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Patients, problems and borders: psychoanalysis and *borderline* cases

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Abstract: The article deals with the clinical condition known as borderline disorder and is derived from an examination of psychoanalytic literature on the case. Our goal is to provide systematic information so that readers can delve into the subject, or even so that they can confront their positions with those of various authors. We'll discuss the several definitions and nomenclatures, psychodynamics, symptoms, etiology, therapeutic techniques, common problems during treatment and the general aspects of the transference and countertransference. In the end, we'll offer a contribution in the psychodynamics, which refers to the identification in the literature of the idea of a borderline object that is part of the psychodynamics essence of the case. In addition, we will analyze the information examined using the idea of borderline object as guideline.

Keywords: borderline cases, psychopathology, psychoanalysis, borderline states, borderline object.

Introduction

The borderline cases, also called borderline states, comprise an area of scientific research, known by the difficulties that these patients present to professionals. It is possible to notice a form of attraction or repulsion immediately to such cases, especially by those using psychoanalysis in its clinical or academic practice, either because of the difficulties in the management of patients, or because of the diversity and lack of cohesion of the theory. For these reasons, we examined the psychoanalytic literature on the borderline disorder (Santos, 2017), which was intended to give some organization to literature through a review that encompassed the beginning of discussions around borderline cases on the 1930s until the current time.

Although we did not in narrow the limits of the research conducted, from which this text is a product, it is necessary to inform the reader of what was accomplished. With a large problem as direction – "What is a borderline case?" – we seek scientific works of authors that, to our view, started from a similar question. We use the PsycINFO search engine using the terms *psychoanalysis* and *borderline disorder.* With this procedure, we found 620 articles references, whose abstracts were read in order to enable the selection of texts attempting to define or understand what is the borderline disorder and the difficulties that it presents to its treatment. In the end, we have selected 45 articles for review, with publication dates stretching from 1930 to 2016.

Our research has had a historical bias, because we compare to each other texts of several decades. This article is not going to do it; However, we include in the review the earliest texts.

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General aspects of the psychoanalytic literature on the *borderline disorder*

Something clear in the literature on the borderline is the absence of a precise definition of what would be this psychopathology and the wide variety of uses of the term. It cannot be said that the definition of psychopathologic categories in psychoanalysis is very accurate, but the borderline disorder seems to be the one that presents the most difficulties in this sense. Zilboorg (1956), for example, says that the psychopathology area corresponding to the borderline is a theoretical penumbra. Green (1977/1986), for its turn, says this area corresponds to a no man's land.

The term borderline, in its origin, refers to a division, a border. Generally speaking, in psychoanalysis, it is the border between neurosis and psychosis. This is perhaps one of the few aspects consolidated and accepted in the early period of investigations. Glover (1932, p. 841), for example, claims that the borderline disorder has "one foot in psychoses and another in neuroses," something that illustrates what we said. Nevertheless, as we shall see, this fact became moot when authors such as Kernberg (1967) proposed the idea of the borderline disorder to be a specific structure and not a mixed phenomenon, or even border.

Another author who refers to the borderline as border between neurosis and psychosis is Stern, whose study (1938) is known as one of the early landmarks of the research subject, describing the typical symptoms of patients he answered (among others, hypersensitivity, rigidity in personality, feelings of inferiority, deep insecurity and difficulties in examining the reality, especially focused on interpersonal relations), as well as the need for changes in classic psychoanalytic technique so that treatment can be possible.

The disposition between neuroses and psychoses and the differences in nomenclature

As we said, the borderline disorder, to the first authors, is seen between neuroses and psychoses. However, the definitions are not the same since 1940. Therefore, several positions arise.

For some, for example, the borderline disorder is not even psychosis, nor neurosis (Deutsch, 1942/2007; Schmideberg, 1947/1986). On the other hand, there are authors who claim there are neurotic and psychotic mechanisms in borderline (Knight, 1953) – and may or may not be an agreement with the idea of border. A third position we found comes from authors who propose to the borderline a psychodynamic of its own (Bychowsky, 1953; Hoch & Polatin, 1949; Kernberg, 1966).

