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Borderline Histories: Psychoanalysis Inside and Out

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Argument

Sociologists and historians have long favored externalist over internalist accounts of practices in the clinical disciplines. This has been particularly true in the case of the so-called new patient or borderline personality, which a range of commentators have located in culturally resonant narratives of decline. I argue here that these narratives, while pleasing, do not hold up as history; most problematic is their assumption that the appearance of the borderline portends the emergence of altogether novel forms of modal personhood. Internalist accounts of the category's consolidation are equally problematic in asserting a coherence and a stable referent that repeatedly proves elusive. In the end, I suggest that a complex account of disciplinary practice that attends to knowledge production in the clinical encounter supports the conclusion that the new patient was new to psychoanalysis. Whether or not he was altogether new cannot be established, undermining the critics' certitude and prophecies of decline.

From the 1940s to the present, it has been a staple of social commentary that the American self is in crisis. A major tradition of social criticism – from David Riesman's *The Lonely Crowd* (1950) and William H. Whyte, Jr.'s *The Organization Man* (1956) to Christopher Lasch's *The Culture of Narcissism* (1979) and Richard Sennett's *The Fall of Public Man* (1976) – has painted a compelling portrait of a nation in cultural and characterological decline. Informed by the notion that, as Lasch put it, that "every age develops its own peculiar forms of pathology, which express in exaggerated form its underlying character structure" (Lasch 1979, 41), this tradition tells of the demise of a disciplined, patriarchal Victorianism that produced autonomous, inner-directed individuals and the rise of a modernity that values appearance over authenticity, yielding the superficial, other-directed, and fundamentally disturbed personality as its paradigmatic figure.

The social critics' indictment of modernity is well known, widely accepted, and rarely interrogated. It has long informed both scholarly and popular understandings of the American character as well as of the relationship between psychic and social forms. That we, as moderns, are characterized by our lack of authenticity and genuineness, and that this lack is manifest in the predominance of false over "real" selves, is an unexceptionable claim. That this is traceable to the conditions of modern life – its instabilities and superficiality, its elevation of consumption over sturdy production – is a commonplace. Any number of indictments of modernity – and, specifically, of

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its American variant – assert that an empty culture such as ours, which valorizes a mindless consumerism and promotes the indulging, rather than the harnessing, of all sorts of impulses, not only tolerates but produces this figure, whose impoverished moral sensibility serves to vividly illustrate the depths to which we have fallen.

For the past sixty years, a number of psychoanalysts and psychiatrists have been making much the same argument about the American self. Like the critics, and often in dialogue with them, they have argued that the American social character has changed, adducing as evidence the appearance of a "new type of patient" in the consulting room and hospital ward. As clinicians have told it, this new patient suffered not, like Freud's patients, from repression and the sexual conflicts occasioned thereby – for, it was widely asserted, social prohibitions of all sorts had been weakened by the mid-century period – but from a range of vaguely defined complaints: feelings of emptiness, aimlessness, futility, and discontent. A series of now-classic psychoanalytic papers registered the demise of the Freudian patient with her classic neuroses and specific symptoms and the ascendancy of the chronically maladapted, character disordered new patient (Stone 1954; Easser and Lesser 1965; Loewald 1979). The exemplary patient of modernity, it was widely agreed, was no longer the hysteric, with her florid conversion symptoms, but the empty, grandiose narcissist and the histrionic, manipulative, impulsive, and self-destructive borderline.[1] Confidently linking clinical phenomena to the temper of the times, one analyst captured the sentiments of many in suggesting that the behavior patterns of such persons "reflect major psychological themes in American culture at large," among them fears of abandonment, excessive focus on the self, and problems with intimacy (Masterson 1988, vii). A popular handbook on the diagnosis struck the same note, proclaiming that many professionals believe "we are living in a 'borderline era'" in which the borderline's "fragmented sense of identity and difficulty in maintaining stable relationships may reflect the fragmentation of stable units in contemporary society" (Kreisman and Straus 1989, xiii).

Around no other of their many categories have clinicians spun such an appealing and popular historical narrative. In locating sources of transformation in broad cultural context, it squares with – and has been conscripted into – the sorts of externalist accounts of the clinical disciplines' practices that sociologists and historians have tended to favor over internalist renderings of the same. Since 1980, marked by the publication of DSM-III (APA 1980), which signaled psychiatry's abandonment of dynamically-inflected nosologies and corresponding embrace of a symptom-based descriptive psychiatry in which diagnosis is the practitioner's scientific métier (Mayes and Horowitz 2005), these accounts have focused all the more insistently on the issue of categories and their relationships to the cultural milieus in which they take shape. The personality disorders in general, and borderline personality in particular, have provided

[1] It is worth noting that Lasch draws on the clinical literature concerning the borderline as well as the narcissist – and does not distinguish between the two – in sketching his own clinical portrait of narcissistic pathology (Lasch 1979).

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critics – especially feminist critics – ample material in this regard, representing attempts, as one put it, to resolve "various cultural problematics" in medical terms (Nuckolls 1992a; 1992b).

I argue here that, for all its appeal, this narrative simply doesn't hold up *as history* under close scrutiny. First, the analysts' and critics' story of confrontation with something new has remained essentially the same over a period of fifty years, a long time in the short history of psychoanalysis. The new patient of the 1940s was, as analysts told it, still – somewhat improbably – new in the 1990s. Second, the story told of the new patient's emergence fails to adequately register transformations internal to psychoanalysis and to the category itself, missing altogether that as the new patient was enthroned as exemplar of modernity he was also transformed from a severely disturbed near-schizophrenic to a rather milder and far more common type and, in the hands of many, from a stock male to a paradigmatically female figure. That is, although the category was manifestly stable, that to which it referred in this narrative – which from this perspective is thus improbably simplistic – was not. Third, and most problematic, critics have consistently failed to distinguish between the appearance of the new type of patient – to which clinicians of all stripes attest – and the emergence of the altogether novel configuration of personhood that figures so centrally in their narratives of decline. Clinicians' new patient may tell us less about society and more about the practice of psychoanalysis and psychiatry, its terminology, categories, and modes of apprehension, than has been thus far recognized.

