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The Treatment of Patients with Borderline Personality Organization[1]

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Introduction

This is the third in a series of papers about borderline personality organization. In the first (1966), I suggested that there exist two levels of ego organization resulting from the degree of synthesis of "identification systems." The term "identification systems" was used to include introjections, identifications, and ego identity as a progressive sequence in the process of internalization of object relationships. The organization of identification systems takes place first at a basic level of ego functioning at which primitive dissociation or "splitting" is the crucial mechanism for the defensive organization of the ego. Later, a second, more advanced level of defensive organization of the ego is reached, at which repression becomes the central mechanism replacing splitting. Splitting can be defined, in this restricted sense, as the active process of keeping apart identification systems of opposite quality.

I also suggested that patients with so-called "borderline" personality disorders present a pathological fixation at the lower level of ego organization, at which splitting and other related defensive mechanisms predominate. The persistence of the lower level of ego organization itself interferes with the normal development and integration of identification systems and, therefore, also with the normal development of the ego and superego.

In the second paper of this series (1967), the term "borderline personality organization" for these conditions rather than "borderline states, " or other nomenclature, was used because it appears that these patients present a rather specific, quite stable, pathological personality organization rather than transitory states on the road from neurosis to psychosis, or from psychosis to neurosis. The clinical syndromes which reflect such borderline personality organization seem to have in common: (i) typical symptomatic constellations, (ii) typical constellations of defensive operations of the ego, (iii) typical pathology of internalized object relations, and (iv) characteristic instinctual vicissitudes. Under severe stress or under the effect of alcohol or drugs, transient psychotic episodes may develop in these patients; these psychotic episodes usually improve with relatively brief but well structured treatment approaches. When psychoanalysis is attempted, these patients may develop a particular loss of reality-testing and even delusional ideas restricted to the transference situation—they develop a transference psychosis rather than a transference neurosis.

In the earlier papers the analysis of the structural characteristics of borderline personality organization was emphasized. Structural analysis referred to two issues: (i) ego strength and the characteristic defensive operations of the ego of these patients, and (ii) the pathology of their internalized object relationships. In regard to the first issue, in the borderline personality organization there are nonspecific manifestations of ego weakness, represented especially by a lack of anxiety tolerance, a lack of impulse control, and a lack of developed sublimatory channels. In addition, there are specific aspects of ego weakness: particular defences in these patients bring about distortions in ego functioning which clinically also manifest themselves as ego weakness. The implication of this observation is that the therapeutic undoing of these particular defences may actually strengthen the ego, rather than create further ego weakness. Splitting, primitive idealization, early forms of projection, and especially projective identification, denial, and omnipotence constitute characteristic defence constellations in patients with borderline personality organization.

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In regard to the second issue involved in the structural analysis of these patients, namely the pathology of their internalized object relationships, I attempted to trace the origin of that pathology, as well as its consequences for ego and superego development, with special stress on the syndrome of identity diffusion **(Erikson, 1956)**.

Finally, I suggested that in borderline patients there is an excessive development of pregenital and, especially, oral aggression which tends to induce premature development of oedipal strivings, and as a consequence, there is a particular pathological condensation of pregenital and genital aims under the overriding influence of aggressive needs. It is this constellation of instinctual conflicts which determines the peculiar characteristics of the transference paradigms of the patients that will be discussed below.

In the present paper I shall examine the difficulties of the treatment of these patients, and present some general propositions about psychotherapeutic strategy with them. A general outline of these propositions follows.

Many patients with borderline personality organization do not tolerate the regression within a psychoanalytic treatment, not only because of their ego weakness and their proneness to develop transference psychosis, but also, and very predominantly, because the acting out of their instinctual conflicts within the transference gratifies their pathological needs and blocks further analytic progress. What appears on the surface as a process of repetitive "working through" is in reality a quite stable compromise formation centered in acting out of the transference within the therapeutic relationship.

Efforts to treat these patients with supportive psychotherapy frequently fail. Supportive psychotherapy aims at reinforcing the defensive organization of the patient, tries to prevent the emergence of primitive transference paradigms, and tries to build up a working relationship in order to help the patient achieve more adaptive patterns of living. Such an approach prevents regression within the transference; transference psychosis does not develop; and the kind of therapeutic stalemate previously mentioned is avoided. However, a supportive approach frequently fails because the characteristic defences predominating in these patients interfere with the building up of a working relationship, the "therapeutic alliance" **(Sterba, 1934)**; **(Zetzel, 1966)**. The negative transference aspects, especially the extremely severe latent negative transference dispositions, tend to mobilize even further the pathological defences of these patients. The final outcome of such an approach is often the splitting up of the negative transference, much acting out outside the treatment hours, and emotional shallowness in the therapeutic situation. The "emptiness" of the therapeutic interaction over long periods of time may be a consequence of such a supportive approach, and this emptiness also tends in itself to produce therapeutic stalemates. In this case, instead of the turbulent, repetitive acting out of the transference within the hours, a situation develops in which the therapist attempts to provide support, which the patient seems incapable of integrating.

In most patients with borderline personality organization, a special form of modified analytic procedure or psychoanalytic psychotherapy may be indicated. This psychotherapy differs both from the classical psychoanalytic procedure, and from the more usual forms of expressive and supportive psychoanalytically-oriented psychotherapies. Following Eissler **(1953)**, this psychotherapeutic procedure can be described as representing the introduction of several "parameters of technique" into the psychoanalytic situation, without expecting them to be fully resolved. The term "modification of technique" seems preferable to that of "parameter of technique, " when such modification is introduced into a treatment situation that corresponds to a psychoanalytic psychotherapy rather than to a classical psychoanalysis (Frosch).

The main characteristics of this proposed modification in the psychoanalytic procedure are: (i) systematic elaboration of the manifest and latent negative transference without attempting to achieve full genetic reconstructions on the basis of it, followed by "deflection" of the manifest negative transference away from the therapeutic interaction through systematic examination of it in the patient's relations with others; (ii) confrontation with and interpretation of those pathological defensive operations which characterize borderline patients, as they enter the negative transference; (iii) definite structuring of the therapeutic situation with as active measures as necessary in order to block the acting out of the transference within the therapy itself (for example, by establishing limits under which the treatment is carried out, and providing strict limits to nonverbal aggression permitted

in the hours); (iv) utilization of environmental structuring conditions, such as hospital, day hospital, foster home, etc., if acting out outside of the treatment hours threatens to produce a chronically stable situation of pathological instinctual gratification; (v) selective focusing on all those areas within the transference and the patient's life which illustrate the expression of pathological defensive operations as they induce ego weakening and imply reduced reality testing; (vi) utilization of the positive transference manifestations for maintenance of the therapeutic alliance, and only partial confrontation of the patient with those defences which protect the positive transference; (vii) fostering more appropriate expressions in reality for those sexual conflicts which, through the pathological condensation of pregenital aggression and genital needs, interfere with the patient's adaptation; in other terms, "freeing" the potential for more mature genital development from its entanglements with pregenital aggression.

Review of the Pertinent Literature

A general review of the literature on borderline conditions is included in a previous article **(Kernberg, 1967)**. From the point of view of the treatment of borderline conditions, Knight **(1953a)**, **(1953b)** and Stone **(1954)** present the most comprehensive overview. The main question raised in the literature is whether these patients can be treated by psychoanalysis or whether they require some form of psychotherapy. Intimately linked with this question is the delimitation of what is psychoanalysis and what is not. Thus, for example, Fromm-Reichmann **(1950)**, who has contributed significantly to the treatment of borderline and psychotic patients, implies that the psychoanalytic procedure may be used for such patients, but she extends the concept of what is referred to as psychoanalysis to include what many other authors would definitely consider analytically-oriented psychotherapy.

