Persona non grata

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Moral insanity

Personality disorders have become, at least in the English-speaking world, a matter of public order and political significance. In Australia, following a few massacres carried out by some men whose madness — according to psychiatric expertise — did not fit within the nosological category of psychosis but was consistent with the prevalent diagnostic criteria for personality disorders, as well as the proliferation of cases in which self-mutilations, suicidal attempts and/or antisocial acts are prominent features, some years ago the authorities in charge of the delivery of mental health services in the State of Victoria decided to create a special service aimed at dealing with such patients. Many of these patients are also clients of the correctional system or have to answer to criminal charges in court. It must be acknowledged that this initiative represents progress (or at least an attempt at progress) in relation to the previous treatment (or rather, lack of treatment) of the patients in question. Before this initiative was implemented, it frequently occurred that mental health institutions refused to provide services to them because they were considered to be more bad than mad, more criminal than mentally disturbed and more dangerous than the ordinary psychiatric patients, while simultaneously the correctional institutions found it very difficult to deal with mad people who created dangerous disruptions in the life of prisons. As a result, a good number of undoubtedly disturbed people were left in a state of limbo, deprived of therapeutic assistance and, when in prison, either in a situation of forced segregation or exposed to cruelty and abuses from other prisoners, and becoming on occasions a positive danger to the others.

In this way the category of personality disorders became, at least in Australia, the name for a public affair requiring the intervention of the political powers, transcending the place that the category has had — for decades now — in the more confined worlds of academia and psychiatric and psychological practices. In these confined worlds too the disorders of personality are an increasingly frequent diagnosis in clinical practice and the object of academic research, particularly since the nosological classification of psychiatric conditions produced by the American Psychiatric Association (APA) — the well-known

Diagnostic and Statistical Manual of Mental Disorders, or *DSM*, now in its fourth edition — became dominant.[1]

Psychiatric matters as a whole have become political issues in the Western world, over and above the state's responsibility for the provision of well-being (that is to say, happiness) in general and mental health services in particular (and who would deny the importance of mental health in the quest for happiness?). This is so if only because of the extraordinary growth of the psychopharmaceutical industry, currently a significant component of the gross domestic product for a number of countries.

To highlight the political status of the personality disorders is also to remind ourselves of the ethical dimension of the problem, if politics represents, as Aristotle hoped, the highest expression of ethics. A psychoanalytic contribution to a debate about the personality disorders — or to any other debate, for that matter — ought to include a reference to the ethical implications of this diagnostic category, especially when it has crucial consequences for the lives of those human beings to whom the category is applied.

An ethical question is also explicitly or implicitly present in the very conception of personality disorder—and this, across the different schools and orientations that in psychiatry and psychology have approached it. Some authors have pointed out that the historical roots of the category lie in the nineteenth century concept of 'moral insanity', later taken over by terms such as 'character neurosis', 'character disorder', 'psychopathy' and 'sociopathy'. In different ways, these terms involve the attribution to the human subjects presumed to be affected by a disorder of personality of a problematic relation with the moral law and a lack of subjective assumption of ethical responsibility.

In Australia, the attribution of such a deviant moral stance to the patients diagnosed as *being* personality disorders is the source of the frankly hostile, rejecting, even segregationist attitude present in some workers (by no means all, but some) of all ranks in the mental health field, for whom the patients with personality disorders, pejoratively called 'PDs', are rather fraudulent and malingering individuals, impermeable to any form of treatment; narcissistically attached to their own egotistic interests; ungrateful to the professionals who have gone out of their way to help them; a waste of tax-payers contributions and of the scarce resources allocated to hospitals and clinics; although mad in their own devious ways, they are not 'proper' psychotics, but at the same time too bizarre in their social conduct and

[1] And, as of 2013, its fifth edition.

pathological manifestations to be considered 'proper' neurotics (or 'anxiety disorders' as they say these days, following the *DSM-IV* nomenclature). To receive the diagnosis of 'PD' or 'borderline' is very bad news for anyone in Australia: it is tantamount to being declared *persona non grata*, an 'ungracious, ungrateful, graceless personality', forever referred to the newly arrived, unsuspecting, naïve member of the team, as a rite of initiation and test of loyalty.