As will become clear, I am skeptical of analysts' and critics' claims for the emergence of a new type of person,[2] more easily persuaded that what we have witnessed over the last sixty years is the fitful coalescence of a new category – assembled from new concepts and new terms – that has enabled clinicians to take note of and diagnose dimensions of personhood they had not formerly been able or inclined to register. This new person, once established as a type, does yeoman cultural work in American social criticism but not, significantly, in the British context, in which there is no analogue to the literature of lament – a long standing American tradition, reanimated by Riesman and his confreres with their condemnation of the ever more insubstantial modal American – that is so characteristic of the post-World War II critical landscape in the United States.

In Britain, postwar critics were focused on the community, not the individual, on the injuries of class, not the deficiencies of individual character. It is understood by all that the culture of narcissism, as Lasch – a gifted polemicist – would so memorably characterize it, is an American culture, conceptually rooted in 1950s social criticism. Similarly, the borderline – bad-boy fraternal twin to the narcissist, a lower functioning variant of the latter employing the same characteristic medley of defenses (Kernberg 1975, 229) – has also long been conceived of as distinctively American. We are told,

[2] I am greatly indebted here and in what follows to Jesse Battan's insightful and powerfully argued examination of this issue with respect to narcissism (Battan 1983).

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for example, that borderline personality disorder "afflicts an estimated 10 million Americans" (Kreisman and Straus 1989, xiii) or an even more impressive – "the statistics take your breath away," cautions an article in Oprah's *O* magazine – 2 percent of the nation's citizenry (Hooper 2005, 134). By way of contrast, in Britain as recently as the 1980s the very existence of the borderline was an open question (Kroll et al. 1982), and studies variously found that a mere one quarter of Maudsley Hospital psychiatrists used the diagnosis (Tarnopolsky and Berelowitz 1984) and that only those who had worked in the United States were likely to employ it (Bateman 1989). This disparity is all the more striking in light of the fact that the conceptual tools integral to what is by now the consensually agreed upon analytic borderline were developed, quietly and with little fanfare, by analysts in Britain working in the object-relations tradition. Only in the United States were the pathological pair of narcissist and borderline big news, their cultural currency underwritten by critics and by the unprecedented visibility of the analytic rock-stars of the late 1970s and beyond, Otto Kernberg and Heinz Kohut. Absent persuasive evidence that postwar and beyond Britons suffered less than their American counterparts from signal borderline symptomatology – from descriptive psychiatry's pervasive feelings of emptiness, intense anger, and instability in sense of self – or resorted less often to characteristically borderline defensive operations, or, alternately, that the two societies were so dissimilar in their embrace of modernity and its ills that critics saw as productive of borderline pathology, it is worth seriously considering the proposition that the new patient's uneven emergence is traceable as much to American cultural critics' long-standing concerns as to any impossible-to-capture true prevalence of borderline personality organization. That is, the critics' insistent evisceration of the American character meant that analysts' explorations of emptiness, shallowness, and instabilities in self-concept found a receptive audience: in the widely championed borderline they could see their prophecies satisfyingly fulfilled.

What follows may be considered a brief for the virtues of robustly conceived internalist histories of clinical categories, of their production in the clinical encounter, and of their extra-clinical fortunes. I first question the historicity of culturalist narratives that assume a congruence between diagnosis and social currents, finding particularly salient on this issue Nikolas Rose's observation that such histories too often reduce the scientificity of the psychological enterprise to "a kind of shadow play, in which the vicissitudes of knowledge claims are merely the ghostly projection of outside forces" (Rose 1996). I then turn to internalist narratives that ignore social contexts altogether, mindful of sociologists' and historians' skepticism regarding such accounts, which are typically organized around a stable referent that is assumed as a given. Pertinent here is Rose's characterization of such accounts as narrating a tradition of great thinkers' progress toward the extra-historical reality that is their quarry, as well as his point they are often punctuated by anticipations and foreshadowings of not-yet-consolidated truths (Rose 1998). Yet, I suggest, the more nuanced of such accounts usefully draw our attention from the culturalists' grand historical claims to the specifics of the clinical encounter, in particular to the challenges clinicians faced in rendering in written form

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feeling states, affects, psychic maneuvers, and inner processes for which there was no consensually accepted idiom. The object-relations new patient is a case in point, a consensually agreed upon type – a patient without a name – years before he was diagnosed as "borderline."

The literature on the borderline is immense and heterogeneous, and I do not attempt to do justice to its many nuances and complexities here. I have bracketed the contentious issue of the category's legitimacy, of whether it is a representation of some "real" pathology, and have focused instead on how clinicians and cultural critics have conceived of it. To be sure, clinicians were full if unwitting participants in the reductionism of which Rose takes note, not only those who purveyed grand narratives of decline but also the many who – in professional papers (e.g., Knight 1953; Rosenfeld and Sprince 1963; Perry and Klerman 1978; Pope et al. 1983; Akiskal et al. 1985), review articles (Gunderson and Singer 1975; Herron 1978; Meissner 1978; Shapiro 1978; Appelbaum 1979; Calef and Weinshel 1979; Liebowitz 1979; Modestin 1980; Groves 1981; Grotstein 1983; Aronson 1985; Boyer 1987; Leichtman 1989), and symposiums (Rangell 1955; Robbins 1956; Schimel et al. 1973; Holzman and Perry 1986) – repeatedly called into question the entity's empirical and epistemological validity, all but issuing invitations to what has proven a long-running social constructivist feast on the category's skeletal remains. Likewise, I have largely sidestepped the question of the extent to which it encodes prescriptive gender norms, the subject of lively debate and controversy, and to which, as such, it is disproportionately diagnosed in women (Casteneda and Franco 1985; Simmons 1992; Grillot et al. 1996; Jimenez 1997; Nehls 1997; Wirth-Cauchon 2001; Skodol and Bender 2003). I have also for the most part focused on psychoanalysis rather than psychiatry, while recognizing that the two disciplines were, in the period under study, at times productively intertwined, at times opposed. My interest here is in unsettling our easy preference for externalist accounts of category and disciplinary formation and, more particularly, in casting a skeptical eye on accounts that collapse distinctions between the individual and social contexts.

