Original Article

Beyond The Medical And Popular Gaze: Writing The Wounds In Kiera Van Gelder's Memoir, The Buddha And The Borderline

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Abstract

This paper addresses exclusively the role of language in the projection of self and construction of identity of individuals who suffer from mental health issues. The language generated through psychiatric diagnoses is extremely reductionist and intertwined with the rhetoric of normalcy. It distorts the understanding of mental health issues in the population's consciousness by utterly negating the self and personhood of sufferers, and it follows a pattern of stigmatisation, devaluation and exclusion. In opposition, Kiera Van Gelder's memoir of suffering and recovery from borderline personality disorder, The Buddha and the Borderline, is an act of resistance that debunks the clinical gaze and provides a counter diagnostic narrative depicting the diverse emotional and existential realities of a sufferer's embodiments. Kiera's narrative in a first-person language shatters the very question of objectivity and subjectivity of truth raised in the context of autobiographical works based on mental health issues and accommodates all considerable incoherencies and inconsistencies temporally and spatially. Her memoir is not merely an act of writing rather it is a courageous act of collapsing the closet, holding the subject position and vocalising the voice of the other.

Keywords mental health, language, stigmatization, identity, memoir.

Introduction

> I've never heard of this strange disorder, and I didn't even know there were personality disorders, but if it means I have a real illness rather than just being a terminal failure, I'm willing to try it on for size. Nothing else has been able to describe the self-destruction, the desperate clinging, the obsession with suicide, and the shifting moods, identities, and perspectives. I have BPD, I tell myself. I'm not a total fuck-up. (Gelder 2010, chap. 2)

Since the age of fifteen, when she cut her wrists for the first time out of the fear of abandonment, Kiera Van Gelder searched for a language which could define her emotional dilemmas, existential realities and varied dimensions of her psychological experiences. She became exhausted with the incomprehensibility and mysteriousness often attached to her character disparagingly. Ultimately, in her thirties, Kiera Van Gelder was assigned a definite pathological label of borderline personality disorder which brought a sense of temporary relief and rekindled hope in her endless journey through the wilderness of linguistic tropes. But the moment Kiera thought about disclosing her new identity publicly, she faced nothing but the same old shame and fear of alienation and social exclusion

due to media-generated discourses around borderline personality traits: '"Listen, borderline is Glenn Close in that movie Fatal Attraction. Think stalking, knives, psychobitch from hell. That is not you!"' (chap. 2).

Then who am I? Am I an insane monster in the world which runs by a measured standard of sanity? or an extremely hypersensitive individual who loses the balance of emotions, unlike the majority? Or just an unwanted aberration with a diverse range of labels by the pseudo-scientific reformations in the diagnostic manual? Kiera van Gelder's memoir of suffering and recovery, The Buddha and the Borderline (2010) chronicles the journey of self-exploration, self-creation and self-actualisation in the everyday life of a sufferer with mental health issues.

Maurice Merleau-Ponty (2008) comments, 'The contact I make with myself is always mediated by a particular culture, or at least by a language that we have received from without and which guides us in our self-knowledge' (66). Our evaluation of ourselves and our identity is not an autonomous process. Rather largely depends on and varies according to how the population in the surroundings feel, think, and discuss us. The 'I' is not at all an exclusive 'I' but rather a historically, socially, culturally, and politically constituted entity, and whether the 'I'-ness will be valued or devalued both by the subject 'I' and as an object 'I' is utterly dependent on how it is situated within 'us'-ness.

This phenomenon plays a crucial role in a sufferer's daily life with mental health issues and is usually accompanied by stigmatisation. The Buddha and the Borderline exposes the nature of language and narratives used to project sufferers with mental health issues within psychiatry and mainstream culture and society, which cause self-stigmatisation and self-devaluation. It exhibits the truth that psychiatry has become an unquestionable authority to disseminate the knowledge about our mental health, and it functions in an extreme reductionist, undemocratic and dehumanising way. Psychiatry leaves no space for ethical and emotional engagement. Instead, it relegates the self and personhood of sufferers to mere tags and labels by totally excluding their own choices, decisions, and narratives. Stigmatising stereotypes of mental health issues are perpetuated through psychiatric and popular cultural discourses that trivialise the perceptions about the sufferers' identity by suppressing their voices and perspectives (O'Hern 2017; Donaldson 2018). And this essentialisation of these stereotypes, as a consequence, follows a pattern of exclusion (Felman 2013, 13).

Kiera says in her memoir about her exhausting experiences of psychiatric diagnoses, 'You share the story of your downfall and honestly admit your faults, and they say you're only as sick as your secrets' (chap. 1). The language Kiera received from professional, personal and medical spaces always served her with blemishes which identified her as an abnormal individual with no worth. Society said, 'Kiera's cutting herself; Kiera's doing drugs; Kiera's shaving her head', and she concluded, '"I'm the very definition of unstable"' (chap. 3). It reflects the intractable pain of sufferers when they are stigmatised as sick and abnormal for having mental health issues.

The self-knowledge she gained was the knowledge disseminated mainly by the population, which considered itself to have no differences and resided in an absolute authoritative position to regulate standards of normalcy, the imagination of the abnormal and exercise power in terms of that. That is why the language of mental health is highly political, and the mad identity is inextricably connected with power relations. The Buddha and the Borderline raises the very question of the generic words like 'difference' and 'sameness'. That is why individuals with mental health issues are assigned a tag of difference. It, in turn, exposes the social construction of a superior identity of being the 'same' through the execution of immense power in consolidating the discourse of normalcy which flows through the 'sameness'. Kiera's memoir showcases that mental health issues are a 'matter of social and cultural power differentiation wrought by the hegemonic operation of the rhetoric of normalcy' (Sati and Prasad 2020, 4). And the language of mental health is a 'discursively constituted phenomenon deeply imbricated in the structures of power in which normalcy had been elevated to the status of an assumed ideal within an ableist social order' (3).