We can illustrate this third position by referencing Otto Kernberg (1966, 1967, 1968), author of great importance in psychoanalysis on the borderline. When developing the concept of borderline personality organization, he brought cohesion and systematization to the concept, defining the disorder as "not only transitional, acute or chronic states, between neuroses, on the one hand, and psychoses, on another, but a specific form and remarkable egoic pathological structure" (1966, p. 250).

As the authors have the borderline disorder in different positions regarding neuroses and psychoses, the nomenclature also diversifies. That is, there are a variety of terms created as an alternative to "borderline," which aim to establish a more precise diagnostic label. This is something notable especially in previous years to the 1960s. For example, Zilboorg (1941) suggests the term "ambulatory schizophrenia" because he noticed in patients he diagnosed as frequent borderline transient psychotic episodes.

On the other hand, it is possible to note on psychoanalytic literature criticism of all this terminology or, better, of an excess of terms that it can be noted. Zetzel (cited by Rangell, 1955), for example, states that the term borderline, in its time, had become a real "garbage dump", because the authors diagnosed as borderline a wide variety of cases, covering many symptoms and deranging the concept.

Psychodynamics: behaviors, symptoms, metapsychology and etiology

In this section, we'll start showing the characteristics of the patient, i.e. specific behaviors, even if not exclusive, which are grouped in the diagnosis label of borderline and are manifested or interpreted during treatment. We will first discuss the characteristics or symptoms related to the subject and then others addressed to the environment, following the division that we perceive to be made, in general, by the authors.

Let's start with aggression. Throughout the literature, this point is treated as important and evident in those patients (Bychowski, 1953; Kernberg, 1967; Zepf, 2012). Zilboorg (1941), for example, speaks of an aggressiveness that cannot be contained, which resembles that of what Hoch and Polatin (1949) says: the hatred reactions of the borderline patient are very intense. Other notable element about the aggressiveness is that aimed at the subject itself. Eisenstein (1951) points the high risk of suicide, and Bion does in regard to suicide threats. Likewise, Stone (1992) points out the frequent self-harm behaviors. In any case, such events are now well known, both by psychoanalysts as psychiatrists.[1]

Another important symptom of the frame would be the lack of identity (Mitchell, 1985; Rosenfeld, 1978); in other words, lack of organization and continuity feeling of features that the individual understands as its own in several aspects, such as sexual desires, work desires, among others. This point is examined in detail by Kernberg (1967), also mentioned by Fonagy (1991), when he talks about a fragmentation in the sense of identity. To Deutsch (1942/2007), the lack of identity is perceived by the constant imitation behaviors employed by borderline patients. For her, it's as if they act in an unusual manner, not in a very genuine manner, i.e. in disagreement with its wishes.

A third symptom that the psychoanalytic literature highlights is the instability of mood (Fonagy, 1991; Mitchell, 1985; Schmideberg, 1947/1986), especially the impulsive behaviors (Kernberg, 1966) and also unpredictable (Fonagy, 1991). Here, it is possible to notice a convergence with the symptoms described earlier, since the absence of identity can be noticed by the environment, causing the behaviors of the borderline subject to be seen as unpredictable. In addition, the intense aggressiveness of the borderline could encourage impulsive behaviors.

On the characteristics of patients who appear to be directed to the environment, we're going to highlight, in the first place, the lack of autonomy. That is, the borderline would not develop the ability to be independent (Zilboorg, 1941) or to tolerate separations (Zetzel, 1971). To Stern (1938), beyond the difficulty in these points, there is also a feeling of inferiority regarding others.

However, there is one aspect of the borderline disorder, as seen by some authors, which highlights a type of interpersonal relationship that makes clear a contradiction. To authors like Stern (1957) and Eisenstein (1951), respectively, patients present a strong demand for love and affection, something close to the dependency mentioned before; However, they address intense hostility and aggressiveness to the person they feel dependent to (Eisenstein, 1951).