History from without

Culturalist histories of the fragmented modern self have been written by psychiatrists and psychoanalysts as well as by various cultural critics and commentators. These histories have been telling much the same story – of decline, fragmentation, and inauthenticity – for the past fifty years, invoking culturally resonant oppositions between the virtues of the past and the shortcomings of the present and deploying clinical categories in doing so. Writing in 1971 from the trenches of the culture wars, two American clinicians warned of the appearance of a new generation of patients – hippies, consumers of pornography, users of psychedelic drugs, and others pedaling "what has come to be called a 'new morality'" – whose collective spurning of the

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once-dominant cultural imperative to repress was, they proposed, reflected in and reinforced by transformations of forces in the culture itself (Schupper and Calogeras 1971). By the seventies, however, this was old news, if in a new idiom of fantasized mass gratification (see also Hamilton 1971; Strean 1971). Clinicians and social critics had already long treated as established fact that patterns of pathology were shifting from the classic to the character neuroses.

Let us start with the critics. David Riesman, who like many critics of his generation read widely in the psychiatric and psychoanalytic literature and mixed the language of the clinician with that of the sociologist, was among the first in a long line of critics to register the characterological shift that would be deployed so widely in narratives of decline. Writing that he took for granted "that there is some observable relation between a particular society and the kind of social character it produces," he described his other-directed personalities – who constituted "a sizable number in America" – as too compliant, insufficiently insightful, and empty. They were, as he put it, "ambulatory patients in the ward of modern culture," characteristic of their time just as hysterics had been of theirs (Riesman 1950, 6, 290).[3] Lionel Trilling likewise highlighted the growing predominance in analytic practice of what he referred to as "so-called character neuroses" with their less overt symptoms, dating their displacement of hysteria somewhat loosely to four decades in the past (Trilling 1971, 167). Christopher Lasch would deploy the same observation in the register of social fact as critical evidence for his wide-ranging condemnation of modernity in *The Culture of Narcissism*, sketching a trajectory from "inner-direction" – the cultural referents of Riesman's phrase so well established by 1979 that it needed neither explanation nor citation – to narcissism to characterize civilization's twentieth-century decline. The borderline who complained to the psychiatrist of vague dissatisfactions, a pervasive sense of emptiness, and an inability get along with people was increasingly common, his deficient personality, Lasch maintained, a realistic response to "the tensions and anxieties of modern life" (Lasch 1979, 37, 50). Similarly, the sociologist Robert Bellah and his colleagues could easily assume that contemporary Americans were less sure than their forbears a mere twenty years earlier had been concerning who they "really" were, and that they had more trouble "in finding an authentic self" (Bellah et al. 1985, 319). Even the philosopher Charles Taylor, among the more skeptical of critics, while noting the phenomenon in a more ironic mode – "it has frequently been remarked by psychoanalysts," he wrote, that the hysterics of Freud's day have been displaced by patients whose "complaints centre around 'ego loss', or a sense of emptiness, flatness, futility, lack of purpose, or loss of self-esteem" – still found it "overwhelmingly plausible" that there would be some relation between styles of pathology and what he called the non-pathological predicaments that parallel

[3] Reviewing *Das Borderline-Syndrom* [The Borderline Syndrome], 1979 (Bern/Stuttgart/Vienna: Verlag Hans Huber), Rudolf Ekstein cited "the work of Riesman, in America, on 'the lonely crowd' as pertinent to a discussion of social factors implicated in the upsurge of this diagnostic subgroup" (Ekstein 1981).

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them. The symptoms plaguing today's patients were in his estimation reflections of a widespread, generalized fear of "a terrifying emptiness," of "a fracturing of our world," and of, "above all, meaninglessness" (Taylor 1989, 18–19).

Psychoanalysts and psychiatrists began to take note of what many observed were shifting styles of pathology and to focus on the new patient as exemplary of the shift in the 1940s and 1950s, roughly coincident with critics' deployment of it as evidence in their jeremiads. The new patient was first registered, in an obscure reference, as distinctively American in 1943 (Glauber 1943, 404), and for some time in the clinical literature *echt* American he – for this patient was invariably referred to by the male pronoun in the early literature – would remain. Fairly quickly, by the 1960s, his existence was among clinicians, as it was among critics, in the judgment of one "a well-known fact," testified to from many quarters of the profession (Lichtenstein 1963). Adolph Stern wrote from New York that "these patients" had increased in numbers, constituting "a large percentage of those who seek treatment for neurotic illness" (Stern 1938 and 1945). Leo Stone observed that the heterogeneous, important group of borderline and other character-disordered patients was constituted of patients at once subtly aloof and supercilious on the one hand and insatiably demanding and controlling on the other, different in important ways from Freud's hysterics (Stone 1954). "These people are love hungry, affect hungry, feel empty, and constantly seek excitement," chimed in an analyst from Topeka (Frank in Rangell 1955, 291). Two others from New York reported that their "more sophisticated, urbanized patients" no longer presented with the florid conversion symptoms of the hysteric but instead complained of "chronic maladaptation in living, i.e., working, loving, and playing" (Easser and Lesser 1965, 390). By 1975, the new patient was familiar enough that one analyst could write that when he referred "to 'this type of patient'... practically everyone knows to whom I am referring" (Giovacchini 1975; Lasch 1979, 42).

This type of patient, thus, was to some extent jointly produced by clinician and critic. Critics mined the analytic literature for evidence of his emergence. But the lines of influence also flowed the other way, with a number of analytic popularizers, writing for non-professional audiences, framing the new patient's appearance in broadly cultural terms. For example, Erik Erikson, who in importing the concept of identity into psychoanalysis enriched the discipline's vocabulary while at the same time broadening its popular appeal (Lunbeck 2000), contrasted Freud's worthy patients, tragically inhibited by hypocritical social convention, with the "patient of today," beset by conflicts over who he was and what he might become (Erikson [1950] 1978, 279). Rollo May, another prolific popularizer, asserting that those persons who sought psychotherapy were not "a cross-section of the population" but, rather, a "barometer of the conflicts and tensions under the psychological surface of the society," reported that he had by the early 1950s seen enough new patients in his own practice and heard enough of them from his colleagues to conceptualize them sociologically, as exemplary of the mid-century decade (May 1953). Analyzing "the malaise of our times" – a Laschian avant la lettre – from "behind the couch" in his popular book, *The Quest*

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for Identity, the psychoanalyst Allen Wheelis unfavorably compared the "weary and skeptical" modal character of 1950s America to the late nineteenth century's sturdy, bourgeois "bearded old men." Like Riesman, Wheelis mixed clinical and sociological observations; like many others he saw everywhere evidence of "vague conditions of maladjustment and discontent" (Wheelis 1958, 40–41). From Riesman he gleaned that the character of the American people had recently changed, from fellow psychoanalyst Erik Erikson that the problem was one of a deficient sense of identity, from critics of mass society that conformity was on the rise. Spinning his narrative in storybook form, Wheelis told of village society superceded by mass society, moral absolutes by relativism, a properly punitive super-ego by an ethos of adjustment, Victorian repression by a celebration of sexual liberation, the hysteric by the character disordered. The readily apprehensible nature of all these works, together with the fact that they sounded the same themes as did the critics, undoubtedly accounts in part for how rapidly the new patient coalesced as a type.

