mainly clinical – that come from these ethologies and incorporated them into Chapter Five, where I discuss micro- and macro- political implications of the entire thesis. Finally, I have edited elements of the paper for clarity and flow within the broader thesis.

3.1.2 Outline of this chapter

> "The focus on BPD as pathologization obscures what living with borderline experience is really like and therefore does not consider the valuable knowledges produced by a borderline perspective" (Lewis 2023b:29).

In what follows, I engage Deleuze's ethology with the micro-politics of borderline, specifically, how we might conceptualize or respond to experiences that are sometimes called borderline 'traits' or 'symptoms' (the sub-assemblage of borderline experiences, not 'BPD,' as traced in Chapter Two). I thus respond to research question 1a), *what can borderline (affects, worldviews, and experiences) do, micro- and macro- politically?* I use Mad conceptualizations of borderline experiences alongside Deleuze and Guattari's concept of the "body-without-organs" (BwO) to trace what borderline experiences can open up (capacitate) and foreclose (debilitate), with a specific focus on what they can capacitate, given the predominating popular focus on the association between 'BPD' and 'destruction.'

We first introduce how we came to conceptualize borderline in relationship to Deleuze and Guattari's "body-without-organs," (BwO). In doing so, we play with conceptualizing these 'symptoms' as affects, worldviews, and experiences that can gesture towards the "full body-without-organs," or, as introduced below, an ethical practice central to Deleuze and Guattari's theory of change because of its ability to disorganize and reorganize oppressive structures without replicating their forms of power; in short, the political *ends* of this chapter is the making of a "full BwO." After situating the BwO and highlighting its practical uses, we offer a cursory ethological analysis of seven out of the nine 'borderline traits,' as they are outlined (but not as they are pathologized) in the diagnostic criteria for 'BPD' (a label that itself could use some ethological analysis). In doing so, we outline what each 'trait' 'is' (as defined by psychiatry), what it does or can do (including how it can debilitate), and what (else) it (might) do (how these traits might be capacitating, not just pathological). By asking not what borderline traits essentially are, i.e. if they are healthy or unhealthy, good or bad, but what (else) they (might) do, these mini-ethologies look beyond pathologizing interpretations of the diagnostic criteria, inviting greater conceptual and contextual analysis of these experiences. While this chapter has implications for how we understand and respond to borderlining as clinicians, friends, family members, and in popular discourse, it also has several limitations, which I discuss at the end. That is, affirming borderline can still obscure many socio-political aspects of madness, reclamation, and distress. Grappling with these tensions thus provides a useful transition point into Chapter Four, which responds to the risks that come with this chapter (and other forms of borderline reclamation).

3.2 Why the Body-without-organs?

> "How can we fabricate a BwO for ourselves without it being the cancerous BwO of a fascist inside us, or the empty BwO of a drug addict, paranoiac, or hypochondriac? How can we tell these three bodies apart" (Deleuze & Guattari [1980] 1987:163)?

I first encountered Deleuze and Guattari's ([1980] 1987) chapter on the "body-without-organs" (BwO) while amid a depressive episode that pulled me from my work as a frontline social services worker and later, led to my various borderline and borderline-related diagnoses. Leading up to my depression, I had also become increasingly discontented with the ways that service users (described and/or diagnosed as borderline) were being labeled and treated by clinical and social services. While reading, I could not help but notice a resemblance between what are considered borderline traits and their warnings against the "failed" or "botched" BwOs; while the authors insist that making oneself a "full" BwO is necessary for ethical social change, they warn that it can be a dangerous process in their discussion of these "botched" BwOs, the "cancerous" and the "empty" ones. I was particularly interested in the resemblance between borderline experiences and the "empty" BwOs: the "hypochondriac, paranoid, masochistic, drugged, schizo, anorexic, and suicidal" BwOs (Deleuze and Guattari [1980] 1987:150). After all, the self-harm, suicidality, starvation, substance use, and paranoia imbued in these BwOs are quite similar to the collection of coping skills entangled with borderline distress (and other forms of mental distress). I thus became curious about potential theoretical and practical relays between borderline and the BwO: *Are borderline affects and behaviors "empty," and to be entirely avoided, or could the BwO help me affirm my own and others' borderline affects? Could it be therapeutically useful for both: affirming while avoiding complete destruction* (see Buchanan 2023b)? I tried to use Deleuze and Guattari's language as a therapeutic means through which to switch my less-helpful coping skills towards more-helpful ones, without judging myself for my impulses. Ultimately, Deleuze and Guattari's ontological and political refusal to conceptualize identities as static, individuals as immoral, and behaviors as inherently pathological pushed me, Tim, and Ed to focus on using the BwO to affirm the ethical potential of what we might call borderline 'traits,' without obscuring the distress that is caught up with them.

Dealing with this concept has been grueling and has mostly felt useless. The language of the BwO can be obtuse and thus I almost did not include it in this thesis. Ultimately, the BwO has provided me with language through which to become curious about my own experiences, as well as to be cautious about seemingly liberatory moves (or false BwOs) that get co-opted for state and

corporate gains (Puar 2007, 2017). The question for me is, how might the BwO help us to depathologize that which has been called borderline, while cautioning against any effort that re-essentializes borderline, ignores non-Western conceptualizations of mental distress and difference, obscures psychological debilitation, or does not ask who and what socio-political institutions are being served by various affirmations of madness. I hope that in what follows, I have alluded to some clear clinical (and societal) implications for how to reconceptualize what we might call borderline 'presentations' amongst patients, friends, and community members, without harping too much on the language of the BwO.

3.3 Introducing the Body-without-organs

Given the numerous conceptual changes the BwO underwent in the Deleuze and Guattari's writing, we consider the BwO of *A Thousand Plateaus*, where they also refer to it as the plane of immanence, or that which encompasses the immanent possibility for what something can do (Buchanan 2021). In short, this BwO resists the organism's organization of bodies (internal and external). Where bodies, for Deleuze and Guattari ([1983] 1986:40), are considered "relationships of forces [...] whether chemical, biological, social, or political," the BwO is useful for reconceptualizing borderline as a potentially ethical intervention that can cut across, disrupt, and reconfigure transcendent impositions over how bodies and minds *should be* (what Deleuze and Guattari refer to as the *organism*).[45]

Deleuze and Guattari describe the BwO in part through French playwright and Antonin Artaud's longing "for the peace of an organ-less body" (Buchanan 2021:47). After many years of psychiatric institutionalization, Artaud (1947) described a longing to become un-organized – for his organs to stop demanding so much from him: "No mouth. No tongue. No teeth. No larynx. No

[45]Viewing the borderline concept as a body, and borderliners as bodies, is useful for this piece, insofar as I want to reiterate Deleuze's point that we cannot know what a body is, we can only know what it does, a point that he derived from seventeenth-century Jewish-Portuguese lens maker and philosopher Baruch Spinoza's (1677) theorization of an immanent body. Spinoza also contested the mind-body separation pervasive since the European Enlightenment, disagreeing with Rene Descartes' 1637 *cogito ergo sum* (I think, therefore I am), which asserted the mind as separate from and superior to the body. Descartes also developed the idea that human bodies are discrete, individual entities that are unaffected by the world, and subordinate to the rational mind. Spinoza's concept of 'parallelism,' instead viewed the mind and body as one in the same, with no ability to directly cause a response in the other (Deleuze [1970] 1988; Lord 2010; Novak 2021). After all: "The body does not end at the skin. We leave traces of our DNA everywhere we go, we live with other bodies within us, microbes and bacteria, we are enmeshed in forces, affects, energies, we are composites of information" (Puar [2012] 2020:410). Although I draw on these ethological questions of the body, and Deleuze's body-without-organs (Chapter Three), I mainly conceptualize borderline in terms of assemblages, noting that bodies and assemblages share the same ontological presuppositions in Deleuzo-Guattarian theory. Bodies can be an element within assemblages, but they can also be considered assemblages themselves.

oesophagus. No belly. No anus [...] When you will have made him a body without organs, then you will have delivered him from all his automatic reactions and restored him to his true freedom." Again, the BwO is not opposed to organs, but to the organization of organs by the organism; for example, "anorexia is not a refusal of the body, it is a refusal of the organism, or more specifically a refusal of what the organism imposes upon the body" (Buchanan 2021:44). Here, the organism refers not simply to the physical body, but the transcendent systems that constrain it, such as "the cancerous body of America, the body of war and money," or psychiatry and its authority to categorize patients with pathologies that define their futures (Deleuze and Guattari [1980] 1987:163). To recall Chapter Two, desire is a productive force caught up in the social and economic field, reminding us that our interests are not really our own, but produced by desire. The BwO, thus, refers to the longing to be relieved from "desire's incessant demands" (Buchanan 2021:42), or when "desire no longer desires to desire" (Buchanan 2021:42), for "[d]esire stretches that far: desiring one's own annihilation, or desiring the power to annihilate. Money, army, police, and State desire, fascist desire, even fascism is desire" (Deleuze and Guattari [1980] 1987:164). The BwO, or plane of immanence, for better or for worse, is where our capacities and interests are not so constrained by the socio-political field and its desiring production.

Making oneself a BwO is thus the process of finding the field of immanence, which is an open assemblage of intensities, upon which constraints, categories, and structures are imposed. Everything is immanent to this field; it is "where everything is played out" (Deleuze and Guattari [1980] 1987:149). In other words, when we see boundaries and categories for what they are – constructed on the plane of immanence – then we have momentarily made a BwO or found the plane of immanence. As the plane of immanence, the BwO thus refers to the immanent possibility for what could happen, or how else things could be, if we were freed from the constraints of transcendence in all its forms. The BwO is thus constructed in the moment of deterritorialization, (escapes from fixed organizations), and obfuscated in the eventual reterritorialization (new organs and organization of organs). Making oneself a BwO is underway the moment someone or something resists a hegemonic structure and the organizations it imposes; reterritorialization occurs when new forms of organization are created – hopefully ones that do not replicate the abuses of power of the prior structure.

3.3.1 The "botched" BwOs

This may be read as a valorization of making a BwO – of wholeheartedly rejecting the organism. However, immanence in itself, or getting stuck on the plane of immanence, is not liberating in and of itself (Buchanan 2021). Reorganization, or reterritorialization, and asking towards what ends we are reterritorializing are necessary processes for ethical practice, lest we create one of "its doubles: empty vitreous bodies, cancerous bodies, totalitarian and fascist" BwOs (Deleuze and Guattari [1980] 1987:165). In other words, making a BwO is a risky process because even though deterritorialization is a vital component of transformation, we cannot predetermine if a reterritorialization will even take place, or if it will be healthy or ethical: "You do not know beforehand what good or bad you are capable of; you do not know beforehand what a body or a mind can do, in a given encounter, a given arrangement, a given combination" (Deleuze [1980] 1987:125; see also Adkins 2015). This is where Deleuze and Guattari distinguish between the full, or healthy BwO (that which reterritorializes, towards ethical ends), the empty or suicidal BwO (never reterritorializes), and the fascist or cancerous BwO (reterritorializes, and takes over everything, or gets captured by oppressive forces).

The *full BwO* is thus indicative of the *set of practices* that might free oneself or others from the organism, without turning immanence into a new transcendent value. Making oneself a BwO is an invitation to deterritorialize, or to disorganize oppressive boundaries *and* create new potentials for ways of doing otherwise: *What else might these organs do, or how else might they be arranged?* For example, a group of mental health support workers that oppose funder-driven imperatives to involve the police in their work, might deterritorialize and break off from their conglomerate non-profit, reterritorializing into a community-based alternative.

For Deleuze and Guattari, the *cancerous or fascist BwO* occurs when reterritorializations occur in the direction of oppressive (i.e. the state and capital) power, perhaps by replicating or being captured by colonial power structures (Deleuze and Guattari [1980] 1987:157). After all, "creative disruption" (Lemoine and Richardson 2019) is central to Capitalist innovation, but Capitalism is a system that constrains, categorizes, segments, and kills in its creation of "fascist" or "cancerous" BwOs. A fascist BwO may start out as a "line of flight [that] immediately turns into a line of death and abolition," that grows, spreads, and takes over everything, before ultimately veering towards death (Deleuze and Guattari [1980] 1987:285). We might think of a manager or politician that, despite efforts to break free from mainstream practices, clings on tighter to their

new experiment, now "micro-managing every situation" (Adkins 2015:106). Dominant systems can also co-opt deterritorializing gestures, for example, concepts originally grounded in liberation become buzzwords that the neoliberal state facilitates for profit and control: "Vigilance must always be at work, especially when connections are disabled to foster creative lines of flight, as well as adulterated or polarized by more subtle forms of fascism" (Reyes 2017: 215; see Puar 2007, 2017).

At the same time, only affirming the BwO risks glamorizing the pain that can come with disarticulation: "The body suffers from being organized in this way, from not having some other sort of organization, or no organization at all" (Buchanan 2021:51). Taking Artaud's desire to its limit could lead to emaciation or suicide. When this happens, we have created an empty BwO, which Deleuze and Guattari describe through the archetypes of the "hypochondriac," "paranoid," "drugged," "schizo," and "masochistic" BwOs.[46] They spend a fair amount of their chapter on the necessity of avoiding these BwOs, which refer to lines of flight that may start as desires to dismantle the organism, but end up being against all organs and organization; these BwOs never reterritorialize.

> Why such a dreary parade of sucked-dry, catatonicized, vitrified, sewn-up bodies, when the BwO is also full of gaiety, ecstasy, and dance? So why these examples, why must we start there? Emptied bodies instead of full ones. What happened? Were you cautious enough? Not wisdom, caution. In doses. As a rule immanent to experimentation: injections of caution. (Deleuze and Guattari [1980] 1987:150)

I first read these empty BwOs as identities to be avoided, and thus read Deleuze and Guattari's above warnings as behavioral dictates – that showing any borderline 'symptoms' was automatically emptying. I relegated myself to being an empty one; after all, borderlining seems to encompass all the empty BwOs. Paranoia, substance use, self-harm, disordered eating, and chronic emptiness are among the diagnostic criteria and/or common comorbidities associated with 'BPD'

[46] Before examining the empty BwOs, I want to highlight that Deleuze and Guattari's examples can be read as stagnant nouns, identities, and outcomes. Imposing Deleuze and Guattari's politics and ontology upon their jarring turns of phrase, however, necessitates that the empty BwOs do not signify individual pathologies, but processes that can be applied to humans, as well as other assemblages. The behaviors or types of bodies that they describe as empty BwOs, then, are not pathological or bad identities. Rather, they are deterritorializing processes that, when no reterritorialization occurs, can leave assemblages with little or no capacity to affect or be affected (at their extreme limits). The "suicidal BwO" mustn't be read as a stagnant state, but a body or assemblage going through the process of causing one's own dying. However, we must not mistake individual humans for the systems they are caught up in and captured by. Deleuze and Guattari are not concerned about "cause" in the neoliberal or linear sense, but in analyzing desire – the systems of production that produce certain behaviors, gestures, experiences, de- and re-territorializations.

(Shah and Zanarini 2018). I thus tried to use their language to will myself to avoid all emptying behaviors, including self-injury, screaming, starving, raging, and drinking. Similarly, the mental health system often views potentially emptying processes like self-injury or restrictive eating as transcendentally unhealthy, and/or as immediate indications of pathology (an already empty BwO). The behavioral turn in psychology also does not help; borderlines become an easy target because we are now identified based on our (potentially destructive) behaviors, not based on our worldviews, onto-epistemological ruptures, or insightful challenges to imposed societal organizations (Lewis 2023b; Redikopp 2018). The mainstream treatment of any borderline 'trait' as indicative of an empty BwO hinders its potential for individual and collective transformation – or at least our ability to notice it.

As I read on and engaged more deeply with Deleuze and Guattari's ontological and political interventions, I learned that thinking with the full, empty, and cancerous BwOs, instead, might help us to ask, "what the masochists, drug users, obsessives, paranoiacs are actually trying to do," beyond psychoanalytic interpretations and behavioral analyses (Buchanan 1997:79). I began to use the BwO to help me evaluate what my gestures might do, rather than judging them:

> 'Lodge yourself on a stratum [...] Dismantling the organism has never meant killing yourself' (Deleuze and Guattari [1980] 1987: 160-161). Evaluate, do not judge based on an action's relationship to a moral code. Assess your decisions with an experimental ethos. What might it do? What risk does this pose? What relations will it enable or disable? Proceed with caution. Play with oscillating to and from the BwO, never going so far that your suicidality or rage have irreversible consequences. Ride the borderline of the BwO.[47]

Central to this is the understanding that Deleuze and Guattari did not view the empty BwOs as 'self-emptying' in an individualist, neoliberal sense. Rather, they are interested in the systems of production that empty and create emptying processes: What conditions may be occurring for someone to strive beyond their physiological limits, towards substance use, self-injury, an empty BwO? Sometimes the social machine offers no option for reterritorialization:

> I'd like to ask the APA: What about depersonalization when the state has made you that way, has removed your agency from yourself [...] What about derealization when the state has detached your environment from you, dispossessed you of your land, or turned your surroundings into something unbearable, something that cannot possibly be real? (Hedva 2016:n.p.)

[47] Journal entry, 2022, July 25.

In fact, pathologizing these processes as disorders can create empty BwOs; labels, institutionalization, and pharmaceuticals can permanently reduce one's capacity to affect and be affected. In other instances, gestures such as starving oneself or consuming substances may show us that which is decreasing capacities, and could use some disorganization: "Should we go a short way further to see for ourselves, be a little alcoholic, a little crazy, a little suicidal, a little of a guerrilla – just to extend the crack, but not enough to deepen it irremediably?" (Deleuze and Guattari [1980] 1987:157–158). This is the ethical potential that must not be overlooked when we encounter borderlining gestures that we might tend to pathologize or ridicule.

3.3.2 The need for ethologies of borderline

Given that we cannot know what borderlining is until we see what it does – how it modulates capacities to affect and be affected (capacitates and debilitates) — we propose the need for ethologies of borderline, which can "[provide] a sketch of that which aids, and that which harms, a particular being's characteristic relations with its surroundings" (Gatens and Lloyd 1999:100). Behaviors like shouting, dissociating, or using substances must be evaluated based on what they do, for whom, in which amounts, in which contexts, and towards what ends: "There is a fascist use of drugs, or a suicidal use, but is there also a possible use that would be in conformity with the plane of consistency?" (Deleuze and Guattari [1980] 1987:165).

We thus mobilize Deleuze and Guattari's theory not to avoid borderlining and borderliners at all costs, but to respect borderlining gestures – their affirmative *and* destructive potential. A borderliner, like any body, has a multitude of potentials, and rather than viewing everything they might do from the lens of pathology, risk, and deviations from health, we invite a consideration of not only all that is reasonable about the borderliner, but the transformative and health-enabling potentials of borderlining gestures. While we could spend equal time on capacitation and debilitation in this chapter, we have spent more time on the affirmative side of affective analysis in these ethologies. This is in part because when I was writing this paper, I was more caught up in Mad-affirmative narratives of borderline knowing and had not adequately wrestled with the risks and dangers that come not only with what are called borderline 'symptoms,' but more perniciously, with how various forces shape what a borderline 'symptom' *does* and what systems cause severe mental distress. How we discuss what else borderline traits might do, then, cannot be generalized, lest I depict a universal, white, elite narrative of borderlining. The other reason we mainly include the health-enabling potential of borderlining in this chapter is that so much of clinical literature

already focuses on the affective and relational capacities that borderlining can cut off; the mainstream pathologization of borderline 'symptoms' relies upon an assumption that these actions, behaviors, gestures, and feelings are necessarily and transcendently unhealthy – that they do not have potential to do anything but harm. This chapter thus serves as a corrective to transcendent and pathologizing viewpoints of borderline that do not consider the capacitating potential of borderline 'symptoms' (including as adaptive responses to oppression), an important intervention particularly for clinicians engaging with people described as borderline. After all, if we were to remove all disarticulation, all that has been pathologized, and stay constrained within transcendent Norms of feeling, perceiving, and acting, then there would be no potential for the full BwO:

> Getting better often seems to be about other people's comfort. It means being more productive. Less disruptive. It means being less emotional, less intense, less confrontational, less needy [...] 'getting better' often means shrinking ourselves down to fit an external expectation of behavior and emotion. (Sostar, Thomas, and Nault 2020:15)

As expressed by the "BPD Superpowers" group, 'symptom remission' might be healthy for the dominant apparatus but may halt the ethical potential in deterritorializing processes. If we do not value the full borderlining BwOs, then we are only left with the cancerous BwOs, empty BwOs, no-BwOs, and the BwOs that disguise themselves towards hegemonic ends. The only alternative to being curious about these gestures is to force a reterritorialization back into the dominant apparatus, or to prevent all forms of deterritorialization and maintain the status quo: "If we don't create these .... then we'll be left on the 'other plane' the emptied or cancerous desire will triumph" (Deleuze and Guattari [1980] 1987:166).

In subverting rampant pathologization and valuing borderlining processes, we also respect the often-debilitating nature of emotional distress – labeled as borderline or not. Without going to the other extreme and affirming borderline entirely, assuming the endless potential that life can offer, we try to discuss the importance of immanent ethological analysis of borderlining, rather than a reliance on transcendent assumptions that borderline is all bad or all in need of reclaiming. Substance use, self-injury and restrictive eating can indeed do great harm, but they need not be archetypal failures of the BwO. Rather, they are but a few examples of disorganizing moves that have the potential to be emptying. As Buchanan (2021:52) writes, "the difficulty is that "one can only achieve either of these outcomes – healthy or cancerous – through a process of experimentation, the difficulty being that at first glance the two look very much the same"

(Buchanan 2021:52). That is, ethologies of borderline traits help us to respect the risks and distress that can come from borderline experiences, without immediately jumping to equally-if-not-more-harmful risk management practices; however, ethologies can also prompt curiosity about other ways to deterritorialize. How might we value disorganization and the desire that produces it, without deterritorializing into an empty BwO? "Could what the drug user or masochist obtains also be obtained in a different fashion in the conditions of the plane, so it would even be possible to use drugs without using drugs, to get soused on pure water" (Deleuze and Guattari [1980] 1987:166).

3.3.3 On 'caution' (and the importance of asking towards what ends)

"You don't do it with a sledgehammer, you use a very fine file" (Deleuze and Guattari [1980] 1987:160).

So how do we make a full BwO, without "botching" it, without plummeting into the abyss of deterritorialization for its own sake, and without replicating the abuse of power? In differentiating between the full and botched BwOs, Deleuze and Guattari advocate for "delicate experimentation," "the art of dosages," and "fine files," to indicate an experimental and *careful* approach to de- and re- territorialization. However, before moving on to our ethologies of specific borderline 'traits,' wherein we try to enact this "caution," I want to note that Deleuze and Guattari's ([1980] 1987:152, 160) invocation of caution can easily be weaponized, in the name of ethics, health, peace, and safety:

> The invocation of personal security and safety presses on our affective and emotional registers and can thus be manipulated to justify everything from racial profiling to war. When people use safe space language to call out people in activist spaces, the one wielding the language is framed as innocent, and may even amplify or politicize their presumed innocence. (Wang 2012:n.p.)

The notion of "caution" or "the need to reterritorialize" can get used against groups and individuals who seem to deterritorialize 'too much,' who then get forced into reterritorializations towards the goals of the settler colonial state.[48] As Jackie Wang (2012:n.p.) reminds, "[e]ven leftists fell into the trap of framing the State and property owners (including small business owners) as victims

[48] Alongside what may be a valuable critique of Deleuze and Guattari's notion of caution (or at least its co-option) is the consideration that they might also be reminding us how structurally marginalized populations often *already* conduct ethological analyses from multiple perspectives, lest they get caught in the path of State violence, our/their deterritorializing moves being captured into a false or empty BwO: "Victims of injustice often face a conflict between getting aptly angry at injustice, and bettering (or at least not worsening) their situations" (Srinivasan 2018:130).

while criticizing rioters for being politically incoherent and opportunistic." In processes of deterritorialization, we thus must ask, *who is saying that it is too much? Is that the State or Capital talking, or a collective enunciation? Who are they deployed against, and what systems are producing these responses? Towards what ends are de- and re- territorializations occurring? How or what system is causing or capturing the deterritorialization, and who or what is preventing the reterritorialization?* Even on the Mad-affirmative side, we must ask what ends are being served in our ethologies; for example, affirming the 'paranoia' of (white, cisgender, elite) women in public, while it depathologizes paranoia, has been done alongside and sometimes even in the service of the rampant incarceration of racialized men, particularly black men (Wang 2012). In this case, Mad affirmation gets captured into a false BwO in order to justify racialized state violence. Although we use the language of the BwO in this chapter, Wang's (2012:n.p.) notion of the "politics of innocence" (which includes the invocation of safety towards imperial ends) returns in Chapters Four and Five. Whether we use the language of de- and re- territorializing, making a BwO, or more approachable activist language, we must be wary of how the politics of innocence can undergird Mad-affirmative approaches, thus justifying measures that benefit the state and capital or that get in the way of that which could actually disrupt these systems. Deleuze and Guattari's analysis thus must be deployed alongside a highly intersectional and geopolitical ethology, because how we determine and desire caution, and what it does, is patterned by structural oppression (Puar 2017). Having an aligned politics and asking *towards what ends* must always drive our making of a full BwO; again, the ends that drive ours is the destruction of racial capitalism and Euro-American empire.

3.4 Introducing Mini Ethologies of Borderline

> "The borderline diagnostician knows that we are all capable of affecting and being affected, and that those affections are never decided in advance or fully knowable" (Lewis 2023b:81)

The rest of this chapter uses ethology to ascertain what (else) borderlining (might do), in an attempt to unsettle automatic assumptions about borderlining, where borderlining, again, encompasses processes, affects, worldviews, subjectivities, and gestures that require curiosity rather than avoidance. Drawing on my own autotheoretical work, my clinical experience, combined with insights from Eduan and Tim, my advisory group, and literature from borderline scholars, these ethologies consider 1) how psychiatry defines what each borderline 'trait' *is,* 2) what they can do (specifically, what they can debilitate, given that this can happen, though is the main focus of

clinical views of these traits), and 3) what else they might do (how they can capacitate – both individuals and the socius). In doing so, we pay particular emphasis on the harms of European humanism, neoliberalism, and the structures of (settler) colonialism. We reconceptualize borderlining as a necessary ethical gesture towards disorganizing and disrupting these systems, and a process that is only potentially emptying. The main goal of this ethology is to:

1. Reorient how we consider the 'health' outcomes of individual borderliners, particularly related to behavior, risk, pathology, and diagnosis. This requires an analysis of how each borderlining gesture can foreclose, or less talked about, enable, affective capacities.
2. Depathologize and affirm that which European humanism has undermined, such as emotionality or the notion of an "unstable sense of self." Where possible, this means turning not towards new conceptualizations like borderlining, but culturally specific conceptualizations and responses to emotional distress and difference that do not necessarily align with the Western formulation of borderline.
3. View borderlining gestures as often in response and resistance to systemic oppression (see Redikopp and Smith 2022).

The intersectional analysis in these ethologies is incomplete, which draws attention to the risks of universalizing analyses – even affirmative ones. I want to highlight critical questions that we revisit in Chapter Four, such as: How does oppression pattern the conceptualization of borderline as already empty and pathological, as opposed to a deterritorializing process full of potential? Who benefits from medicalizing self-injury, and who might be further emptied by poor treatment, institutionalization, criminalization, and/or neglect by the healthcare system (see Redikopp and Smith 2022)? Finally, who or what systems benefit from affirming borderlining affects and worldviews, and whose perspectives of distress *and* difference should we be uplifting in our work and activism (Puar 2017)? We now turn to our seven ethologies of borderline, highlighting the following 'traits' from the DSM: 1) "frantic efforts to avoid real or imagined abandonment," 2) "identity disturbance," 3) "a pattern of unstable and intense interpersonal relationships," 4) "impulsivity," 5) "recurrent suicidal behavior" 6) "inappropriate, intense anger," and 7) "transient, stress-related paranoia and/or dissociative symptoms."

3.5 Frantic Efforts to Avoid Real or Imagined Abandonment

> "Her responses were framed as premeditated and burdensome. Accusations of attention-seeking were never far behind. She grew up with a sense that feeling her feelings and expressing them in the way that felt proportional to that experience, was wrong. Asking for care, nurturance, and love – what others call 'attention; – was wrong" (Lewis 2019, cited in Lewis 2023b:213).

3.5.1 What is it?

Classification based on the DSM-V (American Psychiatric Association 2013:663-664): "The perception of impending separation or rejection, or the loss of external structure, can lead to profound changes in self-image, affect, cognition, and behavior. These individuals are very sensitive to environmental circumstances. [...] They may believe that this 'abandonment' implies they are 'bad.'"

3.5.2 What can it do?

"Extreme measures" to avoid abandonment can include self-injury, suicidal gestures, verbal or physical abuse, and other behaviors that can harm relationships, as well as one's sense of self-worth. This trait is often depicted in popular imagery (as well as in popular clinical literature) in the "stalking, threatening abjection of the psycho girlfriend, a figure of absolute 'to-be-avoidedness,'" which summons a particularly gendered stigmatization of 'BPD' (Johnson 2015:262). In fact, one of the conjectured reasons for 'BPD's' gendered diagnosis and rampant stigma compared to its close cousin, 'antisocial personality disorder,' is the 'clinginess' (or fear of abandonment) unique to 'BPD.' Merri Lisa Johnson (2015) has pointed out this pattern, particularly in reference to the "anti-social turn" in academia:

> In its harshness, the explosive 'hate you' that lashes out at the love object ironically reveals an interplay between what queer theorists have called the antisocial turn and what I am calling (speculatively, experimentally) a borderline turn in contemporary theory, a willingness among queer theorists to jar their readers with brash language and counterintuitive ideas into an awareness that sometimes negotiations—in romance or in critical theory—must turn away from polite exchange, must be willing to be impolite, loud, and messy, willing 'to fuck shit up,' traits Halberstam attributes to antisociality. (Johnson 2015:261, referencing Halberstam 2011:110)

Many theoretical and pop culture discourses about borderline often leave out discussions of this trait, or discussions of borderline at all. Embracing the more anti-social (read: masculine) sides of borderline, such as anger and rage, may be more acceptable than affirming the relational desires associated with borderline: "Likewise, is the culturally ascribed femininity of borderline 'difficulty' the grounds for overwhelming rejection of the affects and people (usually women) attached to the diagnosis" (Johnson 2015:262)?[49] Presenting skepticism and rage is arguably less

[49] In a recent conversation, Francesca Lewis (personal communication, May 4, 2024) taught me more about the gendered dynamics of the autism-borderline relationship. She noted the phenomenon of people being re-diagnosed with autism instead of 'BPD' (a phenomenon that I have seen as well, in the clinical literature, on social media, and in conversation with peers). While this diagnostic replacement likely has clinical utility and autism may well be more

vulnerable than exposing the side of borderlining that desires connection, so much so that we may hurt ourselves or others: *Be afraid of me and my (new) boundaries. (But I will not tell you about how I idolize people, how I am still internally screaming, "please love me, please care about me!" You can see the anti-social side, but not the borderline side)* (Journal entry, 2023, September 6).

3.5.3 What else might it do?

Responses to (potential) abandonment could also be gestures towards the full BwO, where the pathologization of this fear stigmatizes that which may be productive relational desire. Desperate for genuine connection and sensitive to its absence, borderlining fear of abandonment desires and can produce relationality and mutuality not just in intimate relationships, as is often depicted, but in communities. These desires are not simply responses to lack, but generative disorganizations of the neoliberal body politic that gesture towards a world in which interdependence and reliability are prioritized over independence and emotional distance. What if we valued the borderlining gesture towards connection, not despite of, but because of its abjection (Redikopp 2018)? Psychotherapist and anthropologist Rebecca Lester (2013:75) writes empathetically that borderliners "are still struggling to connect with others, despite being told again and again that they are manipulative and controlling and difficult. Far from being inauthentic, then, these individuals are reaching out into the world in the most honest, direct, vulnerable ways they possibly can."

The 'fear of abandonment' may not only be about fear and the abject affect that comes with it, but an insistence upon needing others and a rejection of the neoliberal individualism that suggests otherwise (Lewis 2023b). The abandonment-paranoid borderliner breaks open the organized neoliberal body, exposing its rigidity and individualism and opening space for reterritorialization towards mutual aid, solidarity, and community (Hedva 2016). Might these borderlining desires and cautions break open the strata of respectability politics, corporate gaslighting, managerial neglect, and other modes of organization that thrive off proliferation without material connection? In late capitalism, we are not lacking connection (the cancerous BwO of data mining), but the full BwO of community (Culp 2016). Borderlining sensitivity towards

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useful and resonant for many people, she noted the ways in which there seems to be a preference for autism, or a relief that comes with being autistic instead of borderline. She noted the ways that autism, like 'anti-social PD' have more masculine connotations compared to the highly feminized borderline. This brings an interesting layer into this conversation about gender, abjectness, acceptability, and various aspects of borderline. This dynamic also has implications for the labeling of people as guilty or innocent through various diagnostic patterns, and the ways that diagnoses can both debilitate and capacitate (see Chapter Four).

fake, fabricated, non-transparent, or suddenly withheld community might create a distressed affect not only about the individual situation, but suggestive of the larger need to break open the strata of individualism and reterritorialize towards mutual aid, solidarity, support networks, mutual care, and vulnerability in communities. Might we join in these deterritorializations, be a little clingier, and value borderliners' resistance to abandonment in spheres beyond the privatized parental or romantic relationship?

3.6 Identity Disturbance: Markedly and Persistently Unstable Self Image or Sense of Self

"The question is precisely whether it is necessary to find oneself" (Deleuze and Guattari [1980] 1987:160).

3.6.1 What is it?

Classification based on the DSM-V (APA 2013:663-664): "There are sudden and dramatic shifts in self-image, characterized by shifting goals, values, and vocational aspirations. There may be sudden changes in opinions and plans [...] Although they usually have a self-image that is based on being bad or evil, individuals with this disorder may at times have feelings that they do not exist at all. Such experiences usually occur in situations in which the individual feels a lack of a meaningful relationship, nurturing, and support."

3.6.2 What can it do?

This instability can lead borderliners to depend upon others to understand our own subjectivity: "I longed to stabilize my core identity and to withstand the pressure of other people's words, behaviors, moods, and perceptions. I wanted to be less easily thrown" (Johnson 2010:14). Some call this chameleoning, and others call it inauthentic, given our adaptability to new people and situations. This can be disorienting; we are not sure where we begin, and where the world ends. My partner and I call this experience being "couscous," wherein I absorb flavors around me like a sponge, unsure of who I am outside of the push and pull of other people:

> It is as if this lump of flesh which I am is wrapped in the thinnest cloth, and nothing else. Because this cloth is so thin, it is easily unlaced or undone by life events, irrational fears, or the onset of an inexplicable sadness. In particularly difficult times, I feel as though every thread running between me and the world is loosened until I slip entirely between my own fingers" (Lajoie 2019:554; see also Anzaldúa 1987; Lewis 2023b).