This apparent contradiction is explained by Gunderson and Singer (1975/1986), for whom the romantic relationships of the borderline patients are superficial

1 As well notes Giusti (2013), for the DSM-IV, self-mutilation or self-harm is one of the criteria for the diagnosis of borderline personality disorder. The DSM-V, on the other hand, suggests that self-harm behaviors should be classified in a category of its own.

with some people and intense with others. However, it is Adler (1988) that deepens the understanding of this contradiction. He speaks of a dilemma need-fear, in which the borderline individuals get too close to an object and become dependent of him. They feel threatened then, which can reach an intolerable level, up to the point where the individual leaves the object. That is, they need and want a relationship, but feel threatened by their dependence on the object.

Deutsch (1942/2007) and Stern (1938) called the attention to the importance of narcissism in that case. Something that is very focused in the bibliography reviewed is about the anguish that can unfold in this pathology. An anguish quoted as central in borderline pathology is annihilation (Luz, 2010). Frosch (1988) states that the basic conflict of the borderline is the fear of disintegration. To Green (2000), this anguish appears in the fear of becoming insane, or even in the fear of the individual not being able to protect the boundaries of his individuality, that is, to lose its psychological borders.

Also something interesting is the defense mechanisms. As for these, what we notice is the emphasis on division or dissociation. To Rosenfeld (1978), for example, it is intense to the point of generating confusional states, where aggressive parts attack libidinal parts of the *self*, which is projected in the environment, making it persecutory to the said borderline individual. Green (1977/1986), for its time, says that such division, combined with depression, explained as radical disinvestment, creates empty states in mind. For this author, two dissociations occur in this patient: one between the psychic and the non-psychic, and another within the psyche, where isolated capsules are formed in the ego, remaining without communication (Green, 1977/1986). On the other hand, Zepf (2012) proposes the idea that the *splitting* is a concept used by psychoanalysts as a "jargon," i.e., is employed in a variety of ways, with multiple definitions, which decreases its explanatory value and its communication.

Be that as it may, the idea that the splitting is at the core of borderline psychopathology is very important and is enhanced by another one, the existence of a psychotic germ, that has the potential to generate psychotic breakdowns and works as a split part of the ego (Bychowski, 1953). This idea, close of a borderline object, will come back at the end of our article.

About the etiology, what we notice is the repetition of three main ideas as an explanation for the development of the disorder: (1) linked to traumatic factors, (2) concerning the relationship with their parents and (3) concerning the existence of a strong aggressiveness on the individual. These causal factors are not exclusive, of course, but there are no authors who speak of the three together.

About the traumas in the etiology of the borderline, we see in Greenacre (1941/2010) to appear as in pre or post-natal care, leaving organic marks, a source of anguish. Frosch (1988), for its time, is another author who mentions traumas in childhood, however, more than 40 years before, Stern (1945) spoke of something a bit different; According to him, the borderline individual lives in a traumatic environment, where there is not necessarily a major trauma, but there are constant events that cause the child to experience everyday conflicts and situations as if they were traumatic.

On the relationship with parents as etiological factor, Deutsch (1942/2007) speaks of weakness in identification, and Bion (1959/2013) speaks of denial, by the mother, of the use of projective identification mechanism, which makes communication and the bond between mother and baby impossible. Adler (1988), in its turn, maybe in a Winnicottian way, speaks of parental failures to understand the needs of the child, which grows without internal security.

The third factor we mentioned is the aggressiveness. According to Bion (1959/2013), on the borderline patient there is an innate disposition to hatred, destructiveness and excess envy. Zepf (2012), however, claims to be the environment that has aggressive action on the child, who, stimulated, express its own aggressiveness.

Therapeutic techniques and problems during treatment

There are different approaches in psychoanalysis for borderline cases. On the one hand, there are authors like Schmideberg (1947/1986), who claim that it is impossible to use psychoanalysis in its classical form and recommend the development of a specifically modified psychotherapy; on the other hand, there are authors who claim to be necessary a part of psychotherapy of support, then the use of psychoanalysis itself (Knight, 1953; Stern, 1938). There are, however, some authors, such as Bollas (1996), who criticize psychotherapies for being a form of support to the false self of patients, because they avoid their primary desire, the desire of turbulence.

