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Phenomenological Analysis of Borderline Personality Disorder in the Light of Thomas Fuchs

Análise Fenomenológica do Transtorno de Personalidade Borderline à luz de Thomas Fuchs

Lucas Albuquerque
Paulo Evangelista

Abstract

Borderline Personality Disorder is documented in scientific literature under various terminologies since the late 19th century and has undergone different revisions of its main characteristics up to the present day. This work aims to introduce some of Thomas Fuchs' contributions to phenomenological psychopathology and to critically engage with the DSM-5's proposal to standardize diagnostic criteria. In a second step, a more in-depth analysis of Borderline Personality Disorder and its existential dimensions is taken in light of the mentioned author's contributions. Proposals for the psychological clinic are presented.

Keywords: Borderline personality disorder; phenomenology; psychopathology; DSM-5.

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Resumo

O Transtorno de Personalidade Borderline está documentado na literatura científica com diferentes nomenclaturas desde o final do século XIX e passou por várias revisões de suas características principais até os dias de hoje. O objetivo do presente trabalho é introduzir parte das contribuições de Thomas Fuchs para a psicopatologia fenomenológica e dialogar de forma crítica com a proposta do DSM-5 de padronização dos critérios diagnósticos. Num segundo momento, segue leitura mais aprofundada do Transtorno de Personalidade Borderline em suas dimensões existenciais à luz das contribuições do referido autor. Mencionam-se também propostas de atuação na clínica psicológica.

Palavras-chave: Transtorno de personalidade borderline; fenomenologia; psicopatologia; DSM-5.

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Introduction

Phenomenologically, according to Fuchs (2023), we recognize mental illness as an individual's particular sensitivity in the face of the intrinsic questions of human existence. We can recognize that there is a set of common modes of being of those individuals who manifest themselves in an ill manner and who are like one another. This is due to the existential vulnerabilities inherent to human beings. These similarities allow us to include them in specific groups, which we recognize as ill, affected by a common psychopathology.

This article aims to bring together Thomas Fuchs's phenomenological perspective on Borderline Personality Disorder (BPD). Fuchs is an eminent phenomenological psychopathologist. We shall draw on his publications on the topic specifically, and on phenomenological psychopathology more generally when necessary. We thus hope to contribute to a better understanding of this mode of being, which challenges professionals in diagnosis and clinical treatment.

The material translated into Portuguese on BPD from a phenomenological approach is scarce. Thus, the present work also sets out to contribute to the dissemination of this topic in our context, as well as to the development of future studies. First, we will make some observations regarding phenomenological psychopathology in comparison with the psychopathology that follows the hegemonic criteriological or operational model (Neto & Messas, 2016). Next, we will bring together several texts from the work of the psychiatrist and philosopher Thomas Fuchs, presenting them and outlining his contributions to psychopathology and therapeutic care. Finally, we will provide an exposition of the understanding of BPD from Fuchs' standpoint, of other theoretical perspectives, and of contributions drawn from our own clinical practice experience.

Phenomenological psychopathology and hegemonic psychopathology

There are distinct ways of identifying mental illness from different theoretical perspectives—and when we set out to work in mental health, it becomes necessary to ground ourselves in a basis that can support a serious practice committed to scientific knowledge. The way a professional's gaze is directed toward specific aspects indicated by a given approach means that their conduct is supported by already established paths—without requiring an entirely new theoretical elaboration regarding each human phenomenon encountered, whether in the exercise of the profession or in one's own

existence.