An epidemic of personality disorders

Yet it must be acknowledged that, alongside the very bad reputation that personality disorders have gained, an opposite current of academic researchers and clinical practitioners has taken an enthusiastic interest in the personality disorders as a nosological entity. Research into the aetiology, pathogenesis, treatment and epidemiology of these disorders has developed vigorously over the last two decades.

According to the *Kaplan and Sadock's Comprehensive Textbook of Psychiatry*, the most utilised reference for psychiatric trainees in the USA and Australia, and also according to more specialised texts, such as the recently published *Major Theories of Personality Disorders* statistically reliable sources indicate that the personality disorders represent from 11 to 24 per cent of the population, depending on the severity of the clinical parameters applied (Kaplan, Sadock & Ruiz, 2009; Lenzenweger & Clarkin, 2005).

Leaving aside for a moment the question of the validity of the category itself, it is interesting for us to enquire into the phenomena concerned. These phenomena include the statistical data to which I have just referred (even if the interpretation of statistics always require prudent reservations); the increase in the clinical manifestations that characterise the personality disorders (which, although it is not certain that they necessarily constitute symptoms in the psychoanalytic sense of the term, are nevertheless clinical phenomena), and the enthusiastic development of academic and clinical interest in the field, which has resulted in a multiplication of publications and the creation of new journals and centres for the study of the personality disorders, to the point that — some authors argue — it has become a subspecialty, even a discipline in its own right.

It is of interest for us, psychoanalysts who follow the teachings of Freud and Lacan and others who have contributed to form us as analysts, to enquire into this matter. It is not satisfactory to simply dismiss the question of the personality disorders altogether (as some

colleagues, and for good reasons, have done), in line with the argument that so far the relevant theoretical production that has emerged in psychiatric, clinical psychology and some currents within psychoanalysis itself has not enriched our body of knowledge and has not thrown any new light on the clinical manifestations of those disorders, which would still be better understood by an unequivocal reference to, and a re-affirmation of, our Freudian and Lacanian categories, methodology and ethical principles. In my view, a critical study of these disorders and of the theories that over the last few years have been advanced about them is a necessary and instructive exercise, and so far, in my own experience, leads to a re-affirmation of the Freudian and Lacanian categories and principles that we sustain — but to a better informed re-affirmation. In this sense I, for one, am grateful to the London Centre for Freudian Analysis and Research for having organised this conference, which provides us with the opportunity of learning what different psychoanalysts and other colleagues have so far concluded about the personality and its disorders.

Diagnostic questions

The category of personality disorders — whose very existence and validity we have the right to interrogate — poses, in the first place, a number of diagnostic questions.

We note that the promotion of the personality disorders in the official classifications (the *DSM-IV*, published by the American Psychiatric Association, and the *ICD-10*, published by the World Health Organisation) is correlative of the *demotion* or removal of other categories, precisely those that have been established firmly in psychoanalytic psychopathological studies since Freud. This demotion is more pronounced in the *DSM-IV* than in the *ICD-10*. We are interested, in particular, in the removal of the categories of neurosis, hysteria and paranoia, since they are directly concerned in most cases where a question of differential diagnosis arises in relation to patients suspected of suffering from personality disorders. Those diagnostic terms (neurosis, hysteria, and paranoia) are directly concerned, however, only from a psychoanalytic perspective, in which they designate clinical structures. The terms that approximately replaced them in the *DSM-IV* nomenclature ('Anxiety Disorders', 'Somatoform Disorders', 'Delusional Disorder', plus a considerable number of other categories which a psychoanalysis would reveal as reducible to one of the clinical structures postulated by Freud) could still be considered by a *DSM-IV*-inspired diagnostic formulation. But the changes in terminology introduced by the *DSM* are not

simply an alteration of names: they represent a completely different conception of the human subject and his or her suffering and madness. The fact that the vocabulary of the *DSM* still retains terms that were first proposed by Freud and the psychiatric classifications of late nineteenth century and the first part of the twentieth century should not mislead its readers. The terms that have been retained have been absorbed by a discourse and practices whose methodology, clinical approach, theories and ethics are antagonistic, not only to psychoanalysis but also to the psychiatric schools that have valued the function of the word in the understanding and treatment of the disorders that the *DSM* classifies.