Parallelly, Kiera Van Gelder has also addressed the nuance of objectivity and subjectivity of truth which is a very problematic context in the case of memoirs written by individuals who have suffered from mental health issues.

Roger Woods (2021) analyses the problem of mediation in the reception of testimony which is usually conspicuous in the context of autobiographical narratives and says,

> The agency of survivors of trauma is severely limited by the way in which the debate about the truth value of their testimony has developed. The very associations of the concept 'testimony' with evidence and proof that are readily deployable by others set up an obstacle to using accounts contained in sources such as autobiographies, diaries and interviews since these often lack a single, clear direction. (6)

Memoirs on mental health issues and recovery have largely been mistrusted and pushed aside on the basis of credibility and validity of truth. Watson and Smith raised a very shocking question in their book Reading Autobiography: A Guide for Interpreting Life Narratives (2010), 'How can memoirists authorize themselves as postbreakdown writers?' (145). This question utterly snatches away the chances of individuals with mental health issues to speak for them and projects their identity as extremely imbecile, irrational, and untrustworthy. The Buddha and the Borderline is a text of resistance which opposes this act of incapacitation at the very root level. It raises a question in contrast whether mental health diagnosis is an actual scientific phenomenon or a narrative one. For more than two decades of her life, Kiera identified herself sometimes as a PTSD patient, or a stress and anxiety patient, or a patient with substance use and chemical dependency, or just a psychopathic bitch until eventually she got reidentified as a borderline personality with extremely ambiguous treatment procedures. If mental health diagnosis is itself a relatively changing narrative phenomenon, then why a writer can't have the authority to document her narrative after a certain level of assured recovery, considering the potential inconsistencies and incoherencies. Furthermore, Kiera's memoir is not a text where she has mourned for being blemished and claimed herself normal; instead, it is a text where the writer shamelessly exposes the demons she has struggled within and the angels she has depended on.

Hilary Clark raises a question in the introduction to the book Depression and Narrative: Telling the Dark (2008), 'Why another book on depression?' to which he answers that it is highly needed because

> I would say that there can never be enough visibility for this illness or condition whose stigma causes the sufferer to disassemble and "pass," forgoing needed treatment, or to withdraw from others in shame – a condition misrepresented by myths and stereotypes that inevitably color, and cover, our understanding. (1)

The Buddha and the Borderline is a severe struggle of an individual to come out of that closet of stigma, fear, shame, and all other negativities induced by the cultural understanding of mental health issues and exhibit an altogether unfamiliar reality of a sufferer's existential emotional realities with an ethical sensitivity. It transcends the very question of the deliverance of truth. Instead, it showcases the memoir as a genre which has the potential to go beyond 'what we know, presenting us with an otherworld of some sort – a culture, a time, a set of characters, a set of values or points of view we are not familiar with, often a world we have conceived of as marginal and hidden' (Maginess 2018, 10). It claims that writing a memoir and narrating one's own story of overcoming the panic of stigmatisation and exclusion is the only way to claim agency of voice and establish narrative authority to determine oneself. Since psychiatric diagnosis is a narrative phenomenon that objectifies a sufferer as just a passing label, memoir is a genre of narrative needed to uplift the sufferer to the subject position and provide them with the power to establish authority on the narrative of one's own.

Language, Stigmatization and the Portrayal of Wounded Identity

> On a logical level, I know that everyone feels pain. Everyone suffers. Is my pain really that much greater, or am I just weaker? Where is the line between normal and abnormal emotional suffering? (Gelder 2010, chap. 6)

The language of mental health is fabricated through psychiatric knowledge, discourses and practices (Aubrecht 2012, 36). Psychiatry and its allied medical enterprises have gained through the last century an unquestionable

authority to define, interpret and treat the dysfunctionalities, anomalies, and other conditions of the mind causing any mental suffering. It claims to have an unequivocal knowledge about the functioning of the human mind and provides the population with the offer to reduce and eliminate mental anguish. Foucault (1977) says, 'the exercise of power perpetually creates knowledge and, conversely, knowledge constantly induces effects of power'. Knowledge and power are inextricably linked, and 'it is not possible for power to be exercised without knowledge' and 'it is impossible for knowledge not to engender power' (52). Likewise, power resides in the ways pain is comprehended, discussed and dealt with, varying across time and cultures. In medieval times, pain was believed to have a supernatural origin and had to be tolerated for salvation. The pain was an inevitable consequence of the original and personal sin, and mitigating it was not deemed permissible. So, eventually, resolving guilt, absolution, and redemption under the supervision of prophets was necessary to bring comfort to the lives suffering eternal pain. However, with modernisation, transcendental logic has gradually become obsolete. The phenomenon of suffering has turned into something that can be controlled, overcome, and, if possible, eliminated through the intervention of respective institutions. Psychiatry is no exception, and in exchange for this knowledge, it consolidates its authority and power to define normal standards of human behaviour both in public and private life, including our eating and sleeping habits, speech and usage of language, common sense, expressions of emotions and sexual tendencies and distinguish them from the pathological.

Ian Hacking (1990) writes that the word 'normal' doesn't simply mean 'usual, regular, common, typical'; rather, it is intertwined with power relations, which must be understood from the inseparability of the discourse of being normal from its opposite, that is being pathological (161). The word 'normal' 'uses a power as old as Aristotle to bridge the fact/value distinction, whispering in your ear that what is normal is also all right' (160). It stands for 'what has been, good health, and, what shall be, our chosen destiny' (169). In contrast, pathological is conceived as a deviation from the normal, which must be restricted, isolated and annihilated. Psychiatry, with this "diagnostic style of reasoning" (Tremain 2010, 2015), works in terms of the Foucauldian sense of discipline, which is neither an institution nor an apparatus but rather a particular type of power and a modality for its exercise, comprising a whole set of instruments, techniques, procedures, levels of application, and targets. It undertakes the project of disciplinary normalisation to arrest deviancies and produce minds which can be subjected to regulation, transformation, stabilisation and homogenisation by the set standards of normalcy. It objectifies, compartmentalises, and labels the human mind through a hegemonic diagnostic and statistical manual. It is prescribed as a constitutional framework for differentiating deviant human behaviour from the so-called normal and pathologising it as an abnormality. Psychiatry loses no opportunity of the inexpressibility of the experiences of an embodiment of mental suffering. It forces the minds in pain to enter into the most interior avenues of objectification to reduce human beings into nothing but automatons with a diagnostic label.

