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The Conceptualization of Borderline Personality Disorder Within the Framework of Lacanian Thought.

By

Liliana Rusansky Drob, M.A., M.S. Ed.

A Doctoral Project Submitted in Partial Fulfillment of
the Requirements for the Degree of Doctor of Psychology
in the Department of Psychology at Pace University

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NAME: Liliana Rusansky Drob,MS.Ed.,M.A.

TITLE OF PROJECT: The Conceptualization of the Borderline Personality Disorder within the Framework of Lacanian Thought

DOCTORAL PROJECT COMMITTEE:

PROJECT ADVISOR: Beth Hart, Ph.D.
(Name)
Professor of Psychology
(Title) (Affiliation)

PROJECT CONSULTANT: Florence L. Denmark, Ph.D.
(Name)
Robert S. Pace Distinguished Professor Emerita
(Title) (Affiliation)

FINAL APPROVAL OF COMPLETED PROJECT:

I have read the final version of the doctoral project and certify that it meets the relevant requirements for the Psy.D. degree in School-Clinical Child Psychology.

Beth Hart — 12/6/01
(Project Advisor's Signature) (Date)

Florence L Denmark — 12/7/01
(Project Consultant's Signature) (Date)

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ABSTRACT

The diagnosis of Borderline Personality Organization has taken its place in American psychoanalysis, as a *personality structure* the significance of which has equaled and, in some quarters, even eclipsed the traditionally recognized structures of neuroses, psychosis and perversion. However, the Borderline diagnosis has been largely ignored amongst psychoanalytically oriented clinicians in Europe and South America. One reason for this is that a major theoretical gulf exists between American and European/Latin American psychoanalysis, a gulf that can in part be attributed to the dominance of ego-psychology and object-relations theory in the United States and an equal dominance of the theories of Jacques Lacan in such places as France and Argentina. Within Lacanian thought, there is a theoretical and clinical emphasis upon the three Freudian structures of Neuroses, Psychosis, and Perversion, and a skepticism towards any approach that insists upon adding to this scheme. Lacan's own reaction to the concept of the "borderline" seems to have been that it is the clinician him or herself, rather than the patient, who is "undecided" and on the "border" between the traditional structures (Lacan, 1956).

Nevertheless, there has yet to be a systematic dialog between American

and Lacanian psychoanalysts on the question of the borderline diagnosis. In fact, in spite of a recent surge in interest in Lacan in the United States (mostly outside departments of psychiatry and psychology) there has been very little dialog between American psychoanalysts and Lacanians on any issue of theoretical or clinical significance. When one surveys the literature readily available to American clinicians, one finds 906 books and articles pertaining to Lacan, but less than five of such comparative nature (American Psychological Association, PsychInfo Online, November, 2000. Keyword: "Lacan").

The present study seeks to make contributions of both a general and specific nature. Generally, by comparing the psychoanalytic theories of Otto Kernberg and Jacques Lacan in the context of the borderline diagnoses, this study seeks to initiate and contribute to a long overdue dialog between American and French psychoanalysis. More specifically, by promoting such a dialog this study seeks to make a contribution that may help refine both theory and clinical work with the severely disturbed patients who have been designated "borderline" by Kernberg and others. This study seeks to both "map out the territory" for dialog on a number of issues relevant to the borderline diagnosis and locate the place of so-called borderline pathology within Lacanian thought.

The main vehicles for this comparative and theoretical study are a critical review of the literature and the analysis of an illustrative case. The case of "Katherine," a 25 year-old woman who the author saw for three years in psychoanalytically oriented therapy is presented and analyzed from both Kernbergian and Lacanian points of view. It is shown that Katherine, who readily meets Kernberg's presumptive and structural, can

profitably be understood and treated as a case of neurosis within Lacan's diagnostic scheme.

The question of whether those patients described by Kernberg as structurally borderline, do in fact constitute a homogenous group from the perspective of Lacanian theory is considered. At the close of the discussion some tentative suggestions are made regarding how Lacanian ideas can be of value in the diagnosis and treatment of severe pathology, as well as how certain Lacanian ideas might be operationalized and formulated as empirical hypotheses. The goal of this study is to utilize the controversy around borderline conditions to further a dialog with, and promote a consideration of, Lacanian theory and practice in the context of American psychoanalytically oriented diagnosis and treatment of the so-called borderline patient. The implications for child and school psychology are considered and the limitations of the study described.

