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WHAT DOES "BORDERLINE" MEAN?

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Abstract

The word "borderline," unlike other clinical descriptive terms, has no obvious affective or action referent in the patient. This observation may help in understanding the kind of misalliance so endemic to work with patients so diagnosed. The possibility of who has what problem within an analytic treatment, that it might seriously affect the frame of the treatment, and that it might be an act of projective identification by the analyst are explored. It is argued that "borderline" pathology is not an entity, but rather the vast developmental territory of severe personality disturbance, and that Winnicott's theoretical contributions to an understanding of the psychopathology of the dyad, particularly around boundary development, are especially helpful.

WHAT DOES "BORDERLINE" MEAN?

Speaking of "the pathological side of my identity confusion", Erik Erikson writes:

...no doubt it assumed at times what some of us today would call a 'borderline' character--that is, the borderline between neurosis and psychosis. But then, it is exactly this kind of diagnosis to which I later undertook to give a developmental perspective. And indeed, some of my friends will insist that I needed to name this crisis and to see it in everybody else in order to really come to terms with myself. (1970, p. 742)

This paper represents my own effort to "come to terms" with the term "borderline." After an exhaustive review of the literature on borderline psychopathology, Michael Stone (1986) closes by saying, "I'm haunted by the dark suspicion that the subject has gotten out of hand" (p. 432). By that he means that "The borderline literature has swollen to a size too vast to be digested by one anthologist" (p. 432), and certainly by any one reader as well. I would like to consider something further in

this haunting: an unsettling impression that what we mean by "borderline" has also "gotten out of hand," except perhaps as the term "borderline" has become synonymous with something having "gotten out of hand." My comments will address only briefly the theoretical aspects of "borderline;" rather, my focus will be on diagnostic and treatment practice, and on the word "borderline" as an empty signifier and a complicated speech act within a clinical context.

A few years ago, I was a discussant at a clinical case seminar. After the presentation, and in the course of discussion, I asked the group of about a dozen professionals, a number of whom were quite experienced, how they would think about the patient diagnostically; I added, "And let's think about this without using the term 'borderline'." As might be guessed, the group burst into laughter, which seemed both anxious and relieved. But they then began to use clinical-descriptive terms that had precise meaning in the data of the presentation, and, even more importantly, with which the patient herself would almost certainly have agreed on the basis of her own subjective experience.

This is the place I would like to begin: with phenomenology and with subjective experience. It's my guess that, no matter how vast our literature on this topic, no clinician has ever had a patient enter his or her office and declare "I feel so borderline today," while we have all heard

people speak easily of "obsessing" or being "narcissistic" or feeling "depressed" or "manic," "paranoid," "phobic," "hysterical," even "schiz-y." In other words, there seems to be no ready or obvious affective or action referent in the patient to which the word "borderline" gives a name.

Perhaps this observation means nothing more than that this term "borderline" has not been in circulation long enough to acquire a meaning to those suffering with it. Or perhaps it only raises an old issue about the relationship of subjective experience to the disease condition. Cancer patients don't feel cancerous; they may or may not even feel ill. A schizophrenic patient may be neither feeling nor behaving in a "schiz-y" way to be accurately diagnosed; furthermore, diagnostic assessment on that basis might be utterly inaccurate insofar as it does not include recognition of a formal thought disorder. Indeed, one of the earliest and most clinically captivating papers of the borderline literature is Helene Deutsch's (1942) discussion of the "as if" personality, in which she states clearly that these forms of serious emotional disturbance and impoverishment "were not perceived as disturbances by the patient himself" (p. 302). Perhaps then, "borderline" patients do not have a complaint which would lead them to speak to us with the kind of self-descriptive statement of feeling or action referred to above.

Interesting as Deutsch's observation is, I'll for the moment leave these considerations of a condition-without-a-

complaint and return to the problem of a name, "borderline," without an obvious referent. It seems to me that such a diagnostic action, whatever else it might do at its most professionally sensible and helpful level, involves the clinician in telling the patient what he or she is, through a name that can find no personal experience in the patient. It therefore is an action which immediately shifts the locus of authority away from the patient's potential complaint, with whatever experience of distress may inform that, and into the expert purview of the clinician. At its extreme, this diagnostic action says: "What you are--namely borderline--is something you do not, perhaps cannot, know introspectively or experientially, but I can know about it."