There are authors who propose the use of psychoanalysis without modification, but make recommendations that, somehow, are changes in classical conduct. Eisenstein (1951), for example, advises to avoid regressive situations. For this, it is suggested to not use the divan and the free association. Along these same lines, there is a proposal of Zetzel (1971), which indicates to avoid ambiguous countertransference manifestations, since they can promote regressive situations. Stern (1945), by its side, recommends a more active posture, because the silence of the analyst is painful.

About the interpretations, Schmideberg (1947/1986) states that they can cause discomfort and distress, so, their form would be more important than their content. That is, taking into account the possibility of interpretations that cause distress leading to the patient to give up, this author insists on the importance of interpretations that have the effect of reassuring the patient. Luz (2009), for its part, emphasizes something that we believe to be very

important: the need of the analyst to support and feel the pain of the patient and not just understand it, so that the individual can tolerate the interpretations. For the author, the analyst must choose between protecting the setting or the patient; If he is strict with rules of setting, he may lose important information, and also the analysis can serve only as a repetition of the trauma.

In addition to recommendations, we find among the authors important notes about problems that arise during treatment. To Stern (1938), there are frequent adverse reactions to therapy and lack of associations. Fonagy (1991) and Green (2000) agree with those statements, at least with respect to lack of associations. In addition to these problems, several authors speak of the occurrence of psychotic episodes.

To Greenacre (1941/2010), this occurs when early interpretations of the transference are made and, as a result of thinking that they are caused by the psychoanalytic process, the author called them "psychoanalytic delusions". Hoch and Polatin (1949), in their turn, speak of "micropsychosis," which are short psychotic episodes with possibility of reintegration and could occur during analysis. Nevertheless, in the text of Rosenfeld (1978) we perceive the proposal to use these episodes in favor of analysis. For him, what occurs is the psychotic transference, namely psychotic manifestations in non-psychotic patients. The author tells us that, during this period, the interpretations have no effect, but despite threatening the psychoanalytic process, psychotic transference does not destroy it and can even open new avenues for analysis by making clear the most traumatic points of the patient's life.

Transference and countertransference

As we have seen and as we all know well, the patient that we are treating, through the authors, presents great difficulties in transferring. Let's talk about them.

For Stern (1948), for example, the transference of the borderline individual has childish aspects, pre-oedipal, as if we were treating a traumatized child. Facing this situation, the author proposes to the practician to avoid intense situations of anguish, suggesting face to face care. For Kernberg (1966), in general terms, what occurs in the analysis of borderline cases is a transferential chaos. This happens, according to the author, due to the pathological split that occurs in psychodynamics, where borderline patients develop egoic separate states, which are activated in oscillatory manner, generating chaotic manifestations in transference (Kernberg, 1966).

Also, about the transference, it is interesting to bring something about the link between analyst and patient. There are authors who speak of a complicated link, especially in the early decades of discussion, but not only, as Schmideberg (1947/1986); Zilboorg (1956), by its side, talks about a cluttered link; and Kernberg (1967) speaks of a symbiotic connection.

Rosenfeld (1987) somehow speaks of the primitive bond, saying that projective identification, which occurs heavily in the borderline disorder, generates a state merged with the analyst, which may reflect a desire for symbiosis. In addition, the bond formed by the projective identification raises a state in which the patient feels persecuted by the analyst, once he casts on him the attacks that make to its libidinal part (Rosenfeld, 1978). Nevertheless, projective identification is a way to establish communication between patient and analyst, if the analyst can be the continent to that is designed to him (Rosenfeld, 1987).

Another point about the link or bond relates to the fact that the analyst becomes a source of distress to the patient. For Bollas (1996), that would be a kind of bond. Bateman (1998), another author talking about a link of this type, suggests that the analyst should get involved in the terrors of the patient. Finally, Luz (2009) tells us that the analyst must live together with the turbulence of the borderline patient so that a pair of work can be built. In other words, taking into consideration the complication, lack of order and the search for symbiosis, that can occur in that bond, some authors propose to see there not attacks of the patient seeking a breakup of the pair, but the way in which he can bind.