Gill **(1951)**, **(1954)** has attempted to delimit classical psychoanalysis from analytically-oriented psychotherapies, stating that psychoanalysis, in a strict sense, involves consistent adherence by the analyst to a position of neutrality (and neutrality, he rightly states, does not mean mechanical rigidity of behaviour with suppression of any spontaneous responses). He believes that psychoanalysis requires the development of a full, regressive transference neurosis and that the transference must be resolved by techniques of interpretation alone. In contrast, Gill further states, analytically-oriented psychotherapies imply less strict adherence to neutrality; they imply recognition of transference phenomena and of transference resistance, but they use varying degrees of interpretation of these phenomena without permitting the development of a full-fledged transference neurosis, and they do not imply resolution of the transference on the basis of interpretation alone.

This delimitation is a useful one but exception can be taken to Gill's **(1954)** implication that in psychoanalysis the analyst "actively produces" the regressive transference neurosis. In agreement with Macalpine **(1950)**, Gill **(1954)** states that "the analytic situation is specifically designed to enforce a regressive transference neurosis". However, the analytic situation permits the development of the regressive pull inherent in the emergence of the repressed, pathogenic childhood conflicts. Macalpine's description of what she calls the regressive, infantile setting of the analytic situation seriously neglects the progressive elements given in that situation, such as the respect of the analyst for the patient's material, for his independence, and the implicit trust and confidence the analyst has for the patient's capacity to mature, and to develop his own solutions (G. Ticho).

To return to the main point, Gill's definition is very helpful in differentiating psychoanalysis proper from the psychoanalytically-oriented or exploratory psychotherapies. Eissler **(1953)** has further clarified this issue in his discussion of the "parameters of technique, " which imply modifications of the analytic setting usually necessary in patients with severe ego distortions. He suggests that the treatment still remains psychoanalysis if such parameters are introduced only when indispensable, not transgressing any unavoidable minimum, and when they are used only under circumstances which permit their self-elimination, their resolution through interpretation before termination of the analysis itself. Actually, as Gill **(1954)** points out, this involves the possibility of converting a psychotherapy into analysis. Additional clarifications of the differences between psychoanalysis and other related psychotherapies can be found in papers by Stone **(1951)**, Bibring **(1954)**, and Wallerstein and Robbins **(1956)**.

From the viewpoint of Gill's delimitation of psychoanalysis, it appears that authors dealing with the problem of the treatment of borderline

conditions may be placed on a continuum ranging from those who recommend psychoanalysis, to those who believe that psychotherapy rather than psychoanalysis, and especially a supportive form of psychotherapy, is the treatment of choice. Somewhere in the middle of this continuum there are those who believe that some patients presenting borderline personality organization may still be analysed while others would require expressive psychotherapy; and also there are those who do not sharply differentiate between psychoanalysis and psychotherapy.

The first detailed references in the literature to the therapeutic problems with borderline patients were predominantly on the side of recommending modified psychotherapy with supportive implications, in contrast to classical psychoanalysis. Stern **(1938)**, **(1945)** recommends an expressive approach, with a constant focus on the transference rather than on historical material, and with constant efforts to reduce the clinging, childlike dependency of the patient on the analyst. He feels that these patients need a new and realistic relationship, in contrast to the traumatic ones of their childhood; he believes that such patients can only gradually develop the capacity to establish a transference neurosis similar to that of the usual analytic patient. He concludes that analysis may and should be attempted only at later phases of their treatment. Schmideberg **(1947)** recommends an approach probably best designated as expressive psychotherapy, and is of the opinion that these patients cannot be treated by classical analysis. Knight's **(1953a)**, **(1953b)** important contributions to the psychotherapeutic strategy with borderline cases lean definitely in the direction of the purely supportive approach, on one extreme of the continuum. He stresses the importance of strengthening the ego of these patients, and of respecting their neurotic defences; he considers "deep interpretations" dangerous because of the regressive pull that such interpretations have, and because the weak ego of these patients makes it hard enough for them to keep functioning on a secondary process level. He stresses the importance of structure, both within the psychotherapeutic setting and in the utilization of the hospital and day hospital, as part of the total treatment programme for such patients.

Somewhere toward the middle of the spectrum are the approaches recommended by Stone **(1954)** and Eissler **(1953)**. Stone feels that borderline patients may need preparatory psychotherapy but that at least some of these patients may be treated with classical psychoanalysis either from the beginning of treatment or after some time to build up a working relationship with the therapist. Stone also agrees with Eissler that analysis can be attempted at later stages of treatment with such patients only if the previous psychotherapy has not created transference distortions of such magnitude that the parameters of technique involved cannot be resolved through interpretation. Eissler suggested that in some cases it might be necessary to change analysts for the second phase of the treatment. Glover **(1955)** implies that at least some of these cases are "moderately accessible" to psychoanalysis.

At the other end of the spectrum are a number of analysts influenced to varying degrees by the so-called British school of psychoanalysis **(Bion, 1957)**; **(Heimann, 1955b)**; **(Little, 1951)**; **(Rosenfeld, 1958)**; **(Segal, 1964)**; **(Winnicott, 1949)**, **(1960)**. These analysts believe that classical psychoanalytic treatment can indeed be attempted with many, if not all, borderline patients. Some of their contributions have been of crucial importance to the better understanding of the defensive organization, and the particular resistances characteristic of patients with borderline personality organization. Despite my disagreement with their general assumption about the possibility of treating most borderline patients with psychoanalysis, I believe that the findings of these analysts permit modifications of psychoanalytically-oriented psychotherapies specifically adapted to the transference complications of borderline patients: I am referring here especially to the work of Little **(1958)**, **(1960a)**, **(1960b)**, Winnicott **(1949)**, Heimann **(1955b)**, Rosenfeld **(1964)**, and Segal **(1964)**.

My suggestions for treatment outlined in the present paper would appear in the middle zone of the continuum: in my opinion, in most patients presenting borderline personality organization a modified analytic procedure or special form of expressive psychoanalytic psychotherapy rather than classical psychoanalysis is indicated. This expressive approach should involve consistent interpretive work with those defensive operations reflecting the negative transference and contributing directly or indirectly to maintaining the patient's ego weakness. There are some patients with borderline personality organization for whom psychoanalysis is definitely indicated and I shall attempt to identify them.

Transference and Countertransference Characteristics

An important feature of the therapeutic problems with borderline patients is the development of transference psychosis. Several authors have described the characteristics of this transference regression, and a general summary about this issue can be found in a paper by Wallerstein **(1967)**.

Perhaps the most striking characteristic of the transference manifestations of patients with borderline personality organization is the premature activation in the transference of very early conflict-laden object relationships in the context of ego states that are dissociated from each other. It is as if each of these ego states represents a full-fledged transference paradigm, a highly developed, regressive transference reaction within which a specific internalized object relationship is activated in the transference. This is in contrast to the more gradual unfolding of internalized object relationships as regression occurs in the typical neurotic patients. Clinical experience reveals that the higher levels of depersonified and abstracted superego structures are missing to an important extent, and the same is true for many autonomous ego structures, especially neutralized, secondarily autonomous character structures. Thus the premature activation of such regressed ego states represents the pathological persistence of "non-metabolized" internalized object relations of a primitive and conflict-laden kind.

The conflicts that typically emerge in connection with the reactivation of these early internalized object relations may be characterized as a particular pathological condensation of pregenital and genital aims under the overriding influence of pregenital aggression. Excessive pregenital, and especially oral, aggression tends to be projected and determines the paranoid distortion of the early parental images, particularly those of the mother. From a clinical point of view, whether this is a consequence of severe early frustration or actual aggression on the mother's part, whether it reflects excessive constitutional aggressive drive derivatives, whether it reflects a lack of capacity to neutralize aggression or lack of constitutionally determined anxiety tolerance, is not so important as the final result—the paranoid distortion of the early parental images. Through projection of predominantly oral-sadistic and also anal-sadistic impulses, the mother is seen as potentially dangerous, and hatred of the mother extends to a hatred of both parents when later they are experienced as a "united group" by the child. A "contamination" of the father image by aggression primarily projected onto mother and lack of differentiation between mother and father tend to produce a combined, dangerous father-mother image and a later conceptualization of all sexual relationships as dangerous and infiltrated by aggression. Concurrently, in an effort to escape from oral rage and fears, a "flight" into genital strivings occurs; this flight often miscarries because of the intensity of the pregenital aggression which contaminates the genital strivings **(Heimann, 1955a)**.

