Nurture before Responsibility: Self-in-Relation Competence and Self-Harm

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Abstract:

Borderline personality disorder (BPD) is a disorder that affects mainly women and often manifests itself through self-injurious behaviour and suicide attempts. The perception that these patients are themselves to blame for their self-destructive behaviour is a common reaction when clinical practitioners are faced with this behaviour. Recent philosophical work has tried to reconceptualise the responsibility of personality disorder patients (i.e. Pickard's responsibility without blame). In this paper I problematise the focus on responsibility as a conceptual and therapeutic approach to deliberate self-injury in BPD. I suggest that this thin, content-neutral account of responsibility fails to properly consider the complex phenomenology of BPD selfhood and self-harm. Instead, I forward an alternative model based on a thick account of responsibility to examine in more detail the social formation of substantive content of the will. The paper explains how borderline is a disorder of the self-in-relation, which tracks the socialising, relational factors that contribute to the development of a dysfunctional BPD selfhood premised on self-punishment, self-abnegation, and self-loathing. Moreover, the framework lends itself to an alternative normative standpoint to self-harming behaviour in individuals with BPD which focuses on the therapeutic nurturance and validation of emotion and needs, prior to the treatment of individuals as responsible agents. I explore how such a standpoint is applied in Schema-Focused and Dialectical Behavioral Therapy treatments of BPD.

Key words: self-harm, Borderline Personality Disorder, responsibility, Dialectical Behavioral Therapy, Schema-Focused Therapy

I want to begin my paper with a case study:

> Anne was sexually and physically abused as a child and adolescent. Since an adolescent she has had episodes of engaging in self-injurious behaviour, where she repetitively cuts her arms with a knife or scissors, sometimes so seriously that she has had to go to A&E. She is relatively high-functioning as an individual, where her academic cleverness has enabled her to study for a Philosophy degree at a top university. Due to her history of deliberate self-injury, psychiatrists have diagnosed her with Borderline Personality Disorder. In moments of anger and emotional upset, like when her psychiatrist has seemed cold towards her or her session has stopped early, she reverts to cutting her arms.

Borderline personality disorder (BPD) is a disorder that affects largely women: 78% of those with the diagnosis are women; women between the ages of 16-34 are approximately 4.5 times more likely than men of the same demographic to be given the diagnosis (East Sussex Public Health Department 2013). In the US, 1.6% of the population has BPD, which means about four million people in the US alone have the disorder (NIMH). According to the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5), a 'personality disorder' is defined by enduring patterns of experience and behaviour in areas of (i) thinking; (ii) feeling; (iii) interpersonal relationships; and (iv) impulse control and emotional regulation. These patterns depart from cultural norms and expectations, they are pervasive and inflexible, and generate distress or impairment. More specifically, pathological personality traits in BPD involve impairments in self- and interpersonal functioning: impaired self-functioning revolve around problems of identity (i.e. poorly developed or unstable self-image that is often connected to excessive self-criticism, feelings of emptiness, and dissociative states) and self-direction (i.e. unstable goals, aspirations, and values). Impaired interpersonal functioning involves hypersensitivity and fears of abandonment and rejection. Together, these impairments are expressed in emotionally dysregulated, maladaptive behaviours, such as risky behaviour, repeated self-mutilation with non- and parasuicidal intent, and suicide attempts. The personal costs of PDs are significant: approximately 70% of people with BPD will make at least one suicide attempt throughout their life and about 10% of borderline patients commit suicide, a rate that is about 50 times higher than in the general population (Lieb et al 2004).

The diagnosis remains deeply controversial for numerous (and justifiable) reasons (Lewis et al 2009; Gritti et al 2016; Potter 2009), and despite the prevalence and seriousness of this disorder, these patients are often subject to negative, harsh, and derogatory attitudes in health services (Commons Treloar and Lewis 2008; Black et al 2011). Self-destructive behaviours, particularly around deliberate self-injury (which can include cutting, burning, banging, hitting)

contribute to the widespread stigmatisation, exclusion, and mistreatment of individuals with the diagnosis of BPD. As stated in a report by NIMH(E), these individuals have been called 'difficult, manipulative, bed-wasters or attention-seeking' – in short, they are 'the patients psychiatrists dislike' (NIHM(E) 2003, p. 2). The belief that borderline is untreatable and not a 'real' mental disorder – though changing slowly – remains entrenched in mental health services. Moreover, the perception that these patients are themselves to blame for their self-destructive behaviour characterises the views of some practitioners in certain clinical and psychiatric settings. Bowers states:

> When at large in the community [these people with personality disorder] cause problems for others through their antisocial and irresponsible conduct. Their incessant and contradictory demands upon health service resources (e.g. through repetitive suicidal gestures like overdoses) evoke negative reactions from all professions. […] Some psychiatric staff reject them completely, seeing them as 'psychological vampires' fully responsible for their behaviour, and appropriate cases for punishment rather than treatment (Bowers 2002, p. 2).

Such negative views of BPD individuals can be highly detrimental to their treatment. Recent philosophical work has tried to respond to these troubling attitudes amongst clinicians by conceptualising the responsibility of individuals with personality disorder. For example, Hanna Pickard (Pickard 2011) describes the rescue/blame dilemma, where clinicians have two impulses when faced with self-harming BPD individuals: on one hand, there is a strong impulse to hold BPD individuals morally culpable and blameworthy for their own self-destructive actions. On the other hand, there is the inclination to 'rescue' the BPD individual, treating them as passive victims. Pickard recommends an intermediate response between the two, positing that a framework of 'responsibility without blame' can treat individuals as personally capable of controlling and choosing their actions. Instead of the affective blame which can accompany attributions of responsibility, Pickard recommends that responsibility can utilise what she calls 'detached' blame which 'consists in judgments of blameworthiness' designed to influence subjective change by making BPD individual accountable and answerable for their actions that may also demand the imposition of negative consequences and limit-setting.

In this paper, I want to problematise the focus on responsibility as a conceptual and therapeutic approach to deliberate self-injury in borderline individuals. Firstly, it is not clear that such an approach properly understands the full phenomenology of self-harming behaviour in PD. Secondly, clinical responses focused on responsibility and accountability for self-harming behaviour tends to focus on the *action* rather than addressing important underlying non-intentional *causes* behind the action. Whether these acts can be considered voluntary behaviours is debatable once we consider more substantive conditions of responsibility which demand responsible agents

to *be* a certain way. This approach takes into account the oppressive socialising contexts which also illuminate ways in which self-harming borderline individuals lack the *self-in-relation* competence that is characteristic of an authentic, responsible self.[i] Relational support and affective engagement (rather than disengagement) will be needed if individuals are to build up this competence and meet the interpersonal expectations placed onto them.

The first section of the paper critically outlines Pickard's view of 'responsibility without blame'. In light of weaknesses of this model, I suggest in the second section that a more substantive model of responsibility is required to attend the complexities in the phenomenology of BPD self-harm, and particularly, the process of socialisation that forms and develops a competent self-in-relation. The final section illustrates these ideas generally underline the philosophy behind Schema-Focused and Dialectical Behavioural Therapy for borderline individuals.