Chapter One

INTRODUCTION AND LITERATURE REVIEW

The "Borderline" Concept in America and Europe

The borderline concept has over the past 30 years come to dominate discussions in both clinical psychiatry and psychoanalysis in America. While most American psychoanalysts regard borderline pathology as a distinct nosological entity requiring a specific dynamic formulation and therapeutic techniques, no equivalent acceptance of the borderline concept is to be found among European analysts. In particular, Jacques Lacan, whose "return to Freud" has dominated psychoanalysis in France, much of Europe and South America, has specifically rejected the borderline concept, tacitly denying that "there are any borderline patients, only analysts who are on the border in their conceptualizations of such patient's pathology." Lacan, has preferred to adhere to Freud's basic nosological distinctions between neurosis, psychosis, and perversion, leaving no room for this "fourth" pathology which plays such an important role in American diagnosis and treatment.

A number of factors have hitherto prevented a meaningful dialogue between American Ego, Object Relations, and Self psychologists and their counterparts in France. Among these, are Lacan's radically different conceptualizations of the ego and his rejection of "a unified subject", his notion that the ego is a center of misperception and untruth, and his view that by virtue of language we are constantly "miscomunicating".

Since the borderline conditions are conceptualized as a failure in the development of regulation of the ego or self, Lacan, who rejects the notion that there is an ego which must be regulated and developed, appears to have little place for borderline pathology in his conceptual framework.

Nevertheless, it is clear that Lacanians are indeed treating many patients who American clinicians would diagnose as borderlines. How these patients are conceptualized and treated within a Lacanian framework will not only provide a great deal of insight into the distinction between Lacanian and American psychoanalysis, but should also provide a fresh perspective on the treatment of such patients as well. Further, since the rejection of the borderline concept is one factor preventing a meaningful dialogue between American and French psychoanalysts, a clarification of the reasons for this rejection and the alternative conceptualizations and techniques proposed by Lacan should be helpful in establishing a dialogue between these two camps. A careful analysis of this issue will be helpful in discerning not only the points of contrast among the respective schools of thought but also points of (thus far) unrecognized convergence as well.

Difficulties in the Definition and Study of the Borderline Personality

Clinicians have long described patients who either bordered on schizophrenia or appeared to have features of both neurosis and psychosis. Patients have been classified as "borderline" according to a variety of not always consistent criteria, some of which emerge as a result of specific methodological tools that are utilized in the study of

varying populations (Gunderson and Singer, 1985). In general there have been three main approaches to the classification of such patients. The first, which has been termed the "descriptive" approach, is based exclusively on symptomatic and behavioral observations. The second, the "psychoanalytic" or "structural" approach, groups patients not on the basis of symptoms but rather on the basis of a presumed underlying psychological dynamic or "structure" that individuals with varying symptoms and behaviors share in common. A third classificatory approach shares some features with each of the first two, and classifies such patients on the basis of their performance on psychological tests (Stone, Dellis,1960).

These three classificatory descriptive methods are most often utilized in connection with widely varying sources of data and widely divergent ways of conceptualizing such data. Whereas the descriptive, and to a certain extent, psychological testing approaches, are amenable to wide-ranging empirical studies that examine a large sample on the basis of standardized criteria, the dynamic/structural approach has traditionally been limited to intensive work with individual patients, who in the course of psychotherapy, are found to exhibit specific patterns of transference, resistance, defense, response to treatment, etc (Hoch, Catell, 1959). Psychodynamic theorists argue that the specific features necessary for adequate dynamic/structural diagnosis only emerge in the context of the intensive interpersonal encounter of psychoanalytic treatment, and are largely opaque to more standardized empirical research.