Other common problems that occur in the transference, according to Bion (1959/2013), concern attacks on the ability to think of the analyst, through performances, delinquent acts and suicide threats. To the author, these attacks are based on envy felt by the patient by the analyst's ability to bear the contents of the patient communicated via projective identification.

A particular problem is the misunderstanding of interpretations, given the predominance of non-verbal communication (Rigas, 2012). To Luz (2009), the transference interpretations are insufficient, because there is intolerance to frustration and inability to symbolize. So, the "here and now" of the session is a priority, as well as information about the transference.

A point that also matters is countertransference. Winnicott (1947/1994) gives this point priority in saying that the analyst must be aware of the possible hatred that he will feel of the patient. The patient, therefore, will feel that he can be loved when he sees he can be hated. Eisenstein (1951) recommends that the analyst keep in touch with their own content, because the analysis with borderline patients may cause irritation.

Finally, Green (1977/1986) states that countertransference is an essential tool in the analysis of borderline cases, because the non-verbal communication is massive. That we've seen, back when we mentioned the role of projective identification in these cases.

Finishing: the idea of a *borderline* object

This idea of a borderline object, taken as essential in the psychodynamics of the disorder, is not ours, as we

will explain below; is only alluded to in the literature. What we propose is its development, from the information we presented. It is, however, the beginning of a development, an indication of a few lines to it.

We started thinking about developing the idea of a borderline object from the reading of the text of Bychowski (1953), in which the author proposes the idea of a psychotic germ on the said borderline individual, formed by early states that remain intact due to the action of the splitting. As already mentioned, the author has given this name due to the psychotic breakdowns that sometimes afflicted the patient. This idea prompted us to think there was something in the psychodynamics of borderline disorder that could be its own. We looked for other authors that spoke of something similar.

We have seen that Glover (1932) talks about how one part of the examination of the reality of borderline is linked to drug addiction, while the rest remains isolated of this portion. In Stern (1945), we saw the idea of a deformation in the borderline's ego.

Later, in the 1950s, Bion (1959/2013) spoke of a hostile and persecutory object in the psyche of the borderline and that destroys its bonds. Who, however, mention directly the idea of a borderline object is Bollas (1996), when talking about a primary object, which looks for the accident and feeds itself from the turbulence. To the author, this object would be part of borderline personality.

These ideas, as we said, prompted us to think about the possibility of a borderline object. What we do here, while developing the concept, is to investigate what grounds this hypothesis would have on the literature we cover.

On the nature of borderline object, we separate two ideas that aid us: (1) to Bion (1959/2013), when thinking about the hostile object, it is necessary to think of a partial object seen as a function rather than as morphological structure. To Bollas (1996, p. 6), "if inherently disturbed while infant or torn apart by environment, or both, the primary object is not so much an introjectable possibility, but a recurring effect within the *self*. Like the wind through the trees, it is a movement by the *self*".

The next point that we divided is (2) the anguish: it concerns to search to identify which conflict is essential, or even crucial anguish, would be connected to the borderline object. Basically, the anguish that we can withdraw from the psychoanalytic literature as fundamental is the annihilation (Green, 2000; Luz, 2010), i.e. the fear of disintegration (Frosch, 1988) or fragmentation (Rosenfeld, 1978). We saw earlier that for Bion (1959/2013) the object is a function, and for Bollas (1996), a movement by the *self*. This leads us – nothing stops us – to propose the idea that the borderline object has the function (Bion, 1959/2013) to defend the psyche from this anguish. Or, still, it is a movement by the *self* (Bollas, 1996) toward the withdrawal of the anguish of the conscience. With this, we are proposing the idea of the borderline object to be a product of defenses against the fear of becoming insane, of losing identity, once the anguish of annihilation, in representational and ideational terms, shows as fear of going crazy.

