

WHY SO MANY 'BORDERLINES'?

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The borderline diagnosis has been used more and more frequently since the 1970s. This is an undisputed fact. There is an increase in the number of patients who are presenting the four fundamental characteristics of this syndrome which conform to the specifications laid down by Grinker in 1968 according to statistical evaluations:

- aggressiveness and tendency to anger,
- problems with affective relations, which are anaclitic, dependent or complementary, but rarely reciprocal,
- problems with identity,
- feelings of depression, not melancholic but more linked with a solitary life.¹

The divergencies between clinicians does not focus on the recording of the phenomenon of increase of the syndrome, they begin when it comes to looking into its reasoning and its interpretation. The most common explanation proposed puts forward the progress of knowledge about psychic functioning which allows the isolation of an illness hitherto ignored. It is a seductive, optimistic argument which smoothes the progress of science. It is not ours. An immediate observation allows us to doubt it: as far as the nature of this illness is concerned, its principle theoreticians are in fundamental disagreement: for Kernberg borderline is a stable organisation, for Bergeret it is an astructural state. We will add that Kohut denies the existence of a borderline organisation but distinguishes, in the same clinical field, on one side psychoses and borderline cases, on the other side narcissistic personalities, which develop specific forms of transference.² To recap, some take the borderline state to be a larval psychosis, others to be an undifferentiated state, while yet others take it to be an atypical neurosis. Such divergences on essential points do not very well support the thesis of the emergence of the borderline state as a result of the progress of knowledge about psychic functioning

In fact several factors seem to be brought in which favour the abandonment of the concept. First a schematic history of the term. The term 'borderline' appeared in 1884 in an article *Alienist and Neurologist* written by M. Hugues. It describes 'a frontier state of madness'. The notion did not respond to a true conceptual need and was consequently forgotten. The subsequent introduction of the neurosis-psychosis differentiation, produced in its essentials by Freud's teaching, constitutes a period of relative silence on the question of their limits. If there are debates about them they are rather in relation to the definition of the concept of schizophrenia. The lack of precision in the Bleulerian³ notion gave rise to a profusion of nosological innovations on its fringes: schizoid; schizothymia, schizomania, schizosis, schizoneurosis, benign forms of schizophrenia, schizosthenia, apsychotic schizophrenia, schizonoia, larval schizophrenia, etc.

The birth of the modern concept of the borderline is immediately posterior to the death of Freud. It came from to two American psychoanalysts, Adolf Stern and Victor Eisenstein, who wanted to discover certain limits in Freudian psychoanalysis with certain unanalysable patients who were nevertheless not psychotic. We will come back to this.

Some years later came the discovery of neuroleptics. In often succeeding in reducing delusions, hallucinations and disturbances, these new medications profoundly modified the psychotic symptomatology, so that the number of patients cared for outside the hospital increased considerably. The accent placed on the limit was displaced, while the first authors proceeded from the limits of neuroses encountered in analytic treatment, the effectiveness of neuroleptics shifted attention onto a new clinic of patients placed on the frontiers of psychosis.

It was between 1967 and 1971 that many psychoanalysts in the USA and in France gave more weight to the borderline concept and that of the narcissistic personality, endeavouring to confer on them a metapsychological consistency (Kernberg,⁴ Bergeret,⁵ Kohut). Their work met a considerable echo; since then research has multiplied.

At the end of this century, the borderline state remains a diagnosis in frequent use. If this is not because of the pertinence of the constructions which support the concept, how can its lasting success be explained? Three major givens seem to be able to throw light onto the phenomenon: rapid development of biological therapies, which smooth defensive constructions, the considerable restriction of the field of hysteria and the misunderstanding of un-triggered psychotic structure. Each contributes in its way, as we will try to show, to making a place for the borderline.

The principle characteristics of this concept rest on a wide and poorly defined semiological description, in such a way that nothing really prevents its demolition. Certain authors consider that it is within the borderline states that distinctions must be established: thus for Rinker (1968) the line between neurosis and psychosis must itself be divided into four sub-types: from those closest to psychosis to those which can be confined to neurosis. Others discover original forms, for example considering drug-addiction as 'a borderline state within the borderline state'.⁶ Still others introduce new concepts into the same clinical field: pure psychosis (Donnet, Green), marginal psychosis (Pankow), narcissistic personality (Kohut), etc.

