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Ideology Between Psychoanalysis and Psychiatry: A History of the Borderline Group of Patients

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Since the late nineteenth century, patients who fall under the "borderline" category have presented challenges to both psychiatric and psychoanalytic institutions. In this paper, I delineate the complicated social relations of production encapsulated in the history of the borderline group of patients beginning in the late nineteenth century and continuing into the twentieth, ending with the solidification of the diagnostic category "Borderline Personality Disorder" in the 1980 publication of the *DSM-III*. Although some histories have explored the socially contingent aspects of borderline, none have recognized the more radical potential of this diagnostic category in critically analyzing the diagnostic systems of normative psychiatry. I add to the dynamic history of the diagnosis by exploring the ways that borderline, as an object of medical-scientific study, has challenged the project of European scientific medicine in ways that might help us understand the latent contradictions within this project itself.

KEYWORDS
borderline personality disorder, ego psychology, DSM-III, history of science, psychiatric empiricism

1 | INTRODUCTION: THE "BORDERLINE PROBLEMATIC"

Adolph Stern began his 1938 paper on the borderline group of psychoanalytic patients with a statement as descriptive and defining as it was prescriptive and judgmental: "It is well known that a large group of patients fits frankly neither into the psychotic nor into the psychoneurotic group, and that this border line group of patients is extremely difficult to handle effectively by any psychotherapeutic method" (Stern, 1938, p. 467). Since the late 19th century, this borderline group of patients has presented immense challenges to both psychiatric and psychoanalytic professionals. These patients have historically either occupied a "borderland" of neither sanity nor madness, belonging neither in psychiatric institutions nor regular society, or have resisted categorization as either neurotic or psychotic by 20th century American psychoanalysts. (Rosse, 1890, pp. 669-83.)[1] In this paper, I hope to delineate the complicated social relations of production encapsulated in the history of the borderline group of patients beginning in the late 19th century and continuing into the 20th, ending with the solidification of the diagnostic category "Borderline Personality Disorder" in the American Psychiatric Association's 1980 publication of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders*.

Although a few extensive histories of the borderline group have been written, and of these few many have illustrated the fundamental roots of indeterminacy in the borderline group of patients, none have recognized the importance of this diagnostic category in critically analyzing the internal logic and diagnostic systems of both biomedical psychiatry and 20th century American psychoanalysis. In her book *Betweenity* (2010), for example, Judy Gammelgaard has aptly illustrated the issues that psychoanalysts have faced in treating these patients who do not benefit from analysis designed primarily for neurotics. However, she ultimately renders these patients as essentially "in between"; they are plagued with "insecurity concerning various borders: between fantasy and reality; between reality ego and ideal ego; between desire and fantasy" (Gammelgaard, 2010, p. 5). Although *Betweenity* cuts through many negative stereotypes of borderline patients, it ultimately rests upon a quasi-fetishizing picture of borderline patients as endlessly vacillating between psychoanalytic categories.

Additionally, following the growing prevalence of biomedical psychiatry in the mid to late 20th century, these histories follow the trend of attempting to make intelligible and replicable a diagnostic category that has historically been defined *against what it is not*. Instead of seeking to pin down this seemingly indeterminate group of patients, I hope to use the term "borderline" and its many instantiations throughout the history of American psychiatry and psychoanalysis as a conceptual tool to critically engage with the taxonomic systems utilized by psychiatry and psychoanalysis. When discussing borderline patients, Bruce Fink has argued: "The patient is not on the border between two clinical structures; it is the clinician who is hesitating at the border in his or her diagnostic ponderings" (Fink, 1997, p. 77). Here, Fink locates the crux of the borderline problematic in the diagnostic process rather than the presentation of symptoms on the part of the patient. The borderline problematic has been laid out time and time again, but always in a way that problematizes the patient's disordered behavior where he or she does not fall into one category or another. The focus, I argue, should be on diagnostic processes. Historically, the borderline group of patients exemplifies the poverty of both ego psychoanalytic and biopsychiatric modes of diagnosing and treating mental illness, if not simply the incoherence of the internal logic of both forms of nosology.