So far, then, the idea of a borderline object refers to something precocious, isolated from other parts of the ego and in close relationship with the anguish of annihilation. At this point, we can deepen from what some authors speak of the splitting in the borderline disorder. The reference here is mainly the idea of Kernberg (1966) in which the splitting takes place between good and bad parts of the object, consequently within the object; as well as the idea of Green (1977/1986) in which the splitting occurs in parts of the ego, that is, isolating parts of the ego among themselves. By inspiring us with it, we can think the borderline object as the result of a split between objects, which makes it a partial object, and can be isolated from other objects and parts of the ego through the splitting within the ego itself. It is the defense that we talked about before, from splitting the fear of becoming crazy and isolate it from other psychological content.

From this, it becomes possible to investigate the symptoms (or character traits) that are highlighted in the literature, as well as to know if they can somehow be related to the idea of a borderline object. To do so, we will highlight the symptoms (or traits) of instability, impulsivity, aggressiveness and dependency.

As we said, instability or frequent and rapid changes of mood are common in borderline patients. From the idea of a borderline object, we think that the instability would refer to something approaching in relation to that object – the approach could awaken the anguish of annihilation. Given how the borderline object is isolated from other parts of the ego through splitting, the approach would be immediate, consequently generating the irruptive behaviors of anger and mood imbalance.

However, we can advance in the symptoms/traits, now treating the dependency of the subject or the demand for affection and love. The question that we will consider here is about the possibility of the borderline individual to project or link the object to someone else, which would provide a balance to his anguish. Thus, there would be a strong demand for affection and love, which we understand as demand for someone that supports the bond with the borderline object, offering temporary solution to anguish. This is another aspect of the defense, that is, in addition to splitting fear and isolate him, to kick him out of the psyche.

This point helps us understand the constant changes of romantic partners that often occur in borderline cases. If we think the bond from the idea of projection of the borderline object and remember the impulsiveness with which the borderline subject acts, we could understand the constant changes as a result of a frustration (a feeling of abandonment, for example) that is felt with great intensity by the subject and destabilizes the borderline object binding. Given the individual's impulsiveness, it is not difficult for him to change partner. But not only that; We know since Freud that libido is little plastic, so that

the love object change is always difficult. This makes us think that people who easily make these exchanges invest little in those partners or, yet, that the investment is a lot more on internal object than external, in a way that the support of this object, the real partner, doesn't really matter. This may be a feature of borderline object, an object of projection, whose change of support appears not to harbor great problems.

We must understand, here, the destabilization as return of the threat of becoming crazy. We said that the fear of becoming crazy is the form of the subject to feel his anguish of annihilation and fragmentation, i.e. the possibility of the subject to lose their mental borders, that is, to fully know himself, to recognize himself. At this point, the dilemma need-fear (Adler, 1988) is consistent with our hypothesis. We can understand it from the idea that the subject's fear of losing its psychological borders is encapsulated and projected at another. At one point, the projection itself will be felt as a dependency, considering the temporary solution that the other is giving. So, the threat and the exchange of the relationship arise.

On the other hand, the relationships of the borderline subject that don't involve the borderline object would be superficial, since they would not aid in the solution or balance of anguish. With this, we can understand the ambivalence (superficial and intense) of romantic relationships.

Another theme that we investigate from the idea of a borderline object is the therapeutic techniques. Firstly, we will discuss a technical recommendation to perform a part of supportive psychotherapy before starting the analysis (Knight, 1953; Stern, 1945). In the same way that we related some symptoms to the borderline object, this part of supportive psychotherapy seems to us as some kind of preparation of the pair to bind to the borderline object. However, some technical recommendations seem to avoid contact with the object.

In our research, some authors recommend to not use the divan (Adler, 1988; Eisenstein, 1951; Knight, 1953; Stern, 1945) and others indicate that we should not use free association (Eisenstein, 1951; Knight, 1953). There is, too, those who suggest to have only one session per week, in order to avoid negative or ambivalent reactions of the patient (Zetzel, 1971). Only these technical recommendations do not refer to a work only psychotherapy and not analytical, but, together, they look like a technical direction that avoids the analytical work and contact with the borderline object. In this way, we avoid the possibility of the borderline to project its object in the analyst, left to psychotherapy the option of working with the content which would be around the object, or which would be derived from it.