The *DSM* aims at being an instrument to facilitate clinical diagnosis, the establishment of parameters for research and communication between professionals. It defines itself as 'neutral' as regards etiological theories, and as the culmination of the collective effort of more than one thousand eminent workers in the psychiatric field who have collected and analysed the clinical empirical data provided by a large number of experienced clinicians. The last version (tenth) of the *ICD*, which remains the official or semi-official diagnostic classification used in clinical and statistical records in a good number of countries (including the USA), has been constructed largely on the basis of the *DSM* categories. The writers of the *DSM*, in turn, have made an effort to make their categories compatible with those of the *ICD*.

For over a decade the texts and manuals in the English (and by now also in other languages) versions used by psychiatric trainees and professionals, as well as practitioners in related fields (clinical psychology, psychiatric nursing and others) are organised according to the *DSM* model, even if they contain sporadic criticisms about inconsistencies, omissions and unclear definitions. This is not only true of the semi-official handbook of psychiatry, *Kaplan and Sadock's Comprehensive Textbook of Psychiatry*, but also of more critical texts, such as *Major Theories of Personality Disorder*, which contains a selection of key texts representing seven different theories: cognitive theory, psychoanalytic theory (as interpreted by Otto Kernberg and Eve Caligor), interpersonal theory, attachment theory (based on the concepts of a psychoanalyst, John Bowlby), contemporary integrative interpersonal theory, personology (a theory based on evolutionary concepts) and a neurobehavioral dimensional model of personality disturbance (presented by Richard Depue and Mark Lenzenweger, one of the editors of the volume). Undoubtedly, as a discourse the *DSM* has succeeded in imposing its

terms to the dominant psychiatric schools and institutions in the English-speaking world and beyond.

Scientific status

The writers of the *DSM* put special emphasis on the scientific status of the methodologies that they have used to analyse empirical data and establish clinical categories. To theoretical neutrality they add rigorous requirements of reliability and validity concerning data collection and interpretation. Objectivity is clearly their aim: objectivity, understood as the elimination, as far as possible, of subjective bias. For this reason, for example, taking into account the notorious unreliability of patients suffering from borderline personality disorder in providing honest and truthful information about their lives and circumstances, they suggest that it may be essential to get information from, not only clinical records, but also other people acquainted with the patient. I could not find any discussion concerning the possible presence of subjective bias in those informants. The authors' basic assumption appears to be that a diversity of testimonies is likely to enhance the objectivity of the findings.

The sources of information used to construct the *DSM* are multiple and heterogeneous, with emphasis, in the case of the personality disorders, on material obtained in controlled, experimental conditions. Clinical material has also being used, but it has posed methodological problems to the authors, apparently more comfortable with material obtained following the methodology of academic psychology, that is, self-administered inventories and questionnaires, questionnaires administered by researchers and structured and semi-structured interviews conducted by researchers or clinicians. Methodological problems also arise when adopting such approaches, which have a tradition in behaviourism, cognitivism and psychological studies of personality. It appears that if the populations on which these research instruments are applied are composed of normal (or supposedly normal people), then the information obtained is largely irrelevant; and if the populations are composed of people who are patients suspected of having a personality disorder, then the information obtained is suspect of being contaminated by the pathological condition itself, and therefore unreliable, biased and even highly deceptive.

