

## Parasuicidality and Patient Careerism: Treatment Recidivism and the Dialectics of Failure

Ross Ellenhorn, PhD  
The Edinburg Center

The author interprets parasuicidal behavior as a means certain individuals use to sustain patient careers. Contrary to the current trend to identify this behavior solely as the defining symptom of borderline personality disorder, the author argues that parasuicidality often emerges from the symbiotic relationship between individuals with particular existential needs and the medicalized institutions that serve them.

Throughout the United States, psychiatric hospitals, community mental health agencies, and clinicians in independent practice are using dialectical behavior therapy (DBT; Linehan, 1993a) to treat individuals labeled with borderline personality disorder (BPD). DBT is a highly structured cognitive-behavioral intervention that uses a combination of group and individual treatment. Skills training groups are the hub of DBT treatment. To facilitate the skills training groups, DBT therapists use a workbook (Linehan, 1993b), complete with session-by-session instructions for them as well as handouts and homework assignments for their clients. With its emphasis on prescriptive techniques and achievable cognitive learning objectives, DBT is a novel approach to a disorder that was once the prime subject of the more hermeneutical and fluid process of psychoanalysis.

The use of DBT as a specific treatment protocol designed to ameliorate a specific kind of problem marks the logical consequence of an already well-established historical trend in the psychological professions. Whereas once the term *borderline personality* was used essentially as an interpretive tool for understanding a certain process of the self (Kohut & Wolfe, 1978) or personality organization (Kernberg, 1967), today, especially in community mental health and hospital milieus, the term is more often used to label particular individuals as suffering from a specific illness that distinguishes them as qualitatively different from the rest of the population (Horowitz, 2002; Kirk & Kutchins, 1992). As sociologists would describe it, the diagnosis of BPD is increasingly

intended as a medicalizing label (Conrad & Schneider, 1992).

DBT's contribution to the canon on BPD achieves the predictable apex of this medicalizing trend: the etiological location of the problem in the anatomy of patients with BPD. Marsha Linehan (1993a), the founder of DBT, has argued for a physiomechanistic theory of borderline behavior. For her, borderline personality disordered individuals are differentiated from the rest of the population because they are damaged in their ability to regulate distress. They suffer an imbalance in a regulatory system, something metaphorically similar to an immune deficiency or arthritis. This imbalance is due, partly, to (assumed and unidentified) biological determinants.

Taking a medicalizing stance and using behavioral techniques, DBT emphasizes the most physically observable behavior associated with the borderline diagnosis as its central signifier. For practitioners of DBT, parasuicidality (repetitive, nonfatal suicidal behavior and threats of such behavior) is the central symptom of a certain subtype of BPD. Linehan (1993a) demarcated parasuicidal borderline individuals as the target of her treatment, approaching parasuicidality as a dysfunctional means these individuals use to regulate their distress.

Although parasuicidal behaviors range in their level of actual physical danger, their major outcome is conspicuously reliable: contact with therapeutic professionals at points of crisis. By highlighting parasuicidal behavior as a distinct behavioral problem—like alcoholism or an eating disorder—Linehan (1993a) brought to the forefront of her theory behaviors that are intrinsically linked to hospital and acute intervention recidivism. Focusing on a behavior inherently destined toward the outcome of a clinical response, Linehan's observations lay the groundwork for a competing interpretation of parasuicidality, one

---

Ross Ellenhorn, PhD, The Edinburg Center, Lexington, Massachusetts.

Correspondence concerning this article should be addressed to Ross Ellenhorn, PhD, 220 Barton Road, Stow, MA 01774. E-mail: [rellenhor@comcast.net](mailto:rellenhor@comcast.net)

that identifies the cycle of acute treatment recidivism as a key to interpreting the behavior of individuals she labeled *parasuicidal borderlines*.

I engage in such an interpretation in this article. The theory regarding parasuicidality delineated in the pages that follow is dialectically linked to DBT, influenced by three elemental contradictions in Linehan's (1993a) work. First, whereas Linehan interpreted parasuicidality as the signal and terminal behavior of a particular disorder and clinical interactions as the inevitable consequence of this behavior, I target the habitual access of clinical interactions as the focal point for study. In this view, individuals who habitually contact mental health professionals at points of potential self-harm do not fall into the hands of clinically oriented institutions simply by way of a logical sequence from symptom to medicalized response. They use parasuicidal behavior to access a particular cluster of psychological and social resources that are achieved only through interactions with institutions dominated by medical epistemologies.

The switch in epistemological gaze, from parasuicidality to treatment recidivism, leads to the second dialectical response to Linehan (1993a): that parasuicidally activated recidivism, rather than being a symptom that can be cured through interventions informed by the medical model, is a behavior abetted by the kind of medicalized vision Linehan assumed. Parasuicidally activated recidivism is inseparable from a medical world view and the influence of the norms and roles of medical culture on the behavior and self-perception of both consumers of mental health care and the professionals who treat them. It is, in other words, *culturally iatrogenic*, the term social philosopher Ivan Illich (1982) used for the disease caused by medicine's hegemonic influence on how we think about and approach general problems in our life.

The insight that parasuicidally activated recidivism is contingent on medical culture leads to the third dialectical response regarding the individuals Linehan (1993a) labeled parasuicidal borderlines. Whereas Linehan took the validity of the diagnosis of BPD as a given, I see it as another example of medicalization gone awry (Horowitz, 2002). The epistemological (Kirk & Kutchins, 1992), epidemiological (Widiger & Weissman, 1991), and nosological (Perry, 1990; Rosegrant, 1995) validities of the BPD diagnosis are questionable. As presented in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000), the

diagnostic categories for BPD lead to a vast spectrum of potential permutations, constructing versions of the disorder that are unrecognizable in similarity. BPD is also portrayed throughout the literature as a sort of pastiche of comorbidities with other disorders (Gunderson & Phillips, 1991; Hudziak et al., 1996; Nurnberg et al., 1991; Silk, Lohr, Ogata, & Westen, 1990; Silk, Westen, Lohr, Benjamin, & Gold, 1990), which often makes it difficult to distinguish it as a diagnosis that stands on its own. Aware of BPD's nebulosity as a diagnosis, I do not argue in this article for a new way of understanding BPD as a distinct psychopathology. Instead, I take a somewhat simple stance, rooted in the obvious. We know that individuals Linehan (1993a) labeled parasuicidal borderlines are parasuicidal, and we know that parasuicidality leads to interventions by clinical professionals. I focus on the interplay between individuals who exhibit parasuicidality and the professionals who treat them.

Although I do not approach parasuicidality in this article as a clear and automatic indication of BPD, I do interpret it as a possible indication of a particular existential crisis experienced by people with diverse psychological traits. As I describe, individuals who exhibit parasuicidal behavior are similar to one another in the fact that they access medicalized interventions to avoid or dull the intolerable psychic experience of totalizing personal failure. Driven by the belief that they have inherently failed as people, they seek to diminish this sense of failure by entering the social role reserved for people who are ill and under medical care: a role defined by themes of passivity and minimal accountability. Parasuicidality is their means to both access the sick role and protect a more consistent engagement in this role, what I call a *patient career*.

