‘In good times and in bad’: boundary relations of psychoanalysis in post-war USA

José Brunner
Tel Aviv University

Orna Ophir
Institute for Psychoanalytic Training and Research, New York

Abstract
This paper suggests writing the history of psychoanalysis by focusing on the manifold ways in which its practitioners may relate to the boundaries dividing it from its neighbouring professions. This approach is illustrated by two loosely interrelated examples: the 1950s debate among leading US psychoanalysts on whether borderline patients can be analysed, and the 1990s responses of psychoanalysts to psychopharmacological treatments of schizophrenia. A close reading of psychoanalysts’ journal publications reveals in each instance multiplicity (of voices), instability (of boundaries), duality (of defence and dialogue) and simultaneity (of internal and external addressees). At the same time, a common rhetorical stance emerged in each period, serving as a shared discursive frame while allowing a plurality of boundary relations.

Keywords
Borderline, boundaries, psychoanalysis, psychopharmacology, schizophrenia

Introduction
The history of psychoanalysis in the USA has been dealt with extensively from a number of angles as a history of cultural heroes (Burnham 1967; Hale, 1971, 1995; Oberndorf, 1953; Quen and Carlson, 1978; Wangh, 1962; Zaretzky, 2004) or institutes (Kirsner, 2000; Lane and Meisels, 1994; Noble and Burnham, 1989), focusing on ideas and theories, on its early days or on particular cities and states (Frosch, 1991; Grinker 1995). As a rule, these histories either examine the internal workings of psychoanalysis as a discipline or its role in US culture and society at large. Surprisingly, little has been written on the complex relations of psychoanalysis with its neighbouring professions, such as social work, psychology and psychiatry. Moreover, insofar as such boundary relations have been discussed, dichotomist presentations have generally been offered, suggesting a
simple professional landscape composed of monolithic disciplines operating next to each other within the therapeutic sphere, whereas a closer look – such as the one we propose here – discerns a multitude of diverse and often confusing and contradictory positions within and between each of the disciplines involved. This plurality can be discerned by reading psychoanalytic journals as a repository of strategic moves, made to construct, articulate, defend, shift, undermine or transgress the boundaries of psychoanalysis as a profession situated among a number of related professions, engaged in jurisdictional struggles and boundary disputes over problems and patients (Abbott, 1988). Such efforts tend to be two-dimensional at least; that is, they simultaneously aim at positioning psychoanalysis vis-à-vis a neighbouring discipline and at fortifying the author’s perspective in relation to other schools of thought within the discipline.

In recent years, the notion of boundary has received much attention in the social sciences. We suggest regarding boundaries not only as markers of difference, segregating epistemic and professional jurisdictions, but also as interfaces, enabling communication and cooperation across scientific communities. Boundaries point to distinctions; but in doing so, they also create intersections – borderlands where different knowledge communities and professions can interact. Such border zones allow for the emergence of ‘trading zones’, to use Galison’s (1997) metaphor, in which professionals and scientists from different fields may cooperate and exchange knowledge. Lamont and Molnár (2002: 169) have suggested attributing the current popularity of the notion of boundaries in the social sciences not only to the trend of spotlighting difference and demarcation, but also to the way in which the notion ‘captures a fundamental social process, that of relationality’. Examining boundary disputes from this two-dimensional and also dual vantage point of addressing interlocutors within and beyond the discipline – building bridges as well as barriers – entails not only addressing various means of underscoring dissimilarity, carving out professional jurisdiction and protecting epistemic autonomy; it also involves attending to the manifold ways in which avenues for intra- and inter-professional communication and cooperation are maintained despite differences. Thus, the characteristics of this approach to boundary relations are the following:

1. A two-dimensional focus on boundary formations, shifts and disputes that involve discursive strategies across as well as within given disciplinary boundaries. Hence, a history of such professional discursive strategies continually intertwines ‘history from within’ with ‘history from without’ (Lunbeck, 2006: 155).

2. A dual perspective on disciplinary boundaries refuses their reduction to mere defences or sites of dialogue while always analysing their double function as barriers and borders serving struggles over professional jurisdiction and their utility as sites of intersection and communication between neighbouring disciplines.

3. An awareness of the plurality of discursive strategies pursued within each discipline demands that a number of distinct disciplinary positions and voices be highlighted, each of which holds a distinct position regarding a given boundary.

4. A discursive analysis assumes boundary relations to be unstable and changing over time. It does not depart from or lead to a search for a stable referent, a prior objective, ‘natural’ or ‘rightful’ boundary between discourses. Since boundaries are included in the jurisdiction struggle between disciplines and professions and serve as nodal points of communication, they can shift, contract and expand.

However, underlying and informing this plurality, we detect certain fundamental similarities in the phrasing and presentation of arguments, which tend to be shared even by interlocutors defending contradictory positions. Thus we add a fifth characteristic:
Together with its stress on the multiplicity, duality and multi-dimensionality of discursive boundary relations, discourse analysis also seeks to detect a shared discursive mould within which debates and communications are conducted, but without reducing the former to the latter.

To exemplify this approach, which we advocate as fruitful for writing the history of postwar psychiatry and psychoanalysis in general, we present two interrelated case studies in the history of US psychoanalysis after 1945, providing a close reading of publications in psychoanalytic journals, which we treat as an archive for tracing boundary disputes and communications.