Obviously, there are implications in this diagnostic action, regardless of how silently it is apparently carried out, for the frame of the treatment, insofar as this particular statement, and the imbalances included within it, seem to destroy from the beginning a genuinely psychoanalytic frame of reference, while at the same time inflaming desires and expectations in the patient to be the continued intensified object of the analyst's power. If this action is not merely a singular one, a potential mis-alliance, but a paradigmatic one with these patients, can there be an effective treatment? It was considerations like these that led George Vaillant to entitle a recent paper "The Beginning of Wisdom is Never Calling a Patient a Borderline" (1992).

By an analytic frame, I mean of course our structuring of a relationship to the patient's inner process within which we receive the patient's statement or inquiry about himself, in the confidence that together we can come to know him. This structuring of the relationship defines roles; starkly and schematically outlining the locus of initiatives within this role relationship, Andre Green (1978) has written that "No analysis is conceivable in which, after the statement of the fundamental rule, the analyst speaks first" (p.180). It is my impression that our act of naming the "borderline" patient, with a label he or she cannot know first-hand, is often in practice a kind of "speaking first," a form of therapeutic mis-alliance, setting into motion anti-analytic processes, processes which too often lock the analyst into the position of, in Lacan's phrase, the one who is "supposed-to-know" (Lacan, 1977; Muller, 1992).

This admittedly idiosyncratic train of thought could be carried further! For example, this diagnostic action is most usually carried out by a man upon a woman. It could thus be seen as not only an act of professional imperialism, but also of gender politics. And indeed, many treatments of "borderline" patients in the long run come to look like disastrous marriages, with the patient alternately struggling to liberate herself from this meaningless name, the psychiatrist's name after all, while also attempting to extract her due for having accepted it in the first place. I vividly recall the absolute dread which a

patient of mine, a mental health professional, felt about the possibility that I might think of her as "borderline"; by that term, she seemed to mean both "crazy" and "too much." But more than these meanings and more than her own anxious self-diagnosis, it was the power of my potential diagnostic action my patient truly dreaded, an action transferentially embedded in her family's history of Eastern Mediterranean culture, within which the social status of women was rigidly defined and deeply toned by the male's unconscious fear.

There is more to be developed on this theme as it is actually practiced, but I would like to leave considerations of gender for now and return to the question of experience. It seems to me that the only experiential referent for the term "borderline" (unless we return to its grammatical use as a qualifier, as in "borderline psychotic") is not in the patient at all, but in the clinician. This experience may take the form of a puzzlement as to whether or not one is facing a neurotic or a psychotic phenomenon, but very often it is something more urgent, something of a real dilemma in the clinician's embattled psyche about whether he or she is meeting a need or a demand. In other words, the clinician feels on a frontier of some sort, placed there, indeed pushed there by a force from within the patient and often dreadfully ill-at-ease with standing firm or with stepping across.

My point of view here echoes the words of Robert Knight in his classic 1953 paper on "Borderline States." "The

term 'borderline states'...conveys no diagnostic illumination of a case other than the implication that the patient is quite sick but not frankly psychotic.... Thus the label 'borderline state', when used as a diagnosis, conveys more information about the uncertainty and indecision of the psychiatrist than it does about the condition of the patient" (p. 1). Nearly 40 years later, George Vaillant (1992) writes: "I believe that almost always the diagnosis 'borderline' is a reflection more of the therapists' affective rather than their intellectual response to their personality-disordered patients" (p. 120). He adds, citing two studies: "That, perhaps, is why up to 90% of patients diagnosed 'borderline' can also be assigned another, usually more discriminating, Axis II diagnosis" (p. 120).

It seems to me that the history of work with "borderline" patients, the more recent and very helpful clarifications of Kernberg (1975, 1984) notwithstanding, includes a substantial number of failed treatments which founder on this uncertainty, which either never really get started or drag out to disastrous conclusion as one side or the other of this demand-need dilemma is enacted. Vaillant (1992) describes these twin countertransference pitfalls as the therapist's punitive and defensive setting of limits, on the one hand, or the therapist's attempting to be a better mother than the one he thinks the patient had, on the other. Neither help. In Lacan's terms (1977), the psychotherapy of the "borderline", if it takes off at all, is a psychotherapy in the imaginary order only, a

psychotherapy of desired but illusory images, cut off from and ungrounded in a larger symbolic order of task and meaning, and hence with no place for both parties to become subjects within a matrix of social reality.