The ultimate essentialization of the "in-betweenness" of borderline patients coalesces in the change in psychiatric literature from the "borderline group of patients" to the specific *DSM-III* diagnosis of borderline personality disorder. I will begin by tracing some of the dominant histories that have been written about the borderline group of patients, while revisiting three primary sources: Irving Rosse's "Clinical Evidences of Borderland Insanity" (1890),

[1] In this 1890 paper, Rosse traces through several case studies which present a challenge to the category of "insanity," which I will discuss to greater lengths in the rest of this paper.

Adolph Stern's "Psychoanalytic Investigation of the Therapy in the Border Line Group of Neuroses" (1938), and John Gunderson and Margaret Singer's "Defining Borderline Patients: An Overview" (1975). Rosse's article is often cited as the first psychiatric record of a "borderline" or "borderland" group of patients who do not fit neatly into categories of sanity or madness. Stern's article exemplifies the second life that the borderline group takes on within 20th century American psychoanalysis and is useful in tracing some negative stereotypes about borderline patients' resistance to treatment and generally difficult dispositions. Finally, Gunderson and Singer's article represents the moment at which the borderline problematic becomes a definitive "personality disorder" and not just a diagnostic issue with a group of "in-between" patients. Finally, I will end by discussing some of the literature around the negative stereotypes and patriarchal relations of domination that are encapsulated in the BPD diagnosis. Ultimately, I hope to exemplify the ways that this very real group of patients has become mystified by the institution of 20th century biomedical psychiatry, while resisting a straightforward "medicalization" narrative.

2 | "BORDERLAND" AS AN INDETERMINATE PSYCHIATRIC CONCEPT

In 1890, the American psychiatrist Irving C. Rosse published a collection of case studies detailing his clinical experiences with psychiatric patients on the "borderland" of sanity and madness. He described these patients as "a class of persons standing in the twilight of right reason and despair—a vast army whose units, consisting of individuals with minds trembling in the balance between reason and madness, are not so sane as to be able to control themselves, nor yet so insane as to require restraint or seclusion" (Rosse, 1890, p. 669). Rosse described several borderland patients, explaining "how few are [their] objective symptoms and how unsatisfactory is their treatment" (Rosse, 1890, p. 674). These patients frustrated him: they showed propensity towards mentally pathological and at times criminal behaviors but provided him with insufficient evidence to justify characterizing them as insane.

Judy Gammelgaard has argued that the borderline group of patients can be traced back to this "moral stigmatization of un-reason" beginning with Rosse's paper (Gammelgaard, 2010, p. 12). Rosse's borderland patients did not fit neatly into the realm of psychiatry because they did not exhibit hallucinatory or other classically psychotic, or as Rosse called them, "objective" symptoms. Indeed, Rosse's intentions in compiling and analyzing this collection of case studies were of legal rather than medical concern.[2] The problem that these patients presented to him was one of social control, where borderland patients posed threats to systems of criminal regulation by occupying an indeterminate space in which "insanity" might not be a reasonable explanation in the case of criminal behavior. Ultimately, his question was about these patients' moral and rational credibility: "Who, for instance, would not question the criminal responsibility or the civil capacity of nearly all the persons just mentioned, after knowing their clinical history? (Rosse, 1890, p. 669)." The issue here was whether or not these individuals possessed adequate rationality or reason, and how to legally respond to their intentions, and by extension to their actions.

In addition to Rosse, Emil Kraepelin categorized people who engaged in criminal activity but were not psychotic in the "in-between region" or *Zwischengebiet*: "literally in a border land that was neither psychosis nor normality" (Stone, 2005, p. 2). Michael H. Stone has also traced the origins of borderline patients to the end of the 19th century when psychiatry had to deal with criminal patients who lacked rationality *but not enough to prove insanity*. Stone argues that "in its first uses in psychiatry, *borderline* designated either (a) a condition that approximated another, already well-established disorder, or (b) a condition that occupied a region in between two rather indistinctly boundaried levels of mental functioning" and that "the borderline of our current BPD is derived from both these usages" (Stone, 2005,

[2] Rosse, on page 670 of "Clinical Evidences of Borderline Insanity," explains: "The solution of such interlocutory questions as may arise from the latter point of view being rather juridical than medical, I shall take for granted the pathognomonic character of the malady in question, and without further generalization shall mention a few typical illustrations selected from the experience of my own practice as a neurologist."

p. 1). He interprets physicians' need for this in-between region a result of the discomfort around grouping criminals with the rest of "normal" society simply because they did not display psychotic symptoms. Doctors needed a medical signifier of difference between criminals and normal citizens, no matter how subtle or latent their deviance or lack of sanity and reason might have been.