Problems with Responsibility Without Blame

Deliberate self-injurious behaviour amongst those with borderline can be deeply distressing for those charged with providing them with care, often evoking strong reactive emotions in family members and clinicians. Psychiatric nurses reported in one study 'how angry and frustrated repeated cutting could make them. They also reported feeling distressed, traumatized and stressed by the sheer 'blood and gore' awful things they had to deal with, and by the high level of the patients' distressing emotions' (Bowers 2002, p. 53). Attributions of intentional behaviour and blameworthiness often accompany these reactive emotions – i.e. that the individual's self-injury is deliberately intended to manipulate and coerce others – which can lead to counterproductive therapeutic attitudes and punitive responses.

Pickard seeks to examine the cluster of ideas around this attribution of responsibility and blameworthiness, arguing for the philosophical and clinical importance of viewing individuals as responsible agents who have subjective control over their actions and choices. More importantly, Pickard suggests that viewing patients as responsible is a fundamental therapeutic mechanism to facilitate positive change regarding habitual responses to distress and strong affect. Self-injurious behaviours are not inherently morally harmful, thus confirming a common sense distinction between moral responsibility and responsibility for behaviour. Moral responsibility denotes some kind of moral fault, whereas responsibility for behaviour suggests that individuals with BPD have 'conscious knowledge of what they are doing, and can exercise choice and at least a degree of control over the behavior' (Pickard 2011, p. 215). Holding someone responsible involves treating them as though they can account and answer for their actions. Pickard gives examples asking service users to explain their choices, encouraging others ways of behaving, or the 'agreed imposition of negative consequences, to increase motivation, and show that the behavior, and the harm it causes, is taken seriously' (2011, p. 215).

This conceptual distinction between moral responsibility and responsibility for behaviour helps explain how a clinical stance of responsibility without blame is possible, in that answerability need not entail blaming responses. But in cases where blame might be attributable to a patient, Pickard articulates a further distinction between two types of blame: affective blame has features of entitlement (of the blamer), negative affect (a punishing mental state), and 'stings' the recipient of blame. Detached blame, by contrast, 'consists in judgments of blameworthiness, and may further involve correspondingly appropriate revisions of intentions, the imposition of negative consequences, and accountability and answerability' (Pickard 2013, p. 1146). Indeed, there is some overlap with responsibility: detached blame 'can have a place within effective clinical treatment and, in so far as they encourage responsible agency, may be essential to it' (Pickard 2013, p. 1146). *If* a patient is blameworthy for her behaviour, then the clinician ought to show detached rather than affective blame.

At first glance, responsibility without affective blame seems an improvement to the treatment of self-harming borderline individuals. Negative emotions and a sense of entitlement commonly accompany attributions of responsibility for self-injurious behaviour amongst clinical staff, where 'cutting is seen as a deceitful way to obtain one-to-one interaction' and the 'suffering of the person is deemed to be unreasonable […] manipulative' or forms of 'coercion' and 'bullying' (Bowers 2002, pp. 54, 53). Rather than reacting out of fear, anger, frustration, disgust, distress or stress, this approach recommends clinical responses which encourage the subjective control and agency of individuals with BPD, so that the individuals themselves choose less destructive ways of coping. Returning to Anne, she would be assumed to be responsible for cutting herself (in that it is within her capacity to control her behaviour and do otherwise, even if this capacity is weak). A clinician, family member or friend should not treat her as a justifiable recipient of affective blame and attribute moral fault to her character, but they can treat her as an agent who cuts herself consciously and intentionally. Responses to Anne's behaviour might include questions asking her to justify her behaviour and explain to her how such actions may violate people's boundaries. If Anne refuses to be accountable and continues to cut her arms in defiance of our recommendations, we might impose negative consequences to try and encourage change her behaviour (i.e. clinicians could refuse treatment to her or discharge her from mental health services, place her in an isolated unit, withhold soothing contact after her self-harming episodes). Anne's therapy would encourage her to 'face aspects of [her] personalit[y] and behavior that are harmful to [herself] and others, and take responsibility for them. That process typically involves painful self-reflection, and the potential for self-blame, shame, and guilt' (Pickard 2011, p. 220). Ultimately, the aim would be to change Anne's behaviour by presuming her capacity to control her actions and engage in less self- and other-harming, maladative coping mechanisms. As Pickard states, 'In the face of this complexity, one thing remains clear: clinicians,

family, friends, and others need to hold service users with disorders of agency responsible for their behavior, and ask that they change it, when it causes harm to self or others' (2013, p. 1150).

Responsibility in this sense is content-neutral: the moral perspective of rightness and wrongness are set aside (Pickard 2013, p. 1141). Questions about the content of one's will are also set aside – agency seems to revolve around the procedural ability to control and choose behaviour. Although Pickard states that the responsibility and blameworthiness of borderline individuals who self-harm might be mitigated due to mentalisation defects, an impoverished history, or experiences of trauma, it is never fully extinguished nor can they be fully absolved for their behaviour. Clinicians need to consider the background narratives, traumatic histories and limited options of the individual to cultivate empathy and compassion so as to drive away affective blame, but it is not to alter the view as to whether or not the person is responsible for their actions.

Moreover, external attributions of responsibility may have priority over subjective experience or understanding of action. This isn't to say that the individual's narrative doesn't matter or isn't taken into account, as Pickard suggests how these are important. But say that Anne's narratives describe how she feels completely out of control when she is cutting her arms and cannot help herself, or how this is her way of expressing control over her strong affect. Anne's narrative presents a two-pronged challenge to the clinician who views her as responsible in Pickard's sense: in the first case, her firsthand experience implies a lack of agency and control over her self-harming action, or the psychological and motivational capacity to exercise control is absent. The phenomenology of her own experience suggests she falls short of responsibility, in which case, the clinician who views and treats her as in control of her action departs from her own understanding of her behaviour. In the second case, Anne would be expressing her agency and control as best as she sees fit but fall short of how most clinicians envisage adaptive, 'in control' behaviour. Again, her manner of asserting control over her actions departs from the normative perspective of the clinician. Simply put, borderline individuals may not share the same understanding of responsibility and control as the clinician.

Yet from the perspective of responsibility without blame, these subjective narratives are validated in so far as they might heighten empathy and extinguish affective blame in clinicians – they might mitigate some of her responsibility, but do not fully absolve her of it. Others ought to treat the person with BPD *as if* she can account for her behaviour and are in control of her actions, and through strategies such as limit-setting and behavioural training, the individual comes to learn less self- or other-harming behaviours and responses. Pickard purports that most effective psychological treatments of personality disorders, either implicitly or explicitly, 'are united in treating service users as responsible agents, capable of controlling their behavior, and deciding to change' (2011, p. 213), requiring service users 'to choose and learn to act otherwise, if they are to improve, let alone recover' (2011, p. 210). Even more strongly put, 'the cost of avoiding blame by denying service users agency and thus absolving them from responsibility is high: it precludes

both clinician and service user alike from rationally pursuing psychological treatment, leaving only medication as an option' (2013, p. 1139).