A problem that occurs in the technical field and that we previously mentioned is the insufficiency of interpretations, due to communication of the borderline patient being massively non-verbal (Rigas, 2012). This supports us on the idea that communication or bonding with the borderline object are not done verbally. Therefore, we seek in the literature other forms of possible communication.

Bollas (1996), for example, says that, when we look only for the deficiency of the patient and not to his wishes, we are supporting a false *self*. Perhaps here it is more clear what we talked about, that the avoidance of contact with the borderline object implies the contact only with what would be around the object.

An author who has examined in depth the issue of bonding and communication of analyst with borderline patients is Luz (2009, 2010). For her, the analyst must feel the pain of the patient, not just understand it intellectually. In addition, she believes that patient behaviors that can be seen as attacks on the analyst should be understood as the possibility of expression of their pain. Something that we found in the work of this author serves us for clarification to our arguments about the technique. For her, the analysis with borderline patients occurs on two levels: a neurotic one, via verbal communication, whose main anguish is the castration; and a borderline level, via non-verbal communication, whose main anguish is annihilation (Luz, 2010).

An important symptom of borderline cases, from which derives a serious technical problem that we highlighted at the beginning, is that of psychotic episodes. From the idea of a borderline object, we could understand these episodes as the appearance or the communication of this object. However, the idea of psychotic transference (Rosenfeld, 1978) helps us in the further development of this point. To Rosenfeld (1978), the psychotic transference will highlight the most traumatic subjects of the borderline patient and, despite being an obstacle to interpretation and communication, she shows new ways of analysis. Therefore, these manifestations can indicate conflicts that underlie the patient's symptoms, which would encompass in the anguish of annihilation or fear of disintegration. Once again, it seems to us that this point reinforces the idea that the psychotherapies that don't cover that conflict or the borderline object will be limited.

In short, our interpretation of the technical questions presented and re-discussed here is that there is a variation of approaches and recommendations that can be grouped and guided around the idea of a borderline object. We found three variations, namely: (1) techniques that avoid the appearance of the object or bonding with him; (2) techniques that makes a part of supportive psychotherapy as a means to prepare the pair to link with the object; (3) analytical techniques where the goal is to search linking with object seeking to elaborate the fundamental conflict. The reader should also note that the way the technical approaches are divided has an obvious relationship (almost a repetition) with the types of relationship that the borderline subject builds and discussed here already.

The third and final theme that we will examine is the transference and countertransference. First, we will

quote some information that appear to be consistent with the hypothesis of a transference in that the borderline object is not bound, as when Greenacre (1941/2010) says that the transference starts empty, or when Zetzel (1971) says that it is limited and poor. There are other authors, however, that describe characteristics that we could interpret as a result of any contact with the borderline object, namely, when Schmideberg (1947/1986) speaks of confusion and strangeness or Kernberg (1966), when telling of a transferential chaos. The attributes of the transference that to us reflect the contact with the object would be seen in Stern (1938), when he speaks of a great dependence on the patient in the analyst, or Bion (1959/2013), who speaks of magical thoughts in relation to the analyst.

About the bond, some authors and information already mentioned can also be grouped around the idea of borderline object. To be able to link to the patient, for example, Luz (2009) says that the analyst must live the turbulence with the patient, and Bateman (1998) says that the analyst must be involved in the terrors of the patient. The concept of projective identification, in this point, helps us reinforce the idea that the borderline object can be designed partly or wholly in the analyst. This could generate a symbiotic bond (Kernberg, 1967; Rosenfeld, 1978), however, it could make the analyst menacing (Kernberg, 1968).

The symbiosis with the analyst becomes comprehensible from the idea of projection of the borderline object, as this could generate a balance in the psychological dynamics. However, this balance, now, would depend also on the analyst, which explain the idea that he becomes threatening.

If we take our interpretations as a base, that is, if we understand the dynamics of interaction of the analyst with the borderline patient from the projective identification, symbiosis and non-verbal communication, it is possible to conclude that the borderline implies a puzzle to the analyst, the enigma of bonding or not. The analyst then would choose between not help him, help in the contents around the object, or assuming the symbiotic aspects related to linking with the borderline object.