Among analysts, cultural critics, and analysts-in-the-guise-of-cultural critics, then, it quickly became orthodoxy – a "historic fact" (Fromm-Reichmann in Hawkins and Rangell 1954, 153) – that the modal analytic patient as well as the modal American character had decisively changed. Analysts, not only popularizers but also a number writing in professional venues, were unable to resist donning the social critic's mantle, locating the new patient in morally freighted – and, increasingly, highly gendered – scenarios of cultural decline (e.g., Lazar 1973; Grinker in Schimel et al. 1973). Analysts and critics alike linked the rise of the new patient to feminization, to the waning of the inner-directed, self-reliant personality that, in their collective imagining, was exhibited by the bourgeois Victorian pater familias. In the transition from stability to change, from community to society, that yielded the characterologically disordered personality as its characteristic type, they argued, the importance of the super-ego, which was a necessary condition for the individual's participation in civic life, a mental agency to which women in classical psychoanalysis had at best a feeble claim, was attenuated. Repository of culture and enforcer of the law, the super-ego no longer carried the authority it had in Freud's day. Patriarchy gave way to the disorder of matriarchy. The decline of work and the increase in leisure, the waning of organized religion and religious belief, and the incursion of the wider world into the settled community – all contributed to the super-ego's demise and the new patient's ascent (Hamilton 1971; Schupper and Calogeras 1971; Strean 1971; Engel 1980).

Locating the new patient's ascent to the fears of gender anarchy that were already heightened – visible in a range of cultural and political sites – served only to underwrite the reality of the widely testified to shift in patterns of pathology. Twenty-five percent of psychoanalysts surveyed in 1976, for example, assented to the proposition that borderlines were replacing "good classical neurotics" as analytic patients (Jaffee and Pulver 1978, 620; Battan 1983). Missing from all these accounts, however, was any serious engagement with the premise that underwrote both clinicians' and critics' conflation of the new patient – which, if we are to take analysts at their collective

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word, we may consider was indeed a new phenomenon – with a new type of modal American. The existence of the latter rested on little more than assertion – recall Taylor's invocation of overwhelming plausibility when it came to relations between the normal and the pathological and Riesman's taken-for-granted stance on the same, or consider Lasch's articulation of "the *principle* that pathology represents a heightened version of normality (Lasch 1979, 38; emphasis mine) – or inference from changing forms of pathology showing up in clinicians' offices to a new form, newly prevalent, of personhood in the general population, a move that would raise the eyebrows of any psychiatric epidemiologist.

To be sure, there were some skeptical voices (Battan 1983). A persistent critique termed the category itself as nothing more than a wastebasket for any pathology that was either not understood or not otherwise classifiable (Arnstein 1958; Gunderson and Singer 1975; Aronson 1985; Masterson 1988, viii), and many complained of the term's indiscriminate use. Some suggested it was not the patient but the category that was new (Zilboorg in Rangell 1955, 293). In a variation on this theme, others maintained that Freud's patients were in fact character disordered, not neurotic, and a minor industry devoted to rediagnosing them sprung up. One analyst charged his colleagues with projecting onto their patients a change in pathology that was at best reflective of their own change of interest "from symptoms to character" (Fliess in American Psychoanalytic Association 1950). The skepticism of two others was manifest in their suggesting that psychoanalysts were increasingly turning their attention from the intrapsychic conflict that was the classical analyst's stock in trade to conceptualizing psychological conflict "in terms of conflict with the external world and its representations" (Calef and Weinshel 1979, 488).

But these dissents from the emerging orthodoxy did nothing to unsettle the externalist consensus, with its confident if unexamined linking of the patient on the couch with the man and woman on Main Street. One dissenter noted that "hardly a month goes by, it seems, without a new book, a new conference, a new clinic whose subject matter is the borderline," yet he, like so many others, assented nonetheless to the reality of the characterological shift that underlay what he could only term faddish (Glazer 1979). "Perhaps the crisis is less ominous than we often tend to think," wrote another, while – unwitting culturalist, he – allowing that like others he was alarmed at what was happening to the family and society (Loewald 1979, 764). Yet another more sympathetically held that new types of character formation might be "necessary societal adaptation to a world of rapid change" (Michels 1971, 432), like his colleagues locating his subject in a historical narrative of decline. The indiscriminate theorizing of Roy R. Grinker, Sr., and his colleagues – they on the one hand held it likely that "the borderline always existed," that he was produced by improved diagnostic acumen, and on the other hand offered a laundry list of social factors that facilitated his development, a capacious tally encompassing higher levels of violence and the development of youth cultures, mothers in the workforce and less authoritative fathers, the fragmentation of identity and the refusal of commitment

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(Grinker et al. 1968) – exemplified the totalizing perspective of the clinician-as-historian. Even Grinker appears to have recognized this, later admitting his history was little more than "a superficial run-down" (Grinker 1977, 159).

Still, such narratives held – and continue to hold, as social critics' continuing invocation of them indicates – enormous appeal. But what of the fact the new patient was so improbably new over the fifty-year span of his existence? First noted in 1930s Britain, he was still being registered as new to clinicians – "psychiatrists are increasingly meeting people with complaints that do not fall neatly into the traditional categories of psychiatric problems," James Masterson wrote – in late 1980s New York (Masterson 1988, 5–6; see also Carrilio 1981). Was it really plausible that nothing had changed – concerning a patient so sensitive by this construal to social context – in the half century in between? In light of this, the historian might best conceive of the clinician's refrain, "a new type of patient," as a well-rehearsed gesture toward history rather than as evidence to be marshaled in support of it.