The fact that individuals who engage in parasuicidal behavior repetitively follow a course of behavior aimed at concealing their agency in the world does not make these individuals unique. The anguish and struggle over accepting one's ability to act freely are the basis of the existential angst generally experienced by individuals in differing degrees of intensity (May, 1980; van Deurzen, 2002; Yalom, 1980). Assuming certain behavioral patterns to avoid this angst is also a general human defense. Not all individuals, however, avoid existential accountability by seeking an identity that is as intensely defined by passivity as one based in a patient career. Indeed, many people take the opposite tack, narcissistic omnipotence, whereas others simply choose conformity

(Spinelli, 2003). A patient career is distinct from other forms of existential bad faith because it both provides shelter from existential accountability by means of a self-definition of total passivity and maintains this self-definition in relationship to medical institutions and the professionals who occupy them. This said, a patient career is still not the sole province of parasuicidal individuals. In addition to individuals whom sociologists typically define as having the patient role thrust on them, such as those with chronic illnesses (Parsons, 1951; Scheff, 1963; Whitt & Meile, 1985) or the institutionalized psychiatric patient (Augoustinos, 1986; Goffman, 1961), a host of individuals can easily be described as habitually and actively seeking medical attention as a means of sustaining and generating an identity formed by the parameters of the patient role. Factitious disorders are the most obvious example of this latter group. As described in the *DSM-IV-TR* (American Psychiatric Association, 2000), the hallmark of a factitious disorder is the exhibition of symptoms to “assume the sick role” (p. 517). Individuals exhibiting behaviors associated with Munchausen disorder, conversation disorder, somatization disorder (Wooley & Blackwell, 1975), and hypochondriasis can also all be understood as using certain behaviors to “assume the sick role.” What differentiates parasuicidality from these other treatment-seeking behaviors, however, is that it directly and potentially threatens the liability of clinical professionals. As I show, parasuicidality is primarily an other-oriented gesture aimed to engender in clinical professionals an anxious need to attend to the person exhibiting it. Parasuicidality not only facily attains access to the sick role for those who exhibit this behavior, it motivates (in large part by fear) the vigilance of medical professionals and their compliance to the norms of medical culture. Parasuicidality, in this light, is both a role-seeking and a role-generating behavior, for although it is a means by which to assume the sick role, it is also a means toward generating the kinds of complementary medicalized behaviors that support this role.

In the pages that follow, I initially delineate the means by which failure-induced anxiety operates as a driving concept in regard to parasuicidal individuals. I then investigate how parasuicidal individuals enter the patient role as a means by which to diminish the anguish of failure. Finally, I explicate how clinicians, informed by a medical world view, participate in the coconstruction of parasuicidal behavior specifically and patient careers more generally.

### Dialectical Failure or the Dialectics of Failure?

For Linehan (1993a), as for many theorists who address BPD in general (Gunderson, 1984; Kernberg, 1967; Masterson, 1975), parasuicidal borderline individuals respond to the world through a lens of dichotomous splits. They cannot synthesize competing values, thoughts, or emotions simultaneously. In Linehan’s (1993b) cognitive-behavioral theory of splitting, “dichotomous and extreme thinking, behavior and emotions, which are characteristic of BPD, are viewed as dialectical failures” (p. 2). According to Linehan, their tendency to fail dialectically affects borderline patients in all manner of circumstances. Their inability to bear ambivalence, however, is most obstructive when borderline patients face issues of change. Because personal change requires that one tolerate the specific opposing poles of accepting oneself as one is and changing, Linehan believed that the dialectical dysfunction in borderline individuals makes “progress extremely difficult” (p. 2).

Linehan (1993a) offered an insightful vision regarding the struggle over the ambivalence of change. However, her analysis is limited to reductionistic assumptions by her insistence that the borderline individual’s inability to withstand the polarities associated with change is rooted in a particular cognitive dysfunction. In Linehan’s view, the disability of dialectical failure is fixed within the individual. It is most pronounced whenever the borderline individual encounters the many and diverse challenges to ambivalent thinking. Thus, Linehan saw the process of change and dialectical failures as autonomous phenomena. People suffering from BPD are damaged in their ability to endure any number of ambiguous situations. Change, coincidentally, is one such situation. Contrary to this vision, I identify the challenges of change rather than dialectical failures as the axis of parasuicidal behavior. In this theory, parasuicidality, and many other behaviors exhibited by the individuals Linehan treated, are the gestures of people contending with the vicissitudes of change, not the signifiers of a cognitive dysfunction that is most pronounced when these individuals contend with ambivalent situations (change being one of them).

When an individual makes changes in his or her life, he or she inescapably brings into relief his or her innate power to master this life. Thus, personal change and exposure of one’s personal agency go hand in hand. Change, in this view, is an existential issue rather than a cognitive-behavioral problem. It poses a dialectical challenge to a person, but this

challenge is a universal human one: part of the “web of manifold tensions” (Cooper, 2003, p. 11) spun by the unbearable recognition of existential freedom (Farber, 2000; May, 1980; van Deurzen, 2002; Yalom, 1980). One’s ability to risk change depends on one’s ontological security (Laing, 1969). A person is able to most fluidly enact change when he or she is able to withstand the recognition that he or she is the author of his or her ever-changing life.

The inherent correlation between personal change and exposure of personal agency poses a particularly difficult threat for an individual who identifies himself or herself as a failure. For such a person, acknowledgment of life authorship inevitably means accepting agency in a life he or she perceives as a blunder. Because change is a potent manifestation of life authorship and any act of agency or efficacy brings the unbearable recognition that the person is responsible for a life that has failed, he or she experiences even the simplest change as an arduous challenge. The self-defined failed person is thus trapped dialectically between avoiding the recognition of his or her own accountability and facing accountability by changing. Contending with this trap, the person often behaves in a manner that is perversely self-fulfilling. He or she chooses to continue the life that he or she hates and remain disappointed rather than change this life and face the awful recognition of his or her own life authorship.

Individuals who engage in parasuicidal behaviors as a means to access a therapeutic response are trapped in this difficult dialectic of failure. They are driven by the horrible cognition that somewhere their life course went terribly wrong. More awful than that, they feel themselves as failures in their very being—as if, in common terms, they never amounted to anything. Their repetitive engagement with therapeutic professionals is a means to endure a life within this trap.

In a group I facilitate at a day treatment program, largely composed of parasuicidal women and titled *Ambivalence and Change*, I periodically ask the group to list the 10 most important forces keeping them from changing their life. This is an open group, so the participants change over time. Their answers, however, are remarkably consistent, amalgamating in what the group has labeled the 10 reasons not to change. All the reasons not to change focus on the struggle among enacting change, facing one’s agency and accountability, and, consequently, confronting one’s sense of failure. The first seven of these reasons illuminate how anxiety about one’s accountability hampers change. Although the dynamic between

change and accountability is particularly difficult for individuals who identify themselves as failures, it is a general dynamic inherent to change. The remaining three reasons not to change address valuable resources the individuals in the group feel they will forfeit if they make changes in their life. These resources are more specific to individuals who repetitively engage in treatment.

## The 10 Reasons Not to Change

### *Reasons 1–7: The Threat of Accountability and Rising Expectations*

*Reason 1: Raising one’s own expectations about change.* When a person enacts change, that person raises his or her own expectation about his or her ability to change further. For someone who has experienced multiple failures, acts of competence are thus threatening because they mean the potential of failing to meet the expectations generated by change. Keeping one’s expectations low about success is a central means of avoiding this threat. If one does not have high expectations about oneself, there is little possibility of disappointment. One can only keep one’s expectations low, however, by resisting change.

*Reason 2: Raising the expectations of others.* To make a positive change in one’s life, one not only raises one’s own expectations but inevitably raises the expectations of others. Doing so, one risks that others will witness one’s failing from the new, more positive status one has achieved. The self-defined failed person fears that his or her failure in one project will confirm for others his or her total failure at life.

*Reason 3: Facing where one is in life.* Progressive change requires that individuals assess what they need to change. This confrontation is particularly difficult for an individual who believes his or her life is an awful disappointment. For such a person, evaluating his or her life at present is synonymous with evaluating his or her failure at life.