3.6.3 What else might it do?

> "The point is, for me, what does uncategorisability do, what knowledge can it produce, how can it help us understand ourselves and our world more fully or at least more complexly?" (Lewis 2023a:6)

3.6.3.1 Disrupting Cartesian humanism

"Identity disorganization" can be distressing, but it can also gesture towards the plane of immanence, where our capacities and subjectivities are not constrained by the state, capital, and empire: "Where psychoanalysis says, stop find yourself! We say, go further still, you have not sufficiently dismantled the self!" (Deleuze and Guattari [1980] 1987:150). I am particularly interested in how imperialism, settler colonialism, chattel slavery, and the binaries that accompany these mechanisms, rely upon coherent, stable, and individualist identities. The notion of borderline's "stable instability" – affective, identity, behavioral, perceptual, and otherwise – underlies many aspects of borderlining (Kernberg 1967:641; Lewis 2023b). Further to this, ambiguity, particularly racial and gender ambiguity, is and has been continuously been positioned as a threat to a colonial system that relies on codifying people based on their contribution to Euro-American capital: "My own existential feeling of uncategorizable has often been one of heightened awareness of the expectation to be explainable, and the painful consequences that will come when I am not" (Lewis 2023b:76; see Lovelock 2023; Puar 2017; Tam 2012; Westbrook and Schilt 2014). Like the BwO, borderlining 'instability' exposes the fabricated nature of neoliberal subjectivity, imposed by Western mandates that one should be a "stable, sovereign, and entirely self-governed entity" (Lojoie 2019:559; see Bazzano 2019; Lewis 2023b). As psychotherapist Manu Bazzano (2019:69) writes, perhaps "the fundamentally divided, fragmented nature of the self does not require integration." Borderlining onto-epistemologies do not valorize the Cartesian, organized body as the only way to be in relation with the world, but cut through European humanism and its correlates: "The becoming-imperceptible of the BwO is not about disappearing, but, as in the case of camouflage, a strategy of resistance that may escape the penetrating gaze of the State apparatus and its extensions (Massumi 1992:182, cited in Thanem 2004). Further to this, borderline imperceptibility, in disrupting European humanism, can reassert that which has long been said by non-Western onto-epistemologies and cosmologies of the self that have been relegated as inferior: "Reclaiming becoming-indeterminate [...] means living in open and dynamic entanglement with the world, acutely aware of the contingency of boundaries and the co-

constituting nature of any encounter" (Lewis 2023a:9; Hedva 2016; Todd 2016; Tuck 2010). Perhaps borderline experiences act as an embodied sensitivity to the ways that hegemonic structures contort us; the borderliner does not find belonging and thus cannot comfortably contort themselves to conform.

3.6.3.2 On affective 'instability'

> "We have feelings that splatter, sudden mood changes splashing from up the boiling pot of BPD dysregulation." (Johnson 2015:216).

Although we are not separately discussing the borderline trait of "affective instability," we draw parallels between identity instability and affective instability. The 'instability' of borderlining affects counter normative epistemological preference towards 'rationality,' 'coherence,' and 'stability,' all of which are caught up in European humanism and its co-morbidities of misogyny, sanism, ableism, white supremacy, and other forms of epistemic injustice (Redikopp 2018, 2021). In disrupting epistemological norms, what might be called borderline affects resist and disrupt dominant bodies-with-organs and Cartesian ways of knowing. Quick shifts in emotions can startle, scare, confuse, relieve, liberate, unsettle, shift, and modulate bodies and assemblages. These sudden or unexpected affects can disorganize a situation, exposing undercurrents of power or forcing an assemblage to reterritorialize. Borderlining affective instability, while often distressing for us, can also be read as an epistemological intervention in and methodological approach to social transformation.

3.6.3.3 On neocolonialism and the glamorization of "instability"

> "In essence there has been a call to queer queerness, stressing its fluidity and liminality, but this is itself another framework of race and class privilege. Fluidity as mobility is a privilege" (Puar [2012] 2020:173).

While borderline affective and onto-epistemological instability can disrupt Cartesian dualism, valorizing the fluctuating self can also be a white move of fantasizing about one's "endless capacity" to affect and be affected, as critics of new materialism and posthumanism have pointed out (Puar 2017:20; see also Dixon-Román and Puar 2021; Karera 2019). Ontologically, we *are* all connected to the world, and thus unable to be Cartesian minds and bodies; however, we must also pay attention to the ways in which stability has been taken away from people, and the value of reclaiming stability, truth, and identity (Hardt and Negri 2000:154). Furthermore, while emphasizing and bracketing the ways in which valuing borderline's onto-epistemological relays with new materialism thought risks erasing (or does erase) many Indigenous worldviews and

cosmologies, I want to explore the desire to value this about borderlining. While it is important to disrupt binaries and dualisms imposed by European humanism, many scholars have argued that we are beyond the age of modernist and disciplinary binaries; we no longer need to rely on postmodern critiques, for we have entered a society of control; capital, and thus state power, thrives on flux and flow, uncategorizable, and even diversity. As Hardt and Negri (2000) remind us, we must remember that

> It is salutary to remind ourselves that postmodernist and postcolonial discourses are effective only in very specific geographical locations and among a certain class of the population. [...] This specificity does not invalidate the theoretical perspectives, but it should make us pause for a moment to reflect on their political implications and practical effects. (P. 154)

I, as a relatively affluent white person who presents as a ciswoman can readily take up a more in-flux positionality, and attribute it to my borderline; I can value the parts of myself, like my sexual identity, my relationship to madness, and my inability to pick a career direction, rather than judging myself for how 'unstable I am.' Praising the chameleon nature of borderline, though de-pathologizing, assumes a blank slate, a white identity from which to morph and adapt (Journal entry, 2023, July 27). Due to my chameleon tendencies, I can morph and fit into different places with different people; this is not only an affective skill though, but also phenotypic. My borderline instability is inseparable from and cannot be disentangled from how my whiteness affords me capacities to adapt and morph without consequence. While we should depathologize borderlining, we also run risks with universalizing instability as an affirmative trait. "Becoming-imperceptible" is a Deleuzian concept that resists how subjectivities are imposed upon us; however,

> Becoming is not about trying to make the body more capacitated but about allowing and reading more multiplicity, multiplicities of the impersonal and of the imperceptible [...] none of this is to obscure the fact that becoming has become a zone for profit for contemporary capitalism, for neoliberal piecing and profiteering, a mode through which profit is being aggressively produced. And as such, all theorizations of becoming are generated through and within the geopolitics of racial ontology that it inhabits. (Puar 2017:56)

I discuss this concept of "piecing" (Puar 2017:56) for profit (individual and structural) and the assumed "endless capacitation" (Puar 2017:20) embedded within white elite futurity in Chapter Four, but want to note here, as Jackie Wang (2012:n.p.) notes with regards to "passing," that valuing the "imperceptibility" of borderline "is another idea that only seems possible to theorize from a privileged position." Wang continues, writing, "there are others whose outsider status isn't

so easy to hide or get rid of, who are already and always considered socially abject, non-assimilable, fundamentally Other within society" – perhaps fundamentally unstable, ambiguous, unable to be categorized, or on the contrary, stable in their abjectness or Otherness (see also Musser 2012 on blackness, colonization, and the BwO). So, while we can value "becoming imperceptible," we must remember the safety and unsafety that comes with being im/percetible. We can depathologize the notion of an "unstable sense of self," particularly by valuing non-Western ways of conceptualizing the self. *And,* the question must always be, who is forced to have a stable identity, say by having a 'BPD' diagnosis, and being refused refugee status based on mental health (including when 'BPD' is not treated as mental illness in some jurisdictions)? As Mad scholars have pointed out, who has the safety to lean into instability? Who benefits from it? Whose ambiguity is a threat to the nation (i.e. racial and gender ambiguity as a refugee status seeker), and whose can be used in its favor? Discipline and European humanism still constrict us, and constrict borderliners – particularly multiply marginalized borderliners – and yet we must be cautious about any affirmative approach to a trait that resonates for an elite few.

Another question we might ask, the, is, what makes it possible to focus on how psychiatry incorrectly pathologizes instability, as opposed to the distress that can come with being made unstable by the state?[50] I want to echo those that note the importance of a "stable sense of self" (or stability, for that matter) for many people: "Certainly from the standpoint of many around the world, hybridity, mobility, and difference do not immediately appear as liberatory in themselves. [...] In fact, a stable and defined place in which to live, a certain immobility, can on the contrary appear as the most urgent need" (Hardt and Negri 2000:154). I argue this not in favor of the diagnostic criteria (as indicators of disordered views of the self), but to caution again against a universalizing approach to instability; perhaps "instability" should not be pathologized, but something else should be. Should we pathologize the systems that have stolen so many identities away? Colonization, in its various forms, has engendered an "unstable sense of self," stealing ancestral and land-based connections away from generations of people across the world. Both

[50] Again, I appreciate the nuance that Francesca Lewis (personal communication, May 4, 2024) brings to this. While we could readily dismiss how psychiatry incorrectly pathologizes people's experiences of race and gender as 'borderline,' we can also acknowledge that these experiences can be distressing. That psychiatry locates this incorrectly with the individual's personality does not mean that everything is 'fabricated' or 'made up.' As I attempt to make clear in this section, we can acknowledge that white supremacy leads to both the over-pathologization or blame of racialized people, as well as psychosocial distress that can come with living as a racialized person under the logics of white supremacy (see, for example, the work of Fanon or DuBois).

settler colonialism and chattel slavery wiped out generations of oral and written histories, family genealogies, cultures, and languages, and more, for diasporic and Indigenous populations across the world. The ability to know where one stands and that you are welcome where you stand – tūrangawaewae in Te ao Māori – and to know where you came from – whakapapa – is integral to notions of health around the world. Mass assimilation policies in settler colonial nations also necessitated Europeans to become homogeneously "white" and thus lose our diverse cultures and identities (Brodkin 1998). Further work could explore these colonial contributions to the creation *and* pathologization of "unstable self-image" or "identity disturbance." In terms of asking what this diagnostic criterion does, a more careful reading of Deleuze and Guattari's work would be to understand the contextual importance of identity and truth, while uprooting the ways in which they are imposed, often after being erased:

> One should not take this recognition, however, as a complete refutation. It is not really a matter of either/or. Difference, hybridity, and mobility are not liberatory in themselves, but neither are truth, purity, and stasis. The real revolutionary practice refers to the level of production. Truth will not make us free, but taking control of the production of truth will. Mobility and hybridity are not liberatory but taking control of the production of mobility and stasis, purities and mixtures is. (Hardt and Negri 2000:156)

Future work should perhaps look at the role that colonization has played in creating such a pathology that is not a pathology, but and often distressing response to being uprooted from the land and people that grounded you. We can value that which comes with borderline instability, while calling for the reconciliations of identities never given a chance to have a stable sense of self – not a Cartesian, rational self, but a self that already was understood to be intricately connected to land, spirit, body, family, and ancestors: "In the context of state terror and mystification, clinging to the primacy of the concept of truth can be a powerful and necessary form of resistance [...] The master narratives of the Enlightenment do not seem particularly repressive here, and the concept of truth is not fluid or unstable—on the contrary!" (Hardt and Negri 2000:155).

3.7 A Pattern of Unstable and Intense Interpersonal Relationships Characterized by Alternating between Extremes of Idealization and Devaluation, or "Splitting"

> "According to Straus and Kreisman [authors of "I Hate You, Don't Leave Me"], borderlines cannot tolerate paradox, but they are themselves paradoxes, which leads doctors to consider them 'the most difficult, the most dreaded, and the most to be avoided' patients. Is it not the doctor then who cannot tolerate paradox" (Lewis 202b:93)?

3.7.1 What is it?

This classification is drawn from the DSM-V, as well as my own conceptualization of these experiences. 'BPD,' unlike many other psychiatric diagnoses, is characterized largely by its relational components. Present in romantic, familial, platonic, collegial, and more, "relational instability" can resemble a push-and-pull dynamic, wherein borderliners oscillate between idealizing the other and then devaluing them. The oscillation between idealization and devaluation is often referred to as 'splitting,' and borderliners can split others, ourselves, life paths, places, authors, and ideas as all good/benevolent or all bad/evil. The DSM writes about splitting, where

> [o]pinions are intense, but not stable. Other people are perceived as good or bad, and yet what is good and what is bad can shift abruptly according to the immediate circumstances and minor triggers. These sudden changes lead to the chaotic nature of the borderline individual's experience. If the individual feels someone has disappointed him, that person may be abruptly relegated to a "blacklist"; a positive experience may shift things back equally abruptly. There is no sense of stability or security. The black/white responses to the world have an important impact on the individual's moods: a single frustration may make everything seem bleak, bringing on a depressed mood. A pleasing event even may bring on temporary euphoria. The good/bad categories are rigid and provide little flexibility for dealing with the complexity of the environment and, in particular, of interpersonal interactions. There is no ability to appreciate the subtle shadings of a situation or to tolerate ambiguity, leading to distortions in perceptions since external reality is seen through this rigid internal structure. Thus, splitting and its consequences do not provide for successful adjustment to life and lead to many of the specific symptoms of BPO patients. (Clarkin et al. 2007:479)

3.7.2 What can it do?

Splitting can last for minutes, hours, days, weeks, or longer, and in an attempt to protect ourselves, can get in the way of our ability to see the world complexly and to relate to others. Splitting can shorten relationships, suddenly stall friendships, or create relationships that oscillate between feeling wonderful and terrible. Splitting can occur quite cognitively, wherein we notice it occurring and can name our "black and white thinking." Other times, splitting feels entirely physiological, making it difficult to even recognize the person or thing we have devalued. For example, perceived abandonment in the form of prolonged silence from someone may trigger a split, or the perception that they cannot be trusted, or they do not care, so they are not worth relying upon. In fact, they might even be a bad person –someone I would not want to be involved with anyway. The lack of nuance is not simply a noticed feeling or a brief departure from compassion, but an embodied conviction. We jump to an extreme which is often perplexing to others around us. Splits do not

last forever; we deterritorialize and eventually reterritorialize on complexity and nuance, followed by what might be described as a 'split hangover,' during which our affective responses to the target of the split slowly melt away. The remnants of the split remain like a scar or a bruise long after the damage stops.

> BPD appears in my life as a desire to identify strongly with and fall hard for new people frequently; an overwhelming desire to bail on my relationships the second I feel emotionally vulnerable; very strong, even overwhelming, reactions to perceived red flags; anything that looks like patterns of abuse or neglect in my relationships potentially triggering deep and complex self-loathing and fear; the constant struggle to reason with myself when I have overwhelming reactions; and the fear that when I am reasoning with myself, I am gaslighting myself into believing things are okay while I am being mistreated yet again. (Sostar, Thomas, and Nault 2020:8)

Splitting can also lead to a cancerous BwO; a sudden rupture in perception can become so overwhelming that we quickly reterritorialize everything onto new transcendent and moralizing organizations of Evilness (or Goodness, when idealizing). This brief transcendence can also be emptying, by cutting us off from the world, seeing no reason to reterritorialize from that which we have deemed definitely Bad. Splitting can be highly entangled with chronic emptiness and identity diffusion; splitting pulls borderlines into a tug of war, yanking apart any remaining trust in ourselves or our reality, leaving us in the abyss of a false binary.

3.7.3 What else might it do?

> "Saying someone has no fucking idea what he's talking about and then turning around and describing that person as hot, as I do above, marks a brassy oscillation of attachment that surely invites diagnosis—and dismissal—as a borderline style of cognition. I don't accept this dismissal" (Johnson 2015:261).

Our main point relates to the affects that are often associated with such strong convictions that someone or something is suddenly unequivocally Bad. These affects, such as rage, paranoia, and despair, are often deemed as 'disproportionate, 'inappropriate,' and 'intolerable.' Might a split still be worth listening to, even if seemingly disproportionate, unrealistic, or transcendent? We imagine splitting as a signal that something is dangerous, risky, or potentially fascist – even if not transcendentally Evil, as the borderliner might depict it. Our affective responses in relationships, though perhaps extreme compared to others in society, signal that something is not right. Our signal might be premature, or very intense, but at the very least, they are not devastatingly delayed. These queries are informed by my own life, and by Johnson's (2015:261) astute observations, where she suggests a "refocusing from the individual person to the dynamics of relationships and

invalidating environments, translating a discourse of blame that might point to my hypersensitivity as the problem into a discourse of mutual responsibility for fair and productive communication." That is, borderlining splits signal something wrong with a relationship, environment, or situation; splits rarely occur 'randomly.' In fact, placing responsibility onto the splitting borderliner may stall the shared responsibility necessary for the problem at hand – a problem that the borderliner is highly receptive to (for how sensitivity is valued in Māori cosmologies, see: Kopua, Kopua, and Levy 2021).

Several analogies might be useful here: the canary in the coalmine that signals danger; the frog that immediately jumps out of a gradually heating pot of water (in contrast to the frog that gets boiled alive, unattuned to the incremental changes in temperature). Borderlining gestures, and even splits, are an acute awareness of the warm water, well before others notice it is boiling: "Your body will thus tell you if and when you have reached a threshold or limit [...] Psychoanalysis reduces these to symptoms awaiting interpretation, I see them as corporeal warning signals or boundary markers that express a clear message: 'too much!'" (Braidotti 2011:308-9). Processes of idealization and devaluation may draw attention to injustice that might otherwise be overlooked. For example, when a borderliner calls out abandonment or lack of community, might we consider it as an acute awareness of the rising individualism and separatism that allows capitalism to necrotize the planet and human life. Perhaps the severity of splitting is indicative of an intense desire for connection and an intolerance to systems of individuation and disconnection. Perhaps extreme responses should not only be viewed as indicative of pathology; perhaps abandonment or disconnection *should* cause rage and hopelessness. *What if the split is correct, even if not showing the full picture? What if this was really that cancerous? What might we do then?*

Although splitting involves extreme transcendence (Good or Bad), it may also be conceptualized as merely an experimentation with transcendence. Borderline splitting can involve a conscious or subconscious awareness that the transcendence of splitting is momentary, fleeting, or extreme – even if we cannot escape it (Lewis 2023b). Here, a playful experiment with limits can occur: *Is this cancerous? How cancerous? Can anyone else see how cancerous this is?* Rather than our inability to hold two truths, or a split in our psyche, splitting may signal our ability to fully commit to both poles, and to register the unique insight each one has to offer: "Concepts that we consider binary opposites are usually actually deeply connected and meaningfully entangled.

Love and hate are both states of caring deeply and having a strong orientation towards something or someone" (Lewis 2023b:80). Merri Lisa Johnson (2015) similarly shares:

> [T]he ambivalence is made up of angry, defensive, hard feelings (*hate you*) and vulnerable, desiring, soft, attached feelings (*don't leave me*). Instead of a simple reversal of the phrase from all-negative to all positive, however, this redeployment acknowledges the phrase as incoherent, abrupt, and coarse while also recognizing its capacity for expressing the layered emotions of frustrated intimacy. (P. 261)

As we flip-flop, oscillate, ride the borderline, back and forth between positions, with no central landing point, we not only see multiple perspectives but feel what their materialization in the world feels like in our bodies. What are seen as binaries in the psy-disciplines and much of society may be much more entangled (Lewis 2023b:80). Despite this confusion – this full commitment to seemingly opposing views – we might value that which breaks open the strata, so that reterritorializations towards a full BwO can occur. As Johnson (2015:261) continues, borderline expressivity does not necessarily indicate an inability to hold complex truths, but an in/ability to express needs that are complex and oscillating, sometimes requiring force to be heard and considered: "[H]ate you" can be fairly easily translated to mean 'I am angry because I am not getting what I need from you'" (Johnson 2015:261).

Although affective extremes may read as transcendent commitment towards poles of 'good' and 'evil,' borderlining affective instability may rather be a response to transcendence imbued within organizations, relationships, and society; for example, a borderline's affective outburst at a therapist may be an invitation for the therapist to enter the uncertainty, or for the therapist to reterritorialize with the borderline, if they are participating in an emptying out of the borderline client. Highly receptive to deception, a borderliner might call a therapist or manager an "asshole," for them to respond by saying, "No, you're misunderstanding me," while knowing they were not misunderstood, but caught off guard that the borderline saw through it (see Anzaldúa 1987:38-39).[51] Bringing the abandonment-paranoid borderline into these settings might bring transparency, accountability, and communication; for what may trigger our fears of abandonment most are silence, lack of communication, lack of vulnerability, not being transparent, and pretending to be taking responsibility.

[51] Tim Barlott, personal communication, November 8, 2023.

3.8 Impulsivity in at Least Two Potentially Self-damaging Areas

3.8.1 What is it?

Classification based on the DSM-V (APA 2013:663-664): Impulsivity (with the 'self-damaging' modifier) can be characterized as a response to emotional distress, sometimes in response to idealization or devaluation. Common forms of self-damaging impulsivity are substance use, gambling, binge or restrictive eating, reckless driving, unsafe sex practices, spending more money than usual, changing jobs, or moving, changes in presentation).

3.8.2 What can it do?

For some analysts, impulsive behavior is a response to lack; these behaviors fill up the sense of emptiness, lack of pleasure, or lack of control: "The feeling of emptiness can be so painful that the patient may exhibit impulsive behaviors to avoid this emotion" (Mungo et al. 2020:1335).[52]

3.8.3 What else might it do?

A Deleuzian analysis might ask what these bodies are desiring, without assuming they are 'trying to find themselves' or 'fill their voids.' Impulsivity can bring the BwO into light, exposing the fabrication of organs and boundaries that we call the 'stable career,' 'the normative relational path,' 'the consistent sense of self,' or more broadly, the need for 'rationality.' Impulsivity is a result of productive desire, and perhaps deterritorializes away from how things *should be,* towards how things *could be.* Borderline and other pathologized desires can be valuable, healthy, and ethical, even if they present along the pathological plane of the DSM that all our actions are measured against. We cannot know what a pathologized move will do. Rather, we can de-pathologize, and ask what a certain affect or behavior may do, or what it did do.

For example, suddenly leaving a job may reduce one's relations and connections in the world, but it might also open up new affective and relational capacities not otherwise imagined. To the psychotherapist, this change might be flagged for another symptom, a sign of pathology: "Let's keep an eye on her, she might not be doing too well." The analyst might instead ask: "What did that change do for you?" "What else might it do?" Unprotected sex may increase one's relations

[52] Notably, I am not well-versed in the current psychoanalytic or neurobiological theories of impulsivity and am only analyzing this 'trait' in response to widespread psychoanalytic analyses of lack and filling voids – analyses which I am sure have shaped responses to borderline impulsivity, even if only in popular culture (Deleuze and Guattari [1972] 1980). For some scholars, "impulsivity therefore includes a behavioral predisposition, the absence of planning and a lack of anticipation of the consequences. [Barratt] would not associate it with no emotion or any search for sensations, relief, or pleasure" (Mungo et al. 2020:1334). This neurobiological analysis does not refute my consideration of "what else impulsivity can do," because I am still contesting the pathologization of impulsivity, and again, acknowledge the widespread narrative prop of emptiness, voids, and lack, in patterning popular understandings of impulsive behaviors.

with the world, perhaps a partner, child, health professional, or community of peers. It may decrease one's relations, partly through the emptying processes of societal shame. New hairstyles, body piercings, tattoos, or other external looks are often read as classically borderline (Blay et al. 2023; Vizgaitis and Lenzenweger 2019). However, these changes in appearance could also be read as a desire to disarticulate from the norms of bodily presentation, and to tear open strata, to let the BwO show through, and to reterritorialize on a new set of values or ends. A statement, boundary, curiosity, or even outburst at work could also be read as a productive desire for calling out the status quo, for change, for disruption of Majoritarian forces. This desire for disarticulation, for un-organizing a meeting or rally or service, for example, could expose these bodies for what they are: theaters, plays, fake organs imposed upon on the field of immanence. This exposure might create experimentation, change, new conversations, even fear, lead to resonating friends, start a movement that resonated with this outburst. A disorganizing gesture might do all this, and then still be captured, when the organism brings in security staff to remove the 'disruptive' person from the room (The University of Washington 2024). Here, you didn't empty yourself – they did. The State, the Corporation, the Organization, the Academy, the Charity: they emptied you, and in doing so, created a fascist BwO: "The DSM and APA are only concerned with self-control—not the loss of control, freedom, or agency as it can be affected, granted, rescinded, and mitigated by the state" (Hedva 2016:n.p.). And most likely, the sanism, the racism, the transphobia, the misogyny, the Islamophobia, all emptied you; you were becoming a full BwO, and they/we emptied you. The question is not whether a borderline is a full BwO or an empty BwO, but what a borderlining move might do, how and what type of reterritorialization might occur, and who is participating in the emptying process?

3.9 Recurrent Suicidal Behavior, Gestures or Threats, or Self-mutilating Behavior

> "Reading the skin show of the self-cutting borderline, in fiction and in real life, requires 'epistemic humility' and a 'willingness to remain open to what [the person who cuts herself] may—and may not be saying'" (Johnson 2015:257, citing Potter 2003:5, 11).

3.9.1 What is it?

Classification based on the DSM-V (APA 2013:663-664): People may self-injure (cutting, burning, scratching, biting, pulling out hair, etc.), and/or frequently have thoughts of suicide, gesture towards or threat suicide, or attempt suicide. "These self-destructive acts are usually precipitated by threats of separation or rejection or by expectations that the individual assumes increased responsibility."

3.9.2 What can it do?

Recurrent suicidal and self-injurious moves might be emptying if: 1) the self-mutilation creates further shame, often reducing relational capacities, 2) the system demonizes or institutionalizes borderliners for being in so much pain that we've hurt ourselves or desire to, or 3) when these gestures go "too far" and lead to a completed suicide (this occurs in about 8-10% of people diagnosed with 'BPD') (APA 2013).

3.9.3 What else might it do?

Similarly, self-injury can be a deterritorializing gesture towards the full BwO, rather than always an indication of an impending empty BwO (e.g., as a direct gateway to suicide). I draw much of this section from Mad scholars who have written about self-injury as a way to meet needs, communicate, and cope, rather than a behavior brimming with malintent (for a review, see Redikopp and Smith 2022). For them, self-injury, and suicidality can be conceptualized as desiring machines that disrupt and reorganize desires – for our tear ducts or heartbeats to stop demanding so much from us; for the systems, assemblages, and bodies around us to stop demanding stratification. Although to the outside, these gestures may seem manipulative or merely pathological, they are productive ways to get care, help, validation, love, or connection. I am particularly compelled by Redikopp and Smith's (2022:7) analysis of Strong's (1999:32, 3, xxiv) *A Bright Red Scream*: "Participants stated that self-injury represents a way of 'get[ting] through the moment, unlike suicide, which is a 'permanent exit' [...] self-injury is 'a kind of hope, a way out. It is not giving up' [...] 'I always felt I'd die if I didn't cut.'" Self-harm and suicidality can also be forms of reterritorialization – mechanisms for avoiding the empty BwO or death.

> Dismantling the organism has never meant killing yourself, but rather opening the body to connections that presuppose an entire assemblage, circuits, conjunctions, levels and thresholds, passages and distributions of intensity, and territories and deterritorializations measured with the craft of a surveyor (Deleuze and Guattari [1980] 1987:160).

For many, self-injury can divert suicide, rather than directly funneling into a supposed 'linear' suicidal process: "Many who self-injure describe their motivations for self-injury to be a means of averting suicide" (Redikopp and Smith 2022:10; see: Adler and Adler 2011; Shaw 2016; Simopoulou and Chandler 2020). Breaking through some skin cells or blood vessels might be healthy if it keeps someone alive until morning: though cutting can be deterritorializing from an in-tact body or layer of skin, it can also be a reterritorialization towards not-dying: Referring to

the masochistic BwO, Deleuze and Guattari ([1980] 1987:155) write: “There are other ways, perhaps better ways. But it is enough that some find this procedure suitable!” Cutting or dreaming about the peace that death may offer can reterritorialize us onto the strata of living and carrying on, of creating a full BwO, rather than an empty one. Having a suicide plan, similarly, though often treated as a red-flag and need for crisis intervention, can provide great relief to intrusive thoughts. Sometimes indicators of risk can be reterritorializations that prevent actual suicide: “Mainstream culture and psychotherapy look down on escape; it is swiftly diagnosed as avoidance, denial, manic defense, not wanting to confront ‘reality’. But there is immense value in escape” (Bazzano 2021:7).

Self-harm and suicidality are only emptying processes when there is no reterritorialization: when the bleeding never stops, the pills keep coming, or the hits to the head are too severe, whether momentarily or across the lifespan. We do not mean this just in each instance, but across the lifespan. At some point, continuous patterns of self-injury can be emptying, stopping someone’s life or their ability to affect and be affected by the world and their relations. However, when conceptualized as a compositional survival skill, self-injury and suicidal gestures are healthier than attempting suicide; they are “rational, though dangerous and mostly undesirable, forms of communication” (Johnson 2015:279, citing Price 2015). Still, the act itself need not be whisked away into the category of the empty.

Abstinence or abrupt cessation approaches may increase the likelihood of harm if people have not been supported to develop alternative coping skills or enter more supportive environments. If self-harm is a survival process, then taking it away without a replacement may lead to empty BwOs. In this case, institutions and psy-professionals do the emptying by refusing to acknowledge the utility and desires - not just pathology - of deterritorializing gestures like self-injury and suicidality, or by refusing to ameliorate that which the self-injury and suicide is a response to, such as colonial occupation (Giacaman 2018; Government of South Africa 2023). Is breaking through some skin cells or nails or blood vessels ‘healthy’ or ‘unhealthy,’ if it keeps one alive until morning? For now, it may increase one’s capacity to affect and be affected, and to be in relation with the world: “You have to keep enough of the organism for it to reform each dawn” (Deleuze and Guattari [1980] 1987:161). A harm reduction approach to substance use, for example, might consider the ways in which substances can keep people alive or prevent suicide, particularly when the process of using is less risky.

3.10 Inappropriate, Intense Anger or Difficulty Controlling Anger (e.g. Frequent Displays of Temper, Constant Anger, Recurrent Physical Fights)

> "If a rational politics has no room for anger, then it has no room for one of the few weapons available to the oppressed. Thus, the invocation of 'rationality' (like the invocation of 'civility') becomes an invocation of the status quo" (Srinivasan 2018:141).

3.10.1 What is it?

Classification based on the DSM-V (APA 2013:663-664): The borderliner "experiences difficulty controlling anger, resulting in intense outbursts. Anger is often triggered by perceived rejection. Such expressions of anger are often followed by shame and guilt, leading to a shame-based view of self." This anger, like any anger, can look like verbal abuse, sarcasm, belittling, name-calling, property destruction, and violence against others – often towards the person viewed as having abandoned, neglected, or stopped caring about them/us.

3.10.2 What can it do?

Expressions of anger can reduce affective capacities, consuming all affects and behaviors under the lens of anger, leading towards destruction for destruction's sake. When we tarnish a relational assemblage that is crucial for our own well-being and connection to the world, we can empty others, as well as ourselves.

3.10.3 What else might it do?

> "The nature of anger—how we experience it, what it calls on us to do—might well shift with historical and political circumstance" (Srinivasan 2018:129).

Extreme presentation of borderline anger often renders its content invalid, but borderlining affects will likely appear inappropriate to those who ignore injustice: "Whether a BPD patient's behavior is interpreted as angry depends on who is doing the interpreting" (Linehan 1993:70, cited in Potter 2009:61). While dominant apparatuses like mental health professions get to determine whether anger is "inappropriate" (whether in intensity, delivery, or aptness), we consider the utility of anger for individual and collective change. Deeming someone and their rage as merely in need of a lesson about emotion regulation obscures problematic processes that the rage may be in response to.

In therapeutic services I used to work in, service users' expression of anger was the problem that management thought needed to be addressed, not the apt institutional cause of their anger. Their anger at organizational policies gestured towards how to run better and safer services.

> Therein lies the superpower we are looking for, the ability to remember what made us hurt, what made us feel unsafe, WHO was involved and the contexts. I'm not necessarily telling you to go hate everyone that hurt you for forever, no. What I am

> saying is that we were hurt in our pasts, we have hurt others in the past and there is no denying or escaping that. We can and will hold on to those recollections to be safe, to protect ourselves as well as our communities. This living memory-haunting is a real thing and it carries importance and purpose. (Sostar, Thomas, and Nault 2020:19)

However, management seemed to care more about teaching the pathology out of them than they did learning and thus reorganizing our policies; focusing on how anger is expressed is often "an attempt at social control than a manifestation of genuine concern" (Srinivasan 2018:134). A therapist might also make the 'counterproductivity' argument: that anger may be valid, but expressing it is 'counterproductive' to your goals (with the message being that you are not only hurting other people, but yourself).[53] While clinicians may be ascribable to their early childhood, it may still be 'counterproductive" or 'inappropriate.' This move, the 'counterproductivity' argument, while rendering the anger 'apt,' risks emptying the borderline because of a failure to recognize the call for reorganizations in the moment. Jumping to pathologize anger, regardless of its aptness, tells the borderline that their anger is bad, unhealthy, and empty, and that the reorganization being called for will not occur. Left without invitation to reterritorialize, the anger appears to have been useless; left as invalid, the anger can be destructive towards self or others. In this case, we (the dominant, the clinicians, the organization, the Strata) have emptied the borderline by thinking that the borderline was emptying us. In addition, borderlining anger does not only occur to "fill the gap that their parents left them," but is a desire to break open the material strata in front of them. The appeal to history, to the immediate family, and to 'regulation' often serves as a move to innocence for clinicians to pacify anger – particularly for equity-denied folks like women, people of the global majority (BIPOC), and gender and sexual minorities, borderline or not (Deleuze and Guattari [1972] 1980; Potter 2009; Srinivasan 2018; Wang 2012).[54]

The "counterproductivity argument" misses the fact that the organism cannot be dismantled without the risk of the empty BwO. Borderlining anger creates necessary affective slams that are not for destruction's sake, but for alternative ethical forms of organization: "not as dead-ends roads of resignation nor as states of angst and alienation to be fetishized, but as strategic resources: fuel to the fires which burn through the existent and open up possibilities of other worlds" (Lucrezia [2014] 2015:6). Borderlining anger might push the Major forces to either take a left turn/change

[53] Tim Barlott, personal communication, April 23, 2024.
[54] Also brought up by Sam Leibel, personal communication, January 4, 2023.

practice, or to expose what they really are: violent, dominating, and stratifying: *Show the stratification you are making or do differently; stop sugarcoating, and admit that you're a violent institution under the name of 'mental health care,' and show yourself*. In the earlier example, a borderliner invited an organization to sit in the abjectness of needing to respond to harm differently, in ways that are antithetical to the prioritization of risk management and funding over ethical and decolonizing practice. If we consider the racialized, classed, geo-political, and gendered nature of the social control of anger, we might reflect on the ways in which giving uptake to anger – seeing it as a gesture towards the full BwO, rather than an indication of pathology – can lead to the transformation of dominant institutions like psychiatry, as well as the broader structures it is complicit in. We might also consider the ways in which majoritarian apparatuses – the State, Capital, Army – benefit from the pathologization and/or moralization of anger.

Thus, while clinicians and institutions may react to borderline anger as inherently empty, validating the borderliner, and/or reorganizing that which is being called into question can facilitate a reterritorialization:

> Anger has a present as well as a past. To understand it and assess its appropriateness, clinicians need to contextualize patients' anger in relation not only to the patient's past injuries but in relation to possible present ones [...] Anger has a present and a past, but it also has a future [...] Anger says, 'I still believe in myself; I am self-respecting; I believe in a future in which the injuries I sustain are not all-encompassing, and the hope I bear is that my anger gets taken seriously by you.' (Potter 2009:45)

As Potter suggests, clinicians could ask what anger is doing, and question their readiness to ascribe it to the (pathologized, deemed-as-empty) borderline, or to the conditions that the borderliner, who is perhaps more readily able to deterritorialize, is responding to. That is, borderline rage can construct a full BwO, particularly if we turn towards it, rather than immediately reject it, using disease as a disguise for discomfort or a refusal to listen.

3.11 Transient, Stress-related Paranoia and/or Dissociative Symptoms

3.11.1 What is it?

Classification based on the DSM-V (APA 2013:663-664): "During periods of extreme stress, paranoid thinking, or dissociative symptoms (e.g., depersonalization, derealization) can occur. These experiences are most often triggered by real or imagined abandonment. These experiences tend to be transient, lasting min-utes or hours."

3.11.2 What can it do?

Paranoia can decrease affective and relational capacities; for example, becoming abrasive and accusatory when we think we hear people talking about us, hating us, or conspiring against us, can harm relationships and our sense of safety in the world.

3.11.3 What else might it do?

> "There is a fascist use of drugs, or a suicidal use, but is there also a possible use that would be in conformity with the plane of consistency? Even paranoia: Is there a possibility of using it that way in part?" (Deleuze and Guattari [1980] 1987:165).