From this angle, the act of diagnosing the "borderline" patient as such is, at its simplest level, a statement that "this person has a borderline personality disorder because that's where she places me," that is, at a difficult dilemma about a boundary. Without this countertransference awareness, the act of diagnosing borderline phenomena becomes an act of projective identification by the clinician, insofar as it simply exports an internal distressing quandary into another person for purposes of relief and clarity. (Recall Erikson's need "to see it in everybody else".) It misrecognizes who has what problem within this twosome, and thus invites self-estrangement in both. In Vaillant's terms (1992), "immature defenses have an uncanny capacity to get under the skin" (p. 120); "the epithet 'borderline'" (p. 120) is a doomed and disingenuous attempt to free the therapist from this "contagion."

Before carrying this point further, I should perhaps say that I do not believe that borderline psychopathology is an entity, but rather a vast developmental territory, indeed between psychosis and neurosis, eventuating upon failures of development in a number of seriously psychopathological

disturbances of personality. Rosenfeld's (1979) descriptive typology includes the psychotic character, the Kerbergian borderline with "hardly any mental skin" (p. 197), the "as if" personality, the traumatized patient, and the narcissistic patient with disguised psychotic anxieties. The patients he describes we easily recognize from our own clinical encounters, and, though there is considerable overlap between his groupings, there are also clear differences of emphasis in the forms of defensive operations, in the kinds of affects struggled with and in the transferences.

All of this I believe derives primarily from developmental failure within that vast area defined so neatly by Winnicott's work as the pathology of the two-some. In fact, a simple arithmetical schema of development runs throughout Winnicott's work: psychotic vulnerability has to do with that phase of life within which the un-integrated infant comes, with the help of the as-yet-unknown holding environment, to achieve "unit status," becoming one person; neurotic illness has to do with that phase of life within which the passions of a two-some must be modulated by and re-organized to include a fundamentally important third party. In between zero becoming one and two becoming three is one becoming two, in fact a broad area of potential enrichment and failure, each form of the latter, in Tolstoy's words, "unhappy in its own way."

This is the area of personality disturbance, of defenses against anxiety learned so early in life that they have become fabric to who and how a person is. Their relative immaturity pains others more immediately than they do the person him- or herself, although shame (sometimes in the denied form of shamelessness) is always a potential. Under serious stress, these immature defenses come into full play. The person's functioning reaches the "borderline" of psychosis (and thus the word "borderline" to me implies primarily a level of severity of the personality disturbance) insofar as, preoccupied with survival within a two-person system, all considerations of what Lacan (1977; Muller, 1993) would call "the third" disappear: "the third" signifying the order of task, role, law, language, society; in short, all that situates the two-person system in something meaningfully larger.

It is to the issue of the two-some that I would now like to return. My analysis of the "borderline", that is, of the dilemma in the clinician leading him to name a condition in the patient, a condition un-named in that way by the patient herself, focuses on the interaction between two people, rather than on the patient alone. To paraphrase Winnicott (1957), I am suggesting that there is no such thing as a "borderline" patient, only a couple interacting in a paradigmatic way. Vaillant (1992) calls this couple "an enmeshed clinical dyad" (p. 120-121). To continue with Winnicott, this interaction bears striking similarity to the dynamic development of the

false self (1960), particularly insofar as the "spontaneous gesture" from an evolving subject, that movement or feeling coming naturally from the patient and recognized as his or her own and as meaningful, is lost; in its place, there is substituted a need-driven gesture from the other, in the treatment situation the clinician's diagnostic action (and its theoretical underpinnings), around which the subject organizes for defensive purposes.

Here, in the link between "borderline" and the false self, we connect with Deutsch's (1942) brilliant, original formulation of the "as if" personality, and with Hilde Bruch's (1978) work on the development of anorexia nervosa, itself not an uncommon symptom in those labeled "borderline." Deutsch's definitional statement is illuminating:

My only reason for using so unoriginal a label for the type of person I wish to present is that every attempt to understand the way of feeling and manner of life of this type forces on the observer the inescapable impression that the individual's whole relationship to life has something about it which is lacking in genuineness and yet outwardly runs along 'as if' it were complete (p. 302).