The transference manifestations of patients with borderline personality organization may at first appear completely chaotic. Gradually, however, repetitive patterns emerge, reflecting primitive self-representations and related object-representations under the influence of the conflicts mentioned above, and appear in the treatment as strongly negative transference paradigms. The defensive operations characteristic of borderline patients (splitting, projective identification, denial, primitive idealization, omnipotence) become the vehicle of the transference resistances. The fact that these defensive operations have, in themselves, ego-weakening effects **(Kernberg, 1966)**, **(1967)** is suggested as a crucial factor in the severe regression that soon complicates the premature transference developments.

What is meant by "ego weakness" in borderline patients? To conceive of ego weakness as consisting of a rather frail ego barrier which, when assaulted by id derivatives, is unable to prevent them from "breaking through" or "flooding" the ego, appears insufficient. Hartmann and his colleagues' **(1946)** and Rapaport's **(1957)** analyses of the ego as an overall structure within which sub-structures determine specific functions, as well as being determined by them, convincingly imply that ego weakness should be conceptualized not simply as absence or weakness of such structures, but as replacement of higher-level by lower-level ego structures. One aspect of ego weakness in patients with borderline personality organization is evidence by the "lower" defensive organization of the ego in which the mechanism of splitting and other related defences are used, in contrast to the defensive organization of the ego around the "higher" mechanism of repression and other related defences in neuroses **(Kernberg, 1966)**. Also, the failure of normal integration of the

structures derived from internalized object relationships (integrated self-concept, realistic object representations, integration of ideal-self and ideal-object representations into the ego ideal, integration of superego forerunners with more realistic introjections of parental images into the superego, etc.) interferes with the process of identity formation and individualization, and with neutralization and abstraction of both ego and superego functions. All of this is reflected in the reduction of the conflict-free ego sphere, clinically revealed in the presence of "nonspecific" aspects of ego weakness, particularly a lack of anxiety tolerance, a lack of impulse control, and a lack of developed sublimatory channels **(Kernberg, 1967)**.

In addition, and most importantly from the point of view of psychotherapeutic intervention with these patients, "nonspecific" ego weakness is also evident in the relative incapacity of the patients with such a pathological ego organization tentatively to dissociate their ego into an experiencing and an observing part and in the related incapacity to establish a therapeutic alliance. The dynamics of borderline personality organization are much more complicated than what is conveyed by the metaphor of "flooding" the ego because of its "weak barriers, " because underneath the "weaknesses" are extremely strong, rigid, primitive, and pathological ego structures.

Let us now return to the issue of transference regression in these patients. Once they embark upon treatment, the crucial decompensating force is the patient's increased effort to defend himself against the emergence of the threatening primitive, especially negative, transference reactions by intensified utilization of the very defensive operations which have contributed to ego weakness in the first place. One main "culprit" in this regard is probably the mechanism of projective identification, described by Melanie Klein **(1946)** and others (Heimann, 1955; **(Money-Kyrle, 1956)**; **(Rosenfeld, 1963)**; **(Segal, 1964)**. Projective identification is a primitive form of projection, mainly called upon to externalize aggressive self- and object-images; "empathy" is maintained with the real objects onto which the projection has occurred, and is linked with an effort to control the object now feared because of this projection **(Kernberg, 1965)**, **(1967)**.

In the transference this is typically manifest as intense distrust and fear of the therapist, who is experienced as attacking the patient, while the patient himself feels empathy with that projected intense aggression and tries to control the therapist in a sadistic, overpowering way. The patient may be partially aware of his own hostility but feel that he is simply responding to the therapist's aggression, and that he is justified in being angry and aggressive. It is as if the patient's life depended on his keeping the therapist under control. The patient's aggressive behaviour, at the same time, tends to provoke from the therapist counter-aggressive feelings and attitudes. It is as if the patient were pushing the aggressive part of his self onto the therapist and as if the countertransference represented the emergence of this part of the patient from within the therapist **(Money-Kyrle, 1956)**; **(Racker, 1957)**.

It has to be stressed that what is projected in a very inefficient and self-defeating way is not "pure aggression, " but a self-representation or an object-representation linked with that drive derivative. Primitive self- and primitive object-representations are actually linked together as basic units of primitive object relationships **(Kernberg, 1966)**, and what appears characteristic of borderline patients is that there is a rapid oscillation between moments of projection of a self-representation while the patient remains identified with the corresponding object-representation, and other moments in which it is the object-representation that is projected while the patient identifies with the corresponding self-representation. For example, a primitive, sadistic mother image may be projected onto the therapist while the patient experiences himself as the frightened, attacked, panic-stricken little child; moments later, the patient may experience himself as the stern, prohibitive, moralistic (and extremely sadistic) primitive mother image, while the therapist is seen as the guilty, defensive, frightened but rebellious little child. This situation is also an example of "complementary identification" **(Racker, 1957)**.

The danger in this situation is that under the influence of the expression of intense aggression by the patient, the reality aspects of the transference-countertransference situation may be such that it comes dangerously close to reconstituting the originally projected interaction between internalized self- and object-images. Under these circumstances, vicious circles may be created in which the patient projects his aggression onto the therapist and reintrojects a severely distorted image of the therapist under

the influence of the projected aggressive drive derivatives, thus perpetuating the pathological early object relationship. Heimann **(1955b)** has illustrated these vicious circles of projective identification and distorted reintrojection of the therapist in discussing paranoid defences. Strachey **(1934)** has referred to the general issue of normal and pathological introjection of the analyst as an essential aspect of the effect of interpretation, especially in regard to modifying the superego. This brings us to the problem of the influence of "mutative interpretations" (Strachey) on the establishment and maintenance of the therapeutic alliance.

It was mentioned above that one aspect of ego weakness in patients with borderline personality organization is the relative absence of an observing ego. We may now add that this factor is compounded by the patient's distortion of the therapist resulting from excessive projective operations under the influence of the negative transference. To establish a therapeutic alliance with the therapist becomes equal to submission to him as a dangerous, powerful enemy, and this further reduces the capacity for the activation of the observing ego.

A repeated observation from the Psychotherapy Research Project at The Menninger Foundation, about the psychotherapy of borderline patients, is that a high price was paid when the therapist tried to stay away from the latent negative transference and attempted to build a therapeutic relationship with the patient in an atmosphere of denial of that negative transference. Frequently, under these conditions, the results were an emotionally shallow therapeutic relationship, and a pseudo-submission by the patient to what he experienced as the therapist's demands. Serious acting out or even interruption of the treatment followed periods in which the therapist thought that the patient was "building up an identification" with him, or "introjecting value systems" of the therapist, while the patient remained emotionally detached. The implication is that a consistent undoing of the manifest and latent negative transference is an important, probably indispensable, prerequisite for a broadening of the observing ego and for solidifying a therapeutic alliance.