An evolution can be clearly seen in the approach to the problem which shifts the limit: initially very close to neurosis, it is found today to be situated more and more within the confines of psychosis. Nevertheless, while this tendency is dominant, widely varying points of view co-exist. Some hold the borderline to be a pseudo-neurotic form of schizophrenia, others opt for a form of neurosis with psychotic mechanisms; not to resolve the issue, one could go with Kohut on the pivotal point of narcissistic transference. Or again we could prefer the position of those who challenge all notions of structural exclusion between neurosis and psychosis in such a way that there exists a dynamic equilibrium between psychotic processes and neurotic processes, allowing all patients to be situated along a continuum in the mental processes. In short, it is not because of its coherence, even in the hearts of those who insist that the concept is well-founded, that the theory of borderline states is remarkable. Even an author such as Green, who, while he does not challenge the notion, has to comment on it: he writes in 1976, after having consulted the specialist dictionaries, "the limits are not all situated in the same places by the different writers, who nevertheless are supposed to be competent in the matter".⁷ Some years later, in 1981, one of his colleagues made a similar observation: "to the extent that the success of the term is affirmed", writes Widlöcher, "one has seen its meaning become imprecise, confused, even contradictory. In fact one could speak of a plurality of concepts which certainly cover a widely recognised clinical reality, but while using criteria so different that the definition of this new category loses its precision to the extent that the clinical studies, the etiological hypotheses and the psychopathological theories multiply themselves. It is therefore necessary to speak of concepts, in the plural, of borderline states".⁸

Since then, even in the Anglo-Saxon field, clinicians have emerged who challenge such a vague notion. For example in an article that appeared in 1978 in *The American Journal of Psychiatry*, Rich proposes that patients with uncertain diagnoses be called 'undiagnosed patients', rather than making them into borderline subjects for the sake of convenience. Similarly in 1989 Wurmser refutes the concept of borderline cases because "it is a catch-all term which covers very varied areas of psychopathology".⁹ In 1974 Flournoy thinks that the borderline problems correspond either to a latent psychosis tangled with modes of neurotic defence, or to a neurosis bearing some surface psychotic symptoms.¹⁰ Laplanche and Pontalis, in *The Language of Psychoanalysis* consider that the term borderline does not possess a rigorous nosographic meaning. They consider that, depending on the concepts of different authors, mainly schizophrenics presenting neurotic symptomatology, but also psychopathic, perverse, and delinquent personalities and serious neurotic cases are included in this notion.

How could such a blurred concept as that of borderline know the development that we acknowledge it? Let us remember that there is a precedent, that of schizophrenia, which shows that the

indeterminateness of a concept is not an obstacle to its success as far as clinicians are concerned. Is it a lack of rigour on their part? Or do they consider it advantageous to use jumbled notions in order not to shut the patient into a category which is too constraining?

The rise of the borderlines.

Let us return to the period in which the modern concept of borderline originated. A little after the death of the founder of psychoanalysis a number of analysts, particularly in the Anglo-Saxon sphere, noticed an increasing number of patients who balked at adapting to the type of treatment in which the accent placed on the interpretation of material is diminished in favour of the analysis of resistances. Seriousness of regression, depth of narcissism, weakness of the ego, the importance of the schizoid factor, the explanations differ but the opinions converge in relation to the scarcity of the signs of psychoanalysis. In any case, until the 50s Freud's teaching was still too present to allow any doubt in relation to the hysteric's ability to gain from analytic treatment to emerge. Thus the classic Treaty of Freudian psychology published by Fenichel for the use of students in a hurry, while to a certain extent it does efface hysteria, it nevertheless considers "the best therapeutic results" to be obtained from it.¹¹ Unanalysable subjects were not yet to be found among hysterics.

Things were soon to change. Various factors contributed of which the principal ones were the extension of the field of psychosis, the introduction of the notion of unanalysability, the growth of the concept of borderline, and the development of chemical therapies. We must emphasise that these phenomena appeared simultaneously in the 50s. One of their consequences lies in the fact that they all contributed to re-evaluations of hysteria — always reducing it.