Further, the new patient, who for all his putative emptiness has long shouldered a heavy moral and interpretive load in cultural criticism, would by the 1970s be rendered by both critic and clinician as implausibly shallow and – more problematic – common, transformed by some into a caricature of selfish and regressed hedonism. Take, for example, the 27-year-old Jay, who was reported in 1971 to be desirous of nothing more than "to have a big TV set going all the time and a big icebox chocked full of food," wishes that his analyst noted with some disdain had been realized (Schupper and Calogeras 1971, 63), or the admittedly purposeless and immature New Yorker, her self-image grandiose, who considered entering analysis but settled instead on a doctor offering a mélange of Gestalt, psychodrama, and primal therapies (Lazar 1973) – these shallow figures, readily cast as "not atypical cultural character" types (Schupper and Calogeras 1971, 61) were intended to evoke a knowing, censorious derision. The by-then familiar nature of such types' inner landscape – as limned in the early literature, characterized by omnipotent wishes, primitive splitting, and narcissistic conflicts – was invoked but not examined, their signal symptoms shorn of depth and resonance. They thus appeared as relatively mild and, more important, commonly encountered types, heirs to the first new patients but manifesting none of the aggression, destructiveness, and near-schizophrenic inner processes analysts found characteristic of the latter. As such, they were readily conscripted into stinging critiques of late-capitalist cultural decline.

History from the inside

If in culturalist interpretations the meanings of the new patient's symptoms were overdetermined by – and conflated with – social factors, in what I here call internalist interpretations, they were slow to assume any extra-clinical meanings at all. In outline simple and appealing, the internalist story holds that, building on the insightful, even

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brilliant, work of their predecessors, great figures in the history of psychoanalysis and psychiatry – Helene Deutsch, Robert Knight, Roy R. Grinker, Sr., Otto Kernberg – propose formulations that come ever closer to capturing the reality of the entity now known as borderline personality. This story is in several respects exemplary of internalist histories of disciplinary formation as characterized by Nikolas Rose. It constructs "a continuous tradition of thinkers"; it effects "a division between sanctioned and lapsed texts and authors," between those insights and discoveries that are congruent with current understandings and those that represent abjured "false paths," errors and strayings from "the path of progress"; it abounds in anticipations and foreshadowings; and it assumes a stable, extra-historical referent that practitioners come ever-closer to rendering intelligible (Rose 1998, 42–43). Yet in the case of the borderline the stability of the referent was illusory, repeatedly asserted, but never established. Clinicians were never in agreement on to what the term – or terms, for whatever it was, it went under a number of different rubrics, chief among them borderline personality organization (Kernberg 1967) and borderline personality disorder (APA 1980) – referred, whether to a type of patient, a state, a syndrome (e.g., Masterson and Rinsley 1975), a spectrum (Meissner 1988), a stable form of personality organization (Kernberg 1975), or to cases that fell at the margins of psychosis (Gunderson and Singer 1975; Leichtman 1989, 230).[4] Was borderline a noun or adjective (Akiskal et al. 1985; Weinshel 1988), a go-between (Grotstein 1983) or a distinct entity? Had the concept by the 1980s come of age (Soloff and Millward 1983) or was it still "a semantic mess" (Aronson 1985)? Was it forever fated to be "clinically useless" (Rich 1978, 1401), attended by "speculation and dogmatic assertion" (Holzman and Perry 1986), "chaos and confusion" (Meissner 1978, 559), or did it refer to a unique and recognized form of pathology (Green 1977)? The protean quality of the category meant that in fashioning internalist histories – tracing terms and concepts in linear fashion through classic papers and books – psychiatrists and psychoanalysts were engaged in the rhetorical equivalent of herding cats.

Abbreviated internalist histories appear as introductory or background material in numerous articles and books on the borderline (e.g., Arnstein 1958; Chessick 1974; Stone 1980; Grotstein 1983; Leichtman 1989). Although one such history, in an extravagant gesture, located the borderline in the seventeenth-century physician Thomas Sydenham's characterization of those to whom "all is caprice," loving "without measure those whom they will soon hate without reason" (Groves 1981), the usual starting point is in schizophrenia, from which, in an exemplary rendition, borderline personality must eventually be uncoupled before it can stand phenomenologically distinct, an "entity unto itself" (Stone 1986, 149). The 1930s and 1940s are from this perspective shot through with anticipations, a staging ground for its eventual emergence, a period in which central concepts are first adumbrated and key symptom clusters noted. Thus, the psychoanalyst Adolph Stern's description of a very difficult

[4] The complaint that the term had multiple and conflicting meanings appears early in the literature (Rosenfeld and Sprince 1963) and is a constant in it (e.g., Rich 1978).

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to handle "border line" group of patients who fit neither under "the psychotic nor the psychoneurotic" rubric is routinely cited as pivotal (Stern 1938), both for its anticipation of the term borderline and for its delineation of a number of what would come to be seen as core borderline concepts, most significantly the patients' narcissism and the difficulty of treating them (Stone 1986, 46). Similarly, the analyst Helene Deutsch's delineation of the "as-if" personality type (Deutsch 1942), can be seen as laying "the foundation for contemporary psychoanalytic formulations of the borderline" (Stone 1986, 43). Although Deutsch is especially commended for her focus on the "as-if" patients' deficient sense of self and on their emptiness, both writers, in the teleology of the internalist perspective, were wrongly still seeing the borderline concept in the context of schizophrenia.[5] At the end of the decade, in 1949, Paul Hoch and Phillip Polatin described patients, whom they designated "pseudoneurotic schizophrenics," characterized by their "overvalued ideas," magical thinking, depersonalization, and "polymorphous anxiety," anticipating the observations of any number of later clinicians (Hoch and Polatin 1949). From this perspective, it remained for Robert Knight to sever what would become the borderline personality from schizophrenia (Knight 1953). His paper, "Borderline States," is considered by many the single most important early formulation of the condition, cited as foundational by subsequent authorities and, from the perspective of Michael Stone, the compiler of *Essential Papers on Borderline Disorders*, anticipating the solidification of current psychoanalytic concepts that took place in the 1960s (Stone 1986).[6] Knight focused on the impaired ego functioning of patients termed borderline, highlighting their egos' lack of integration and judgment as well as the patients' diminished capacity for realistic planning and maintaining relationships, relatively frail hold on reality, and primitive defense mechanisms.