That said, two distinct ways of looking at what are called the pathological characteristics of the human being will be described here. First, in phenomenological psychopathology, it is understood that the ill individual experiences a particular sensitivity to the contradictions of human existence. To complement this:

> [...] We all live under these basic conditions, we may also suffer from the contradictions, for instance, between autonomy and dependence, freedom and security, zest for life and certainty of death. But mentally ill persons suffer from this in a special way, such that for them, even quite everyday situations of danger, conflict or loss may become limit situations [...] (Fuchs, 2023, p. 66)

It is interesting to note that the author draws a connection between pathological experience and what is intrinsically human. Phenomenology sets out to recognize in the ill individual aspects common to human existence that, in general, are to some degree impaired by the disorder that is diagnosed. This opens space for seeing the individual as someone who can still share experiences and can greatly benefit from the support of the people around. However, the greatest challenge to such social experience is that the illness itself makes room for the segregation of that subject. According to Evangelista (2017):

> [...] illness takes place in the deviation from this [social] norm and in the impossibility of returning to it, isolating the ill person from shared worlds, losing collective significations and the possibility of sharing and, therefore, of coexisting. [...] The 'real' or 'unreal' criterion, which guided classical psychiatry, collapses with Daseinsanalysis, which overcomes positive epistemology, which conceives reality as objective, external, and unique (pp. 184–185).

Daseinsanalysis is a discipline proposed by the psychiatrist Ludwig Binswanger based on his reading of philosopher Martin Heidegger's *Being and Time*, one of the most important works of phenomenology. It is one of the main approaches that set out to understand the human being in the light of phenomenology.

Continuing with the proposed comparison, the alternative perspective to phenomenology would be the proposal of a classification based on a summation of symptoms and a standardization of processes, with the premise of evaluating, classifying, operationalizing, treating, and quantifying.

This model aims to specify with a certain degree of predictability the behavior of individuals with disorders. In a way, it limits the gaze toward the patient, positioning him as the bearer of a set of isolated behaviors—and not as an individual endowed with a life history situated socio-historically. Thus, a certain standardized conduct is induced for each behavioral pattern. As a result, the so-called operational model brings with it a massification of treatments, as well as a depersonalization of the human being. Neto and Messas (2016) make explicit that:

> In the criteriological/operational model, signs and symptoms are observed in isolation and then "checked" against the criteria that determine the diagnosis. Since there are no pathognomonic symptoms, it is necessary to observe exclusion criteria in order to differentiate, as much as possible, one condition from another, but it is possible for the same patient to receive two or more diagnoses (p. 26).

The limitation of this model lies in its gaze being directed exclusively toward the treatment of a disease, and not of an ill person. The critique here is grounded in the fact that the perception of care abandons a personal perspective, one that would take into account the history of a subject inserted within a context. As Messas (2008) describes, the consequence of adopting this procedure in psychiatry leads to a simplification of psychopathology. As a result, it seeks to identify previously described symptoms and behaviors that are amenable to modification—along with a limitation of the human factor in favor of achieving the diagnosis, suppressing the importance of the therapeutic relationship, and narrowing the therapeutic function, then limited to "identifying only the point at which its pharmacological instrument can act" (p. 221).

It is worth noting that criticism of the operational model does not necessarily require us to renounce the contributions that the standardization of disorders has brought in enabling a more cohesive multidisciplinary dialogue. As Neto and Messas (2016) point out, this shared language has made it possible for research in different parts of the world and across diverse cultures to be shared in a way that is accessible and comprehensible to a larger number of investigators. This does not, however, preclude a critique of how this model fails to encompass philosophical and anthropological foundations, or the very nature of mental illness.

Borderline Personality Disorder in the DSM-5

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) is an internationally standardized classification of symptoms, manifestations, diagnostic criteria, and general characteristics of mental disorders, as documented over the last 60 years. Currently in its fifth edition, it proposes to serve as a practical guide to assist in what is called the objective diagnosis of the disorders described.

The DSM-5 lists mental disorders based on its own numerical classification and the alphanumeric classification of the specific diagnosis contained in the *International Statistical Classification of Diseases and Related Health Problems* (ICD-10). The ICD-10 is the medical classification list of the World Health Organization.

BPD is presented in the DSM-5 with the essential feature of "a pervasive pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts" (DSM-5, 2014, p. 663).

Its reference codes in the DSM-5 and the ICD-10 are, respectively, 301.83 and F60.3. For the diagnosis to be made, the patient must present at least 5 of the 9 criteria described as characteristic of the disorder:

1. Frantic efforts to avoid real or imagined abandonment.
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood (e.g., episodic dysphoria, irritability, or intense anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms (DSM-5, 2013).