The notion of borderline disorder, on which our first example centres, is a distinctive North American concept; hence, it is appropriate to discuss it within US psychoanalysis (Lunbeck, 2006: 153–4). The borderline achieved recognition in the late 1960s under the influence of Kernberg’s seminal work that defined it as a particular ‘personality organization’ (Kernberg, 1967, 1975; see also: Abend, Porder and Willick, 1983; Fonagy, 2000; Gabbard, 2001; Meissner, 1984; Paris, 2005; Searles, 1986). By the mid-1970s, the borderline had turned into a specific ‘type of patient’, with whom American psychoanalysts could be assumed to be familiar (Giovacchini, 1975, cited in Lunbeck, 2006: 157; Gunderson, 2009). However, we wish to focus on the mid-1950s, the first period in which the borderline played a major role in the psychoanalytic discourse of the USA. We choose to look at this time period precisely because in those years the notion of borderline did not yet constitute a diagnosis of its own. Rather, it served to demarcate the boundary between schizophrenia – a disorder traditionally considered to belong exclusively within the realm of psychiatry, that is, beyond the bounds of psychoanalysis – and neurosis, which psychoanalytic practitioners considered to be within their therapeutic jurisdiction. With borderline patients, who could be diagnosed neither as neurotics nor as schizophrenics, jurisdiction could be disputed.

Over the following decades, schizophrenia became more narrowly defined and associated with paranoia, and it appeared more severe and threatening in terms of the symptoms attributed to it, while the borderline expanded into a personality disorder in its own right, achieving diagnostic ‘independence’. Hence, psychoanalytic treatment for borderline patients was no longer questioned. Of course, this by no means indicated that psychiatry contracted along with schizophrenia. On the contrary, new boundary relations between psychoanalysis and schizophrenia emerged – relations that conformed not only to the new understanding of schizophrenia and its narrower boundaries, but also to the new psychopharmaceutics available to psychiatry, which expanded its reach. In the second period that will be explored in this essay, the 1990s, the prevalence of pharmacotherapy forced psychoanalysts to seek new strategies to conceptualize the relationship between psychoanalysis and schizophrenia. Demonstrating that boundary relations are not limited to struggles over boundary objects located in a border zone between disciplines (that can be spatially envisaged), we will show that such boundary relations may also involve different forms of trans-boundary communications, in which psychoanalysts defined their position vis-à-vis psychiatric technologies, such as medication.

The scope of this article does not suffice to cover the developments leading from the first period we portray to the second, in both of which we explore the boundary disputes/dialogues between psychoanalysis and psychiatry, as well as psychoanalysis and schizophrenia, which simultaneously also constituted discursive stances on what psychoanalysis could and should be. All we can offer are two snapshots which aim to illustrate the historical understandings that can be achieved by reading psychoanalysts’ publications as a corpus demonstrating multiple positions, shifting boundaries, dialogues within the discipline as well as with neighbouring ones, and attempts at developing channels of communication and establishing defences.
The first case study presents the notion of the ‘borderline patient’ as a boundary object in the debate on the scope of psychoanalytic jurisdiction, which developed in American psychoanalysis during the course of the 1950s. Psychoanalyst Adolph Stern (1879–1958) introduced the category of a ‘border line group of patients’ in 1938, referring to those whom he diagnosed as suffering from a mild form of schizophrenia, and hence situated on the ‘borderline’ between neurosis and psychosis (Stern, 1938; see also Stern, 1945).

The notion of ‘borderline’ introduced a spatial metaphor into the psychoanalytic discourse on mental disorders, whereby neurotic patients were placed on the analysable side of the ‘line’ and schizophrenics on the other, non-analysable side. In other words, schizophrenia was the illness at whose border borderline patients were placed. As Stern (1938: 469) explained, these patients constituted ‘a large indefinite group between the psychoses and the transference neuroses, partaking of the characteristics of both but showing frank tendencies in the direction of the psychotic’. The problem was that these patients were not disturbed enough to be classifiable as schizophrenic, but nevertheless shared some deep mental disturbances with schizophrenics. In fact, all aspects of their personality were disturbed: their sense of identity, their relationships (they tended to total idealization or absolute devaluation), and their emotional household (they could feel suicidally empty or uncontrollably angry). Stern argued that since these patients are highly disturbed and their ego is involved in illness rather than health, as is the case among neurotics, psychoanalysis is possible but ‘more difficult, and the prognosis more grave, than in psychoneurotics’ (Stern, 1938: 489).

Traditionally, psychoanalysts had considered psychoanalysis possible only with neurotic patients, who were considered healthy enough to be able to enter into a therapeutic alliance with their analyst, so as to make analysis of transferences and overcoming of resistances possible. In psychoanalytic parlance, psychoanalysis – which proclaimed a high frequency of sessions necessary for a significant transference neurosis to emerge and encouraged free associations to allow for interpretation of the associations and the resistances surrounding them – could be curative only for patients whose ego was strong enough to tolerate periods of regression without losing control over the mind. Patients whose ego was not considered sufficiently healthy to tolerate a procedure involving regression, such as psychoanalysis, had to be offered other forms of therapy, aiming at strengthening their ego. For patients with a frail ego that lacked integration, which was how borderline patients were defined, such a therapeutic procedure could be dangerous; thus, psychoanalysts more cautious than Stern warned that instead of improving, the condition of these patients would deteriorate in analysis.