Tracking the growing popularity of the diagnosis, which within a decade more was the focus of growing numbers of books and articles, the internalist story showed signs of strain, the coherence and linearity toward which it aimed repeatedly proving elusive.[7] There were simply too many players, too many articles, too many competing definitions. In the 1960s and 1970s, what are in retrospect considered core features were outlined for psychoanalysis – to draw the distinction broadly – by Otto Kernberg (Kernberg 1967) and for psychiatry by John Gunderson and Margaret Singer (1975). Large-scale studies of putative borderlines were carried out by Roy R. Grinker, Sr., and his colleagues (Grinker et al. 1968) and by Robert S. Wallerstein and his (Wallerstein 1986). In 1980, the diagnosis appeared, for the first time, in psychiatry's

[5] Reviewing Stone's anthology, Martin S. Willick wrote of his admiration for Stern's ability to foreshadow "most of the present-day work" on the borderline (Willick 1990).

[6] A differently accented internalist account might privilege Stern's 1938 paper over Knight's; the former is certainly more resonant with now-popular object-relations construals of borderline pathology than the latter, written from an ego-psychology perspective.

[7] Leichtman 1989 provides perhaps the most sophisticated internalist history in the literature.

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official nomenclature, the *Diagnostic and Statistical Manual* (APA 1980). By then the category of the borderline was conceived of as at once the most intriguing and the most controversial of classifications. It was the subject of not only an enormous professional literature but also of popular media attention.

The term belonged to both psychoanalysis and psychiatry, but could mean different things within each tradition. Increasingly, the psychoanalytic focus on the structure of the personality and the operation of its characteristic defenses as well as its insistence on the uniqueness of the individual (e.g., Zilboorg in Rangell 1955, 293) squared poorly with the more popular descriptive, symptom-based psychiatry of the DSM, which promulgated a disease model of mental disorder – defining entities, the validity of which psychiatrists attempted to establish in a series of large-scale studies (e.g., Perry 1992), in terms of specific etiologies, courses, and outcomes (e.g., A. Cooper in Holzman and Perry 1986). Emboldened by what many considered their discipline's long-overdue embrace of science, some psychiatrists charged their analytic colleagues with relying too much on case reports, too little on science, in setting the parameters of the condition;[8] analysts responded that they found it difficult to affix symptom complexes to any one specific diagnostic entity (Easser and Lesser 1965). Further, analysts were themselves divided on the question to what extent, at all, psychoanalytic technique might legitimately be revised such that "more disturbed" patients could be treated (e.g., Stone 1954; Rangell 1981). Stone, a reliable and confident guide through the early years of the borderline, admitted to being "haunted by the dark suspicion that the subject has gotten out of hand" (Stone 1986, 432), and the historian can only agree. The coherence of this sort of internalist story is imposed, achieved through a process of after-the-fact exclusions, premised on a thinly conceptualized understanding of the knowledge production in the clinical setting, and held together in places by the term borderline and little else.

Anticipation or similarity?

Sociologists and historians have with good reason been skeptical of internalist accounts of disciplinary formation. Insufficiently contextualized, such accounts take as given that progress – in this instance better theories, better categories, and better therapies enabling clinicians to classify the patient whom many assumed had existed all along, either misdiagnosed by Freud or, alternately, beyond the analyst's ken – will win out. Some analysts associated with the British school of object-relations revisionism advanced a variant – itself weakly conceptualized, embedded in their clinical writing not separate from it – that envisioned the new patient's emergence facilitated by new and better modes of analytic perception and by the development of their own ever-finer

[8] Grinker 1977, for example, wrote that "the era of the Freudian 'Grand Theory' is over and individual cases are not sufficient to support new theory."

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technical skills, and that envisioned the new patient as the product of the consulting room, of what they argued was brilliant and subtle clinical observation that brought him into increasingly clear focus. Likewise, others pointed to their own and their colleagues' "increased clinical acumen" to account for what all agreed was an increase in the numbers of new patients.

Critics are quick to dismiss such statements as instances of self-congratulatory professional ideology. I would suggest, however, that we need not take clinicians at their most self-avowedly whiggish. Substituting "different" for their "better," we might consider as plausible that analysts did indeed develop different ways of looking at patients as they honed their craft, different modes of perception that allowed them to describe dimensions of personhood they had not earlier conveyed in print. The revisionist analysts' writings on the disjuncture between observation and theory, which again might be read in a self-justificatory register, usefully offer us the occasion to take note of the process by which what is observed is transformed into writing, a transmissible form. As these analysts suggest, this process is fitful, not linear and, as such, is not part of the standard internalist story. I would suggest further that a properly critical history of the category would not seek to fix the meanings and track the appearances of the term, as internalist histories typically do, but would conceive of it broadly as a conceptual space in which both novel and enduring symptoms and behaviors have been subjected to examination. Both the culturalist and internalist narratives are relatively simple and straightforward. It may be, however, that what we need to explain the emergence of this particular analytic figure is not a parsimonious but a complex account. Particularly in light of how saturated with culture the borderline has been, it might be useful as a counterpoint to sketch a more richly conceptualized history of the concept that sees clinicians' disciplinary knowledge as the product of the consulting room and attends to developments internal to their disciplines without reducing them to, as Nikolas Rose observed is all to common, shadow play. From this perspective, it was less that the world had changed, more that psychoanalysis itself had.