The DSM-5 model follows the direction indicated by North American psychiatry since the DSM-III, published by the American Psychiatric Association (APA) in 1980, namely: the elimination of psychoanalytic concepts in favor of the creation of a criteriological architecture—that is, symptom lists that make up each diagnosis—thereby bringing psychiatry closer again to medicine by formulating "a nosology composed of specific diseases with diagnostic criteria (...) that are clinically well defined, verified by physical findings and laboratory data, and validated by specific responses to treatment" (Shorter, 2015, p. 65). As Neto and Messas (2016) explain, the empiricist logic inaugurated with the

DSM-III suggests replacing holistic clinical assessment, considering it nonobjective and therefore unscientific. The hermeneutics of psychopathological symptomatology in light of life history, of ways of being and relating to things and to others, situated in a shared historical world, considering ways of temporalizing and spatializing oneself is the phenomenological model defended in opposition to the criteriological one. Within this phenomenological model, Thomas Fuchs is one of the important contemporary representatives.

In line with the phenomenological perspective, and understanding BPD from a sociocultural standpoint, Fuchs (2007) points to the ways in which two main aspects of postmodern society may have a direct influence on a higher incidence of cases of BPD: first, the disintegration of a sense of community and family; second, the growth of ideological pluralism at the expense of rites of passage or obligatory patterns of behavior that bind the individual to a group with a shared worldview.

As Resende, Pontes, and Calazans (2015) point out:

> What we see in practice is a return of organicist explanations of disorders that aim to justify the subject's malaise in modern society. We see the old and flawed attempts to find in the body something that would justify the symptom, however wearing a new mask (pp. 542–543).

It is therefore necessary to adopt a critical gaze to understand the function that the use of diagnoses may have in sustaining a discourse that constantly seeks pathologies—pathologies that at once disqualify, while distinguishing and medicating behaviors that do not fit within a prevailing social normativity or convention.

Thomas Fuchs's Phenomenological Psychopathology

Fuchs's phenomenological approach to psychopathological diagnosis and treatment is that the understanding of human suffering must be formulated in light of the patient's existence as a whole in his milieu—not merely by identifying isolated symptoms or neurological conditions. This is because it involves more than the illness of the brain, given that experiences of human suffering are not encompassed, predictable, or classifiable on the basis of observations of a specific organ. We are dealing with "cascade of subjective, neuronal, social, and environmental influences continuously interacting with each other" (Fuchs, 2012, p. 342), for the author maintains that "mental illnesses are always illnesses of the person and of their relations to other persons" (Fuchs, 2012, p. 342). Existential illness significantly affects the individual's dealings with the world around them. This can be exemplified as follows: in the distancing of the interpersonal relations of the person with

schizophrenia, since they do not share their experiences of the world; in the changes in the perception and experience of temporality both in the person with depression and in mania, who move away from the rhythm shared by the non-ill people around them; and in BPD, in which the subject demands immediate satisfaction of their needs, not being affected by how they can harm the shared world in which they are situated. Social interactions unfold between subjectivities: one person relates to another, and both have their perspectives and intentions, and seek to respond flexibly to the situations of the social environment in which they are embedded.

Temporality

In his conception of temporality, Fuchs (2013) draws a distinction between lived time and experienced time. In doing so, he introduces perceptions of time as influential factors in the way we relate to ourselves and to the world. Distortions in our temporality themselves are processes of illness characterized as desynchronization, with specificities as to how this manifests and is experienced by each individual in each pathology.

Lived time, also conceived as implicit or pre-reflective time, concerns the experience of living time when one is immersed in some activity. In this time, the past or the future does not matter. The individual is taken up by that moment in a fluid and unimpeded way. It translates into the experience of not even noticing the passage of time while absorbed in something that captures his attention. The example brought by Fuchs (2010) is that of a child who becomes distant from the world when they are interested in playing with their toys.