In the ethology of this final trait, I would like to draw parallels between splitting and paranoia, particularly because of the ways in which my black and white thinking (splitting) has relays with paranoia (another experience people often refer to in terms of all or nothing thinking). While I do not discuss dissociation in this ethology because of my lesser relationship with dissociative compared to paranoia, I want to note that Lewis (2023b) has done extensive work on the experience of dissociation and dissociative-like experiences (see also Hedva 2016):

> Borderline dissociation and reality diffusion are described in the DSM criteria as 'transient,' and though the DSM does not characterize these experiences as constitutive of any kind of special knowledge (hence my entire project here) psychoanalytic work did make reference to the idea of borderlines' impossible knowing [...] the borderline patient was even considered potentially clairvoyant for their ability to read the analyst. (Lewis 2023b:202)

Furthermore, I do not have a close relationship to psychotic-like experiences and would defer to others' lived experiences. We do note that dissociation, like self-injury (and often caught up with it), can be a form of escape: a gesture to live. We also defer to and prioritize non-Western approaches to understanding and learning from different perceptual experiences (see: Kopua, Kopua, and Bracken 2020; Ngata 2014; NiaNia, Bush, and Epston 2018; Taitimu, Read, and McIntosh 2018).

Once again, we argue that listening to 'paranoia' is instructive because of the rare insight it offers to take seriously systemic and micro-political harm. Paranoia could be thought of as a perceptual version of splitting, in that transient paranoia is an embodied or perceptual attunement to all that confirms the split. If splitting experiments with the idea that certain bodies or concepts are cancerous, then paranoia also takes seriously that the world may not be healthy or safe. What might it do to consider this perspective? Paranoia does not always signal 'delusion,' though the psy-disciplines' reliance on pathology may obscure this potential. 'Paranoia,' instead of an

experience that automatically leads to a psychiatric label, may create a full BwO. Paranoia can signal danger and could also be thought of as an act of evading capture. Paranoia can be only deterritorializing but can also create reterritorializations towards alternative forms of organization. We describe this by way of examples.

I once worked with someone who was convinced that all phones and emails were being tapped by their abuser, who was connected to the police state and its networks with organized crime. Although the extremity of their fears made accessing certain resources difficult, and we might plop them into the pop culture trope of people with delusions about the government or computers, their concerns were far from delusional. They were highly attuned to the mechanisms of control that we know are occurring through large data mining corporations and markets hosted by platforms like Facebook and Zoom but cannot bear to face or resist because of our reliance on these technologies (Dixon-Román and Puar 2021; Zubaff 2018). They took lines of flight, detaching themselves from the technology apparatus. Arguably doing so emptied themself more than it led to our liberation from societies of control; this is not because they emptied themself from all these opportunities to communicate how most resources communicate in the twenty-first century, but because the social structure in place ostracizes their forms of communication, rather than valuing them and making them work. Furthermore, the fact that their individual minoring gesture did not lead to a large uprising likely has more to do with their socioeconomic status, gender, housing precarity, and other circumstances, rather than any innate emptiness or falsity of their 'paranoid' thoughts and actions.

Those labeled with bipolar disorder or schizophrenia, and sometimes 'BPD,' are often considered delusional when they talk about how computers and cars and infrared technology are destroying their bodies. They even have a label for 'delusional disorder,' which has been applied to people convinced that doctors are injecting them with drugs for the dictatorship (that they are refugees from). I could see how some of my service users might be considered 'emptying,' because these beliefs only led to their neglect of their physical health. Again, we, the system, emptied them. We empty them by dismissing their claims as delusional, rather than building on their desires to write manifestos against the chemical and data mining state. These examples are not meant to create more binaries or make simple what is complex in social work practice. However, a reorientation around what is considered delusional, who is doing the dysfunction-ing or emptying, and the potential value of minoring gestures, may be useful towards supporting those in distress –

or simply – without access to shelter and presenting in ways that we have labeled as 'unwell.' What might happen if we see these desires not as some disordered way to cope or seek pleasure, but as desires for different organizations of society and its organs?

3.12 Pitfalls of this Analysis

August 15, 2023: Autotheoretical note on borderline
I'm not sure what intervention this is making, but all of this helps me see borderline as immanent, even for one person – it is immanent, not a definer of pathology. 'BPD' is a definer, though immanent in what it *does* and *for whom.* Borderline, a concept, experience, ontologically, is immanent. Which is interesting, because immanence is such an intrinsic component of the borderline concept (and diagnosis) itself. AND that none of this can be done/said/acted upon without a geopolitical analysis.

These alternative ways to conceptualize borderline have clear clinical and societal implications that I discuss in Chapter Five. First, however, I want to use this space to transition to the next Chapter, by highlighting the pitfalls of using ethology for borderline 'traits' – particularly if we affirm them in a universalizing way – and through the Western lens of borderline. As Chapter Four explores, any affirmative analysis that does not contend with geopolitics and intersectionality, can end up serving macro-political agendas caught up in power systems like corporate profit and Euro-American empire.

First, this type of analysis runs the risk of essentializing borderline as one type of experience. Borderline scholars have been careful to both honor the uniqueness of what people describe as borderline, while keeping the experience quite contextual, and open to variety; after all, the psy-disciplines often note that there are (200+) different combinations of the borderline 'symptoms' that can present in a given individual (Hawkins 2014). Still, we must always remember that the borderline concept, no matter how resonant, was created by Western psychiatry and psychoanalysis.[55] That is, attributing the above experiences to borderline reifies the Western concept of borderline, both because I have traced the diagnostic criteria themselves (perhaps a lazy move), and because borderlining still may signify 'BPD' for many people. The affirmation of madness can risk universalizing narratives of these experiences that do not attend to the different ways in which these experiences can debilitate and capacitate across intersectional and geopolitical lines (for example, the various discussions to be had around the 'unstable sense of self'). Ethology

[55] Sarah Redikopp, personal communication, December 20, 2023.

must always have an intersectional analysis, ontologically and epistemologically, which means that ethologies of borderline might end up becoming ethologies of *moving on from borderline.*

Like Redikopp (2018) and Lewis (2023b), I seek to reconceptualize these borderlining experiences outside of the harmful category of 'BPD;' however, I acknowledge that this may mainly be a project for Western borderlines. Borderliners situated within Western epistemes, like me, might ask "what does it do to conceptualize borderlining outside of 'BPD,'" and "what else can borderlining do, outside of Western, Cartesian, neoliberal responses to it?" However, we must not assume that these are the questions necessary to disrupt the harms of 'BPD' and how it is responded to across the world.

That is, perhaps more important than this project is to 1) affirm that which has been pathologized (or rather, conduct ethologies; affirmation without analysis can be a whitewashing project), and 2) look to and uplift non-Western approaches to experiences that might otherwise be lumped into Western categories, including borderlining (see Chapter Four; Armstrong 2016; Gone 2013; Kopua, Kopua, and Bracken 2020; Mamea 2016; Ngata 2014; NiaNia, Bush, and Epston 2016, 2019; Taitimu, Read, and McIntosh 2018).[56]

Finally, as I have alluded to, the full BwO and ethology do not simply mean affirmation, because this not only obscures diverse experiences, but debility and distress. They require contextual analyses for what a certain move might do, including what it might do to situate them in the medical model (see Chapters Four and Five). While it might do great wonders to consider borderline as a neurotype, in the words of narrative therapist Tiffany Sostar, we also cannot neglect distress and debility – both that which comes from being neurodivergent in a neurotypical world, but also, direct forms of imperial violence that create mental distress and trauma. [57]As I discuss in the next chapter, we can learn much from other reclamation movements (i.e. queer pride and

[56] I want to thank Verity Armstrong in particular for reorienting my attention towards the necessity and value of culturally specific perspectives of mental, emotional, and spiritual distress and difference – which may or may not align with a focus on the Western concept of borderline, which many people will not resonate with, regardless of how much we reconceptualize it (personal communication, February 21, 2024). The question for her might be something akin to "how is it that both affirming borderline or replacing it with C-PTSD still keep us situated within Western frames?" "What might it do to take only a wairua [~spirit, derived from wai, or water, the cleanser of the soul] and whakapapa [~genealogy, lineage] approach to these experiences?" "Even if someone has 'BPD' on their file, what can tohunga [~healers, medicine people] teach us about this cluster of experiences?" As stated throughout, more work, ours included, should support, and prioritize culturally specific conceptualizations of experiences that might otherwise be labeled as 'borderline.' The examples and references provided are from kaupapa Māori approaches in Aotearoa New Zealand, partly because of the breadth and depth of work done by Māori practitioners, tohunga, and researchers, as well as my personal and professional experiences with these teachings and approaches.

[57] Personal communication, November 27, 2023.

disability pride) that have prioritized white, elite voices and experiences, and that have been captured by neoliberal states who use narratives of progress and acceptance to accept certain people into the neoliberal state and for the project of Euro-American imperialism. Furthermore, these movements can obscure the widespread "social suffering" (Meekosha 2011, citing Kleinman, Das, and Lock 1997; see also Giacaman 2018) that still occurs, as a result of these symptoms, that "liberal (disability) rights frameworks, advocating for social accommodation, access, acceptance, pride, and empowerment, are unable to account for, much less disrupt" (Puar 2017:x). We must differentiate our micro-political questions from our macro-political ones, and even in micro-political encounters, ask what ends are being served with our interventions? While in a clinical encounter we should ask what else these symptoms are doing, we must also ask what ends are served if we only affirm borderline experiences, without attending to the risks of universalizing and the ongoing psychological debilitation by living under racial capitalism.

All this is to say that while 'BPD' is problematic (and sometimes necessary for insurance and treatment), there are borders to borderline. There are borders to the utility of borderlining, and there are borders that seek to impose themselves on this reclamation if we are not careful. There are borders to our ethologies, where the answers to our ethological questions will drastically change if we are attuned to geopolitics. There are borders to any Mad movement that does not address its own nationalistic tendencies. What I want to make clear throughout this thesis is that we can de-pathologize neuro- and physical- diversity from harmful normative standards, while preventing widespread corporate and state violence. This is the topic of the next chapter: The borders of borderline, the borders of 'BPD,' and where our reclamations or even reconceptualizations of the concept may not do what we think they are doing.

CHAPTER FOUR: DEBILITY, CAPACITY, AND THE 'BORDERLINE PERSONALITY' ASSEMBLAGE

*Note: A short version of this chapter has been accepted and is undergoing its final revisions for publication as a commentary piece in *Atlantis: Critical Studies in Gender, Culture, and Social Justice* (see preface).

> To dismiss assemblage in favor of retaining intersectional identitarian frameworks is to miss the ways in which societies of control apprehend and produce bodies as information, as matter that functions not or predominantly through signification, as modulation of capacities, as dividuals in populations with any array of diverse switch points [...] and surveilles bodies not on identity positions alone but through affective tendencies and statistical probabilities. But to render intersectionality as an archaic relic of identity politics then partakes in the fantasy of never-ending inclusion of capacity-endowed bodies, bypassing entirely the possibility that for some bodies—we can call them statistical outliers, or those consigned to premature death, or those once formerly considered useless bodies or bodies of excess—discipline and punish may well still be the primary mode of power apparatus. (Puar [2012] 2020:414)

4.1 Introduction

Chapter Four ethologically focuses on the macro-politics of the 'borderline personality' assemblage. However, it is also a result of my initial ethology, wherein I asked, "what does borderline do?" Asking this question as I read theory and engaged more with not just Mad Studies, but with mainstream 'BPD' discourse, pushed me to conduct an ethology of the various sub-assemblages of 'borderline personality.' Working with these sub-assemblages helped me to highlight the distinctions and overlaps between how the 'BPD' label and the borderline concept each get used, avoided, deployed, taken up, and reclaimed in popular discourse, and what this says about the socio-political. This ethology is different from the one in Chapter Three, not only because it engages more with the macro-political, but because I rely more on Jasbir Puar's concepts of debility and capacity to analyze what each assemblage forecloses and enables, affectively and materially. Again, Chapter Four uses slightly different analytic tools from Chapter Three because they are each a product of my ethological engagement with borderline and social theory.

In this chapter, I not only use Puar's notion of debility and capacity but situate my analyses of the 'borderline personality' assemblage within her broader critiques of rights- and empowerment- based movements. I thus first introduce her work, particularly on the assemblage of homonationalism (in relation to queer pride and rights) and on the affective registers of debility and capacity (in relation to disability pride and rights). I then put her work to use in analyzing how the various components of the 'borderline personality' assemblage interact with one another, what they do socio-politically. I specifically explore, in this order, what 1) the clinical label of 'BPD,'

2) the psychocentric identification with 'BPD,' and 3) the Mad affirmation of borderline all do, for whom, in which contexts, and towards what ends. I pay particular attention to how both Mad-affirmative and psychocentric reclamations of borderline and 'BPD,' respectively, have helpfully normalized and destigmatized these experiences, and yet, might not be as liberatory as they seem. I conclude by showing how all three sub-assemblages, and the 'borderline personality' assemblage as a whole, contribute to the ends of Euro-American empire, while obscuring how it produces acute and chronic emotional and mental distress that may not have access to an affirmative account or rights-based movement.

4.2 Introducing Jasbir Puar: "What Happens When 'We' Get What 'We' Want?" (Puar 2017:xviii)

> "That human rights are pharmakon-like (both medicine and poison) has become axiomatic of any critical position. Yet, how does one work with rights under conditions where nation states legitimize their monopoly over violence through rights" (Puar, in Sircar 2020:345)?

Much of this chapter uses Jasbir Puar's (2007) heuristic of "homonationalism," as well as her conceptual tools in *The Right to Maim: Debility, Capacity, Disability* (2017) to critique the rights-based discourses surrounding 'BPD,' as well as the potential "elite capture" (Táíwò 2022) of reclaiming borderline and other forms of madness (see also Eromosele 2020; Gorman 2013; Redikopp 2021; Tam 2013). Central to Puar's work is the analysis that so-called rights are granted based on being included in the white, neoliberal, settler colonial nation, thus based on the exclusion and vilification of racialized, gendered, and sexualized 'others' whom the U.S. (and other global powers, such as Canada) deem as both continuously exploitable as well as threats to its imperial projects (for similar critiques, see Conrad 2014; Ferguson 2018; Markotic and McRuer 2012; McRuer 2010; Mitchell and Snyder 2015; Peers 2015; Spade 2015). Puar's work overall leads us to ask, what do rights-based movements do, and for whom? How are these movements co-opted, and on whose backs?

Puar's 2007 first book, *Terrorist Assemblages,* introduces the assemblage of homonationalism, exploring how the U.S. uses the rhetoric and practice of queer inclusion to profess its 'progressivism' while justifying the invasion and extraction from nations that it deems as threats to its national and imperial projects. While the U.S. has mobilized and benefitted from homonormativity, or the normative aspirations and achievements of certain (white, Western, affluent, reproducing, male, cisgender) queer people, it simultaneously and continuously demonizes racial and sexual 'others,' whose cultures and nations are depicted as 'inherently homophobic' (Puar 2007:10, 15). Puar argues that the ability for mainly elite populations to attain

rights and be "successfully integrated into national legibility" is only made possible by the elision, removal, neglect, and "inconceivability" of geopolitically and intersectionally subjugated populations' access to these rights, movements, and their ensuing subjectivities (Puar 2017:47; see also Peers 2015). Homonationalism is not just about elite or racist queer people but serves as a heuristic through which to trace how "emerging intimacies between racism, nationalism, and Islamophobia were recruiting queers to further the ends of U.S. imperialism and exceptionalism [...] and mobilizing the consent of white queer Americans by luring them into the folds of liberal citizenship" (Puar, in Sircar 2020:332). Viewing homonationalism in assemblages helps me to see how nationhood, empire, sexuality, and race operate through the ongoing "contradictions of liberalism" (Puar 2022:3), where "the disavowed and perverse are not denied nationhood but become emblematic of it" (which does not mean they are treated well across the board) (Ben-Moshe 2018). Puar (2007, 2022) notes, for example, how homophobia can be produced by and remains rampant within the U.S., while its liberal inclusion of queer people in marriage and in the military gets used towards invasion, in the case of Afghanistan and Iraq, as well as a narrative device to proclaim Israel's 'progressive superiority' over Palestine, thus obscuring its violent occupation (see also Blackmer 2019; Conrad 2014; Ferguson 2018). I discuss homonationalism (and its provisional correlate, Mad nationalism) later in this chapter, with specific reference to how both borderline and 'BPD' could get, or are already getting, co-opted, not only to narrowly benefit elite populations, but in the service of Euro-American empire and corporate profit.

Puar's second book, *The Right to Maim* (2017), continues this analysis of liberal co-option (and elite participation in it), within the context of disability studies and empowerment movements. In introducing this book, I want to remind that we could replace 'disability' with madness or 'mental health,' given the affinities between destigmatizing disability and 'mental illness,' and between the more radical Critical Disability, Crip, and Mad Studies (Beresford 2020; Ingram 2016). This is because we can see how both Mad-affirmative and psychocentric discourses about destigmatizing borderline, like disability, do different things across and within geopolitical contexts. In *The Right to Maim,* Puar highlights the contradictions between the pride- and accommodation- based rhetoric in disability studies and movements, who they exclude, and the ongoing *production of disability* by the 'Global North,' where much of this advocacy is centered – the advocacy and scholarship that necessitates that "disability is not a restriction, but a resource" (Garland-Thompson 2014:339, cited in Puar 2017:67). Insofar as the conditions to refute disability

or madness as lack or undesirable are *not* available for the majority of the world's disabled or mad populations, Puar helps us to ask what empowerment-based narratives capacitate and debilitate, what futures they imagine and for whom, and what they obscure. The first part of Puar's critique is the ways in which rights get dished out along registers of racial, gender, and neoliberal normativity. Like disability scholars David Mitchell, Sharon Snyder, and Robert McRuer, Puar remarks on the limitations of rights-based movements, when neoliberal states "discriminate which bodies are vested with futurity, or more accurately, they cultivate (some/certain) bodies that can be vested with futurity" (2017:17).[58] She argues that much of disability activism and scholarship, at least in the 'Global North,' remains a "highly privileged conversation" that participates in and ignores the role of U.S. imperialism in producing impairment across the world – impairment that may not even be granted the status of disability by identity-based arms of the disability movement nor by the state; after all, state and medical institutions are largely the ones to validate who counts as disabled and thus what accommodations people can access. As Puar (2017:73) reiterates repeatedly, "disability can be negotiated through access to medical care only for the very few" (see also Jamjoum 2002; Livingston 2005).

Puar also furthers Mitchell and Snyder's (2015) ablenationalism and McRuer's (2010) crip nationalism by looking not only to who is excluded and included into "the biopolitics of disability" (and sexuality), but as I have alluded to, upon whose debilitation these rights rest and obscure. This is what she refers to as the biopolitics of debilitation, which better accounts for "the economy of injury that claims and promotes disability empowerment at the same time that it maintains the precarity of certain bodies and populations" (Puar 2017:xvii). What Northern disability studies obscures in its valorization of the social model[59] over the medical model, for Puar, is the (geo)political nature of disability, particularly the deliberate production of disability – whatever it gets called – through state and corporate violence (see Connell 2011; Erevelles 2011; Kazemi

[58] In other words, "Inclusion in (national) invocations of collective futurity is thus consent to genocide" (Puar 2017:85).

[59] The social model of disability, for example, importantly denounces the idea of disability as a 'deficit' or 'illness,' and differentiates between impairment (a physical limitation, bodily pain, or change in one's abilities) and disability (caused by discriminatory and inaccessible social and environmental conditions; an experience to mobilize in order to gain accommodations within an ableist world; an identity to be reclaimed). Puar (2017:73) writes, however, that "[m]aintaining a construction of the social that revolves around built infrastructure and obstacles to them, rather than a social that includes work and warring as debilitating processes, is a function of racial, class, and locational privilege" (see also Erevelles 2014; Meekosha 2011; Mollow 2006).

2018; Livingston 2005; Meekosha 2011; Mingus 2011b).[60] That is, as with Puar's argument in *Terrorist Assemblages,* the very nation that grants rights for certain people, thus professing its progressive exceptionalism, is the same nation that debilitates populations through the endemic violence of racial capitalism and settler colonialism; both projects – progressive rights and endemic state violence – work in tandem to maintain the capital and colonial structures of the Global North (Puar 2017:65; see also Erevelles 2011). Given these foreclosures, "identifying as disabled [and prioritizing a politics of affirming disability] is practically an insult to a future-injured, available-for-injury body, for whom long-term bodily health and integrity is already statistically unlikely" (Puar 2017:72; see also Mingus 2011b on white people being the ones to identify as disabled).[61] Femi Eromosele (2020) makes a similar point about the geopolitical limits of Mad identity, writing:

> The way that a celebratory understanding of madness may work to occlude more immediate forms of injustices in which such conditions represent an indictment against their perpetrators; and of the way that national, ethnic, or other sorts of allegiances are likely to have a stronger political hold on individuals than their experience of madness. (P. 17)

These contradictions, exclusions, and assumptions embedded within much of disability rhetoric in the West (or more accurately, amongst elites, and propagated by institutions, in the West), for

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[60] This critique is also a central analysis of much of Disability Justice organizing. Mingus 2011a, b; Piepzna-Samarasinha 2018; Sins Invalid 2019. See also Sona Kazemi's (2018) work on transnational approaches to disability (and its production).

[61] Although it is beyond the scope of this thesis to detail how Puar traces the workings of American Empire in relation to disability, I do want to highlight that the main context in which Puar analyzes these mechanisms in *The Right to Maim* is Israel's occupation of Palestine, where Israel is a proxy for Euro-American empire. She ultimately shows how disability empowerment in nations like the U.S., Canada, and Israel, as well as their rhetoric of being LGBTQ+ friendly, obscure their systematic debilitation of populations within their borders and across the globe for imperial and corporate benefit (called 'pinkwashing,' see Blackmer 2019; Puar 2007; Puar 2017:96). Puar also details how the Israeli state maintains control over Palestinians by debilitating individuals, communities, and infrastructure en masse, under the guise of a 'humanitarian' move away from direct murder (e.g., shooting people in the legs), while it benefits from the funding granted to rehabilitate Palestinians who have been shot in the legs, "deemed available for injury" (Puar 2017:81). Of course, Israel has continuously been exercising its "right to kill," "right to kill slowly," and increasingly, 'humanitarian' "right to maim" throughout its seventy-five-year occupation; however, its right to kill has been obliterated by a right to slaughter in the genocidal events of the past six months (Government of South Africa 2023). Although we are witnessing a genocide that should not be equivocated with other forms of settler colonial violence, it is important to note, in support of this thesis' broader critique of Euro-American empire, that the occupation of Palestine *is* an example par excellence of settler colonial and neoliberal control – the same control and debilitation exercised by the U.S., Canada, Australia, New Zealand, South Africa and other settler colonial nations (Clarno 2017; Puar 2017). The references to debility – psychological and physical – that I make with regards to borderline and 'BPD' are towards the ends of critiquing racial capitalism and empire. Thus, they are not separate from, but set against the backdrop of this genocide, and embedded within their own settler colonial contexts of most specifically, the U.S., Canada, and New Zealand.

Puar, invites an ontological and intersectional shift that acknowledges that disability as a concept, label, or identity can be supportive or harmful depending on what the disability is caused by, what rights are granted, and by whom, where the rights of some populations are made possible by the debilitation of others (see also Erevelles 2014). To analyze these geo-political and ontological shifts, convivialities, and contradictions mentioned above, I turn now to Puar's conceptualizations of debility and capacity, which she uses to analyze what disability *does*. Given the various relays between disability, borderline, and 'BPD,' that I have alluded to, I then use debility and capacity to analyze the ethological question: "What do assemblages of 'borderline personality' do?"

4.3 Thinking with Debility and Capacity

Puar's conceptualization of debility and capacity ontologically accounts for the ways that experience that are (and arguably should be) reclaimed can end up increasing the powers to act, or capacities, of certain elite populations, while decreasing capacities, or debilitating, structurally precaritized population. That is, debility and capacity help us to understand not what disability essentially is, in Puar's example, but how it can both capacitate and debilitate; like borderline, disability can be a form of institutional violence, can result from institutional violence, can mitigate institutional violence, and, as a neoliberal identity to be reclaimed, can obscure institutional violence: "[T]here are gradations of capacity and debility in control societies—rather than the self-other production of being/not being—the distinction between disabled and non-disabled becomes fuzzier and blurrier" (Puar 2017:22). These analyses are useful in keeping the micro-political interventions from Chapter 3 from being universalized or co-opted, insofar as what borderline, 'BPD,' and any reworking of either of them, *do* will vary based on geopolitical and intersectional assemblages (see Chapter Two and Puar 2017 on a "locationless ontology"). I start by introducing debility and capacity in their most obvious uses: how they can be processes of direct and indirect state and corporate violence *or* support, both of which can get obscured by mainstream rhetoric surrounding disability or other empowerment-based concepts. However, I also want to note that debility and capacity are also processes of affective control: the limitation or enablement of individuals, dividuals, and populations' powers to act, futures, potentials, life chances, and capacities or desires to imagine futures. I thus discuss debility and capacity in terms of affect after introducing their most material and disciplinary applications, using examples from *The Right to Maim.*

4.3.1 Debility

For Puar, viewing disability as only a product of societal exclusion ignores the fact that some impairments will never be recognized, let alone, be recognized as anything other than the daily workings of labor exploitation and racist state violence. For her, disability, rather than exception, chance, or something that 'could/will happen to any of us,' is endemic, and specifically endemic (disproportionately distributed) to disenfranchised populations (see also Meekosha 2011). Nevertheless, "wide-ranging injuries inflicted by settler colonialism are not accorded recognition or rights as debilitating conditions" (Gunaratnam 2021:1846). What we might call workplace 'accidents,' an 'unfortunate disease,' or 'bad luck' are not random events but are outcomes of the "systematic wearing down" of racialized and overexploited populations (Puar 2017:65). This "systematic wearing down" is often not recognized as a disability, formally and discursively, and thus is what Puar refers to as *debility:* the endemic physical, psychological, and socio-economic impairment caused by colonial violence, labor extraction, and global powers that define (and grant or deny resources based on these definitions) what is considered an accident, sickness, disability, 'mental illness,' and what is considered "expected" under racial capitalism.[62] Debility is thus that which is obscured by disability, but it is also a *process* of biopolitical and necropolitical control – control not by direct state murder, but by more insidious tactics that can get painted to look like simple 'social determinants of health,' 'lifestyle choices,' or 'unfortunate accidents' (Puar 2017:64). Debilitation is a process through which the neoliberal, colonial state produces specific populations as statistically likely and "available for injury" (while extracting their labor) and targets them for injury, (re)capacitating them under a cloak of benevolence to maintain control (what Puar refers to as "maiming") (2017:128-129). Some jobs are simply more dangerous than others, and certain populations are more likely to be working in harmful jobs, in addition to experiencing the effects of pollution, getting amputations[63] due to war or genocide, or in the case

[62] In fact, for Southern disability scholars, experiences of racism and poverty should be viewed as disabilities or forms of disablement, and yet these experiences do not fit neatly into the category of the disabled/non-disabled binary that so much of Northern disability activism promotes (Connell 2011; Erevelles 2011; Livingston 2005; Meekosha 2011; Mingus 2011; Puar 2017).

[63] See AHPs for Humanity (@ahps4humanity). 2024. Instagram, January 30. https://www.instagram.com/p/C2vgVJ9twND/?igsh=ZG8yMnhmenA1b3Ru (see also UNICEF 2023; United Nations 2019).

of madness, experiencing high levels of emotional distress due to the continued violence of Euro-American imperialism (see Government of South Africa 2023).

Maiming (the targeted form of debilitation and capacitation) can be direct, for example, in the Israeli Defense Force's targeting of Palestinian protesters' lower limbs or the production of post-traumatic stress amongst Palestinian children; maiming can also occur through the intentional deprivation of electricity, healthcare, food, water, employment, and other necessary resources – mechanisms that we see in occupied Palestine and across the world (Puar 2015:220). For Puar, both debilitation and maiming "foreclose the social, cultural, and political translation to disability" (Puar 2017:xiv) because under capitalism, imperialism, and colonialism, "certain populations are *expected* to yield themselves to bodily debilitation, deterioration, and outright harm" (Puar 2017:73, italics added). Through the various tactics of disability policies, debility, and maiming, the nation-state renders certain populations worthy of rights and others as profitable statistical write-offs and/or direct "objects of disposability" (Puar 2018:80).

4.3.2 Capacity

As Puar highlights with the case of Israel, the neoliberal state profits from the (selective) rehabilitation of its debilitated populations, where debilitation "does not work in isolation but in careful balance with *capacitation,*" thus, the state's right not only to kill, but to maim (Breedt 2023:n.p.). Capacitation increases the possibilities of what a body can do – its powers to act. To capacitate a body – whether an individual or population – is to enable greater potential for health, in the Deleuzian sense. Materially, capacitation can look like being granted access to rehabilitation services, state-granted accommodations within the neoliberal state such as marriage rights with tax, citizenship, and healthcare benefits. These are all experiences that disproportionately benefit elite populations, as well as the nation state (Puar 2007). While debility often does not necessarily grant access to rights, if rights and resources *are* granted to systematically disenfranchised populations, it is because it serves the state's financial and geopolitical interests. Well beyond Gaza, profit is possible when healthcare companies need to treat this endemic debilitation, while not capacitating people enough to grant them safe working conditions or citizenship rights: "debilitated bodies are more valuable than dead ones because it keeps bodies in capital circulation" (Puar 2017:153). Via the relays of debility and capacity, people are not as often simply 'outcast,' relegated as useless to society, but are put into institutions, rehabilitation centers, psychiatric wards, and treated by healthcare practitioners; these institutions and services become "a source of

value extraction from populations that would otherwise be disposable" (Puar 2017:79). As I expand upon below, the problem is not capacitation, but who is capacitated and debilitated (and to what extent), who is not afforded certain types of capacitation, and who is made to undergo repeated cycles of debilitation and capacitation, where the neoliberal state "produce[s], sustain[s], and profit[s] out of disability" (Meekosha 2011:668). This relay between debility and capacity helps us to become less concerned with "whether an injustice occurred" (a focus only on debility), but with "what material conditions of possibility are necessary for such positive re-envisionings of disability [and madness] to flourish, and what happens when those conditions are not available," as well as what the propagation of these narratives – to various degrees of ableist fantasies of "overcoming" or the pride-based affirmation of difference – do, geopolitically, and how that may or may not contradict the justice-based intentions espoused by these movements (Puar 2017:xix).[64]

4.3.3 Debility and capacity as affective processes

> "Affect is at once an exchange or interchange between bodies and also an object of control" (Puar 2017:19).

The affective question, with regards to this relay between debilitation and capacitation is always "[w]hich debilitated bodies can be reinvigorated for neoliberalism, available and valuable enough for rehabilitation, and which cannot be?" (Puar 2017:13). I explore these questions in this section, showing how debility and capacity are affective, not simply material processes; "rather than an identity or attribute," debility and capacity each are "a verb and a doing rather than a happening or happening to or done to" (Puar 2017:73). That capacity and debility can be, but are not, "discretely of the body" is because "affect is an exchange or interchange between bodies," human and non-human, organic and inorganic (Puar 2017:19). Puar goes beyond analyzing the individual intersectional and material patterns of debility and capacity, tracing instead how disability (as one example) affectively capacitates and debilitates populations through discourse, feelings, potentials, and access to futures – or lack thereof.

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[64] As I alluded to in Chapters One and Two, these were analyses that I did not consider early on in my desires to affirm borderline knowing, thus the reason I was compelled to only write Chapter Four. Still, affirming borderline knowing and calling out the conditions that make such affirmations hard to access, imagine, or benefit from, are not mutually exclusive. I note that much of this chapter leans towards painting a binary between Mad affirmation and anti-imperial critiques of sanism and psychological violence, particularly due to my own workings through these various agendas, departures, and convivialities. Still, affirming Mad knowledge is an important part of anti-imperial work, so long as anti-imperialism and the prevention of psychological violence get foregrounded. The main argument throughout this chapter (and the next) is that this is not often the case, and thus our reclamation movements (particularly those that reify psychiatry) need greater geopolitical specificity and analysis.

As an affective concept, capacity is "shaped by and bound to interface with prevailing notions of chance, risk, accident, luck, and probability, as well as with bodily limits/incapacity, disability, and debility" (Puar 2017:19-20). For example, capacitation can look like having an identity to mobilize around, an empowerment narrative to be inspired by, or a future to imagine. Here, disability or madness can become concepts embedded in ideas of futurity, empowerment, and "living well" for some (Breedt 2024), an experience unthinkable for others whose physical and psychosocial disabilities come from the daily "expected" and in fact "precalculated" logics of exploitative labor relations, war, genocide, settler colonialism, and other forms of state and corporate violence (Puar 2017).

Debility, on the other hand, disrupts the affective investment in and assumption of being endowed with "endless capacity" (Puar 2017:20), such as the idea that being 'able-bodied' (or 'able-minded') necessarily means being endowed with capacity and futurity, if only discrimination did not exist. Having a normative "able" body or mind, however, globally, does not necessarily afford capacity, rights, recognition, or futurity. Being granted material or socioeconomic accommodations because of disability advocacy does not necessarily afford capacity or futurity, for example, when one expects to be killed as a teenager, by anti-black police violence, or by the Israeli Defense Force; for many people, debility is a "banal feature of quotidian existence that is already definitive of the precarity of that existence" (Puar 2017:16; see also Ruth Wilson Gilmore 2007, who defines racism in terms of exposure to premature death). While disability (or madness) can be affectively capacitated into a "life worth living" (Linehan 2020) by "circuits of white racial and economic privilege, citizenship status and legal, medical, and social accommodations" (Puar 2017:20), for others, disability (or madness) is always a "deliberate product of exploitative labor conditions, racist incarceration and policing practices, militarization, and other modes of community disenfranchisement [e.g. environmental racism and intergenerational trauma]" (Puar 2017:65). Identifying as disabled (or mad) is only thinkable when disability (or madness) is imagined as an unexpected or random occurrence within a capacitated life, rather than pre-calculated and statistically predicted for specific populations, shaping their life chances and outcomes.

Furthermore, if and when debility does not translate into the profitable capacitation system – if and when debility *does not* pay – and people *are not* turned into "objects of care" who are still profitable despite not being able to work (as capacitated healthcare consumers), debility maintains

affective control through the maintenance of a social class of disposability, upon which nationalistic, white supremacist, settler colonialist, and elitist rhetoric gets targeted: "Populations that are not roped into an economy of rehabilitative objects of care are sites of profit [and control] precisely for their availability for injury, their inability to labor, their exclusion from adequate health care, and their ideological production as lazy, criminal, and burdensome" (Puar 2017:93). This maintenance of a "disposable" class – a racializing and geopolitical phenomena, Puar notes – is central to debilitation and often excluded in the biopolitical critique of the profiteering from disability and rehabilitation: "Populations are constructed as objects of imminent disposability, continually subjected to paternalistic austerity regimes, violent institutionalization, and debilitation that is not in any way redeemable through cultural rehabilitation" (Puar 2017:79). In other words, populations deemed not only as "available for injury," but as "disposable," are productive insofar as they become symbolically valuable, signifying a location of undesirability, for populations to be threatened with, compared to, and controlled through. Through debilitation-without-capacitation, the neoliberal state can maintain control over populations seen as a threat to the nation-state, limiting their resistance, normalizing their disenfranchisement, and maintaining their discursive demonization. Crucial to this point is that debilitation is not about using bodies for profit in terms of productivity (through its relays with capacitation), nor is it only a material move towards blatant extermination of populations (though this is clearly caught up with these moves), but about affectively ensuring their continued vulnerability, for both profit and control.