In fact, as Gunderson (1979: 17) has shown, the attempt to prevent unforeseen schizophrenia-like reactions of otherwise helpful treatment methods can be traced back to Eugen Bleuler (1857–1937) and Hermann Rorschach (1884–1922), both of whom referred to patients whom they described as ‘latent schizophrenics’. Moreover, Bleuler and Rorschach did not seek to delineate rigid boundaries between pathologies, considering them discrete, classifiable illnesses as Emil Kraepelin (1856–1926) did. Rather, they regarded patients as situated on a continuum between disorders. Finally, Bleuler did not consider features such as hallucinations or delusions, which later came to be seen as defining schizophrenia, as fundamental to the disorder. Instead he pointed to the four ‘A’s: associative loosening, affective blunting, ambivalence and autism as characteristics of schizophrenia, all of which, to a lesser degree, are also part of normalcy. In consequence, following the Bleulerian approach, which influenced American psychiatry only after the translation of his book into English at the beginning of the 1950s, a diagnosis of schizophrenia did not require as distinctive a difference from the normal as it would in later years. Hence it also provided one of
the inspirations for those psychoanalysts who regarded schizophrenic patients as analysable (Andreasen, 1989: 520).

Strikingly, psychoanalytic publications of the 1950s on the scope of psychoanalysis not only assumed it to be the treatment of choice for neurotic patients, but also described those who were portrayed as unsuitable for analysis exclusively by means of psychoanalytic terminology. A leading US psychoanalyst, Robert P. Knight (1902–66) described the latter patients as ‘too fragile’, ‘too inflexible’, ‘too defensive’ or ‘too ill to cooperate in the usual analytic procedure’ (Knight, 1949: 107–8). Repeatedly, the main reason offered for not treating such patients with classic psychoanalysis was that they were not capable of coping with it. In other words: in the discourse of American psychoanalysts of the 1950s, it was not that psychoanalysis was too weak a method for borderline patients but that the patients were too weak to be able to benefit from what psychoanalysis had to offer and, due to their own weakness, might be harmed by it.

Even though American psychoanalysts tended to regard psychoanalysis as the queen of the psychotherapies, one can already discern the seeds of the debate of the 1950s in statements from the late 1940s. On the one hand, for historical reasons stemming from the 1930s and even earlier periods, US psychoanalysis had developed as part of US medicine; as is well known, until the 1980s all members of the American Psychoanalytic Association were psychiatrists and neurologists. Its medical status undoubtedly endowed American psychoanalysis with prestige. On the other hand, the success of US psychoanalysts in treating neuropsychiatric casualties during and after World War II by means of brief psychotherapy (Grob, 1990) and their ability to offer a method of treatment for patients suffering from common emotional problems, as well as their commitment to social reform (Grob, 1986), bestowed an aura of progress and success upon American psychiatry.

Thus, while mainstream US psychoanalysis could use the psychiatric context to its benefit, its conceptual and therapeutic repertoire was advantageous for US psychiatry. This enabled psychoanalysis to inspire a new generation of psychiatrists, who were soon to lead American psychiatry. As Grob (1991: 430) recounts, by 1960 ‘virtually every chairperson of a department of psychiatry stated unequivocally that the psychodynamic frame of reference (as contrasted with the descriptive or organic) was dominant’. However, this extraordinary success also led psychoanalysts to be concerned that their science may be gradually becoming diluted.

By providing US psychiatry with a powerful vocabulary and a promising therapeutic technique, psychoanalysis had given rise to schools that came to be called ‘dynamic’, in that they accepted the basics of psychoanalysis but modified them in various ways. In the spring of 1952 a conference on psychiatric education took place at Cornell University, under the auspices of the American Psychiatric Association, the American Association of Medical Colleges and the U.S. Public Health Service’s Division of Mental Health. A joint commission of psychoanalysts and other dynamic psychiatrists had prepared an extensive statement on the ‘Principles of Dynamic Psychiatry’ for this conference (Fromm-Reichmann, 1954: 711).

Moreover, the boundaries of psychoanalysis also seemed to be threatened from within. Shortly after World War II, Franz Alexander (1891–1964) and other leading analysts at the Chicago Psychoanalytic Institute caused quite a stir in analytic circles, advocating brief therapy while calling it ‘psychoanalytic’. They claimed that differences between psychoanalysis proper and the psychotherapy they advocated ‘lie merely in the extent to which the various therapeutic principles and techniques are utilized’ (Alexander and French, 1946: vii). Instead, they suggested distinguishing between supportive therapy on the one hand and uncovering or expressive therapy on the other.

All this led to confusion concerning the boundaries of psychoanalysis, which brings us back to the question of borderline patients, whose conditions fell neither typically within nor clearly
beyond the bounds of psychoanalysis. How, then, were psychoanalysts to cope with these patients? The answer to this question demanded, of course, addressing the larger questions of how American psychoanalysis was to configure its boundaries with related and derivative therapeutic outlooks that belonged to the same medical framework, acknowledging affinities while highlighting differences.

**Radical change**

Merton Gill (1914–94) was one of the founding members of the *Western New England Psychoanalytic Society*, who became a training analyst in its institute in 1950 as well as vice president and later president of the society; in 1951 he described psychoanalysis as leading to ‘a revolution in the mind’, effecting ‘as complete a “structural” alteration of the neurotic aspects of the personality as possible’ (Gill, 1951). Gill’s paper offers rhetoric of radical change insofar as the results of psychoanalytic practice are concerned, but portrays non-analytic psychotherapy as recuperative and backward-oriented, aiming at ‘the restoration of the previous integrative capacity of the ego’ (p. 63). In his words, while psychoanalysis seeks to break through the defences of the ego, psychotherapy is appropriate in cases in which breaking through them ‘may initiate more pathological defenses’ (p. 63). On the basis of this argument, Gill places borderline patients beyond the reach of classical psychoanalysis, yet does not relegate them to restorative therapy. Instead, he holds them capable of undergoing an in-between type of therapy, which he calls ‘modified analysis’:

> In borderline cases with marked regression one cannot strengthen the defenses of the ego with the aim of restoring a previous satisfactory adjustment because there was none. In such cases modified analysis is used: it analyzes the transference and the resistances, but only with the assistance of strong supporting techniques to avert the danger of impairing whatever small degree of integration the ego has retained. (p. 64)

**Growth**

In 1952 Knight (1953a) discussed in his ‘Presidential Address to the American Psychoanalytic Association’ the problematic effect such modifications had, in his view, on the psychoanalytic profession. He maintained that since the ‘psychoanalytic technique has been modified in numerous ways in the last decade and a half in an attempt to treat successfully the psychoses, the borderline conditions, the character disorders, and various psychosomatic conditions,’ consensus no longer existed within the profession as to how psychoanalysis is to be defined (p. 216). But Knight stressed that he did not regard the loss of consensus at the core of psychoanalysis ‘as an indication that psychoanalysis is losing its identity and is merging completely with psychiatry and psychotherapy. I would rather think of it as an expansion of the clinical application of psychoanalytic technique to the much wider variety of disorders now encountered.’ (pp. 216–17).

Knight phrases his presentation in terms of ‘growth’. For him, the loss of consensus is a result of an influx of a new generation of medical residents that is a sign of the growth of psychoanalysis, which will lead to further growth or, as he put it in his concluding words, psychoanalysis ‘might be regarded in 1952 as an overgrown adolescent, with more growth in prospect’ (p. 219).

Knight devoted another paper specifically to borderline states, explaining that all the term means is that: ‘the patient is quite sick but not frankly psychotic’ (Knight, 1953b: 1). He held psychoanalysis to be unsuitable for such patients, arguing that it was ‘contraindicated for the great
majority of borderline cases, at least until after some months of successful analytic psychotherapy’ (p. 10). According to Knight, the aim of such a therapy would be to strengthen the patient’s ego. In other words, the role of ‘analytic psychotherapy’ was to play a preparatory role, endowing the ego with the strength that it needed to cope with the demands of psychoanalysis.

The continuum

In an article entitled ‘The widening scope of indications for psychoanalysis’ published in the Journal of the American Psychoanalytic Association in 1954, the prominent New York analyst Leo Stone (1904–97) argued, ‘in the last decade or two, at least in the United States, any illness or problem which has a significant emotional component in its etiology has become at least a possible indication for psychoanalysis’ (Stone, 1954). He singled out ‘that vast, important and heterogeneous group – the “borderline” cases’ among the psychiatric syndromes that he claimed belonged within the scope of psychoanalysis (p. 567). Stone’s rhetoric constructs a broad continuum, along which he places the whole gamut of mental disorders. He describes the field of psychosis, which he places out of bounds for psychoanalysts, as constituting a wide range of its own. Then he moves the borderline from the mid-point between psychotic and neurotic to a location so close to the neurotic that the spatial metaphor makes the inclusion of the borderline in the realm of psychoanalysis seem almost self-evident:

In the psychoses, we have a tremendous range, extending from those who are not independently viable, or who require hospital restraint or protection, or who cannot or will not establish voluntary co-operative contact with a therapist, or — specifically — with his therapy. From these, regardless of the particular type of psychotic expression, there is a continuous gradation down to the incipient or very mild psychotic who complains of his symptoms and seeks help exactly as a neurotic does; and perhaps in the very end zone of this continuum is the ‘borderline’ patient, who is in fact neither medicolegally nor clinically psychotic. (pp. 577–8)

A few pages later, Stone even explains that ‘the “borderline” patient under certain special conditions may be a better patient in the long run, for all of the intrinsic difficulties, than the hysterics’ (p. 591). The reverberation of such a statement within psychoanalytic discourse, whose inception is unthinkable without the hysterics who were Freud’s original and paradigmatic patients, hardly requires further elaboration.

Spreading thin

Anna Freud (1895–1982) opposed extending the jurisdiction of psychoanalysis in the fashion Stone advocated (Freud, 1954). She articulated her position by applying an economic model of scarcity to psychoanalytic knowledge, juxtaposing breadth and intensity, depth and surface, in the development of psychoanalytic theorizing. According to her, the expansion of psychoanalytic thinking had been achieved at the cost of losing intensity at its core:

For years now, our most experienced and finest analysts have concentrated their efforts on opening up new fields for the application of analysis by making the psychotic disorders, the severe depressions, the borderline cases, addictions, perversions, delinquency, etc., amenable to treatment. I have no wish to underestimate the resulting benefits to patients, nor the resulting considerable gains to analysis as a therapy and science. But I regret sometimes that so much interest and effort has been withdrawn from the hysterics, phobic and compulsive disorders, leaving their treatment to the beginners or the less knowledgeable and
adventurous analytic practitioners. If all the skill, knowledge and pioneering effort which was spent on widening the scope of application of psychoanalysis had been employed instead on intensifying and improving our technique in the original field, I cannot help but feel that, by now, we would find the treatment of the common neuroses child’s play, instead of struggling with their technical problems as we have continued to do. (Freud, 1954: 609–10)