The gradual broadening of the conflict-free ego sphere together with a broadening of the observing ego throughout therapy facilitates the disruption of the vicious circle of projection and reintrojection of sadistic self- and object-images in the transference. Strachey **(1934)**, in his description of mutative interpretations, identifies two phases of such interpretations: the first phase consists of a qualitative modification of the patient's superego; and the second consists of the patient's expressing his impulses more freely, so that the analyst can call attention to the discrepancy between the patient's view of him as an archaic fantasy object, and the analyst as a real external object. Strachey implies that first the patient permits himself to express his aggression in a freer way, as his superego prohibitions decrease; only then can the patient become aware of the excessive, inappropriate nature of his aggressiveness toward the external object and be able to acquire insight into the origin of his reaction; so the need to project such aggression once again onto the analyst gradually decreases. I would add to this description that, both in the phase of superego modification and in the phase of differentiation between the patient's fantasied object and the analyst as a different object, an observing ego is needed. Thus, the observing ego and interpretation of projective-introjective cycles mutually reinforce each other.

The discussion of projective identification leads to the issue of how the intensity of projection and reintrojection of aggressive drive-derivatives in the transference interferes with the observing functions of the ego; and this interference in itself contributes to the transference regression. Yet, the most important way in which projective identification contributes to the transference regression is the rapid oscillation of projection of self- and object-images; this rapid oscillation undermines the stability of the patient's ego boundaries in his interactions with the therapist.

In previous papers **(1966)**, **(1967)** I have commented on the differentiation between self- and object-representations which are part of early introjections and identifications. The organizing function of this differentiation of ego boundaries was stressed. In the psychosis, such differentiation between self- and object-images does not take place sufficiently and ego boundaries are therefore missing to a major extent. In contrast, in patients presenting borderline personality organization, this differentiation has taken place sufficiently, and therefore ego boundaries are more stable. The borderline patient is capable of differentiating the self from external objects, internal experience from external perception, and reality testing is also preserved to a major extent. This capacity of the borderline

patient is lost within the transference regression.

Rapidly alternating projection of self-images and object-images representing early pathological internalized object relationships, produces a confusion of what is "inside" and "outside" in the patient's experience of his interactions with the therapist. It is as if the patient maintained a sense of being different from the therapist at all times, but concurrently he and the therapist were interchanging their personalities. This is a frightening experience which reflects a breakdown of ego boundaries in that interaction, and as a consequence there is the loss of reality testing in the transference. It is this loss of reality testing in the transference which most powerfully interferes with the patient's capacity to distinguish fantasy from reality, and past from present in the transference, and also interferes with his capacity to distinguish his projected transference objects from the therapist as a real person. Under such circumstances, the possibility that a mutative interpretation will be effective is seriously threatened. Clinically, this appears as the patient experiencing something such as, "Yes, you are right in thinking that I see you as I saw my mother, and that is because she and you are really identical". It is at this point that what has been referred to above as a transference psychosis is reached.

At this point, the therapist and the transference object become identical, the loss of reality testing is reflected in the development of delusions, and even hallucinations may complicate the transference reaction. The therapist may be identified with a parental image: one patient felt that the therapist had become her father and would rape her. At other times the therapist may be identified with a projected dissociated self-representation: one patient became convinced that his analyst carried on an affair with the patient's mother and threatened to kill him.

"Transference psychosis" is a term which should be reserved for the loss of reality testing and the appearance of delusional material within the transference that does not affect very noticeably the patient's functioning outside the treatment setting. There are patients who have a psychotic decompensation during treatment which is for all purposes indistinguishable from any other psychotic breakdown, and which affects their life in general as well as the therapeutic situation. It may be that regression in the transference did contribute to the breakdown, but it is questionable whether the term transference psychosis is always warranted under these conditions. In contrast, patients with a typical transference psychosis may develop delusional ideas and what amounts to psychotic behaviour within the treatment hours, over a period of days and months, without showing these manifestations outside the hours. Hospitalization may sometimes be necessary for such patients, and at times it is quite difficult to separate a transference-limited psychotic reaction from a broader one. Nevertheless, in many borderline patients this delimitation is quite easy, and it is often possible to resolve the transference psychosis within the psychotherapy **(Holzman and Ekstein, 1959)**; **(Little, 1958)**; **(Reider, 1957)**; **(Romm, 1959)**; **(Wallerstein, 1967)**. Control of transference acting out within the therapeutic relationship becomes of central importance.

Transference acting out within the therapeutic relationship refers to the acting out of the transference reaction in the hours, within the treatment setting itself. As part of the transference regression, any patient may tend to act toward the therapist rather than reflect on his feelings about him. For example, rather than verbally expressing strong feelings of anger and reflecting on the implications and sources of this anger, a patient may yell at the therapist, insult him, and express his emotions in what amounts to direct actions rather than verbally, over a period of weeks and months. This, of course, is not exclusive to borderline patients, but in the typical analytic treatment of neurotic patients such acting out during the hours only occurs at points of severe regression, after many months of build-up, and can usually be resolved by interpretation alone. This is not so in the case of patients with borderline personality organization, and the therapist's efforts to deal with acting out within the therapeutic relationship by interpretation alone, especially when it is linked with a transference psychosis, frequently appears to fail. This is partly so because of the loss of the observing ego by virtue of the projective-introjective cycles mentioned and because of the loss of ego boundaries and of the reality testing that goes with it. To a major degree, however, such unrelenting transference acting out is highly resistant to interpretation because it also gratifies the instinctual needs of these patients, especially those linked with the severe, pre-oedipal aggressive drive-derivatives so characteristic of them. It is this gratification of instinctual needs which represents the major transference resistance. Two

clinical examples will illustrate this point.

A hospitalized borderline patient literally yelled at her hospital physician during their early half-hour interviews, and her voice carried to all the offices in the building. After approximately two weeks of such behaviour, which the hospital physician felt unable to influence by any psychotherapeutic means, he saw her by chance shortly after leaving his office. He was still virtually trembling, and was struck by the fact that the patient seemed completely relaxed, and smiled in a friendly way while talking to some other patients with whom she was acquainted. Before entering the hospital, the patient had engaged in bitter fights with her parents for many years. In the hospital, all this fighting centred on her physician, while the hospital staff was surprised by the relaxation she showed with other personnel. It gradually became clear that her angry outbursts toward her physician reflected a gratification of her aggressive needs far beyond any available to her before she entered the hospital, and that this gratification in itself was functioning as the major transference resistance. When this was conveyed to her, and the hospital physician limited the amount of yelling and insulting that would be permitted in the hours, the patient's anxiety increased noticeably outside the hours, her conflictual patterns became more apparent within the hospital, and shifting attitudes in the transference became apparent, indicating movement in the therapy.

Another patient who was seen in expressive psychotherapy demanded an increase of his hours in an extremely angry, defiant way. Over a period of time it was interpreted to him that it was hard for him to tolerate the guilty feelings over his own greediness, and that he was projecting that guilt onto the therapist in the form of fantasies of being hated and depreciated by him. It was also interpreted that his demands to see the therapist more often represented an effort to reassure himself of the therapist's love and interest in order to neutralize his distrust and suspiciousness of the therapist's fantasied hatred of him. The patient seemed to understand all this but was unable to change his behaviour. The therapist concluded that the patient's oral aggression was being gratified in a direct way through these angry outbursts, and that this development might contribute to a fixation of the transference. The therapist told the patient of his decision not to increase the hours and at the same time presented as a condition for continuing the treatment that the patient exercise some degree of control over the form and appropriateness of the expression of his feelings in the hours. With this modification of technique in effect, a noticeable change occurred over the next few days. The patient became more reflective, and finally was even able to admit that he had obtained a great satisfaction from being allowed to express intense anger at the therapist in such a direct way.

The acting out of the transference within the therapeutic relationship becomes the main resistance to further change in these patients, and parameters of technique required to control the acting out should be introduced in the treatment situation. There is a danger of entering the vicious circle of projection and reintrojection of sadistic self- and object-images of the patient as the therapist introduces parameters of technique. He may appear to the patient as prohibitive and sadistic. This danger can be counteracted if the therapist begins by interpreting the transference situation, then introduces structuring parameters of techniques as needed, and finally interprets the transference situation again without abandoning the parameters. Some aspects of this technique have been illustrated in a different context by Sharpe **(1950)**, who demonstrates how to deal with acute episodes of anxiety.