That is the price to pay for being scientific—according to a certain conception of science, that derived from the discourse of Science itself (Science with a capital S), which Jacques Lacan identified as requiring the foreclosure of the subject. Taken to its logical

extreme, the scientistic endeavour to avoid the risk of contamination by subjectivity would make of empty statements (as when one says 'empty set') the only valid ones. But the *DSM* and the researchers on personality and its disorders do not reach that point of absurdity: they have something to say, and what they have to say has had real effects.

Dimensions, categories and axes

In the conception of its authors, the *DSM* has been constructed on the basis of two broad perspectives: the dimensional and the categorical.

The dimensional point of view concerns phenomena, traits or variables which can be detected across different nosological entities, types or categories, such as depression, or aggressiveness. Some researchers favour the dimensional perspective because they believe that it is better suited for the use of quantification than the categorical perspective. They may try to develop scales to discriminate between various levels of depression, for example. They may introduce complex multifactorial analyses of the multiple variables that they identify in the components of personality, under the classical rubrics of temperament, character and environmental influences, which lend themselves (according to these researchers) not only to sophisticated modalities of quantification but also to establishing correlations between variables that represent the integration of neurobiological, psychological and sociological knowledge — since the integration of these different spheres of research is the ideal pursued by most of the workers in this field, an ideal which strictly corresponds to a notion of the human personality as an integrated entity, or being, and its pathologies as a variety of failures in a process of integration conceived of as realisable.

The categorical perspective discriminates between qualitatively different types or nosological entities. It is, the authors of the *DSM* point out, preferred by clinicians, who for practical and therapeutic reasons need to positively identify typical clusters of signs and symptoms so as to have a clear point of reference to organise a treatment strategy.

On the whole, the model followed by the *DSM* is categorical — some would argue, excessively categorical, in that it has introduced a considerable number of diagnostic types which were not of generalised use beforehand. The proliferation of nosological entities, it is argued, follows advances in clinical observations and a permanent endeavour to achieve precision in differential diagnosis.

The *DSM* has introduced, in addition the parameter of *axes*. A complete diagnosis should consider the five axes proposed, namely:

1. clinical disorders and other conditions that may be a focus of clinical attention;

2. personality disorders and mental retardation;

3. general medical conditions;

4. psychosocial and environmental problems, and;

5. global assessment of functioning.

Here we face a curious situation. Why are the personality disorders, which have supposedly been proliferating in epidemic proportions and are certainly considered as pathological developments, not classified within the axis of clinical disorders? And why are they included in the same class as the mentally retarded? The rationale given by the text of the *DSM* is rather peculiar:

> The listing of Personality Disorders and Mental Retardation on a separate axis ensures that consideration be given to the possible presence of Personality Disorders and Mental Retardation that might otherwise be overlooked when attention is directed to the usually more florid Axis I disorders. The coding of Personality Disorders on Axis II should not be taken to imply that their pathogenesis or range of appropriate treatment is fundamentally different from that for the disorders coded on Axis I. (APA 2000, 27)

A different pathology, then, but no attempt is made no define its distinctiveness in a positive way. One may try to infer the reasons for this lack of precision.

An ideology

The *DSM* may well be atheoretical, but it is not without *ideological* foundations. The notion of personality upon which the category of personality disorders is constructed corresponds approximately to the definition given by Gordon Allport (1937):

> [Personality is] the dynamic organization within the individual of those psychophysical systems that determine his or her adjustment to the environment.

The *DSM's* own definition of personality disorder (APA 2000) is as follows:

> A Personality Disorder is an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.

A list of the different types follows: paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, dependent, obsessive compulsive, plus a residual category: personality disorder not otherwise specified. The *DSM* discriminates between clusters of these disorders: the paranoid, schizoid and schizotypal forms are put together in the first cluster, called 'odd-eccentric'; the antisocial, borderline, histrionic and narcissistic types are called 'dramatic-emotional', and the avoidant, dependent and obsessive-compulsive types are clustered under the name of 'anxious-fearful'. The text adds that these clusters may be viewed as 'dimensions representing spectra of personality dysfunction on a continuum with Axis I mental disorders (or mental disorders 'proper')' (APA 2000, 634).