In this one sentence, Deutsch anticipates the argument I am putting forward; i.e., she pays conscious attention to the

naming or labeling process, she sees it as the result of something forced inescapably on the clinician, and she highlights something utterly inauthentic in something that looks complete. Erikson might describe this seeming contradiction as the failed effort to use multiple, partial, transient identifications to solve the problem or the crisis of personal identity.

It seems to me that our practice with "borderline" psychopathology must address this issue of the false and the true. So much from such a patient, and elicited by such a patient, can feel utterly inauthentic, a dealing with smoke and missing the fire; yet these patients also bring a true force that must be reckoned with. Indeed, this force or this intensity seems to be the bottom-line of the "borderline," at least as I read DSM-III. I believe that the falsity in the "borderline" represents that lack of "spontaneous gesture," of play in the system, which would be signatorial of a secure, if ailing, personality; and it also represents a defensive adaptation to the system of care in which that person finds herself.

Here one finds enormous potential for collusion, the perhaps most crude if frequent example of which takes place in psychiatric hospitals. In these systems, increasingly impinged upon by externally imposed values, values of "cost containment," of "risk management," of "problem-oriented treatment plans,"

etc. (important values, perhaps, if integrated with treatment values), a patient who speaks or acts "as if" she is suicidal meets, all too infrequently, an "as if" response: a response, analogous to the patient's pathology, based on external identifications rather than on the true identity of the hospital's treatment program; a response that looks "as if" it is complete, except that it leaves out a genuine grappling with the patient's communication and responsibility. This patient may indeed be engaged in a serious manipulation of the system, while acting out hidden needs or wishes (for example, to be seen, or touched, or vengeful, or chosen over others), but too often this kind of system has already defined itself as there to be manipulated, as therefore not worthy of the patient's respecting its function as a potential genuine container, and even as itself engaging in manipulation of the patient to get off some imagined hook of accountability.

Andre Green (1977) has written that "the borderline is the problem patient of our time" and that "the mythical prototype" is "no longer Oedipus, but Hamlet" (p. 15). But the "to be or not to be" question raised at times so casually in the system described above and responded to so collusively represents a terrible miscarriage of communication and a chronic depletion of the language and human resources with which to meet the true problem. I will not elaborate here the treatment philosophy, concretized in the totally open and voluntary hospital setting in which I work, which grounds our efforts to

meet this problem therapeutically; nor would I want to suggest that this particular hospital is immune to these dynamics. Recently, as the hospital was working its way toward a major leadership transition, our patients took to assembling, as a group project turned to by various people throughout the day and evening, huge jigsaw puzzles. And, as we have been lately adapting ourselves, we hope sensibly, to various exigencies facing hospitals currently, our patients have become concerned about, as one feature of their effort to organize their community life, the dangers of passive smoke. There are times when I feel that the distinction between manifest and latent obscures the equally important distinction between manifest and blatant; our patients' wondering about how the parts fit together into a single, coherent picture and their worrying about the un-seen effects of everything we are all quietly, regularly breathing in seem like essential communications in their basic self-preservative effort to correct any warp developing in the holding environment they so need. The only question is: can these communications be honestly received? To the extent that the treatment personnel are "supposed to know," this necessary receptive capacity, and the vitalizing dialogue it initiates, are seriously compromised.

For treatment personnel or for the individual practitioner, a patient's acting out around the magical word "suicidal" is again their being placed, with urgency, on a border: between need and demand, often between management and

interpretation. For the patient, it is many things: perhaps a response to the threat of being lost, but perhaps also, as Ghent (1992) points out, a response to the threat of being found in the treatment. The defensive function of false-self adaptation is to hide the true self, that core of personality seriously vulnerable to "primitive agonies" if ever it is allowed another "regression to dependency." All of these are Winnicott's terms. As Ghent suggests, we might see the demand or neediness of the patient, a barrage of affectivity so potentially dis-orienting to the therapist, as confounding and hiding the real need, a need threatened with potential exposure, as much to the patient herself as to her therapist. The therapeutic task is the sustaining of this paradox, the validation of need without gratification of neediness, the holding, rather than splitting, of different emotional parts or points of view. For Ghent, "borderline" acting out is the result of real environmental failure and results in a tendency to ab-use the object rather than use it in the important sense outlined by Winnicott (1971a) in one of his major and final theoretical statements.