Finally, while debility and capacity are opposites, they are not inverse. They can happen simultaneously and in multiple ways. As Puar (2017:xv) writes, "they exist in a mutually reinforcing constellation, are often overlapping or coexistent." For example, madness can capacitate white elites like me who gain clout by writing through and about our madness, even as it debilitates us in other aspects. Analyzing with debility and capacity, as I do below, is then not about individuals' various levels of debility and capacity, but about how "bodies and their affective modalities [are] modulated in control societies" (Puar 2017:20) In my analysis of 'BPD' and borderline, I show how they can debilitate and capacitate, not to produce a quantifiable net sum, but to understand the discursive, affective, material, and physiological processes a population or individual is undergoing, when, where, in which contexts, and in relation to which other populations, and by which processes; I use these concepts to understand how and why rights-based movements and their discourse proliferate, when, to apply Puar's analysis, 'mental health' rights

"creates more [psychological] disability and relies on, if not engenders, a deeper entrenchment of [psychological] debility in disenfranchised sectors of society, of the globe" (Puar 2017:87; see also Erevelles 2014).

4.4 What does the 'Borderline Personality' Assemblage do?

> "This isn't just a question about lexicon, or words, or terminology, but really: what kinds of travels those terminologies inhabit, and how they reproduce particular kinds of relationships of knowledge over others" (Puar, in Adler-Bolton and Gill-Peterson 2022).

In this section, I repurpose Puar's conceptualization of debility and capacity with regards to disability for the purposes of analyzing assemblages of 'borderline personality' – in order to untangle the relationship between affirming borderline, the limits of neoliberal analytics for 'BPD,' and ending debilitating (settler) colonial psychic violence. To do so, I trace the debilitating and capacitating potentials of 'BPD' as a signifier in the medical industrial complex, as well as its close cousin in psychocentric reclamation or awareness projects. I start with these analyses of what 'BPD' does because even in destigmatizing contexts, the invocation of 'borderline,' in popular discourse, mainly seems to refer to being diagnosed with or identifying with the diagnosis of 'BPD' (and the various relationships to psychiatry that each entail). This section thus focuses on what 'BPD' (the imposed diagnosis) can debilitate and capacitate, and what the chosen identification of 'BPD' can capacitate (often in the form of elite identity politics), even while being caught up with debilitation. After this, I examine 'BPD's more critical and liberatory counterpart, the assemblage of borderline affirmation, situated in a Mad critique of psychiatric harm. Here, Mad affirmations of borderline can capacitate white, globally elite people, while also working to obscure rampant psychological debilitation under racial capitalism. I conclude this chapter with an analysis of what all three of these sub-assemblages do together, showing how the 'borderline personality' assemblage as a whole – its psychiatric, psychocentric, and Mad components – obscures psychological debilitation while contributing to Euro-American empire and white supremacy. I want to note that not all my examples are directly about 'BPD' or what might be labeled as 'BPD;' although the demographics of 'BPD' are understudied, 'BPD' and borderline-like experiences likely track with socio-political patterns of other 'mental health' diagnoses (see Chapter One).

4.4.1 What does the 'BPD' diagnosis assemblage do?

> "Medicalization can be experienced as transformative, capacitating, debilitating, or all of the above, not to mention exclusionary" (Puar 2017:40).

As is well documented in the clinical and feminist literature, the 'BPD' diagnosis can debilitate, particularly when it is stamped onto one's medical files, for insurance companies and medical providers to evaluate.: "Receiving a formal diagnosis can mean that this label becomes the dominant story of our lives, at least when we're interacting with health professionals" (Sostar, Thomas, and Nault 2020:13). As discussed in Chapter One, "[r]eceiving a diagnosis from the DSM is a life sentence: its ICD codes, once scratched into your file, will remain with you until death, and even afterward" (Hedva 2016:n.p.). Scholars, research participants, influencers, myself, and tāngata whaiora I worked with have all heard the following rhetoric from mental health staff: "you are high risk; you're doing this for attention; you're not going to make it; we can't do much for you; why didn't you just do it [commit suicide]; you're a waste of resources."[65] When we enter emergency rooms, or any institution that has our diagnosis on-hand, we can get coded for either extreme treatment or confinement, or in many cases, to be turned away because 'we are not really mentally ill.'

As an example, I worry that I will be deemed "medically inadmissible" by Immigration Canada.[66] And, of course, I'm a white U.S. citizen with savings and a higher degree. I will contribute to the Canadian economy, and I will prove this in part by spending hundreds of dollars on an English language exam, a medical evaluation, and the application itself. My geopolitical privilege shapes my experiences so much that I did not even flag these concerns to my psychiatrist before he diagnosed me, or to my therapist before she referred me to specialized services. Although I am still worried about my admissibility, being inadmissible is highly unlikely. Regardless, what is interesting is that as an immigrant, I have been willing to use my diagnosis to get proper care, or, at least, to have my providers be using the same language. The healthcare and immigration systems are both relatively safe for me; so, is it a wonder that so many 'BPD' influencers and openly Mad folks are white citizens of the 'Global North?'

Not all bits of matter form legible assemblages, because assemblages are actualized by

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[65] Adapted from a variety of social media videos, literature (see Chapter One), clinical and personal experiences. See for example: Cait (@caitsrecovery). 2023. TikTok, August 24. https://vm.tiktok.com/ZMMt6DpXj/.

[66] According to Immigration Canada, people with 'mental health' diagnoses can be deemed inadmissible if we are evaluated to be too much of a risk to ourselves or the public, as well as if we are deemed to be a risk to public healthcare infrastructure; there is a dollar amount per year that we should not exceed in our uses of healthcare services, lest we risk being deemed too costly for the system. At the same time, if we are diagnosed, we should be seeking treatment in order to 'recover' from and/or mitigate the risks imposed by our 'disorders' (Immigration Canada 2024). Lou Tam (2012:71) notes that racialized migrants cannot safely come out as Mad, but must come out as 'mentally ill,' lest they "risk deportation if they do not disclose their psychiatric diagnoses on their visa applications."

desire; only some mental health data forms a desiring assemblage for the state (Buchanan, 2020). The state is likely interested in (occupied with, desiring) the mental health data of all the white folks in my therapy group or, to be frank, with an American student with a relatively high points profile in the immigration system, only insofar as to form an assemblage that highlights the success of the system – a capacitation assemblage – which invests in the securitization of acceptable 'BPD' immigrants and thus the white, capitalist nation state. At the same time, the state may form another desiring assemblage with immigration policies, nativism, geopolitical agendas, and the data of racialized migrants accessing 'mental health' services, who it can and will siphon into different streams of potential threat, burden, and risk, where "risk is a form of international tutelage" that gets used to rank individuals and nations (Tam 2012:x). Migrant mental health diagnoses – again, certain precaritized migrants – get used to determine who can and cannot stay, either in terms of their risk or in terms of their home country's 'lack of adequate care' – care that is defined by the "exceptional" forms of mental health 'care' we have in the West (Howell 2011; Tam 2012). These risk analyses, population metrics, and rankings of nations and individuals, unlike the assemblage formed with populations that are useful for the white nation state, serve to invest in the *insecurity* of racialized and otherwise 'unacceptable' migrants, who get used by the state to 1) control populations in relation to vectors of acceptability and security, and 2) reiterate its geopolitical prowess and power. Where Puar (2020:170) has spent considerable time analyzing the ways in which sexuality is "produced through [...] discourses of the nation," Tam (2012, 2017, 2023) tracks the ways in which the mental health data and affective states of racialized (as well as classed, gendered, religiously-othered) migrants are mobilized not only to determine admissibility, but to access funding for "greater mental health treatment for migrants," often a guise for greater confinement, forced treatment, and/or palliation of Mad migrants.

As several Mad-affirmative scholars have discussed, the 'BPD' diagnosis itself can also be capacitating, even if "cruelly optimistic" (Lewis 2023b; see Chapter One). Being diagnosed, particularly in Western healthcare systems, can be the only way to access treatment, be prescribed medication, or have an appointment covered by insurance (Price 2015; Redikopp and Smith 2022). Capacitation through the 'BPD' label can also look like validation and can work towards advocacy on behalf of people with the diagnosis (see Figure 2). Advocacy based on the 'BPD' diagnosis, such as legislation that necessitates more insurance coverage for 'BPD,' can capacitate those who are diagnosed. This legislation may play a part in reducing disparities in what the diagnosis does

for different populations, but whether or not clinicians refer people to programs, diagnose people, or if the treatment is culturally appropriate for all people remains up for debate, thus limiting the

Figure SEQ Figure * ARABIC 2. The 'BPD' Diagnosis and Advocacy. Text on advocacy signs reads: "Evidence-based treatments for Borderline Personality Disorder work. Make them accessible! Hope is more research, treatment, support for Borderline Personality Disorder." See image references in Appendix One.

universally capacitating potentials of the diagnosis.

The 'BPD' diagnosis, beyond its institutional capacitating and debilitating abilities, can also lead to a capacitation of self-understanding, a neoliberal identity, or even building a brand based on 'BPD' empowerment (Emotions Matter 2024; see Puar 2017 on neoliberal identification; next section). In the next section, I examine these aspects of capacitation, which I include in the sub-assemblage of 'BPD' reclamation. The uptake of 'BPD' as an identity to mobilize around, still through the lens of psychiatry, is one of the predominant ways in which we can see 'BPD' capacitating people (even as they're debilitated), towards the ends of whiteness and perhaps Mad nationalism.

4.4.2 What does the 'BPD' reclamation assemblage do?

While researchers, influencers, and advocates have heavily documented how the 'BPD' label can debilitate, and much of the above critiques have also been the subject of conversation amongst feminist and Mad-affirmative scholars, we can also see this arguably iatrogenic diagnosis capacitating populations. More accurately, capital and control are operating through increasingly insidious means to capacitate globally elite populations, and the systems that we are made to serve. This is an important intervention because while the clinical and popular discourse around borderline is still quite detrimental, focusing on this disciplinary critique might keep us stuck in a 1990s analysis. Merri Lisa Johnson's (2021:635) intersectional argument that 'BPD's' traditional representation through "disarming, difficult, or dangerous white women" can "erase borderlines

of color even as it criminalizes white borderlines" assumes that the 'BPD' stigma can only ever (differentially) harm people; however, we are seeing that 'BPD' can capacitate certain (white, elite) populations, while debilitating them/us, and while *only* debilitating other populations. That is, not all white borderlines are vilified by our 'BPD' diagnoses in all contexts; those of us who are moderately affluent, who have not been incarcerated, and who represent a normative depiction of femininity, whiteness, and eliteness, offer prime positionalities for social media giants and advocacy groups to mine for empowerment narratives and participation in the psychiatric industrial complex. This section traces the capacitating potentials of the 'BPD' label, an analysis that we miss if we only analyze the intersectional patterns of 'BPD's debilitating nature. Intersectional analysis that does not comprehend how capital and the state apprehend positive uses of these stigmatized labels for their own means cannot adequately comprehend how or why health disparities and inequalities continue to expand.

As I have alluded to, we have a non-Mad[67] type of 'reclamation' movement going on, marked by the open identification with 'BPD' on social media and YouTube – mainly amongst white, globally elite women (see Figure 3).[68] Although my social media algorithm certainly is just that – a self-reinforcing algorithm that surely does not represent all accounts of borderline on the internet – I find it telling that when I search anything related to borderline, approximately 95% (in my rough estimation) of accounts that come up across social media platforms are held by white presenting women, and in second place, elite women of color from the 'Global North.' Across the internet, there's a swath of people – both clinicians and service users – educating about 'BPD,' trying to destigmatize it, and *sometimes* sharing its positive aspects. There is greater acknowledgment that borderlines need to be treated better, and that it should be considered a trauma-related disorder. Influencers build platforms around identifying with 'BPD' and depicting

[67] What I discuss in this section is distinct from Mad approaches, but I note that I am interested in their convivialities here, because of the ways in which whiteness and eliteness modulate what both Mad-affirmative and psychocentric narratives around borderline and 'BPD' are doing, for whom, and towards what ends.

[68] During a presentation I gave, Dr. Erin Stapleton made a welcome remark that the people I am presenting are not just white, globally elite people; they are cisgender, thin, fashionable, and present an image of Western beauty norms. I could not agree more, and there are important things to be said about the registers of white femininity and its caught-up-ness with ableism, fatphobia, and more. However, in the context of the "ascendency of whiteness," I take Puar's (2007) analysis that whiteness (and eliteness, to draw on Táíwò 2022) means more than just skin color, though eliteness and whiteness "have gone hand in hand in many parts of the world for the past few hundred years" (Táíwò 2022:22; see Chow 2002; Puar 2017).). That is, white supremacy has several vectors, including heteropatriarchy, fatphobia, ableism, and classism, and the concepts of the ascendency of whiteness and elite capture are meant to account for the various ways in which the state and capital benefit from and perpetuate a normative image of who can be capacitated and included, and who cannot be.

"what it's like:" "There aren't enough content creators who make realistic content about what it's really like to live day to day as someone struggling with & recovering from a mental illness :-)."[69] This identification with 'BPD' can look like re-interpreting it as a pathology to accept and perhaps identify with, but it can simultaneously look like identifying with 'BPD' while emphasizing 'recovery,' where recovery is a code for fixing or ridding of borderline experiences – or at least distressing ones).

I do not describe each influencer or their posts in detail for several reasons. First, this chapter is not about tallying numbers, nor about shaming or ridiculing individuals, but about analyzing assemblages of 'borderline personality,' the forces that yoke it together, and the movement and exchange of affect (capacity and debility). Second, this section is not about 'BPD' specifically either; in fact, I want to caution against any reification of the trope of the 'self-involved' or 'attention-seeking' borderline through my analysis of 'BPD' influencers on social media. Being an influencer based on one's social positionality is not unique to 'BPD.' Rather, influencing is caught up with an array of subject locations. Being an influencer across the board (to various degrees) is caught up with, affected by, and participates in capital accumulation, corporate profit, and neoliberal control. These arguments are thus not about elite people with 'BPD' being specifically corrupt or apolitical but are nestled within a broader phenomenon of social media and capital, as it interacts with Mad nationalism and elite capture. This section highlights the relays between neoliberal capitalism, empire, affective control, corporate profit, psychocentrism, and state violence to call out the elite capture of 'BPD' reclamation and to caution against the risks of identity-based reclamatory movements.

The point here is that content creation is a thing, where 'BPD' can become a "privileged category by virtue of state recognition," as well as recognition by medical institutions, peers, and even self, e.g. through the building of a social media platform where one makes money by sharing about their journey, as Puar writes about the neoliberalization of disability: "[A]nother definition of disability may well be that body or that subject that can aspire both economically and emotionally to wellness, empowerment, and pride through the exceptionalized status it accrues" for populations whose primary focus is on futurity and "living well," and not with survival (Puar 2017:xvi; Meekosha 2011). What started as democratizing knowledge about physical and

[69] Sabrina Flores (@withlovesabrinaflores). 2023. TikTok, November 30. https://www.tiktok.com/@withlovesabrinaflores/video/7307337370880265514.

emotional health (which still happens) is now a system where influencers have managers who help

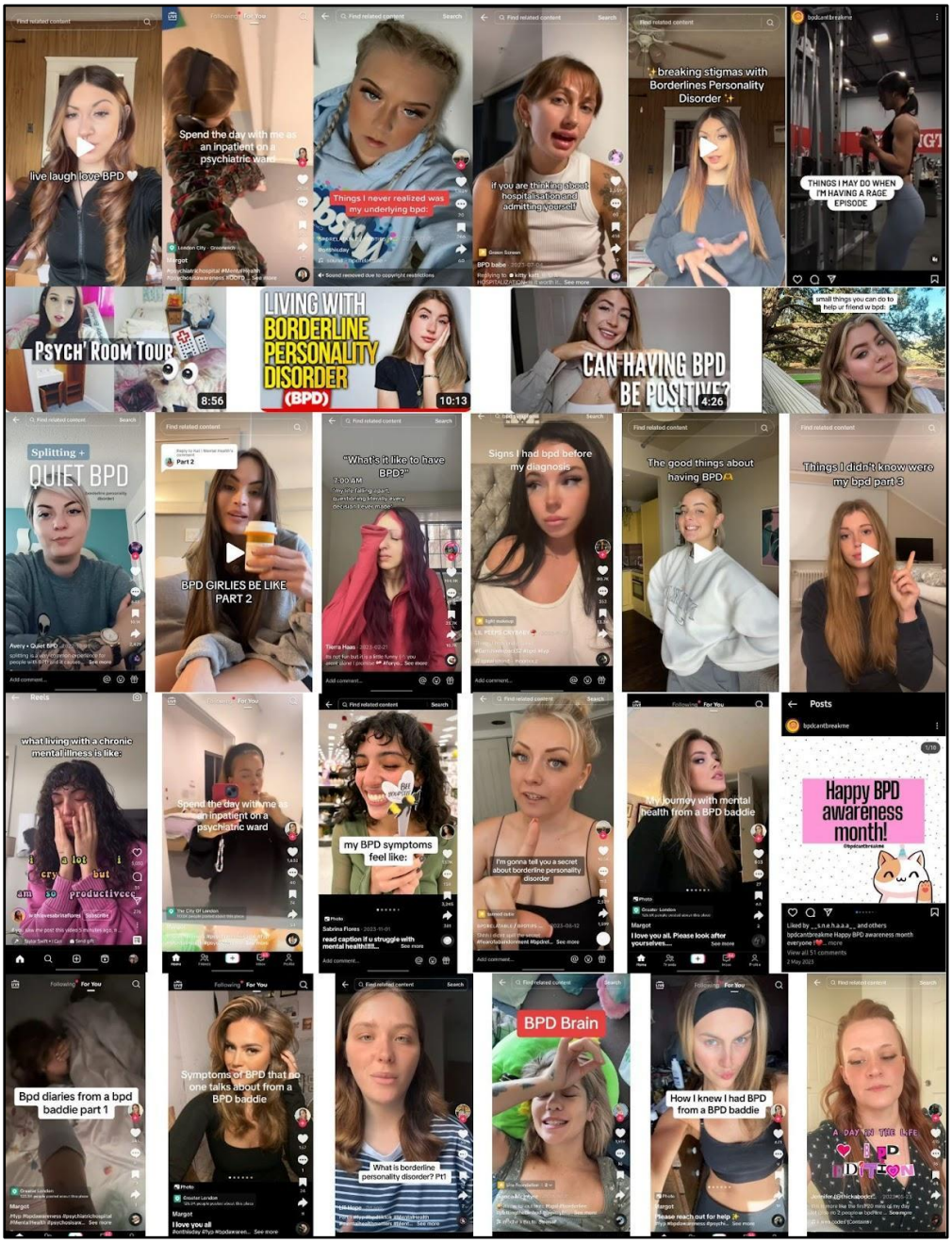

Figure 3. Service Users, Awareness, Destigmatization, and Reclamation. The text shown on each image, from left to right, reads: "live laugh love BPD;" "Spend the day with me as an inpatient on the psychiatric ward;" "Things I never realized was m underlying bpd;" "if you are thinking about hospitalisation and admitting yourself;" "breaking stigmas with Borderline Personality Disorder;" "THINGS I MAY DO WHEN I'M HAVING A RAGE EPISODE;" "PSYCH ROOM TOUR;" "LIVING WITH BORDERLINE PERSONALITY DISORDER (BPD);" "CAN HAVING BPD BE POSITIVE;" "small things you can do to help ur friend w bpd;" "SPLITTING + BPD;" "BPD GIRLIES BE LIKE PART 2;" "What is it like to have BPD?" "Signs I had bpd before my diagnosis;" "The good things about having BPD;" "Things I didn't know were my bpd part 3;" "what living with a chronic mental illness is like;" "Spend the day with me as an inpatient on a psychiatric ward;" "my BPD symptoms feel like;" "I'm gonna tell you a secret about borderline personality disorder;" "My journey with mental health from a BPD baddie;" "Happy BPD awareness month!" "Bpd diaries from a bpd baddie part 1;" "Symptoms of BPD that no one talks about from a BPD baddie;" "What is borderline personality disorder? Pt1;" "BPD Brain;" "How I knew I had BPD from a BPD baddie;" "A DAY IN THE LIFE BPD EDITION." To view the references for each social media post used in this figure, see Appendix One.

them build marketable content. Hashtagging "borderline personality disorder," "bpd," "cptsd," "ptsd," "anxiety," "bipolar," "splitting," "mental health awareness," and "mental illness" – anything that one can claim or claim their video falls under, no matter how problematic the term "personality disorder" – gets used to spread and mobilize content.[70] In a comment on one of her posts, one influencer shares some updates for her audience: "my creative team & i are just taking some time to think about what the best ways to tell those stories are, & in what order to tell them :-) they are coming soon, pinky promise!!! 2. I just got off the phone w my manager & she gave me the push i needed to finally start looking towards long-form & YouTube:-)."[71] Yes, sharing lived experience is important, but we must not treat it as isolated from the fact that we are living in a late capitalist era in which "becoming has become a zone for profit for contemporary capitalism, for neoliberal piecing and profiteering, a mode through which profit is being aggressively produced" (Puar 2017:56).

"A community of people just like me:" Documenting Borderlined Babe's (2024) website

"I set out on a mission to become a voice for those who are struggling. I started to advocate for mental health and began to break down the stigma that surrounds it. *I became passionate about educating my peers about Borderline Personality Disorder FROM somebody who HAS BPD, with real experience living with this disorder.* (Not from a 60-year-old man who read 1 chapter 40 years ago when he got his medical degree). I had a drive to *create a community of people just like me, where they could feel safe, supported, and know that they are not alone.* I know just how scary the beginning of your journey can be, so I wanted to become a guiding light to help you."

"All I wanted was to see representation of somebody who struggled with the same things I did, who felt the same way I did, who saw things my way and could validate my human experience. So, I became that person."

"Now I am reaching hundreds and thousands of people, just like me. It has given me a sense of purpose and passion during a time where I couldn't find one reason to keep fighting. Now I create content to help others struggling with their mental health."

"I also recognize that access to mental health services is such a privilege and not accessible to everyone."

Influencers like @borderlinedbabe (as one example) claim to "show us what it's really like," and

[70] Sabrina Flores (@withlovesabrinaflores). 2023. TikTok, November 30. https://www.tiktok.com/@withlovesabrinaflores/video/7307337370880265514.

[71] From a social media post that is no longer available on: Sabrina Flores (@withlovesabrinaflores). Instagram. https://www.instagram.com/withlovesabrinaflores/.

to "struggle in the same way as you do" (Borderlined Babe 2024). While they espouse to show a realistic account of living with 'BPD,' they seldom mention that they are amongst less than one percent of the population, who can work remotely, travel across the world, access the citizenship rights granted in the U.K. and U.S.A., and other obfuscations we might think of when we consider what is meant by 'realistic.'

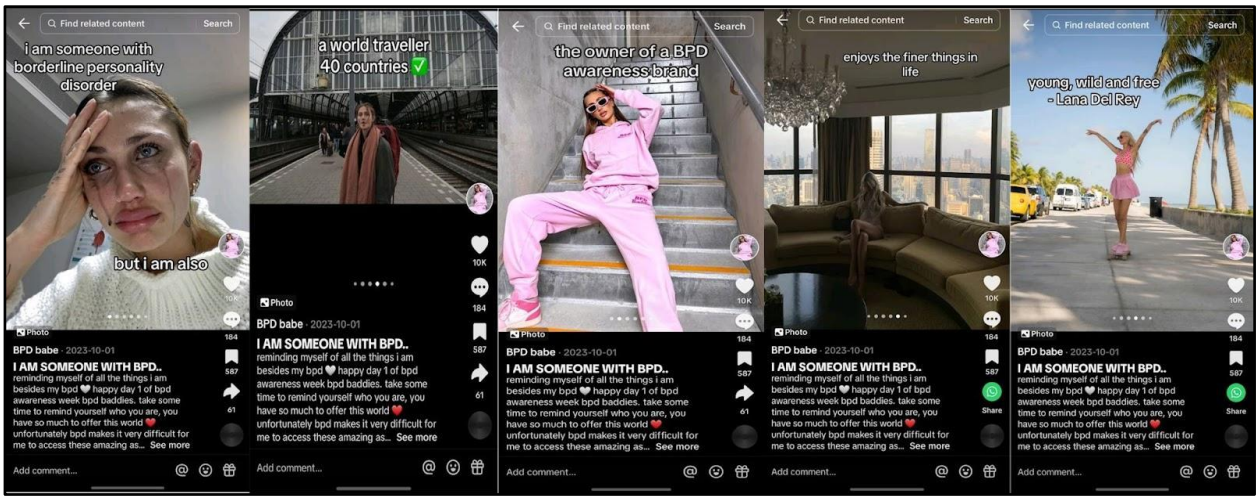

Figure 4. "I am someone with BPD, but I am also…" Selected text on the above screenshots reads: "I am someone with borderline personality disorder, but I am also … a world traveler 40 countries … the owner of a BPD awareness brand … enjoy the finer things in life … young, wild, and free – Lana Del Ray."

Many influencers not only try to destigmatize 'BPD,' but reminds us that we are "more than our illnesses;" that we can "still be successful, even with a mental illness," a phenomenon that is only safe for certain people to share on the internet (Llewellyn 2021). We can be a "BPD Baddie," while also being a foodie, and a "dreamer that can achieve big things" (see Figure 4).[72] Where 'BPD' awareness is rampant, so is the assumption that recovery or perseverance returns us to an already capacitated body; this affective move not only neglects those who cannot "perform exceptional cultural rehabilitation," but those continuously debilitated by state and corporate violence whose dreams will not be realized, if the state has it its way (Puar 2017:72). This page, as with many others, obviously depict an elite image of 'BPD,' private psych wards, and of the safety that whiteness offers. But will having more borderlines of color on Tik Tok solve this? The politics of representation has done good, but also obscured a lot, been unevenly distributed, and contributed to debilitating corporate and imperial structures debilitate (Táíwò 2022).

[72] These quotes, as well as Figure 4, are derived from: BPD Babe (@borderlinedbabe). 2023. TikTok, October 1, 0:01. https://www.tiktok.com/@borderlinedbabe/photo/7284939073867762949.

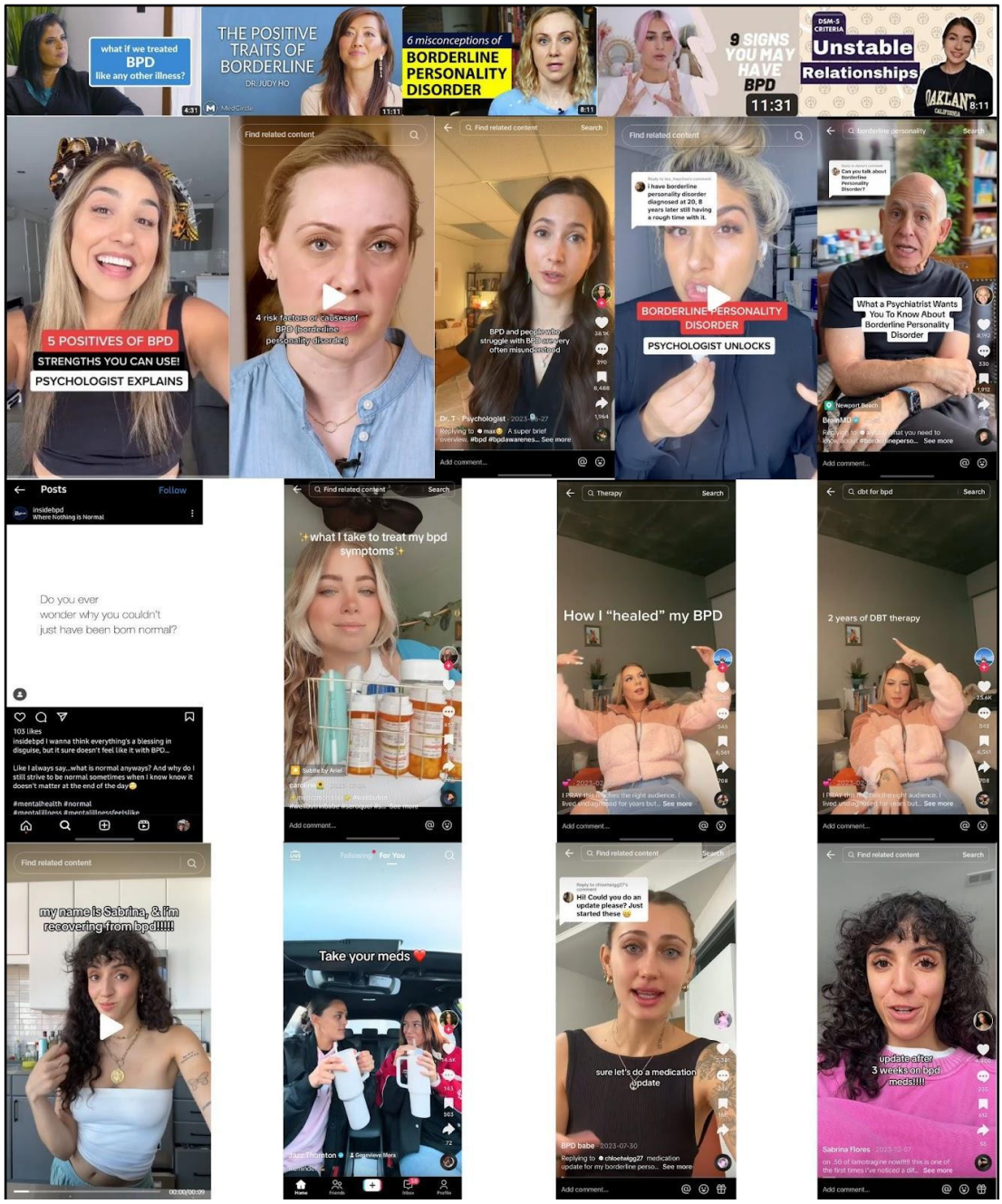

Figure 5. Clinicians, Service Users, and the Reification of Psychiatry. Text displayed on images and videos, from left to right: "what if we treated BPD like any other illness?" "THE POSITIVE TRAITS OF BORDERLINE;" "6 misconceptions of BORDERLINE PERSONALITY DISORDER;" "9 SIGNS YOU MAY HAVE BPD;" "DSM 5 CRITERIA: Unstable Relationships;" "5 POSITIVES OF BPD - STRENGTHS YOU CAN USE! PSYCHOLOGIST EXPLAINS;" "4 risk factors or causes of BPD (borderline personality disorder);" "BPD and people who struggle with BPD are often very misunderstood;" "BORDERLINE PERSONALITY DISORDER: PSYCHOLOGIST UNLOCKS;" "What a Psychiatrist Wants You To Know About Borderline Personality Disorder;" "Do you ever wonder why you couldn't just have been born normal?" "what I take to treat my bpd symptoms;" "How I 'healed' my BPD;" "2 years of DBT therapy;" "my name is Sabrina, & i'm recovering from bpd!!!!;" "Take your meds;" "sure let's do a medication update;" "update after 3 weeks on bpd meds!!!" For the references for Figure 5, see Appendix One.

Much of what we see occurring in social media discourse also remains within the psychiatric frame of 'BPD' (see Figure 5). The narratives espoused by influencers online obscure that 'getting help' and 'destigmatizing getting help' both largely rely on psychiatric discourses and practices; there is a push to teach each other how to engage with psychiatric systems, to get diagnosed, to try medications, and more, with the focus is on individual and the helping professions. In these discussions, there is little criticality of 'BPD's' well documented diagnostic issues, the harms of psychotropic medications, and the violence inflicted by psychiatric institutionalization – particularly against racialized and structurally vulnerable people (Gorman 2013; Redikopp 2021; Tam 2012). This is the case for 'mental health' activism in general. Lady Gaga (in WeightWatchers 2020), for example, talks at length about how people should really be seeing psychiatrists, because general practitioners do not know enough; however, she neglects to mention the harms of psychiatric medication, that psychiatrists rarely agree, that psychiatry can be harmful, and that not everyone can access psychiatric care without paying hundreds of dollars per hour, or being brought to the hospital by emergency services (see Mollow 2006).

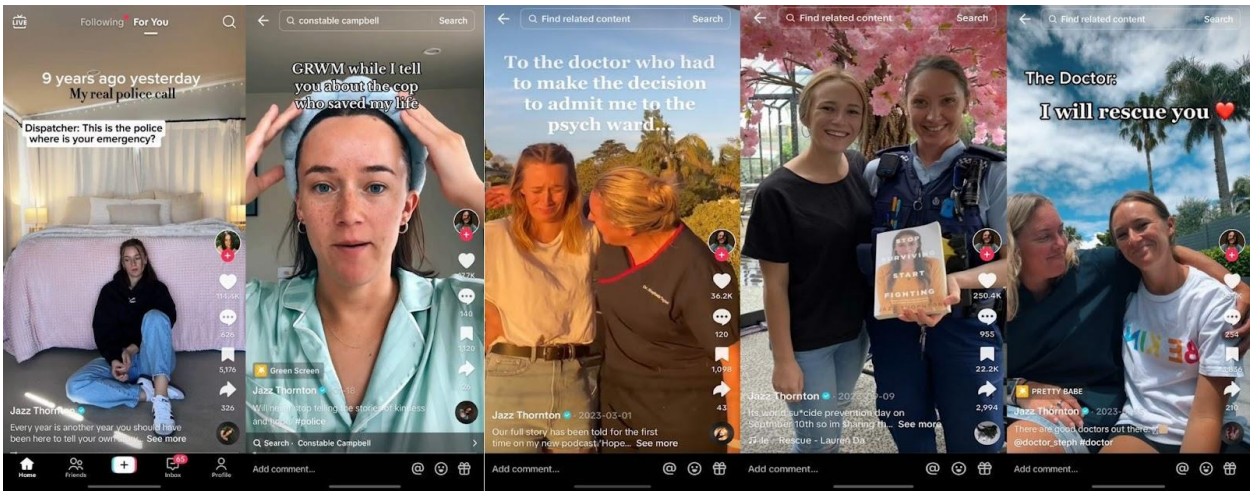

Figure 6. The Benevolence of Emergency Services. Text on images and videos, from left to right: "9 years ago yesterday – My real police call;" "GRWM [get ready with me] while I tell you about the cop that saved my life;" "To the doctor who had to make the decision to admit me to the psych ward…" "The Doctor – I will rescue you." For the references for this figure, see Appendix One.

One Pākehā (New Zealand European) mental health activist, whose experiences could easily be, but may have not been, chalked up to C-PTSD and/or 'BPD,' often espouses the life-saving qualities of police, paramedics, and forced hospitalization (see Figure 6). Without naming any official diagnoses, likely for protective reasons, she has built a platform (and a non-profit, books, movies, among other things) based on her survival and recovery from various experiences with

mental distress and psychiatrization. Where many Mad activists discuss how they survived the mental health system itself, this person survived because of it. She frequently re-tells the story about the police officer who saved her life and the family doctor that sent her to inpatient care. In her documentary in memorial of her late friend, this influencer and advocate speaks about the importance of emergency services in getting people hospitalized (in Aotearoa New Zealand, the police are often the first to respond to any incident involving suicide, self-injury, or suicidal ideation). I am glad that she is alive, and I wish that her friend, who she talks about in a documentary, had received more support and was still here today (see Pooley 2020). The problem comes with universalizing narratives about the hope found in these services, that "if we just keep fighting," we will live longer. Evangelizing the mental health system and the police has probably helped an elite few seek support; however, messages like these have likely neglected, ostracized, and been ignored by people who know that an encounter with the police could be debilitating, if not fatal. People like this influencer have enormously powerful platforms, and as much as they have made a difference in many lives, they arguably have a responsibility to name what they are obscuring, and what they benefit from by having such a platform; for every post they makes about their saviors in uniform, they gets compensated (not directly perhaps, but through social media algorithms, influencing, and their rewards, which are based off of brand advertising and partnerships, as well as how many people – including me – watch, keep watching, liking, commenting on, and saving content like this).