This is not exactly a paradigm of accuracy and precision, and contrasts with the phenomenological rigour with which classical psychiatry (for example, Emil Kraepelin, Eugene Bleuler, Gaëtan Gatian de Clérambault, Henri Ey and others) attempted to classify nosological entities on the basis of pathognomonic signs and symptoms. It certainly contrasts even more with the efforts that Freud made to identify the formal properties of symptoms and their structural functions at the levels where the subject's position is determined: intrasubjective, intersubjective and beyond intersubjectivity. This enabled Freud to postulate the existence of clinical structures which, although generally bearing names inherited from psychiatric classifications, represented a subversion of established nosologies and clinical practices. He established the paradigm for psychopathological categories based on the analytic experience and to do so he also had, at times, to introduce new nosological terms, which corresponded to true clinical discoveries: psychoneurosis; actual neurosis;

conversion hysteria; anxiety hysteria; obsessional neurosis; transference neuroses; narcissistic neuroses.

The problem with personality disorder

The problem with personality disorder, as I see it, has to do, on the one hand, with the problems that contemporary psychiatric discourse and clinical practices have created in a generalised way, and on the other hand with what constitutes a particular subculture that has emerged around clinical presentations like the ones I evoked at the beginning, a subculture that comprises not only patients but also professionals and theoreticians involved with those patients, or at least with their histories.

The text of the *DSM* is a symptom of the malaise that affects contemporary psychiatry. I have not met any psychiatric trainee, registrar or consultant who has anything good to say about the *DSM*. Yet they all use it, even when they are not compelled to use it because of institutional pressures or established procedures; they speak its jargon and formulate their diagnoses according to its terms and rules.

The *DSM* is a manual of *dis*orders, that is, of dysfunctions and deficits. It represents a clinic in which psychopathological phenomena are considered *deficits*. Freudian and Lacanian psychoanalysis, instead, approaches psychopathological phenomena as involving *productions*. Freud included the neurotic symptom in the series constituted by the formations of the unconscious, all of which result from the work of the unconscious, not from deficits in personality functions.

For the DSM, personality as a notion is unquestioned, despite the fact that the largely imaginary nature of the term has been the object of critical appraisal, and not only by psychoanalysis. It is true, however, that the psychoanalytic school of ego psychology has made of the integrated personality a theoretical and therapeutic ideal. The work of Otto Kernberg, on the whole inspired by the principles of ego psychology, represents the most consistent and sustained effort to theorise and clinically deal with the personality disorders, in particular what he calls the severe borderline personality disorders. Yet, and despite the fact that Kernberg regards these disorders not as mere disorders but as organisations, that is, as involving a positive order, his conceptual and clinical approach remains subordinated to the categories of a theory of personality inscribed in an academic behaviouristic psychology that ignores the findings of psychoanalysis, which were made public one hundred and ten

years ago and which put once and for all the personality (which largely corresponds to the agency of the ego, if one restricts oneself to the psychological approach) in its place. When Freud referred to the 'psychic personality' (in his *New Introductory Lectures*), he did so in terms of its division: id, ego, and superego. These agencies are not compartments of a supposed 'whole' personality, but the representatives of functions which are not whole in themselves either, but which replicate at every moment the fundamental splitting of the subject.

Somebody could raise an objection against Freud's conception of a split personality as normal and normative. He or she could say: 'Aha! It is all very well to speak of subjective divisions, lacks-in-being and invisible, unconscious structures that determine the subject's existence, rendering it fragmentary and profoundly ignorant of its own affairs (and the affairs of the Other, for that matter). But, don't we possess some sense of unity and identity, the perception that we are still one and the same, despite changes in time and space? Don't we recognise ourselves when we wake up in the morning, despite the transient strangeness of our dreaming? It is only in the depersonalised stages of a psychosis that a sense of personal identity is lost. And isn't my personality a distinctive mark of my style, by means of which others identify me without hesitation and do not confuse me with anyone else? If you want me to recognise your unconscious, you will have to acknowledge my personality!'