This problem continued into the early 20th century, especially after Kraepelin's dementia praecox morphed into Eugen Bleuler's diagnostic category of schizophrenia in 1911 (Beuler, 1950). Following the development of the schizophrenia diagnosis, doctors began to construct and define multiple categories that approached but did not satisfy the diagnostic criteria for schizophrenia. For example, Gunderson and Singer listed eight diagnostic terms for psychiatric patients who were not fully schizophrenic: preschizophrenia, schizophrenic character, abortive schizophrenia, pseudopsychopathic schizophrenia, psychotic character, subclinical schizophrenia, borderland, and occult schizophrenia (Gunderson and Singer, 1975). This multitude of quasi-schizophrenic diagnoses illustrates one instance of chaotic indeterminacy in the history of psychiatric pathologies. Bleuler himself developed the term "latent schizophrenia" to describe "persons whose conventional social behavior he felt concealed underlying schizophrenia," revealing perhaps the first instance of the stereotype of manipulative, duplicitous, or deceitful behavior in these not quite insane, though not quite healthy patients (Gunderson and Singer, 1975, p. 1). Additionally, Gregory Zilboorg developed the diagnosis of "ambulatory schizophrenia," a term to designate patients who were functionally schizophrenic or delusional without hallucinations or full psychotic episodes. Ambulatory schizophrenics were also as much an issue for the law as they were for medicine, as many of Zilboorg's patients "were men with criminal backgrounds, with impaired social relationships, and poor work histories" (Stone, 2005, pp. 5-6). In these cases, ambulatory schizophrenia acted as a diagnosis to differentiate people who, otherwise seemingly of the same mental constitution, engaged in socially unacceptable behaviors from those who did not—even some as innocuous as the inability to work.

From Rosse and Kraepelin up to Zilboorg, the borderland patients presented not only a medical and diagnostic problem, but also a legal problem: the social control of criminal and borderline-insane behaviors. These cases display an overt collapsing of scientific and theoretical discourse into legal and administrative, ideological discourse. This was the realm of medical psychiatry in the late 19th and early 20th century, and as I have shown, historians have traced the borderline group of patients to these borderland and not quite schizophrenic categories. Next, I will address the shifting of the borderline problematic in 20th century American psychoanalysis.

3 | "BORDERLINE" AS AN INDETERMINATE PSYCHOANALYTIC CONCEPT

While the borderland concept problematized the distinction between sanity and madness in the late 19th and early 20th centuries, the borderline concept similarly problematized psychoanalytic discourse in the mid to late 20th century. Adolph Stern, an American psychoanalyst, first officially used the term "borderline" in a lecture to the New York Psychoanalytic Society in the Spring of 1937. The lecture was later published as "Psychoanalytic Investigation of and Therapy in the Border Line Group of Neuroses" in 1938. In the paper, he delineated the first clear picture of a diagnostic category called "borderline" that was more than its relationship to the psychiatric diagnosis of schizophrenia: he argued that the "border line group of patients [showed] a fairly definite clinical picture and fairly definite clinical symptoms" (Stern, 1938, p. 468). Working within the tradition of post-Freudian ego psychoanalysis, he served as the President of the American Psychoanalytic Association from 1927-1928, and of the New York Psychoanalytic Society on three separate occasions. He was analyzed by Freud himself in 1920 and remained a member of the American Psychoanalytic Association until his death in 1958 (Eisendorfer, 1959, pp. 149-150).