*Reason 4: Taking small steps.* To change his or her circumstance, an individual is required not merely to face the status of his or her life momentarily but to do so repetitively, as he or she takes the incremental steps toward a goal. Thus, when one forges into change, one is potentially confronted by one’s current (self-authored) predicament each step of the way. For an individual who defines himself or herself a failure, these incremental steps toward change feel injurious, for each one reflects his or her

status. The person sees that he or she has many small steps to take to reach his or her goals and is thus confronted, every step he or she takes, with his or her overall lack of accomplishment.

*Reason 5: Being accountable for what's next.* The more a person changes, the more the outcome of his or her life is potentially seen by that person and others as within his or her hands. For someone overwhelmed by a sense of personal failure, making positive changes is like stepping onto a slippery slope of accountability from which there is no return to a previous life shielded from expectations regarding autonomy and personal agency.

*Reason 6: Facing the unknown.* Enacting change in his or her life, a person faces the unknown possibilities of a life created by his or her own free actions. He or she thus must contend not only with an inherently capricious world but also with the unpredictability of the future created in part by his or her own actions. The self-defined failed person sees little information in his or her past to predict a successful future. For such a person, facing the unknown means facing a menagerie of possible failures.

*Reason 7: Feeling alone (existential aloneness).* Anxieties about one's aloneness as an existentially accountable actor in the world invade all of the first seven reasons not to change. Whether one is concerned about rising expectations, recognizing one's own status in life, or facing an unknown future, change poses a particularly difficult challenge, for it inevitably brings with it the revelation of one's agentic powers.

The final three reasons not to change are less about the intrinsic angst of change than they are about accessing important social resources through contact with clinicians. They highlight the ways engagement in treatment can operate as a means for some individuals to defend against the anxieties inherent in the process of change.

### *Reasons 8–10: Engagement in Treatment and Staying the Same*

*Reason 8: Losing a network of treaters.* Therapy aims toward change and the amelioration of symptoms. Thus, when a person makes positive changes in his or her therapy, he or she inevitably forges the path that leads out of this therapy. For the self-defined failed person who is well invested in treatment, this polarity between change and loss is threatening. For him or her, losing therapy means losing vital social-psychological resources. The daily activities and the types of relationships that compose the social life of

individuals engaged in the mental health system provide a full prescription of artificial and often superficial psychological and social panaceas that mimic basic social supports: pseudointimacy and quasi-friendship found in relationships with therapists, day programs, and hospital staffs, and an extended family of providers. These tangible resources also offer more subtle psychological goods—the guarantee that someone is paying attention, and the promise to understand an individual as comprehensively damaged—the loss of which one client called “destroying the negatives.”

*Reason 9: Losing the guarantee that someone is paying attention.* To approach life securely, every individual needs a sense that he or she exists in the consciousness of someone else—that, although he or she is alone, he or she matters to others. Therapy and therapeutic communities provides this sense. With their charts, their tendency to “begin where we left off,” their propensity to remember and remark on the progress of each client's life, therapists promise continuous attention to individuals. Therapists and therapeutic communities offer an enduring recognition to those they treat, providing their clients the important sense that they exist in the mind's eye of someone else even when they are out of physical sight. As I describe further, therapy typically provides this attention without the pressures or expectations regarding existential accountability.

*Reason 10: Destroying the negatives.* Therapy is partly a process of sharing the daily memory of the daily life of an individual. It is also a process of commemorating the individual's past hardships. For someone overwhelmed by a sense of failure, the need for others to recognize past damage is often insatiable. For this individual, the therapist's recognition of his or her difficult history is not only therapeutically empathic but a means to a life narrative imbued with themes of external forces and individual passivity.

For the self-defined failed person, acts of independence are signs to others that the past was not as bad as he or she portrays it. Independent functioning signals that past events might have been painful, even traumatic, but they were not so oppressive as to destroy the individual's ability to survive. As one of my clients described it, change is “like destroying the negatives” to her past (a remarkable term, for it can mean both destroying the memory of negative experiences and, more metaphorically, destroying the snapshot record that they occurred). Becoming better, for this client, means partially obliterating the proof of her hardships. Therapy and belonging to a therapeutic community, conversely, offer the hope that

someday someone will merge with the individual in his or her pain and endorse his or her narrative of total passivity.

For the self-defined failed person, failure is intrinsically biographical. It is the personal road he or she has taken until now, his or her disappointing destination at present, and his or her destiny. The first seven reasons not to change match this biographical continuum of failure. People avoid changing because of concerns about the past (their accountability for previous decisions and actions), the present (their responsibility for who they are in the moment), and the future (which threatens unpredictability and potential for disappointment). The final three reasons not to change give evidence that some individuals engage in treatment as a means of developing an alternative biographical self-description that avoids the anxieties of change. I call this form of self-description a patient career.

### The Patient Career

“Like victims of epilepsy, muscular dystrophy, and neurofibromatosis (the ‘Elephant Man’s’ disease), victims of borderline neither asked for, deserved or caused their affliction,” wrote psychiatrist Leland Heller (1999). “They are terrified of being abandoned, yet are powerless to keep the illness from destroying relationships. Borderlines are VICTIMS—they did not cause their illness. They do not want their illness. They want to be treated and possibly cured” (p. 211). People who habitually present as distressed and at risk in clinical milieus often use a particular language to describe their experience, markedly similar to Heller’s. Using adjectives of illness, they often use a passive voice, speaking of their self-destructive behavior as “triggered” by a force outside their control. They “become suicidal,” “cannot control the urge to cut,” and “are hospitalized.” Such individuals use the lingua of people assuming the role of patients under medical care.

The word *patient*, in the medical sense, means to passively suffer. Similar to the roles of victim and child, the patient role is differentiated from other social roles by its sanctioning of passivity (Morrison, Bushnell, Fentiman & Holdridge-Crone, 1977; Parsons, 1951; Scheff, 1963; Whitt & Meile, 1985). To be defined a patient, a person must shed agency and accept passivity. This is the threshold across which a person must pass as he or she enters the patient role. For someone trapped by the dialectical tensions of failure, this role is a haven in which he or she can partially escape the difficult struggle of accountabil-

ity by entering a socially authorized status congruent with his or her own self-description (Warren & Messinger, 1988). In this light, being a mental patient is not a purely macrosociological phenomenon defined simply by the parameters of the role itself. It is, instead, a form of identity. In the sense that patienthood is an identity easily accessible for the description of oneself to others and is based on biographical accounts that are used to forecast the future, it also has all the hallmarks of a career.

Careers are social and psychological resources that fluidly link one’s internal experience of self with the world of others, allowing “one to move back and forth between the personal and the public, between self and its significant society without having to rely overly for data upon what the person says he thinks he imagines himself to be” (Goffman, 1961, p. 127). Careers are efficient in portraying a depiction of a person’s social status because they capture a concise chronological portrait of the individual. By definition, a career (with the word’s linguistic relationship to *carry*, *careen*, and, of course, *car*) connotes an ongoing endeavor, articulated in stories about where one has been, where one is located at present in a life course, and where one is going. Linking the psychological with the social and telling stories of movement over time, careers offer cohesive narratives regarding each person’s existence in the world and his or her effect on this world (Goffman, 1961; Warren & Messinger, 1988).

Careers balance issues of personal agency and effectiveness with a linear narrative about change and movement. They are, in this sense, an existential compromise. They offer both a means for an individual to personally and socially acknowledge his or her own authorship of his or her life and a chronological narrative construction about a logical progression of life events that delivered the person to his or her current status. Careers safely contain issues of authorship in an easily comprehensible package of biographical steps. Thus, typical careers blend what existentialists (Sartre, 1956) call good faith (i.e., acceptance that one is fully accountable for his or her existence; e.g., “She built her career”) and bad faith (i.e., denial of one’s existential choice to be who one is in the moment; e.g., “She’s on the right career path”).