For us, the idea of a borderline object does not correspond to a theoretical solution, much less a clinical evidence. Our goal is to offer a clinical targeting that, although it does not arbitrate definitions or technical recommendations, urges clinicians to pursue something borderline itself, i.e., not to be satisfied with the idea that this is a confused and unpredictable patient, without solution. What it is possible to see in our text is that borderline patients are slippery: sliding on the diagnostic labels, sometimes more serious, sometimes lighter, on their symbiotic bonds or links, aggressive and superficial, and on the analysis, with outbreaks of anger, attacks on the analyst, or linking to it, in times of turbulence. However, primarily, they glide over its borders, as someone who slides across a thin layer of ice that break without a signal.

Pacientes, problemas e fronteiras: psicanálise e quadros *borderline*

Resumo: O artigo trata do quadro clínico conhecido como *borderline* e é derivado de um exame da literatura psicanalítica sobre o quadro. Nosso objetivo é oferecer informações de maneira sistematizada para que os leitores possam se aprofundar no tema, ou mesmo para que possam confrontar suas posições com as de diversos autores. Trataremos das diversas definições e nomenclaturas, da psicodinâmica, dos sintomas, da etiologia, da diversidade das técnicas terapêuticas, dos problemas comuns durante o tratamento e dos aspectos gerais da transferência e da contratransferência. Ao final, ofereceremos uma contribuição acerca da psicodinâmica, a qual se refere à identificação na literatura da ideia de um objeto *borderline* que é parte da essência psicodinâmica do quadro. Ademais, desenvolveremos análises das informações examinadas nos utilizando da ideia de objeto *borderline* como baliza.

Palavras-chave: quadros *borderline*, psicopatologia, psicanálise, estados-limite, objeto *borderline*.

Patients, problèmes et frontières: psychanalyse et cadres *borderline*

Résumé: L´article traite cadre clinique connu sous le nom *borderline* et est dérivé d´un examen de la littérature psychanalytique sur le tableau clinique. Notre objectif est de fournir des informations de manière systématique afin que les lecteurs puissent s'approfondir le sujet, ou même pour qu'ils puissent faire face à leurs positions avec celles de plusieurs auteurs. Nous aborderons les différentes définitions et classifications, les psychodynamique, les symptômes, l'étiologie, la diversité des techniques thérapeutiques et des problèmes communs au cours du traitement, et les aspects généraux du transfert et contre-transfert. A la fin, nous offrons notre contribution sur les psychodynamique, qui fait référence à l'identification dans la littérature de l'idée d'un objet *borderline* qui fait partie de l'essence du cadre psychodynamique. De plus, nous allons développer des analyses des donnés examinées en utilisant l'idée de l'objet *borderline* comme objectif.

Mots-clés: cadre *borderline*, psychopathologie, psychanalyse, états limites, objet *borderline*.

Pacientes, problemas y fronteras: psicoanálisis y cuadros *borderline*

Resumen: El artículo trata del cuadro clínico conocido como *borderline* y se deriva de un examen de la literatura psicoanalítica sobre el cuadro. Nuestro objetivo es ofrecer informaciones de manera sistematizada para que los lectores puedan profundizarse en el tema, o incluso para que puedan confrontar sus posiciones con las de diversos autores. Trataremos de las diversas definiciones y nomenclaturas, de la psicodinámica, de síntomas, de la etiología, de la diversidad de las técnicas terapéuticas y de los problemas comunes durante el tratamiento, y de los aspectos generales de la transferencia y de la contratransferencia. Al final, ofrecemos una contribución nuestra acerca de la psicodinámica, la cual se refiere a la identificación en la literatura de la idea de un objeto *borderline* que es parte de la esencia psicodinámica del cuadro. Además, desarrollaremos análisis de las informaciones examinadas utilizando la idea de objeto *borderline* como baliza.

Palabras clave: cuadros *borderline*, psicopatología, psicoanalisis, estados limites, objeto *borderline*.

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