While Stern acknowledged that it was "well known that a large group of patients fit frankly neither into

the psychotic nor into the psychoneurotic group," his paper included ten distinct clinical symptoms of the borderline patient (Stern, 1938, p. 467). After myriad failures in trying to treat these patients as neurotics, he realized the necessity for a new group of patients that seemed neither to fall under the psychoanalytic category of neurotic nor of psychotic. In contrast to the borderland psychiatric patients, Stern's borderline patients did not present an overtly moral or legal problem; rather, they did not respond adequately to psychoanalysis despite not presenting as fully psychotic. The problem that these patients presented involved a disturbed and unsuccessful transference relationship, while in neurotic patients the brunt of classic ego psychoanalytic work happens via the transference relationship between analyst and analysand.[3] To the American ego psychoanalysts of Stern's time, the two main categories of pathology were psychosis and neurosis, where neurosis was treatable by analysis and psychosis was generally not. This distinction between psychotic and neurotic patients has been criticized in that it "functioned as a kind of self—other polarity, defining the boundary between pathology that was treatable and illness so dire that it could only be isolated and managed in asylums (Lakoff, 2005, p. 46)." In other words, neurotic patients saw improvement in symptoms as a result of regular analysis, while psychotic patients did not and were often relegated to psychiatric institutions.

The borderline patients, then, were particularly pesky. According to Stern, they presented as neurotic on an everyday basis; however, when encountering the analyst in the transference process, they presented the classic psychotic problem of projection, which is what ultimately linked them to psychotics (Stern, 1938, p. 478). Stern linked the presentation of psychotic symptoms to a narcissistic maladaptation in the borderline patient, in response to which the patient would idealize and idolize the analyst, rendering him or her as a "personal, corporeal god and magician (1938, p. 480)." Of the ten diagnostic criteria for the borderline patient, "reality testing" was the one that aligned them with the psychoses the most. In analysis, these patients could not adequately "test" the reality of their interpersonal, transference relationship to their analyst: Stern explained, "Some of these patients [came] uncomfortably near to a psychotic state in such phases of their transference," when the god-like picture of the analyst was threatened by reality; in response, patients would "make violent attempts to recapture the old beatific illusion," because "it [was] the imago [the delusion] that [operated] for a long time upon the psyche of the patient, rather than the analyst as a *reality person* (1938, pp. 481-482)." These patients displayed a displacement of identification, where they could never identify with the analyst as such; rather, the borderline patient identified "with his conception of him," thereby foreclosing the possibility of the psychoanalytic process (Stern, 1938, p. 484).

Although Stern was fairly forgiving and impressively descriptive in most of his paper, his descriptions of the delusions about the borderline patients' analysts (here, one can assume he refers to himself as analyst, as he was describing his experiences with his own patients) were extremely infantilizing and perhaps revealed more about the analyst-analysand relationship than about borderline patients independently. Take this passage from clinical category number five, "Negative Therapeutic Reactions," for example:

> *The margin of security of these patients is extremely narrow, and an enlightening interpretation throws them, at least for the moment, into despondency, so that only rarely does one notice a favorable reaction to discoveries. Furthermore, in estimating the significance of the negative therapeutic reaction one must bear in mind that the marked immaturity of these patients, and their insecure, depleted narcissism impel them to react to interpretations as evidence of lack of appreciation or love on the part of the analyst. (Stern, 1938, p. 473).*

[3] As Gammelgaard demonstrates, classic Freudian psychoanalytic theory argues that psychoses are incompatible with psychoanalysis: "Freud believed – and this was the reasoning behind his conservatism – that the so-called narcissistic neuroses (psychoses) were inaccessible to psychoanalytic treatment. His argument was that these patients were unable to establish transference. Thus, according to this line of thought, the narcissistic dimension presents an obstacle to psychoanalytic work outside the area of neuroses" (2010, p. 22).

While psychoanalysis afforded psychotics a definitive and forgivable reason for not responding to analysis (despite the aforementioned pathologization that has been criticized as a consequence), borderline patients were treated as infantile, doting, and insecure; their "negative therapeutic reactions" were highly moralized, however implicitly.