Frequently these classificatory methods also vary according to the setting in which they are employed. For example, it is frequently the case that behavioral and symptomatic observations are conducted by psychiatrists in hospital or other residential treatment settings, whereas psychoanalytic formulations have evolved mostly within the context of private, outpatient clinical work. Further, the communication of findings and theory is often limited to a select audience. Psychologists, for example, who have diagnosed the borderline syndrome through the administration of a battery of psychological tests, although often working in the same or similar settings as descriptive psychiatrists, generally publish their findings in specialized journals with limited readership among other mental health disciplines (Gunderson, Singer, 1970). Finally, the various groups working with so-called borderline patients are often suspicious of each other's methodology, sources and personal biases. Adding to the confusion regarding the borderline diagnosis is the fact that, as a result of a variety of factors, those utilizing different classificatory approaches may not actually be referring to the same, or even similar, patient populations. It may very well be that so-called inpatient borderline subjects will present symptoms and structures that are quite different in comparison to their outpatient counterparts and those seen in public settings may be quite different from those classified as "borderline" in private practice (Grinker, et.al. 1968).

Over the years, research studies on borderline subjects have set varying selection criteria for their samples. One study may include outpatients with or without overt psychotic symptoms such as delusions and hallucinations at the time of the study; while another may be limited to inpatients who exhibited brief psychosis either on mental status

or in their recent psychiatric history. For example, Hoch and Catell (1959) selected their patients on the basis of severe psychoneurotic symptoms but later found on closer evaluation during psychotherapy conducted by psychoanalysts that these very patients exhibited signs of schizophrenia in their thinking, feelings and physiological functioning. Others, such as Grinker, et. al (1968) who conducted a widely recognized long-term study of borderline patients, selected subjects on the basis of good functioning in between hospitalizations and the presence of an ego alien quality to any psychotic symptoms. It is clear that the selection of patients impacted upon the conclusions reached regarding the borderline diagnosis and its relationship to schizophrenia. Whereas Grinker found very few subjects with psychotic episodes at the end of the study, 5 years later, Hoch and Catell, in contrast, had an expected subgroup of schizophrenics among their patients.

In summary, four major variables may be considered in any description of the so-called borderline patient: (1) Methods of classifying patients—descriptive, structural, psychological testing, (2) settings in which research is conducted—inpatient, outpatient, public, private, (3) nature of the data base—empirical studies, or intensive psychoanalytic psychotherapeutic investigation, (4) selection criteria of original sample, prior to their classification performed with matched blind experiments.

Empirical studies using the psychoanalytic model have been developed in the last twenty years focused on the borderline personality disorder (Shapiro, 1989). When Gunderson was approaching the issue of borderline diagnosis from an empirical point of view, he posited that unless there was external validation of the criteria or some level of predictability based on family prevalence or course of illness, the diagnosis would not

sustain inclusion in the DSM-III. However, he insisted on including two criteria that were essentially psychoanalytic: vulnerability to regression and psychosis under transference-like conditions.

Certainly by 1990, if not before, the borderline personality was by far the best researched of the personality disorders, indeed accounting for the majority of scientific publications on this topic (Efrain Bleiberg,1995). While there is a relatively high degree of agreement on the phenomenology of the borderline disorder, a major controversy exists regarding the etiology of this condition. Further, while psychoanalysts have taken a lead in examining this condition, and there is even a certain level of agreement regarding the psychostructural characteristics of these patients, the psychoanalytic literature lacks nosological congruence with the general psychiatric descriptions, suggesting that psychoanalytic structural classification may not (in spite of Kernberg's affirmations) correspond to the descriptive Borderline Personality Disorder syndrome. Since the nature of the borderline disorder goes to the heart of psychoanalytic ideas regarding the nature of the human subject, the function of the ego, the major drives and their vicissitudes, etc. one would expect different formulations regarding so-called borderline patients among different psychoanalytic theoreticians and schools.