As Wallerstein has documented carefully, this debate was resolved by the emergence of a majority consensus on what constituted psychoanalysis proper, which left borderline states beyond the pale of classic psychoanalysis due to their ‘fragile egos’ (Wallerstein, 1995: 86). This consensus was to hold for about a decade and a half through the end of the 1960s, when it was displaced by Kernberg’s influence, but there is no doubt that the debate of the 1950s was to have an even longer-lasting impact on how the boundaries of American psychoanalysis were conceived by many of its mainstream practitioners. As we have seen, leading psychoanalysts portrayed the boundary conditions of psychoanalysis in different ways: some placed borderline patients squarely within its jurisdiction; others allocated them a place at its margins; a third voice demanded special preparatory measures for them; while a fourth advocated expelling borderlines from the domain of psychoanalysis altogether. Although psychoanalysts provided substantively different answers to the question of where to place this boundary object, they concurred in the way they phrased their answers. When psychoanalysts in the 1950s wrote about the boundaries of their profession and the borderline as a boundary object, they did so in a purely psychoanalytic repertoire. Certain of the ascendancy of their profession and its eminent status in American psychiatry, they described patients whom they considered unfit for psychoanalysis as being limited in their mental capacities, rather than describing their own practice as limited. Moreover, they visualized the dispute with psychiatry as a spatial division, and, for the most part, considered the borderline to be located on the boundary between the disciplines. In their eyes, it was the patients’ inability to cooperate, the weakness of their ego, their lack of integrative functions that placed them beyond the bounds of psychoanalysis, making them unsuitable for the radical promises it had to offer – for psychoanalysts who held borderline patients to be unsuitable for psychoanalysis did so mostly by pointing to the radical nature of the psychoanalytic process.

... and in bad

Hitherto, we have elaborated on a phase in which American psychoanalysis was an ascendant discipline; now we turn to the 1990s, a period characterized by severe decline and by the comprehensive dismissal of the relevance of psychoanalysis to the understanding and treatment of schizophrenia. One might, perhaps, divide this development into four stages. The first stage was ushered in by the introduction of neuroleptic medication as the cheapest and most effective therapy for schizophrenic patients during the late 1950s and the beginning of the 1960s. This innovation played a major role in a much wider revolution initiated by John F. Kennedy’s ‘New Frontier’, the de-institutionalization of the mentally ill, and the rise of community psychiatry (Lerman, 1982; Scull, 1984). The second stage included two further formative events during the 1970s: Snyder’s (1976) ‘Dopamine Hypothesis’ and Kety’s genetic findings concerning schizophrenia (Kety, Rosenthal and Wender, 1978) were considered the two major accomplishments of psychiatry during this period (Strauss, Yager and Strauss, 1984). They engendered a neo-somatic trend in psychiatry in general and most prominently in the field of schizophrenia. The third stage was initiated in the beginning of the 1980s, with the publication of the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) by the American Psychiatric Association. Much more than simply a manual, its appearance was accompanied by a plethora of courses,
educational presentations and instructional aids, which became a growth industry of their own (Skodol, 2000: 439; see also Skodol, Spitzer and Williams, 1981). All these developments conjoined to replace the psychodynamic view of mental disorders by a neo-Kraepelini an phenomenological approach that lacked aetiology and theory, thus implicitly declaring dynamic psychiatry and psychoanalysis to be obsolete (Wilson, 1993). The DSM-III led to a dramatic and decisive shift from Freud to Kraepelin, from dynamic thinking to descriptive psychiatry, in other words, from the search for what is ‘behind the symptom’ to the phenomenology of what was visible. Through this trend, the borderline entered the classification system of the DSM-III in the guise of a distinctly recognizable ‘borderline personality disorder’. This, of course, sparked research; as Gunderson (2009: 532) reports, ‘until 1980, fewer than 15 research reports on borderline personality disorder had been published; in the decade from 1980 to 1990 more than 275 appeared’ (see also Andreasen, 1989: 525–6).

This short and admittedly unsatisfactory sketch of three stages, spanning the period from 1960 to 1990, is all that can be provided here to set the scene for a more detailed exploration of the discursive strategies American psychoanalysts deployed in the fourth stage, which commenced at the beginning of the 1990s. At that time, most psychiatrists regarded schizophrenia as marked primarily by hallucinations, delusions, as well as severe cognitive and social dysfunctions. They traced the disorder to a biological infrastructure, above all to functional abnormalities of the frontal lobe with a hereditary and genetic background, which necessitate pharmacological means of treatment. How did American psychoanalysts respond to this view? As we did in our discussion of the psychoanalytic debate on borderline, we wish to highlight some of the discursive strategies American psychoanalysts used in a rearguard battle over jurisdiction against psychiatry, while also trying to keep the channels of communication open. This time, however, we focus on the way psychoanalysts attempted to take up a professional stance towards schizophrenia itself, rather than towards a boundary phenomenon, such as the borderline of the 1950s (which, as pointed out above, since the late 1960s has no longer been considered to be situated on the boundary of schizophrenia).

In traditional psychoanalytic terms, such patients have no significant ego strength and are presumed by most analysts to be incapable of forming a transference relationship with the analyst. One might argue, therefore, that schizophrenic patients are completely outside the scope of psychoanalysis. However, things are not that simple: there have always been psychoanalysts who sought to include schizophrenic patients in their professional jurisdiction; even Freud treated a few psychotic patients. Not only did he comment on schizophrenic delusions, such as those of the paranoid judge Paul Daniel Schreber, but he also supported Ernst Simmel (1882–1947) in opening the Tegel psychoanalytic sanatorium that accepted schizophrenic patients. However, by and large, Freud’s engagement remained a theoretical one.