In many cases, the consistent blocking of the transference acting out within the therapeutic relationship is sufficient in itself to reduce and delimit the transference psychosis to such an extent that further interpretive work may suffice to dissolve it. The very fact that the therapist takes a firm stand and creates a structure within the therapeutic situation which he will not abandon tends to enable the patient to differentiate the therapist from himself, and thus to undo the confusion caused by frequent "exchange" of self- and object-representation projections by the patient. Also, such a structure may effectively prevent the therapist's acting out his countertransference, especially the very damaging chronic countertransference reactions which tend to develop in intensive psychotherapy with borderline patients (Sutherland).

Chronic countertransference fixations are to an important degree a consequence of the patient's success in destroying the analyst's stable and mature ego identity in their relationship **(Kernberg, 1965)**. In order to keep in emotional contact with the patient, analysts

working with patients presenting borderline personality organization have to be able to tolerate a regression within themselves, which on occasions may reactivate the remnants of early, conflict-laden relationships in the therapist. Aggressive impulses tend to emerge in the analyst, which he has to control and utilize in gaining a better understanding of the patient. The extra effort needed for this work with the counter-transference and the very tolerance and neutrality toward the patient which is part of the analyst's effort to keep in emotional touch with him, increase the stress within the therapist. At the same time, the aggressive behaviour of patients with severe transference regression continuously undermines the analyst's self-esteem and self-concept in their interaction, and thus also the integrating ego function of the analyst's ego identity. Thus, the analyst may be struggling at the same time with the upsurge of primitive impulses in himself, with the tendency to control the patient as part of his efforts to control these impulses, and with the temptation to submit in a masochistic way to the patient's active efforts of control **(Money-Kyrle, 1956)**. Under these circumstances, pathological, previously abandoned defensive operations and especially neurotic character traits of the analyst may become reactivated, and the patient's and the analyst's personality structures come to appear as if they were "pre-matched" to each other, interlocked in a stable, insoluble transference-countertransference bind. The establishment and maintenance of structuring parameters or modifications of technique is, then, a fundamental, protective technical requirement at that point and often has to be maintained throughout a great part of the course of the psychotherapy with borderline patients.

The issue of the indications for hospitalization, in order to provide this structure when it is not possible to provide it otherwise, is beyond the scope of this paper. I would only stress that for many patients hospitalization is indispensable to creating and maintaining an environmental structure which effectively controls transference acting out.

Does the transference psychosis also represent the reproduction of unconscious, pathogenic object relationships of the past, and thus provide further information about the patient's conflicts? Sometimes it appears difficult to find evidence in the patient's past of interactions with the parental figures characterized by the violence and primitiveness of the transference reaction at the level of a regressive transference psychosis. At other times, the transference indeed appears to reflect actual, very traumatic experiences that these patients have undergone in their infancy and early childhood **(Frosch; Holzman and Ekstein, 1959)**. It is probable that the transference in all of these patients originates, to a large extent, in the fantasy distortions which accompanied the early pathogenic object relationships, as well as in the relationships themselves, and in the pathological defensive operations mobilized by the small child to extricate himself from the threatening interpersonal relationships. The transference psychosis represents a condensation of actual experiences, a gross elaboration of them in fantasy, and efforts to modify or turn away from them **(Klein, 1952)**. This brings us to the technical problems of dealing with the pathological defensive operations characteristic of borderline patients which were mentioned above. Interpretive work attempting to undo these pathological operations as they enter the transference may further serve to resolve the transference psychosis and to increase ego strength.

Because the acting out of the transference within the therapeutic relationship itself appears to be such a meaningful reproduction of past conflicts, fantasies, defensive operations, and internalized object relationships of the patients, one is tempted to interpret the repetitive acting out as evidence for a working through of these conflicts. The repetition compulsion expressed through transference acting out cannot be considered working through as long as the transference relationship provides these patients with instinctual gratification of their pathological, especially their aggressive needs. Some of these patients obtain much more gratification of their pathological instinctual needs in the transference than would ever be possible in extra-therapeutic interactions. The patient's acting out at the regressed level overruns the therapist's effort to maintain a climate of "abstinence". At the other extreme, to maintain such a rigid and controlled treatment structure that the transference development is blocked altogether, and especially the negative transference remains hidden, appears also to induce a stalemate of the therapeutic process, which is as negative in its effect as unchecked transference acting out. A "purely supportive" relationship, understood as a careful avoidance of focusing on the transference, often brings about a chronic shallowness of the therapeutic relationship, acting out outside

the treatment hours which is rigidly split off from the transference itself, pseudo-submission to the therapist, and a lack of change despite years of treatment. There are patients who in spite of all efforts cannot tolerate transference regression, nor the establishment of any meaningful relationship, without breaking it off; nevertheless, the overall psychotherapeutic chances are much better when attempts are made to undo emotional shallowness and bring about a real emotional involvement within the therapy. The price is high, the danger of excessive transference regression unavoidable, but with a careful and consistent structuring of the therapeutic relationship it should be possible in most cases to prevent the development of insoluble transference-countertransference binds.

How much of a "real person" does the therapist need to appear to be in the patient's eyes? Several authors have stressed the importance of the therapist appearing as a "real person, " permitting the patient to use him as an object for identification and superego introjection. Gill **(1954)** has stated that "… we have failed to carry over into our psychotherapy enough of the non-directive spirit of our analysis". If what is meant by "real person" refers to the therapist's direct and open interventions, his providing structure and limits, and his active refusal to be forced into regressive countertransference fixations, then the therapist should indeed be a real person. However, if what is meant by "real person" is that the regressive transference reactions of borderline patients, their inordinate demands for love, attention, protection, and gifts should be responded to by "giving" beyond what an objective, professional psychotherapist-patient relationship would warrant, objection must be made to the therapist being such a "real person". What has been called the excessive "dependency needs" of these patients actually reflects their incapacity really to depend upon anyone, because of the severe distrust and hatred of themselves and of their past internalized object images that are reactivated in the transference. The working through of the negative transference, the confrontation of the patients with their distrust and hatred, and with the ways in which that distrust and hatred destroys their capacity to depend on what the psychotherapist can realistically provide, better fulfills their needs. Clinical experience has repeatedly demonstrated that the intervention of the psychotherapist as a particular individual, opening his own life, values, interests and emotions to the patient, is of very little, if any, help.

The supposition that the patient may be able to identify himself with the therapist while severe, latent, negative transference dispositions are in the way, or are being acted out outside the treatment setting, appears highly questionable. The development of an observing ego appears to depend not on the therapist's offering himself as an unconditional friend, but as a consequence of a combined focus on the pathological cycles of projective and introjective processes, on transference distortion and acting out, and on the observing part of the ego itself. In this connection, what Ekstein and Wallerstein **(1956)** have observed in regard to borderline children, holds true for adults also:

> This maintenance of the therapeutic relationship, often made possible by interpreting within the regression, thus lays the foundation for the new development of identificatory processes rather than the superimposition of an imitative façade …

A systematic focus on and analysis of the manifest and latent negative transference is essential to undo the vicious cycle of projection and reintrojection of pathological, early self-and object-representations under the influence of aggressive drive derivatives. This systematic analysis, together with the blocking of transference acting out and a direct focusing on the observing function of the ego, represent basic conditions for change and growth in the therapy. In addition, the interpretation of the negative transference should stop at the level of the "here and now, " and should only partially be referred back to its genetic origins, to the original unconscious conflicts of the past. At the same time, the ventilation and interpretation of the negative transference should be completed by a systematic examination and analysis of the manifestations of these negative transference aspects outside the therapeutic relationship, in the patient's immediate life in all areas of interpersonal interactions.