When Kiera was having issues with cutting and burning during her school days, the counsellor asked her parents to take it not in an overwhelming way and accept it as a matter of adolescence. And since then, in the course of growing up and through the years of adulthood, the issues of adolescence got labelled like addiction, substance abuse, chemical dependency, PTSD and many others:

> I start at the trailhead of my first suicide attempt and try to describe this overwhelming pain I've had for as long as I can remember. I show him the scars on my arms, and I name all the diagnoses I've gotten: depression, anxiety, PTSD, and chemical dependency. I list the medications, therapies, 12-step programs, religions, and nutritional supplements I've tried. I describe my previous stay in this hospital when I was seventeen, put on a ward for the summer before I turned eighteen, and my other hospitalization in college, when I dropped out and went into AA and NA to get sober. (chap. 2)

Whenever Kiera sought help to recover throughout the years, she got prescribed mood managing pills and dumped into some management programmes, which often worsened her situation. While Kiera was in a job of addiction education, she often had anxiety issues. When She sought help, her doctor prescribed immediately an anti-depressant which affected her physical condition so severe that she couldn't withstand it and ultimately lost her job:

> I call my doctor and he switches me to a newer antidepressant said to help with anxiety, but it's no match against my biology. In fact, every day I feel like I'm getting worse. Then, one night a group of students harasses me during a workshop on the dangers of marijuana, and I burst into tears in front of fifty high school seniors. (chap. 1)

Similarly, the psychiatrist who diagnosed Kiera with borderline personality experimented with her with lithium drugs to manage her stress and anxiety, which eventually led her to such a depressive state that she could barely move out of her place for weeks: 'Time. Now I leave a message on Dr B's answering machine, telling him that I'm so depressed I can barely move. I know it's because of the lithium. I can barely lift my fingers to pick up the phone' (chap. 5). Furthermore, instead of generating a sense of healing and coming out, the management programmes evolve instead a feeling of being doomed. Watching everyone in the crowd with scars, wounds, and terrible stories of hitting the bottom Kiera was every time induced with hopelessness and impossibilities, which led her to damage herself eventually:

> Seeing all the scars on the others' arms in group tipped me back into the realm of possibility. And then impulse took over. The blade drew a slim, beaded thread of blood along my arm, and another. And perhaps not surprisingly, I grew more mindful as the slow rhythm of bloodletting rinsed me with clarity. (chap. 4)

The Buddha and the Borderline presents us with snippets of incredibly dehumanising ways psychiatrists situate themselves in the subject position and interview sufferers with mental health issues as mere objects to be examined in terms of prescribed standards of normalcy. After almost twenty years of knocking at the doors of multiple mental health institutions, the psychiatrist diagnosed Kiera Van Gelder as a borderline patient and questioned her in a way that ignored an individual's self and personhood and existential realities of her embodiment. Kiera was asked, 'How intense are your emotions, on a scale of one to ten?' and 'Are they fairly steady, or do they change rapidly?', which reflects that a sufferer's mind in the eyes of psychiatry is reduced to just a stripe mark on a measurement scale and treated to adjust with other stripe marks. The psychiatrist, after throwing at her some more questions of this sort, like whether she had ever been able to sustain a stable relationship, how she used to cut and burn her regularly or why she couldn't maintain her sobriety, reached an immediate conclusion that 'It's a condition of extreme mood instability. A fear of abandonment. An uncertain sense of self" (chap. 2), i.e., borderline personality disorder. The language generated due to these kinds of interactions, treatments, and diagnoses is inextricably linked with binary relations between the normal and pathological. It insidiously leads to stigmatisation and devaluation.

Allen Thither (2004) comments,

> The center of our discourses on madness has had many names: thymos, anima, soul, spirit, self, the unconscious, the subject, the person. Whatever be the accent given by the central concept, access to the entity afflicted with madness is obtained through a language game in which these concepts or names play a role, organizing our experience of the world even as the world vouchsafes criteria for correct use of these notions' (3).

How a society talks about mental health issues and frames the sufferer's identity depends on this language game played historically at multiple levels. Geoffrey Reaume (2006) says that none of these terms in the history of mental health discourses is ever neutral (182). Every term interprets a phenomenon in itself, and interpretation has its own biases. Furthermore, these terms are products of permutations and combinations of the resources available in a language, which the tongues of an ableist society have always formulated.

Kiera writes, 'accepting a psychiatric diagnosis is like a religious conversion. It's an adjustment in cosmology, with all its accompanying high priests, sacred texts, and stories of origin. And I am, for better or worse, an instant convert'. Psychiatry situates the sufferers in such a helpless situation that, in both ways, they are trapped. Suppose an individual decides to refuse the psychiatric diagnosis. In that case, it will leave them actually in a void with no concrete pathway to reducing the pain. If one accepts to undergo diagnosis, then the individual

self and personhood get suppressed and stereotyped with a psychiatric label. And eventually, these labels and the discourses intertwined with them evolve a language which devalues an individual's self and personhood and frames a stigmatised identity. In both ways, sufferers get stuck in a riddle out of which they find no escape route. Kiera bursts out in disgust while recalling her years of painful experiences of carrying diagnostic labels and says with exasperation: 'I'm just going in circles, like circles of hell, where there's no escape' (chap. 2). Kiera's years of suffering exhibit psychiatry as just a cul-de-sac with walls inscribed with tenets of normalcy and shreds of evidence of the crucifixion of the pathological.