Strange bedfellows

One major discursive strategy pursued by psychoanalysts was to subsume psychoanalytic terminology into the biological idiom of schizophrenia prevalent in American psychiatry at the time, for example, by defining the pre-schizophrenic condition as a ‘genetically constituted disturbance in the limbic system’ (Greenberg, 1993: 1023). They justified integrating neurobiological terminology into their discourse by referring to neurobiology and psychoanalysis as ‘neighbors’ (Robbins, 1992: 428). Not only were the different symptoms understood as related to a variety of brain structures (Willick, 1993: 1148), but also the treatment of these conditions was now sought in (at least partial) psychiatric medication, as suggested by the New York psychoanalyst Eric
Marcus (1999: 846). This fusion of somatic psychiatry and psychoanalysis led to a rather strange hybrid discourse, conjoining the concrete terms of neurology with the abstract concepts of psychoanalysis, thus enabling suggestions to study, for example, the effect of medication on ego functions (Marcus, 1996: 573).

Of course, psychoanalysts advocating this line of thought did not deny that schizophrenic patients had psychological conflicts that could be treated by means of psychotherapy, but they argued, like Martin Willick (1993: 1136), that these conflicts ‘are taking place in an ego whose functions are impaired by biological abnormalities’. According to Willick, ‘we can be successful in achieving an integrated and comprehensive understanding of schizophrenia only if we abandon questionable formulations about etiology and pathogenesis, formulations for which there is little supporting evidence.’ (p. 1155). Since all accepted that psychoanalysis could not contribute to the aetiology of schizophrenia, at best it could hope to formulate ‘a correlation of recent findings of abnormalities in brain structure and function in schizophrenia with the pathology that we have described from the psychoanalytic point of view’ (p. 1141).

How did psychoanalysts justify the biologization of their discourse on schizophrenia, which, at least superficially, seems to run counter to the emphasis psychoanalysis places on meaning and the mind? Often they legitimized such a move historically, by the resurrection of Freud as a brain scientist and by placing emphasis on the importance of his early studies on anatomy, thus expanding the boundaries of psychoanalytic jurisdiction, as it were (Greenberg, 1993: 1018). Freud’s two best known biological writings, ‘On Aphasia’ and ‘The Project for a Scientific Psychology’, were often invoked as the seal of approval for a biologized psychoanalysis in the decade of the brain. Proponents thus increasingly argued that with the advancement of technology, molecular biology, brain imaging, genetics and computer models, psychoanalysis could finally continue where Freud himself had left off when he had abandoned his ambitious ‘Project’ (Olds and Cooper, 1997: 219).

Ancillary services

Another way of accepting the dominance of somatic psychiatry and biological aetiologies was to present psychoanalysis as an auxiliary profession in the treatment of schizophrenia. During the 1950s, psychoanalysts regarded dynamic psychiatry and other psychotherapies as preparatory devices, necessary for patients whose ego was considered too weak to cope with the radical structural transformation that psychoanalysis was to effect in their minds. By the 1990s, the tables had turned and some psychoanalysts tried to present psychoanalysis as helpful by suggesting that it could support patients in coping with the difficulties posed by somatic therapies. In the 1950s psychoanalysis was still relevant, Willick suggested, because of the crippling side effects that medication had at the time, due to the inhuman treatment techniques of somatic psychiatry such as psychosurgery and multiple insulin shocks (Willick, 2001), and since cognitive behavioural, psycho-educational and rehabilitative techniques were still very much ‘in their infancy’ (Munich, 1999: 939). With this kind of response to the somatic triumph, the New York psychoanalyst Richard Munich, who still serves on the editorial board of the prestigious Bulletin of the Menninger Clinic, suggested that while the increasingly effective neuroleptic medications were rightly becoming the main treatment for schizophrenia, psychoanalysis could still be of use, by helping recuperating patients ‘fill in the missing pieces of their humanity with adaptive skills and an interpersonal repertoire’ (Munich, 1999: 943; see also Munich, 1987, 1997). Martin Stone’s keynote address at the Annual Meeting of the American Academy of Psychoanalysis in 1998 also expressed acceptance of the ancillary position of psychoanalysis in treating schizophrenia:
Our views about the most effective psychotherapeutic interventions have changed dramatically over the past 25 years. There is general agreement that analytic psychotherapy is not effective with schizophrenic patients, although the insights about their often unusual dynamics … are useful to therapists in helping them fashion more effective alternative treatment methods. We currently place greater reliance on rehabilitative measures and on social skills training, by way of helping schizophrenic patients compensate for the deficiencies in understanding and in coping with the social field that so commonly hamper their efforts to live harmoniously in the community. (Stone, 2000: 213)

**Holding on**

Some analysts sought to develop conceptual models that preserved an equal status for psychoanalysis. Michael Robbins, in a paper originally presented at the Annual Meeting of the American Psychoanalytic Association in New York in 1990, suggested regarding neurobiological and psychoanalytic findings as ‘equally valid’ (Robbins, 1992; see also Robbins, 1993).