Fair enough. It is not such a bad deal. For the personality is one of those ghosts that exist even if we do not believe in them. Freud and Lacan were not afraid of looking at this ghost in the face and learning from it. They opened lines of enquiry regarding the so-called personality that we could fruitfully pursue. To mention only a few: the functions of the ego, narcissism and the imaginary register, forever the source of resistances in analysis, but also the field of constructions which are absolutely indispensable for the human subject, in that they provide him or her with a body where to live and others whom to love; the functions of the *persona* (etymologically at the root of the word 'personality'), that is, the mask, and also the masquerade, which are imaginary and signifying supports of the primordial identifications; the questions concerning personal style, letter and signature, that is, the subjective inscriptions in the real which serve as essential reference points in life; the more circumscribed, but always fertile and enlightening questions concerning the persona, the representation of the body and the relations with the alter ego in schizophrenia and other conditions, not necessarily psychotic, in which the image of the body is severely compromised. I mention these and other topics of research that concern the question of the

personality (which is not one of fundamental concepts of psychoanalysis, but which is nevertheless a legitimate epistemic object of enquiry) simply to remark that this question can be approached psychoanalytically without falling into the ideological trap of notions and categories (those of pharmacologically-oriented psychiatry and behavioural and cognitive psychology) which are affiliated with a normative conception of the personality representing an ideal of success in a society of consumers. At least in Australia, our patients, too, are called 'consumers', since the prevalent discourse has become intolerant of modalities of social bonds other than those promoted by technology and the financial markets. Psychoanalytic research and clinical praxis has something positive to offer in the field of personality and its disorders, over and above the critique of practices and theories which result, at best, in the construction of myths, and at worst in impasses that leave patients a limbo state, despite the good intentions and honest efforts of practitioners that subscribe to those practices and theories.

A clinical reflection

A research group of psychoanalysts and students of the Australian Centre for Psychoanalysis have worked regularly on matters of clinical interest, following-up patients in psychoanalytic treatment over years. We have collected, discussed and analysed material derived from a good sample of patients, many of whom are treated in hospital settings and clinics supported by the public sector. Problems of differential diagnosis arise frequently. The same happens in different group, a study group on clinical problems, some of whose members work in the special service for borderline personality disorders which I mentioned at the beginning of this presentation.

In fact, the problems of differential diagnosis that emerge in these groups correspond to patients who have a long psychiatric history and who, before being treated by my psychoanalytic colleagues, had been in the care of numerous professionals. These patients present all or some of the features that the DSM associated with borderline personality disorder: a history of self-mutilations, suicidal attempts, resistance to treatment, acting-out and antisocial behaviour, schizoid or highly histrionic traits. For this reason they have usually being diagnosed as 'being', rather than 'having', or 'suffering from' a borderline personality disorder. In my own practice I have received, too, patients who have presented with similar features.

What analytic work with these patients demonstrates — rather unequivocally — is that the label of borderline personality disorder, which has become for them a disadvantageous mark of irreversible social identity, represents as well a gross misunderstanding of their subjective position and a clinical failure. For the analytic experience offers them the possibility of speaking and thus developing a transference-relation by means of which their history, their real symptoms and their true psychopathological position becomes clear and the fertile source of alternative measures with which they can deal more creatively and constructively with the burden of the self-destructive, masochistic *jouissance* (enjoyment) that they carry. The opportunity for non-delusional forms of establishing stable and stabilising forms of relation with themselves and others arise, as well as the more efficacious (in practical terms) supplementary constructions (which Jacques Lacan called the *sinthome*). The latter are not always achieved with every patient, but its possibility should not be dismissed for any patient. Freud had already discovered that until the symptom 'joins in the conversation' (those are his words) there is little chance of learning from it and about it. But one has to be prepared to let it into the conversation, even to invite it to join the analytic dialogue, which is not as easy as it sounds.