This study focuses upon the borderline diagnosis within the context of psychoanalytic theory and treatment. Without discounting their significance, I will not elaborate in detail on the descriptive or psychological testing investigations of the borderline phenomena, except insofar as these methods impact upon psychoanalytic theory. I do not intend in the course of this study to examine the diagnosis of borderline

disorder in every conceivable context, but rather to focus upon the meaning, relevance, and utility of this diagnosis within the context of psychodynamic theory and treatment. However, the emergence of the borderline concept in American psychoanalysis initially involved a confluence of both descriptive and psychoanalytic formulations. In addition, many analysts who considered the borderline diagnosis (Kernberg among them) were profoundly influenced by developmental theorists who worked within academic psychology. Part of the reason for this, is that during the years of the borderline concepts' initial formulation (roughly, 1941-1975), American psychiatry was far more closely identified with psychoanalysis and developmental psychology than it is today. As a result, only by tracing the roots of the borderline concept first within descriptive psychiatry/psychology and then within psychoanalytic and developmental theory can we come to understand its emergence as an important diagnosis among American psychoanalysts. After doing so we will be in a position to explore some of the reasons why this diagnosis failed to emerge among psychoanalysts practicing outside of North America.

Early Conceptions of Borderline Pathology

According to Salman Akhtar (1992) the earliest tentative description of a mental disorder that was not clearly viewed as insanity was made by J.C. Prichard (Treatise of Insanity, 1835). He referred to a syndrome of "moral insanity" which he characterized as "a form of mental derangement in which the intellectual faculties appear to have sustained little or no injury". Prichard's initial patient was described as presenting with

perverse feelings, habits, and temper without a defect in his or her reasoning faculties and mainly without illusions or hallucinations (Prichard, 1835). However, the concept of "moral insanity" came to be restricted to antisocial individuals and the other types of dysfunction noted by Prichard and were largely ignored.

Emil Kraepelin (1905), the German psychiatrist who is often credited with being the founder of modern descriptive psychiatry, had a keen interest in what had been referred to as "morbid personalities." He viewed this condition as a "borderline state" between insanity and normalcy. He presented several different combinations of healthy and abnormal personalities, emphasizing that such individuals, in spite of their eccentricities, were not cognitively deficient and could even be gifted intellectually. Kraepelin even created a nosology of subtypes of the morbid personalities: (1) patients with instability of will (who probably come close to today's borderlines), (2) liars and swindlers (who by today's descriptive criteria would be classified as antisocial), and (3) "pseudoquerulous" individuals (who might be regarded as paranoid personalities).

Kraepelin described the first group as childish, presumptuous, overbearing, irritable, unmanageable, selfish, and with no sympathy for others. Although it appears that he was trying to describe what might now be classified as borderline personalities, the general trend for at least the next decade was to group all such "morbid personalities" under the diagnosis of "psychopathy" and again, the "borderline" disorders fell into a state of neglect.

A decade later, Bleuler reopened the investigation of the field of severe non-psychotic disorders. First, Bleuler questioned the term Dementia Praecox used by

Kraepelin and replaced it with the term: schizophrenia. For Kraepelin Dementia Praecox had represented the end-state of a chronic psychiatric deterioration. For Bleuler, Schizophrenia simply represented a disorganization of psychic functions. Bleuler also described two forms of non-psychotic disorders characterized by the absence of hallucinations but with a tendency to turn to fantasy in place of reality. These he termed simple and latent schizophrenias, disorders which today would be descriptively classified under schizotypal personality disorder. Bleuler's contribution was to broaden the scope of severe non-psychotic psychopathology, expanding the field of clinical psychiatry to the realm of personality disorders. From then on, a series of researchers were encouraged to embark on clinical and empirical studies of a group of unstable individuals who were thought to be neither neurotic nor frankly psychotic and who, in these researchers' views, required not only a new diagnostic category but psychotherapeutic interventions tailored to their particular level of pathology.

Zilboorg (1941) described a group of patients that he called "ambulatory schizophrenics." These patients presented with a "normal" appearance, which was, however, accompanied by shallow emotionality, dereistic thinking, an incapacity to settle on one job or life pursuit and inability to sustain friendships. Zilboorg noted that these patients were able to function without the need for hospitalization. He included among this group psychopathic personalities, murderers, and sexual perverts. He discarded the term "borderline" as he viewed these patients as a subtype of schizophrenia.

Hoch and Polatin (1949) described a condition which they termed "pseudoneurotic schizophrenia". Although these patients appeared to be neurotic, Hoch