In his influential work, Stigma: Notes on the Management of Spoiled Identity (1963), Erving Goffman defined stigma as 'an attribute that is deeply discrediting' (3). Across cultures, stigma has been attached undeniably 'to a massive number of circumstances ranging from race and ethnic differences to incarceration, sexual minority status, psoriasis, incontinence, and many more' (Link and Stuart 2017, 3). While in ancient Greece, stigma used to be a symbol 'physically cut into or burned onto the bodies of those deemed to be of an inferior status' or a 'marking of one's tarnished and flawed character' (Thachuk 2011, 140-141), in modern times instead of a physical marking, stigma functions as a social and cultural signifier to identify those who are different and deviate from the normative standards (i.e., race and complexion, sexual choices, economic position, political affiliations, religious beliefs, national identity and physical attributes and traits of personality). It is 'applied more to the disgrace itself than to the bodily evidence of it'. It plays a pivotal role in the forms of exclusion and marginalisation, and stigmatisation is the discourse that regulates our attitudes towards the excluded and marginalised.

Among the most common prejudices about sufferers with mental health issues are dangerousness and unprecedentedness. When Kiera was about to believe in and embrace her borderline personality's identity, she was shocked after seeing how dangerously borderline sufferers are framed in the public imagination. Her friend Laura instantaneously denied the possibility of her being borderline as, according to her, borderline individuals are really disturbed, and she referred to the movie from '70s, Fatal Attraction, where she got a glimpse of a borderline woman stalking her boyfriend with lethal weapons. Similar attitude was shown by her friendly counsellor Anna who said that borderline individuals are really dangerous and extremely disturbed. Popular Media is always overflooded with evidence of stigmatisation and devaluation of sufferers with mental health issues. Venkateshan and Saji (2021) argue, 'failing to navigate through a median reality about mental illness, these media representations capitalize on the common anxiety about these monstrous and imbecile patients' (147). These common media portrayals undoubtedly exacerbate the panic and distort the image more. It impacts 'how willing the public is to have people with serious mental illness as friends, neighbours and colleagues' (Sheehan et al. 2017, 46). When Kiera went through online platforms, she saw even the family members and close acquaintances had very often narrated borderline sufferers as individuals who can be highly vengeful, destructive and utterly remorseless for their wrongdoings:

> On the website's bulletin boards, they write heartbreaking messages about how they suffer in relationships with people they say have BPD. Words like "cruel," "indifferent," and "incapable of empathy" swarm on the screen. Seen through the eyes of these people, BPD looks nightmarish in ways I can barely fathom. (chap. 3)

Kiera's character was also endorsed frequently with another stereotype: a lack of consistency and competence. It led her 'family members or care providers to assume a paternalistic role and behave in a paternalistic role and behave in a controlling or coercive manner by unnecessarily assuming guardianship, payeeship, or other decision-making roles' (Sheehan et al. 46). While Kiera was sharing accommodation with her boyfriend Bennett and his ex-girlfriend Alexis just to avoid loneliness and be in a caring company, she was repeatedly categorised advertently or inadvertently as an individual who had utterly collapsed and pieces could not be gathered anymore: '"Look at how much you're suffering! This isn't addiction you're dealing with. This is mental illness. Think of it like being hit by a bus, and now you can't walk"' (chap. 1). The boyfriend, who at the beginning of the affair showed solidarity with Kiera and said that they were exactly like recovering drug addicts and that is why they would understand each other's plights of living, reversed his attitude after weeks of living together and said that she was just mentally ill who needed psychiatric assistance not love. He utterly denied the

matter of necessary caregiving and instead projected her as a person who could not manage her everyday life: '"Do you want to be with me because you love me," he asks, "or because you can't stand being with yourself?"' (chap. 5). The parents' attitude was in no way different, and it was just sufficed with ignorance and negligence. When years after the incident of cutting her wrist in the school days, Kiera asked her mother why she totally ignored her helplessness and just drove away, abandoning her; Kiera's mother said she was confused about taking a decision and thought Kiera could alone get away through it:

> She says, "Adolescence is always difficult; I thought maybe it was just a phase." She says, "I didn't know what to do; the whole thing was overwhelming." She says, "The counselor told me you would be okay." (Prologue)

In her most depraved situations, Kiera had searched for the presence of her parents and entered into a void. Every time she had lost a job, messed up in her love life and ended up having periodic hospitalisations, she had craved to be under the protection and guidance of her mother, who remained most of the time silent as well as unreachable:

> At this juncture, I'd typically pack up my things and beg my mother to take me in until I could find another job or a hospitable boyfriend. But she's out of the country, in Bali, on a yearlong sabbatical from her teaching job. (chap. 1)

And on another side, Kiera got a father recovering from addiction. Whenever Kiera tried to reach him to address her problems, the only solution he had was to join moral inventories irrespective of the kind of situation his daughter was going through:

> Whenever I'm in pain, falling apart, or in crisis, he gives me slogans: Easy does it. First things first. Keep it simple. Ask your higher power for help. Go to a meeting. If I were to call and tell him I've just split up with Bennet (read, yet another man), I doubt I'd get sympathy. He'd probably just suggest I do another moral inventory. (chap. 5)

As a daughter, Kiera felt the most vulnerable due to her parents' unwillingness to understand her predicaments and take responsibility for her in the hard times of her suffering.