Some of the object-relations theorists argued that revisionism – shifts from classical analysis's drive model to the relational model of object relations, from focus on the Oedipal triangle to that on the mother-child dyad, and from the assumption, in the classical model of an intact ego, to the attention, in the revisionist model, to its defensive maneuvers – allowed them to see previously overlooked symptoms or to hear things that had not formerly crossed what one called "the threshold of audibility" (Green 1975, 3). We read repeatedly in the British literature of observation outdistancing understanding and of clinical intuition juxtaposed to premature theorizing. In 1950, for example, the émigré analyst Michael Balint highlighted a disjuncture between psychoanalysts' technical and theoretical skills, noting they were well able to treat complicated problems that they could not describe theoretically. Too often, he noted, lacking proper terminology, they resorted to "lengthy and clumsy formulae" to describe otherwise sharply delineated clinical pictures (Balint 1950, 119). The collective assessment of the Edinburgh-based analyst W. R. D. Fairbairn's work was especially pointed along these

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lines. Heralded now as one of the first to have provided a phenomenologically rich portrait of the new patient, for having theorized "what analysts had long sensed before – and after – him" (Kernberg 2000, 59–60), Fairbairn was in his day lauded as "an extremely gifted observer" (Zetzel 1955, 537) whose overcomplicated theories were inassimilably strange, "bogged down a few miles in the rear" of his unparalleled capacity for conveying clinical insight (Winnicott and Khan 1953). In all these appraisals, observation and technique had outrun theory; clinical intuition pure and simple, it was suggested, might yield the analyst more information about a particular case than reference to accepted terminology (Zilboorg in Rangell 1955, 287). As for terminology, "our type of patient" (Khan 1960) and "this clinical picture" (Arnstein 1958) would, for the moment, have to suffice.[9]

The new patient of this particular internalist telling took shape as a clinical type – not a national or a cultural type – in a series of loosely related papers by a number of leading British analysts, Fairbairn, Masud Khan, and D. W. Winnicott chief among them, in dialogue with colleagues in the United States. Writing of this patient, they attended little to his social environment, focusing narrowly on his clinical characteristics, attempting to precisely describe his disturbed inner landscape, his feeling states and mental processes, and the character and quality of his relationships with others, both external, in the real world, and as they were represented internally. Their new patients first entered the literature at the borders of psychosis. Too anchored in reality to be termed psychotic, they were at the same time clearly not neurotic, their inner and outer relations disturbed in ways observers claimed fit no existing models of illness. Like schizophrenics, it was noted, they were isolated and detached, their relations with others superficial and lacking in genuineness and real warmth. Yet they were observed to be far more socially competent than schizophrenics, their behavior and intellectual abilities outwardly normal upon first acquaintance. Helene Deutsch used the term "as if" to describe the intangible sense of something missing such individuals stirred in others, a sense that invariably prompted wonderment at what was wrong. The "as-if" type might appear, for example at a social gathering, as stimulating, amusing, and attractive, and she might, in an intimate relationship, appear loving, sympathetic, and understanding. Inevitably, however, her warmth would be exposed as an empty form, with no inner resonance, her behavior exposed as that of an actor, an impersonation of normality. Her hold on reality undisturbed, the "as-if" patient was not psychotic. Yet the impoverishment of her total personality, the simulated quality of her affective experiences, justified, in Deutsch's estimation, the designation schizoid – a term used in reference to a condition of incipient or threatened schizophrenia. Fairbairn, writing from Edinburgh, like Deutsch used the rubric schizoid to categorize the new patient. Fairbairn told of an outwardly normal but in fact isolated and detached individual who, as a result of unsatisfactory early experience, could invest little real emotion in

[9] A persistent strain in the literature is that there was a common clinical core even if it could not readily be named (Rich 1978).

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relationships with others. This patient's ego narcissistically inflated, his inner sense of self grandiose, he treated others badly, as less than inherently valuable in themselves. Such patients were, like Deutsch's, actors and role-players, persons who exhibited rather than actually gave to others – exhibitionism being "a technique for giving without giving" – and who kept others at a distance, able neither to love nor be loved (Fairbairn 1942, 16; Khan 1960, 431).

Other analysts, both independently and in conversation with Deutsch and Fairbairn, rounded out the portrait of the new patient. Leo Stone described subtly but discernibly detached and aloof individuals, with inner lives strikingly similar to those of Fairbairn's schizoids: grandiose, controlling, insatiably demanding and primitively destructive (Stone 1954, 584–85). Ralph Greenson, writing from Los Angeles, described highly accomplished and socially successful patients who, again like those of Fairbairn, were incapable of perceiving others as "whole, composite human beings." Restless and discontented, they were insatiably hungry for new experiences and new people; outwardly generous, they gave only in order to get the narcissistic supplies that were critical to their functioning (Greenson 1958). Referring to him only as "this type of patient" or "the new 'model patient'," Khan portrayed the new patient as enthusiastic for analysis, even to the point of over-responsiveness, yet at the same time casting the analyst as spectator to his psychic exhibitionism, his pseudo-cooperation masking a dread of his real emptiness being found out. He and others like him relied on a constant supply of new objects "to experience themselves personally" and to sustain periods of vital ego-functioning, but ended up manipulating and controlling others such that they were left feeling defeated and demoralized, "rendered inane and useless." This became especially clear in the transference, as such patients made the analyst feel "the anger, rage, neediness, despair, love, and tenderness, destructive violence, and panic which is inside them," none of which they could experience in an integrated way in themselves. The new patients, Kahn observed, called on a medley of defenses – splitting, projective identification, devaluation of objects and experiences as well as idealization – that offered the analyst clues as to the "*actuality* and *reality*" of their infantile experiences. In particular, they internalized an idealization of the analyst as they attempted to ward off the feelings futility, despair, and disillusionment they were certain would be their fate in a real relationship (Khan 1960).

"Gradually articulating himself into clinical focus," in Khan's precise characterization (1960, 430), by 1960 this new "model patient" had assumed recognizable form, though not a consensual designation, in the analytic world. Schizoid, borderline, narcissistic, or, in more general terms, character disordered – despite the terminological imprecision, the patient's existence in analytic practice was widely accepted. The observation that analysts of the borderline could more easily share their perceptions than their conceptions, that they would agree on the clinical data but part ways when it came to theory (Green 1975, 16), may speak to the relatively late adoption of the diagnosis in Britain (Zetzel 1971; Macaskill and Macaskill 1981; Kroll et al. 1982; Tarnopolsky and

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Berelowitz 1984; Bateman 1989) despite what many agree was existence early on of a vividly drawn and consensually agreed upon clinical picture.[10]

In this clinical picture various more recent observers have seen foreshadowings of the narcissist as limned by Kohut and Kernberg in the late 1960s and 1970s. The notion of prefiguring is threaded through the literature, as is its darker double, the charge of unacknowledged borrowings and appropriations. Thus, Julia Kristeva has seen Helene Deutsch prefiguring Winnicott, Deutsch's early explorations of patients "who give the impression of being empty, absent, and cold, regardless of their apparent devotion to their activities or love life" brilliantly anticipating the Winnicottian "false self" (Kristeva 1995, 196). Fairbairn has been seen to anticipate Kohut or, more expansively, "the extensive compass of modern clinical work and theory" (Buckley 1995 and 1997). Kohut, for his part, is accused of borrowing without acknowledgement, his self-psychology, Michael Robbins and others have noted, uncannily resembling Fairbairn's object-relations theory (Robbins 1980, 477; James 1973; Cocks 1994, 278–280; Strozier 2001, 223–224).