There are two issues with this emphasis on responsibility. First, particularly when the BPD individual's experience of agency might depart significantly from that of her clinicians, it seems to me that there is a danger that such an approach could inadvertently revert to a punitive response to self-harm from the perspective of the person with BPD, *even if the intentions of the clinicians are otherwise*. Second, the content-neutrality of this framework fails to track the complex phenomenology of self-injury and fractured selfhood in BPD and how this might bear on our conceptual understanding of responsibility. These will be explained in this and the next section respectively.

The first issue becomes pressing when we consider what happens after Anne is held to account for her self-injurious behaviour, when she begins to cut herself again, and the manner in which Anne is held responsible. As Pickard herself states, responsibility without blame does not rule out the possibility of imposing negative consequences and limit-setting to discourage the behaviour – indeed, this is part and parcel of treating individuals as accountable agents. But there is the possibility that this approach could revert to a punitive response to self-harm.[ii] Even if the intent behind holding the person responsible is admirable, it could be subjectively understood by the patient as a mode of punishment that could exacerbate the triggers for self-injurious behaviour.

For instance, how responsibility without blame – or indeed, detached blame in certain circumstances – qualitatively differs from stigma-driven emotional withdrawal in its subjective impact on the borderline individual is unclear. The focus on responsibility suggests individuals need to account for themselves should they fail to implement change in their behaviour. But compare this with explanations of stigma-driven emotional withdrawal. Pre-existing stigma about the disorder amongst clinical staff (i.e. how difficult these people are) often frame interpretations of self-injury (as a form of manipulative behaviour); emotional withdrawal and voluntary distance is then viewed as a justifiable and appropriate response (Aviram et al 2006). Clinicians with negative attitudes towards those with personality disorder commonly make behaviouristic judgements that patients have the ability to control behaviour and symptoms, and therefore need to 'learn' through sanctions and consequences, as a way of inducing self-control (Bowers 2002; Lewis and Appleby 1988). Pickard's description of both responsibility and detached blame has some behaviouristic overtones, stressing the importance of 'appropriate revisions of intentions' and where needed, 'the imposition of negative consequences, and accountability and answerability' (2013). But calling attention to the behaviour, even whilst avoiding the anger or entitlement of affective blame, can at times exacerbate the triggers for self-harm. Emotional withdrawal, affective detachment, or the instalment of consequences and limit-setting, often prompts fears of abandonment and rejection for the borderline individual, intensifying self-negating mechanisms which can motivate self-injury. 'It is not difficult to imagine how a

therapist's emotional distancing can unconsciously initiate desperate reactions by a person with BPD,' Aviram et al state. 'For example, sensitivity about rejection and its association with being unworthy can increase self-loathing and, ultimately, self-destructive behaviors' (2006, p. 252).

In response, Pickard might claim that these potential harms are avoidable with an empathetic stance. Empathy and compassion comes with attending to individuals' past history and backgrounds, allowing clinicians to better understand why individuals behave they way they do. 'A fuller life story or narrative comes into view', she writes, in which the service user is seen not only as one who harms, but as one who has been harmed' (2011, p. 220). Stigma-driven detachment and holding someone to account are qualitatively different, one might argue, simply by virtue of the presence of empathy. Empathy tempers affective blame so that, even if we have to hold someone as 'blameworthy', detached blame is achievable. However, as Potter rightly suggests, whether empathy can coexist with detached blame is questionable. As well as cognitive judgements, the ability to affectively engage with someone is a key constituent of empathy (Potter 2011; Kong 2015). Warmth, feeling, and a sense of genuine caring all help make empathy effective and real to another human being. Pickard nonetheless claims that detached blame may be an 'essential' part of 'effective clinical treatment' (Pickard 2013, p. 1146). Yet the subjective impact of strategies used to hold individuals answerable for their behaviour, whether it be responsibility without blame or the appropriate use of detached blame, might not substantively differ from that which stems from stigma-driven detachment or negative behaviouristic judgements.

Potter moreover rightly argues that it is neither fair nor accurate to attribute certain motives and reasons behind the BPD individual's self-harming behaviour, especially 'without critical reflection into the service user's perspective, the clinician-service user relationship, and the cultural influences on the clinician's interpretation' (Potter 2011, p. 226). From Anne's point of view, it seems unlikely that she grasps the full range of options and has the motivational capacity to choose to behave in ways that are in fact external and alien to her. If reasons to stop cutting her arm have no 'grip' or traction with her, why should we assume it is within her subjective power to choose otherwise? Phenomenological accounts of self-injury indicate that such behaviour in itself expresses an attempt to regulate and gain control over strong affect and extreme distress. Other self-abnegating motives behind self-injury include blaming and punishing the self (Brown et al 2002). Self-harm moreover has been described as a 'paradoxical solacer', where the notion that cutting provides comfort is contrary to most people other than those with borderline: even as it is an external, expressive act, it shares aspects with an 'internalized sense of soothing and object constancy because cutting can be relied upon to be available on demand to comfort and diminish pain' (Gallop 2002, p. 20).

Crucially, these subjective reasons are often egosyntonic: the behaviour is consistent with an individual's personal identity or internal narrative. The egosyntonic nature of the disorder

suggests that the self might technically 'control' or 'intend' to engage in repetitive self-mutilating behaviour (e.g. cutting), such behaviour is also consistent with one's higher-order preferences (e.g. the need to control affect and relieve pain, the belief that one deserves punishment) and it likewise enjoys the endorsement of the self that has been inculcated and internalised as a child (e.g. overarching beliefs that she is worthless and undeserving of anything good). However harmful these coping behaviours, the reasons behind them are consistent and valid expressions of the agent's motivational structure, reflect the options that are available to her, and fulfil a certain function, which may well be an attempt to assert control over herself and her situation. Self-harming behaviour is explicable and intentional, but *not necessarily perceived as maladaptive and wrong from the subjective point of view*. Without an alternative frame of reference or picture of the self (i.e. 'I am worthy of respect', 'I don't deserve to be punished', 'I am not going to be abandoned') then it means that this subjective reality will feed into what behaviours and actions make sense to the self; her distorted understanding of the self is presumed to be true, accurate and is fully endorsed.

One might still insist that the mechanisms of change in therapy for BPD must necessarily presuppose responsibility over the self from the very beginning – that one is an active participant rather than passive recipient of external or internal influences. In short, individuals have to be willing to address and change the subjective experience of action and this rests on the presumption that such individuals are responsible agents in the first instance. Thus, the basis of any productive therapeutic relationship is to draw attention to a patient's self-responsibility, so that she may be open to the critical evaluation of her perceptions, beliefs, values, and aims.[iii]

In the first instance, I am sceptical that this is always the case (as we will see in the third section) – a productive therapeutic relationship in fact need not be entirely focused on self-responsibility and opening channels of critical evaluation. As we will see in my discussion of Dialectical Behavioral Therapy and Schema-Focused Therapy, these might be implicit long-term goals, or aims that are to be achieved further down the line in subsequent phases of treatment once a trusting, stable therapeutic alliance has been established. But therapies, for good reason, do not uniformly focus on the BPD patient's self-responsibility, nor necessarily enjoin the person to directly engage in critical assessment of her maladaptive coping and behaving.