In summary, in this reclamation movement, there is seldom a Mad or an anti-sanist critique. I raise this point not to say we should not reduce stigma and discrimination, or that we should not all be able to learn more about how we might get support for ourselves or someone else in distress (Facebook and Reddit peer support groups might be a useful alternative?). This is to ask, what else is going on? How do these seemingly well-intended campaigns perpetuate the idea that some of us need to be fixed and treated, and what industries does that benefit? Influencing often paints an elite picture of 'BPD,' obscures debility, and contributes to that which proliferates debility. 'BPD' and borderline pride benefit capitalism, which "reproduces itself by inducing us to produce ourselves, to express our identities through consumer choices, to base our politics on the affirmation of our marginalized identities" (Wang 2012:n.p.). Second, influencing, anti-stigma movements, the medical and non-profit industrial complexes they are entangled with, are lucrative businesses, not grassroots campaigns. As an example, influencers partner with corporations to

promote different brands, thus raising awareness and benefiting corporations, directly and indirectly (see Figure 7).

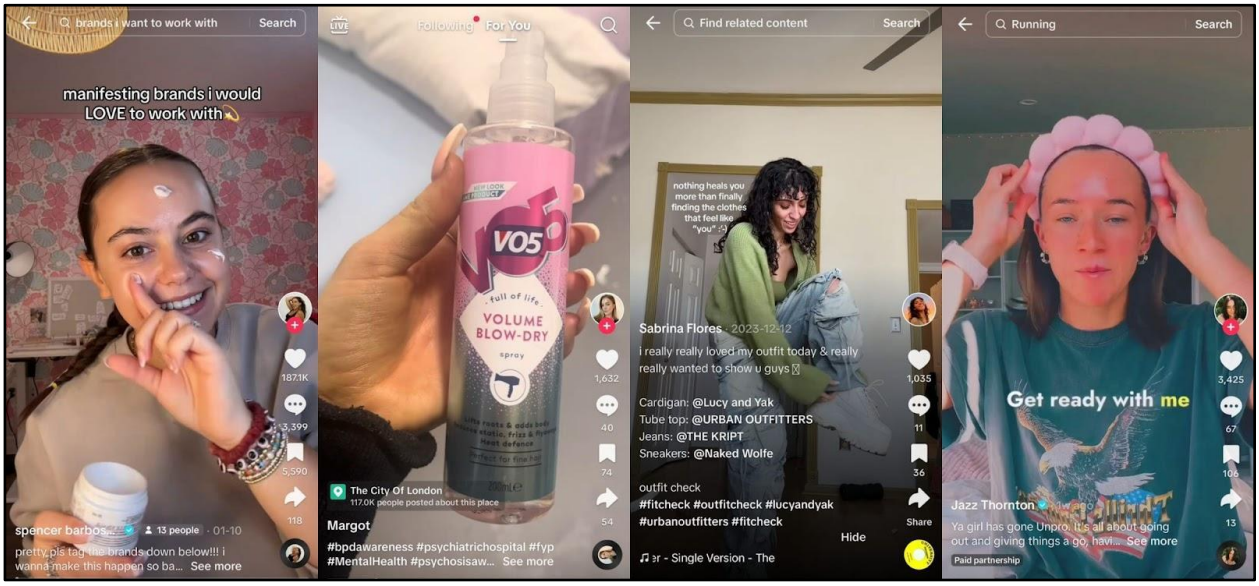

Figure 7. Corporate sponsorships and Advertisements. Influencers of all types, to different degrees of overtness and covertness, partner with various brands as part of their content creation. While some people simply post information online, others are full-time influencers that make a living in part by advertising various brands for corporations. Others may not have official partnerships, but show off the brands that they use, perhaps in the hope of a partnership. Perhaps one of the most popular trends is the "GRWM (get ready with me)" (shown early), wherein people show each skincare, hair, and makeup product they use while getting ready, often while talking about some other topic, such as 'BPD." See Appendix One for the references for this figure.

In other words, regardless of intent, the more data, the more corporations can cater to and reproduce our desires. Many factors create the 'BPD' assemblage, and 'BPD' assemblages do very different things, depending on if we are looking at influencers' audiences, their bank accounts, corporate profit, the psychiatric institution, or the experiences of incarcerated people diagnosed with 'BPD.'

Figure 8. 'BPD' Merchandise. See references in Appendix One.

"You'll find solace in our hoodies, t-shirts, joggers, and accessories for years to come:" Documenting BorderlineBabe's (2024) website

"BORDERLINED crafts each hoodie with love, without comprising comfort or quality. These designs are more than just clothing; they're your long-term companions, offering a therapeutic embrace day after day. Therapy is expensive. So, I wanted to create a budget-friendly solution that wraps you in warmth and will be there to support you, ensuring you'll find solace in our hoodies, t-shirts, joggers, and accessories for years to come."

"Now I'm not going to say that happiness is just a purchase away, but you can skip the hefty therapy costs and savor the (retail) therapeutic joy of your new and luxuriously comfortable emotional support hoodies, joggers and accessories (and get a nice hit of serotonin too)."

"I take immense pride in curating a collection of meticulously chosen products that reflects my commitment to quality and attention to detail. I understand the significance of investing in products, which is why I've opted for nothing less than the best. Emphasizing superior craftsmanship, each piece maintains its integrity; even after multiple uses and washes, avoiding the disappointment that comes with most subpar items on the internet these days."

"By choosing to support BORDERLINED, you're not only choosing quality, you're investing in your own well-being and actively contributing to a community that's fighting mental health stigma."

"Rest assured, receiving these at your doorstep will undoubtedly exceed your expectations. My wish is that they give you the same joy and serotonin boost they brought me ❤️"

"I created this brand with a few things in mind. I noticed there was a lack of high quality, durable, comfortable and stylish mental health awareness brands out there. I became so tired of seeing the same mockups, the same shirt with a different 5 minute canva design on it and the same cheesy slogans on crappy quality t-shirts and hoodies. I wanted to create something unique, that stands out. Something that makes you feel PROUD (and sexy) to be a BPD Baddie. I wanted to give you a voice, and show that you advocate for mental health too. I wanted to create sustainable products and empower you to be proud of who are you. I poured to much thought and love into every small detail of this project. From choosing the right quality of the materials, hours of meticulously creating the designs, supporting small and reliable manufacturers, building, designing and filming the website, content and marketing. All of this has come from the depths of my heart. Why? Because I wanted to create comfortable, premium products that empower those of us who struggle with BPD. Even though fighting BPD is hard work, you can still look cute while doing it."

"I am a PROUD BPD Baddie and I am a PROUD advocate for Mental Health Matters. I want to fight the stigma mental health has, and show the world BPD MATTERS. And I want to look damn hot while I do it."

> "While this collection may carry a higher price tag, rest assured that every aspect has been meticulously considered. BORDERLINED prioritizes the finest quality materials, longevity, the most comfortable clothing on the market, and top-notch products & accessories, that not only meet – but exceed your expectations. While prices might be higher than some alternatives, I firmly believe that the value and satisfaction you gain from these products justify the investment. BORDERLINED is committed to delivering an unparalleled experience that goes beyond mere affordability, focusing on providing you with the best that truly lasts."

To clarify again, this is not about an individual borderline subject or 'BPD Baddie.' I admit, though, that these influencers' language of longevity, living well, investment in life, and sexiness are hard to accept, given the assumed capacity-laden body that this destigmatization is for (see Karera 2019; Puar 2017). What Puar makes clear in her discussions of homonationalism as an assemblage is that there are no individual homonationalist subjects, even if we all exist along vectors of homonormativity: "The good homonationalist queer can easily become a bad one in an instant depending on circumstances and where" (Puar, in CLAGS 2013); furthermore, we are all produced by homonationalism and Mad nationalism, even if we do not like them (Puar, in CLAGS 2013). Suggesting that we have some Mad nationalism going on is not about what individual borderlines are doing or that there are racist people in the Mad or mental health movements (though there are, as there are everywhere), but about the assemblage of Mad nationalism, including how we get recruited into Mad nationalist campaigns. I thus do not care that this individual makes money. I care about the system that profits off mugs, videos, and t-shirts, and what our collective activism is doing and not-doing: "That impairment is not something that is marginalized as 'incapable' or 'lacking' becomes this incredibly valuable resource that is productive for capitalism, and it's productive for empire" (Puar, in Adler-Bolton et al. 2023; see Figure 8). We give fodder and fuel to corporate profit in a variety of ways, Mad-affirmative and psychocentric, and influencers like these, unlike those with a Mad critique, do so while often reifying borderline as something to be 'fixed' by psychiatry. Viewing various borderline and 'BPD' subjects as coming in and out of assemblages means that I am not attempting to make claims about some coherent Mad normative identity, nor to "homogenize the unevenness" with which borderline and 'BPD' move; rather, thinking in assemblages, helps us to see who and what systems are being served through the ebbs and flows of identity, its formation and dissolution, and how various institutions respond to (dis)identification (Puar, in CLAGS 2013). What desires our movements to look a certain way, and not other ways, for example, in support of the most structurally vulnerable

borderlines? What compels us to build a Mad nation, perhaps inadvertently, rather than being anti-imperialism? (Gorman 2013; Wekker 2021). I now shift to an analysis of what the Mad-affirmative concept of borderline does, with an acknowledgment that the relays between borderline and 'BPD' are messy, sitting in both contradiction and symbiosis depending on the milieu we are discussing.

4.4.3 What does the borderline assemblage do?

I introduced the concept of the borderline "constellation," a term taken from Sarah Redikopp and Merri Lisa Johnson, which describes the array of affective, emotional, and onto-epistemological experiences that accompany what might be called 'BPD.' Mad scholars and Mad Studies have promoted borderline as a concept in critical relationship to the psychiatric diagnosis of 'BPD,' arguing that 'borderline' does describe a real set of unique experiences, but that the psychiatric label of 'BPD' harmfully pathologizes these experiences. The borderline concept, conceptualized outside of the psychiatric realm, instead, offers a way of understanding these ways of knowing and feeling that can be distressing, but that can also provide insight into trauma, injustice, and power dynamics (see Chapter One). This borderline assemblage has complex arrays of attachment to 'BPD,' and likewise, can both capacitate and debilitate; that is, the experience that can be reaffirmed and reconceptualized as borderline (counter)knowledge (Redikopp 2018), and the Mad identity that comes with them, can both capacitate and debilitate. This is not a critique of the concept but is part and parcel of an intersectional and ethological analysis of symptoms, traits, affects, experiences, and neoliberal uptakes of identity.

I do not detail all the ways in which borderline experiences can debilitate and capacitate, because this was the main topic of Chapter Three. As discussed, many borderline 'traits' can be debilitating, the severity of which likely tracks based on levels of trauma, access to resources, and genetic and neurobiological vulnerability – all of which are socio-politically patterned (see, for example: Anglin 2023; Huggard et al. 2023; Martin et al. 2022; Mulligan 2021; Puar 2017; Toyokawa et al. 2012; Ventriglio 2023). These experiences may be particularly debilitating if they are not validated as external to the person (e.g. as Complex-PTSD instead of 'BPD') and/or are pathologized as an individual, maladaptive condition, or disorder, rather than a response to debilitating conditions (see Giacaman et al. 2011; Giacaman 2018). In other instances, borderline experiences can be capacitating. For example, self-injury or suicidal ideation can maintain one's connection to the world, when the only alternative to suicide. What is called 'inappropriate anger' can also be capacitating, for individuals and the socius, because anger is often a response to

injustice that needs to be called out and rectified. Mad scholarship on the borderline experience helps us to comprehend the capacitating nature of these experiences, beyond the confines of pathologization. I now turn specifically to a discussion of the borderline concept, as laid out and taken up by several Mad scholars (with the potential to be taken up more broadly by the Mad community in the coming years).

August 29, 2023: Autotheoretical comment
Well, the borderline (conceptually, perhaps not truthfully, whatever), feeds my lack of validation, my emptiness, feeling in liminal space, not knowing who or what I am, so that makes sense. Lodge me on a stratum!! Signify me!!! Please!!! I'm done with this field of immanence! (referencing Deleuze and Guattari [1980] 1987).

The borderline concept, particularly if it is divorced from psychiatric labels, can itself be validating and thus capacitating; 'borderline,' whether or not attached to an official diagnosis of 'BPD,' can provide language through which to perceive experiences or worldviews that might otherwise feel or be deemed "uncategorizable" (Lewis 2023b). Although exposing oneself as Mad and/or diagnosed with a 'mental illness' (not mutually exclusive, but sometimes separated based on a political stance or individual preference) can be risky, claiming the borderline identity too can capacitate people based on assemblages of global privilege. Identifying with borderline can serve to reclaim or rectify the harm done by the psychiatric label of 'BPD' and other harms that come with psychiatric 'care,' but it can also come from access to expensive private psychological testing or from self-identifying based on internet memes and videos (this is more likely for those that gladly take up the 'BPD' identity). Puar (2017:36) refers to this capacitation-even-during-debilitation as "piecing," "a recruitment into neoliberal forms of fragmentation of the body for capitalist profit." Let's look at me for example: Entering my work from a subject position of madness or sharing my specific diagnoses mainly capacitates me, while serving the academic industrial complex and recreating the image of the white elite Mad subject:

> The [Mad] body convert[s] the debility of a nonnormative body [or mind] into a form of social and cultural capacity, whether located in state recognition, identity politics, market economies, the medical industrial complex, academic knowledge production, subject positioning, or all of these. (Puar 2017:42)

In both psychocentric and Mad settings, I 'fit in;' I have official diagnoses and can use them to access accommodations when I need them; I also have supportive people around me who will accommodate me without knowing my diagnosis – just that I am Mad or experience some form of

psychosocial disability. Situating this scholarship, however, or my Tik Tok channel (if I had one) from the positionality of borderline, yes helps me to understand myself, but also mainly capacitates me. It gives me academic clout, and may profit me through publication, or simply through job opportunities. Identifying with my diagnos(es) likely capacitates me more than it debilitates me, for now, even as I navigate the debilitating fear of having overshared with people and being discriminated against in the workplace. I can fall back on my productivity for academia, my potential productivity for academia, my ability to communicate with healthcare providers in their language, and my lesser racial, socioeconomic, and gender risk to the settler colonial nation (Puar chapter; see also Price 2016:277; Johnson 2021:651). My subject positioning from a Mad or borderline perspective mainly works to reify a normative picture of borderline, and even if I personally do not profit (yet), it provides data and metrics for corporations (academic publishing agencies, universities, and tech conglomerates) whether I like it or not.

This analysis is not to discount the importance of self-validation or to delineate "who is really borderline or not," but to trace the concept's various capacitating abilities, which do not exist in isolation from its debilitating aspects (or its relation to psychological debilitation); the problem is not capacitation, but who is capacitated, who is debilitated, determined by who, and towards what ends. Validation, whether through Mad Studies, Tik Tok, or psychiatry, "cannot be the end of the story, because what counts as disability [or even 'mental illness'] is already overdetermined by 'white fragility' on one side and the racialization of bodies that are expected to endure [mental and emotional] pain, suffering, and injury on the other" (Puar 2017:xiv). This also does not mean that these institutions will not harm me, but begs us to ask, what might identifying as Mad or 'mentally ill,' whatever the frame, do, for different populations. This analysis does not tell us what borderline *is* or what it *always* does, but does orient to understand borderline's relationship to eliteness, white supremacy, productivity, and other vectors uplifted by racial capitalism: "Intersectionality attempts to comprehend political institutions and their attendant forms of social normativity and disciplinary administration, while assemblages, in an effort to re-introduce politics into the political, asks what is prior to and beyond what gets established" (Puar [2012] 2020:414).

I next turn to an analysis of what ends are being served by these various moves. One of these ends is the ascendency of whiteness, which can operate through the politics of "self-subalternization," or as I discuss it, "the politics of innocence" (drawn from Wang 2012), where

white elites are focusing more on our debilitation than our capacitation, thus bifurcating possibilities of solidarity that start with an acknowledgment of implication. Rather, as both Mad-affirmative and psychocentric white elites, are largely basing our politics on marking ourselves from an innocent subject position made possible by the capitalization off our various "wounded attachments" and the obfuscation of our geopolitical complicities and implications (Puar, in CLAGS 2013, citing Brown 1993). This is all said with great respect to the politicized nature of Mad identity, an identification against psychiatric harm and its kindred forms of state institutionalization and carcerality. And yet, some Mad folks will simply not be incarcerated, and some will be both institutionalized in psychiatric holdings *and* incarcerated in prison – a kindred, but highly different experience and type of racializing project (Gorman et al. 2013:n.p.).

4.5 What Does All of this Obscure? Examining the 'Borderline Personality' Assemblage as a Whole

> "This framework [on our investments in life] is decidedly white, for it asserts that power is not enacted by direct relations of force or violence" (Wang 2012).

4.5.1 Psychological debilitation

Thus far I have provided a largely biopolitical and economic critique about which populations are deemed able to 'live well' with madness, and which populations, systems, and institutions are capacitated by discourses on 'BPD.' However, this critique can neglect the necropolitical side of this calculation – that certain populations are made to wear out, or not live long enough, to make this claim (Puar 2017:2; Mbembe 2019). Power is enacted by inequality and by exploitation, but it is also enacted by "direct relations of force or violence," specifically racializing, colonial, and settler colonial violence (Wang 2012:n.p.). The debility and capacity caused by the 'BPD' diagnosis, 'BPD' reclamation,' and borderline affirmation can obscure the *psychological debilitation* perpetuated by Euro-American powers – much of which never gets diagnosed, or only does so for profit and control – through the expansion of mental health services and mining of epidemiological data (Giacaman 2018; Howell 2011; Mills 2013; Tam 2012; see also Mian 2021 on "the maiming of psychic life"). This section attends to this obscurement, and highlights where the sub-assemblages that I discussed above (the 'BPD' diagnosis, 'BPD' reclamation, and Mad affirmation) come together into the larger assemblage of 'borderline personality.' That is, while desire draws together distinct assemblages of the 'BPD' diagnosis, the 'BPD' identity, and borderline affirmation, they exist together in a broader 'borderline personality' assemblage that takes what each of them have in common – their relationship to whiteness and eliteness – to

obscure the psychological debilitation and suffering perpetuated by the very systems that enable the more affirmative sub-assemblages in the first place.

Central to the notion of psychological debilitation is the fact that Euro-American financial power relies on the continuous traumatizing and rehabilitation of subjugated populations, and the under- and over- treating of mental distress (including through criminal legal incarceration and immigration detention) based on specific calculations of extractability, profitability, and disposability: "Limiting people's futures can be far more oppressive than the illness itself" (Jarman 2011:16; see Giacaman 2018; Government of South Africa 2023:35; Mollow 2006; Puar 2017; Tam 2023). It is widely documented that oppression and state violence produce acute mental distress, chronic psychosocial disability, and neurobiological vulnerability to these experiences (Anglin 2023; Fanon [1952] 2008; [1961] 2021; Giacaman et al. 2011; Huggard et al. 2023; Martin et al. 2022; Mulligan 2021; Puar 2017; Toyokawa et al. 2012; Ventriglio 2023). That 'BPD' and distressing borderline experiences "circulate[s] in tandem with the kind of real injuries and violence experienced by colonized populations" is "another way in which this kind of neocolonial structure works" (Puar, in Adler-Bolton et al. 2023). While this neocolonialism suggests we be cautious about the European humanist norms embedded in diagnoses and how they are conceptualized, a decolonial critique also means that we cannot simply dismiss the differential effects of a flawed diagnosis; when psychological violence occurs directly, sometimes diagnosis is the only way to name "the dynamics of previous unnamed forms of discomfort and dysfunction" that "may desire access to a term like damage as a validating description of past experience and current states" (Johnson 2021:645; see also Chapter Three's discussion of identity disturbance). To address the psychological violence that the biopolitics of 'BPD' and borderline obscure, we need look no further than Palestine, though what I will share is relevant to other settler colonial contexts. We also do not need to look at 'BPD' specifically, particularly given the links between 'BPD' and post-traumatic stress (Amad et al. 2019; Fernández-Guerrero 2023; Frías and Palma 2015).

Prior to the most recent genocidal onslaught of Palestine, researchers conducted a study with practitioners that found that "the economic, educational, and health-related consequences of the ongoing blockade of Gaza were the main determinants of psychological burden among clients" (Diab et al. 2023:577). In 2022, eighty percent of Palestinian children experienced higher levels of emotional distress, with over half engaging in self-harm and/or having suicidal thoughts

(Government of South Africa 2023:35). In Gaza, overcrowding due to poverty, high levels of unemployment, and fear of losing homes and family members, increase their risks of "a range of mental health conditions, including PTSD, anxiety, depression, conduct disorders, and substance abuse," especially PTSD (Thabet and Vostanis 2011:216; see also: Diab et al. 2023; Giacaman et al. 2011; Giacaman 2018; Khamis 2015; Qouta & El-Sarraj, 2004; Thabet, El-Buhaisi, and Vostanis 2014). That these categories are inadequate and colonial in themselves is not lost on practitioners and researchers in Palestine; Rita Giacaman et al. (2011:554), write, for example, that "trauma and war-related suffering in Palestine provides no clear boundaries that can be labeled as distinct syndromes." These are the only diagnostic codes that are often available, and they serve a purpose for the imperial state: a purpose for profit, and a purpose to use normative measures to rank a population's humanity, resilience, and ability to resist (Dixon-Román and Puar 2020; Puar 2017; Tam 2012). Perhaps psychiatry is not necessarily wrong in saying that mental distress has chemical and neurobiological markers that medications can sometimes help. However, it clearly is ill-equipped to evaluate what is causing these changes. Psychiatric diagnoses cover up the causes and consequences of colonial violence, and primarily become data points, for insurance companies to mine, to justify the expansion of profitable mental health services, and for epidemiological research that reiterates the risk – including the financial risk – that certain populations impose (Howell 2011; Tam 2012, 2017). For example, skyrocketing rates of diagnoses of PTSD amongst Palestinians in the past two decades has brought in a lot of humanitarian aid to treat PTSD (among other forms of disability), which benefits the international non-profit and humanitarian aid sectors, further obscuring the violence of occupation (see Puar 2017:111). When debility is responded to with either the medical model or social model of disability, occupation and imperial violence gets obscured.

Saying that colonial violence and overexploitation causes, facilitates, or exacerbates debility – in the form of amputations or PTSD might be called sanist or ableist. Like Puar (in Adler-Bolton et al. 2023), I am wary of this claim – even if 'post-traumatic stress disorder' inaccurately pathologizes how our bodies' wisdom, and how people cope with trauma (Becker 2000; Burstow 2005; H 2018; Taylor 2022).[73] Lou Tam (2012) asserts that the suggestion of "colonialism triggering higher rates of mental illness in postcolonial societies [...] prescribes a

[73] See also Francesca Lewis (personal communication, May 4, 2023) and our discussion of how the inaccuracy of 'BPD' does not negate the experiential realities of distress caused by empire in its various forms (see Chapter Three).

vague, overdetermining victim narrative, in which the authors [Titchkovsky and Aubrecht 2010] fail to recognize how mental illness is constructed, calculated in its construction, and used in the deployment of international development programs (Howell 2011).” I would amend this, however, and note that although numbers and definitions of ‘mental illness’ may not be reliable, given the Western norms and profit incentives caught up in diagnosis, it must not be obscured that colonial violence creates and activates neurobiological vulnerability to long-term emotional distress that we might as well call sickness. This was Afro-Caribbean psychiatrist and theorist Frantz Fanon’s ([1952] 2008; [1961 2021) assertion, an assertion backed up by the public health field, epigenetics, and neuroscience, but that probably does not need to have been (see Martin et al. 2022; Toyokawa et al. 2012). Fanon, and many of his contemporaries, have argued that colonialism and anti-black racism leads to alienation of the self and mental distress (see Anglin 2023; Eromosele 2020). Though Fanon, trained in psychiatry, might have regarded this distress as pathological, rather than an adaptive response to environment and structure, does not negate his observation that colonialism causes debility, whether or how we label it, and in fact, means that many people will not be concerned with reclamatory politics of madness:

> In order to point out the destruction wrought by racism and colonialism, madness had to be understood as damage, and not in any way a quality the subject would desire to have reflected back at it from an “other.” This is where Fanon parts ways with emancipatory discourses of madness that favor notions of identity and culture. (Eromosele 2020:12-13)

Referencing Helen Meekosha’s (2011) essay on decolonizing disability studies, Puar also wonders if “Maybe it is too confronting to deal with the continuing disabling of people in the global South because in trying to claim the positives of a disability identity it becomes difficult to acknowledge the overwhelming suffering that results from colonization, war, famine, and poverty” (Meekosha 2011:677). Puar (2017:92) continues, with an important intervention on disability that we could apply to madness: “When its [madness or disability] cause is unknown, reclaiming [madness] as a valuable, empowering difference may be more possible than when [psychological] debilitation is caused by practices of global domination and social injustice.” In these analyses, distinguishing disability, and madness from Eurocentric ableist norms of the ‘human’ is one conversation, but a conversation that perhaps requires one to be considered and treated as human first: "The key debates around disability and impairment, independent living," the medical vs. social model, "care and human rights are often irrelevant to those whose major goal is survival” (Meekosha 2011:670).

Puar (in Adler-Bolton et al. 2023) notes this tension with her use of debility in relation to disability, wondering why critiques of colonial violence are considered ableist, including those suggesting we should prevent amputations by preventing bombing. This doesn't mean people are not extraordinarily resilient, but that it is not eugenicist to prevent violence and its consequences.

Finally, to return to relays of debility, capacity, and disability, it is not only the case that reclaiming 'BPD' relies on an ignorance of borderline-esque distress, diagnosed or not, and the distress that comes with (highly stratified) psychiatric harm. The 'BPD' label, diagnosis, and identity are also caught up with the imperial and corporate structures that require this "obfuscation and in fact deeper proliferation of debility" (Puar 2017:xvi) through the very same structures that promote empowerment and awareness on the one hand, and as noted in the prior sections, exploitation, debilitation, and maiming on the other.

4.5.2 Non-Western views of borderline

Finally, the 'borderline personality' assemblage as a whole obscure non-Western approaches to these clusters of experiences, affect, and worldviews. Although this has not been the primary focus of this thesis, this has implications for how we mobilize around and deploy borderline. A Mad-affirmative approach to borderline may well be a liberating concept for those of us without an alternative cultural reference point, or who retain (perhaps fraught) relationships with our Western onto-epistemologies and/or upbringings. Many people, however, do not resonate with the borderline concept at all, particularly given its origins in Western psychoanalysis. Thus, focusing on reclaiming or reconceptualizing borderline should not cover over the importance of non-Western onto-epistemological and cosmological approaches to mental distress and difference, much of which has been erased or pushed down under colonialism in its various forms. I want to thank Verity Armstrong, Kim McLeod, and Karlene Mamea in particular for reorienting my attention towards the necessity and value of culturally specific, particularly Indigenous, perspectives of mental, emotional, and spiritual distress and difference – which may or may not align with a focus on reconceptualizing borderline. As stated throughout, more work, mine included, should support and prioritize culturally specific experiences that might otherwise be labeled as 'borderline.' I admit that I did not spend enough time on this line of inquiry over the past few years, perhaps in part due to borderline's maintenance as a highly Western concept, and my English-language-focused approach to conducting a literature review, which only turned up Fromene and Guerin's approach to more culturally responsive treatment of borderline diagnoses

amongst Indigenous people in what is called Australia. Throughout the thesis, I have included borderline-related references mainly from kaupapa Māori approaches in Aotearoa New Zealand because my personal and professional experiences with these teachings and approaches, and my lack of attention to more culturally specific approaches to what might be called borderline in other parts of the world.

4.6 Towards What Ends?

> "Capitalism, war, forced migration, settler colonial occupation, and, in the case of this chapter, U.S. capitalist imperialism are the generators of much of the world's disability, yet contribute unruly source material for rights discourses that propagate visibility, empowerment, identification, and pride" (Puar 2017:65).

I want to finish this analysis of the 'borderline personality' assemblage, debility, and capacity with some preliminary arguments about how psychiatric, psychocentric, *and* Mad discourses about 'borderline' could serve or are serving Euro-American empire, particularly its late capitalist and white supremacist arms. Here again, I am analyzing the 'borderline personality' assemblage as a whole, tracing the ways in which the psychiatric industrial complex, psychocentric narratives about 'BPD,' and Mad conceptualizations of borderline work together, in their different ways, to contribute to Euro-American Empire, a process obscured by each sub-assemblage's critiques of each other.

4.6.1 Global mental health: Profit, control, & exceptionalism

One way that 'BPD' discourses could contribute to empire is through the global mental health agenda, where the focus on rights, inclusion, and access for people diagnosed with 'BPD' can uplift the psychiatric industrial complex and fuel Western nations' narratives about their 'exceptional' provision of mental healthcare – even as they actively debilitate populations – for profit and control. For example, organizations like the W.H.O (2022) and *The Lancet* have called for an expansion of mental health services across the globe, especially in what we might call the 'Global South.' Mad Studies scholars Peter Beresford and Diana Rose (2023) describe *The Lancet's* (Frankish, Boyce, and Horton 2018) "Mental Health for All" series:

> The Series papers argued that a growing and worldwide burden of mental disorders was a global health crisis. The authors issued an urgent call for action to scale up services for people living with mental health problems and to close a substantial treatment gap, especially in low-income and middle-income countries, where the proportions of people receiving treatment are lowest. (P. 1)

Beresford and Rose (2023:1) wrote that this movement is not merely a replication of Western

psychiatry in colonized places but is a call for a "rapid expansion of psychiatric interpretations and responses to human mental distress and difficulty." The expansion of mental health discourse, which would include 'BPD,' plays a role in uplifting American Empire through a few mechanisms. There is first the somewhat obvious expansion of Western profit and Western norms is through the expansion of psychiatry's reach through industries of "therapists, psychiatrist, doctors, self-help books, crisis lines, and apps" across the world, including in places that either have not struggled with widespread mental distress and/or that have their own ways of responding to distress that are not rooted in Western epistemes (Frazer-Carrol 2023:7; see Eromosele 2020). For example, researchers Tyrer and colleagues (2010:56) have stated that

> personality disorder is now being accepted as an important condition in mainstream psychiatry across the world [...] although it remains unrecognized in ordinary practice, research studies have shown it is common, creates considerable morbidity, and is associated with high costs to services and society.

They then call for a new framework for personality disorders, including one that can allow "personality disturbance to be identified long before the current cut-off age of 18." Similarly, the National Education Alliance for Borderline Personality Disorder (NEABPD:2024) advocates for the "early detection and timely intervention for young people with 'BPD,' improved access to evidence-based treatments, increased availability and variety of treatments across all levels of the healthcare system," and more aims related to advocacy, destigmatization, and the expansion of treatment (for a still highly contested diagnosis). While psychiatry clinics are being exported to the Global South to ensure people are properly diagnosed with and treated for various conditions (the message that their own practitioners are inadequate, and that individual neurobiology is the primary cause for any distress or difference), college students are being prescribed and/or buying stimulants at skyrocketing rates to enhance academic performance; I will not debate the nuances, merits, or complexities of these shifts, but will note that they most definitely benefit the psychopharmacological industrial complex (Davis et al. 2024; Puar 2017). That medication and early intervention is lifesaving for some, that medication should be destigmatized, and that we should be skeptical of psychopharmacological responses are all arguments that can co-exist in concert with one another:

> The conversation is very reductive that we have [...] [actually let's talk about the way that diagnosis functions for capital [...] 'Vulnerable populations' are a tremendous avenue for capital accumulation, for the building of power, for things like public health and medicine, global trade regimes, etc. And none of that power

> is ever transferred to the people who supposedly need the care (Adler-Bolton, in Adler-Bolton et al. 2023; edited for clarity).

The increase in diagnoses and psychiatric clinics across the world expands Western profit and norms in somewhat obvious ways, but these ends are also served through an increasingly granular modulation of dividuals, or as Puar suggests, not against individual identities (though this still occurs), but as a matter of degrees, potentiality, and prognosis: "It will not occur through the hailing and interpellation of depressed subjects—and a distinction between who is depressed and who is not [...] – To what degree is one depressed," she asks, citing the advertisement of the antipsychotic Abilify (aripiprazole) that can be prescribed as a "top-up treatment" for those whose antidepressant is not quite working well enough. Calculations of profit and control occur not just through strict identity categories, but through pervasive analyses of risk, prognosis, capacity, and debility that, and through industries such as medical debt and health insurance that ensure maximal benefit for the neoliberal state (Puar 2009, 2017). Who is too severely 'disordered in their personality' to warrant treatment, and who is 'just severe enough' to medicate, while working part-time? Which populations, and through which discourses about distress and difference? As Puar (2017:25) writes of disability, we may consider our conceptualizations of 'mental illness' and even madness: "How the disaggregation of depressed subjects into various states, intensities, and tendencies will change the dimensionality of disability remains an open prospect, but at the very least, it forces recognition of the limits of disability as a category."

January 29, 2024: Autotheoretical comment on bipolar 'disorder' and risk analyses

In research on bipolar disorder, there are huge pushes to figure out exact risk factors and indicators for the development of bipolar in those of us with a family history or simply who 'present with a disruptive mood or behavioral disorder' in childhood. Much of this seems benevolent, and researchers and clinicians do want to help keep people like me from being loaded up on anti-depressants that will only make us worse. But what else could we see happening? How could the scanning of brains, and assessment of a plethora of 'risk factors' and attributes shape how people are funneled into different systems, risk categories, and treatment options? What types of racializing risks come with this?

Both the Global Mental Health agenda and Mad nationalism can also both promote Western exceptionalism, whether with regards to treatment, destigmatization, or both (see Eromosele 2020). That is, Puar refers to how rights-based frameworks not only exclude a plethora of people within the U.S. borders but are used to critique and even invade those nations depicted as inherently homophobic, transphobic, or misogynistic, or maybe just: threatening to American empire. The

question that homonationalism begs echoes "the woman" question of the nineteenth century, where Gayatri Spivak (1988) remarked on "white women saving brown women from brown men" (in Puar 2017:98). Homonationalism, for Puar (2022:2) "how and why the notion of "how well do you treat your homosexuals [or women, or disabled people] emerges as an arbiter of the capacity for national sovereignty, governance and self-determination." Importantly, viewing homonationalism (and thus any mentions of Mad nationalism in this thesis) an assemblage, and not an identity for white queers or a stable attribute of a nation.

I am curious if the next question in this assemblage is the "mental health question" – 'how well do you treat your mentally ill? Don't worry, we will come add infrastructure,' or 'we'll come teach you about destigmatization – even if our approaches are inadequate and if we are the ones causing the distress.' Perhaps more insidiously, but in line with the use of LGBTQ+ policies to determine if different countries get foreign aid from the U.S., we will determine the "capacity for sovereignty" based on access to mental health treatment or levels of destigmatization. We can already see this happening, when refugee status claims often take into account if people could get adequate mental health treatment in their home country; what might this seemingly humanitarian move in immigration hearings mean for other measures of sovereignty, "development," and situatedness in geopolitics (Howell 2011)? Here again, the U.S. (and its allies) is positioned to set themselves up as the "arbiter of appropriate ethics, human rights, and democratic behavior" elsewhere (Kaplan 2004:5-6), while "ignoring such abuses within its borders" (Puar 2007:5; see also Grewal 2005). The hypocrisy does not matter, because as Puar (2022:4) notes, homonationalism – and perhaps Mad nationalism – is first and foremost a "theory of U.S. racial formation, a disciplining of U.S. subjects in relation to U.S. empire, a dual movement of incorporation and abjection, that instrumentalizes the discourses and affects of American exceptionalism… to laud and demonize different populations." In fact, we might think of the lack of adequate mental health services and rampant stigmatization within the U.S. (and Canada), and the exportation of Western models elsewhere as "operating in a tandem formation that is only seemingly contradictory" (Puar 2022:4). American (or Canadian) mental health systems, awareness campaigns, accommodations, and rights are depicted as superior to the 'backwardness and incapacity' of other countries, whereby "the global north holds the key to the liberalization of disability while the global south bears the brunt of its weaponization" (Puar 2017:66; see Howell 2011; Mills 2013). The U.S. not only declares who is civilized and who is not, but covers up its

systematic debilitation of its citizens and of population around the world, including through the psychological debilitation of folks in Global South when we back dictatorships in order to retain resources: "The USA creates the impression that empire is beyond the pale of its own morally upright behavior, such that all violences of the US state are seen, in some moral, cultural, or political fashion, as anything but the violence of empire" (Puar 2007:8). Where might 'BPD' slot into these equations, and where is it merely important to point out the limits of identity-based movements, whether Mad-affirmative or psychocentric, unless these movements are first and foremost about calling out corporate and colonial violence, much of which is committed on behalf of or in the name of 'our rights?'