Experienced time, or explicit time, in turn, superimposes itself upon implicit time. This superimposition occurs when something unexpected interrupts the course of the fluid experience in the implicit mode. Some of the examples given by Fuchs (2007) are: the irruption of a loud noise, a disappointing or shameful situation, a rupture in an interpersonal relationship, or even a significant loss. Such events relegate to the past those others that had previously been lived as the present moment. Thus, what Fuchs (2007) states is that this experience of no longer being what one was tends to be something painful.

Bodily continuity

From the perspective of temporality in consonance with corporeality—which will be

explored in greater depth later—we have Fuchs's (2016) contribution in the recognition of the self based on the continuity of the body. He mentions that through the appropriation of lived experiences, the human being acquires a non-conscious memory that supports the notion of the continuity of existence over time. Fuchs describes this as "qualitative continuity of self that must not be actively produced through remembering, but rather integrates the person's entire past in his present being and potentiality" (p. 22). That is, it is a description of the importance of the notion of the human being as endowed with a past and a future, in integrating a self-perception of continuity as existence.

Circular Causality

Circular causality is the concept that Fuchs (2012) uses to understand the mutual influence of person, body, and environment. In summary, it introduces the theory that perception and movement are inseparable. This implies that what a living being "senses is a function of how it moves, and how it moves is a function of what it senses" (Fuchs, 2012, p. 333). This is a phenomenological theory that he applies to psychopathological understanding, and it is divided into two main concepts: "vertical circular causality" and "horizontal circular causality." The author explains that:

> [...] mental illnesses are marked by a disruption of vertical circular causality; that is, the interplay between lower-level processes and higher faculties of the organism. This primarily affects a mentally ill person's relation to themself which continually co-determines the course of the illness. On the other hand, mental illnesses are characterized by a disruption of horizontal circular causality; in other words of social relationships and the ability to respond adequately to the demands and expectations of others. This leads to negative feedback loops in socio-functional cycles that influence the course of the illness from the very beginning (Fuchs, 2012, p. 331)

Vertical circular causality plays a decisive role in BPD. This is because, in becoming ill, the individual becomes "fragmented" from themselves, or self-alienated—which is to say that one characteristic of illness is the lack of control over the aspects manifested in the individual, who does not recognize them as their own. Fragmentation lies in the loss of autonomy and in the encounter with something strange, manifested within oneself, which takes control over the course of that person's life. Thus, symptoms manifest as an absence of autonomy, the production of anguish, an absence of freedom, and an invasion by uncontrollable emotional reactions. The person who becomes ill no longer has control over their impulses, bodily manifestations, and what affects cognition. As a result, the image constructed of oneself becomes limited and distorted, and no longer has validity as a faithful description of who one is. This cannot be encompassed by neuroimaging or any examinations that capture brain activity, because the mere perception of the electrical

impulses manifested in the organ's functioning, in the face of an expression of anguish, cannot describe how this relates to a person's life history, how they are affected by it in their daily life, or how much it has harmed them in important relationships with people close to them.

Horizontal circular causality, in turn, indicates that it is not possible to define mental illness as "purely individual dysfunctions" (Fuchs, 2012, p. 336), just as we have mentioned that it is not possible to consider illness as a purely biological manifestation. This is because:

> Irrespective of their causes, mental illnesses are always disturbances of the patient's interactions and relationships. They are accompanied by various impairments of the freedom to flexibly and autonomously respond to situations, offers, and demands of the social environment (Fuchs, 2012, p. 336).

When an ill individual demands interaction, care, shelter, and attention from those around him, this draws the other person into a shared phenomenon of suffering. At first, support may be mediated by responsibility and willingness, but the prolongation of the pathological condition can give rise to boredom in the caregiver, who then begins to want to distance themselves, for instance, from the depressive person's pessimistic worldview or the psychotic person's delusional discourse. Fuchs (2020) maintains that:

> [...] If psychic life extends into the world, then psychiatric disorders should not be localized "within" the individual, be it in the psyche or the brain. They should rather be regarded as disturbances of being-in-the-world, and of interacting with others in accordance to one's needs for resonance and response. In other words, psychopathology changes from an individualistic to a relational, from an internalist to an (inter-)enactive framework (p. 32).