During this period the spreading of the work of M. Klein and the translation into English of the major works of Bleuler are influential in a way that converges with Fairburn's work on the schizoid factors, producing a disproportionate extension of the psychotic mechanisms across the Atlantic. Learning on these researches, anyone feels able to proceed to a re-evaluation of the cases presented by Freud and Breuer in 1895 in their Studies on Hysteria. It is in San Francisco that a respected representative of Ego-psychology takes it upon herself. Reichard does not hesitate: Anna O. and Emmy von N. were schizophrenics. She finds this diagnosis on various criteria which share a common reference to a vague notion of accentuated seriousness. Comparing them with three of Freud's other major cases, she concludes that these two patients came from more disturbed families, that their symptoms were more numerous, that the results of their treatment was less good, and above all that the weakness of their egos produced a decisive differentiation. Hysteria, according to her, is a neurosis characterised by conversion symptoms which derive from unresolved Oedipal desires. She finds persistent sexual conflicts on the phallic or genital level which can only be compatible with a minimal degree of ego weakness.¹² Consistent with the limitations of her approach Reichard even refuses, against Reich,¹³ Fairburn and Marmor,¹⁴ to consider that oral fixations could be part of this pathology. Most of the Ego-psychologists approve of her effort to put hysteria in its place. Thus when, twenty two years later in New York (1978), Krohn writes the monograph which codifies the renewed hysteria, he emphasises that what determines it is founded in the end on the functioning of the ego. He considers that the debates concerning the degree of libidinal maturation detectable in this neurosis, which lead one to discern a genitalisation of the mouth (Reich) while another cites oral use of the genitals (Marmor), evoke the scholastic debates on the sex of angels. We can hardly disagree with him.

In any case no one inquired into Freud's reasons for considering that hysterics existed who were 'not very prone to conversion' producing problems more psychic than somatic. Reichard rejects them as a sleight of hand, considering that notions of 'hysterical psychosis' and 'dementia' belong only to old psychiatric terminology. To this she prefers the Bleulerian renovation promoting a tentacular schizophrenia. She accepts that the diagnosis of schizophrenia remains obscure but does not doubt that it comes first from a deficiency of the ego. Like Bleuler, she considers that this pathology is very common and is not necessarily of a psychotic nature.¹⁵ In fact, into this confused mass of schizophrenias, in which the majority of patients will be found, her colleagues are already introducing new discriminations beneath which the great neurosis will succumb even more.

The constriction of hysteria is supposed to isolate a pathology which constitutes a good indication of analytic treatment and of which the prognosis is judged to be favourable. Fenichel, Fairburn, Glover, Reichard all agree on this point. This is less the case by the beginning of the 60s. At this time Ego-psychology conceives the notion of 'analysability'. Shortly afterwards its negative, 'unanalysability', will be heard like a gangrene all the way to the reduced field of hysteria. It is in New York, precisely where Kris' study group is elaborating Ego-psychology that, according to Easser and Lesser, from 1965, the repeated inability of analytic treatment to reverse the course of hysterical symptoms, leads therapists to uncertainty, discouragement and disinterest, even causing some to turn away from this field of unproductive research.¹⁶ From this time only a restricted number of subjects sufficiently mature and adapted are to be included in the category of 'hysterical personality'. They will have to be differentiated from a large group of 'hysteroïd' patients who react in a negative manner to the efforts of the analytic treatment. Three years later, still in New York, E. Zetzel divides what is left of hysteria into four groups within which the 'analysability' of subjects will decrease. 'The good, true hysteric', as he calls her, can only be found in the first category, difficulties arising in the others.¹⁷ The incomprehension which has been installed between the hysterics and the Anglo-Saxon analysts is carried to its ultimate point in 1974 in an article by M. Khan: it is towards a theorisation of a fundamental unanalysability of the great neurosis that this author directs himself. "The internal world of the hysteric", he claims, "is a cemetery of refusals." Her memories are incarnated in somatic states of a kind that they lend themselves "neither to psychic elaboration nor to verbalisation".¹⁸ If we follow this argument through it is nothing less than Freudian conversion that should be thrown into the dustbins of psychopathology. In short the very inventors of psychoanalysis seem, three quarters of a century later, to be fundamentally rancorous and protesting. Do they not in fact have good reason? Psychoanalytic treatment has become full of traps: those who escape the tentacles of Kleinian interpretations risk being called upon to bring about a good therapeutic alliance or to proceed in order starting with the resistances. Hysterics are too aware of the impossibility of the sexual relation to accommodate themselves to these kinds of knowledge that are being force-fed to them.