4.6.2 The ascendency of whiteness

> "To be excused from a critique of one's own power manipulations is the appeal of white liberalism, the underpinnings of the ascendancy of whiteness, which is not a conservative, racist formation bent on extermination, but rather an insidious liberal one proffering an innocuous inclusion into life" (Puar 2007:31).

On macro-political scales, we can see how mental health discourses can obscure and/or serve as conduits of imperial projects. On a micro-political scale, we can also see how whiteness and affluence shape and are shaped by the capacitation granted by both psychocentric and Mad discourses on borderline. Rey Chow's (2002) "ascendency of whiteness" refers to how whiteness maintains its primacy as the norm to achieve and through which to be welcomed and capacitated through. Whiteness in this sense is not about literal skin color but is deployed and defined by whiteness and white supremacy (Puar 2007:32). It is also about the other vectors of white supremacy – heteronormativity, patriarchy, "inclusion in the global economy," "incorporation into the American Dream," "fitness-within-capitalism" the reproduction of whiteness, or at least of "acceptable" or "model" minorities, access to material and cultural capital, and tolerability by the nation state (Puar, 2020, 173; 2007:25-26, 31-32, 200). The ascendency of whiteness points to where liberal inclusion is in fact highly exclusionary; it excludes the sexual, racialized, classed "others," thus bolstering white supremacy and nationalism under the guise of liberalism.

There are different ways that the ascendency of whiteness can function through borderline: the "acceptable Mad subject" and who asks what of the healthcare system (Easterbrook-Smith 2022; Tichenor 2019), "the politics of innocence" (Wang 2012), and its close relationship with the use of "trauma as white property" (Mayor 2023). The "acceptable Mad subject" is relatively self-explanatory: Those who are capacitated by madness – even while being debilitated – are likely to

fall along registers of whiteness, whether that be literal whiteness, and/or education status, citizenship, socioeconomic status, heteronormativity, affluence, and participation in the producer and consumer market. Furthermore, while white Mad folks are certainly harmed by the psychiatric system and often reject it, there is a stark difference between asking for more trauma-informed care or better treatment within the health and services (whether from a Mad or psychocentric perspective), and knowing that these systems are violent from the start and will *disproportionately* be violent towards multiply marginalized people: "The neoliberal [white] consumer subject of health—an object of care—assumes the right not to be injured in the usage of products, even as accidents that derive from product design can be predicted with statistical precision, mapping the bodies that are likely to be implicated in these dynamics" (Puar 2017:81; see also Chapter One's discussion on sanism, racism, and colonialism; Spade 2020 on the need to look beyond the system for better care). These points are not to flatten important differences, but to query whether the Mad movement is doing what it thinks it's doing, when biopolitical and necropolitical power works through piecing and puzzling us based on our risk and/or contribution to capital and the white settler nation.

More psychocentric narratives about 'BPD' contribute to the valorization of whiteness – and specifically phenotypically white people – through the delineation of who the system assumes to be innocent victims, and those who are read as dangerous – always potentially criminal; these are categories long established as racializing projects:

> When considering safety, we fail to ask critical questions about the co-constitutive relationship between safety and violence. We need to consider the extent to which racial violence is the unspoken and necessary underside of security, particularly white security. Safety requires the removal and containment of people deemed to be threats. White civil society has a psychic investment in the erasure and abjection of bodies that they project hostile feelings onto, which allows them peace of mind amidst the state of perpetual violence. (Wang 2012:n.p.; on race and guilt/innocence, see Alexander 2014; Muhammed 2012)

The appeal to being on the innocent side of this demarcation is what Jacqueline Wang (2012) refers to as the "politics of innocence." Attaining innocence, whether in subject positioning or activism, can occur in multiple ways such as remaining focused on one's "wounded attachment narrative," "self-subalternization," or "injury," instead of one's privilege (Puar, in CLAGS 2013). For the purposes of borderline, I am interested in how the politics of innocence operate through how we locate ourselves (see trauma as "white property"), what we focus on, what and who we advocate

for, and the limits of destigmatizing the "acceptably Mad" (i.e. perhaps *some* borderlines, but not the narcissists), all of which seems to be marked by the ascendency of whiteness. One main undercurrent to this analysis, and to my final chapter on implications, is that: implication. Why is it that – what compels us to – focus on our debilitation (our "injury") rather than from our capacitation? What compels us, as white elite borderlines and 'BPD' activists, not to start from the fact that we are all implicated in these geopolitical structures, and build our analyses and activism from there?

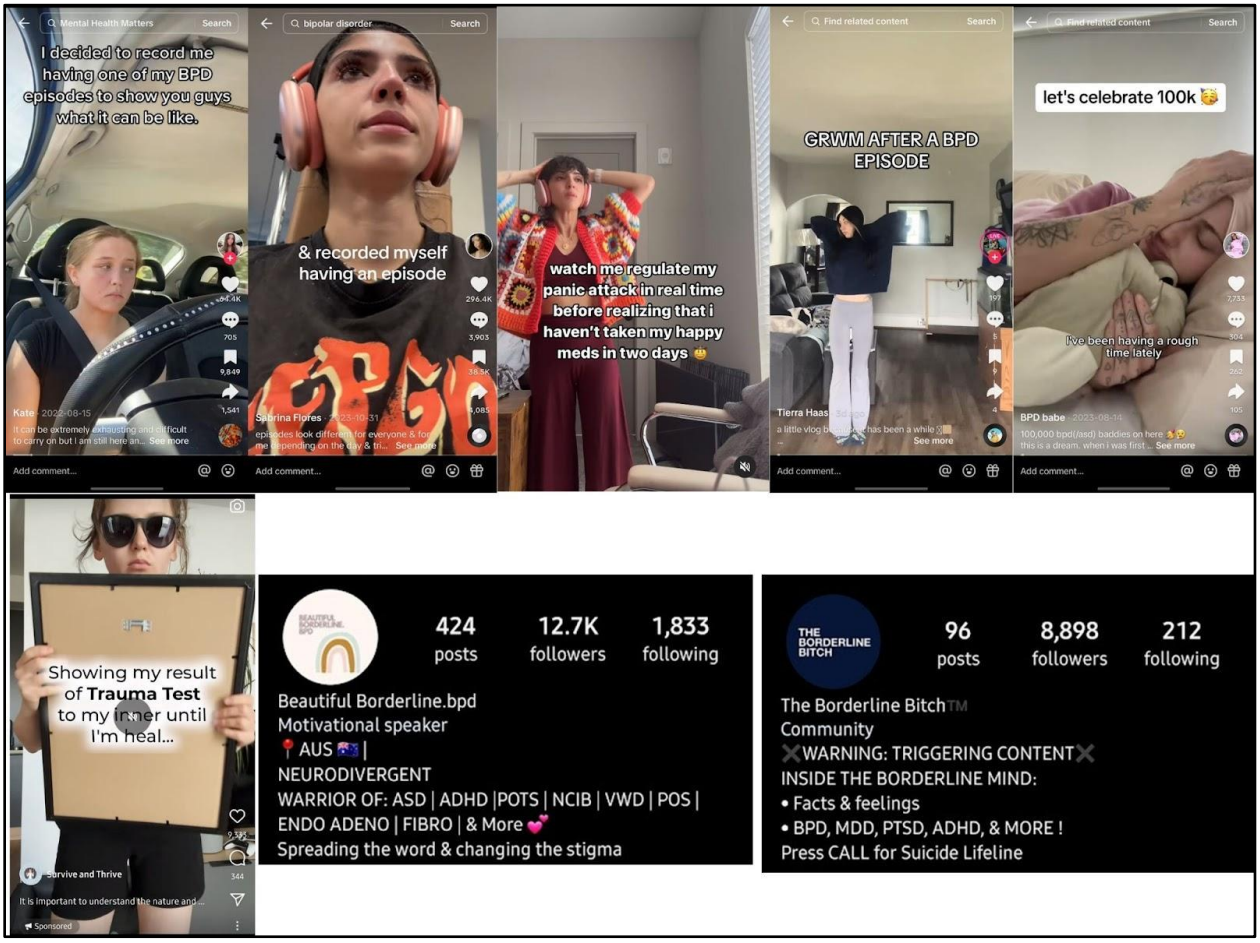

Figure 9. "Piecing" and "Trauma as White Property." Text on images or videos, from left to right, reads: "I decided to record me having one of my BPD episodes to show you guys what it can be like;" "& recorded myself having an episode;" "watch me regulate my panic attack in real time before realizing that I haven't taken my happy meds in two days;" "GRWM AFTER A BPD EPISODE;" "let's celebrate 100k [followers];" "Showing my result of Trauma Test to my inner until I'm heal…. [sponsored Instagram advertisement for a trauma test on the internet]; biographical text for two Instagram profiles read: "Beautiful Borderline bpd; Motivational speaker; AUS; NEURODIVERGENT; WARRIOR OF: ASD, ADHD, POTS, NCIB, VWD, POS, ENDO ADENO, FIBRO, & MORE; Spreading the word & changing the stigma;" "The Borderline Bitch; Community; WARNING: TRIGGERING CONTENT; INSIDE THE BORDERLINE MIND: Facts & feelings; BPD, MDD, PTSD, ADHD & MORE! Press CALL for Suicide Lifeline." See references for this figure in Appendix One.

Social work scholar Christine Mayor (2023) recently introduced the notion of "trauma as white property," arguing that trauma (and I would add, open identifications with diagnoses or madness), is being used as a way to mark innocence and inaction for white people – often to capacitate our unique identities, knowledges, rights, and financial prospects – while black trauma is still continuously invalidated and criminalized (see Figure 9).[74] White trauma as property can function as a way to "rehabilitate the white privilege lost with madness," which makes a lot of sense if we understand sanism as a racializing project (Gorman et al. 2013; Redikopp 2021). As The Mad People of Color Manifesto states, "ask yourself whether your goal as a Mad activist is to regain the white middle-class privilege you lost when you were psychiatrized" (Gorman et al. 2013:n.p.). This does not invalidate the experiences of individual people but reminds us how desire works in the Deleuzo-Guattarian sense; our interests are caught up in the political economy: "Our seemingly spontaneous reactions, our fears and desires, are as much a product of the narratives we consume as productive of them" (Read 2020:22). "What appears to be spontaneous and popular [...] is itself structured or formed by narratives that are disseminated from on higher, are transcendent to the social order" (Read 2020:22), such that some of us may collectively and inadvertently use our madness to our advantage, propping up our Mad epistemologies, even as they debilitate us, and most importantly, doing this in a way that diverts our focus from our political (particularly racialized and classed) responsibilities (a move towards innocence, in Wang's theorization):

> When people identify with their victimization, we need to critically consider whether it is being used as a tactical maneuver to construct themselves as innocent and exert power without being questioned [...] That does not mean delegitimizing the claims made by survivors — but rather, rejecting the framework of innocence, examining each situation closely, and being conscientious of the multiple power struggles at play in different conflicts. (Wang 2012:n.p.; see also Puar 2017).

This differential uptake of trauma as capacity or incapacity points to an ongoing observation in the racialization of innocence versus guilt, for example, in the propping up of white victimization in discourses about white male mass shooters or the opioid epidemic, next to the demonization of black protesters in Ferguson or in the punitive response to the crack cocaine epidemic (Alomar 2020; Puar 2017): "Morally ennobled victimization has become the necessary precondition for

[74] Puar has related this concept both to homonationalism and to disability, where disability becomes a "commodity" for the ascendency of whiteness: "That is not to claim that all uses of the category of disability are a capacitation of (not always literal) whiteness, but rather to note the explicit instances in which disability is biopolitically mobilized in the service of white supremacy, liberal racism, and nationalist projects of modernity" (Puar 2017:66).
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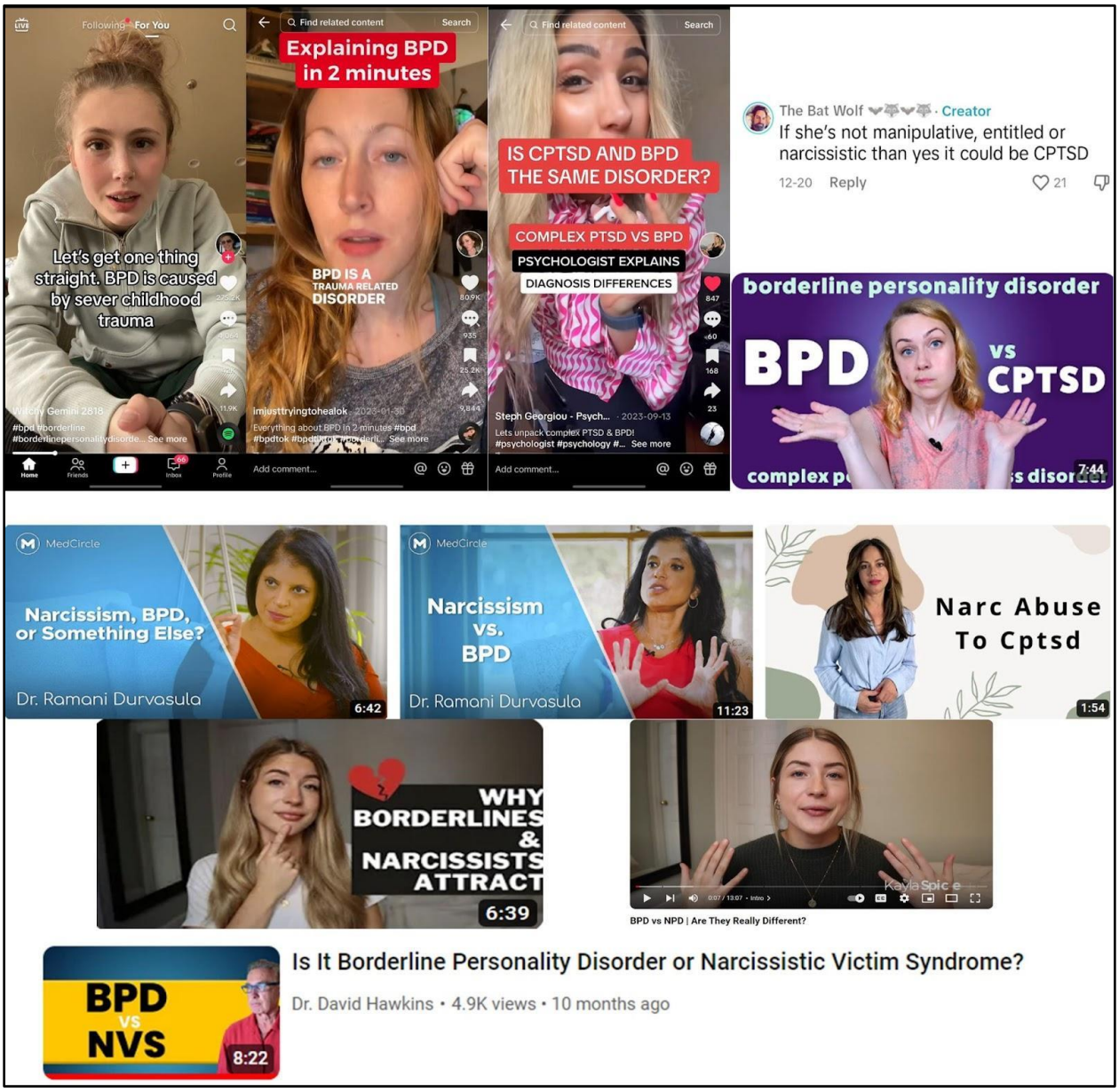
determining which grievances we are willing to acknowledge and authorize" (Wang 2012:n.p.). These various moves, with regards to innocence, are always "code for nonthreatening to white civil society" (Wang 2012:n.p.). Like the ascendancy of whiteness, the politics of innocence can work in seemingly progressive ways, ultimately functioning, however, to uplift the state's right to determine who can commit violence and how, and what and against whom or what violence or threat are constituted: "Authentic victimhood, passivity, moral purity, and the adoption of a whitewashed position are necessary for recognition in the eyes of the State" (Wang 2012:n.p.). Here, we can reconsider the notion of the false bodies-without-organs, where we must be (ironically) careful about how we are considered notions of 'careful,' 'care,' 'caution,' 'safety,' 'peace,' 'violence,' and 'threat,' and what structures are determining or benefiting from these demarcations. For Wang, the politics of innocence is widespread amongst even liberal activists, who, while they/we claim our own victimhood under various structures of oppression, denounce any attempt to challenge state authority and violence through anything other than passive means.

We can see similar patterns happening in distinctions made and not made between borderline, complex-PTSD (C-PTSD), and narcissism (see Figure 10). I discuss this in terms of the disciplinary formation of subjects first, and then evaluate how control operates through logics of racial capitalism regardless, through, and beyond the differential uptakes of diagnostic categories. First, all these aforementioned diagnoses have significant overlap, though some people are strongly tied to their differences, and some to their similarities. Many therapists, for example, suggest that C-PTSD is a more apt description for borderline, while the field of psychology as a whole seems caught up in their distinctions (a conversation about scope of practice, professional power, and gatekeeping may be useful here). In the case of C-PTSD, externalizing the problem to trauma, rather than the individual person, removes some of the stigma so attached to 'BPD.' A re-diagnosis of C-PTSD might do wonders for my former service users in Aotearoa, because the blame will go to society, colonization, and their family (though this is still often from a Euro-centric approach), and less on their personality (see H 2018) What would be better, for most of them, is a kaupapa Māori or Pasifika approach that situated their experiences within the context of colonization, whakapapa, and their more holistic models of hauora (health) (such as Te Whare Tapa Wha and Fonofale; see Haami 2024; Fitzpatrick and Allen 2019).

At the same time that C-PTSD might be a liberating alternative to 'BPD,' the international classification of disease (ICD) and DSM's stubborn distinction between the two can or could be



used to separate the innocent from the deviant. C-PTSD engenders more of a compassionate view, e.g. "that person suffered from trauma," whereas 'BPD' can then be used to focus on the maladaptive traits and coping skills that people have, with and without trauma. As psychologist Jay Watts (2023:n.p.) notes,

> Asking one's psychiatrist if one meets criteria for C-PTSD now it exists as a diagnosis only to be told, 'no, it's definitely a personality disorder'? To stand up to abusive partners, poisonous family members, unsympathetic healthcare professionals, and barristers vying for custody of our kids, only to be met with the contemptuous retort, 'If they genuinely believed you were traumatized, they would have diagnosed you with C-PTSD, wouldn't they?

The publicized Amber Heard and Johnny Depp trial made this quite obvious, with the psychologist on Heard's team suggesting she has complex PTSD, and the psychologist for Depp diagnosing her with both borderline and histrionic personality disorders – indicating her proneness to 'manipulation,' 'dramatization,' and 'exaggeration for attention.'

Finally, there's also a plethora of teachings about how borderlines are abused by narcissists, and/or how one can get complex PTSD from narcissistic abuse. Now I wonder, how the clear demarcation of which diagnosable conditions are innocent and which are guilt functions or might function as a racializing project; although we still do not take seriously enough nor have we addressed interpersonal domestic emotional and physical abuse, we also have to contend with our long history and present of criminalizing men of color – black men in particular – while uplifting the innocence (through victimization) of white women:

> It is precisely by denying culpability or assuming that one is not implicated in violent relations toward others, that one is outside of them, that violence can be perpetuated. Violence, especially of the liberal varieties, is often most easily perpetrated in the spaces and places where its possibility is unequivocally denounced [...] It is easy, albeit painful, to point to the conservative elements of any political formation; it is less easy, and perhaps much more painful, to point to ourselves as accomplices of certain normativizing violences. (Puar 2007:25)

If psychology is going to insist upon their distinctions, then who will get labeled what? Will the 'difficult' patients of color who are 'frequent flyers' in the ER get labeled as borderline? What about service users who are transgender, racialized, and on refugee visas? There is a long and ugly history (and present) of white women being propped up as victims of men of color, particularly black men, and as Jackie Wang (2012) notes, still influences our seemingly liberating discourses about 'women's safety in public,' for example. In interpersonal violence cases, how will C-PTSD and narcissism or narcissistic abuse be deployed, and when will 'BPD' be used, with no reference to trauma, only to a maladaptive personality?

Given all of this discourse, is "fulfilling C-PTSD's promise and binning the diagnosis of BPD once and for all" the solution to all of this (Watts 2023)? The problem is that while there have been and continue to be racial patterns in diagnoses, increasingly, control operates regardless of diagnosis, capacitating populations that serve capital and the state, and debilitating populations left "available for [physical and psychological] injury." For example, within the 'BPD' label, there are good ones and bad ones. A mental health nurse recently told me that providers will likely look fondly at me as a service user because I have zero "no-shows" flagged in red on my electronic

medical record (EMR) and because I do not go to the emergency room too often. This of course worried me when I slept through an appointment while I was overcoming jet lag. However, I have confidence and familiarity with communicating with health providers – among several other structural advantages – and I let them know that I had intended to come, apologetic for not showing up. They understood, and subsequently changed my "no-show" to a cancellation, with fewer implications for my file. As a former frontline social services provider, I understand the desire for and even the necessity of certain parameters (that I would think should be agreed upon, not imposed). However, the "no-shows" flag on our EMRs likely cannot account for the variety of socio-political circumstances that could lead to someone missing their appointment without communicating with a program. Instead, this flag can become an almost automatic mechanism for sorting patients, not only into categories of "good" and "compliant," but into deserving of health or not. That is, remarks about whether patients are "respectful enough to cancel in advance" do not just have discursive effects, but have material consequences not only in emergency settings, but across health services. I later learned from another mental health therapist that how often one "no shows" affects group treatment options, further modulating and tweaking life chances. There are increasingly built-in technologies, discourses, policies, and practices in our health systems through which individuals, communities, and populations get siphoned into different streams of access, care, health outcomes, and thus potential futurity.

How diagnoses capacitate us, or how people like me are referred to as the "good borderlines," show us the ways in which certain images of whiteness and eliteness are always capacitated (not mutually exclusive to debilitation), in service of whiteness and empire. Certain populations are simply capacitated to "live well with our conditions" (Breedt 2024) to be "Mad and proud," or like me, deemed to be the "good borderlines." Other populations are systematically debilitated, blamed, overmedicated, neglected, institutionalized, and are not granted the capacity to imagine an affirmation of madness (see Eromosele 2020; Meekosha 2011; Puar 2017). This is not about invalidating white trauma. This is a query around what we are mobilizing around, identifying with, and advocating for. When we advocate for trauma-informed labels, identities, and approaches, particularly to situate ourselves as in more knowledgeable subject positions, we get clout. I'm not sure this 'trickles down' to people most subjugated by state violence, police violence, and the healthcare system. I think this is a crucial question for us as individuals in elite positions – influencers and scholars – and I think it is a broader question for the Mad movement:

how and *if* the (white) Mad movement should carry on.

In other words, we should definitely give up the notion of 'borderline *personality disorder'* and the reification we see online in the name of 'destigmatization.' However, as I explore in the next chapter, I wonder if we should also consider giving up on Mad Studies. It is not eugenicist to prevent state and corporate violence, and Mad discourse cannot exist without the call to *prevent* psychological debility, including that which cannot fathom a pride-based movement because of ongoing capitalist and settler colonial violence (Meekosha 2011; Puar 2017). In the final chapter, I outline in more detail the practical and more impractical implications of all of the arguments in this thesis.

CHAPTER FIVE: IMPLICATIONS & CONCLUSION

5.1 Introduction

I conclude this thesis with a summary of some of the practical implications of my analyses of the 'borderline personality' assemblage as a whole, both micro-political and macro-political. I hope that I have embedded some practical takeaways throughout, such as the need for clinicians to ask what a behavior might be doing, rather than what it indicates (Chapter Three). The macro-political implications, particularly for activism and scholarship, are just as relevant, though perhaps more daunting; if we are spending our time and energy doing activism, advocacy, or awareness building, then what ends are we serving (Chapter Four)? As white elite borderlines in particular, might our labor be better used elsewhere, or at the very least, with greater contextualization? These are some of the preliminary curiosities I have in this chapter, while pushing against any universalizing 'answer' or 'solution' that will likely be co-opted.

I present the implications based on the various analyses in this thesis, and what I am most compelled to write about; after all, this thesis could have implications for specific disciplines (such as social work or psychiatry), as well as specific treatment modalities or advocacy movements. Instead of choosing one of these directions, I offer reflections for three broad realms concerning borderline and 'BPD:' 1) clinical practice, broadly speaking; 2) psychocentric mental health advocacy; and 3) Mad Studies and Mad activism. Instead of offering concrete 'solutions' or 'steps,' I invite readers to join me in conducting intersectional ethologies, and to reflect on the various micro- and macro- political implications for these three topics. I do this in part to caution against any quick fix without critical reflection, and in part to value my ethological method thus far; the implications I am compelled to write about are a product of asking what borderline does, as well as an extension of it. In fact, one of the major themes of this chapter is to ask exactly that: what (else) are our practices, movements, and efforts doing? As Danielle Peers articulates, what are some "uses and dangers" of our seemingly liberatory or therapeutic approaches, how might inviting more micro- and macro- political analysis into these questions help us to ascertain 1) why we do the things we do (desire), and 2) how else we might go about these efforts? Before introducing and summarizing the three components of this chapter, I want to share a few reflections on theories of change, and what I think research can and cannot do, because these reflections shape my approaches to each implication section.

5.1.1 Theories of change

I hope that in my introduction, I made clear the events that compelled me to write this thesis, as well as those that pushed me to modify the project as I went. This project started out as a therapeutic and theoretically interesting endeavor for me as I navigated Deleuze and Guattari, my clinical practice, and my own relationship to borderline. It borne out of both frustration with how specifically structurally marginalized borderlines are treated in social and community health services, as well as a conceptual interest in affirming the affective knowledge embedded in what are pathologized as borderline 'symptoms.' As I was starting this project, I did not (and still do not) have much hope for my research to do or change anything, but ultimately hoped that my presentations might resonate with some psychocentric clinicians, advocates, and researchers. In particular, I hoped my work would help clinicians be more intersectional and contextual in their practice and conversations with patients.[75] At the same time, I grappled with the limitations of a Master's thesis, and with academic research more broadly; as Eve Tuck and K. Wayne Yang (2014:813) write "research is not always the intervention that is needed." In fact, I do not think we need more empirical research on 'BPD' and structural inequality is necessary to understand what the problems are; as Ian Buchanan (in Nicholls 2023) discusses with regards to the climate crisis, we know where the inequalities are, what the problems are, and in many cases, what to do (e.g. reparations and the rematriation of land). Theory, rather than empirical research, can help us to ascertain *why* we are not simply doing the better thing, or why these inequalities persist despite all our best efforts. Why do we, and those in power, continue to invest in projects counterproductive to our stated goals (noting that what people in power state is not always what they intend)?[76] As Tim Barlott has helped me to understand, perhaps research is not needed for proving or understanding inequality, but for praxis; research can be the doing, the learning, and the trying – including the trying to understand how to actually enact our supposed values, intentions, and desires to ameliorate inequality and injustice, in a system that thrives off of their existence.

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[75] When deciding on my methodological approach, I also contended with the ethical dilemmas of conducting extractive empirical research in a community that I am new to (geographically and diagnostically), and over such a short degree program. These ethical dilemmas, with extractive qualitative research as a whole, and with these circumstances, ultimately led me to do an autotheoretical project (which, as I detailed in Chapter Two, has its own limitations and shortcomings).

[76] Notably, I am referring to an undifferentiated "we" here and note that as much as we are all complicit in these systems, a very specific group of global elites are the reason things are not changing; activists know this, but researchers, policy advisers, and advocates that are not situated within a broader historical struggle against Euro-American empire and capitalism do not.

This is also to say that while I could simply speak back to the psychiatric industrial complex (which I do in part), psychiatry and the disparities it grapples with are but symptoms of the colonial, capitalist system we live in. I do not purport to be able to upend these systems, particularly in a thesis that will give me a credential (so that I can participate in capitalism) and that few others will read. I am generally cynical about our collective abilities to upend the world order as it stands, but that *is* the goal we should be working towards, and we cannot do that without an adequate critique of the problems we are facing. Thus, I hope, at least, to locate the problem where it is, and for clinicians, activists, and researchers to do the same. I hope that in whatever presentations I do, conversations I have, or writing I do, that we as clinicians or frontline workers, as white borderlines, and as psychiatrized people can locate the problem where it is – with racial capitalism, (settler) colonialism, and their conduits (such as psychiatrization and sanism, the disparate effects of which are highly patterned by racial capitalism and colonialism). This does not mean that we give up our other efforts, some of which I outline below, but that we situate them within and use them towards a critique of Euro-American empire. In working towards these ends, micro-political shifts (such as in diagnostic practice, clinical teaching, and where we focus our energy as influencers) are important, even as we know they will likely be captured and picked up by capital. I am willing to risk anti-imperial arguments getting picked up by capital and mainstream discourse for at least Mad activists and mental health activists to support decolonizing and anti-racist movements. I hope that we can collectively locate the problem where it is, lest we stay siloed in a white version of activism or even improved clinical practice that only sees a small part of the picture; the desire to focus on inclusion within a violent nation is a desire for an inclusion that is only thinkable because of other exclusions and violences.

Nothing that is said here is new, and thus are the limitations of research and the ways in which whiteness reasserts itself (including through how I am writing this thesis). As someone who enjoys reading and writing, and who is compelled to participate in capital, this is where my critique will rest, for the moment. I am still caught up in my own futurity, a futurity that is bent on remaining a settler on this land in so-called Canada, though that hopes for a radical shift in governance and guardianship over the land that could mean that I might not get to be here, or that my life will not look the way I was taught it would when I was growing up in white, affluent America. While I will not pretend like I do not have vested conscious and unconscious interests in the proliferation of academia, "we cannot do this work with any hope that our jobs, our institutions,

our scholarship, our disciplinary attachments, or our ideas of knowledge will remain recognizable in the process" (Fawaz and Peers 2022:174). I hope that I continue not to recognize the world I am in, because it has done away with a false reliance on mainstream theories of change in research and the academic industrial complex's complicity in the very systems it (sometimes) critiques.

The only theme that seems to run throughout these tentative implications is the notion of starting from complicity (Puar, in CLAGS 2013) or implication.[77] Whether considering our or my activism, clinical practice, or scholarship, I, following others, invite us to start from an assumption that we are embedded and thus complicit within – to various degrees – systems that debilitate people, particularly structurally precaritized people, throughout the world. We are not innocent, and we cannot avoid this. We simply contribute to these systems, particularly as settlers, global elites, white people, healthcare providers, academics, and people with other forms of influence. From there, we can call out these systems, build solidarity, engage in micro-political forms of resistance, consider how and where we are willing to be complicit, and ask what else we might do.

5.1.2 Overview of this chapter

Given that the arguments in this chapter mainly come from reflection and lived experience, I had trouble parsing out what the main points were. Gayla Grinde, in a recent conversation we had, helped me to honor my methodology, while cohering on a few themes that undergird each section of implications. I am grateful for this conversation, because it helped me move from listing a hodgepodge of different reflections on diagnosis, dialectical behavioral therapy (DBT), and activism, to sharing three main points, each of which I support by reflection and example, rather than mandate or recommendation.

First, I wanted part of this thesis to have implications about clinical practice. While acknowledging that the ultimate goal is to upend many of the systems as we know it, and for Indigenous sovereignty over their healthcare, there are important socio-political shifts we might make in our various clinical engagements with people who might be described as borderline. The overarching desires I have for clinical practice are 1) for clinicians to engage in more micro- and macro- political analysis in their practice, and 2) for clinicians to be wary of any universalizing approach to 'treatment' or 'care:' ask what something does, might do, or how else it might look – rather than uncritically applying an evidence-based treatment, a manualized therapy, a diagnosis,

[77] Danielle Peers, personal communication, August 4, 2023.

or a universalizing affirmation (such as in Chapter Three) that does not consider geopolitics or intersectionality. In this section, I share some general reflections on what a politically informed ethological approach could look like in clinical practice, and what types of questions it could open up. I also share specific anecdotes surrounding diagnosis, individual and group therapy, therapeutic relationships, clinical incidents, and DBT. These examples are not meant to exhaust each point, or adequately address all the nuance and socio-politics surrounding each topic – each of which I do not know enough about. They are, rather, to share in an explorative analysis about how else we might examine a clinical situation, and what possibilities for action that might open up.

In the second section, I join Mad Studies in specifically calling out the 'mental health activism' done by clinicians, advocates, and service users online and in large advocacy campaigns. This is perhaps the easiest group to address, given the reification of psychiatry, psychopharmacology, and the therapy industrial complex being done (alongside the whitewashing). The main point of this section is for advocates and researchers to ask what ends we are serving, and where we are locating the problem. I then provide a transition between psychocentric advocacy and Mad Studies, through a discussion of the politics of innocence. Building off Chapter Four's critique, I highlight the ways in which both movements can get caught up with a focus on injury that absolves ourselves of political – specifically racial and geopolitical – responsibility.

Finally, I address the question of Mad Studies – what we should do about it. This is more difficult, given its valuable anti-oppressive stance *and* significant limitations. I build on Mad and borderline scholars who have called out the whiteness of Mad Studies, addressing the Mad scholarship and activism – mine included – that risks reifying a universalizing imaginary of borderline without geopolitical specificity and context. Thus, like the psychocentric implications, I join those who ask Mad Studies to question why it is so white, as well as some of its assumptions about futurity, "living well," and the endless capacitation of life.

This chapter, as a whole, thus traces this project's overall morphing from an interest in affirming borderline 'traits,' specifically with micro-political implications for clinicians, into having a main focus on white borderlines – both Mad affirmative and psychocentric. Following Hesses' (in Rico and Sargent 2021) call for white people to become race abolitionists, this thesis has turned more into an (albeit inadequate) form of (I hope) white criticality – a critique and exposure of whiteness, a speaking back to whiteness and the ways that so many borderline and

Mad activists "won't speak/act in solidarity publicly because [they/we are] benefitting from whiteness in public."[78]

Finally, I briefly discuss the methodological and theoretical implications and limitations of this work, circling back to Chapter Two, where I hope that I have made most of my points about Deleuze and intersectionality. I also highlight a future area of research that would have important theoretical and practical implications with regards to borderline, Mad Studies, and related fields.