Second, this argument expresses the worry that if we set aside an account of responsibility premised on critical reflection and volitional control, we end up assuming that individuals are mere passive observers who don't act, who have no role in their own healing and subjective change. This would seem an anathema to the whole point of therapeutic treatments. From this approach, cutting, burning, etc. would be classified as acts that can be controlled, or more fundamentally, that there is a capacity to control these acts. However, self-responsibility conceived of as volitional control mistakenly assumes that agency is exhausted by subjective power over actions, or to change one's behaviour in light of self- and other-assessments. There is

the further assumption that a rejection of responsibility in this sense requires committing oneself to a strict dichotomy between passivity and activity. But as the next section shows, I neither deny the agency of BPD individuals nor am committed to this passive-active dichotomy. Labelling BPD patients as passive victims is deeply disempowering and perpetuates harmful stereotypes which question whether these individuals are agents who deserve consideration. Rather, BPD self-harm reveals the breadth of *interactivity* within practical agency, particularly in instances of psychological trauma and oppression. This is important if our conceptualisations of agency are to acknowledge a person's biography and her status as a victim of oppression and harm warranting repair or redress (see Meyers, forthcoming). Such individuals may be agents but not necessarily responsible. A more relational perspective of how BPD selfhood develops will draw attention to how it falls short of certain competency conditions of responsibility, as well as help justify the normative force of certain ways of relating to ourselves and towards others – even as they are initially external to the patient herself. Moreover, as the third section of the paper explores, the force of these reasons can be reinforced, not necessarily through a framework of responsibility, but by clinicians providing non-punitive validation and nurturing to heal the fractured self in the first instance.

Self-Relating Competency Conditions and Developing Borderline Psychopathology

As seen thus far, the problems experienced by borderline individuals are commonly assumed to have a purely intrapsychic origin; fixing them will therefore depend on one's internal resolve for change. This appeals to a picture of responsible agency as the power to exercise volitional control over one's behaviour and action, where its normativity rests on conditions of executive control and critical reflection rather than standards of valuable action. Feminists rightly challenge this picture on two grounds: first, it is implicitly gendered through its celebration of norms that are quite removed from women's experiences, such as the priority of reason over emotion and bodily coping, individual power and control over relational support and interdependency. Second, it abstracts from the patriarchal norms and social practices that can infiltrate one's psychology, affecting one's agency and choices. Background oppressive norms can fundamentally distort a person's selfhood, values, and desires, inhibiting the authentic exploration of the self. Or these norms could pathologise certain emotions in women, as is commonly noted in the value-laden description of anger in BPD individuals (Potter 2009). This suggests we should be cautious about imposing this normative framework on a diagnosis that disproportionately affects women.

Responsibility has resonance for both philosophers and practitioners because our actions disclose our normative orientation – namely the standards of action and conduct that we apply for ourselves. But this self-disclosure reveals all sorts of things – not just whether a person has

control over their actions, but also whether or not a person has *normative competence* – the ability to understand, appreciate and apply certain standards of action and conduct to ourselves (Benson 1990, 1994). In Susan Wolf's words, such normative competence requires us to '*be* a certain way, even if it is not within our power to determine whether we are that way or not' (Wolf 1988, p. 55). Conditions of normative competence mean that we consider, not just whether someone like Anne has freedom of action (conditions of behavioural control), but whether she meets the conditions of freedom of will – namely the freedom to govern those desires or values that one chooses to make effective in action. Our valuational system must reflect 'a desire that our self be connected to the world in a certain way,' to have beliefs about ourselves and our situation within the world which allow us to enact change within it or to take responsibility for who we are, despite the fact that we ourselves did not create who we are (Wolf 1988, p. 55). In short, certain agentic skills that make one responsive to reality or certain reasons are important conditions of responsibility, where one appreciates and is aware of certain normative standards that apply, and the ability to apply these in a manner that helps disclose oneself in an authentic manner.

Responsibility as normative competence focuses attention on how one develops the range of skills, capacities, and psychological and epistemic values needed to develop such appreciation and awareness in the first place. Crucially, this is contingent on socialisation in important ways. Our appreciation of features in the world involves a social process of constituting personal identity and presupposes the inculcation of emotional, perceptual, motivational, and cognitive competencies. For example, our relational context might discourage or suppress the procedural conditions of the will (i.e. subjective control and abilities) that are central to intentional agency. It could shape the substantive content of the will (i.e. perceptions of ourselves, our relationships, and the world around us) in such a way that tracks reality or rests on distortion, conducive to expanding or reducing our perceived options accordingly. On this account, I take agency to encompass the capacity for a range of actions – including, not just intentional action motivated by reasons, mental states, and conscious willing, but also embodied actions that are involved in our everyday coping, engagement with, and responsiveness to the world around us (Dreyfus 2014).

Moreover, responsibility as normative competence does not rest on a passive / active dichotomy which fuelled the objection discussed earlier. In fact, this more nuanced account helps us understand how BPD individuals can be victims and still be agents. On one hand, looking at how the substantive content of the will is socially formed takes into consideration how a person might be a victim – i.e. the oppressive relational / social / cultural circumstances which shape the maladaptive psychological reactions lying behind one's actions. On the other hand, the ways in which a person engages with that oppressive environment can be understood as interactivity rather than passivity (Meyers, forthcoming). This mode of engagement isn't necessarily conscious, effortful, or deliberate action, but includes embodied, subconscious interactions, based on mimetic capacities and linguistic, interpretive skills. Interactivity so described demands relevant forms of

capacitation – capacities of varying levels of awareness and deliberation which enable interactivity.

Agency as interactivity and capacitation means the BPD individual remains an agent but isn't responsible for her self-harm: her interactivity with deeply oppressive, unchosen situation and circumstance means she still acts, but these are based on false, distorted desires, epistemic beliefs, and so on. She might be coping with her situation, enduring pain and trauma, adjusting her feelings and desires based on the resources she has and which are available to her. As Meyers states, '[w]hat may appear to be passive submission from the outside is anything but from the perspective of the victim' (forthcoming). This is why a narrow focus on responsibility as internal control and critical self-reflection in some respects misses the point. Both Pickard and I agree that BPD individuals *are* agents, even as they are self-harming or attempting suicide. But whereas Pickard would say this indicates they can be held accountable for their actions, I am saying they cannot because a person's interactivity and capacitation endorses certain intrapersonal frameworks and ways of being which reflect a lack of necessary agentic skills to be responsible. Even as they are interacting with their pain, relying on their subconscious capacities of interpretation of their situation, the relevant forms of capacitation are fundamentally skewed: their subjectively endorsed ways of understanding themselves reflect socially inculcated values that fundamentally distort reality or reflect unjust, oppressive norms. The fact the BPD individual might exercise control in some parts of her life (i.e. Anne's localised control over her studies and education) reveals nothing about how her capacities of self-soothing may revolve around deeply undermining, pernicious views about her self which have been socially inculcated.

The competency conditions on a more substantive account of responsibility will therefore involve a backdrop of self-relating skills as a constitutive part of normative competence, in addition to the epistemic and motivational abilities typically stressed in philosophical accounts. The attitudes and narratives of others in the socialisation process mediate our self-narratives, motivational structure, belief system, and perceptual lens, resulting in a *self-in-relation*. This term captures how the self is always in some kind of relation towards others, our environment, and ourselves: it is a relation-to-others as well as a relation-to-self. As Mitchell describes, '[b]eing a self with others entails a constant dialectic between attachment and self-definition, between connection and differentiation, a continual negotiation between one's own subjective reality and a consensual reality of others with whom one lives' (Mitchell 1988, p. 149).