The rationale for this suggestion is that the regressive nature of the transference reaction makes it hard enough for the patient to differentiate the therapist as a real person from the projected transference objects, and that genetic reconstructions, by further opening up regressive channels, may further reduce the reality-testing of the patient. This does not mean that the patient's past should not be drawn into the transference interpretation when that past is

a conscious memory for the patient rather than a genetic reconstruction, and when it reflects realistic aspects of his past and preconscious fantasy distortions of it. Sometimes a reference to an experience from the past relating to what the patient erroneously perceives in the therapist now, may actually help the patient to separate reality from transference. The secondary "deflection" of the negative transference by incorporating its interpretation into the broader area of the patient's interactions outside the treatment and his conscious past tends to foster the patient's reality testing and to provide considerable support within an essentially expressive psychotherapeutic approach.

The question of "insight" in borderline patients deserves discussion. Unfortunately, one frequently finds that what at first looks like insight into "deep" layers of the mind and into unconscious dynamics on the part of some borderline patients is actually an expression of the ready availability of primary process functioning as part of the general regression of ego structures. Insight which comes without any effort, is not accompanied by any change in the patient's intrapsychic equilibrium, and, above all, is not accompanied by any concern on the patient's part for the pathological aspects of his behaviour or experience, is questionable "insight". Findings from the Psychotherapy Research Project at The Menninger Foundation encourage a restriction of the concept of insight, especially in applying it to the description of borderline patients. "Authentic" insight is a combination of the intellectual and emotional understanding of deeper sources of one's psychic experience, accompanied by concern for and an urge to change the pathological aspects of that experience.

The differentiation of "positive" and "negative" transference requires further scrutiny. To classify a transference as positive or negative is certainly a rather crude oversimplification. Transference is usually ambivalent and has multiple aspects within which it is often hard to say what is positive and what is negative, what is libidinally derived and what is aggressively derived. Patients with borderline personality organization are especially prone to dissociate the positive from the negative aspects of the transference, and often tend to produce an apparent "pure" positive or "pure" negative transference. It is important to undo this artificial separation, which is one more example of the operation of the mechanism of splitting in these cases. It would be misleading to understand the emphasis on a consistent working through of the negative transference as implying a neglect of the positive aspects of the transference reactions. On the contrary, emphasis on the positive as well as on the negative transference is essential for decreasing the patient's distorted self- and object-images under the influence of aggressive drive-derivatives, and for reducing his fears of his own "absolute" badness. The positive aspects of the transference have to be highlighted therefore, in combination with the ventilation of the negative aspects of the transference. It is important to deal with the here-and-now of the positive as well as the negative aspects of the transference of borderline patients, without interpreting the genetic implications of their aggressive and libidinal drives (G. Ticho). At the same time, a good part of the positive transference disposition available to the patient may be left in its moderate, controlled expression, as a further basis for the development of a therapeutic alliance and for the ultimate growth of the observing ego **(Schlesinger, 1966)**.

Psychotherapeutic Approaches to the Specific Defensive Operations

I referred in earlier papers **(1966)**, **(1967)** to the mechanism of splitting and other related ones (primitive idealization, projective identification, denial, omnipotence), all of which are chacteristic of borderline patients. Here I will limit myself to stating how these defensive operations appear from a clinical point of view, and to suggest overall psychotherapeutic approaches in dealing with them.

1. Splitting

It needs to be stressed once more that the term "splitting" is used here in a restricted, limited sense, referring only to the process of active keeping apart of introjections and identifications of opposite quality; and this use of the term should be differentiated from its broader use by other authors. The manifestations of splitting can be illustrated with a clinical example.

The patient was a single woman in her late thirties, hospitalized because of alcoholism and drug addiction. She appeared to make remarkably steady progress in the hospital after an initial period of rebelliousness. She started psychotherapy several months before her discharge from the hospital, and then continued in outpatient psychotherapy. In contrast to her

previously disorganized life and work, she seemed to adjust well to work and social relations outside the hospital, but established several relationships, each of a few months duration, with men who appeared to exploit her and with whom she adopted quite masochistic attitudes. The therapeutic relationship was shallow; the patient was conventionally friendly. A general feeling of "emptiness" appeared to hide a strong suspiciousness, which she emphatically denied and only later admitted to her former hospital doctor but not to her psychotherapist. After a period of several months of complete abstinence, she got drunk, became quite depressed, had suicidal thoughts, and had to be rehospitalized. At no point did she let the therapist know what was going on and he only learned about this development after she was back in the hospital. Once out of the hospital again, she denied all transference implications and indeed all emotional implications of the alcoholic episode. It must be stressed that she had the memory of strong emotions of anger and depression during the days in which she was intoxicated, but she no longer felt connected with that part of herself and repeatedly expressed her feelings that this was simply not her, and she could not see how such an episode could possibly occur again.

This marked the beginning of a long effort on the therapist's part, over a period of several months, to bring the usual "empty", "friendly" but detached attitude of the patient together with her emotional upheaval during the alcoholic crisis, and especially with her efforts to hide that crisis from the therapist. Only after two more episodes of this kind, separated from each other by periods of apparently more adaptive behaviour and good functioning over several months, did it become evident that she was experiencing the therapist as the cold, distant, hostile father who had refused to rescue her from an even more rejecting, aggressive mother. The patient, at one point, told the therapist with deep emotion how on one occasion, in her childhood, she had been left abandoned in her home, suffering from what later turned out to be a severe and dangerous illness, by her mother who did not wish her own active social life to be interfered with. The patient felt that if she really expressed to the psychotherapist-father how much she needed him and loved him, she would destroy him with the intensity of her anger over having been frustrated so much for so long. The solution was to keep what she felt was the best possible relationship of detached friendliness with the therapist, while splitting off her search for love, her submission to sadistic father representatives in her masochistic submission to unloving men, and her protest against father in alcoholic episodes during which rage and depression were completely dissociated emotionally from both the therapist and her boy friends.

Efforts to bring all this material into the transference greatly increased the patient's anxiety; she became more distrustful and angry with the psychotherapist, the drinking reverted to her old pattern of chaotic involvements with men associated with excessive intake of alcohol, and all efforts to deal with this acting out through psychotherapeutic means alone failed. The decision was made to rehospitalize her. It should be stressed that from a superficial point of view the patient appeared to have done quite well earlier in the psychotherapy but now appeared to be much worse. Nevertheless, it was the psychotherapist's conviction that for the first time he was dealing with a "real" person. He hoped that a continuation of psychotherapy combined with hospitalization for as long as necessary might help her to finally overcome the stable, basic transference paradigm outlined above.

This case illustrates a strong predominance of the mechanism of splitting, its defensive function against the emergence of a rather primitive, predominantly negative transference, and its consequences evident in the shallowness and artificiality of the therapeutic interaction. A therapeutic alliance could not be established with this patient before the mechanism of splitting had been sufficiently overcome. Only consistent interpretation of the patient's active participation in maintaining herself "compartmentalized" finally could change the stable, pathological equilibrium. Consistent efforts had to be made to bridge the independently expressed, conflicting ego states, and the secondary defences protecting this dissociation had to be sought out and ventilated in the treatment. With these patients it is not a matter of searching for unconscious, repressed material, but bridging and integrating what appears on the surface to be two or more emotionally independent, but alternately active ego states.

2. Primitive idealization

Primitive idealization **(Kernberg, 1967)** manifests itself in the therapy as an extremely

unrealistic, archaic form of idealization. This idealization appears to have as its main function the protection of the therapist from the patient's projection onto him of the negative transference disposition. There is a projection onto the therapist of a primitive, "all good" self- and object-representation, with a concomitant effort to prevent this "good" image from being contaminated by the patient's "bad" self- and object-representations.