5.2 Reflections on Clinical Practice

As a service user and former frontline worker, I would love for clinicians to have an understanding of history, inequality, and politics, particularly those surrounding the 'mental health' system. As Gayla Grinde remarked, "know your tools." This means understanding the history, debates, consequences, and potential benefits and consequences of your/our tools – whether those tools are psychiatry as a whole, the biomedical model, the biosocial model, dialectical behavior therapy, diagnosis, the DSM, medication, inpatient treatment, psychodynamic treatment, or otherwise (again, with a note that every one of those terms has been and should continue to be critiqued, given their embeddedness within a neoliberal and colonial structure of healthcare). Understanding the socio-politics, and not just the clinical evidence, of these various tools, techniques, and approaches is crucial for understanding why they might not work for a patient, why they might harm a patient, what else they might be doing, why treating the patient as an "individual" will not work in the first place, and what types of micro-political changes we might make. That is, the macro- and micro- must always be in conversation with one another. We might be heavily constrained to address the macro-political in our clinical practice (e.g. we might have to put a diagnosis on someone's chart lest we get fired, or in the United States, for insurance to cover their treatment). Still, approaching these limitations with a socio-political awareness and understanding can help us to create micro-level interventions that mitigate some of the problems that come with our system. For some patients, this could look like having a frank conversation about their/our diagnostic options, why a diagnosis needs to go on the chart, and what other approach we might take. Perhaps we, the clinicians, service user, and anyone else involved, can agree on a diagnosis for the chart and then defer to cultural and community support for coming up with a formulation and approach that works for the patient. Perhaps this approach I outlined has many potential harms

[78] Hesse, Barnor, in The Slow Factory Foundation (@theslowfactory). 2023. Instagram, August. (https://www.instagram.com/p/CJyvriYFHMb/?hl=en).

that I have not considered. These are just a few examples of questions we could explore. In the rest of this section, I share three reflections about how clinicians could engage with micro- and macro- political questions in clinical settings. First, I reflect on how clinicians can get curious about, rather than immediately pathologizing, borderline 'traits.' Second, I reflect on ethologies of diagnosis. Third, I reflect on some – certainly not all – aspects of DBT, based on some recent experiences I have had as a service user.

5.2.1 Ethologies of borderline 'traits' or 'symptoms'

Moving from pathologizing to ethological analysis, as shown in Chapter Three, has implications for how we (clinicians and the broader community) support and respond to people labeled as borderline, and suggests a more generous perspective of behaviors that may resemble 'BPD.' First, be curious about 'borderline' affects, behaviors, and worldviews, and validate them. They are in response to something, and productive of something. Echoing Redikopp's (2018:90-91) call to "compassionately contextualize" and value borderline knowledge would not mean reading everything said or done as healthy or true but approaching borderlining gestures with curiosity – asking what they do (see also Johnson 2021; Lester 2013; Lewis 2023b). What if practitioners utilized and valued the borderlining gestures that we often deem as maladaptive, even while trying to *collaboratively* prevent empty BwOs? I thus invite clinicians (as well as family members and acquaintances) to ask ethological questions, rather than defaulting to transcendent assumptions about borderline or 'BPD.' Question could include:

- What came prior to and as a result of this assemblage? (For example, see Whakakupu Limited 2024).
- What might it do to value this deterritorializing gesture? To extend it further?
- What are we learning from this deterritorializing gesture? What made it possible? What did it create or expose?
- Are these processes emptying or generative? Who is doing the emptying?
- How (else) might we reterritorialize, when, and with whom?

Considering what else a borderlining gesture might do, or even accompanying it, might allow a clinician to let the gesture do more than what a pathological perspective would say it can do. For example, 'abject' borderline affects may invite observers to disorganize norms, morals, policies, and ethics that needed disorganization, such as the therapeutic assemblage: "There is no difficult borderline object, there are only difficult encountered phenomena" (Lewis 2023ba:9). As my friend and former colleague, psychotherapist Karlene Schwencke (Mamea) reflected, borderline affects may open up opportunities for our own disarticulation and reorganization as clinicians, who are so

often taught to blunt our own affects, as well as those of our service users. Giving uptake to borderlining gestures, particularly anger, as Nancy Potter (2009) describes, allows for the potential of full BwOs – potentials that the psy-disciplines, as they stand, foreclose in their attempts to prevent all disarticulation through risk management and deficit-based frameworks. In Wang's (2012:n.p.) conclusion, she comments on Maria Lewis' response to a protest. Though I do not want to conflate borderline gestures with the specific Occupy Oakland protests occurring at the time, Wang's commentary highlights some of the important nuances I want to invite with regards to deterritorializing gestures that are often pathologized and/or criminalized:

1) Affirm the deterritorializing gestures.
2) "Refuse to purify" the gestures by "integrating, rather than excluding" the abject or violent elements.
3) "Legitimize the anger and desires" [of the protestors].
4) "Shift the attention to the structural nature of the problem, rather than getting hung up on making moral judgements about individual actors" (numerical list added for clarity).

To put this in a psychiatric context, imagine a so-called borderline (or someone you are considering diagnosing) has been violent. Perhaps, during a conversation on the ward, one of their peers told them that they "might as well go kill themselves." The 'borderline' then responded by lashing out physically at this person.

1) Affirm the deterritorializing gestures. Affirm that what the other person said was not okay. Affirm the impulse to rectify the injustice that occurred. Anger is a response to injustice, and thus this person's rage was apt. We cannot simply denounce violence or say that the expression of anger was wrong if we do not first validate the anger. Affirm its validity, and that the person responded in the best way they knew how to rectify the injustice. Then look at the behavior (e.g. the punching and screaming). Collaboratively consider what that punching did. There are multiple things it did; it perhaps validated the anger the person was feeling, but it also put them at risk of having charges pressed against them (an issue with the transcendent and retributive legal system). The violence may have also induced a shame spiral within themselves, and it hurt someone else. Thus, this person's reaction could both be a valid response to an injustice that did occur, *and* ultimately be emptying, given that it harmed someone else, and potentially exposed the person who was violent to further vulnerability.
2) "Refuse to purify" the gestures by "integrating, rather than excluding" the abject. A simple statement that someone's anger was valid, but their violence or rage or screaming was not can still serve to de-legitimate the gestures. Again, affirm the gesture and the desire that produced it – both the feeling of anger and the behavior. Then ask together what the behavior did, will, or could do, and what other form of de- and re- territorialization we can do.
3) "Legitimize the anger and desires" of the borderline.
4) "Shift the attention to the structural nature of the problem, rather than getting hung up on making moral judgements about individual actors." Collaboratively address the underlying

> issues, perhaps, that the fact that both people are in this confined ward is difficult and unjust, and makes it harder to respond kindly to each other. Perhaps the person who said the harmful words was white, and the person who punched them was Indigenous. Address the structural layers of the insult, and further validate the deep seated colonial and racial harm that came with the gestures. Address the fact that the threat of being charged with assault by the police state is not a justice-oriented way to respond to interpersonal harm. Collaboratively come up with ways to respond to harm, perhaps by drawing on teachings from transformative, restorative, Indigenous, and culturally specific principles and practices about justice (see Brown 2020; for critiques on the co-option of restorative justice, see Tauri 2022).

Here is another example. Someone in a group therapy program has started screaming expletives because they learned that someone else got to join the group, despite being intoxicated, even though there are strict rules about joining the group intoxicated (I am not commenting on the legitimacy of this rule). This person is screaming, reminding you, the clinician, of all the times they were kicked out of the group for being intoxicated and saw the same thing happening to their friends. They are calling the person names and yelling about the hypocrisy of management and the policies.

1) Affirm the deterritorializing gestures. Affirm, again, that the screaming and rage is in response to an injustice. This person has identified an injustice, in this case (and in many cases), a very real one (though who are we to determine if someone's feeling of injustice is valid or not). We cannot deny that this policy has been applied differentially. We may not have control over that or be able to fix that, but this did occur (and occurs frequently in these settings).
2) "Refuse to purify" the gestures by "integrating, rather than excluding" the abject. Avoid the "counterproductivity" argument (Srinivasan 2018) and integrate the expletives. They are in line with a response to rage. Then ask what they are doing? Could we mobilize that anger towards addressing the situation with management? Could we mobilize it towards teaming up with fellow service users to address the inconsistency of management, rather than taking it out on each other? This would not mean you (the clinician) are 'splitting staff,' or 'going against management;' if it is seen that way, then management needs to do better. This is validating an observation and supporting an injustice to be rectified.
3) "Legitimize the anger and desires" of the borderline. So often we (clinicians) dismiss anger in these settings because of our institutional authority. We should not sugarcoat that *we do* have institutional power and authority in these situations, but we can acknowledge that, and validate the anger at the system; perhaps we are angry at it too. Perhaps our feelings are not so different from our service users.
4) "Shift the attention to the structural nature of the problem, rather than getting hung up on making moral judgements about individual actors." Rather than focusing our energy on the "counterproductivity" argument, what if we focused it on addressing the policy, or at least the inconsistency in management? Let's also make sure we are looking carefully at the intersectional patterns of its implementations. What are the subject locations of people that are enforcing the policy, and for whom? How might a disparity here be contributing to

> injustice and anger, and rightfully so? This becomes an analysis of not whether "there is a crime taking place, nor determining who is at fault, but rather asking, what are the affective conditions necessary for the event-space to unfold," and what do we do from there (Puar [2012] 2020:413)?

These are but a couple of examples that might occur in a more institutionalized setting. However, there will be constant examples, to various degrees of extremity, where a service user is presenting with something that 'matches' the diagnostic criteria for 'BPD.' Perhaps they are pushing you away as a therapist. This could easily be read as indicative of an attachment issue that originated with their primary caregiver, likely their mother. To use an Oedipal analysis, you, the therapist, might remind them of their mother, and thus might be producing a negative reaction from them; they do not want to be abandoned again, so are pushing you away. This all *might* be true, or at least a strong contributing factor. In their critique of the Oedipal complex, Deleuze and Guattari ([1972] 1980) never say that it is wrong or should not be considered; instead, they question the production of the primacy of the familial analysis, and what gets obscured when this becomes a transcendent model through which all behavior is understood (see Buchanan 2023b). What else could be happening? What could the person's rejection be produced by, indicative of, or producing? Perhaps you remind them of a corrections officer they once had, and are evoking harmful memories of state institutional violence, not motherly abandonment. Perhaps they are rejecting the way that you handle the therapeutic relationship, and the fact that you have said you will have to call the authorities if they express intent to harm themselves. Perhaps, again, they are responding to the threat of state violence. Perhaps you do not 'represent' anyone else; perhaps there is nothing to interpret, but only a question to ask: what is this distance doing for them? Do we always need to find the root cause, or can we affirm the desiring production behind different affects and behaviors? When we do look at 'causes,' can we look at assemblages, conglomerates, singularities, intersections, and the entire socio-political milieu this person might be caught up in, and see how that might interact with their childhood wounds?

All these shifts push us to look beyond whether behaviors fit into a certain diagnostic category or theoretical framework. They push us to be curious about them, and to know that they are real and valid. Something can be real and valid, and we can still question the utility of it. From there, we can ask not only what the behavior might be doing, but how else we might be able to get that outcome (can we get soused on pure water, as Deleuze and Guattari ask). This call for ethology does not mean prioritizing a solely affirmative view of borderline but means asking what

borderlining affects and worldviews might do, rather than using them to justify diagnosis and treatment that may cause greater harm. To conclude this section on borderline 'symptoms,' I want to direct our attention to a call from the 'BPD' Superpowers group, which calls on clinicians to:

> Question the assumption that BPD = bad, broken, dangerous, or irrational [...] Normalizing an assumption that anyone identified with BPD will behave abusively, that BPD means someone cannot be trusted, or that they are somehow fundamentally deficient or incapable of having 'healthy' relationships (all stereotypes that are weaponized against this community), causes harm and is not accurate. Anyone can behave in abusive ways, and speculating about diagnoses (including BPD, but also narcissism, sociopathy, and all the other labels that get tossed around in response to abusive behavior) invites less accountability and less justice in relationships. Rather than locating harmful behavior within a diagnosis, which in turn locates the problem within a person, it is more effective and more just to talk about the behavior [and what it does] itself. 'Mental illness' is not required for harmful behavior – our colonial, patriarchal, misogynist, heteronormative, transantagonist, and ableist culture invites people to behave in abusive and harmful ways, regardless of neurodivergence or diagnosis. (Sostar, Thomas, and Nault 2020:29)

5.2.2 Ethologies of diagnosis and treatment

> "Critically inhabiting a label, as opposed to identifying straightforwardly with it, means rewriting it from the inside out rather than adopting wholesale the culture's beliefs and expectations for people in that category, a crip cousin to the concept of 'disidentification' in queer-of-color theory: working with and against a category at the same time [...] One might also think of this intellectual maneuver as cripping or poaching a psychiatric label: conducting an 'impertinent raid' [..] on the DSM by thieving categories for our own purposes" (Johnson, 2015:642, citing Muñoz 1999, then Jenkins 1992:24).

As clinicians, service users, family, and community support, we can also get curious about what a diagnosis or not, therapeutic framework, or treatment modality might do. Many clinicians, as it stands, 'split' the 'BPD' diagnosis: they either demonize it, embrace it, or remain completely vague and unclear about where they stand (see Chapter One). Is splitting not one of the traits that the psy-disciplines are supposedly intervening upon? Regardless, when clinicians (specifically psychiatrists) use (highly contested) research, personal opinions, or their medical authority to justify their decision to diagnose or not, service users are left out of the conversation, sometimes with little grounds upon which to reterritorialize. In my experience, there is often little consideration about what a diagnosis may do for a given patient, across different contexts. This is an intersectionality patterned phenomenon I am sure (who gets 'clued in' to these discussions), but also widely aligns with clinical approaches to keep information from patients, to create case

formulations without letting patients know about them.[79] As I discussed in Chapter Four, diagnoses can do several things, as can diagnostic language. Rigidly relying upon a transcendent notion of borderline pathology is likely harmful, but the use of diagnoses and concepts are not inherently unhealthy or unethical; diagnoses can grant access to treatment, community, or an understanding of oneself – even though they are certainly fabricated by Western psychiatry. Diagnostic language can be validating, because it provides a conceptualization of someone's experience without giving them an institutional label. In other instances, particularly in the United States, an institutional label is the only way for their treatment or medication to be covered by insurance (Price 2015; Redikopp and Smith 2022). I am not sure about all the institutional barriers that clinicians face, but I do appreciate creativity when it comes to getting around them. For example, is there a way to provide a label to insurance providers, while using a less iatrogenic diagnosis to get a medication approved? The first thing that is necessary is the acknowledgment of the institutional power that diagnosing and prescribing professionals have, and a discussion of the harms and benefits that can come with the decision to label or not, and with what.

Why are these conversations gatekept from us service users (see H 2018 on the harms of leaving patients out of the conversation)? I imagine that this is in part because clinicians are not having these conversations themselves, but are simply following dogma, whether it comes from the DSM, the feminist literature, their own experiences, or opinions from those that trained them. So, I might ask, what is producing this desire to diagnose or not, and in which contexts? Are you, the doctor, diagnosing it as a form of social control and 'warning' to other clinicians, more often for structurally vulnerable populations? What are these diagnoses doing for your patients, and how else could you approach these decisions? What are your patterns in diagnosis, across intersectional lines? If we move beyond the individual as a unit of analysis, we can consider how the need for people to receive diagnoses in order to be supported serves the neoliberal profiteering off data, insurance, and other feedback loops of the medical industrial complex (Puar 2017). Are there other ways to facilitate reterritorialization or validation, without feeding this system? Can you have this conversation with us (perhaps, after you go learn about the social field and political economy)? I realize that I have asked many rhetorical questions here: "My questions about borderline are my truths. Every answer I give is untrue."[80] This is because, again, I shy away from universalizing

[79] Gayla Grinde put language to this common phenomenon, personal communication, February 29, 2024.
[80] Adapted from Eduan Breedt, personal communication, March 16, 2021.

approaches, given the diverse and adaptive ways in which power operates. For example, conversing with a patient about their diagnosis might not work for everyone. There are benefits and consequences of private clinical rounds or interdisciplinary meetings, but there are also benefits and consequences, micro- and macro- political, of engaging in this conversation with patients.[81] Furthermore, we must always remember that going beyond diagnoses and questioning their sociological and political history and present; adapting clinical practice cannot be divorced from a macro-political analysis and contextualization. Overall, I hope that these questions invite an analysis of power and desire into clinical practice instead of transcendent reliance on other rules, protocols, and cultural norms that we so often engage with uncritically.

Providing and/or taking up a 'BPD' label is also highly shaped by geopolitics; whiteness, being cisgender, affluence, and citizenships status, in my observations, all probably make it more likely for a provider to be careful about a diagnosis and discuss it with a patient; they also provide a protective layer against the stigmatization, neglect, and criminalization associated with 'BPD' if it is diagnosed. Some people resonate more with complex post-traumatic stress disorder, and others with culturally specific frameworks for emotional distress, intergenerational trauma, and diverse perceptual and emotional experiences (see Gesink, Whiskeyjack, and Guimond 2019; Gone 2013; Kopua, Kopua, and Bracken 2020; Ngata 2014; NiaNia, Bush, and Epston 2018; Taitimu, Read, and McIntosh 2018; Walls et al. 2014). An ethological approach means asking what various diagnostic frameworks, psychoanalytic interpretations, pharmaceuticals, treatment approaches, and more may do in each encounter. For example, how might conceptualizing this distress through a Jungian lens provide validation? How might taking an activist orientation to their experiences, and mobilizing their so called 'symptoms' towards rectifying injustice be therapeutically supportive? Diagnosing borderline traits, or 'BPD,' or C-PTSD, or nothing, or referring someone to an Indigenous healer, will all do different things, for different people, and in different contexts (with family, in emergency rooms, in primary care, at your clinic, in society, on social media, with oneself, etc.). I thus invite collaborative and contextual conversation between clinician and service user, amongst clinicians, and with communities, about what a formal or informal diagnosis of 'BPD,' 'borderline traits,' or otherwise, may do or not do for someone based on their social location, legal and financial contexts, movements in the world, and relationship to psychiatry and

[81] Gayla Grinde, personal communication, April 25, 2024.

madness. I outline more examples of the need for ethological analysis by way of some vignettes I have written over the course of this thesis.

July 12, 2023: Autoethnographic comment

What do they do? CPTSD and borderline do much different things for me in different moments, and for Francesca Lewis, CPTSD doesn't do much at all.[82] For many therapists, CPTSD seems to better non-pathologize their clients. Who is to decide though? Is it the therapists' discomfort (the diagnosis-that-should-not-be-named), the client's, or both? Could therapists have nuanced discussions about what different labels mean and bring and in which contexts?

April 27, 2023: Autotheoretical comments on diagnosis

Immanence is not just an intervention in terms of diagnosis and label, but an intervention in terms of therapeutic approach.

I explained to a psychologist at an outpatient program, before I was diagnosed with anything other than depression (well, in Canada), that I was having trouble with all the confusing messages from different psychiatrists. I had been told I am depressed, likely to be bipolar, highly likely to be bipolar, have borderline traits, have borderline PD, do not have borderline but am depressed, a number of things. I expressed that I understood that diagnoses can only do so much, do not show the full picture, that there are critiques of diagnoses, and that I understand why I might not get diagnosed until they are 'certain' (to whatever extent that can be said) about what direction to go in. Still, I shared that I was struggling with all the whiplash in different ways to conceptualize what was going on – something that likely needs medication, or therapy, this approach or that approach, how do I conceptualize my sense of self? The psychologist said something to the effect of "we do not really care about the diagnosis; we care more about what things work for you." I reiterated that I understood this, but that having language to describe one's experience is extremely useful. I cannot simply try a million therapies and meds to find what works; it is also helpful to have some general guide for how we might conceptualize something in the moment. This does not require that we take diagnostic categories as truth but can be an ethological analysis. What concepts are compositional, and what resonate? How might my affective and relational capacities increase if we are sharing the same language? Why can't you be curious about what I am asking for? I am handfeeding it to you: saying I need validation, clarity, direction, a plateau to land on, a way to make sense of what I am going through – even if that sense-making changes. Yet, there was little curiosity and little understanding of what I was saying. Immanence, and this patient-centered (supposedly) version of it, does not require that we throw all disciplinary formulations out the window; it requires that we see them as fabricated, though sometimes useful, concepts to be considered ethologically, with each person, in each moment, and across different settings. What this psychologist thought to be liberating – not worrying about my diagnosis – was constraining because she made immanence, un-organization, vagueness,

[82] Personal communication, May 4, 2024.

deterritorialization a new transcendent norm or truth. Taking heed from the harms of quick and rigid diagnoses, she was rightly hesitant about telling me 'What I am.' Still, she could have acknowledged the plane of immanence upon which psychiatric diagnoses are fabricated and said that we could play with these options and consider what they do for me. Again, collaborative reterritorialization, without imposing a new transcendent order of what 'I definitely am.'

July 12, 2023: Autotheoretical comment

What does the Oedipus complex stuff do? When it helps connect childhood power dynamics to current things, it is useful. When it obscures social structure in psychotherapy, not useful … the field of immanence necessitates asking what something does, not if it's right/wrong/good/bad.

5.2.3 Reflections on DBT

DBT is still one of the main go-to treatments for 'BPD,' along with off-label psychotropic medication. It is not within the scope of this thesis to go into the history and details of DBT but want to highlight a few tension points that have come up in my own experience getting taught DBT (notably, through a short-term, manualized approach, rather than the intensive group and individualized treatment program that Marsha Linehan originally called for). The first thing we might ask is what produces the proliferation of DBT programs, randomized control trials for DBT, and calls to expand access to DBT treatment around the world. Individuals and corporations profit and benefit from psychiatric treatment and research. Second, we can be critical about the research on DBT: who is diagnosed with 'BPD,' and who gets recruited into studies? Which populations does DBT help, and which does it not resonate with at all? Who will react to its co-option and whitewashing of Eastern spiritual practices? What systems benefit from teaching emotion regulation and interpersonal effectiveness in a highly individualistic and Western way? In a recent conversation we had, social worker Sam Leibel shared how the notion of emotion regulation (a core element of DBT) often serves to regulate, control, and invalidate marginalized populations.[83] Sam suggested that we need a DBT that is not just biosocial (Linehan 1993) or bio-psycho-social, but that is also structural – that contains an analysis of the political, and the conditions we are made to live in. I elaborate on this important suggestion by way of two recent anecdotes from my own therapy.

[83] Personal communication, January 4, 2023.

The other week, I learned a DBT exercise called “check the facts.” My main point with this example is to highlight the ways in which therapeutic language, particularly around ‘emotion regulation’ can get used to validate and redirect distressing emotions but can also be used by external parties to determine what thoughts, feelings, and behaviors are valid and which ones are not. The external parties can include therapists and clinicians, as well as the media, politicians, and broader public discourse that uses the language of ‘mental health’ to validate or dismiss certain behaviors, based on their socio-political utility.

In using “check the facts,” we are meant to see if our emotion was a valid response – if it lines up with what the emotion is biologically meant to respond to. For example, if I am angry, I might consider what happened and see if an injustice occurred, because anger is a response to injustice (see Chapman and Gratz 2015; Potter 2009). If I look at the triggering event and instead find something that produced shame, I can realize that anger is a secondary emotion (perhaps I am angry that I am feeling ashamed). I can recalibrate and realize that I am feeling shame and respond accordingly (turn towards people and be vulnerable, rather than isolate). However, if an injustice did occur, then my anger is apt, and I can ask myself if the intensity of my anger “fits the facts.” Throughout the examples given in therapy, there seemed to be an assumption that sometimes our emotions fit the facts and sometimes they do not; this was for the group to discuss and decide. Though this therapy focuses more on validating one’s emotions, “checking [actual] facts” is a key component of cognitive behavioral therapy (CBT), another first line treatment for ‘BPD’ and key component of DBT.

I do understand the utility of this specific tool for understanding and validating my own emotions and I acknowledge that when I asked what happens when other people are the ones in/validating our emotional responses because they have a different interpretation, that the therapist basically implied that checking the facts is for you only (if, of course, we can validate our own responses). This implies that DBT’s “check the facts” strategy can only be used for internal calibration of what something is in response to, or might do; however, when it becomes a tool for external in/validation, as it often does, it is clear how structural disparities, invalidation, and gaslighting can occur (as is certainly the case with CBT). There is so much power in determining for (or even with) someone else whether their emotions fit the facts that I am not sure about the utility of some of these tools in therapeutic practice. Imagine the number of times someone has a “perceived injustice” that the therapist does not think fits the facts or deems minor compared to

the person's affective response.[84] We can see how differences in life experiences or structural analyses can exacerbate this. The implication for this, then, is that therapists do not really get to determine if an emotion is valid or not, counterproductive or not, or inflated or not, because they cannot see the facts from another person's perspective; they can never have the full story, interpersonally or socio-politically.

There are clearly implications for clinical practice here and the problem with invalidating structurally marginalized people's emotional responses (a phenomenon that is widely discussed online, in pop culture, and in the literature) (see Johnson 2015; Redikopp 2018).[85] However, the perhaps more harmful part of this is the way in which therapeutic language gets taken up in popular discourse for certain political ends. Unfortunately, external in/validation occurs often; "check the facts," among other forms of 'therapy talk' seems to be a go-to response amongst politicians, the media, and clinicians alike when someone responds emotionally to something that the observer might not (or refuses to) understand. The Death Panel podcast (2024), for example, discussed Aaron Bushnell's self-immolation for Palestine. In this episode, host Beatrice Adler-Bolton and guest Stefanie Lyn Kaufman-Mthimkhulu remarked how in the name of 'mental health awareness,' many people in the media were denouncing Bushnell's suicide as a 'maladaptive' response that we should invalidate, indicative of his 'pathology' and thus invalid view of and response to events in the world. This of course, through the Western media, served to invalidate the injustice that Bushnell's suicide was in response to – the American funding of Israel's genocide against Palestine (Albanese 2024; Government of South Africa 2023; International Court of Justice 2024). We can see here how the language of emotion regulation gets used discursively to dismiss certain deterritorializing gestures as either invalid or counterproductive. Following Chapter Three, one might even label Bushnell's suicide as an "empty BwO;" he did in fact kill himself. This, however, assumes that he is the individual unit of analysis. What if we asked what ends it served? Perhaps he constructed a full BwO towards the liberation of Palestine; his suicide was a forceful event that pushed some to reconsider their perspective on the matter. I do not want to spend too much time on Bushnell as a "martyr," given that forty thousand Palestinian people have been murdered, and

[84] Eduan Breedt spoke to me about the measuring of "perceived injustice" amongst clients in physiotherapy. This measure is used to predict therapeutic outcomes and determine therapeutic approaches (personal communication, February 13, 2024).

[85] For clinicians challenging this narrative, see, for example, Patricia (@pat.radical.therapist). 2024. Instagram, March 28. https://www.instagram.com/p/C5D5RBGO7K5/.

they, I assume, were the focus of his act. I use this example simply to highlight the limitations of DBT, and to call for, as Sam does, a structurally informed DBT.

Here is another anecdote. I am currently in a mindfulness course that is part of a larger DBT group therapy module. I have been impressed by one of the practitioner's engagements with the social and political in this module, and still wish we could have more. I missed one week of therapy, and when I returned, the practitioner wanted to address someone's concerns from the previous session about the notion of "acceptance," where acceptance can often sound like a lesson to accept harm, injustice, and mistreatment. Although acceptance is a popular and highly effective component of mindfulness (in its various modalities around the world), invoking acceptance can often sound like saying, or be used to say, "do not try to change anything. Accept that we live in a violent, unjust world. Accept your exploitation, accept genocide, accept the climate crisis, and so on." The provider made an incredibly useful distinction between acceptance and *approval,* using the Civil Rights Movement in the United States to elaborate on their point. Their point was that acceptance can propel action, and that action and change often come from acceptance of reality, rather than denial. In their example, they discussed how activists throughout the movement had to accept – not deny or overlook – the fact that the federal government was not enforcing African Americans' equal rights under the law, and that many individuals, businesses, and communities were going to continue to discriminate against them. This acceptance allowed them to then take action, through sit-ins, boycotts, voting campaigns, and more. Later in the movement, other activists accepted that certain nonviolent tactics were not necessarily working, and thus acted with more militant approaches (such as the Black Panther Party for self-defense). Again, rather than continuing to try to appeal to white people or the government's benevolence, these activists accepted that the state was not set up to treat them well, and thus sought alternatives. Although I may trouble some of this practitioners' analysis if I were to re-examine some aspects of these movements more in-depth, I found it quite notable that he used a political example to highlight that acceptance of reality does not mean approval; in fact, acceptance means and often requires disapproval and thus change. I have seldom heard a clinician invoke anything having to do with inequality, race, racism, politics, or activism, and I find it troubling how rare these discussions are. This is not to say that this is not occurring; in fact, many therapists of color that I follow on social

media frequently invoke analyses of capitalism and systemic racism in their therapy talk.[86] I suppose the implication of this story is to highlight that it is likely still rare for therapists – particularly white elite therapists – to invoke the political and connect an individual's or groups' struggles with the world beyond their own individual emotions and behaviors. This has been the case throughout group DBT therapy for me, in cognitive behavioral therapy (CBT) programs I have been in, and in intensive outpatient programs that use a variety of approaches. Clinicians that focus so much on individual emotion regulation, fact-checking, mindfulness, acceptance, distress tolerance, and more could learn from this practitioner who connected individual coping skills, practices, and hardships to the broader world – the world that we live in, are all differentially affected by, and that shapes our experiences of distress much more than we give it credit for in individualistic Western therapies like DBT.

To circle back to my main calls for micro- and macro- political engagement amongst clinicians, therapists and therapy programs can and should integrate political analyses of the systems that rightfully cause so many of our feelings and behaviors, rather than focusing on our 'maladaptive' behaviors that *they* have decided are maladaptive. See, for example, Sam's suggestion for a structural-bio-psycho-social DBT, or Sostar's (2021) community project on creating a justice-informed DBT: "We want to create an accessible DBT resource that is informed your deeply held values of disability justice rather than ableism, decolonization rather than colonialism, collective action rather than individualism, and neurodiversity rather than pathology." Further to this is the importance of community-based and culturally specific modalities that ground us in our ancestry, land, spirituality, culture, and tradition, so much of which has been stolen by colonialism and replaced with inadequate psychotherapies like DBT (for examples, see Armstrong 2016; Haami 2024; Mamea 2016; Niania and Bush 2018). I conclude this section, again, through the advice of the 'BPD' Superpowers group (Sostar, Thomas, and Nault 2020:39):

- Think about what you were taught about BPD in your professional education. What is the story of this community, of us as individuals, that you received?
- Interrogate what you have been taught or told about what it means to live with BPD experiences. If you find that, on reflection, you have received a story of BPD that is informed more by stigma and ableism than by a trauma-informed and community-inclusive awareness, be willing to challenge it.
    - Who does the narrative serve, and what are the potential outcomes of the narrative?

[86] See again, Patricia (@pat.radical.therapist). 2024. Instagram. https://www.instagram.com/pat.radical.therapist/.

    - What, and who, is being supported in this narrative? What, and who, is being diminished?
    - Where is the problem being located?
- What are the structures of accountability within your professional relationships with people who identify with (or have been labeled as) BPD? How do you check back in with us to make sure your service has been supportive?
- Collaborating with us is a significant part of being supportive and in solidarity. Ask us what we need, what we know about our own experience and our context.
- How are you practicing in trauma-informed ways, and with a focus on justice-doing in your work?
- As service providers, you have the power to facilitate or to deny us help, to make notes in our files that will be with us for years (and these notes can be either a help or a harm), to perpetuate ableism and injustice or to challenge it. If you want to support us and countless others you work with, you have an obligation to challenge stigma and ableism in your profession, and to stand in solidarity with our community and with other communities that experience oppression. (Points added for clarity)

5.3 Reflections on Psychocentric 'Mental Health' Advocacy

As I have hopefully made clear, psychocentric advocacy campaigns and influencers could benefit from a Mad Studies approach. As several Mad scholars have pointed out (Fey and Mills 2021; Tam 2012; White and Pike 2013), mainstream mental health campaigns, whether in the form of advocacy, destigmatization, or awareness building by clinicians and service users, tend to reify the psychiatric lens of mental distress and difference.

July 2, 2023: Autoethnographic comment on social media
All this mental health education and at least awareness and maybe destigmatization online is maybe better than stigma and all, but wow, still treating them all as disorders, lacks, pathologies, and looking at behaviors and causes. Need an ethology: what do they do? What does categorizing them do? What does teaching about these, in this way, do? Etc. etc. Psychologists online are annoying me…I am frustrated and angry. Why can you be so inattentive to how you're depicting madness and neurodivergence, even as you're claiming to educate (or is that how it started, and now you just make money by saying random stuff you learned in your training? Huh? Probably that. Because everything is captured and commodified. Tired of this).

July 12, 2023: Autoethnographic comment
This makes me think about the utility of flipping patient-centered research on its head – putting people in control of their labels *and* taking responsibility for their complicity in privileging (i.e. all the thin white women on social media talking about borderline …. Look at your advantages, not just your hurts. Think about the consequences, what something does …

as Kim Smith once said, "what type of world are you/we building through this?" What ends are we serving?

For these campaigns, the problem supposedly lies with stigma and lack of education, not with the broader structures that are producing mental distress or with biomedical and punitive approaches to distress and difference. What seems most useful to me (and for Mad Studies) would be for us to first name and locate the problem where it is – with the socio-political structures that (interacting with genetics and neurobiology) produce mental distress, that pathologize mental difference or deviance, and that respond inadequately and disproportionately to these differences across populations. Locating the problem with not just psychiatry, but with settler colonialism, racial capitalism, and European humanist notions of how the mind should be, would be a first step to adequately addressing the problems that compel us to advocate for people with psychiatric diagnoses. As Lou Tam (2012) writes in response to the Ontario Federation of Community Mental Health and Addiction Program's (2009) campaigns, their advocacy not only fails to address root problems, but places responsibility on individuals to better advocate within the health system that has and continues to be places of violence for racialized populations. Tam (2012) writes that the report

> assumes that equity involves transforming the self and feeling good as opposed to acknowledging and resisting ongoing systemic violence [...] what are the consequences of these thoughts and interventions? What kinds of knowledge or experience are written out of the 'reality' of racialized people's encounters with mental health as an institution? (P. xviii)

We can also learn from Jackie Wang's (2012:n.p.) analysis of how domestic violence supports, which are often caught up in the punitive and racializing criminal justice system, neglect to reach out to communities of color:

> [W]e should be careful when noting the widespread neglect of the most vulnerable populations by police, the legal system, and social institutions — to assume that the primary problem is 'neglect' implies that these apparatuses are neutral, that their role is to protect us, and that they are merely doing a bad job. On the contrary, their purpose is to maintain the social order, protect white people, and defend private property. If these intuitions are violent themselves, then expanding their jurisdiction will not help us, especially while racism and patriarchy endures. (see also Karera 2019)

We thus must ask what ends we are serving, not only who benefits; mere inclusion in a violent system does not solve these disparities, but only exacerbates them. Most advocacy and

destigmatizing campaigns are focused on rights, which as I have discussed, tend to benefit an elite few, while propping up the nation state – whether through narratives of exceptionalism, the ascendancy of whiteness, profiteering off cycles of debilitation and capacitation, or the recruitment of 'acceptable others' into the folds of citizenship. Rights based interventions are likely to capacitate those that have access to statehood, citizenship rights, healthcare, self-advocacy, and racial and economic advantage. Those that are most likely to be capacitated by social media campaigns are white, globally elite people, who can see themselves in these campaigns and are often much safer to turn to the healthcare system for support, as these campaigns advocate for. That is, mental health awareness campaigns have differential effects, because they capacitate certain populations, and debilitate, *and* they obscure the debilitation of other populations. Further, however, the ends these campaigns serve are often the ends of greater profit from psychotropic medications, advertising, the psychiatric industrial complex, the therapy industry, and the reification of European humanist notions of normal and abnormal; thus, the inclusion of some relies on the further debilitation of others, while retaining the notion of 'disorder' and 'pathology' and painting people as deficits rather than having unique experiences and contributions to offer.

In short, clinicians that do advocacy on social media or through more conventional approaches can be wary about the transcendent ways in which they are depicting and educating about 'mental health.' Rather than depicting the DSM's criteria as the truth, they can contextualize these diagnoses within the context of Western psychiatry. There are certainly other approaches and conceptualizations out there, and both clinicians and service users – usually white, Western ones – tend to universalize their psychoeducation and advice about different conditions as if these conditions 'exist in nature,' are stable, knowable, and must be responded to with medication or Western psychotherapy. Consider which institutions – your own included – that are benefiting from advocacy for treatment and diagnosis, and how this can be a neocolonial project, as well as one that accelerates the "modulating and tweaking" of debilitation and capacitation of populations around the world (Puar 2017). Service users can ask themselves similar questions in their advocacy. Who benefits from your discourse, and what systems are you propping up? What experiences are erased, and <u>again</u>, what systems are you serving in the name of awareness or 'sharing your experience?'