The unanalysability of those rare subjects who still enter the reduced field of hysterical neurosis is a thesis which hardly appears in texts prior to the 60s. The novelty is judged contemporary with the advances in the psychology of the ego concerning the notions of working alliance and analysability. These new concepts require as a condition of a psychoanalysis the presence in the subject of a sphere of autonomous ego free of conflicts. It is on the basis of this healthy mode of apprehension of reality that a transference can be analysed which is understood as inherent to the lived pathology. In fact, even hysterics with a strong ego assumed able to profit from an analysis, even these, according to Krohn (1978) balk now at the treatment-type. "The hysterical personality", he claims, "tends to evaluate hypothetical-deductive words and reasoning, even if the person is intelligent and capable of such reasoning. When she functions in this way verbal interpretation loses its therapeutic effectiveness. The hysterical personality hears words as caresses, gifts or chastisements. She often uses them to try to combat the mistaken explanations of her behaviour." One gathers from these lines that the ideal analysand according to Krohn and Ego psychology is a rational being capable of distancing herself from all manifestations of her unconscious. On grounds such as these analytic treatment would not even be adapted to those who wanted to become analysts, even to the least neurotic among them. Nothing in common with this irrational, infantile, contrary being who would be, according to him, the hysteric. "This kind", he continues, "judges the interpretation as being proper to the therapist only as long as he remains a passive receptor. This disinvestment of words is the integrating part of the cognitive style of the hysterical personality. The inattention to words becomes a mode of banal defence for the hysterical personality who often simply does not hear the therapist. Her wish is to observe him speaking, to listen to the tone or quality of his voice, while considering the words as a boring and unimportant part of the therapy. In relation to some patients such an attitude to words and thoughts can be usefully interpreted as characteristic resistance. With others this attitude cannot give way to interpretation, so that the results of the treatment can be limited. With this last type of patient, interpretations remain unheard for a long time, earlier insights are forgotten, such that the masculine and scientific therapist who understands 'such complex things' is responsible, for the author, for all the insights except the most superficial".¹⁹ At this point we are not surprised that such patients are often accused of manipulation, sometimes provoking the therapist into reacting with anger or anxiety. Krohn does not forget to note that the difficulties encountered in the treatment can lead to measures of retaliation on the part of the analyst. So the hysteria of which he speaks

to us is a neurosis 'which slips away', according to the title of his book, a neurosis of which the field of extension shows itself to be considerably amputated in relation to Freudian hysteria.

Does this not remind us again that the first hysterics treated by Freud, those with whom he invented psychoanalysis, presented on the contrary serious forms of neurosis? "To date I have only been able", he wrote in 1904, "to establish and try out my therapeutic procedure on very seriously ill patients, on more or less hopeless cases. I have only had access to patients who have tried more or less everything else without success, who have spent years in institutions (...). Psychoanalysis has been created on a study of patients incapable of adapting themselves to existence and to their inattention. It is a great triumph for it to see a great number of these unhappy people rediscover the possibility of living".²⁰ Everything leads us to believe that the New York progress in psychoanalysis led to a considerable restraining of the field of action in the analytic treatment at the same time that hysteria was reduced to shrinking away.

Well before Krohn's work, a large part of hysteria had been shifted by his colleagues into other nosological categories. If a delirious idea or some suspicion of hallucination were discerned, the concept of schizophrenia was in general called up. In any case, between this and the remains of hysteria a field was formed, constituted by patients who fitted badly into the analytic process disinfected by the therapeutic alliance. To circumscribe it new concepts had to be developed, 'pure psychosis', 'affective perversion' or 'narcissistic personality', but it was above all the category of borderline that acquired wide usage.

Freud ignored it. It was introduced in its modern form in 1938 by Adolf Stern, an Anglo-Saxon analyst, but it was above all Victor Eisenstein who, from 1949, established the basis of its acceptance. One after another found their departure not within the scope of semiological research, armed with statistical work or with a review of established criteria, rather it was from the difficulties encountered in the therapeutic treatment with certain patients that the notion of borderlines arose in their writing. They considered that despite the apparently neurotic symptomatology presented by certain patients, they did not behave in the treatment like ordinary neurotics. Eisenstein observed for example that they tended to transform an interpretation into a 'threat'.