In this paper Winnicott describes the developmental movement from what he calls object-relating, that early phase of one becoming two when the other is only perceived on the basis of projections and has only self-object or subjective status, to object-usage, the phase of two people, recognized as separate and different, though related. This is the object objectively perceived, available potentially for use according to its own

inherent properties. This major developmental move, one feature of what Winnicott calls "realization," occurs through the child's aggression and the other's survival of that aggression without retaliation. In the child's act of destroying the fantasy-other, that which survives must be a real other, and inter-subjective living becomes a possibility. For Winnicott, the function of aggression in the finding of reality, and the belief that only the true self can feel real, are old themes. His "use of the object" concept sums up for him the major differentiation and integration achievements of the weaning process: the me from the not-me, fantasy from reality, the mother of care as one with the mother of hunger, libidinal ruthlessness integrating with reparative capacities.

For the patient presenting us with the "borderline" problem, we can often see within this false-self defensive enactment an enormously compromised appreciation of reality coordinate with major difficulties with aggression. As Knight (1953) writes of "borderline states," "The break with reality, which is an ego alteration, must be thought of not as a sudden and unexpected snapping, as of a twig, but as the gradual bending as well..." (p. 3) One recurrent clinical feature with some "borderline" patients is deeply aggressive behavior wrapped in sentimentality, a chronic bending of reality which once again invites, even plays upon, the clinician's collusion and choosing sides. But sentimentality so suffused with aggression both represents something and does something, and the representation

can easily be lost in the doing, or vice versa. It conjures up an image of a good but lost object-relationship, something evanescent, nostalgic, childishly purified of anything disruptive, fragile, and not fully real. But the clinician also feels the aggression and can choose to deny it, as the patient seems to, or to push it back into the patient and thus become the disruptive, destructive intruder into the sentimentalized internal relationship. This is the "borderline" place and pitfall. Both parts are true: there is a lost love relationship in this sentimentality, perhaps to a part of the self (Bollas, 1982), as well as to an other, and Winnicott's statement in his classic paper "Hate in the Countertransference" (1958) also holds: that a person cannot tolerate "the full extent of his own hate in a sentimental environment. He needs hate to hate" (p. 202).

Andre Green (1977) and Harold Searles (1986) have, in very different ways, highlighted the use of the countertransference with borderline patients. Green returns us to a concept of "borderline" inherent in Freud's definition of instinct:

an 'instinct' appears to us as a concept on the frontier between the mental and the somatic, as the psychical representative of the stimuli originating from within the organism and reaching the mind, as a

measure of the demand made upon the mind for work in consequence of its connection with the body.

(Freud, 1915, p. 121-122, italicized by Green, 1977, p. 30) For Freud, the work of the mind required optimal frustration. Green (1975) accents this condition differently; the work of the mind, or the capacity for thought, depends on the experience of tolerable absence, with its implication of potential presence. An object too much there or too utterly lost destroys the conditions for thinking.

Perhaps this underlies the "borderline" paradigm. (See also Fonagy, 1991) That transformation from body to mind, that "borderline" which Freud called instinct, does not happen in a two-person psychology fraught with serious loss or intrusive affective presence. Instead of movement across a boundary, there is a split or barrier. Affectivity is simply evacuated, and, if there is a treatment situation, evacuated into the other, "forced upon us" (1942, p. 302) as Deutsch said. This other may or may not be able to do, and enlist the patient's assistance in doing, the work of transformation within himself. If he cannot, some variant of counter-projective processes must occur, the putting of the "borderline" back into the patient and holding it at arms length. If he can, there is an incremental sense of the reliability of the container and the tangibility of a content. It is this failure of metabolization in the primary other that Rosenfeld (1979) and many others see as central to this area of psychopathology. Winnicott writes:

"In the extreme of a borderline case, everything boils down in the end to what I have tried to describe as the survival of the analyst" (1987, p. 181); by this, Winnicott means surviving as an analyst, without retaliation and with technique and the analytic setting intact. Intact technique would mean, at least ideally, the analyst's ability to deal with his "borderline" or "frontier" problem: that is, to make that transformation from his body (given what the patient is bringing to it) to his mind which we call interpretation, delivered, if at all, with that gracefulness and courtesy so thoroughly a part of Winnicott's clinical care (1989).