The dehumanising psychiatric approaches, exaggerated media portrayals and discrimination in public and private life filled their knowledge repository of Kiera about herself with so negativities that manipulated the language she started using to identify herself, which was highly self-stigmatising. Self-stigmatisation happens when an individual's self-esteem and perception of their own identity gradually reduce due to the reflections in the eyes of the surrounding population that they are unacceptable socially (Vogel et al. 2007). It is an outcome of the internalisation of the stereotypes applied disparagingly through discriminatory public attitudes towards them, and the individual suffers diminished self-esteem and self-efficacy (Corrigan and Shapiro, 2010). Throughout the memoir, whenever Kiera tries to introduce herself and answer what she is in person, she fails to explain and ends up listing some labels and citing some tormenting incidents to project her identity:

> By the time I meet Bennet, I've quit two teaching jobs, spent over six months in mental hospitals, been on a dozen medications, and seen even more therapists. I dropped out of high school, then out of college. I'm like a cat with nine lives: prep, punk, goth, hippie, hipster… My periodic breakdowns somehow coincide with shifts in musical taste, and they generally lead to more diagnoses: depression, anxiety, posttraumatic stress disorder (PTSD), alcoholism, and drug addiction. Right now I call myself a recovering drug addict and alcoholic. (chap. 1)

Every time she tried to explain to herself the graphs of her relationship, dynamics of her sexuality, and other interpersonal trajectories, she used a language constituted with negative metaphors about herself. She consistently said to herself it was she who remained at the root of all problems, and it was because she oscillated between polarised extremes of emotions, she faces failure in relationships:

> Beginnings have never been too hard for me: to shape a first line' choose the right outfit—to pull off a good first act. For me, it's always after the entrance that things deteriorate, especially in relationships. Fifteen years after the episode with Jimmy, I've pulled myself together somewhat. No more drinking until I puke in men's laps. No more taking bottles of pills and being hospitalized. If you met me, you'd never suspect the suicide attempts, hospitalizations, and diagnoses. But if you saw me in a relationship, you'd know something isn't quite right. I'm always good in the beginning, but after that first flush of romance, my lipstick will be smeared like a clown's and I'll revert to the dismay of a child lost in the department store, curled up and wailing on the floor. (chap. 1)

She had internalised the image of instability so profoundly that even when few of her empathetic acquaintances tried to look at her conditions alternatively, she showed reluctance to come out of the eggshell of stereotypes. When Kiera's counsellor advised her that it is not necessary to always frame an identity totally around some diagnostic labels and pathologise own self, Kiera repeatedly insisted that she is mentally ill. Since her symptoms match with the label, she should fit in that.

> I urge her to look at the list of symptoms. "Tell me if this doesn't sound like my life: 'a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity.' (chap. 3)

Power is ubiquitous and it is everywhere. And it emerges from words, from epistemes, as Foucault calls them, discourses of truth. It is a product of both forms and the contents of already meaningful social acts and practices. As such, power is not to be found out there in the hands of a particular class, profession, or gender. Instead, it is inscribed in ordinary conversations: in gossip, in written communications, and nondiscursive body talk (Foucault 1977, 1998). Kiera's Journey of self-exploration drags the whole attention to the fact that self and identity are all a matter of game of language through which we perceive our existential and emotional realities. Throughout a significant part of her life, Kiera understood her mental health issues through the lens provided to her by psychiatry, popular media and other agents of her surroundings. The lens which engendered a language based on the hegemonic reference framework of the so-called normal population and constituted with stigmatising signifiers in order to understand mental health issues as deviance. The Buddha and the Borderline is an attempt to debunk that lens altogether and replace it with a narrative narrated through the eyes of a sufferer in the first person in a language of one's own.

Memoir Writing, Language, Truth and Agency

> I don't know if I'm looking in a mirror, or if the people looking on are caught in their own distortions. (Gelder 2010, chap. 3)

The gaze of normalcy distorts the perceptions about mental health issues and manipulates a de-personifying imagination of the pathological. Kendler (2014) says, 'We are 'stuck' with the dappled casual world for psychiatric disorders' (937). To alter the order of the world, we need humanistic and democratic frameworks for non-reductionistic clinical practices that will urge us to look into sufferers' issues not as 'we want them to be constituted, but rather as a real, lived experiences inextricably embedded within social, psychological, and biological contexts'. An expanded clinical gaze will 'remind us that responsible treatment requires more than prescribing a single modality, such as a psychotropic drug, but instead addressing multiple levels of interacting factors, including families, living situations, social networks, and what makes patients' lives meaningful' (Braslow et al. 2020). And that needs to attend to both third-person explanations and first-person understandings.

But for these explanations and understandings, sufferers' voices and their narrations about themselves have to be acknowledged. We are in a society where we consider health a norm and illness a condition to be corrected, never accepted. Smith and Watson write that 'securing the authority of some experiences is a tricky rhetorical process of speaking credibly and ethically about a dehumanizing and self-alienating past' (2010, 35). But, 'to be mentally disabled is to be disabled rhetorically' (Prendergast 2001, 57). Individuals with mental health

issues or those who have recovered are very usually denied the privilege of rhetoricability (56), and that is, they are not accepted as valid subjects who can narrate their own stories, and they are just denied agency.

Flaherty (2005) regrets, 'the memoirs of the mentally ill and of drug addicts are often, and sometimes rightly, ridiculed by reviewers for just this obsession with the author's own suffering'. But she says these narratives at least 'let other sufferers know they are not alone' (36). The purpose of any narrative of suffering and trauma is not at all to document and testify 'external truths', rather the survivor's testimony targets to articulate the 'internal truth' of experience (Schmidt 2017, 96). Waxman (2007, 48) argues, that the narratives of suffering are not about objective facts but about the immediacy and misery of lived experience'. The critical academic investigation needs not to be in the direction of what merely happened but how the events were experienced by the individual (Assmann 2006, 261, 263). In the psychiatry's 'diagnostic empire' (Wilson and Beresford 2002, 141), sufferers with mental health issues are objectified as voiceless invalid creatures in the narrative of diagnosis and in contrast memoirs undertake the task of infusion of the sufferers' transcendent, affective, and cognitive state into the psychiatrist's knowledge of the sufferers' experiences of mental health issues (Cassell 1991, 202).