A competent self-in-relation is developed through three kinds of interpersonal, recognitional bonds: (i) respect; (ii) trust, and (iii) esteem (Kong 2017; Kong forthcoming). First, when others treat us with respect, individuals are viewed as selves whose bodies and reasons have worth and deserve consideration – we internalise this as a form of self-respect where we believe ourselves to be of value; our reasons deserve regard, as does our physical integrity, choices, and values. Second, trustful interpersonal relations become internalised as self-trust. When others

recognise and validate conative aspects of our agency – our emotions, needs, perceptions, and desires – we likewise come to explore, trust, and validate these facets of our agency. We view and assert our own needs as appropriate and accurate responses to the situations we encounter in the world. Third, self-esteem is developed when we internalise a dynamic self-definition and belonging within our community and relationships; our activities are seen as positive contributions, leading to a sense of connection yet individual separateness. Nurturing recognitional bonds ultimately become reflected in a relation-to-self constituted by realistic, nurturing attitudes towards one's needs, agency, and identity. It equips the self with the competencies and tools to maintain sufficient flexibility in engaging with others, yet firm in one's resolve about the fundamental relation-to-self, constituted by self-respect, self-trust, and self-esteem.

By contrast, the internalisation of punitive, distrustful narratives culminates in problems navigating selfhood as situated within relation, both vis-à-vis others as well as with oneself. This is a particular problem in individuals with borderline. Ample evidence reveals that the diagnosis is closely connected to past experiences of trauma, sexual and physical abuse, deprivation, punishment, and subjugation (Young et al 2003). The subjective impact of this interpersonal context is profound, leading to the internalisation of different modes of misrecognition based on disrespect, distrust, and lack of esteem. When we experience subjugating, degrading, and disrespectful treatment by others, we come to see this as acceptable behaviour and replicate it in our engagement with our own selves. When a recognitional framework of trust is absent, our intrapersonal framework can become inflexible, underdeveloped, or fail to track the features of the world accurately. Conative reactions to the world are suppressed; we become uncertain about our needs and how to respond appropriately towards them. When we lack self-esteem, there is detachment from our community; our own personal characteristics, activities and goals are devalued, contributing to our sense of displacement. Ultimately, dysfunctional belief systems and self-destructive coping mechanisms become consistent expressions of the self.

Relational contexts characterised by invalidation, fear, and hostility cultivate a fractured, inauthentic self-in-relation, precisely because 'the individual is encouraged to bring into play only those aspects of her inner experience that fit the inner experience of another' (Becker 1997, p. 108). Here the importance of trust demands deeper examination. Trust fosters authentic responsiveness to and discernment of reality so that one has 'a balance of giving and receiving which helps her respond to that situation with care, competence, and an attitude of fairness' (Cotroneo 1986, p. 414). Interpersonal and intrapersonal trust are dialectical parts of the same coin. A trusting self-in-relation constantly negotiates between one's own perceptions and interpretations of reality with that of others, oscillating between one's attachment to and separateness from others. One situates oneself within relation to others, but also adopts a separate

stance from this interpersonal relation, particularly should it depart from one's relation-to-self (see Meyers 1984, pp. 83-4).

By contrast, an invalidating environment breeds distrust of one's own experience and interpretation of reality. Such an environment tells the individual that she cannot trust herself, her needs, and her responses to the world, making her reality outward orientated so that she looks to others for cues as to how she should act or feel (Becker 1997). Attending to the social process behind the development of inauthentic but egosyntonic disordered selves illuminates precisely why women in particular have been prone towards borderline personality. Many girls are raised to suppress their own need for care and nurture, particularly in familial environments dominated by fear and conditionality. Conative expressions of one's authentic self – emotions, feelings, and needs – are punished, minimised, or treated in an erratic manner. Subjective assessments of her own experience are viewed as wrong, inaccurate, and untrustworthy (Becker 1997). Or her emotional response is attributed to shameful characterological traits, such as 'overreactivity, oversensitivity, paranoia, a distorted view of events, or a failure to adopt a positive attitude' (Linehan 1993, p. 50). In short, she is told her real, private self, comprised of suppressed emotions and needs, is of little value. With threats of hostility or fear around loss of love, her subjective reality becomes the reality of those around her, stifling the constant negotiation between attachment and separateness, between connection and self-definition, which is necessary to develop a healthy self-in-relation. The self becomes conflated with other, and subsequently becomes the model that is replicated in future relationships. Individuals are unable to articulate their private experiences and manage their emotions. They distrust their grasp of the world, and struggle to set feasible expectations on themselves as well as others. In Becker's words, 'Clearly for women on the border, there is little flexibility within the self to draw upon; there is barely a self to call up' (1997, p. 127).

Indeed, the context of invalidation and distrust helps explain the characteristic overdependency in borderline individuals. In such an environment, she literally lives 'in the eyes of others' (Becker 1997, p. 124). She depends on, not just the critical second-personal judgements which comprise her identity, but also on caretakers who may in fact harm her, further distorting her ability to discern the reality of abusive circumstances and those that mean her harm. The idealisation of altruism, other-regardedness and nurturance in feminine socialisation exacerbates her distorted perceptions and the development of the inauthentic self. Girls are often raised with the view that they need to put others first and suppress their need for care. In environments of conditional love and invalidation, a daughter may nurture and affirm the needs of her abusive parents to the neglect her own. This impulse, Horney explains, is motivated by the girls' need for safety and love, and her fear that she will lose both. Alongside this fear will be anger, as a protest against those who denigrate, neglect, and abuse her. But ultimately, her fear comes to trump the anger against those who devalue her authentic needs and emotions. She represses her anger and

the caretaker who is feared and resented, is idealised and admired. Instead, anger is turned towards herself, converting her 'true and warranted accusations of others' to 'untrue and unwarranted self-accusations' (Horney 1942 p. 50), thereby making herself 'the object of […] her own hostility' (Westkott 1986, p. 75). Emotional invalidation and narratives about her bad or evil character lead to secondary negative emotions of self-blame, self-accusation, and self-punishment which eventually motivate self-injurious behaviour (Becker 1997).

This complex picture of developing borderline psychopathology explains how, in Benson's words, the self-harming individual acts 'willfully' but is 'unable to govern the content of [her] will' (Benson 1994, p. 651). To return to Anne, the abusive context in which she has become the person she is has meant that certain features of herself are unavoidable, even if these features are mistaken, unwise, harmful, or rest on a skewed perception of the world and of herself. Her interactivity rests on capacities that have developed from coping with her oppressive circumstances. These capacities might have done her very well to endure her trauma or abusive context, but they outlive their usefulness as she attempts to navigate and interact with new circumstances. She lacks a competent self-in-relation at two levels: at an epistemological level, she lacks the ability to know and trust herself, as well as the right and wrong way of relating to herself and to others; at an ethical level, she lacks the motivational resources to treat herself with nurturing care and act from an authentic self. The ability to recognise certain reasons and control the content of her will (i.e. reasons of self-care, self-nurturing) remain entirely external to her. This isn't to say that Anne doesn't have the potential to change, but it would be unjustifiable to hold her accountable for her self-injurious behaviour at the present time, even if her clinician has encouraged her to act otherwise. This nuanced account of developing borderline psychopathology indicates that a therapeutic approach focused primarily on responsibility for action may in fact replicate internalised forms of self-blame and self-accusation, inadvertently holding victims – particularly women – as accountable for their own psychological abuse and oppression.