The real fortune of the borderline concept seems to have been correlative with the introduction of unanalysability promoted in the 60s by New York Ego psychologists. All agreed, following the work of Knight (1953), in considering that the weakness of the ego in borderlines rendered them little able to form a 'therapeutic alliance' deemed necessary to the progress of the psychoanalytic treatment type, such that the therapeutic methods had to be modified with certain patients. In 1974 Green put forward the opinion that it would perhaps be better to consider them as 'borderlines of analysability', adding, "one knows that what characterises these clinical pictures is the lack of structuration and organisation — not only in relation to neuroses, but also in relation to psychoses" — thus joining Bergeret against Kernberg.²¹

What is it from then on that differentiates a borderline patient from an hysteric made acrimonious? Essentially a notion of excess proper to the former: the weakness of the ego more marked, libidinal regression more accentuated, richer symptomatology. On this basis of deficiency arise problems of identity, acting out, hallucinations, and passing delusions. That it was necessary to integrate great hysteria into this pathology Kernberg suggested clearly when he included the dissociative problems of the DSM. Moreover Krohn places Esser's 'hysteroids' and Abse's 'hysteromorphes' in the same category.

The work of the New York analyst Otto Kernberg constitutes today one of the major references concerning borderlines. His 1975 work on borderline personality problems aims at a complete, methodological study of this nosological entity. He considers that 'borderline' describes "an organisation of the personality which is neither typically neurotic, nor typically psychotic". He tries to describe it by writing of the persistent problems in ego functioning. In the same year in France Bergeret published *La dépression et les états-limites*. The title is justified because he believes, in opposition to Kernberg, that depression constitutes the most characteristic symptom: it proves to be an evolutive risk constant in

borderline pathology. Further, in an original way, he considers that this testifies to an astructure. The subject would be too massively dependent on the variations of external reality to fit the solidity and fixity of one of the two structures that he recognised: the neurotic and the psychotic. Kernberg and Bergeret differ on several points in relation to the metapsychological apprehension of the borderline; nevertheless they agree in considering that in most cases modification of the analytic treatment type was necessary in order to deal with such patients. On what was to be modified there were deep divergences: Bergeret proposed "an organisation in two stages of the treatment type in what concerns the interpretative game of the analyst." It entailed first dealing with the pre-genital problematic before analysing, at a second stage, the Oedipal material.²² In reply, Kernberg proposed 'a psychoanalytically inspired interpretative psychotherapy' which takes place face to face, which aims to reinforce the ego, clarify reality and not allow the transference develop too much.²³

The similarities between 'rancorous' hysterics and borderline patients appears to be interesting. Each one notes that the latter possess a large number of hysterical traits: their exhibitionism is described, their narcissism, their erratic behaviour, their intolerance of frustration combined with a propensity to angry behaviour, the common presence of conversion phenomena, and the increased frequency of this pathology in women. In the domain of sexual life the majority of the authors describe problems with object relations, resulting from the persistence of Oedipal conflicts, which lead to an unrealistic idealisation of the partner. It results in an instability in heterosexual relations bringing out the most banal means utilised by the hysteric to maintain her desire unsatisfied. On the other side the borderlines show themselves to be subjects who adapt badly to the analytic treatment and are changeable and sarcastic, we are told. They show themselves to be disagreeable with the therapist, trying to manipulate him. Bion claims that they dodge the comprehension, avoid insight, paralyse the dynamism of the analytic process; in apparent agreement, they conceal in fact a rejection of interpretations.²⁴ The similarities with what Krohn claims concerning the attitude of hysterics in analysis is clear to see. All of which leads us to believe that the same causes produce the same effects. The similar handling of the treatment, centred on reinforcement of the ego, provokes identical rejections on the part of patients no doubt less differentiated than their therapists suppose.

The case of Gilberte

An observation of a borderline syndrome, qualified as 'very pure' by Bergeret who reported it, allows us to put this hypothesis to the test. It concerns Gilberte, a very beautiful young woman of 29, who is suffering from depression for which she has already consulted several doctors. Without success. She has also recently interrupted an attempt at analytic treatment.