Writing a memoir transforms from merely an act of documentation of own experiences into resistance, which Margaret Price (2009) calls counter-diagnosis. Psychiatric diagnoses perpetrate closeting that 'involves things not merely concealed but difficult to disclose' and 'the inability to disclose is, in fact, one of the constitutive markers of oppression' (Siebers 2004, 2). The narrative of diagnoses arrests the flow of sufferers' narratives by interrupting them with multiple complications, renders them confused, deflects them from their righteous paths and fragments them. In contrast, with its counter diagnostic potential, a memoir gives the sufferer freedom to use language to 'subvert the diagnostic urge to 'explain' a disabled mind. It attempts to 'not merely parallel or replace the conventional diagnostic story' rather 'it ruins it all together, attacks its foundations, queers it' (17).

Kiera Van Gelder's memoir The Buddha and the Borderline, on the one hand, mourns the devaluation and stigmatisation suffered by individuals with mental health issues due to the reductionist psychiatric diagnoses and negative stereotypes essentialised through popular cultural discourses and, on the other, shows the sensitive and sensational pathway of claiming agency on narrating the story of one's suffering and establishing authority by transcending from the object position to the subject position. Her memoir is a story of how Kiera has suffered and also recovered in the end. Still, it is not a stereotypical feel-good story of an individual who has succeeded despite mental health issues and achieved a sense of triumph. Kiera's story utterly refuses the 'cultural demand of cheerfulness'. Andrea Nicki (2001) argues

> A person who tells others she is suffering from a mental illness such as depression may be told, like a person suffering from a physical illness, that it is "all in her mind." … [But by] insisting that a person suffering from clinical depression be cheerful, [others] demand that she not only hide her Illness−her tearful or raging negativity−but that she immediately overcome it in order for them to continue to respect her as a person. (94)

Kiera hides nothing; she sticks to recalling her first-hand experiences throughout the years of her suffering and narrates them in the first person. Mental health professionals believe 'clinicians should help people with borderline personality disorder to avoid black-and-white thinking, such as right/wrong, good/bad, and all-or-nothing styles of thinking' (Ries et al. 1994, 57) which creates a belief that borderline personalities are extremely invalid and instable and the psychiatric approaches can define the normal mind. But, diagnosis itself is a narrative phenomenon and there is no such objective truth in it. Rather, Kiera's story about her borderline experiences is a proof of

> two important truths about disorderly minds. First, such minds show up all the time, in obvious and not-so-obvious ways; and second recognizing their appearance is not a yes-no proposition, but rather a confusing and contextually dependent process that calls into question what we mean by the 'normal mind'. (Price 2011, 3-4)

Kiera Van Gelder's narration from the position of first-person executes what Margaret Price (2009) calls creative incoherence (18) as a rhetorical strategy for the purpose of debunking the popular discourses and patterns of thinking about mental health issues and construction of alternative ideas and imaginations. 'Incoherent' colloquially indicates a lack of organisation, pattern and structure in the narration which develops a sense of unreliability, inconsistency and invalidity in the deliverance of truths and meanings. But Margaret Price has delineated the strategic advantage of incoherence in the memoirs based on mental health issues due to its potential to play in the space of negotiation between the author's and reader's consciousness. She borrows on Charlotte Linde's understanding of coherence in life writings as an outcome of negotiation between the author and the audience. Linde (1993) suggests,

> [Coherence] is not an absolute property of a disembodied, unsituated text. The speaker works to construct a text whose coherence can be appreciated, and at the same time the addressee works to reach some understanding of it as a coherent text and to communicate that understanding. The coherent text that the addressee constructs may not, of course, be the same as the text that the speaker believes was constructed. As long as the gap is not too great, the discrepancy will probably not be noticed. But if it becomes very large, further negotiation about the meaning of the text may be necessary. (12)

This 'further negotiation' opens up possibilities of resisting the hegemonic discourses of normalcy and altering those with more empathetic approaches towards sufferers. Therefore, Price has suggested introducing necessary incoherence in these kinds of narratives and advised to think of it as a-coherence or anti-coherence, which can be turned into 'strategic advantage rather than accommodated as impairment' (19).

Furthermore, Kiera has converted this incoherence into a strategy as if she is using the oppressor's tools of operating power in order to abrogate altogether oppressor's discourses and replace them with realities of the sufferer's embodiment. The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, DSM-V (2013) identifies a borderline individual with primary traits like 'frantic efforts to avoid real or imagined abandonment', 'a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation', 'identity disturbance', 'recurrent suicidal behaviour, gestures or threats, or self-mutilating behaviour', 'affective instability due to a marked reactivity of mood' and 'chronic feeling of emptiness'. These traits briefly imply that an individual with borderline personality lacks stability and coherence in his or her everyday life, actions and decisions. Kiera embraces those same identifying criteria of being unstable and incoherent and channelises it into a strategically advantageous tool in order to document her counter diagnostic narrative. Her memoir targets to engage the addressees in the realities of being incoherent through an incoherent narration of suffering by the annihilation of shame and stigma otherwise attached with incoherence.

In the prologue of her memoir, Kiera with extreme candour and frankness described how she desperately tried to tie a boy emotionally with her and make him guilty for not reciprocating her love approaches on one hand and at the same time she was quite aware that she might not damage herself in an unrecoverable way. Kiera says that she first thought to cut her pinkie finger and gift it to the boy but instantaneously she felt extreme affection for her finger and spared it ridiculing her decision:

> I consider cutting off my pinkie finger and giving it to him. I'd go to the art studio where they have those paper cutters with three-foot blades. Lop it off, wrap it up. Here. Look what you've done to me. You're leaving me, and taking me with you. But I like my fingers. Even the somewhat useless pinkies.