Therapeutic mechanisms instead need to problematise the presumed authenticity of and responsibility for the substantive content of the will in the fractured self-in-relation. Nurturing recognitional bonds focused on intrapersonal and interpersonal emotional connection, validating and accepting the person's current perspective and meeting suppressed subjective needs, will eventually help cultivate a dynamic, authentic, and responsible self-in-relation.

Two Therapeutic Examples

Not all therapeutic treatments of BPD take the responsibility of the individual as a point of departure in treating BPD. Other therapies rely on different mechanisms for change which track and respond to the complex egosyntonic nature of borderline self-narratives and self-harming behaviour. In the remainder of the paper, I want to illustrate this with two therapies that have been

shown to be highly promising treatments for BPD: Schema-Focused Therapy (SFT) and Dialectical Behavioural Therapy (DBT) (Giesen-Bloo et al 2016; Bamelis et al 2014; Linehan et al 2006; Bohus 2004). Both therapies emphasise listening and understanding the testimony of the BPD individual and on establishing a strong therapeutic relationship premised on Rogerian positive regard, warmth, genuineness, trust, and acceptance.[iv] But there are a number of crucial differences between the two (Fassbinder et al 2016): DBT emphasises the acquisition of emotional regulation skills, whereas SFT rarely addresses emotional regulation directly but focuses on healing adverse childhood experience and trauma. This divergent focus reflects important differences in the background and theoretical basis of each therapy. To be clear, I am not proposing that one therapy has greater efficacy than the other (and no studies thus far compare the two in clinical trials). Rather, my primary aim in this section is to draw out how the analysis above plays out in both, particularly in the use of validation in DBT and limited reparenting in SFT.

DBT rests on a dialectic of acceptance and change. This dialectic is important because the very basis of the therapy recognises the counterproductive nature of focusing exclusively on change strategies which emphasise the BPD individual's self-responsibility and ability to do otherwise. DBT developed out an observation that the problem-solving skills used in standard Cognitive-Behavioural Therapy (CBT) could be experienced as emotionally invalidating to BPD patients and thereby detrimental to therapeutic goals. For example, Linehan describes how emotionally invalidating environments are 'generally intolerant of displays of negative affect' and the 'attitude communicated is similar to the "you can pull yourself up by the bootstraps" approach; it is the belief that any individual who tries hard enough can make it' (Linehan 1993, p. 50). A therapeutic approach based solely on the BPD individual's need to change could work to *reinforce* her subjective emotional invalidation, distrust, and self-punishment. Indeed, DBT warns against the presumption of apparent competence of the BPD individual:

> The discrepancy between appearance and actuality simply perpetuates the invalidating environment. The absence of expected competence is attributed to lack of motivation, "not trying," playing games, manipulations, or other actors discrepant with the individual's phenomenal experience. Thus a major consequence of this borderline syndrome is that it supports the therapist and others in "blaming the victim" and blinds them to the patient's need for assistance in learning new behavioural patterns. (pp. 83-4)

Validation strategies which nurture and acknowledge the wisdom of the patient's point of view within her *current* context are the necessary counterpart to change strategies (cognitive and behavioural treatment) in DBT. Validation is crucial, not just to situate and balance behavioural techniques, but because it is 'needed to teach the patient to validate herself' (p. 225), particularly

to trust her own original emotional and cognitive perspective on events and behavioural reactions. In fact, 'At the beginning of therapy, before a strong relationship has been formed, *validation may be the principal intervention*' (Linehan 1997, p. 387, emphasis added).

There are four dimensions of validation in DBT: (i) emotional; (ii) behavioural; (iii) cognitive; and (iv) cheerleading. Emotional validation strategies apply a distinction between primary / authentic and secondary / learned emotions: the maladaptive emotions typical of BPD are seen as learned reactions to a primary, authentic emotion. It could come in the form of suppressing that emotion, inhibiting full expression of the authentic emotion. The point of this distinction is so that the primary, authentic emotion is recognised and affirmed, where it is acknowledged that both sets of emotions provide understandable adaptive information for a person's motivation and response to an event (p. 227). Behavioural validation strategies likewise reinforce that a person's actions and current behaviour is understandable, where therapists seek out the validity within their responses. Crucially, this requires challenging a distorted sense of 'should' in BPD individuals – where they have a strong sense of a need to do otherwise, that they 'should' behave differently. In fact, DBT recommends appealing to a mechanistic explanation of behaviour at times, to communicate that 'everything that happens should happen, given the context of the world; in principle, everything is understandable' (p. 238). Cognitive validation focuses on recognising, verbalising, understanding, and seeing the kernel of truth in the person's expressed and unexpressed thoughts, beliefs, and the underlying rules behind their thinking. This approach differs again in an important way from standard CBT approaches, which stress critically challenging or refuting the logic of certain patterns of thinking. Instead, DBT focuses on validating the knowing of the patient, to have an orientation towards the patient which recognises their experiential ways of knowing and respecting their different way of seeing things (pp. 240-2). Finally, cheerleading strategies are essential to counteract a sense of hopelessness, emphasise the therapist's belief and confidence in the patient and her inner capabilities, assuming the best of her, and encourage her based on a realistic assessment of her capabilities.

The different levels of validation together provide a source of support and nurture for BPD individuals as they currently are; they facilitate a therapeutic connection between the patient and therapist by making them understood. They ultimately function as a model to teach self-validation, where individuals acquire in the first place skills of *'nonjudgemental* self-observation and *nonpejorative* descriptions of the self' (Linehan 1997, p. 388, emphases added). The goal is for individuals to cultivate trust in their self-in-relation, where they trust their emotional, behavioural, and cognitive responses modelled after the validating and trustful bonds in the patient-therapist relationship. The noncritical, nonjudgemental nature of this is crucial, because it indicates that to promote change and a different kind of agency need not demand nor impose on the BPD person that she should be able to exercise better volitional control, that she needs to do otherwise and somehow falls short. Instead, DBT validation displaces capacitation and

interactivity based on *invalidation* to that of *validation* and the safe exploration of authentic emotional, behavioural, and cognitive parts of the self.

Validation strategies in DBT overlap in some ways with Schema-Focused Therapy, and indeed, the nonjudgemental nature of the therapists' acceptance is likewise essential to the latter. However, whereas DBT focuses on accepting the current self and the emotional, behavioural, and cognitive dimensions of the patient's perspective, SFT's explicit focus is nurturing the unmet needs of the child within the BPD self. DBT's use of validation to improve coping strategies and symptom reduction will lead to some exploration of the BPD person's past, but this isn't its main focus. For SFT, by contrast, emotional regulation is not addressed directly and the therapeutic focus is on cultivating a shared understanding of root causes for BPD symptoms stemming from the psychological trauma of adverse childhood experience (Fassbinder et al 2016).