Helene Deutsch, a contemporary of Stern's, painted not just an infantilizing picture of borderline patients, but also a blatantly fear-mongering one. She named these patients the "as-if" personality type (Deutsch, 1942). For Deutsch, these patients presented as deceptively well-adjusted—however, upon further inspection, they proved to be duplicitous, and lacking an essential quality of humanity. She described the experience one of her neurotic patients had when meeting one of these "as-if" types: "He spent part of his next analytic hour telling me how stimulating, amusing, attractive, and interesting she was, but ended his eulogy with, 'But something is wrong with her.' He could not explain what he meant (Deutsch, 1942, pp. 326-327)." Most strikingly, perhaps, is Deustch's description of the as-if's utter lack of originality: "when they pursue their not infrequent impulses to creative work they construct, in form, a good piece of work but it is always a spasmodic, if skilled, repetition of a prototype without the slightest trace of originality" and upon "closer observation, the same thing is seen in their affective relationships to the environment (Deutsch, 1942, p. 327)." Just as Stern's borderline patients identified with a delusional stand-in for their analysts, thereby precluding any analytic work, Deutsch's as-if personalities lacked any relationship to personal and interpersonal reality. They lacked connective capabilities, attempting endlessly to "give content and reality to their inner emptiness and establish the validity of their existence by identification (Deutsch, 1942, p. 329)." For Deutsch, and for her neurotic analysand, the as-if personality was frightening because it would not stand still; it would not present a picture of identity stable enough to then identify adequately with others or its environment, despite otherwise seeming "normal."

In both Stern's and Deutsch's heavily psychoanalytic renderings of the borderline or as-if type of patient, the main problematic was one of indeterminacy. In her history of BPD, Gammelgaard ultimately asks whether, since the borderline group of patients has been historically defined by this indeterminacy in relation to diagnostic categories, it might be better to take a phenomenological approach to understanding the "borderline problematic" by focusing on the "strange no man's land where these patients find themselves (Gammelgaard, 2010, p. 14)." She argues that borderline patients not only present a problem for treatment of the specific symptom cluster of borderline patients; they also illuminate the "contradictory discourses characterizing the entire treatment system (Gammelgaard, 2010, p. 11)." However, by focusing on the phenomenological experiences of borderline patients, we avoid engaging with the history of the diagnostic category at all, thereby reifying "borderline" as some essential state of being, or here, of indeterminacy. I argue that it is better to delve directly into *what constitutes* this "no-man's land." As evidenced in the work of Stern and Deutsch, many of the characteristics of "betweenity" are highly gendered and infantilizing. While early psychiatry's borderland problematic was one of overt social control and institutionalization, Stern's and Deutsch's borderline or as-if problematic was one of implicitly moralizing language that served to construct borderline patients as possessing this essential indeterminacy based on the collection of empirical behavioral evidence completely severed from any actual "phenomenological" experience. As we will see, this indeterminacy would be written into the official *DSM-III* diagnosis of BPD.

4 | *DSM-III* AND THE RE-ABSORPTION OF BORDERLINE PATIENTS INTO PSYCHIATRY

The diagnosis of borderline personality disorder was first officially included in the *DSM-III* in 1980. In order to better understand the reasons for BPD's inclusion in the *DSM*, I will briefly provide the historical context for the third edi-

tion of this diagnostic manual and discuss Gunderson and Singer's 1975 article that provided the rational basis for a coherent diagnostic "personality disorder" category.

While the *DSM-I* and *DSM-II* were heavily psychoanalytic, the *DSM-III* became a touchstone for the emergence of biomedical psychiatry in 1980: the "new edition of the [DSM] put in place a set of standards regulating diagnosis according to the model of disease specificity" instead of psychoanalytic pathology (Lakoff, 2005, p. 12). As Andrew Lakoff has demonstrated, the *DSM-III*'s diagnostic categories were meant to facilitate higher translatability and replicability of mental pathologies across the globe: "based on directly observable traits, and ostensibly atheoretical, the new diagnostic standards structured a broader system of communication" and these standards liberated psychiatry "from the idiosyncrasies of subjective judgment (Lakoff, 2005, p. 12)." But how did such a highly subjective group of patients, so reliant on their perceived indeterminacy, become reified into a category designed to facilitate replicability? Importantly, the *DSM* has historically been a means of legitimizing psychiatry in the broader field of the medical sciences. While originally "born in asylums, places of exclusion as much as cure," psychiatry has historically attempted to separate itself from its connection to the implementation of social control (as evidenced in section one of this paper) and integrate itself into the logic of objective, empirical science, and medicine (Lakoff, 2005, p. 5). Psychiatry, then, has always been a somewhat contested medical science, in that it has struggled to locate and define its pathological objects. BPD is one such object.