Contiguous theoretical domains in such a hierarchical system, such as neurobiology and psychoanalysis, must meet certain requirements. Each must respect its limits and the autonomy of its neighbor, and avoid hypotheses and assertions that tend to penetrate and reductively consume the other’s domain. And they must be compatible, consistent, and congruent with one another at their interface or boundary. The requirement to abstain from reductionistic consumptive efforts devolves mostly upon the lower-order discipline (neurobiology), and the responsibility to adapt or be consistent rests mostly on the higher-order discipline (psychoanalysis). Neurobiological theory may properly attempt to account for both normal and disordered mental functions, and for the effects of thinking and meaning on the nervous system, including the effects of psychoanalytic treatment, but it must respect that these are not reducible to biology. … But in order to function in a hierarchical system, the domain of psychoanalytic theory is constrained by limits, as well. Psychoanalytic theories of mental illness ought to be compatible with, or at minimum not incompatible with, known neurobiological findings. (Robbins, 1992: 428)

While presenting neurobiology as being a ‘lower-order’ discipline and describing psychoanalysis as belonging to a ‘higher order’, Robbins regards the two approaches as independent, urging mutual respect and restraint, so as to allow them to complement one another. ‘Of course, I would not be advancing these arguments were it not that years of clinical experience treating hospitalized schizophrenic patients with intensive psychoanalytic therapy has taught me that a significant minority of such cases may be treated very successfully.’ (Robbins, 1992: 433; see also Robbins, 1993). Robbins can claim the talking cure to be effective even in severe disorders with a biological groundwork because he defines the latter as ‘vulnerabilities’ only, thus denying them any direct pathogenic effect in the absence of additional psychosocial and psychodynamic factors.

**Counter-attack**

The discursive strategies presented above constitute attempts to enter a close cooperation with somatic psychiatry, while acknowledging psychiatry’s supremacy or accepting that the scope of psychoanalysis should be narrowed. However, during the 1990s, psychoanalysts were sometimes reduced to demanding at least to be tolerated by biologically and pharmaceutically-minded colleagues. In 1998 the US National Institute of Mental Health (NIMH) published treatment recommendations in the *Schizophrenia Bulletin*, which were formulated by the Schizophrenia Patient Outcome Research Team (PORT) (Lehman et al., 1998). The PORT gave detailed recommendations for the treatment of schizophrenia, advising that individual and group psychotherapies adhering to a psychodynamic model should not be used in the treatment of persons with
schizophrenia. In fact, recommendation 22 declared such treatments as harmful, even when undertaken in combination with pharmacotherapy, stating explicitly: ‘Individual and group psychotherapies adhering to a psychodynamic model (defined as therapies that use interpretation of unconscious material and focus on transference and regression) should not be used in the treatment of persons with schizophrenia.’ (Lehman et al., 1998: 7; original italics).

Evidently, this recommendation amounted to an official exclusion of psychoanalysis from the field of schizophrenia, denying it what little jurisdictional powers its practitioners still tried to claim. In response, the International Society for the Psychological Treatments of Schizophrenia and Other Psychoses (ISPS) established a task force and its US chapter, led by Ann-Louise Silver, organized a group of professionals that produced a selection of papers dealing with the indispensability of psychological (as opposed to biological) treatments for schizophrenic patients (Silver and Larsen, 2003). Surprisingly enough, this critique succeeded in changing the PORT recommendations; a revised version was published, omitting the recommendations directed against dynamic therapies, although the psychosocial interventions that were recommended were clearly in no way psychoanalytic or dynamic (Lehman et al., 2004). This example shows that even at the turn of the century, American psychoanalysts could still mobilize effective discursive resources in a dispute with a much more powerful professional group.

Members of the ISPS argued that somatic psychiatry still lacked animal models, biological markers or aetiological evidence for schizophrenia, and that proofs and documentations for the modern biological thesis were not yet available, in spite of the availability of powerful new scientific instruments (Silver and Larsen, 2003). Medication was said to offer only symptomatic relief, while psychoanalysis offered a change in the morbid process itself (Nagler, 1991). Moreover, Silver (1993) argued that pharmaceutical treatment interfered with the work of analysts with their patients and claimed that the conviction that schizophrenia is simply a brain disease requiring medications brought ‘hopeless and broken people’ to be ‘warehoused, their suffering ignored’ (Silver and Larsen, 2003: 2).

In his presidential address to the Division of Psychoanalysis of the American Psychological Association in 1991, Bertram Karon not only opposed biological explanations and treatments, but also psychoanalysed those advocating them.

In our time, psychoanalytic psychotherapies for schizophrenia are not fashionable; not because they are not helpful, but because they make therapists, as well as the public at large, so uncomfortable. It is usual to assume that this discomfort is felt because schizophrenic people are extremely different from the rest of us, but the truth is just the opposite. What makes both professionals and the general public alike uncomfortable with schizophrenic people is not so much their difference from us, but their similarity. We do not want to know what they have to teach us about the human condition. (Karon, 1992: 191)

According to Karon, somatic psychiatry does not bring us knowledge; rather, its theories and pharmaceutical treatments fulfil a defensive function, justifying our refusal to ‘grasp painful facts about the human condition that we would rather not know, or, more frightening, to be reminded of painful facts we once knew, but repressed’ (Karon, 1992: 198). Since he considered biological aetiologies of schizophrenia defensive and misguided, he offered a purely psychoanalytical aetiology of schizophrenia, bringing back the concept of schizophrenogenic parents (Karon and Widener, 1994).

To sum up: as the psychoanalytic publications of the 1990s on schizophrenia show, American analysts responded to their marginalization in American psychiatry in (at least) four different ways: some adopted the language of the ‘conquering profession’, declaring it to be their ‘father’s tongue’; others sought to prove their relevance as auxiliaries; a third attempt was to offer complementarity
on the basis of mutual respect and equality, while an organized, fourth group denied the validity of biological research, attempting to protect the jurisdiction of psychoanalysis in the field of schizophrenia by sticking to psychogenic aetiologies as well as claiming efficacy for analytic treatment.