This divergent focus stems from the underlying philosophy of SFT which views individuals with borderline as psychologically and emotionally very young children with inadequate intrapersonal / interpersonal supports, unmet needs, as well as a core fear of abandonment (Kellogg and Young 2006). Schema refers to 'a pattern imposed on reality or experience to help individuals explain it, to mediate perception, and to guide their responses' (Young et al 2003, p. 6). Early maladaptive schemas develop as a result of adverse childhood experiences and are 'reality-based representations of a child's environment' (i.e. 'my environment is unsafe'; 'my caretakers do not care for me', 'I need to suppress the expression of anger'), but are no longer accurate or useful later in life. Different modes of the self form part of the borderline personality constellation; these modes involve specific schemas or ways of coping which become dissociated from other modes – indeed, the therapy works towards the reintegration of the different modes by targeting an individual's suppressed needs. These include child modes (the abandoned / abused and the angry / impulsive child); dysfunctional parent modes (the punitive parent); dysfunctional coping modes (the detached protector); and the healthy adult mode.

The *abandoned / abused child* is a core state of the borderline child, representing 'the suffering inner child'. Here 'the patient appears fragile and childlike […] seem sorrowful, frantic, frightened, unloved, lost' where they are seeking a parental figure to take care of them (Kellogg and Young 2006, p. 308). The *angry and impulsive child* represents the part of the child who recognises that her needs were unmet and expresses rage about her mistreatment caused by abuse, abandonment, deprivation, subjugation, rejection, and punishment (Young et al 2003). As discussed, the BPD individual is in a doublebind with the expression of anger: even as it is expressed, it often triggers the desire to self-punish the abandoned/abused child, since childhood experiences frequently meant the expression of anger and emotion was forbidden, suppressed or punished. Displays of rage are often followed by self-punitive acts such as cutting, effectively replicating dynamics of the family situation (Kellogg and Young 2006). The expression of normal needs and reactions – like anger – can trigger the *punitive parent* mode, dominated by a form of

inner abuse which represents the individual's identification with and internalisation of her parents' 'loathing, abuse, subjugation' (Young et al 2003, p. 310). The self is punished for 'being bad or evil' through self-injurious, parasuicidal and self-destructive behaviour. The *detached protector* mode is also connected to the suppression of normal needs and feelings. Here the BPD patient behaves in a disconnected, isolated manner and can give the impression of 'apparent competence': individuals are 'good patients', acting in accordance with others' expectations, and many therapists mistakenly reinforce the detached protector mode as a result. But remaining in this mode can be counterproductive to treatment due to individuals' focus on the therapist's approval and disengagement from their own needs and feelings. It can suppress a healthy negotiation between connection and self-definition, encouraging instead longstanding patterns where the person's subjective reality is based on that of others due to the threat or fear of their disapproval.

The mode completely absent or extremely weak in the BPD individual is the *healthy adult* which helps nurture other aspects of the self (i.e. protects and affirms the vulnerable child, sets boundaries for the angry child, and challenges the punitive parent mode). Through the use of limited reparenting and experiential techniques, SFT helps establish and strengthen this mode whilst reintegrating the child schema modes by meeting their unmet needs. Limited reparenting differs in important ways from the 'good' parent who is educating her child on acceptable and unacceptable behaviour. A child could be chastised and experience negative consequences, without major harm to herself, so long as the environment and relationship is one of unconditional love, acceptance, and encouragement. The admonishment is contextualised within overwhelmingly affirming recognitional bonds. Yet the opposite often holds in the experience of borderline individuals. Reprimands and punitive measures will be mediated through the lens of one's experience of belittlement and misrecognition. Limited reparenting – the 'first among equals' (Kellogg and Young 2006, p. 451) – is more like a good foster parent who intervenes in a child's life after years of subjugation, invalidation, and neglect. Similar to validation strategies in DBT, this good foster parent recognises and affirms the expression of emotions and needs whilst overturning prior self-punitive, self-subjugating narratives that are internalised by the child. Limited parenting supports the core belief that BPD individuals did not have their fundamental emotional needs met by their caregivers and an important part of therapy is to compensate for this absence, providing an 'antidote' within certain professional boundaries, creating an environment that is safe, nurturing, protective, forgiving, and encouraging of self-expression' (Young et al 2003, p. 326). This provides individuals with a nurturing base, a 'holding environment' (Kellogg and Young 2006, p. 452) to help BPD individuals displace these dysfunctional modes and internalise the nurturing, validating narratives of the therapist. In other words, *prior* to any cognitive and behavioural retraining, SFT focuses on meeting the emotional needs of the child, of providing crucial self-nurturing skills that provide the necessary infrastructure on which responsible agency can develop in the first place. Phases of treatment and mechanisms of change

are structured accordingly, with a particular focus on emotion-focused / experiential techniques involving the use of dialogue and imagery work to help individuals to connect and process emotions, clarify its biographical background, and alter the meaning of emotions and needs through emotional restructuring.

For instance, an extremely powerful strategy used in SFT is imagery rescripting, where maladaptive schemas are connected to childhood trauma, effectively bridging the current self with the unmet needs of the child modes. In these rescriptings the therapist tries to connect with the vulnerable child – nurturing, praising, and encouraging this part of the self, or validating her sense of injustice and anger, whilst defending her against the punitive parent voice. The therapist intervenes in the connective memory by stopping the perpetrator of abuse and caring for and soothing the child in the image, and taking her to a place of safety and security. This technique in SFT helps heal the child modes and their unmet needs which cause the dysfunctional coping modes, until the healthy adult mode of the person is strong enough to intervene. Chair dialogs can also be used to try and externalise the punitive parent voice, where modes are placed on different chairs and dialogues are performed from the relevant mode. This technique can be used to encourage the self-punishing part of personal identity to become egodystonic, gradually creating a separation between the burgeoning authentic self and the punishing, critical voice.

This therapeutic process can be difficult. Affirmations praising the abandoned child will often be rejected and instead intensify the punitive parent voice, particularly given the external nature of self-nurturing narratives to the borderline individual's personal identity. Indeed, nurturing the abandoned / abused child can itself trigger self-mutilating, self-punitive behaviours. For this reason, SFT also uses cognitive techniques to enact a proactive process of narrative repair, where BPD individuals are educated about the truth of self-nurturing reasons, affirming their valid needs to have a stable base, receive love and acceptance within a relational framework of respect. Importantly, SFT eschews any punitive or blaming responses and maintains that positive shaping is a more effective way of altering one's behaviour. When it comes to self-harm, the therapeutic task is to convey an attitude of warmth, concern, and empathy for the borderline patient whilst creating distance from the action.[v] The therapeutic focus remains on resolving the underlying causes of borderline selfhood rather than explicitly managing the destructive acts and behaviours which express the psychopathology. In fact, *too* much attention on the act of self-harm, particularly in adolescents, can inadvertently reinforce the behaviour by creating dependency on the therapist. Instead, the approach stresses that therapists need to strike a delicate balance between compassion and kindness for the BPD individual, offering alternative short-term coping strategies for addressing distress and eliminating the reinforcement of secondary gains (i.e. self-harm as a strategy to elicit care).[vi]