One patient felt that he was extremely lucky to have a psychotherapist who represented, according to the patient, the best synthesis of the "intellectual superiority" of one country where the therapist was born, and the "emotional freedom" of another country where the patient though he had lived for many years. On the surface, the patient appeared to be reassured by a clinging relationship with such an "ideal" therapist, and protected against what he experienced as a cold, rejecting, hostile environment by a magical union with the therapist. It soon developed that the patient felt that only by a strenuous, ongoing effort of self-deception, and deception to the therapist about himself, could he keep his good relationship with the therapist. If the therapist really knew how the patient was feeling about himself, the therapist would never be able to accept him, and would hate and depreciate him. This, by the way, illustrates the damaging effects of overidealization for the possibility of utilizing the therapist as a good superego introjection, in contrast to an overidealized, demanding one. It later turned out that this idealization was developed as a defence against the devaluation and depreciation of the therapist, seen as an empty, pompous and hypocritically conventional parental image.

It is hard to convey in a few words the unrealistic quality of the idealization given the therapist by these patients, which gives quite a different quality to the transference from the other, less regressive idealization that may be seen in the usual neurotic patients. This peculiar form of idealization has been described as an important defence in narcissistic personality structures **(Kohut, 1966)**; **(Rosenfeld, 1964)**. Psychotherapists who themselves present strong narcissistic traits in their character structure may at times be quite easily drawn into a kind of magical, mutual admiration with the patient, and may have to learn through bitter disappointment how this defensive operation may effectively undermine the establishment of any realistic therapeutic alliance. To firmly undo the idealization, to confront the patient again and again with the unrealistic aspects of his transference distortion, while still acknowledging the positive feelings that are also part of this idealization, is a very difficult task because underneath that idealization are often paranoid fears and quite direct, primitive aggressive feelings towards the transference object.

3. Early forms of projection, and especially projective identification

Projective identification is central in the manifestations of the transference of patients presenting borderline personality organization. Heimann **(1955b)** and Rosenfeld **(1963)** describe how this defensive operation manifests itself clinically.

One patient, who had already interrupted psychotherapy with two therapists in the middle of massive, almost delusional projections of her hostility, was finally able to settle down with a third therapist, but managed to keep him in a position of almost total immobility over a period of many months. The therapist had to be extremely careful even in asking questions; the patient would indicate by simply raising her eyebrow that a question was unwelcome and that therefore the therapist should change the subject. The patient felt that she had the right to be completely secretive and uncommunicative in regard to most issues of her life. She used the therapy situation on the surface as a kind of magical ritual and, apparently on a deeper level, as an acting out of her needs to exert sadistic control over a transference object onto which she had projected her aggression.

The acting out within the therapy hours of this patient's need to exert total, sadistic control over her transference object could not be modified. The therapist thought that any attempts to put limits on the patient's acting out, or to confront her with the implications of her behaviour, would only result in angry outbursts on the patient's part and in interruption of the treatment.

This raises the question of how to cope with patients who begin psychotherapy with this kind of acting out, and who attempt to distort the therapeutic situation to such a gross extent that either their unrealistic demands are met by the therapist or the continuation of the treatment is threatened. Some therapists believe that it may be an advantage to permit the patient to start out in therapy without challenging his unrealistic demands, hoping that later on, as the

therapeutic relationship is more established, the patient's acting out can be gradually brought under control. From the vantage point of long-term observation of a series of cases of this kind, it seems preferable not to attempt psychotherapy under conditions which are unrealistic. If the therapist fears that an attempt to control premature acting out would bring psychotherapy to an interruption, the necessity of hospitalization should be considered and this should be discussed with the patient. One indication for hospitalization is precisely that of protecting the beginning psychotherapeutic relationship with patients in whom regressive transference acting out cannot be handled by psychotherapeutic means alone, and where the confrontation of the patient with his pathological defensive operations threatens to induce excessive regression. Hospitalization under these circumstances may serve diagnostic as well as protective functions, and should be considered even with patients who, even without psychotherapy, would most likely continue to be able to function outside a hospital. If psychotherapy is indicated, and if the psychotherapy is unrealistically limited by premature acting out, hospitalization, even though stressful for the patient, is preferable to undertaking a psychotherapy within which the necessary structuring is interfered with by the same pathology for which definite structuring is indicated.

Projective identification is a main culprit in creating unrealistic patient-therapist relationships from the very beginning of the treatment. The direct consequences of the patient's hostile onslaught in the transference, his unrelenting efforts to push the therapist into a position in which he finally reacts with counter-aggression and the patient's sadistic efforts to control the therapist, can produce a paralysing effect on the therapy. It has already been suggested that these developments require a firm structure within the therapeutic setting, consistent blocking of the transference acting out, and in the most simple terms, a protection of the therapist from chronic and insoluble situations. To combine this firm structure with consistent clarifications and interpretations aimed at reducing projective mechanisms is an arduous task.

4. Denial

In the patients we are considering, denial may manifest itself as simple disregard for a sector of the patient's subjective experience or a sector of his external world. When pressed, the patient can acknowledge his awareness of the sector which has been denied, but cannot integrate it with the rest of his emotional experience. It is relatively easy to diagnose the operation of denial because of the glaring loss of reality-testing that it brings about. The patient acts as if he were completely unaware of a quite urgent, pressing aspect of his reality.

One patient, who had to meet a deadline for a thesis upon which his graduation and the possibility of a job depended, simply dropped the subject of the thesis in the psychotherapy sessions during the last two weeks before the deadline. He had discussed with his psychotherapist his fear of and anger toward the members of the committee in charge of examining his paper, and his denial here served the purpose, primarily, of protecting him against his paranoid fears of being discriminated against, and from those teachers whom he supposed wished to humiliate him in public. The therapist repeatedly confronted the patient with his lack of concern about finishing the paper and with his lack of effort to complete it. While interpreting the unconscious implications of this neglect, the therapist explored and confronted the patient with the many ways in which he was preventing himself from completing the paper in reality.

Denial can take quite complex forms in the transference, such as the defensive denial of reality aspects of the therapeutic situation in order to gratify transference needs.

One patient, in an attempt to overcome her anger about the analyst's unwillingness to respond to her seductive efforts, developed fantasies about the analyst's hidden intentions to seduce her as soon as she expressed her wishes for sexual intimacy with him in a submissive, defenceless way. At one point this fantasy changed to the fantasy that she was actually enjoying being raped by her father and by the analyst, and at one time intense anxiety developed in her, with a strong conviction that the analyst was actually her father, that he would sadistically rape her, and that this would bring about disaster. Out of the several implications of this transference development, the need to deny the reality of the analyst's lack of response to her sexual overtures, and her anger about this, seemed to predominate. The analyst pointed out to her that in one part of her she knew very well that the analyst was not her father, that he was not going to rape her, and that as frightening as these fantasies were, they

still permitted her to deny her anger at the analyst for not responding to her sexual demands. The oedipal implications were excluded, for the time being, from his comment. The patient relaxed almost immediately and at this point the analyst commented on her reluctance to enter into an intimate relationship with her fiancé because of the fear that her unrealistic angry demands on him would stand in the way of her sexual enjoyment, and because her projection onto her fiancé of her own anger would turn the actual intimacy into a threat of sadistic rape for her. This opened the road to further insight about her denial of aggressive impulses as well as of reality.

This last example illustrates what the consistent working through of the pathological defences which predominate in borderline patients attempts to accomplish. The working through of these defences increases reality-testing and brings about ego strengthening, rather than inducing further regression. This example also illustrates the partial nature of the transference interpretation and the deflection of the transference outside the therapeutic relationship.

At times the patient especially needs to deny the positive aspects of the transference, because of his fear that the expression of positive feelings will bring him dangerously close to the therapist. The patient fears that such excessive closeness will free his aggression in the transference as well as the (projected) aggression of the therapist toward him. Schlesinger **(1966)**, in illustrating this particular use of denial, has suggested that denial in the area of positive transference reaction should be respected because it may actually permit the patient to keep himself at an optimal distance from the therapist.

