

# Commentary

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## Keep on Pushing My Love Over the Borderline

Review of 'Unshrunk' by Laura Delano

by **Sally Satel**

**A**T THE START OF EIGHTH GRADE, SEEMINGLY OUT OF THE BLUE, LAURA Delano—class president, squash champion, and future debutante—sensed herself coming apart. Looking into the bathroom mirror as she brushed her teeth, she felt herself “disintegrate into a million pieces, floating, fuzzy, disembodied in space,” she recalls feeling at the time. “I am nothing....Who am I?”

In bed that night, the 13-year-old ruminated about being a “fake” and a “fraud.” She’d been “brainwashed” by her parents and teachers at the all-girl Greenwich Academy. “They controlled all the girls,” she concluded. “They convince us we have to look a certain way, talk a certain way, perform a certain way.”

Delano struggled to contain an inchoate rage. She cut her arms with razor blades, fought bitterly with her family, and complained of intense academic and social pressure. That former President Franklin Delano Roosevelt was part of her lineage couldn’t have helped.

Delano’s 14-year tenure as a “professional psychiatric patient” (her words) lasted through prep school, then Harvard (where she thought, early on, that she might become a psychiatrist-anthropologist), and into her late 20s. She received eight

separate diagnoses and admitted herself to a psychiatric hospital on four occasions. At 25, she almost died after downing handfuls of pills with swigs of wine.

And then, two years later, Delano was done: “I decided to leave behind all the diagnoses, meds, and professionals and recover myself.” *Unshrunk* is the memoir of her life under the influence of my profession and how she broke the spell.

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The first psychiatrist Delano saw at age 14 wasted no time imposing a medicalized narrative on the teen. The doctor confidently diagnosed Delano with bipolar disorder and prescribed medication—a mood stabilizer (Depakote) and an antidepressant, Prozac. An error. More properly, the doctor should have gotten to know her young patient better before making a definitive diagnosis, prescribing medication, and, for good measure, warning Delano that she had a serious life-long condition and would always require medication.

Gradually, however, Delano warmed to having bipolar disorder and came to regard her myriad problems—an eating disorder, alcohol and cocaine abuse, suicidal fantasies, promiscuity—as proof that she suffered from an “incurable brain disease....I wasn’t bad or lazy or a failure. I was sick.”

Yet medication did little to treat that sickness. At one time or another, Delano’s medicine chest housed antipsychotics (Seroquel, Geodon, Zyprexa, Risperdal, and Abilify); mood stabilizers (Depakote, Topamax, Lamictal, and lithium); antidepressants (Prozac, Effexor, Celexa, Cymbalta, Wellbutrin, and Lexapro); *and* anti-anxiety drugs (Klonopin and Ativan). For alcoholism, she tried Antabuse and naltrexone. Alone or in combination, these pharmaceuticals dampened the author’s sexuality, blunted her emotions, and slowed her thinking.

Delano was also treated at the storied McLean Hospital, made famous by past residents such as Sylvia Plath (*The Bell Jar*, 1963), Susanna Kaysen (*Girl, Interrupted*, 1993), and David Foster Wallace (*Infinite Jest*, 1996). To Delano's chagrin, psychiatrists at McLean's changed her diagnosis to borderline personality disorder.

The diagnosis entails a host of features, such as problems regulating emotion, idealizing-then-rejecting personal relationships, unstable self-image, and impulsivity. Disavowal of personal agency is common, as are suicide attempts, chaotic romances, and substance abuse. In Delano's eyes, "being borderline" meant that people would see her as "annoying, impossible, attention-seeking, manipulative, needy. Huge slut"—things over which one might be expected to exert some control.

After graduation, she remained financially dependent on her wealthy parents and lacked a sense of purpose. "I surrendered personal agency," she writes, attributing her troubled thoughts and erratic behaviors to a broken brain. Attending Alcoholics Anonymous at 26, however, stirred some hope and prompted a momentous question: "Who would I be off my meds?"