In the Austen Riggs Center's long-term follow-up study (Plakun, 1991), one set of results had to do with patients diagnosed as "borderline;" two variables, one historical, the other clinical, were predictors of good outcome: the absence of a parental history of divorce and the presence of self-destructive acting out during the course of treatment in our hospital. If Erikson (1961) was accurate when he said that it is the task of the family, "in one of its exemplary forms," to help the child "gradually delineate where play ends and irreversible purpose begins" (p. 156), perhaps the converse is also true: families that do not survive create more severe "borderline" difficulties, including a constriction of the reversible processes of play, in confusion with something more irreversible and purposeful. And perhaps also the treatment environment must be tested and used fully and survive in a vital

working way, in order for the patient to finally and securely achieve these differentiations, along with the "shrinking to life-size," in Harry Stack Sullivan's phrase, so joyfully experienced upon being survived. This is the task of establishing real and helpful boundaries, boundaries that are not barriers, but that establish "edges" for both interchange and contact.

Winnicott (1971b) once wondered what would happen if the baby looked into his mother's eyes and did not see himself? What I suspect can happen is the simultaneous establishment of no-boundary and of enormous gap, the gap between an image held urgently by the mother and the child's felt potential in and of himself. The imposition of the former upon the latter is the boundary violation. Shapiro's (Shapiro et.al., 1989) research on the contradictory, projectively-toned images of the child-at-risk held by each of his parents might lead to the same conclusion. Perhaps the "borderline" is the child's internalization of the no-man's-land between his parents, or between image and inner experience, especially as parental figures receive and react to his developing personality and affectivity. This gap may also be the formative precursor of the fault lines in the treatment situation, which the patient must actively exploit rather than passively suffer. The actual meaning in the word "borderline," which has been the subject of this paper, may most simply reflect the problems of people around borders or boundaries. For some people, the earliest

efforts at contact and at separateness have encountered unbridgeable gaps, external then increasingly internal, brought both hopefully and assaultively to the therapist, who feels, in the words of Françoise Davoine, "the paradox of frontiers": "that they are never more present than when they are broken by an invasion" (1989, p. 595).

The "splitting" so regularly described as basic to the "borderline" condition fits in here. It represents the failed integration, and then the exploited dis-integration, of the unsuccessful depressive position. Two fully developed and fully perceived people do not emerge from this developmental landscape. Rather, two partial people do, each alternately deprived by and falsely enriched by projective processes, and each needing the other for conflictual equilibrium. Most importantly, hate is not saddened by love, nor is love matured by hate. Instead, the intensity of affects related to loss and to intrusion mitigates against such ordinary integrations and against the capacity for concern as well, which would be its natural outcome (Winnicott, 1956b). There is thus also superego pathology: a conscience which cannot accurately gauge the effect of behavior and needs interpretation from the countertransference, and an ego ideal which knows it needs, but is otherwise without signifiers for, a real and truly meaningful grounding in something larger.

Hamlet, like Dr. Stone, was haunted by dark suspicions. Like the false self, he was invited to live out a lie. Like trauma victims, which some research links to "borderline" functioning, his life, as we know it, begins after a death. He both feigns madness and actually carries the madness of overwhelming knowledge and feeling. While he places others in that quandary Deutsch describes--What is wrong with him?--he himself struggles with abandoning himself to a rage both vengeful and random, since all is already lost. He has no "other." Becoming an "other" for a patient so injured is not a task to be taken lightly. It is to meet both loss and rage, in the patient and in oneself. It requires a deeply and a well-grounded two-person perspective, and a steady effort to find the pulse of integrity within the shifting affective and defensive energies of the relationship. And, like the depressive position itself, that first paradigm of two-person relatedness, it challenges us to bring together empathic care with something in the direction of ruthlessness. Winnicott (1987) will have the last word:

If the patient feels that it is worth doing, it is worth doing, in spite of the fact that every stage which could be called an advance brings the patient into closer contact with pain. In other words, the patient gives up defenses, and the pain is always there against which the defenses were organized. This kind of work, as I have pointed out in talking about

the treatment of psychotic children, could be described as cruel. When it succeeds, of course, the cruelty and the suffering are forgotten. p. 181)

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