It would be difficult to find a more exemplary observation of the most common form of this neurosis met today in our culture. The need to maintain desire unsatisfied is manifest. "The frustrations of childhood", wrote Bergeret, "had left in her an effective inexhaustible protest, an irreducible dissatisfaction, a permanent fishing for favours".²⁵ Seductive behaviour correlated to a shrinking away as soon as the other looks as if he is going to respond to this seduction is noticed by the analyst from the first meeting. We see that she is interrogating the master, going from doctor to doctor, lying in wait for faults in their knowledge, ready to expose it, as the first attempt at a psychoanalysis, quickly ended, suggests. In her love relations she is looking, as Lacan points out, for "a master over whom she can reign", which she finds by taking a lover much older than herself, with the allure of authority but seriously wounded in the war. Bergeret commented pertinently: "She had looked for a relation with an ideal protector and this she found, while at the same time she could dominate him and keep him at a distance." Even the childhood seduction scene was there. What would have been associated with it remained marked by a partial repression. We know that Freud had started to build his theory of hysteria on similar material, so characteristic is it of the hysterical fantasy.

Why then does Bergeret not consider this patient to be an hysteric? It seems that there are two essential reasons. The first is the absence of a specific symptomatology, in particular that of conversion, apparently lacking. In fact, according to him, "every neurotic picture is more often dominated economically by symptoms rather than by depression".²⁶ An affirmation which the banality of the association of somatic

ailments and depressive feelings in the contemporary hysteric contradicts, even more than the fact that most of the American authors describe the presence of conversion phenomena in borderlines. Further, if Gilberte were hysterical she would have been able without too much difficulty to adapt to the treatment type; however Bergeret only describes three preliminary sessions without indicating whether or not they constituted the prelude to analytic work. Effectively, the experience shows that after a first unsuccessful effort due, according to Bergeret, to the inexperience of the analyst, too quick to disengage the Oedipal desires and to handle the penis and the maternal breasts, it thus proves to be difficult, not only to undertake a second treatment, but even more to make it good. Everything leads us to believe that if Gilberte did get involved again she would turn out to be a difficult patient, ready to argue with interpretations, even to refuse to lie on the couch, trying to get the analyst out of his chair but ready to push him back into it if he took the risk, in short she constituted, according to my understanding, the prototype of an hysteric become a borderline. A badly handled treatment seems to have left her disabled, undermining perhaps even the symptomatic constructions, leaving her prey to a depressive state, and no doubt making her into what was for some an 'antianalysand'.

Which seems to indicate that the Gilberte case undoubtedly has a more general interest. It is the modifications brought to analytic treatment by certain post-Freudians that aroused an increase in the number of subjects resistant to analysis, a phenomenon which found a more acceptable justification in blaming the borderlines, rather than taking up a revision of the well-foundedness of the novelties introduced into Freudian treatment. In short, ever less analysis of fantasy, ever more emphasis on the ego. The analyst being thus led to appeal increasingly to rational comprehension of a subject summoned to form a therapeutic alliance, he slides towards a position of mastery. At first the hysteric might be seduced by this, but very quickly she cannot bear it any more, she panics and turns to the borderline.

It remains only to re-write history erasing the Freudian discovery: Anna O, exemplary observation of hysteria according to Breuer and Freud, proves to be a borderline; Kernberg includes the majority of dissociative problems in DSM-III in the same category; while others tend to assimilate the mechanism of conversion to the simulation of an illness in order to cleanse it of all reference to repression.

The misunderstanding of the un-triggered psychotic structure

Nevertheless the borderline concept does not only get its substance by annexation of a whole branch of hysteria. It has another major source: un-triggered psychotic structure is misunderstood by many clinicians for many reasons, the principle one being that many refuse *a priori* the very notion of psychotic structure, while those who do admit it have hardly studied it. Works on this question remain rare.

Let us remember briefly what presides over its identification. On one side, the presence of signs that testify to the fact that the elements of subjective structure are not knotted in a Borromean way. In the imaginary dimension the problems of identity (interweavings of identity, illusions of doubles, functioning as if, etc.). In the symbolic dimension the indications of rupture of the signifying chain (neological creations, irruption of the letter, deficiency of phallic signification...); in the dimension of the real, the non-extraction of the object a, which has numerous consequences (fleeting emergence of unlimited *jouissance*, opening up of push to the woman, deficiency of the fundamental fantasy, affective effusiveness, sign of the mirror etc.). On the other side the subject must be capable of putting in place a compensating mechanism, more or less elaborated, to screen the structural fault, by the construction of a work, by leaning on a partner or on imaginary identifications, by the adoption of a determining fantasy etc., eventually by having recourse to many of these methods.