Soon, an answer began to form as she read Robert Whitaker's 2010 *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America*. A vocal critic of the psychiatric establishment, and a reckless guide to the anatomy of mental illness, Whitaker argued that the long-term disability of schizophrenia is caused by the medications intended to treat the condition. As proof, he offers the less dire fate of schizophrenic patients in developing countries, where medication is not used. In reality, however, the afflicted were not schizophrenic; they suffered from an acute, reversible condition, likely viral encephalitis. "Love and food and understanding, not drugs," are the treatments he urges.

Delano, 27 at the time, was prim-ed to receive Whitaker's message. "Holy s—t. It's the f—ing meds," she thought. "What if it wasn't treatment-resistant mental illness that had been sending me ever deeper into the depths of despair and dysfunction, but the treatment itself?"

To discover who she would be off her meds, Delano endured many agonizing months of self-withdrawal. (At the time, about 15 years ago, psychiatrists underestimated the degree to which the body adapted to psychiatric meds and that tapering off of them might need to take place over many months.) She went cold turkey off psychotherapy, too, and eventually emerged to found a nonprofit, the Inner Compass Initiative, that coaches paying clients through the medication-withdrawal process. The Initiative website says its aim is to help people get "beyond psychiatric drugs and diagnoses."

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No question, psychiatry has its weaknesses. Researchers and clinicians are still grappling with as basic an issue as the optimal way to diagnose patients, for example. Despite half a century of promises to the contrary, researchers have yet to map mental disorders onto abnormal brain mechanisms or genetic risk factors. We still lack clinically useful diagnostic tests, such as a signature pattern on a brain scan or EEG, or consistently good responses to medications that correspond to the disorders listed in the Diagnostic and Statistical Manual (DSM).

Because the clinical picture of each patient depends on a jumble of other factors, including childhood adversity, head trauma, life experience, and simple chance, two people with the same genetic predisposition to mental illness may manifest their conditions differently. Conversely, "mild depression," a formal designation within the DSM's fifth edition, could just as easily represent inchoate misery molded into a diagnostic shape by convention, social suggestion, or the emotional gratifications of the sick role.

So, while the manual offers a serviceable framework for organizing clinical phenomena, it does a poor job explaining their origins. To be fair, the DSM architects have been very candid about that. As new taxonomic schemes are under development, we can take some solace in knowing that our medications mainly, though not always, treat symptoms, not diagnoses.

Another problem is that we psychiatrists both under- and over-treat the population. Severely mentally ill individuals, generally considered those with psychotic disorders, do not get nearly enough clinical attention. Meanwhile, the distraught are pathologized and, too often, reflexively given prescriptions. I encounter this routinely in the methadone clinic in which I work. The vast majority of our patients do not have a mental illness. What they have are difficult lives, harrowing childhoods, poor impulse control, and weak problem-solving capacities.

When they speak of “depression,” most of the time it’s demoralization that ails them. Many claim to be bipolar. When I ask them, with genuine interest, “How did you get that diagnosis?” The predictable response is “Because I have ‘mood swings.’” That is *not* bipolar. True bipolar disorder is a grave, though usually treatable, condition marked by manic states, paranoia, and delusional thinking alternating with immobilizing depression. If I had a Swiss franc for every patient who told me he had been diagnosed with bipolar disorder, but who is actually not afflicted, I could open a thermal spa in Zurich.

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Laura Delano, now 42, is a skilled writer, and *Unshrunk* is a highly readable book. But the reader is dared (*this* reader, anyway) to disentangle the author’s innate, troubled self from the iatrogenic effect of treatment. In short, how much of Delano’s anguish was Delano, and how much was inflicted upon her by psychiatry? There is no pat answer: Few things in human psychology are linear and

monocausal. The impact of experience, traumatic and otherwise, can have delayed effects. What's more, we may unwittingly elicit responses from others that make us feel victimized.