Then she shifted to the decision of running blades on her arms but again she felt extremely cautious about choosing the right blade so that it would just release faintest film of blood sparing any damage to her vital veins:

> So instead I make myself bleed, as I've learned to do. The instrument can't be too sharp, or it will go too deep and sever important bits. It can't be so blunt as to be useless. I like the thin,

> flexible razor blades that can be taken off a disposable plastic shaver—ubiquitous and easy to remove from the plastic casing. I enjoy the slide of metal into giving skin.

Slow drips of blood served her purpose of writing emotional words of pain and attachment and she assured creating an emotional sensation she was expecting out of the whole incident. Kiera's narration is a strategic display of incoherent emotions which oscillate between the desperation of showing off suffering in love and the priority of self-affection. It neither completely settles down on the side of being completely unstable as she was not at all mutilating herself without a sense of physical consequences and nor on the side of being completely stable as she didn't avoid taking common frantic efforts to exhibit loss of love. It was neither true that she was decisive about sacrificing herself nor it was a lie that she would be ready to bear little if there was a possibility that she could gain her love back.

Kiera's memoir exhibits a recurring resonance of incoherence of voices or rather say multiplicity of voices which don't go along with each other in a so-called coherent pattern. Susanne Antonetta says in the introduction to her book A Mind Apart: Travels in a Neurodiverse World (2005):

> My husband, Bruce, reads this [introduction] and says, Tell them it's a bipolar book. Hey, out there. It's a bipolar book. Though I, too, have to ask him what that means. He says, a linear, associational: I always have many things happening in my mind at once. To be honest, I am some of the many voices in this book. (12-13)

Similarly, Kiera very often has relied on this polyphonic exhibition in order to process and generate alternative meanings. The way the clinical gaze attaches a stereotypical image of incoherence projects the thought process of sufferers as extremely irrational, uncontrolled and unreliable. The strategic usage of incoherence in Kiera's memoir shows, in contrast, the embodiment of carrying on with discordant voices and an endless struggle to compose and balance a tune, which utterly disregards reductionism.

Margaret Price has identified another strategic narrative technique intertwined with I which can be executed in the memoirs of mental health issues and that is proliferation (21). Price means by 'proliferation', 'the construction of many selves to tell a single "person's" story'. She relates it with a proximate diagnostic trait of splitting of the selves which 'happens when a troubled consciousness divides itself, retreating into a fugue state or other alternative (protective) state of consciousness' (21) and suggests it as a desirable technique in counter diagnostic narratives.

Likewise, Kiera's memoir executes the deployment of many "I" s in the construction of the wounded "I" as well as an "I" of resistance. The glimpses of interpersonal relationships Kiera has given, offer readers to get acquainted with an individual whose consciousness can't be bifurcated into either-or binaries but rather needs to be understood only through its inherent multifacetedness and ambiguities. Kiera was extremely insecure about her boyfriend Bennett's bonding with their flatmate Alexis who was also his partner in the past and whenever she looked at them spending time together with their pet bird, jealousy boiled her blood and filled her mind with destructive intentions: 'I don't know what threatens me more—Alexis the Ex or Bancha the Bird. When I witness the three of them bonding in the kitchen, I want to throw knives' (chap. 1). But at the same time, Kiera confesses that she was fully aware that jealousy was insidiously creeping into her nerves and poisoning her relationship which could again exhaust her in the end. She carried on distinguishing vice and virtue and struggled to choose and act in accordance with her moral standards. On one hand, she just wanted to break things into pieces and simultaneously she went on giving reasons to herself for settling things down gathering the broken pieces. Not only that, but eventually, Kiera finds no shame in exposing the extreme contradictoriness of her emotions amidst all these jealousy, envy and vengeful thoughts, she also started exploring a possible bond of sisterhood with Alexis:

> To confuse matters, Alexis is steadily growing on me. Some evenings the two of us prepare dinner, like co-wives, confiding in each other and discussing delicate information, such as the admirable size of Bennet's penis. We sip tea and revisit the times in our lives when both of us

> were desperate for drugs. Like Bennet, I've gotten into the habit of hugging her good night. I've missed the friendship of a woman. Also, I realize she's quite hot. (chap. 1)

Moreover, whenever Kiera tried to answer herself why she was at all tolerating this relationship in spite of her jealousy, she sporadically up with an image of Bennett and Alexis which was just an altogether opposite of the persons, she usually wanted to get rid of:

> I am always on the verge of drowning, no matter how hard I work to keep myself afloat. And the only way I know to stay afloat—to survive—is to find a savior. Bennet, as it turns out, has a bit of a savior complex. (chap. 1)

The moment she decided to leave Bennett's place and stay alone on her own she used to get haunted by the loneliness and stayed back in their company. And finally, when she after sometimes went out as she wanted every time, she ended up collapsing:

> Instead, panic and rage explode inside me as soon as I close the car door. I start screaming when I turn onto the highway toward Waltham. If passing drivers were to look, they'd glimpse a wild-haired woman-child at the wheel, swerving along her lane, mouth open, eyes like slits, her voice—and her life—trapped inside a vehicle careening toward destruction. (chap. 5)

The strategy of proliferation provided Kiera with the advantage of the depiction of embodiment which otherwise in the diagnostic narrative gets utterly negated. Kiera has given voice to the symptoms of the diagnostic manual and a language to normalize the negatively imagined pathological and philosophize it. What stands for the clinical gaze as a borderline personality now gets transformed through Kiera's narrative into an existential reality of an individual's journey through the multiple phases of human consciousness. It frames the phenomenon of interconnection among projection of self, use of language and construction of identity as extremely dialectical. After a psychiatrist labelled Kiera ultimately as a borderline patient her friend Anna outrightly rejected the labelling in contrast and tried to convince her to look at and talk about her own symptoms in a more humanistic way instead of just using a terminology picked up through mix and match from a diagnostic manual.