The patient career is both similar to other careers and exactly their opposite. It offers a biographic explanation for an individual’s existence and identifies this individual as assuming a particular status in society, yet it is composed of bad faith narratives only, denying the individual’s agency in this career.

In a patient career the polarities between having a career and making a career are skewed significantly toward the former attitude: that the careerist not only was led by a career path but had no agency in its navigation. Whereas the typical career offers an individual a means to efficiently portray his or her status in society as partially reflective of his or her effectiveness (e.g., “She is self-made”), a patient career identifies the individual’s current context as reflective of events acted on him or her (e.g., “She suffers a mental illness”). Similarly, whereas the typical career is generally used by an individual to identify himself or herself to others as an active agent in the world (e.g., one asks a new acquaintance not, “What is your job?” but, “What do you do?”), a patient career is a means for an individual to efficiently identify himself or herself without raising the expectations of others or risking their assumption regarding the individual’s authorship or accountability (e.g., one does not ask the mental patient, “What do you do?” but instead queries about his or her rehabilitation: “How are things coming?”). In a similarly paradoxical mode, whereas experiences of failure are precursors of crises of identity and social standing for individuals participating in typical careers, success is the ultimate threat to the patient careerist. Accordingly, consistent failure rather than success is the means by which to maintain such a career.

A patient career gains a strangely paradoxical form of status and social acceptance based on the denial of the very attributes we often associate with self-actualization, achievement, and even mental health. It is thus remarkably reflective of the existential needs of individuals who have defined themselves as failures. Although such a career is contingent on the negation of accountability for one’s place in life, the expectation of personal agency, or a respect for one’s life authorship, it provides individuals the opportunity to take part in a collective identity and offers a social network of people familiar with this identity who validate it as legitimate and justifiable.

In its paradoxical nature, a patient career achieves two important relational and psychological resources typically associated with both independence and self-awareness, without raising the risk of exposing the patient careerist’s agency in the world. It provides a sense to the individual that he or she is held in the gaze and consciousness of others—what I call *conditional enduring attention*—while modulating his or her experience of agency in these others—what I term *Medusaization*. Concurrent with its access to these resources, a patient career attains for the self-

defined failed person the ability to affect the world around him or her while shielding his or her own effectiveness. I call this process *effective ineffectualness*.

### *Conditional Enduring Attention*

Like most individuals, the self-defined failed person finds a sense of comfort and safety when he or she feels held continuously within the consciousnesses of others. He or she wants and needs a sense not simply that someone is paying attention to him or her in the moment but that he or she remains in the consciousness of another long after this person is out of sight. The individual seeks a reverberating, enduring attention. Although the self-defined failed person yearns for the assurance that someone is paying this kind of attention to him or her, he or she does not want to be looked at too closely. (This tension between wanting to be “seen” but “not seen” is similar to Laing’s [1969] description of “primary ontological insecurity” [p. 39].) The person needs to be seen but not seen in the glaring light of full authenticity. To be seen by others in the latter manner means the possibility these others might observe the person’s success, begin to expect more from him or her and thus possibly watch him or her fail again, or simply accept him or her as an active social agent. The person thus vacillates perpetually between seeking witness from others and fleeing from their gaze for fear that if they observe him or her, they will bear witness to his or her failure. A patient career provides a partial solution to this anxiety-ridden vacillation. It guarantees that someone is paying attention in an enduring manner, yet it attains this attention through highly conditional and fairly inauthentic ways.

The following is an example of how a sense of enduring attention is achieved through parasuicidality: A client had been unexpectedly absent from her day treatment program. Returning to the program, she was dissatisfied by the staff’s lack of concern regarding her absence. That night, she presented at a local emergency room after superficially cutting her wrists. She met with a member of the intake staff there. The staff member attempted to counsel her, inquiring about any particular precipitant to her current crisis and attempting to engage her in a conversation about her emotional state. The client became increasingly agitated in response to this line of questioning, explaining emphatically that she simply “felt the urge to cut.” She was hospitalized.

The client’s behavior in this example was motivated not by her wish to manipulate a singular treater

but by a need to influence a more dispersed social spectrum. Indeed, she did not seek others who might understand how difficult her day was or who could exhibit a full and authentic empathy regarding her plight. Instead, she sought a more automated interaction from hospital professionals with only tertiary relationships to her care. Doing so, she attained an acute surveillance from these others with a low expectation regarding her agency. She reinvigorated the experience of enduring attention that she had lost in her day program.

This example is only one illustration of many in which the patient careerist attains a sense of continuous attention from others devoid of the threat that these others will hold him or her accountable. When a client begins scratching his or her wrists during a group session, hints at a potential suicide near the end of a session with his or her therapist, or simply leaves repeated messages on the therapist's voice mail, these behaviors—all typically associated with BPD—are signs of an individual seeking a means by which to be held in the consciousness of others without being held accountable for his or her actions.

### *Medusaization*

The self-defined failed person fears authentic interactions with autonomous others because these interactions always pose the threat that others, left to their own agentic capacities, will judge him or her or see his or her actions as the evidence that fuels their expectations regarding change. Conversely, for the self-defined failed person, total isolation from others is as awful an alternative to being captured within an authentic gaze, leaving the self-defined failed person alone in his or her shame, without human contact. To attain a sense of being held continuously in the consciousness of others without being threatened by the authenticity of these others, the patient careerist seeks a Medusa-like relationship with them (Laing, 1969), one in which these others watch him or her (often intensely) but are experienced by him or her as muted in their own agency.

The patient careerist can most easily gain Medusa-like relationships by entering hospitals. Here, the patient is likely guaranteed interactions in which he or she is studied and observed but treated by individuals who will approach him or her in a somewhat automated manner. In hospital, the individual is a transient occupant, and specific tasks must be performed on him or her before he or she can be discharged. Although therapeutic in their stated mission and populated by caring and empathic professionals,

hospitals follow an organizational course steered by instrumental rather than interpersonal objectives. Treatment protocols are followed, and a client moves through a sequential system of care. Thus, the opportunity to reach the particular compromise sought by a patient careerist between being watched and not being seen is preset in the hospital. Indeed, as I explicate further, in these environments, surveillance rather than authentic, spontaneous interactions is the driving cultural norm.

Outpatient settings are less formalized in their interactions than are inpatient settings. In outpatient settings, in which staff are more familiar with the client and treatment is not overdetermined by protocols, the patient careerist's need for Medusa-like relationships is more often threatened. When this occurs, the patient careerist reverts to parasuicidal behavior to regain more automated relationships. The following is an example: A client was waiting to meet with her therapist. It was the therapist's lunch break, and she was meeting over lunch with her colleagues. The client heard laughter from the staff office. When the clinician finished her break and asked to meet with the client, the client angrily refused to enter her office, stating that she "heard you laughing about me in there." Despite the clinician's assurance that the client was not the topic of the laughter, the client continued to assert, "You were making fun of me in there." Finally, the client told her therapist, "I feel like cutting myself because you triggered bad thoughts." The client has dampened the perceived spontaneous agency of her therapist while simultaneously attempting to divert the therapist's gaze away from her colleagues and onto the client.

Clearly, direct threats of suicide engender a watched-not seen relationship, for the immediate experience for the clinician is typically to tread lightly on issues of accountability while spending an exhaustive amount of energy caring for the surveillance of the client. Indeed, in such circumstances, the clinician's goal is often to muster appropriate resources so that someone other than the clinician watches the client. In this situation, the clinician hands over surveillance to other professionals and institutions. When a client presents as parasuicidal, the clinician may attempt to reach out to the client to provide empathy, but in the back of his or her mind are the more instrumental imperatives of the type, duration, and quality of observations the client requires. Thus, parasuicidal-ity is an effective means of initiating an interpersonal dynamic that is as powerfully defined by the



automated surveillance of one individual by another as it is vacant of a process in which each individual sees the other as an agentic human being.