Notably, both DBT and SFT are long-term, intensive therapies; both rely heavily on the skill of the therapist to withhold judgement, criticism, and blame. They demand advanced skills of

empathy, acceptance, interpretation, and an appreciation of the complexity of BPD selfhood, just to even establish trust with individuals whose default mode is to distrust others, keep them at arms-length, and self-punish.[vii] DBT validation and SFT limited reparenting pinpoint neatly where responsibility without blame could be therapeutically detrimental. First, the focus on taking responsibility may in fact encourage the ways of relating to oneself which can impede the development of a competent self-in-relation. Both DBT and SFT caution against therapists mistakenly assuming the competence of borderline patients, which can lead them to distrust and disengage from conative aspects of one's identity rather than the subjective acceptance and understanding that is sorely needed in BPD individuals to develop an authentic sense of their own identity. Second, a focus on self-responsibility ignores the nurture that is needed prior to self-reflection and subjective change. Validation and limited reparenting strategies constitute the crucial first phases of therapy in DBT and SFT respectively, with these approaches recognising that behavioural change techniques when introduced too early can be highly rejecting, invalidating, and punitive to the BPD individual – not only confirming their self-abnegating narratives that often motivate self-mutilation, but potentially damaging the therapeutic alliance irrevocably.

By contrast, agency understood in terms of interactivity and capacitation in relation to DBT and SFT therapy is twofold: first, it is truer to the complex phenomenology of self-harming in borderline, involving a cycle of unmet needs, difficulties with and attempts to control strong emotion, as well as punitive, egosyntonic motives. Even as the borderline person acts, she lacks the normative competence of responsibility, as her motivational structure, beliefs, and perceptions are so egosyntonically shaped around pernicious, subjugating narratives that they cannot be said to reflect an authentically competent self-in-relation. In other words, the interactivity of the BPD individual is premised on invalidating capacitation. Indeed, the therapeutic intervention is *precisely* to create some space between subjugating, oppressive narratives and the self, to provide an alternative cluster of validating and nurturing capacities premised on self-acceptance, self-trust, self-respect, and self-esteem. Second, the fact that the self-harming coping behaviour of the borderline individual emerges out of relational circumstances suggests that treating it therapeutically will likewise be a relational rather than individual endeavour. Strategies of narrative repair, positive validation, and the establishment of nurturing recognitional bonds work to counter individual's subjective experience and cultivate an authentic self-in-relation. These are necessary preconditions for a responsible self to emerge in the first place. The possibility of responsible agency that is premised on validating and nurturing capacitation remains necessary for therapy because it provides a crucial orientation of optimism and hope. But this should not be a normative perspective imposed upon the self-harming, BPD individual in the first instance, particularly if she has experienced nothing but belittlement and invalidation. What is more important is how this optimistic, hopeful orientation from a therapeutic perspective can help build

mutual relations of trust, vulnerability, and affective engagement which will teach fractured selves crucial skills of self-nurture, emboldening them to trust and validate their legitimate needs, and *eventually* internalise and believe in the possibility of relating to themselves and to others in an authentic and responsible way.

Conclusion

I am in agreement with Pickard's view that clinical attitudes towards those with personality disorder often falls worryingly short. But the argument in this paper is that Pickard's solution of responsibility without blame does not prioritise sufficiently the subjective phenomenology of self-harm, nor provides sufficient distance from widespread clinical views about these patients possessing control over their behaviour. The more dangerous trajectory of such narratives is how it implicitly holds women responsible and answerable for their inability to nurture and care for themselves. Rather ironically, '[t]he woman who believes her character to be at issue may have difficulty protecting herself from maltreatment in the future' (Becker 1997, p. 138). Instead, I have questioned in this paper whether it makes sense to speak of the borderline person as responsible for her self-harming behaviour from either a philosophical or therapeutic perspective. From a philosophical perspective, we need to consider the social and relational constituents of substantive content of the will which may encourage or oppress the development of a competent and authentic self-in-relation. Prior to the development of responsible agency is the meeting of emotional and conative needs in a trusting intersubjective context that is validating and accepting, without which the intrapersonal and interpersonal relations of the self are prone to distortion and inauthenticity. As I have also explored through validation in DBT and limited reparenting in SFT, behaviour that accords with what is perceived to be 'responsible behaviour' does not necessarily reflect an authentic self-in-relation. Future qualitative work could further elucidate the clinical application of my argument by undertaking in-depth examinations of the subjective experience and phenomenology of self-harm, as well as the attitudes towards BPD agency amongst clinicians practicing SFT and DBT. Ultimately, cultivating a dynamic and authentic self-in-relation depends on a collaborative, therapeutic process based on of mutual vulnerability and compassion, so as to cultivate a nurturing personal identity that can navigate a necessary dialectic between self and other, between separateness and connection, between subjective reality and the consensual reality of those around us.[viii]

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[i] In Kong forthcoming, I suggest that authenticity is a problematic criteria on which to base assessments of mental capacity. The argument here coheres with this claim, particularly as decision-making capacity is often equated either with (i) a thin account of autonomy which may reflect deeply self-abnegating, egosyntonic disorders or (ii) an account of authenticity that equates the mentally disordered self with the inauthentic (and incapacitous) self. The view I am proposing here is a refinement of my argument – I am not committed to the view that an egosytonic, disordered self is necessarily inauthentic, but rather emphasise the importance of understanding the genealogical origin of developing psychopathology, particularly in contexts which denigrate expressions of authentic needs and emotions and socialise individuals accordingly.

[ii] According to Gallop 2002, p. 25: 'Attempting to stop behavior through self-harm contracts or other restrictive means will only escalate self-harm efforts, reduce any ambivalence about the self-harm behavior, and add to secrecy. If a nurse or therapist refuses to see or treat a woman because of self-harm, he or she may be removing the only effective coping strategy, which may lead to more serious self-harm behavior or

suicide. The goal is to help the person deal with the intense affect and the function of self-harm, not to become involved in power struggles.'

[iii] Thanks to an anonymous reviewer for raising this objection.

[iv] These have important overlaps with other therapies, such as Judith Herman's classic work on trauma and recovery (1997). For the sake of brevity, however, I focus mainly on SFT and DBT.

[v] Thanks to Suky MacPherson for making this and the next couple points.

[vi] i.e. Encouraging individuals to use red markers instead of scissors, holding ice rather than cutting, smashing plates. This might be through a kind but not overly dramatic or effusive response to a young girl's self-harming behaviour. It is akin to Aristotle's virtue of the mean – being responsive and understanding, but not so much so that it becomes a barrier to the patient's healing.

[vii] Young et al state that 'majority of patients with BPD cannot accept and benefit from cognitive-behavioral techniques until they trust both the therapist and the stability of the reparenting bond' (2003, p. 327).

[viii] My thanks to Julia Blazdell for our discussions about BPD and self-harm, Hanna Pickard for comments on an earlier draft, and two anonymous reviewers for their helpful suggestions. Many thanks also to Diana Bogner, Michel van Vresswijk, Arnoud Arntz, and especially Suky MacPherson for explaining crucial aspects of their clinical expertise on Schema Therapy in treating BPD, as well as to Gillian Butler for discussing at length her observations around issues of selfhood in the context of her clinical approach to BPD treatment.