In 1975, Gunderson and Singer published "Defining Borderline Patients: An Overview," one article that rationalized the category of the borderline patient enough to legitimize it as a medical pathology, leading to its inclusion in the *DSM-III*. In this paper, we can see the direct reification, via medical objectivity, of the same implicitly moralizing behaviors delineated in Stern and Deutsch. Gammelgaard has argued that psychoanalysis developed in opposition to biomedical psychiatry, resisting the moralizing discourses hidden behind a guise of scientific or medical objectivity (Gammelgaard, 2010, p. 14). However, we can see through Deutsch and Stern the latent moralizing features of 20th century American psychoanalysis at work between the borderline and their analyst, in addition to the processes by which these features were directly absorbed by biomedical psychiatry decades later.

If we accept that premise that the diagnosis of homosexuality is outdated and imbricated in homophobia that circulated in the psychiatric and psychoanalytic community during the 1970s in the United States, we can also accede to the premise that many of the behaviors in Gunderson and Singer's litany of maladaptive borderline symptoms are in fact steeped in misogyny, or at the least are behaviors markedly less acceptable in women at the time than in men. Of these "obvious behavior disturbances" include "diverse sexual problems" such as "preoccupation with sex," "polymorphous perverse sexuality," "a prominence of organ pleasures at the expense of object relations," with a tendency towards comorbid patterns of "antisocial, addictive, alcoholic, and homosexual behavior (Gunderson and Singer, 1975, p. 4)." Additionally, as Gunderson and Singer pointed out, the borderline patient's propensity towards "chronic acting-out patterns" led Kernberg to argue "for a new classification of character types based upon what he believes are more fundamental *personality features* than behavior" (Gunderson and Singer, 1975, p. 4). Here, "borderline syndrome" and the behaviors associated with it become an issue of individual *personality*.

What is the relationship between a "wastebasket" diagnosis, so seemingly broad and all-encompassing, or indeterminate, amorphous, and pesky in terms of diagnostics, to a category so specific and essential to a person's identity such as "personality"? This is the moment at which a specific encounter between diagnostic insufficiency and the struggle between this insufficiency and the suffering patient become mystified into a quite damning category: "personality" disorder. The process of difficult negotiation or struggle between medical professional (or psychoanalyst) and "sick" patient is transmuted into a pathology related singularly to a patient's pathological "personality." Importantly, this is not a simple case of the medicalization of behavior, although this narrative does begin to explain the complicated processes at play in the development of BPD. Rather, what we are witnessing is the combination of the weight of a

term historically ill-defined, ephemeral to both psychiatric and psychoanalytic diagnostic procedures; the specific need preceding the publication of the *DSM-III* for a renewed rationalization and replicability of diagnostic categories and procedures; and a specific manifestation of patriarchal relations where mentally ill women exhibit propensities towards multiple gender-pathological behaviors.

Again, Gammelgaard has delineated what she argues is the separation of psychoanalysis from psychiatry during the process in which the borderline group of patients became patients with borderline personality disorder:

> *During the last third of the twentieth century, we see increasing effort on the part of psychiatry to systematically differentiate the borderline group descriptively, thereby scientifically and empirically underpinning what had hitherto been assumptions as to the aetiology. Descriptive diagnostics and theories emphasizing genetic factors gained ground at the expense of psychoanalytic and psychodynamic explanations. (Gammelgaard, 2010, p. 14).*

However, what this description fails to capture is the co-constitutive relationship between psychoanalytic and psychiatric discourses in the 20th century. These two systems of pathological representation did not exist separately from one another. As I have shown, many psychoanalytic and psychodynamic explanations (always embedded in their own relations of power) have been absorbed by psychiatry in order to make this historically indeterminate group of patients intelligible and (oddly enough) rational to the institution of biomedicine.