### *Effective Ineffectualness*

The self-defined failed person finds a means in the patient career to be effective while simultaneously denying his or her effectiveness in the world. Through his or her career, he or she has (as it is colloquially and appropriately called) impact, but only as if he or she is an inert object propelled within this world by a force outside his or her control.

As I have described, many parasuicidal individuals do not immediately call on their primary treaters when distressed but instead enlist clinicians employed to respond to emergency situations, who have a more peripheral involvement in their care. In most cases, it is the job of emergency clinicians to act as gatekeepers for managed care and insurance companies. They are also charged with the more general social responsibility to seek the least restrictive environment for the clients who present to them. A particular interaction between emergency clinicians and clients is thus predetermined in such circumstances: The client seeks something from the clinician that the clinician is hesitant and, at times, resistant to offer. At the onset, then, this interaction is marked by one party coveting a particular good and another party withholding this good.

By guarding hospital admittance, hospital personnel inevitably raise the perceived value of an admission, for it is demarcated by their actions as a resource worth guarding. They also present hospital admission as a benefit that one can only achieve through interpersonal effectiveness. One must engage in the thrust and parry of assessments and interviews to attain it. Once attained, a hospital admission is quite significant, for the client not only has obtained the concrete resource of a hospital bed but has moved an entire organizational system, as intake staff, social workers, and psychiatrist prepare to admit him or her. In most cases, a client can gain admittance to the hospital by asserting that he or she is not able to control his or her ideas or plans for suicide. Thus, through the effective portrayal of his or her own ineffectualness, the person is successful in influencing a complex system that is resistant to serving him or her.

Although the example of a client seeking admittance to the hospital is a rather conspicuous version of how an individual creates a process of effective ineffectualness, many patient careerists develop a more subtle repertoire. For example, near the end of a therapy session, a client presented to her therapist in a markedly passive manner that had historically preceded her parasuicidal behavior. Hugging her knees to her chest, she responded to her therapist with noticeable poverty in speech and withdrawn affect. The therapist, anxious about the client's well-being yet also concerned about maintaining the confines of the therapeutic hour, attempted to assess the client's safety by asking direct questions regarding her potential self-harm. The client responded only minimally. The therapist was now under pressure, concerned about her next therapy session with another client and anxious that her current client might behave in a self-destructive manner once she left. The therapist offered to telephone the client later in the day to check in, asking whether the client could maintain her safety "at least until I reach you." The client agreed that she could do so. She left the session 15 min later than her allotted time. In this example, the client affected her therapist precisely through her presentation of ineffectualness. By simply being passive, she facilitated a context in the session in which her therapist verbally introduced the possible threat of suicidality and then responded to the threat that she had introduced. The therapist then offered the client a plan for safety in which the therapist extended attention outside the typical therapeutic bounds.

For someone overwhelmed by a sense of failure, who might also have few occupational outlets in which he or she can witness his or her own social impact, parasuicidality is often his or her most effective skill for attaining recognition of his or her own presence in the world. On a daily basis, an individual can find in a patient career a safe balance between personal efficacy and an identity that is socially sanctioned as passive in nature. When this balance is threatened, the patient careerist typically exhibits parasuicidal behaviors.

Linehan (1993a) described parasuicidality as treatment or relationship interfering, precisely because it hampers the therapist's ability to remain authentically engaged in the therapeutic process. A theory of patient careerism interprets parasuicidality as treatment and relationship generating, for it creates and sustains a particular interaction with treatment providers that feels somewhat safe for the client, one in which the agency in these providers is muted and

potentially modulated. Parasuicidal behavior interferes with the therapist's authenticity in service of an automated treatment relationship.

### *Threats to a Patient Career and Parasuicidal Behavior*

Traditional theorists on BPD (Gunderson, 1984; Kernberg, 1967; Masterson, 1975) generally view issues of abandonment as the precipitants to their clients' suicidal behavior, whereas DBT theorists believe the precipitants are rooted in any number of emotional or often biological points of distress that the borderline individual cannot regulate. In a theory of patient careerism, conversely, precipitants to parasuicidal behavior are seen as rooted in four specific, interrelated psychosocial threats. These threats endanger the three central dynamics of patient careerism: conditional enduring attention, the regulation of the agency in others, and effective ineffectiveness.

*The threat of authorship.* When the patient careerist realizes that he or she has been witnessed by others as accountable for his or her own behavior, he or she feels threatened by the potential that others will define him or her as the author of his or her own fate. The condition of passivity intrinsic to a patient career is broken, for the patient careerist is seen by an agentic other as actively effective in his or her life.

*The threat of aloneness.* The patient careerist is threatened by the potential of his or her own aloneness in the world when others do not exhibit continuous and secure attention to him or her. Conversely, the individual also faces his or her aloneness when these others offer a full and existentially authentic attention in which he or she is seen as an autonomously effective being.

*The threat of change.* When others express hope or optimism about the patient careerist's potential for change or when they directly express their wishes for this individual to enact specific changes in his or her life, they, as sentient perceivers of the individual's behavior, simultaneously express a message regarding their belief in his or her potential for effectiveness in the world. They take a stance of watching him or her but seeing him or her as a potential author of change.

*The threat of agency in others.* A person's patient career is threatened when he or she perceives others on whom he or she depends to maintain the patient career as exhibiting their own individual life authorship. For individuals who define themselves as failures, perceiving others as imbued with autonomous agentic power means that these others cannot provide

enduring attention to him or her. Furthermore, the agency of these others threatens the possibility that they will witness him or her as an effective individual.

All four of the threats described above potentially reveal the patient careerist as an alive and active agent in the making of his or her life, exposing him or her as alone in the world without conditions and as a social agent whose gestures affect his or her environment. Parasuicidal behavior is the individual's means to defend against these four threats.

As Laing (1969) wrote, the ontologically insecure individual forgoes his or her "autonomy [as a] means to secretly safeguarding it" (p. 51). For such a person, "to play possum, to feign death becomes a means to preserving one's aliveness. To turn oneself into stone becomes a means of not being turned into stone by someone else" (p. 51). A patient career is a social sanctuary in which individuals both activate and maintain this possumlike stance. Like any professional career, however, patient careers do not exist in a vacuum. They are contingent on particular professional norms, roles, and beliefs. Specifically, patient careers are contingent on medical culture—a culture distinctive in its designation of particular members as passive and other members as charged with the responsibility of both observing and mending them. Patient careers, in other words, are coconstructed between clients and clinicians.

Clearly, harming oneself physically can become a medical problem and is a behavior most often defined as a symptom best ameliorated by psychiatric interventions. Yet the marriage of parasuicidal behavior and medical institutions is not simply the result of an inevitable sequence of events from symptom to treatment. It is, instead, a much more symbiotic, culturally coordinated marriage in which each party shares specific cultural meanings and the parties often arrive at mutually acceptable arrangements.

### The Clinical Gaze and the Focus on Mending

Linehan (1993a) wrote,

I once had a client in skills training who every week reported doing none of the behavioral homework assignments and insisted that the treatment was not working. When after 6 months I suggested that maybe this was not the treatment for her, she reported that she had been trying the new skills all along and they *had* helped. However, she had not let me know about it because she was afraid that if she showed any improve-

ment, I would dismiss her from skills training. (p. 2, italics in original)

For Linehan (1993a), this client exhibited a dialectical failure etiologically located in BPD. Linehan saw the client's resistance to leave treatment as a generic example of a particular dilemma borderline individuals experience in a spectrum of relationships and circumstances. She did not see the unique social contours of therapy as the specific psychic goods the client feared losing. In a theory of patient careerism, however, Linehan's client is understood as wanting to remain in therapy because therapy, as part of a unique cultural and epistemological field, offers a social arrangement in which he or she can withstand the powerful dialectics of change.