Thus, we can criticize the attempt to reduce the individual to a neurobiological perspective characterized by recognizing the human being as a product of brain structures and their functioning. Human suffering is shaped by more than biological markers are able to encompass. It involves interactions of intentionality, guilt, memory, anguish, relationships, fears, traumas, religiosity, desires, regrets, achievements, longings, expectations, and an endless list of other subtleties proper to existence that do not fit into a quantitative or deterministic model. A change in one's view of oneself, and the way this influences one's relation to the surrounding world, can only be described subjectively—and, moreover, through the difficult work of elaboration.

Corporeality

In an article on the diachrony of bodily existence (Fuchs, 2016), Fuchs criticizes the Cartesian dichotomy in understanding the human being either as a "psychological

continuity" of the persistence of individual characteristics manifested throughout one's existence, from a first-person retrospective; or as identity changes from a biological perspective of the continuity of an organism as the "operator of personal existence", from a third-person perspective. Thus, the author constructs an account with the intention of unifying the Cartesian dichotomy, stating that:

> The experiential self of bodily subjectivity and the autopoietic self of the living organism should ultimately be regarded as two aspects of one and the same life process which cannot be reduced to brain activities (Fuchs, 2016, p. 312).

Autopoiesis refers to the term used by Francisco Varela and Humberto Maturana, who describe the human being as an autopoietic machine, characterized as "a self-homeostatic system that has its own organization as the variable that it keeps constant" (Maturana & Varela, 1997, p. 71). This is realized in the individual's constant striving for self-production. However, it does not represent a process that unfolds in isolation within each organism, since openness to and interaction with the world are important components of this organization. Human beings are, ambiguously, products and producers of themselves, mutually modifying themselves and the world around them. Biologically, the body undergoes constant modifications to maintain life, through which it heals or dies—psychologically, one might mention the constant task of having, every day, to be an existence that relates to the difficulty of predicting any future. This perspective is consonant with the phenomenological perspective of coexistence.

This theme is articulated with bodily memory. In this sense, one point to be highlighted, as a complement to the concept of the body, is Fuchs's exploration of the memory that the body stores on the basis of its lived experiences. Not as episodic memory, accessible to consciousness or processed through a mental effort, but as access to sensations that refer back to previous experiences. One example is the feeling of comfort upon entering a familiar environment, or the calm of being in the presence of someone with whom one has built a shared life history, or even the stomach that turns at the smell of something ingested in the past that made one ill. These are manifestations of memories to which the body itself responds quickly, even before one becomes conscious of them or even while remaining unconscious.

In his words:

> [...] the lived body also exhibits a specific form of memory that results from the continual embodiment of existence: it consists of all the affinities, capacities and experiences, which the person has acquired throughout his life. Thus, it also provides a qualitative continuity of self that must not be actively produced through remembering, but rather integrates the person's entire past in his present being and potentiality (Fuchs, 2016, p. 312).

Therefore, it is interesting to recognize that it is not only self-reflection and conscious perception of oneself that provide the human being with a sense of continuity of existence. The body itself, as a whole, reverberates in the individual's perception of themselves as something constituted through a location in time. It is worth emphasizing that this also allows for a certain opposition to the biological model that places the brain at the center. The wholeness of experience passes not only through consciousness, but through the individual in their entire constitution. In our contact with the world, we affect and are affected as an integral being, with body and consciousness occurring at the same time.

Narrative self

Human beings relate constantly to their past and to their future when seeking to understand themselves as an individuals endowed with a life narrative of their own. When one aims to define oneself in terms of a story, that is, a biography, existence draws on part of what it is in the present, retrieves parts of its life history, and projects itself into the future. Thus, in trying to become coherent with itself, existence draws on its capacity and freedom of self-control in the face of a momentary desire—it seeks to build a narrative of itself and a constancy that locates it in the world. It seeks to act in accordance with its principles, beliefs, and its relation to the world, in which the social milieu and people individually expect each person to be coherent with what they have already shown in prior situations.