In virtually all the cases to which I have been referring, a diagnosis of psychosis (paranoic or schizophrenic) had been proposed previously, one or more times, during their psychiatric history. Yet there has been a tendency to obliterate such clinical assessment in favour of the diagnosis of personality disorder, usually at the moment when the psychotic structure, although present and manifest for the clinician who is alert in relation to it, is not 'florid', that is, does not involve an evident disturbance of psychological and other living functions.

The analyst should not retreat in the face of psychosis: that was Jacques Lacan's clinical recommendation. It is not a recommendation that is easy to follow, and even less to sustain. If analysts, despite their own human vulnerabilities, may sustain it, it is because they are able to occupy a position which is supported and animated by what Lacan called the analyst's desire. This desire, a 'desire to obtain absolute difference' (Lacan 1977, 276) is not a genetically transmitted or inborn quality but the product of the analyst's laborious encounter with the real and the reality of the unconscious, from which he has been able to learn about his own singularity, his own neurosis, his own *jouissance*. The experience of his own analysis, and of his own analysis alone, may (this is not sure in every case) enable him or her to

tolerate the patient's mode of *jouissance* and to learn, together with the patient, about its rationale, the sense it makes and also (and more importantly) its senselessness, its idiosyncratic ways which makes of it, as Lacan puts it, something that is 'good for nothing'.

The ethics of psychoanalysis requires a familiarity with, a positive desire to know the secrets of the different 'good for nothing' that each one has unconsciously erected as his or her unique, irreproducible way of living. And who else, but the patient himself or herself, can give an authentic testimony of his version of 'good for nothing', for someone, an analyst who is prepared to listen to it?

In the last analysis, the difference between psychoanalysis and the *DSM* is an ethical one. The testimony that the analyst receives is only possible within the frame of a discourse, an engaging social bond, in which the words that have strangulated the subject's experience can be expanded so as to open the path to forms of *jouissance* which are compatible with life (to use the happy expression of our friend Vicente Mira).

Without naming it, the *DSM* is more inclined to favour forms of *jouissance* that can be prescribed according to the dominant ideals and values that are part and parcel of the discontents of the culture that promotes them, through the workings of a cultural superego (which is Freud's expression) of unprecedented ferocity.

In inscribing the personality disorders on a separate axis, outside the clinical syndromes, the *DSM* apparently adopts the benevolent attitude of including the whole of the patient's personality, and not just his or her pathological productions, in the patient's clinical assessment. The *DSM* considers the personality disorders as a category that coexists with that which encompasses the clinical syndromes, that is, florid — but frequently transient — pathology. Yet, in practice the category of personality disorder has been applied categorically and as an exclusive diagnosis, and in this way well-intentioned clinicians had been led to miss what psychoanalysis has demonstrated beyond reasonable doubt: the fundamental subjective positions, or clinical structures, which mark the orientation and limits of the subject's experience.

I am aware that some colleagues have found that many patients diagnosed (or misdiagnosed) as suffering from borderline personality disorder are in fact neurotics, hysterics who present 'atypical' symptoms which are becoming increasingly typical. I do not contest their findings: it is possible to overlook, or deny, the existence of a hysterical structure as it is possible to disavow the existence of a psychosis. For all the progress made

over the century during which psychoanalysis has been around, the segregation of the psychotic is still one of the disgraces of our culture, but the repudiation of the hysteric is not a lesser source of shame.

The fundamental question is whether we let the patient talk and learn from him or her about his or her suffering or whether we impose a categorical framework which, for all its credentials, is actually based on dubious scientific methodology, with the consequence that the subject is reduced to the quantifiable variables of a scale. Roman Jakobson once said that there is nothing wrong with quantification (which essentially means counting), provided one knows what is being counted. And Donald Winnicott also wrote that if you ask some questions, you are going to get some answers; but that is not the point in psychoanalysis: the point in psychoanalysis is to listen to the patient's questions. It then becomes evident that the analyst does not have any answers, and should not pretend to have any. If the questions are good questions, then the patient will find the answers.

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