The appearance of the 'as-if personality' of H. Deutsch is an example in this respect of misunderstanding of un-triggered psychotic structure. When she objectified this syndrome in 1934, she underlined, according to the title of her article, 'their relation to schizophrenia'.²⁷ She claims that her schizophrenic patients gave her the impression that the schizophrenic process passes through an 'as-if' phase prior to the construction of 'the hallucinatory form'. Also it is perfectly justified to consider that what H. Deutsch presents consists in making evident one of the clinics met in the antecedents of a triggered psychosis. Lacan also considered this discovery when he drew attention to it in 1956. He met the 'as-if' as

a 'mechanism of imaginary compensations' to which subjects have recourse who "never enter into the play of signifiers, except by a sort of exterior imitation".²⁸

Emigrating to the United States in 1934, welcomed by the Psychoanalytic Society of Boston, in an intellectual milieu in which the analytic discourse was increasingly putting the functioning of the ego to the fore, H. Deutsch had no difficulty in considering that the borderline concept provided a inviting category for the 'as-if' syndrome: did it not seem precisely to bring a contribution to the problems of the ego? According to this new perspective, it appeared to be coming from a certain degree of faultiness in the ego — which, in being accentuated, could give birth to a clinical psychosis — and not as resulting from a phenomenon of compensation. Nothing stood in the way of this contribution to the antecedents of schizophrenia could find themselves captured in the 60s by a concept which many considered to be a theoretical advancement: its wide and imprecise semiology allowed the inclusion of most subjects in whom the defences were not structured on a neurotic or psychotic model identifiable by the classics. It is precisely during these years that the discoveries of chemical therapy would multiply such clinical pictures. The progressive reduction of delirious and hallucinatory phenomena, the fragmentation of the evolution of psychotics permitted the much more frequent observation of a wide variety of symptomatic slidings; nevertheless, despite the neurotic appearance of certain evolutionary modes, the subjective structure knew no mutation, at worst it was disorganised, at best the processes of stabilisation were elaborated. In addition, the foreclosure of the Name of the Father was not interpreted, so that H. Deutsche's patients who had psychotic structures presented the same characteristics as those of Eisenstein who were placed on the edge of neurosis. They too showed great difficulties in settling into the treatment type. The borderline concept veils the fact that the identity of the phenomena of rejection of the interpretations rests on reasons which are extremely different. Thus it constitutes an epistemological obstacle in relation to any study of the differences in conducting the treatment.

There certainly is not room to deny that the 'border' symptomatology constitutes an objective syndrome. On the other hand it is very doubtful that it constitutes a trustworthy clinical type. The borderlines category has two major sources in the psychoanalytic field. On one side, it is a creation of a treatment-type, a notion rejected as much by Freud as by Lacan, who insisted that psychoanalysis be rediscovered with each analysand; in fact if an hysteric balks too much against the therapeutic alliance her pathology risks being considered as coming from the borderline field. On the other side of this syndrome, in particular when it comes to H. Deutsch's 'as-if' personalities, one meets subjects with psychotic structures, not discerned as such, for lack of a sufficiently precise grasping of it. In brief, Rich commented correctly in 1978 that the borderline syndrome constituted a junk room in which undiagnosed patients could be assembled.²⁹ We would add that this happens when one economises on a rigorous approach to the structure of neurosis and that of psychosis.

No doubt the borderline concept, born out of the psychoanalytic discourse, owes its success to circumstances favourable to its expansion met in the field of psychiatry ever since its emergence. Its spread, since the 50s is contemporary with that of psychotropic medicines. In somewhat reducing the subject's anxiety they take the edge off the defensive work and the elaboration of symptomatic constructions. They support the appearance of a new clinic in which unconscious formations are smoothed over rather than foregrounded, diffused anxiety and depression becoming dominant. The pictures, formerly classical, are suffused by chemical therapy in a jumbled syndrome of which the definition is darkly negative, neither neurosis nor psychosis — such as they were known.