In fact, the significant difference in the tone of the 1990s debate in comparison with that in the 1950s is quite striking. During the 1950s, psychoanalysts formulated their responses to the question of whether borderline patients were strong or healthy enough to be able to cope with the difficulties of classic psychoanalysis, or whether they had to make do with other forms of therapy that were considered less radical. In the 1990s, psychoanalysts phrased their positions from a different perspective, for now they had to take a stand on the issue of whether psychoanalysis could provide the knowledge and the therapeutic practice needed to treat schizophrenics. While psychoanalysis had ruled the field in the 1950s, defending its role as the senior and superior partner vis-à-vis other, supposedly less demanding methods of treatment, in the 1990s psychoanalysis had to face the challenge of proving that it still possessed the strength to refuse being dismissed as a geriatric leftover by its energetic, somatically-oriented and pharmaceutically equipped neighbour. Interestingly enough, under these conditions, the spatial metaphor no longer figures in psychoanalytic discourse in order to conceptualize boundary relations. It has given way to hierarchical images of higher and lower disciplines, dominant and ancillary tasks, and, perhaps, mutuality.

Conclusion

We have argued that discourse analysis is a fruitful approach to the history of psychoanalysis after 1945. Why is discourse important? Professions cohere not only by means of institutions, such as associations, institutes and licensure procedures, but also by constructing and gathering around a shared professional discourse on their particular expert knowledge and practices. Mental health professionals, such as psychoanalysts, manifest their professional identity not only in their clinical practice and in institutional structures, but also in the way they articulate and formalize their knowledge, disseminating it among their fellow practitioners. Thus, it is important to take note of the variety of discursive strategies that are to be seen at once as cognitive and social processes by means of which a profession legitimates its jurisdiction from within, deploying these strategies also in its struggles and dialogues with other professional groups.

Within this discourse-analytic outlook, we have advocated a method of reading that focuses on multiplicity (of voices), instability (of boundaries), duality (of defence and dialogue) and on simultaneity (of internal and external addressees). We have chosen to illustrate this approach by providing two loosely interrelated examples, referring to the ways in which US psychoanalysts sought to communicate within and across the boundaries of their disciplines at two different points in time. As we have seen, such attempts spark discursive strategies that deploy metaphors and conceptual framing in order to delineate boundaries, and to expand, retract or transcend them. While noting the multiplicity of voices, we have also discerned a certain basic rhetorical stance shared by the various psychoanalysts – a common vantage point informing their arguments, be it a spatial metaphor or a more hierarchical ordering of disciplines that is implicit in what they write. Reading psychoanalytic publications from this angle involves considering arguments concerning therapy and mental illness as strategic acts in a discursive field – though they are always also more than that. Of course, writing the history of postwar psychoanalysis (of US psychoanalysis in our case) from this perspective does not supplant other histories. But it highlights the interdependence of psychoanalysis with its neighbouring professions, its enmeshment in a continuous internal and external struggle and dialogue, which play a crucial factor in its development and self-understanding as a therapeutic profession, though hitherto they have not been explored adequately. Moreover, it
counteracts the excessive emphasis that is sometimes placed on the positions of the eminent figures in the psychoanalytic canon, which are taken as emblematic for institutes, associations or the entire discipline at a given period. By noting the disparate and often conflicting stands taken by leading psychoanalysts as well as by less prominent members of the profession whose views were published in psychoanalytic journals, one becomes aware of the range of options in boundary relations that were available and articulated at any point in time. Raising more questions than providing answers, perhaps, this form of analysis may invite scholars to pursue further research into the relative weight, advantages and disadvantages of different discursive strategies that were attempted and advocated by psychoanalytic authors in order to position their discipline vis-à-vis psychiatry and other neighbouring professions, exploring why some prevailed while others were disregarded.

Acknowledgements
The authors are grateful to two anonymous referees for their insightful and critical comments, and to the editors for their advice and patience.

Notes
1 For the use of Abbott’s model with reference to American psychoanalysis, see: Eisold, 2007; Winter, 1999.
2 There has been much talk of social and cultural boundaries, as well as of their intersection. A variety of boundary processes have been scrutinized closely, such as boundary construction, institutionalization, subversion and displacement, as well as boundary crossing, bridging and violation. Rigid boundaries have been distinguished from fuzzy ones, aesthetic boundaries from moral ones. Sociologists have been pondering the social role of cognitive boundaries for quite some time, starting, perhaps, with Emile Durkheim’s classic exploration of the distinction between the sacred and profane, through Claude Lévi-Strauss’s structuralist approach to myths and Mary Douglas’s investigation of the categories of everyday knowledge. For the various topics and approaches in this field, see: Abbott, 1995; Douglas, 1966, 1973; Durkheim, 1912; Fuller, 2003; Galand and Irvine, 1995; Gieryn, 1983; Lévi-Strauss, 1958/1973; Pachucki, Pendergrass and Lamont, 2007.
3 For a social analysis of the change in schizophrenic symptoms, see Metzl, 2009.
4 Other psychoanalytic authors used other schizophrenia-related terms for these patients during the 1940s and 1950s, e.g. Federn, 1947; Zilboorg, 1941.
5 Stone was to head the New York Psychoanalytic Institute and Society in the 1970s.
6 On the fragmentation of the consensus, see Wallerstein, 1995: 124–61. On the continued impact of formulations of the mid-1950s, see e.g. Grand, 1995.
7 For a concise account of psychoanalytic approaches to schizophrenia, see Stone, 1999.
8 In 2009 Willick gave the 43rd Brill Lecture under the title: ‘From Freud’s Schreber to modern neurobiology: evolving concepts of schizophrenia’; see also Willick, 1990.

References