Finally, all this analysis can be applied to global mental health campaigns, advocacy, and research. As several Mad and Mad-allied scholars have shown, expanding psychiatry's research

globally bolsters profit and Euro-American control over minds and bodies (Beresford and Russo 2023; Eromosele 2020; Howell 2011; Mills 2013). Although the view of 'mental illness' as a social construction has gained steam, particularly in Western contexts, people and places experiencing ongoing colonization, including in Turtle Island, are still advocating to be humanized, to be treated rather than criminalized, to have access to health services, and for their own healing practices to be validated (Eromosele 2020; Muhammad 2010).

5.4 Linking Psychocentric and Mad Activism Through the Politics of Innocence

The other narrative I want to touch on with these movements applies to Mad movements as well, and that is the politics of innocence, which is closely related to the "politics of injury" (Wang 2012) or starting from one's own "self-subalternization" rather than advantages (Puar, in CLAGS 2013). Where Mad activism and psychocentric activism overlap with regards to innocence is in rhetoric about trauma (and trauma as white property – as in, property used to justify one's innocence and turn away from responsibility). Both psychocentric and Mad advocates have been increasingly calling for trauma-informed analyses and approaches. Their respective approaches are quite different, in that psychocentric discourse tends to focus on trauma or trauma responses as a pathology needing to be fixed, often under the label of post-traumatic stress 'disorder.' Mad scholars and activists, on the other hand, value the adaptive knowledge of our bodies' trauma responses, locating the problem with pathologization and the socio-political and interpersonal conditions that produce harm (Eales and Fawaz 2023). Still, both often advocate for the acknowledgment of trauma and for trauma-informed practice, which is an important intervention so long as it is not used to bifurcate political responsibility and appeal to the politics of guilt and innocence: "When people use safe space language to call out people in activist spaces, the one wielding the language is framed as innocent, and may even amplify or politicize their presumed innocence" (Wang 2012:n.p.).

On the psychocentric side, so much of the discourse online is focused on childhood trauma and C-PTSD, which is often defined as originating in childhood. There is little mention of the role of socio-political structures like racism and poverty, and again, white women get foregrounded in these analyses. Elite white women of course do experience childhood trauma and domestic violence, but these experiences are highlighted while others are not – nor are the capacitating mechanisms of white elite womanhood. While discourses on C-PTSD versus borderline, for example, or trauma as a whole, can importantly validate women and gender minorities' responses

to mistreatment, we can also see how these discourses can capacitate white people as victims, often as a form of innocence that takes away accountability for our roles in racial, economic, and nativist harm. Furthermore, these discourses often depict a perpetrator in a punitive way, suggesting that one's parents or ex-partners are inherently bad, evil, or narcissistic: "The invocation of personal security and safety presses on our affective and emotional registers and can thus be manipulated to justify everything from racial profiling to war" (Wang 2012:n.p.). This uplifts a Western, colonial approach to trauma and harm, rather than, for example, a transformative or restorative justice approach that acknowledges dehumanization, and values the humanity and differential needs of both or all parties involved (Brown 2020).[87] While the Mad approach is more affirming of traumatic affect and centers non-punitive responses to harm, there is still a discourse of innocence, victimhood, and harm – particularly amongst globally elite, white Mad folks – that, when uncoupled from an accountable analysis of one's capacitation (and capacitation on the backs of other people), reifies those who can be made innocent by these narratives, and those who will not be. When the focus of trauma-informed practice is on preventing or responding to harm, but only one or a few people get to name what this harm is, for a variety of reasons, then 'safe space' and 'trauma-informed' language can be used as a mechanism for innocence, rather than accountability. While people are not necessarily outrightly calling themselves innocent, the plethora of globally elite people focusing on their own trauma, with little recognition of their participation in global power structures or of diverse experiences of these forms of trauma, suggests that something more is going on than a simple analysis that white women mainly benefit from and are depicted in these important discourses. When white, particularly white feminist, narratives of trauma are not coupled with responsibility and accountability, they seem to reify the long-standing imaginary of white women as innocent. A main undercurrent of this thesis, I want to make clear, is not just "who is left out of the conversation," or the differential effects of various campaigns. I also want to discuss how, in a society of control, we, as white elites, are also capacitated by these discourses, even if we are harmed by various structures of power. Across social media and even the intersectional literature on borderline and madness, there is a dearth of acknowledgment of white capacitation and how (and the white supremacist nation) benefit from these discourses based on our injuries (Peers 2015). As Jasbir Puar (in CLAGS 2013) states, "can

[87] We could draw, for example, from critiques of the punitive nature of the white version of the #MeToo movement when thinking about our conversations about borderline and complex PTSD (see Hamid 2020).

we start from implication, and then go, now what?" Finally, narratives focused on harm and innocence, and not also accountability, bypass possibilities for collective action and resistance (Butler, Gambetti, and Sabsay 2016).

5.5 Reflections on Mad Studies and Mad Activism

> "There is more than one way, as it turns out, to be a borderline defender, depending on what one wishes to defend borderlines from" (Johnson 2021:646).

5.5.1 Context specific analysis

I do not have much more to say about Mad Studies and Mad activism aside from what has already been by other scholars, in particular, those who came together to write the Mad People of Color Manifesto:

- Stop asking us to educate you about racism, and then ignoring or contradicting us when we do.
- Stop basing your ideas about a collective Mad identity on the dominant culture.
- Stop presenting the white Mad movement as a culture to be celebrated as part of Canada's multiculturalism.
- Stop saying things like 'even people in prisons have it better than we do.' Some of us experience both.
- Make anti-racism and anti-oppression training a priority, especially for consumer/survivor organizations.
- If you want us to educate you, pay us.
- Acknowledge your racism and take action to end it.
- Ask yourself whether your goal as a Mad activist is to regain the white middle-class privilege you lost when you were psychiatrized.
- Ask sincere questions, and then listen to the answers.
- If you are wondering if psychiatry is like colonization, ask someone who has experienced both! If you want to know if the hospital is worse than prison, ask someone who has experienced both!
- Stop pretending you've never heard these criticisms before.
- Stop pretending our work doesn't matter.
- Stop pretending you've never heard of us.
- Stop pretending we don't exist.
- Stop appropriating anti-racist struggles (Gorman et al. 2013:n.p., points added for clarity).

White Mad scholars, myself included, need to take these calls seriously, and to bolster an anti-racist Mad critique, because the two cannot be separated (see Eromosele 2020; Gorman 2013; Redikopp 2021; Tam 2013, 2017, 2023; Peers 2015). Instead of starting from our own experiences of injury, we can start from complicity and implication in these harmful systems, and go from there (Puar, in CLAGS 2013). Furthermore, Mad scholars in the West – particularly white ones – should be careful not to universalize our accounts of madness, psychiatry, or make transcendent their

supposed solutions and concepts. As Helen Meekosha (2011:678) writes with regards to disability studies, "One immediate task is to be conscious about the lack of geopolitical specificity in disability [and Mad] studies and acknowledge the issues of access and exclusion inherent in the universalizing tendencies of the discipline" (see also Puar 2017:84).

One insidious example of this is Beresford and Rose's (2023) call for Mad Studies utility for launching a critique against *The Lancet's* call for "mental health for all." They write that there is great "significance" for Mad Studies in the 'Global South,' given Mad Studies' ability to "see the relations of madness with society, its Maddening effects, as well as the interconnections of 'mental health' with colonization" (Beresford and Rose 2023:5). My question is, however, why do we need to export a "Western response to the West's problems" to the 'Global South,' where critiques of colonization (psychiatrization is just one part of this) have been ongoing for centuries (Miller 2018:314). Beresford and Rose (2023:5) continue, saying that there are similarities between mental health service users and colonized populations. While they write that they are "not suggesting [they] are the equivalent," this relay is problematic in itself; it ignores those that have experienced both, and that psychiatry has been a primary project for racial and social control, both within the 'Global North,' and in its exportations to the 'Global South.' The Global South does not need Mad Studies' "helpful lens and force for change," but perhaps the other way around (Beresford and Rose 2023:5); after all, those whose primary focus is survival are launching a critique against colonial rule, not the albeit harmful medical model of psychiatry (Eromosele 2020; Meekosha 2011; Puar 2017). Perhaps Mad Studies and activism should simply join decolonizing and anti-colonial movements: "It's not an inclusion that we're asking for. It's a shifting the models of what you're talking about to a different center which is 80% of the world's disabled people," and towards decolonization (Puar, in Adler-Bolton et al. 2023). I offer most of the rest of this section by way of reflection on these questions: Can we produce a white Mad movement that is towards anti-imperial, anti-colonial, and anti-racist ends, which will then do enormous things for combatting sanism and psychiatric harm? I say white Mad movement, because Mad people of color have long intricately connected (not equated) the struggles against psychiatrization with the struggles against racism; white Mad scholars have not.

5.5.2 Reflections on anti-sanism and anti-empire

> "We cannot solidify our good intentions without substantive indigenous-led, anti-colonial action" (Fawaz and Peers 2022:174).

These critiques of identity-based movements like Mad Studies is not to ignore every important intersection besides race, but to turn towards empire; as Jasbir Puar says (in Adler-Bolton et al. 2023), there has not been sufficient analyses of Euro-American empire and its ongoingness in all of our critical theory: "Disability studies without, you know, tackling this [US empire, empire, imperialism, and settler colonialism more broadly] becomes a kind of handmaiden to U.S. Empire," where the U.S. is creating disability at the same time that it (and its corporate sponsors) are uplifting "northern disabled subjects and subjectivities" (Puar, in Adler-Bolton and Gill-Peterson 2022). The frustration, I outline in this section, mainly by way of reflection, is the proliferation of turning towards our, and our groups' oppression, *as white folks and global elites*, without also towards empire, with empire being the ways in which Euro-American imperialism, settler colonialism, and chattel slavery, along with the proliferation of global neoliberal and racial capitalism particularly target, extract from, debilitate, and kill racialized people in the 'north' and 'south.' The frustration has continuously been, *why am I even talking about borderline?* I highlight this frustration through several autotheoretical reflections on borderline and empire, but first want to know that my turning towards macro-political analyses of empire are also caught up in a different type of removal of accountability and responsibility. While I have been grappling with the role of academia in producing extractivist, damage-centered research and the important role of feminist autotheory, I am also caught up in the safety of "self-subalternization" that comes with my diagnoses and experiences, even if this thesis started in complex response to this. Moreover, I am *still* caught up in the politics of innocence; shifting this thesis towards a more macro-political rant also removes me in part from the difficult and messy micro-political conversations about what we do in community: "We are not the Hero of this story. Nor of our histories. This is not a happily-ever-after story. Not in our lifetimes" (Fawaz and Peers 2022:173). These are questions for me to grapple with in terms of my research and the rest of my life, but notably, complicity and an inability to see things outside of my own white elite subjectivity run throughout this thesis and thus its limitations.

January 11, 2024: Autotheoretical rant on empire and borderline
I have spent two years thinking about borderline, madness, and feeling so much internal resistance to my work. Yes, I suffer, and yes borderlines suffer. I hate *hate* how people are treated. *Particularly* structurally precaritized borderlines – how the criminalization, surveillance, and pathologization of unhoused, trans, sex worker, Indigenous, racialized, migrant, substance-using folks are treated when they 'present as borderline' or have the 'BPD'

diagnosis. All of this is embedded in empire, and is how empire operates through psychopolitics, social control, confinement, extraction, debilitation, and more. Perhaps this is thus an invitation to focus our efforts against empire instead of sanism. Or a focus on empire *through* madness and anti-sanism (echoing others who have said this for a long time). As discussed before, we all perceive empire through different lenses, and I wonder what this means for our movements. What lenses do we use, what do we focus on, how do we build solidarity, where do we prioritize difference, where do we prioritize solidarity? Who are we (I) rooting for? Where are we (I) focusing our energies? Who are we (I) accountable to? Can we talk about both affirming difference – like 'borderline' ways of knowing' – *and* preventing the debilitation, slaughter, maiming, and extraction of people for imperial profit?

I am not sure that I think that Mad Studies should not exist; these movements and specific critiques of how state power harms people have brought a whole lot of important and necessary and lifesaving change. Still, Mad Studies has such little potential as a solidarity movement if it's not about Empire, including how Empire shapes psychiatrization and mental distress or debilitation. What is the utility of a Mad analysis, if we are not also calling out empire and its evolving mechanisms? The (white) Mad movement should thus not simply be "allied with" other anti-oppressive movements, but have its starting point be a critique of empire, racial capitalism, and (settler) colonialism: "Movements need to be intersectional, says Angela Davis, and the rapid uptake of this seasoned observation is invigorating and hopeful. This invocation of intersectional movements should not leave us intact with ally models but rather create new assemblages of accountability" (Puar 2017:xxii).

August 4, 2023: Autotheoretical reflections on mobilizing as white borderlines(?)

"There are clearly important differences between politics grounded in shared ideological commitments—such as antiwar, health-care reform, environmental, or socialist movements—and movements designed to secure rights for a group that has in common a given identity" (Mollow 2004:n.p.).

Imagine all the white BPD girls on Tik Tok had to contextualize their experience within their own family history, social positionality, but still totally validated themselves and their experiences, and had to make some political accountability. Something about valuing and drawing on their sense of injustice or lack of identity or even anger to do something with. Use it towards ends that psychiatry doesn't want you to use it towards. Take it, use it as a tool, borderline some systems, fuck some systems up. Value your 'disorder' while also seeking treatment (in whatever form) if you want. And we could mobilize politically around borderline (Think Emotions Matter) and all the other political injustices causing distress and discrimination.

5.5.3 Prevention and the medical model

"Although the rehabilitation model and the notion of a cure threaten to eradicate the unique cultures of people with disabilities, there would seem to be no ethical reason for studying debility or structural oppression, aside from wanting to end it" (Hsu 2019:83).

So, what are we trying to prevent? The ethologies in Chapter Three have shown that asking what certain 'traits' *do* can give us insight into how borderlining can be in response and resistance to oppression and the trauma it causes; at the same time, as we learn from Mad Studies, what does it do to imply that various types of trauma *cause* 'BPD' or some borderline traits? Should borderline be prevented? Or, as Tiffany Sostar suggests, can we prevent the trauma and distress caused by 1) structural oppression, 2) the accompanied psychiatric violence, and 3) the accompanied invalidation of borderline (and other non-normative) affects and worldviews?[88] Again, we can de-pathologize neuro- and physical- diversity from European humanist conceptualizations of the self, while preventing widespread corporate and state violence. We need not pathologize, but yes, we must prevent debilitation by imperial violence: "The prevention of impairments as social products on a global scale as a result of, for example, war and environmental pollution, calls for a global perspective by disability scholars that specifically incorporates the role of the global North in 'disabling' the global South" (Meekosha 2011:668). Sometimes this acknowledgement may require pathologizing language, diagnoses, or discourse so that we can adequately call out harm (Eromosele 2020:16; see also Meekosha 2011; Puar 2017).[89]

Mad Studies, at times, critiques psychiatry for its pathologizing discourse, and does not pay adequate attention to the causes of mental distress or chronic debilitation. Other movements, such as public health, pay attention (though inadequately) to structural causes, but continue to pathologize any sign of non-normativity. Psychiatric diagnoses are not all social construction; they are institutionally and socially constructed labels and categories, but they are also socially and materially productive, and thus with vast consequences. They also map onto *some* material realities; people also do experience suffering and distress; they also experience being "different," which should not be a disorder. This is not about reifying the medical, but also not about obscuring

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[88] Personal communication, November 27, 2023.

[89] Again, I bring us back to the discussion on pathologization coursing throughout, in Chapter Three's section on identity disturbance, and Chapter Four's section on psychological debilitation. I also remind of my several nods to Francesca Lewis' (personal communication, May 4, 2024) insights into the importance of valuing borderline knowledges (perhaps without glamorizing them as superpowers), while accounting for and preventing the distress that can be described as borderline (a point that the reference to borderline's inaccuracy or social construction often misses). She remarked on another interesting trend going on with regards to borderline and trauma, that I want to highlight here. While there is a depathologizing discourse that many Mad experiences are "rational," "expected" or "reasonable" responses to an "irrational world," there is perhaps value in sticking to the irrationality and abjectness of the responses we have to trauma. While traumatic affect results from our body's wise defense systems working the way they ought to, it is *wrong*, and entirely *unreasonable* that we need to rely on these responses, and that specific populations are made to bear the brunt of these painful, if insightful, experiences because of the distribution and targeting of state and corporate violence.

what empire does to our bodies and minds. Empire produces pathology, and not in terms of any difference from a European humanist ableist norm, but empire produces vulnerability and suffering that we cannot ignore (while we also need to respond much differently). Empire creates the conditions for pathology, and we need to call this out (without denying agency and resistance). Certain populations are made materially and biologically vulnerable to physical and psychological debilitation, not only to being constructed as such.

When we say that oppression and marginalization produce distress, we should not bypass the biological in favor of some social thing 'out there.' Social phenomena have biochemical markers, and those biological markers do not invalidate their (geo)political or economic creation. Everything is material, and everything comes out in the form of neurobiological or chemical changes at the molecular and atomic level. In other words, let us not obscure that empire creates psychological vulnerability, but that our measures of vulnerability are inadequate (and paint populations as subhuman and unable to resist, rather than people who continuously contribute to their communities in the face of colonial violence (see Puar 2017 on the normative measure of 'stunting' used in statistics about Palestinians). Psychiatry is not necessarily wrong in saying that some medications can change some brain chemistry things and maybe make some of us feel better some of the time. Psychiatry has simply not gone far enough to see what is causing this suffering that medications can sometimes relieve – sometimes. Psychiatry has missed the boat on what exactly the material mechanisms are, and on how we treat, respond, and prevent them, and it is also consumed in imperial neoliberal logics of what is profitable: psychotropic medications and individualistic therapy, not the end to occupation and capitalism. Psychiatry has also pathologized non-normative (European humanist) forms of emotionality, *and* it has inadequately diagnosed, treated, and attributed cause for debilitation mental distress. The problem is with psychiatry either way, but perhaps that means that the problem is with empire, and how it has created, shaped, molded, and propagated psychiatry and related fields.

February 27, 2024: Autotheoretical reflection on bipolar 'disorder'
Affirming madness, but also, trauma of all types, including racism and poverty and violence, can all cause or induce or uncover bipolar (which I think is a 'thing,' as much as I'm critical of psychiatric constructs), and bipolar has a high rate of premature death as well as suicide … So do we affirm, or do we look at the bio- and necro- politics at play and the destruction of certain lives … Difference is okay, and yet we must acknowledge racializing predispositions to

psychiatric harm, incarceration, psychiatric drugs (which can cause obesity, heart issues, tardive dyskinesia, and more).

5.5.4 What could borderline galvanize?

"How, then, do we take such alienating and debilitating experiences and turn them outwards to politicize them?" (Frazer-Carrol 2023:2)

What can borderline galvanize? I conclude then with considerations about what borderline can galvanize (that is, how we can affirm borderline subjectivities and mobilize them as socio-political forces) and then a query that we abandon borderline and madness as sites that we mobilize around. I am first curious about what borderline can galvanize when we conceptualize borderline outside of the psychiatric frame of 'BPD,' as Mad scholars do so skillfully: "the borderline [is] someone who knows things, someone who can make meaning, and whose differences can have value beyond the clinical sphere" (Lewis 2023b:210; see Redikopp 2018; Johnson 2021). Perhaps in doing so, we make sense of the borderline subjectivity as an *intolerance of domination over bodies, minds, and communities*. Borderline is then an insightful, useful – and sometimes distressing – cluster of affects, as well as a *socio-political force* (Barlott and Turcotte 2022) that we can mobilize against psychiatric violence, settler colonialism, and racial capitalism. What might it do to conceptualize borderline as a socio-political force, that is, as a valuable way of being that can be mobilized through and against structural violence? How do we use borderline/madness politically, and should we? How do we build solidarity, and what are borderline and 'BPD' doing to this effort? These are particularly important questions for white elite borderliners to grapple with, for our solidarity should not start from a place of our own "self-subalternization," but of implication and solidarity. The following questions are also important for white elite borderlines, mental health advocates, and Mad activists.

5.5.5 What could debility galvanize? (Puar 2022)

I am also wondering what it would do to abandon borderline and madness as sites that we mobilize around. Drawing on Jasbir Puar's question "what can debility galvanize" I query if I am ready to "give up on Mad Studies" (Redikopp, 2021). What kind of solidarity could we build if we mobilized not by homogenizing ourselves, but by gathering around our differential relationships to debility under racial capitalism? As Eromosele (2020:16) writes, cautiously, "To constitute a politically viable collective, individuals must see themselves as sharing similar experiences which

in turn shape the demands they make of society." Puar (2017) suggests that debility might be a concept through which we can find solidarity, without homogenizing our differences:

> These movements may not represent the most appealing or desired versions of disability pride. But they are movements anchored, in fact, in the lived experiences of debilitation, implicitly contesting the right to maim, and imagining multiple futures where bodily capacities and debilities are embraced rather than weaponized. (P. xxiv)

What might it do to galvanize around debility, with and through strengths-based and affirmative approaches to these differences? Where do we flatten difference, and where do we emphasize it? Or rather, can we build solidarity against imperial debilitation without flattening difference?

Mobilizing around debility, as Puar notes, would not be about flattening difference, as many Mad, anti-capitalist, and post-anthropocentric scholars have done – the idea that we are all "equally f-ed." Frazer-Caroll (2023:5), for example, writes that "We must all 'dissociate' to some extent – smiling for our employers and crying about it in therapy; tolerating daily microaggressions and venting about it within our communities; exhaling when we arrive home and feel able to finally remove our mask. Few of us can safely and fully exist in this world, and the mental toll catches up with us." First, access to therapy and work reveals a certain geopolitical positionality. We all have a relationship with debilitation by living under neoliberal capitalism, but debility and its mechanisms, and thus our relationships to disability (and madness), are modulated across populations based on the population's supposed threat to and ability to be extracted from by the (neoliberal) state and its empire. There is thus a danger to universalizing all our experiences, especially since anti-capitalist critiques cannot account for "gratuitous anti-black violence" (Wang 2012:n.p.). Wang continues elsewhere, "There is a constant appeal to the 'universality of the status of pariah, of our status as pariah' as a way to flatten difference by saying we are all equally fucked, equally abject, and that even class differences don't matter or are meaningless under this new configuration of power" (Wang 2018:n.p., citing Tiqqun). In other words, we are all f–ed, but we are not equally f–ed (see Karera 2019). What if we could collectively mobilize against "global violence in all its forms" (Meekosha 2011:668), turn to non-Western approaches to difference and distress, *and* prioritize difference and heterogeneity where they matter. Mobilizing against debility can build solidarity, without producing a "coherent subject" or "homogenizing the unevenness" of assemblages of mental distress, madness, and psychological debilitation (as examples) (Puar, in CLAGS 2013).

Following Puar, I thus wonder what it would do to organize around assemblages of debility, being careful that our organizing does not mainly serve to capacitate elites, the state, or the corporation. Rather than saying it is ableist or sanist to suggest that colonialism and racial capitalism cause distress, we can mobilize against the system that produces this distress and that pathologizes difference through Eurocentric norms, where it is not only the disabled or Mad body that is deemed unworthy, but that "all colonized bodies are deemed unworthy and unfit and [disability justice] actively works through these tensions by valuing and prioritizing the knowledges that disabled people bring to the struggles to end ableist hate and imperial violence, rather than kind of reiterating this false binary, for example, constructed around Fanon's work" (Puar, in Adler-Bolton et al. 2023).

5.6 Theoretical and Methodological Implications and Limitations

I hope that this thesis has aided in the project of repoliticizing Deleuze, and has explained, or rather, shown, how a political ethological analysis might be done. I hope that I have both centered myself in writing, while also decentering the subject. That is, I am writing this, and our social locations and positionalities shape our work – what we include and exclude, and how. At the same time, this analysis is less about individual subjects and intersections of discrete identities than it is about assemblages of power, debility, capacity, affect, and possibility. I have not expanded enough on affect theory, notions of subjectivity, or how control operates through aggregates or dividuals, rather than individuals. I hope that this thesis has been a preliminary and rudimentary introduction to assemblages of debility and capacity, and that my doctoral work will expand more on these theories. I also have briefly critiqued predominantly white uses of Deleuzian theory (mainly through new materialism, posthumanism and affect theory) – particularly those that assume the "endless capacitation of life" (Puar 2017:20). Still, I have not adequately delved into each of these theoretical lineages. For more in-depth critiques, see: Buchanan 2020; Chen, 2016; Galloway 2013; Jackson 2021; Karera 2019; Puar 2017).

The other important context that I have not situated enough is accounting for societies of control and what that means for intersectional analyses. As I briefly introduced in Chapter Two, state and corporate power now oscillates between control and discipline, where control mechanisms are "disciplinary par excellence" (Puar 2017:57). The "toggling" between control and discipline, as Puar (2017:120) notes, acts upon individuals as well as dividuals, populations and aggregates of data, life events and "possibility of actions;" that is, it is an affective form of control

that exists alongside disciplinary forms of bodily control (see also Dixon-Román and Puar 2021; Han 2014; Read 2022). Future research could analyze all the above in the context of control and psychopolitics, where discourses on 'BPD' operate not only explicitly on our futures through disciplinary measures, but through our desires, interests, and what we consider possible. Control operates by limiting the futurity and life possibilities for certain populations, by asserting an endless capacity for adaptation and "living well" with our 'conditions' for others, while still making an anti-capitalist or anti-racist world seem impossible (see Breedt 2024; Galloway 2023):

> If the panopticon kept the prisoner controlled by creating in him or her an awareness of being watched, framing every possible action by its possible repercussions, then the mediated forms of control also act on actions by shaping a sense of what is possible or desirable [...] power becomes all the more pervasive, all the more effective, as it becomes all the more abstract, acting not directly on bodies but on ideas and thoughts, on the possibility for action. (Read 2020:22)

Chapter Four, in particular, could benefit from an analysis of control, where power becomes so insidious that it becomes "virtually indistinguishable from our own desires [....] it is harder and harder to know where control spots and we begin" (Read 2020:22). We can see how power operates through our motivations, that seem so intrinsic, to become influencers, advocates, and Mad scholars. Rather than taking our motivations for granted, we can examine how power operates diffusely through the affective and bodily potentials imbued in various movements, both psychocentric and Mad-affirmative. An analysis of the society of control would also help us to more adequately see how racial violence is operating today; while it still operates through direct bodily and land-based violence and extraction, it also operates through "prognosis [...] in which everyone is living and dying in relation to 'risk coding'" (Tam 2012:2, citing Puar 2009:165). Supposedly anti-racist tools like risk assessments that account for the social determinants of health end up siphoning populations through notions of financial and infrastructural risk: "[S]ome populations are regulated for disorderly behavior more than others regardless of whether or not they identify as disabled [...] Highly exploitable populations are exceptionally medicalized; emergent therapeutic modulations help constitute racial taxonomies" (Tam 2012:2, 5). This happens through implicit bias, say the discretionary decision of whether to put a differential diagnosis (BPD? BP? ADHD? Schizoaffective?) on someone's insurance file or not – a pattern that I have seen happen in racializing ways, and without informing the patient at all. Racializing taxonomies can also happen in automatic ways, such as the use of "no shows" in electronic records

to determine access to treatment, allowing for little analysis of why certain populations might "no show" or not feel comfortable to cancel their appointment in advance.

One other aspect I would want to address in future work is how to define and conduct the 'empirical' in ethological analysis. While I have mainly embarked on a theoretical and conceptual endeavor in this ethology, using my own reflections with theory and the world as my 'data,' other work could more empirically study how "affective and relational capacities" are debilitated and capacitated. I do not know entirely where I stand on the definition of the empirical and tend to reject any hint of post-positivist calls for empiricism; at the same time, rigor and accountability in our theory is important, lest we espouse our opinions with little analysis or political utility (see Latour 2004). I do not want my future ethologies to only come back to me, nor do I want to remove myself in the name of 'objectivity.' An ongoing question for Deleuzian ethology, then, is accounting for our subject locations and theoretical lineages, while drawing from the empirical – whether that empirical is numbers, theory, conversations, voices, critiques, or world events – to measure the utility and shortcomings of our analyses.

Finally, as I have only briefly mentioned throughout, this analysis has focused on the Western concept of borderline, a derivative from psychiatry's construction of 'borderline personality disorder.' As I have only rudimentarily mentioned throughout, this has perhaps been a misguided focus for this thesis, because it recenters Western notions of distress and difference. That is, again, this thesis may be of particular use to those who already have a relationship to the concept or label of borderline, and those who are giving it out. What I do not want it to do – though it will – is erase or obscure non-Western ways of conceptualizing and responding to distress, which I seek to uplift in my other work in the academic community. To conclude these limitations, I learn from Anzaldúa's calls, and an acknowledgment that this thesis is likely a distraction from this important call. I hope that throughout the chapters, it evolved to more adequately call out white supremacist and imperial violence, but would like my future work to more pointedly 1) trace state violence in white institutions, such as healthcare, and 2) uplift, fund, and support Indigenous, Black, and other racialized perspectives of health, healing, and well-being, and ultimately, sovereignty and self-determination over specific communities' health, with the rematriation of land to Indigenous peoples and to Africa central to these ends.

> Individually, but also as a racial entity, we need to voice our needs. We need to say to white society: We need you to accept the fact that Chicanos are different, to acknowledge your rejection and negation of us. We need you to own the fact that

> you looked upon us as less than human, that you stole our lands. We need you to make public restitution: to say that, to compensate for your own sense of defectiveness, you strive for power over us, you erase our history and our experience because it makes you feel guilty—you'd rather forget your brutish acts. To say you've split yourself from minority groups, that you disown us, that your dual consciousness splits off parts of yourself, transferring the 'negative' parts onto us. (Where there is persecution of minorities, there is shadow projection. Where there is violence and war, there is repression of shadow.) To say that you are afraid of us, that to put distance between us, you wear the mask of contempt. (Anzaldúa 1987:107-108)

5.7 Conclusion

5.7.1 Summary of the thesis

This thesis started by asking "what does borderline do," and evolved to ask more specifically, "what do assemblages of the 'BPD' diagnosis, 'BPD' reclamation, and borderline affirmation do, for whom, in which contexts and towards what ends?" This final chapter has served somewhat as a summary of the thesis, in that the conclusions and potential implications that I have come to have been in response to the main points in Chapters One through Four. Moreover, Chapters Four and Five almost serve as (tentative) conclusions in and of themselves, in that they have resulted from the ethological journey that I have mapped through this thesis. However, I do not want to overlook the important micro-political interventions made by Chapter Three, or that all these questions have come from that I outlined in Chapter One. Thus, to summarize, this thesis has addressed the following: 1) clinical, feminist, and Mad debates surrounding 'borderline personality disorder;' 2) how else we might approach these debates, and what other types of questions we might ask about borderlines, borderline experiences, 'BPD', and the borderline concept; 3) how we might move beyond pathologizing accounts of borderline 'traits' or 'symptoms' and value the ethical potential embedded within them, without denying the distress that they can cause; 4) the risks that come with any version of reclaiming, identifying with, or reconceptualizing borderline and 'BPD,' and 5) how we might bring more micro- and macro- political nuance into our clinical, advocacy, activist, and epistemological approaches to borderline, 'BPD,' and madness more broadly.

In Chapter One, I discussed the variety of factors that shaped why I chose this thesis topic, including: how people labeled as borderline were mistreated in the social service I worked for, the importance of these individual's affective responses to injustice at this organization, my own resonance with their responses, my theoretical interest in valuing borderline gestures from a Deleuzo-Guattarian perspective, my own evolving relationship with the borderline concept and

intersectionality, given how my whiteness and eliteness, among other things, seems to have interacted with my experiences. Chapter One also served as a literature review, wherein I outlined the degree to which borderline is a contested topic and diagnosis across a variety of fields. I also introduced a central tension to this thesis, which has been the relationship between intersectional analysis, elite co-option, and the affirmation or reclamation of subjugated knowledge.

Chapter Two outlined my theoretical and methodological approaches to this thesis, informed mainly by Deleuze and Guattari and Jasbir Puar. I introduced the concepts embedded in ethology, and the ways in which intersectional analysis is integral to ethology. As I have discussed throughout, I introduced ethology in Chapter Two, conducted two different ethologies in Chapter Three and Four, and also was practicing ethology throughout this thesis process – in developing it, conducting autotheoretical research, and in writing.

Chapter Three responded more to my initial theoretical ponderings about borderline: what it can do, or what else it might do, beyond how psychiatry conceptualizes it. Here, I used ethology and drew from Mad-affirmative scholarship on borderline to explore how we might go beyond our go-to, risk-based, and pathologizing interpretations of and responses to borderline 'traits.' I used Deleuze and Guattari's body-without-organs as an analytical tool through which to understand the debilitating, capacitating, and ethical potentials of affects, worldviews, and behaviors that are so often immediately ridiculed or shut down.

Chapter Four responded to the risks of affirming borderline knowledge, as well as the risks of reclaiming 'BPD,' where both phenomena seem to be happening amongst white, globally elite populations. Although I originally came in with a broad question about the intersectional risks of affirming borderline in Mad Studies, my advisory group helped me to piece apart that which is caught up with 'BPD' and the psychiatric framing of borderline, and that which is affirming borderline while refusing the psychiatric gaze. In Chapter Four, I used ethology to trace the various macro-political implications of each of these trends, as well as where they come together in the service of whiteness, capital, and Euro-American empire.

Finally, the various arguments in this thesis have implications for how we respond to borderline affects and worldviews, for how clinicians discuss the borderline concept with patients, for how we discuss prevention, and for how borderlines, particularly elite 'BPD' activists, might mobilize against debilitation and neo-colonial calls in global mental health agendas.

5.7.2 Concluding thoughts

I feel that I have concluded this thesis several times, at the end of each chapter, and in this chapter on implications – without ever reaching a final 'conclusion.' I thus finish this thesis with a reflection that I wrote while grappling with the relationship between Chapter Three and Chapter Four. In doing so, I remind of the value of ethological analysis, wherein we continuously ask what something is doing, rather than whether it is good or bad, right or wrong. Asking ethological questions, whether in micro-political encounters or in terms of macro-political implications, does not necessarily lead to conclusive answers, but to greater analysis, attentiveness, and accountability to implication and complicity. This thesis, and the concluding thought I share below, are but one example of how ethological analysis can play out – what it can do affectively, methodologically, theoretically, stylistically, and politically.

Borderline does not have to be doomed to the trope of the "crazy ex-girlfriend," but affirming borderline (through whatever lens) also cannot be separated from preventing the imperial psychological debilitation of certain populations – many of whom never get diagnosed, or only do so for corporate benefit. People who identify with or who have been identified as borderline deserve to be asked "what are your affects and worldviews doing," rather than being immediately pathologized. Elite borderlines like me perhaps deserve to imagine our futures, in ways that many of us will have struggled with throughout our lives. Yet, we must not forget that "to claim unfettered access to futurity is already predicated upon the genocide or slow death of others" (Puar 2017:149). Perhaps, then, as we collectively support and value each other through the debilitating pains and instructive affects of borderlining, we might become less concerned with access to a futurity caught up in the imaginaries of the neoliberal state, and more accountable to those whose futurity has always existed outside of *and* been foreclosed by this very system.

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APPENDIX ONE: REFERENCES FOR FIGURES 2-10

*Note: While ASA citation style calls for social media references to be placed in footnotes throughout the text, I have referred all footnotes to this appendix for greater clarity and readability. For each figure, I have listed the references as they appear from left to right and top to bottom in the image.

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