Conditional enduring attention, effectual ineffectualness, and Medusaized interactions are readily accessible from medicalized institutions precisely because these types of interactions are elemental to the norms of the professional culture of medicine. Three entwined and elemental epistemological tendencies in medicine reciprocate the ontological needs of individuals who have defined themselves as failures. First, modern Western medicine is an epistemological field marked by a way of seeing. With X-rays, stethoscopes, thermometers, weight scales, blood tests, and so forth, observations of human beings are elemental to medicine. Modern Western medicine simply would not exist without the surveillance and inspection of people. Foucault (1975) called this form of gazing "the clinical gaze" (p. 134).

The clinical gaze participates in a pervasive, modern, epistemological phenomenon of making human beings "the objects of knowledge" (Foucault, 1970, p. 348). It is distinct from other modern epistemological fields in the fact that it is focused on categorizing people in the service of fixing their diseases. Thus, at the epistemological spine of medicine is a way of viewing the body and issues of health and illness that always seeks a status quo. This is the second tendency in modern medicine, intrinsic to patient careers. Medicine focuses on mending. Steered by the target of facilitating a return to a previous or an average level of functioning, it seeks to conform its patients to the status of a larger group. Doctors, within the basic medical epistemology, do not create but fix. The basic doctor's tools vividly demonstrate this tendency: Stethoscopes, thermometers, and blood pressure tests are all set to test the patient's conformity to a number derived from an average. When clinicians in psychiatric institutions speak of maintenance in the community, the return to

a safe psychiatric baseline, or the need for day structure for their clients, they participate in the norm of mending that is intrinsic to medical culture.

When clinicians break from the clinical gaze and the focus on mending, they defy the very epistemological foundation of the field in which they work. Doing so, they typically face the central societal sanction for deviance from the norms of medical practice: the threat of liability. Like its etymological siblings *ligament* and *obligation*, *liability* means "to bind." When one is liable for another, one is bound to him or her by a responsibility for his or her well-being. One experiences the threat of liability when one fails in this responsibility. Clinicians encounter the threat of liability when they deviate from their responsibility to maintain the doctor-to-patient bind of the clinical gaze or are derelict in their practice of mending. Concerned about a possible lawsuit, loss of licensure, or investigation, clinicians may encounter the threat of liability overtly. More frequently, however, they experience the liability of medicine as an unconscious yet consistent social force guiding their behavior. Again, Foucault (1977) proves instructive, for the threat of liability in this latter, subtle, and socially introjected sense disciplines clinicians to behave in a certain manner. Clinicians experience it as an anonymous source of social surveillance guiding them to conform to the norms of their profession.

The pervasive threat to clinicians of liability is the third tendency in modern Western medicine's contributing to the coconstruction of patient careers. It is also a resource to individuals attempting to invigorate and maintain their patient careers. In the following sections, I describe further the nexus between the clinical gaze and the focus on mending. In both these descriptions, I show how concerns about liability guide these two tendencies in medical culture.

### *The Clinical Gaze*

When an adverse event occurs in psychiatric and psychotherapeutic milieus, the point of liability that investigators typically identify as the site of clinical negligence involves the staff's level of observation during the incident. When, for example, a client completes a suicide, the first question clinicians are typically asked by investigating parties regards the intensity of surveillance these clinicians prescribed to their client. "Why," the investigators might ask, "did you decide to let your client go home?" instead of placing the client under observation in the hospital. The second question typically regards the level of accuracy of the surveillance. "Did you detect a dif-

ference in her behavior that night?" It is understandable that the pervasiveness of the clinical gaze is most pronounced at points of crisis. It is, however, a norm that is intimately tied to the majority of processes associated with psychiatric care. Indeed, clinical attention and inattention are not simply the preoccupation of patient careerists but the central measures of normative behavior in the psychiatric and psychotherapeutic professions. Influenced by the medical model, therapists are bound with their clients by the responsibility to gaze at them.

The clinical gaze is infused in the elemental functions of most clinical milieus. In case conferences, for example, social workers, case managers, psychiatrists, psychologists, and other professionals gaze on the patient as the patient reports on symptoms. Often these conferences vacillate between simple reporting on concrete progress and quasi-therapy sessions in which patients are requested to open up and describe feelings, cognitions, and attitudes. Charting is another example of the pervasiveness of the clinical gaze in psychiatric milieus. Clinical charts are intrinsically the documentation of contiguous observations made by one party gazing on another. They are, in this sense, similar to an experiment log in which the scientist documents his or her observations each time he or she conducts the experiment. Although sterile and quasi-scientific, charts are also a form of biography, holding within them a personal history. They are documentations of an existence of a life, but the life they document is one defined by medicalized observations that render their subject passive. Like case conferences and charting, the actual therapeutic interventions designed and implemented by clinicians are intrinsically imbued with an epistemology that targets the individual as an object of knowledge. As it is commonly understood, therapy requires a certain surgical maneuver in which an individual opens up a hidden world to the therapist—a world often obscured to even the patient—that is then deciphered, perhaps even adjusted (by new introjections, altered cognitions, and behavioral adjustments). Wondrous, creative, and spiritual experiences occur in therapy, but the ethos of analysis and observations intrinsic to most therapeutic approaches can also become distorted and skewed, especially within institutional settings. Here, the interpretation of the noumenal inner life of the individual is replaced with a deductive analysis of the client's experiences as objective phenomena easily grasped and understood by the therapist. Life problems, in these situations, are interpreted as symptoms, and the overall therapeutic process is marked by an investigation

into pathological mechanisms rather than a more human and intimate interaction.

Clearly, the clinical gaze is intrinsic to the basic practices of the psychotherapeutic and psychiatric professions. Foucault (1975) viewed the clinical gaze as part of a modern form of power and oppression, rendering people passive. However, for the ontologically insecure person struck by a totalizing sense of failure, being seen by others through this gaze is experienced more as a haven from existential loneliness and accountability than as a site of oppressive observation. The clinical gaze is both penetrating and analytical, even as it recognizes its subject as void of agency. It thus offers two simultaneous relational resources conspicuously mirroring the needs of the patient careerist: being witnessed by others, and being marked as a passive sufferer. Availing himself or herself of institutions steered by the clinical gaze, the patient careerist is witnessed as if under the harsh light of an operating table. He or she is viewed, watched, and observed. However, although he or she is acutely seen by others, his or her agency as a person is just as acutely denied. He or she is surveyed, but only as a passive object of attention.

For the patient careerist, the clinical gaze is an institutional provision of conditional enduring attention. When this provision is threatened, the patient careerist is able to reinvigorate it by exhibiting parasuicidal behaviors. He or she is able to do so because clinicians are held by normative expectations embedded in the defining epistemology of gazing within medical culture. Guided by this epistemology, clinicians, as a rule, intensify their gaze, or seek an institutional arrangement for the client in which he or she can be gazed on further, when the client threatens them with behaviors that potentially render them liable.

### *The Focus on Mending*

The central tenet in the Hippocratic oath, "do no harm," touches the surface of an elemental ethos in medicine: Do not generate, only rehabilitate. The term used for deviations in medicine—those instances when medical interventions do harm—emerges from this world view. *Iatrogenic* means "doctor generated." It is telling that this term is only used for the negative consequences of medicine. One speaks not of iatrogenic wellness but of iatrogenic symptoms. In the psychotherapeutic and mental health professions, the norms of mending and concerns about iatrogenesis translate as concerns regarding the agency of clinicians.

