

The 'borderlinization' of our society and the mental health crisis

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We appreciated Dr. Nasrallah's recent editorial¹ that implicated smartphones, social media, and video game addiction, combined with the pandemic, in causing default mode network (DMN) dysfunction. The United States Surgeon General's May 2023 report echoed these concerns and recommended limiting the use of these platforms.² While devices are accelerants on a raging fire of mental illness, we observe a more insidious etiology that kindled the flame long before the proliferation of social media use during the pandemic. I (MZP) call this the "borderlinization" of society.

Imagine living somewhere in America that time had forgotten, where youth did not use smartphones and social media or play video games, and throughout the pandemic, people continued to congregate and socialize. These are the religious enclaves throughout New York and New Jersey that we (MZP and RLP) serve. Yet if devices were predominantly to blame for the contemporary mental health crisis, we would not expect the growing mental health problems we encounter. So, what is going on?

Over the past decade, mental health awareness has permeated all institutions

of education, media, business, and government, which has increased compassion for marginalized groups. Consequently, people who may have previously silently suffered have become encouraged and supported in seeking help. That is good news. The bad news is that we have also come to pathologize, label, and attempt to treat nearly all of life's struggles, and have been exporting mental disease around the world.³ We are losing the sense of "normal" when more than one-half of all Americans will receive a DSM diagnosis in their lifetime.⁴

Traits of borderline personality disorder (BPD)—such as abandonment fears, unstable relationships, identity disturbance, affective instability, emptiness, anger, mistrust, and dissociation⁵—that previously were seen less often are now more commonplace among our patients. These patients' therapists have "validated" their "victimization" of "microaggressions" such that they now require "trigger warnings," "safe spaces," and psychiatric "diagnosis and treatment" to be able to function "normally." These developments have also positioned parents, educators, employers, and psychiatrists, who may share "power and privilege," to "walk on eggshells" so as not to offend newfound hypersensitivities. Interestingly, the DMN may be a major, reversible driver in BPD,⁶ a possible final common pathway that is further impaired by devices starting to creep into our communities and amplify the dysfunction.

Beyond treating individual patients, we must consider mandating time away from devices to nourish our DMN. During

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Clinical Point

We must consider mandating time away from devices to nourish our DMN

a 25-hour period each week, we (MZP and RLP) unplug from all forms of work and electronics, remember the past, consider the future, reflect on self and others, connect with nature, meditate, and eat mindfully—all of which are DMN functions. We call it Shabbat, which people have observed for thousands of years to process the week before and rejuvenate for the week ahead. Excluding smartphones from school premises has also been helpful⁷ and could be implemented as a nationwide commitment to the developing brains of our youth. Finally, we need to look to our profession to promote resilience over dependence, distress tolerance over avoidance, and empathic communication over “cancellation” to help heal a divisive society.

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