Those clinicians may come again who draw the same conclusions from these claims as those of Bally-Salin, who, accompanying the introduction of neuroleptics, observed that they had "the essential effect of pacifying the ill, which was the achievement of the disappearance of positive symptoms". "We were unable", he continued, "to bring the patients something which would be sufficient to allow them to

structure a new mode of existence and a new psychic economy. Thus we had to force ourselves to find something of the sort. That brought me to analysis".³⁰

Translated by Heather Menzies

1. R.R Grinker, B. Werble, R.C. Drye, *The Borderline Syndrom, a Behavioral Study of Ego-functions*. Basic Books, New-York, 1968.
2. H. Kohut, *Le soi*, 1971, P.U.F., Paris, 1974.
3. J.-C. Maleval, *Smembrare la schizofrenia in Clinica*. Milan. Spirali, 1981, 3, pp. 43-59.
4. O. Kernberg, *Borderline Personality Organisation in Journal of American Psychoanalytical Association*, 1967, 15, pp. 641-685.
5. J. Bergeret, *Les Etats-limites in Revue Francaise de Psychanalyse*, 1968, 32, 5-6, pp. 1001-1004.
6. A.-J. Charles-Nicolas, J.-C. Archambault, J.-P. Macher, *Un état limite dans l'état limite: la toxicomanie in Actualités psychiatriques*, 1979, No 8, pp. 53-57.
7. A. Green, *Le concept de limite in La folie privée. Psychanalyse des cas-limites*. Gallimard. Paris, 1990, p. 107.
8. D. Widlöcher, *Les concepts d'état limite in Actualités de la schizophrénie (sous la direction de P. Pichot) P.U.F.* 1981, pp. 55-70.
9. L. Wurmser, *Un commentaire divergent concernant la pathologie des cas-limites in Psychothérapies*, 1989, No 2, pp.109-116.
10. O. Flournoy, *Les cas-limites: psychose ou névrose in Nouvelle Revue de Psychanalyse*, 1974, 10.
11. O. Fenichel, *La théorie psychanalytique des névroses*, 1945, P.U.F., Paris, 1953.
12. S. Reichard, *A re-examination of 'Studies in hysteria' in Psychoanalytic Quarterly*, 1956, XXV, 2, pp. 155-177.
13. W. Reich, *L'analyse caractérielle*, 1946, Payot, Paris, 1971.
14. J. Marmor, *Orality in the Hysterical Personality in J.A.P.A.*, 1953, I, pp. 656-671.
15. E.A. Gaw, S. Reichard, C. Tillman, *How common is Schizophrenia? in Bulletin of the Menninger clinic*, 1953, 17, 1, pp. 20-28.
16. B.R. Easser, S.R. Lesser, *Hysterical Personality: a Re-evaluation in Psychoanalytic Quarterly*, 1956, XXXIV, 3, pp. 390-405.
17. E.R. Zetzel, *The so-called Good Hysteric in I.J.P.*, 1968, 49, pp. 256-260.
18. M. Khan, *La rancune de l'hystérique in Nouvelle revue de psychanalyse*, 1972, 10, pp. 151-158.
19. A. Krohn, *Hysteria: the Elusive Neurosis*, International Universities Press. New-York, 1978, p. 323.
20. S. Freud, *De la psychothérapie*, 1904, in *La technique psychanalytique*, P.U.F., Paris. 1953, p. 16.
21. A. Green, *L'analyste, la symbolisation et l'absence in La folie privée, op.cit.*, p. 73.
22. J. Bergeret, *La dépression et les états-limites*, Payot, Paris, 1975, p. 300.
23. O. Kernberg, *Les troubles limites de la personnalité*, (1975), Privat., 1979.
24. W.R. Bion, *Aux sources de l'expérience*, 1962, P.U.F., Paris, 1979.
25. J. Bergeret, *op.cit.*, p. 165.
26. *Ibid.*, p. 188.
27. H. Deutsch, *Divers troubles affectifs et leurs rapports avec la schizophrénie*, 1942, in *La psychanalyse des névroses*, Payot, Paris, 1963.
28. J. Lacan, *Le séminaire III, Les psychoses, op.cit.*, p. 218 et 285.
29. S. Rich, *Borderline Diagnosis in American Journal of Psychiatry*, 1978, 135, 11, pp. 1399-1401.

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