The description of BPD in Thomas Fuchs's psychopathology

Based on the foundations presented thus far, we now turn to an understanding of BPD in Fuchs's phenomenological psychopathology from the standpoint of existential dimensions.

Temporality

For Fuchs (2007), BPD is a disorder in which the individual experiences the fragmentation of their own existence regarding the perception of temporal continuity—as if they were devoid of a past or a future, existing in constant experiences of present moments. This would be a form of defense that, unlike repression, exempts them from "constancy, bonding, commitment, responsibility and guilt" (Fuchs, 2007, p. 379). The challenge

encountered in living under these conditions is that of having to deal with what the defense itself establishes as one's relation to temporality.

The person with BPD experiences a limitation of self-control in the face of a momentary desire. As Fuchs (2007) reminds us, "impulsive spending, promiscuity, binge eating, substance abuse, reckless driving and violence are common symptoms of the disorder. They express the patients' inability to contain and regulate emerging moods and affects" (p. 381). This affects their "narrative self" in such a way that self-definition is tied to a "being-in-the-making" in that exact moment, without there necessarily being a perception of change from what has already been, resentment toward the past, guilt over mistakes made, or even a relation to the consequences of one's actions in a future that has not yet been realized. Thus, there are implications for how this way of temporalizing influences impulsive behavior and difficulties in interpersonal relationships.

The existential fragmentation characteristic of BPD, as described by Fuchs, produces suffering. The immediacy of experiences and relationships endows them with marked intensity, both positive and negative. Passions are overwhelming, and the pains of separation are, proportionally, violent. Differences in ways of being with people in one's circle tend to erupt forcefully and abruptly—and when they arise, they provoke aggressive and combative responses. In this way, experiences and relationships come and go, entering and leaving the life of the BPD person, constituting episodes that do not stitch together into a story, thereby amplifying the sense of fragmentation that tends to be lived as suffering.

Freedom

Freedom is a determining ontological factor for understanding human existence (Fuchs, 2023). On its basis, the possibility is founded of yielding to an impulsive desire—which may even put survival at risk—or of deciding not to take survival as a priority.

In BPD, there is a tendency not to impose restrictive constraints in the face of the immediate desire to fulfill some need. Thus, risk behaviors are readily identifiable—such as abusive substance use, risky sexual behavior, outbursts of anger, episodes of aggressiveness, binge eating, self-mutilation, and suicide attempts (Fuchs, 2007). Such activities point to a lack of temporal perception of continuity, since the individual does not see itself projected into the future nor capable of preserving an identity built upon its past. The present moment becomes what defines needs as the beginning, the middle, and the

end in itself, constituted only by a temporal band of slight thickness, which accompanies, little by little, the individual's isolated experiences and satisfies the desire to distance oneself from existential boredom. Fuchs (2007) adds that these are people who are "curious, constantly seeking for novelties and events, but they do so without patience, desperately searching for immediate satisfaction or reward" (Fuchs, p. 381).

Intersubjectivity

The BPD patient is also characterized by impairment in interpersonal relationships. In this sense, Fuchs (2007) refers to them as unable to sustain lasting interpersonal relationships and thus living through a succession of disconnected episodes with people who enter and leave their lives. Even sexual orientation may be a fluid factor for these individuals given their tendency not necessarily to follow social norms when these run counter to their impulse. Thus, sexual behaviors and relationships are lived as expressions of freedom, but they are not stitched into a temporal history that narrates a historical identity.

Fuchs mentions that these individuals are characterized by the defense mechanism of dissociation, understood here as a lack of integration among perceptions, sensations, affects, memories, and identity. With such fragmentation, the construction of self-perception becomes unfeasible. In practical terms, one becomes a different person depending on one's mood state. It is not uncommon to hear reports from family members or professionals who are frustrated by the constant repetition of these individuals' inappropriate behaviors, as if they were unable to learn from their own mistakes, in addition to being demanding of constant vigilance, attention, and care.