Since Freud, therapists have either accepted or struggled against a tableau of therapy as a sterile operating room in which the therapist's free will is like a contaminant (Bettelheim, 1984). Indeed, although other contradictory and demedicalized norms in these professions also exist, such as the importance of relationships, humor, authenticity, and hope, the norm of a tightly harnessed agency in the clinician is pervasive in the psychotherapeutic professions. When therapists comply with this norm, they view as therapeutic failures the exacerbation of symptoms activated by their own authentic gestures. Accordingly, they often respond to even the most vague suggestion of risk and liability by restricting their own authenticity.

With clients who repetitively present as parasuicidal, therapists often respond in this manner even in situations in which their clients have made no direct threat of self-harm. The threat is always implied, and, accordingly, therapists take extra caution in intervening in even the most mundane behaviors associated with a patient career. They act out a script that is partially generated by the patient, in which their behaviors conform to the patient's need to be witnessed yet not fully and authentically seen.

When therapists are guided in their attitude by concerns about the iatrogenic consequences of exposing their own agency, they participate in a medical dramaturgy in which the doctor interviews the patient about his or her disease. In this dramaturgy, both the client's and the therapist's agency are muted. Both parties participate by rote, following a familiar routine. The client reports on the symptoms he or she suffers while subtly threatening that the therapist's authentic, creative gestures will exacerbate these symptoms. In turn, the therapist complies with the norms of sterility within medical culture by treating the therapeutic arena prophylactically, guarding it against the contaminant of his or her own authenticity.

An ethos of mending also invades the way many individuals in the mental health field respond to patient careerists. Concerned about their own liability for the patient's behavior, they are often apprehensive about their interactions. Thus, for the patient careerist, the threat of liability is a means by which to regulate the level of authenticity in these professionals. When the patient careerist senses the clinician's potential agency, he or she becomes more symptomatic, often to the point of direct threats regarding his or her own life. Through the threat of liability, via the norm of mending in medical culture, the patient careerist is able to efficiently access ontological resources that are essential to his or her psychic ho-

meostasis. He or she is able to gain the experience of being watched but not seen by others, regulate the level of personal agency others assert in their relationship with him or her, and experience his or her own gestures as affecting the world around him or her while remaining defined by this world as ineffective.

With its guiding norms of gazing, mending, and liability, medical culture is shaped in a particular manner uniquely conducive to the social and ontological needs of individuals who define themselves as failures. Entering medical institutions, these individuals find a social-psychological configuration—an identity, a career—that then informs their behavior. They also find a psychologically conjunctive experience between their need to be witnessed by others and their need to be effective while remaining defined as passive. The liability assumed by doctors toward patients—the said and unsaid expectations that doctors are bound and obliged to observe their patients and to restrain from contaminating milieus through their own generativity—is the foundation for this molding interaction. When patient careerists experience the environment around them as failing in its obligation to watch (but not see), to allow for agency (without witnessing effectiveness), they resort to the threat of liability as a means by which to regulate this environment.

I invoke a metaphor often used by social ecologists (Kondrat, 2002) in noting that the problem of patient careerism can be seen as similar to a set of Chinese boxes, with each smaller box fitting inside another. At the center is an individual suffering a deep sense of ontological insecurity, specifically rooted to issues of failure and, accordingly, with the struggle over change. Surrounding this individual are institutions infused with medical norms and expectations offering him or her a means by which to endure his or her ontological insecurity. Both the ontologically insecure individual and the medicalized institutions he or she enters are contained within the hegemony of medical culture itself, which (to appropriate Linehan's, 1993a, term) consistently fails dialectically, reifying human complaints into clusters of symptoms and interpreting human activity through a lens that rigidly divides the world into passive sufferers and watchful, mending interventionists.

### Treatment for Treatment-Seeking Behavior

Authentic relationships are the antidote to patient careerists. Authentic relationships and the role-bounded

relationships shaped by careerist themes contrast sharply. They are different from one another in two important ways. First, they are different in the degree to which personal agency drives the relationship. Whereas authentic relationships are characterized by the flow of personal agency, careerist relationships are characterized by an agency constrained within the bounds of social role. Second, these two types of relationships are different temporally. Authentic relationships are based on the implicit recognition that each party in an interaction is fully engaged as the author of his or her experience in the very moment of that interaction. They are here-and-now encounters. Careerist interactions, conversely, are constrained by fixed ideas about the past and the future of the parties involved. They are thus intrinsically linear in their outlook.

Authentic relationships involve processes and cognitions that counter and possibly erode relational structures shaped by careerist themes. They are a central threat to patient careers. However, a person engaged in a patient career does not experience such relationships only as a source of psychic danger; he or she recognizes authentic relationships as the means to his or her salvation as well. Indeed, the polar tension between the annihilating threat of authenticity and its promise of a better life forms the contours of the trap of the dialectics of failure. Fear of authenticity is what keeps the self-defined failed person confined, but it is this same authenticity that promises the freedom he or she covets.

Authentic relationships provide their own form of ontological safety, unattainable in a patient career. When a patient careerist participates in an authentic relationship, he or she is focused on accountability in the moment, not on the accountability for his or her past or future. This in-the-moment accountability is an anxiety-ridden experience but one that also offers an alternative form of safety to the automated embrace of the patient career. Engaged in a self-authored relationship, the patient careerist assumes accountability for what happens between him or her and the parties with whom he or she relates; in addition, he or she is relieved of the nagging harassment of future expectations regarding change as well as the shameful fixation on how he or she contributed to past failures. In such a relationship, the individual not only is offered the opportunity to experience himself or herself as existing enduringly in the eyes of another but, because the relationship is freed from the impingement of expectations about the past and future, also feels safe enough to venture into this relationship with a fellow self-author, without conditions.

For the patient careerist, authentic relationships are both an ontological destination he or she yearns for and the very means by which to reach this destination. In this sense, his or her experience of authenticity is no different than that of other individuals who enter psychotherapy because of an overwhelming ontological insecurity. Offered a secure and trusting relationship, the individual will, over time, begin to appreciate the fruits of authentic interactions and risk exposing his or her own agency. In a traditional psychotherapeutic relationship, however, attaining authentic, mutually authored encounters takes persistence and requires a continuous relationship between therapist and client. This poses a specific dilemma for both patient careerists and the individuals who treat them. Patient careerism is, in part, a problem of institutional rather than individual transference. It is rooted in a cathexis onto medicalized institutions and a fixated desire to engage their cultural resources. This is why the patient careerist often seeks help from unfamiliar emergency personnel rather than treaters familiar with his or her care when his or her career is threatened; he or she seeks reengagement with medicalized institutions, not a connection with a single individual or specific group of individuals. The defensive structure of a patient career is contingent on this form of diffused engagement and, thus, dependent on numerous contacts with a scattering of clinicians. Because so much of a patient career is spent making these contacts, it is also characterized by inconsistent attendance to therapy (partly because of multiple hospitalizations) and, thus, is inevitably a serial but interrupted record of forming relationships with different therapists and then ending them.

The typical way professionals approach the spasmodic nature of treatment associated with a patient career is to view it as a sign of deviance, for even though the patient careerist identifies himself or herself as ill, he or she deviates from a central component of the sick role: to conform his or her behavior to the advice of experts and follow through on prescribed treatment (Parsons, 1951; Whitt & Meile, 1985). The individual is thus often labeled by professionals as treatment resistant, difficult to engage, noncompliant, exhibiting treatment interfering behavior, or even untreatable. Taking this approach to the patient careerist, clinicians assume that the treatments they provide are objectively appropriate and that the client is simply not complying with the legitimate prescription for his or her ills. Accordingly, their choices are reduced to cajoling the patient (or even forcing him or her) into therapy, simply waiting until he or she is ready, or giving up entirely.