5 | CONCLUSIONS: IDEOLOGY IN MEDICINE

In his book *Psychiatric Hegemony*, Bruce Cohen attempts to trace the sociological developments in mental health and the proliferation of mental illness in the past century. He argues that ignoring "the development and current dynamics of capitalist society has been a significant omission of most other scholarship in the area" and his own unique contribution involves "getting critical social theory back to the heart of research and scholarship in the sociology of mental health (Cohen, 2016, pp. 1-2)." The aim of this paper has been to address a similar problematic, in that I hope to contribute to a rerouting of the conversation surrounding mental illness to a focus on structural problems and relations of power, whether explicit or implicit, that contribute to its historical development.[4] The historically rich "borderline group of patients" is a fruitful example of the scientifically indeterminate and highly social character of a specific diagnostic category. Cohen importantly switches the focus from individuals who present disordered behavior to a critique of the structures that attempt to taxonomize, define, and order these people and behaviors accordingly. When looking closely at some of the history of the always-shifting, liminal diagnostic category of "borderline," one begins to see quite glaringly that the uncomfortable stigma surrounding borderline patients is a product not of the "difficulty" of their symptoms or their classic "resistance to treatment"; rather, it is a product of a faulty professional attempt to pin down a set of symptoms that (by definition) criticize the very professional structures in which they exist.

I have delineated three stages in the history of the borderline group of patients. The first involves the need for social control of criminal behavior and the demarcation of insanity in order to construct criminals differently than

[4] However, at times Cohen's historicist problematic collapses the crucial dimension of "mental illness" into purely political terms, falling upon a straightforward narrative of medicalization, which is immensely self-defeating and displays implicit voluntarism. I hope to have demonstrated the more complicated negotiations that have historically unfolded around the borderline group of patients and their metamorphosis into BPD. For example, the thread of indeterminacy in the context of scientific systems of representation challenges a singularly patriarchal interpretation of the BPD diagnosis and indicates a structural and ideological issue within the medical sciences that goes much deeper. Mental illness exists in the intersection between subjectivity and relations of social production; it is not so constructed as to not have a material basis in reality.

"normal" citizens in the late 19th and early 20th centuries. These demarcations were legitimized through psychiatric discourse. The second involves the process of transference in 20th century American psychoanalysis. The tradition of ego psychoanalysis included a need for the establishment of the transference relationship in constructing a *workable* and therefore compliant unconscious structure. Borderline patients did not have the ability to establish this. The duplicity of borderline patients and their inability to establish transference was presented implicitly in both Stern and Deutsch as evidence for their moral suspiciousness and duplicity. The third involves the mystification of these two entangled historical processes into *one* psychiatric diagnosis of "borderline personality disorder" in the *DSM-III*. The need within late 20th century psychiatry to create diagnostic categories that were free of subjective or interpretive adulteration facilitated the reification of a set of indeterminate diagnostic categories into a personality disorder.

Frantz Fanon (1967) has detailed the way that relations of production are foreclosed and mystified by the institution of medicine in his 1967 *Toward the African Revolution*. He outlined the medical deprivation of colonized subjects, in that "the attitude of medical personnel is very often an *a priori* attitude. The North African does not come with a substratum common to his race, but on a foundation built by the European. In other words, the North African, spontaneously, by the very fact of appearing on the scene, enters a pre-existing framework (Fanon, 1967, p. 7)." Fanon importantly pointed out that "There is a flaw in the *practitioner's thinking*" and it is an "extremely dangerous flaw" (Fanon, 1967, p. 7). This flaw is the presumption of medical objectivity and the dominance of empiricism where relations of production, and by extension Eurocentric and misogynistic, for example, ideologies are hidden. We should always look more closely at "empirical" evidence to seek the ways that "objectivity" hides their essentially value-laden social character.[5] Fanon (himself a psychiatrist) later applied this logic more directly to psychiatry: "If psychiatry is the medical technique that aims to enable man no longer to be a stranger to his environment, I owe it to myself to affirm that the Arab, permanently an alien in his own country, lives in a state of absolute depersonalization (Fanon, 1967, p. 53)." Ultimately, the thread that links both early 20th century American psychoanalysis and psychiatry is a medico-empiricist model where observable behaviors, necessarily steeped in complicated ideological relations, are catalogued and organized under the guise of medical or generally scientific objectivity.

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[5] For a history of scientific objectivity, see Lorraine Daston and Peter Galison's *Objectivity* (New York: Zone Books, 2007). For a more detailed scientific and social history of the empirical, experimental mode of scientific production and its 17th century origins, see Steven Shapin and Simon Schaffer's *Leviathan and the Air Pump* (Princeton: Princeton University Press, 1985). They describe the construction and social origins of empiricism that largely inform the import that scientific "objectivity" still has on knowledge production today.

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