Nor is memoir, the most subjective literary form, an ideal way to get at unfiltered personal history. Still, it is clear that Delano was in considerable mental pain before her crisis of identity and authenticity hit one night as she readied for bed. For instance, the author had started cutting herself before her first appointment with the psychiatrist and berated herself as "Slut. Whore. Pathetic. Dirty. Disgusting. Trash. Ruined." During that appointment, her inner voice described her as an "ashamed, bewildered fourteen-year-old girl overwhelmed by painful emotion."

Feeling improperly loved and comforted as a girl is an insistent theme. When her mother handed her the Depakote and Prozac to take with her milk, Delano recalled how "a part of me wanted to collapse into [my mother's] arms, for her to hold me, rock me, for her to tell me all of this had been a big mistake." After a bad date with a boy and the soothing ministrations of her Greenwich Academy, she laments "how long it had been since I felt taken care of." As for the medication, it drowned out "all other emotions—sadness, loneliness, shame, grief."

Why those emotions had been surging through her in the first place, I can't know. But I do know that existential misery and profound self-reproach are not side effects of psychiatric medication.

In fairness, the author acknowledges "that many people feel helped by psychiatric drugs, especially when they're used in the short term." (Note the phrasing "feel" helped, as opposed to her saying they *are* helped.) In truth, medications are often essential in helping many people with severe, chronic mental illness live more rewarding and productive lives.

Nor are most people with psychiatric illness straining against the system. Delano learns this when she works briefly as a peer specialist in a state-funded Boston-area community mental-health organization. When she started, she said, “I imagined I’d be spending my days helping people stand up against psychiatric coercion, spring themselves from locked wards, and successfully get themselves off meds they’d decided they no longer wanted to take.”

But she had no takers. As befit her worldview, she ascribed the patients’ complacency to false consciousness borne of their dependence—psychic and material—on mental-health care and social-service systems.

Many of the patients in the Boston facility, it turned out, were very ill, unable to live full, independent lives. Yes, some of them, perhaps a lot, may have had potential when they first became ill—if they did take medication reliably. Sadly, many public clinics and hospitals lack sufficient and talented staff. They are drab and unimaginative spaces. Yet as heartbreaking as institutions can be, it never occurred to Delano that these patients still found some value in what psychiatrists and psychologists offered them. Part of that repertoire may well have been medication.

Delano wants to warn readers about psychiatric medications, but *Unshrunk* is not a reliable guide. The author, for example, lauds a 2022 analysis of the literature in *Molecular Psychiatry* that purported to upend the consensus that serotonin is involved in depression. Research is ongoing, and the serotonin story will almost surely evolve. But the author should have acknowledged the three dozen researchers who critiqued the methodology of the *Molecular Psychiatry* article.

*Unshrunk* and Whitaker’s *Anatomy of an Epidemic* go on the same shelf. Both are written by smart, passionate people. Both highlight undeniable problems with the mental-health-care system. Yet, their flagrant biases could mislead readers and harm fragile and seriously ill readers who are convinced to stop their medications.

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For many years, Laura Delano was vulnerable and suffering. She was drawn, as many are, to the exonerating power of a diagnosis. She could then blame her brain, in addition to her parents, her school, and, later, the psychiatric establishment. But perhaps the crowning irony is that psychiatry can explain a lot.

Recall Delano's first year at Harvard, when she rejected borderline personality disorder? The fact is, seen from afar and based solely on her own account, the designation appears to have fit her. For one thing, borderline personality disorder is a condition for which meds are not especially helpful—but where alcohol, cocaine, and other street drugs tend to be, at least in the short term. Second, it is typical for borderlines to receive many diagnoses over the course of their lives. Third, the personality disorder tends to remit over time, in the sense that patients no longer meet the diagnosis but often retain scattered symptoms, or what psychiatry might call symptoms, such as the ones Delano says she still has.

The married mother of two continues to experience “intense emotional pain and paranoia and debilitating anxiety and unhelpful impulses.” Yet, overall, she has greater mastery of herself, knowing, at last, how to engage the “art of leaning into the darkness of being alive.” Having a mission—trying to help people in pain—has surely helped. But being fueled, as she is, by the organizing power of an enemy, means that anyone contemplating her ministrations must do so with a strong dose of caution.

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