Another characteristic listed by Fuchs (2007) is projective identification, through which negative feelings are immediately attributed to others. Thus, in order not to assume, defensively, responsibility for unwanted and intolerable feelings, they point to others as the producers of these feelings. Others may therefore appear as hated or deserving combative hostility. What is being fought, after all, is one's own personal characteristics, though unpleasant ones, as they are lived within interpersonal relationships. Hence, it becomes clear that this movement is characteristic of the person's difficulty in establishing a realistic self-perception that acknowledges imperfections and limitations as a human being. As a result, we observe the consequent difficulty in establishing lasting and meaningful relationships, since impaired self-criticism produces constant conflicts with other people

who may not be willing to constantly assume errors they did not make, but that are attributed to them.

Clinical implications

Fuchs's analysis contributes to the formulation of ways of being therapeutically with these people. That is, his understanding of BPD makes it possible to indicate certain specific demands within therapeutic care. The first is the need to build alongside the patient a relationship of trust and care. At times, the therapist is one of the few who sustains a place alongside a person who proves unpredictable and impulsive. The therapist needs to be willing to be with the patient as far as is possible for them at each moment.

Since interpersonal relationships are impaired, with various very brief episodes of contact with other individuals, the therapeutic relationship is a possibility of constancy that contributes to the construction of a historical narrative. A good therapeutic proposition for work with borderline patients would be to attend to help them understand themselves as an integral part of the world around them. Their actions have consequences and, at least for a moment, they may be able to grasp the limits of their freedom when they intrude upon the space of people close to them. In doing do, one can work so that the patients build self-perceptions grounded in the recognition of themselves within each relationship. Then, based on recognizing personal characteristics, this individual constructs, even if in an incipient way, an appropriation of their own existence.

It is important for the therapist to present himself in the life of the patient with BPD as a proposition of continuity. The therapeutic relationship endures even when thoughts of death arise, when there are outbursts of aggressiveness, and when opinions shift constantly. There are no guarantees that the patients will not want to hurt themselves or die, but within certain limits one can be willing to be there in each turbulent moment, as someone prepared to keep them company until the storm passes.

Amid the uncertainty and discontinuity experienced as characteristic of the disorder, the therapist is a reminder that there is much that the person itself has managed to overcome. The therapist will not do for the patients what they cannot do but is a presence who is willing to have the patience to accompany someone who can only take small steps at a time.

Final considerations

Understanding the mode of existence referred to as BPD contributes significantly to psychopathological knowledge. From an epistemological standpoint, it proposes an overcoming of the Cartesian duality that tends to dehumanize patients, taking them as effects of underlying causes. The notion of circular causality, which accomplishes this overcoming, also offers elements for understanding the action of psychopharmaceuticals in treatment, as support for modification in the milieu, feeding back into existence itself.

The understanding of existence as temporal, bodily, and intersubjective, constituted as a historical narrative, introduces advances in the field of phenomenological psychopathology. The articulation of the conception of (human) existence drawn from philosophy in consonance with the cognitive sciences and psychopathology carries out an important epistemological dialogue, fertile for the development of advances in these areas of knowledge. Above all, understanding BPD as a historical, narrative mode of being and being-in-the-world invites more assertive ways of meeting people who are limited to existing in this manner, making possible pertinent attention and care in the face of their suffering.

Fuchs's analysis highlights the importance of recognizing that self-perception and social integration are correlated and inseparable. Mental illness therefore cannot be understood as a mere individualized neurobiological maladjustment. In keeping with the understanding that suffering is socioculturally situated, one may consider that the experience of fragile and inconstant relationships, as lived in BPD, also occurs in other kinds of postmodern relationships that overvalue individuality at the expense of a collective understanding of the shared world and that are not necessarily psychopathological. That is, this mode of being characteristic of BPD is consonant with contemporary interpersonal relations and cannot be understood as something individualized or idiosyncratic.

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