In the patient-careerism-as-deviance approach, tertiary treaters with whom the patient careerist interacts on multiple occasions—such as crisis evaluators, acute hospital staff, and case managers—are viewed as neutral elements within a system and charged with ensuring that the client both complies with prescribed therapies and maintains his or her safety in the community. They are viewed as part of a funneling system that leads to treatment but not as the providers of treatment itself. Clearly, in this mode, tertiary treaters are not charged with the relational work associated with therapy. Hence, for someone engaged in a patient career, a vicious cycle is put into place: The patient careerist, who will only transcend the confines of his or her career in the safe arena of authentic relationships, makes multiple contacts with professionals who respond to him or her in an automated manner. By accessing tertiary treaters, the individual satisfies his or her need for an existentially dishonest relationship, yet his or her opposite wish, to enjoy the fulfillment of an existentially honest relationship, is never met.

In an article currently in preparation (Ellenhorn, 2004), I describe a particular cluster of strategies presently used in a psychiatric day treatment program that enhance the possibility of more existentially honest encounters between patient careerists and all the professionals with whom they contact, no matter the breadth or intensity of their relationship. These strategies do not always facilitate the depth of personal encounter associated with psychotherapy. They do, however, offer a chance, rarely given to the patient careerist, to venture into the world of authorship and accountability when he or she meets with numerous tertiary providers as well as therapists. When these strategies are shared among professionals, they offer an alternative to the medicalized institutional response. Indeed, they are intentionally demedicalizing strategies, aimed at addressing institutional transference. When they are used consistently by a single therapist in the confines of a more traditional therapeutic encounter, they provide a means by which to protect this encounter from the impingements of medicalizing culture while simultaneously offering a fertile and safe environment to which the client may wish return regularly.

## References

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.
- Augoustinos, M. (1986). Psychiatric inpatients' attitudes toward mental disorder and the tendency to adopt the sick-role. *Psychological Reports*, 58, 495–498.
- Bettelheim, B. (1984). *Freud and man's soul*. New York: Random House.
- Conrad, P., & Schneider, J. (1992). *Deviance and medicalization: From badness to sickness*. Philadelphia: Temple University Press.
- Cooper, M. (2003). *Existential therapies*. Thousand Oaks, CA: Sage.
- Ellenhorn, R. (2004). *Treating the problem of treatment recidivism with parasuicidal individuals: A multi-model approach*. Manuscript in preparation.
- Farber, L. (2000). *The ways of the will* (expanded ed.). New York: Basic Books.
- Foucault, M. (1970). *The order of things: An archeology of the human sciences* (A. Sheridan, Trans.). New York: Pantheon.
- Foucault, M. (1975). *The birth of the clinic: An archaeology of medical perception*. New York: Vintage Books.
- Foucault, M. (1977). *Discipline and punish: The birth of the prison* (A. Sheridan, Trans.). New York: Pantheon.
- Goffman, E. (1961). *Asylums: Essays on the social situation of mental patients and other inmates*. Oxford, England: Aldine.
- Gunderson, J. (1984). *Borderline personality disorder*. Washington DC: American Psychiatric Press.
- Gunderson, J. G., & Phillips, K. A. (1991). A current view of the interface between borderline personality disorder and depression. *American Journal of Psychiatry*, 148, 967–975.
- Heller, L. (1999). *Biological unhappiness*. Okeechobee, FL: Dyslimbia Press.
- Horowitz, A. (2002). *Creating mental illness*. Chicago: University of Chicago Press.
- Hudziak, J., Boffeli, T., Kriesman, J., Battaglia, M., Stanger, C., & Guze, S. (1996). Clinical study of the relation of borderline personality disorder to Briquet's syndrome (hysteria), somatization disorder, antisocial personality disorder, and substance abuse disorder. *American Journal of Psychiatry*, 153, 1598–1605.
- Illich, I. (1982). *Medical nemesis: The expropriation of health*. New York: Knopf.
- Kernberg, O. (1967). Borderline personality organization. *Journal of the American Psychoanalytic Association*, 15, 641–685.
- Kirk, S., & Kutchins, H. (1992). *The selling of DSM: The rhetoric of science in psychiatry (social problems and social issues)*. New York: Aldine de Gruyter.
- Kohut, H., & Wolfe, E. (1978). The disorders of the self and their treatment. *International Journal of Psychoanalysis*, 59, 413–425.
- Kondrat, M. (2002). Actor-centered social work: Re-visioning "person-in-environment" through a critical theory lens. *Social Work*, 47, 435–448.
- Laing, R. D. (1969). *The divided self: An existential study in sanity and madness*. London: Penguin Books.

- Linehan, M. (1993a). *Cognitive behavioral treatment of borderline personality disorder*. New York: Guilford Press.
- Linehan, M. (1993b). *Skills training manual for treating borderline personality disorder*. New York: Guilford Press.
- Masterson, J. (1975). The splitting mechanism of the borderline adolescent: Developmental and clinical aspects. In J. Mack (Ed.), *Borderline states in psychiatry* (pp. 51–73). New York: Grune & Stratton.
- May, R. (1980). *Freedom and destiny*. London: Norton.
- Morrison, J., Bushnell, J., Fentiman, J., & Holdridge-Crone, S. (1977). Relationship between psychiatric patients' attitudes towards mental illness and attitudes of dependence. *Psychological Reports*, *41*, 71–94.
- Nurnberg, G., Raskin, M., Levine, P., Pollack, S., Seigel, O., & Prince, R. (1991). The comorbidity of borderline personality disorder and other *DSM-III-R* Axis II personality disorders. *American Journal of Psychiatry*, *148*, 1371–1377.
- Parsons, T. (1951). *The social system*. New York: Free Press.
- Perry, C. (1990). Challenges in validating personality disorders: Beyond description. *Journal of Personality Disorders*, *4*, 273–289.
- Rosegrant, J. (1995). Borderline diagnosis in projective assessment. *Psychoanalytic Psychology*, *12*, 407–428.
- Sartre, J. (1956). *Being and nothingness: A phenomenological essay on ontology*. New York: Washington Square Press.
- Scheff, J. (1963). The role of the mentally ill and the dynamics of mental disorder: A research framework. *Sociometry*, *26*, 436–453.
- Silk, K., Lohr, E., Ogata, S., & Westen, D. (1990). Borderline inpatients with affective disorder: Preliminary follow-up data. *Journal of Personality Disorders*, *4*, 213–224.
- Silk, K., Westen, D., Lohr, N., Benjamin, J., & Gold, L. (1990). *DSM-III* and *DSM-III-R* schizotypal symptoms in borderline personality disorder. *Comprehensive Psychiatry*, *31*(2), 103–110.
- Spinelli, E. (2003). *The interpreted world: An introduction to phenomenological psychology*. Thousand Oaks, CA: Sage.
- van Deurzen, E. (2002). *Existential counseling and psychotherapy in practice* (2nd ed.). Thousand Oaks, CA: Sage.
- Warren, A., & Messinger, L. (1988). Sad tales in institutions: A study in the microsociology of knowledge. *Journal of Contemporary Ethnography*, *17*, 164–183.
- Whitt, P., & Meile, L. (1985). Alignment, magnification, and snowballing: Processes in the definition of "symptoms of mental illness." *Social Forces*, *63*, 682–696.
- Widiger, T., & Weissman, M. (1991). Epidemiology of borderline personality disorder. *Hospital and Community Psychiatry*, *42*, 1015–1021.
- Wooley, S., & Blackwell, B. (1975). A behavioral probe into social contingencies on a psychiatric ward. *Journal of Applied Behavior Analysis*, *8*, 337–339.
- Yalom, I. (1980). *Existential psychotherapy*. New York: Basic Books.

Received October 1, 2003

Revision received February 20, 2004

Accepted March 1, 2004 ■