> "I'm sure there are other ways of looking at them." She read off the first of the criteria: "Frantic efforts to avoid real or imagined abandonment…" She pauses for a few seconds, trying to choose her words carefully. "Well, of course you're sensitive to that. Your parents divorced when you were young. You never knew when your dad was going to show up, or when your mom was going to pay attention to you. We've discussed how they weren't there for you in the ways you needed. Anyone with your upbringing would have some abandonment issues." (chap. 4)

Anna's method of understanding, way of talking about a symptom and ideas conveyed about suffering stand in straight opposition to reductionism and that attempt to lend an altogether different viewpoint in the journey of self-exploration. So, the language through which one comes in contact with one's self and identity is extremely dialectical and it has both the power to lead to self-stigmatization on one hand and motivate one to keep one's self-esteem high to fight depression.

After, being diagnosed with borderline personality disorder, she was prescribed dialectical behavioural therapy which emphasizes the dialectical nature of the interconnections of language, self and identity. Dialectics stresses on 'fundamental interrelatedness or wholeness of reality' that is not at all static but 'comprised of internal opposing forces (thesis and antithesis) out of whose synthesis evolves a new set of opposing forces' and assumes that the fundamental nature of reality is 'change and process rather than content or structure' (Linehan 1993, 1-2). Likewise, self and identity are dialectical realities and they are neither truly based on the symptoms so-called abnormally shown from time to time nor also on complete assurance of so-called normalcy. Rather they are constituted with the presence of altogether contrary traits and must be accepted in that way. Kierra has always remained in a confusion that how much normal and abnormal her behaviour, perception and actions are, 'how

much of what I perceive is accurate, and how much is a distortion?' (chap. 11). Now, the dialectics resides in the fact that in one way she is becoming capable and in other way she is not also capable under some circumstances. Dialectics is not about either-or rather it suggests the presence of both. And, this way of looking towards own self undoubtedly resists devaluation and helps to enhance self-esteem. During the period of her recovery, Kiera was searching for accommodation and she was hopeless because she was doubting who would be willing to give a place to a mentally ill person on rent. So, she took the advice of her therapist and tried to apply a dialectical behaviour that revealed herself not as a psychiatric consumer but as an artist who was in a dire need of a studio for engaging in artworks. Now, it was in no way a lie as obviously, Kiera was a professional artist by then and though her life was going through avenues of psychiatric diagnoses her artist self was intact within her as before.

> A married couple and longtime Harvard professors, they're used to renting the studio to traveling scholars, not former mental patients, so I know I have to put on my game face and present myself as capable and self-sufficient. I tell them that I'm an artist, looking for a quiet place to work when I'm not at my day job—which is true. Remember the dialectic: Two seemingly opposite things can be true at the same time. (chap. 12)

The 'I' is never a coherent or consistent entity; it is the medical and popular discourses which pathologize the parameters of difference and deviance in 'I' when they address 'I' in an objectifying way through 'you' and memoir as a counter diagnostic narrative opens up possibilities for 'I' to normalize the otherwise pathological 'I'.

Conclusion

Language has both the capacity to stigmatise and also to counter it. It just depends on the gaze through which it is mediated and generated and varies in accordance with the subject and object position. The Buddha and the Borderline presents us with both the exclusive and inclusive nature of the language and its operation in regulating the perceptions about mental health issues in the public consciousness. Mental health issues are not just assimilation of abnormal psychiatric symptoms. Rather, it is 'a complex phenomenon, composed of several different aspects, including the person's cognitive, sensory and emotional experience; how their social experience is affected by mental distress, including changes in their social behavior and in other people's responses and behaviors towards them; their experience in mental health services; their identity and self-perception regarding mental distress; and the meanings they create and adopt to explain their own experiences' (Chassot and Mendes 2015, 374). If only the diversity of the subjective experiences of mental health issues, is socially, culturally acknowledged and empathized with and taken into account during the process of diagnosis, then only the stigmatization can be prevented. But for that in one way, the individuals suffering from mental illnesses must have the agency to narrate their own experiences and decide for their own needs i.e., nothing about me without me and parallelly, for the erasure of the politics of disavowal (Bérubé 1996, 85), the collective consciousness also needs to be redressed to acknowledge and accept the alternative dimensions of their self and personhood. Kiera's memoir has helped to 'connect her own multiple selfhood to a more liberal notion of community'. It witnesses the grim aspects of drug use and alcoholism, failures in interpersonal bonding, paranoia and delusions and self-harming and suicidal tendencies which very often constitute the causes and consequences of mental suffering. Kiera's journey through psychiatry was never a liner one and she became a part of a variety of therapy sessions available in the western society like 12 step recovery, NA and AA groups, behavioural therapy classes, MAP programs and others where she came across a diverse range of population including persons dealing with minimum workspace anxiety as well as those who had just recovered from a failed suicide attempt. Therefore, Kiera's memoir is not just an individual experience but rather a story of 'the varied and collected experience of all the persons described and addressed therein, many heads and one head alike'. Price says, 'in the area of psychosocial disability', 'the common response to the announcement '"I have depression"' is '"Oh yes, I get depressed too"' (21). The Buddha and the Borderline targets to trigger that response in the minds of the people whose voices are confined in the closet and this purpose has given the memoir some verisimilitude. Instead of evaluating parameters of truth in autobiographical works through a predetermined myopic framework, Eakin (1999) suggests, that it is better to investigate 'what such texts can teach us about the ways in which individuals in a particular culture experience their sense of being 'I'—and, in some instructive cases that prove the rule, their

sense of not being an 'I''. The Buddha and the Borderline is not just a piece of literature or artwork, it has the pedagogical capacity to redress society's attitudes toward mental health and democratize and humanize the institutional interventions in the phenomenological understanding of mental health issues.

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