If "anticipation" is recast as similarity, however, what these observations suggest is that over the span of his conceptual life the new patient has remained a remarkably stable figure, with whom has been associated a relatively unchanging constellation of core symptoms and behaviors. If the clinical portraits sketched by the early analysts anticipated – or, alternately, were similar to – those produced twenty and thirty years later, this calls into question the historical narrative both analysts writing in the culturalist tradition and cultural critics have spun around the figure of the new patient – who was, it appears, consulting psychoanalysts in depression-era Edinburgh and postwar London in numbers large enough to prompt analysts' observations and theoretical speculations, hardly the sites where one would expect to find concentrations of the me-decade self-absorption that figures so centrally in the critics' indictments. Anticipation and similarity prompt an examination of the category's conceptual antecedents in the largely disavowed – by psychoanalysts, less so by psychiatrists – diagnosis of psychopathic personality, the earliest of the personality disorders, delineated in the early years of the twentieth century. The psychopathic personality was an expansive rubric that provided psychiatrists a framework, contested but nonetheless legitimate, within which they could reorient their discipline away from its near-exclusive nineteenth-century focus on insanity and toward normality, in the process dramatically expanding their discipline's purview. The category was an unstable epistemological amalgam, cast on the one hand as a serious disease (most likely constitutional or inborn) and on the other as a diffusely defined abnormality from which anyone might suffer. The theoretical and clinical confusion that attended early delineations of the borderline is strikingly similar to that surrounding the introduction of the psychopathic personality. Like the borderline, the

[10] See, for example, Arnstein 1958, who refers to "this clinical picture" while critiquing the term as a wastebasket. Calef and Weinshel 1979 note that in Britain a different vocabulary was used.

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psychopathic personality was repeatedly labeled a wastebasket category, an ill-defined entity that denoted little other than that the patient in question was not normal, and a diagnosis for those who did not fit any of the other categories of disease. Both diagnoses have served as fertile sources for the indictment of modern society, and both are categories around which psychiatrists have reoriented their discipline. Early clinical descriptions of psychopaths resonate with those of borderlines. The psychopath was said to exhibit "poor inhibition, . . . egotism, boldness, and vanity," his "emotional instability and impulsiveness" constantly landing him in trouble (Visher 1922). Egotistical but "possessed of an unusual amount of personal magnetism," he was often thought a "charming personality" who was nonetheless inclined to "exaggerate and magnify trifles," a "delightful companion" who nonetheless suffered from a self-described "emptiness in the head" (Oberndorf 1912). He was "superficial" and "shallow," "motivated almost entirely by the desire of the moment" (Scheetz 1924, 187; Johnson 1922–1923, 470). Most presciently, he was seen to be so self-satisfied, "his narcissism giv[ing] him an illusionary sense of superiority which compensates for his inferiority," that he was thought to be utterly untreatable. A successful transference with him was impossible (O'Malley 1924). The glib, superficial, unempathic, impulsive, reckless, seductive, and manipulative disordered personality of DSM-IV can be seen quite clearly in the early formulations of the psychopathic personality (APA 2000). Yet any threads of connection between the two conditions have dropped from the official memory of psychiatry and psychoanalysis. Still, the overall project of which the personality disorders were an expression – of charting the relationship between individual and social pathology, between the personality and society, and, from an anthropological standpoint, between particular personality types and a range of cultural norms – lives on in culturalist narratives of the borderline's emergence.

A skeptic's conclusion is in order. Cultural critics have mimicked the analysts' refrain, "a new type of patient," asserting that his appearance marks a significant turning point in our nation's long history of decline. But the weight of the evidence suggests that the analysts' refrain might rather be qualified than mimicked, that conceiving of the patient as not altogether new but new to psychoanalysis better captures the historical dynamic of his debut. What is clear is that increasing numbers of patients whom clinicians characterized as more disturbed than Freud's – or, more precisely, than those whose cases Freud wrote up – were making their ways to psychoanalysts, who were themselves increasing in numbers, and that these patients could be construed, either implicitly or explicitly, as the occasion for the analytic revisionism that identified the tools and concepts to both treat them and to convey their characteristics in analytic prose.[11]

[11] Addressing the issue of whether there was "a 'new' or 'modern' analysand" or "a new or modern narcissism," the analyst Joyce McDougall astutely asked whether it might "not be more apposite to speak in terms of a new demand made upon psychoanalysis, and to which today's analysands are seeking a response?" (McDougall 1982).

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A psychologist ten years ago asked why the richest country on earth is also the emptiest, suggesting a partial answer in outlining the social factors that come up in any discussion of the modern self's deficiencies: fragmentation, meaninglessness, and empty consumerism (Cushman 1995). What is interesting here is not his answer but his question, his easy presumption that the American self is indeed empty. Demonstrating that the modern sense of self is changeable, inconsistent, and deficient – or, in the language of the clinician, characterologically disordered – has been one of the major preoccupations of twentieth-century cultural critics. Circulating across disciplinary boundaries, popularized in a number of landmark books, and resonating with simple but powerful historical narratives, this consensus understanding of the modern American self has enjoyed wide currency. As I've argued here, diagnoses and diagnostic trends may tell us less about society, and more about factors internal to psychoanalysis and psychiatry, than many critics have supposed. Critics have argued the empty self is created by the world. We might rather consider it produced – as a transmissible social fact – by psychoanalytic theory and practice.

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