5. Omnipotence and devaluation

These two, intimately linked defensive operations of omnipotence and devaluation refer to the patient's identification with an overidealized self- and object-representation, with the primitive form of ego-ideal, as a protection against threatening needs and involvement with others. Such "self-idealization" usually implies magical fantasies of omnipotence, the conviction that he, the patient, will eventually receive all the gratification that he is entitled to, and that he cannot be touched by frustrations, illness, death, or the passage of time. A corollary of this fantasy is the devaluation of other people, the patient's conviction of his superiority over them, including the therapist. The projection of that magical omnipotence onto the therapist, and the patient's feeling magically united with or submissive to that omnipotent therapist, are other forms which this defensive operation can take.

This defensive operation is actually related to the primitive idealization mentioned above. The fractionating of the defensive operations which are characteristic of borderline patients into completely separate forms may clarify their functioning but it does necessarily over-simplify the issue. There are complex inter-twinings of all these defensive operations, and they present themselves in various combinations.

A patient with severe obesity and feelings of intense insecurity in social interactions eventually became aware of her deep conviction that she had the right to eat whatever she wanted and to expect that whatever her external form, she would still be admired, pampered, and loved. She paid only lip service to the acknowledgement that her obesity might reduce her capability to attract men, and became very angry with the therapist when the reality of this consideration was stressed. The patient began psychotherapy with the assumption that she could come for her appointment with the therapist at any time, take home the magazines in his waiting room, and need not care at all about leaving cigarette ash all over the furniture. When the implication of all this behaviour was first pointed out to her, she smiled approvingly of the therapist's "perceptiveness", but no change occurred. It was only after the therapist made very clear to her that there were definite limits to what he would tolerate, that she became quite angry, expressing more openly the derogatory thoughts about the therapist that complemented her own feelings of greatness. The conscious experience of this patient was that of social insecurity and feelings of inferiority. Her underlying feelings of omnipotence remained unconscious for a long time.

Instinctual Vicissitudes and Psychotherapeutic Strategy

A predominant characteristic of the instinctual development of patients with borderline personality organization is the excessive development of pre-genital drives, especially oral aggression, and of a particular pathological condensation of pregenital and genital aims under the overriding influence of aggressive needs. This instinctual development has direct

relevance for the therapeutic approach to these patients. The therapist should remember that in the midst of the destructive and self-destructive instinctual manifestations are hidden potentials for growth and development, and especially that what appears on the surface to be destructive and self-destructive sexual behaviour may contain the roots of further libidinal development and deepening interpersonal relationships.

There was a time when a typical misunderstanding of the implications of psychoanalytic theory and practice was the assumption that sexual activity in itself was a therapeutic factor. We have advanced a long way from such misunderstandings, and have learned that often what appears on the surface to be genital activity is actually in the service of aggressive, pregenital aims. With patients presenting borderline personality organization the opposite danger of seeing only their pregenital, destructive aims, to the neglect of acknowledging their efforts to overcome their inhibited sexual orientation, appears to be a frequent clinical problem.

A promiscuous, divorced, young woman, hospitalized after a psychotic regression which followed years of disorganized behaviour, was restricted in the hospital from male patients. On several occasions a few minutes of unobserved time had been enough for her to have intercourse in an impulsive way with other patients, practically strangers. Over many months this patient was regularly controlled and in the sessions with her hospital doctor the implications of her behaviour were discussed only in terms of her "lack of impulse control" and her "inappropriate behaviour". When a new hospital doctor tried to evaluate further the implications of her sexual behaviour, it evolved that her sexual activity had deep masochistic implications, and represented the acting out of her fantasy of being a prostitute. The hospital doctor took the position that not all sexual freedom implied prostitution, and in discussing these issues with her, the patient became very angry with him stating that he was "immoral", and she became very anxious and very angry with him when he eliminated the restrictions. She then became involved sexually with several other patients in a provocative manner, all of which the hospital doctor used further to confront her with the masochistic fantasies and the pattern of becoming a prostitute, and the implication of her submission to a primitive, sadistic superego which represented a prohibitive, combined father-mother image. She was finally able to establish a good relationship with one patient, with whom she fell in love, went steady for a two-year period, and whom she eventually planned to marry. During the latter part of these two years they had sexual intercourse, characterized by her being able for the first time in her life to have tender as well as sexual feelings toward just one man and by her taking precautions not to get pregnant, which was in contrast to her previous behaviour.

To dissociate the normal, progressive trends within the pathological sexual behaviour from its pregenital aims is easier said than done. This must be a continuous concern of the psychotherapist working with such patients.

Further Comments on the Modality of Treatment

This particular form of expressive, psychoanalytically-oriented psychotherapy is a treatment approach which differs from classical psychoanalysis in that a complete transference neurosis is not permitted to develop, nor is transference resolved through interpretation alone. It is an expressive psychotherapeutic approach in that unconscious factors are considered and focused upon, especially in regard to the negative transference and to the consistent work with the pathological defences of these patients. Parameters of technique or modifications of technique are used when necessary to control transference acting out, and although some of these parameters may be resolved during the course of the treatment itself, this is not necessarily possible nor desirable with all of them. There are also clearly supportive elements implicit in this approach. First, in the manipulation of the treatment situation, which the therapist has to undertake as part of the need to structure it. The frequency of the hours, the permissiveness or restriction in regard to out-of-hour contacts, the limits to which the patient may express himself, all may be considered as examples of factors which may be changed as the treatment demands. Second, clarifications of reality take up an important segment of the therapist's communications, and direct suggestions and implicit advice-giving are difficult to avoid under these circumstances.

The therapist should try to remain as neutral as possible, but neutrality here does not mean inactivity, and beyond certain degrees of activity on his part, the issue of whether the therapist is still neutral or not becomes academic. In general, it appears preferable to keep this kind of therapy in a face-to-face situation in order to stress the

reality aspects of it, but there is nothing magical in itself about either lying on the couch or sitting in front of the therapist. There are treatments carried out on the couch which in effect are psychoanalytic psychotherapy rather than psychoanalysis.

The goal of ego strengthening is ever present in this expressive, psychoanalytically-oriented treatment. The working through of the pathological defences characteristic of the borderline personality organization permits repression and other related defences of a higher level of ego organization to replace the ego-weakening, pathological defences of the lower level: this in itself strengthens the ego. Conflict resolution is necessarily partial, but at times a great deal can be achieved with this kind of treatment approach.

One final and very important question remains. Are some of these patients analysable either from the beginning of the treatment, or after a period of preparatory psychotherapy of the type suggested? The differences of opinion in this regard were referred to above in the review of the literature. There are specific patients within the large group presenting borderline personality organization who appear to benefit very little from the expressive, psychoanalytically-oriented treatment approach I propose, and where non-modified psychoanalysis is the treatment of choice from the beginning. This is particularly true for patients presenting the most typical forms of narcissistic personality organization.

Such patients present an unusual degree of self-reference in their interactions with other people, a great need to be loved and especially to be admired by others, and present an apparent contradiction between a very inflated concept of themselves and an inordinate need for tributes from others. Superficially, these patients do not appear to be severely regressed and some of them may function very well socially; they usually have much better impulse control than the average patient presenting borderline personality organization. They may be quite successful and efficient. It is only their emotional life which, on sharper focus, appears to be shallow and reflects an absence of normal empathy for others, a relative absence of enjoyment from life other than from the tributes they receive, and a combination of grandiose fantasies, envy, and the tendency to depreciate and manipulate others in an exploitative way.

These patients usually have such solidified, functioning pathological character structures that it is very difficult to mobilize their conflicts in the transference using the therapeutic approach proposed in this paper. Many of these patients appear to tolerate classical psychoanalysis without undue regression. Some of them unfortunately not only tolerate the analytic situation but are extremely resistant to any effort to mobilize their rigid characterological defences in the transference. Ernst Ticho (1966) has suggested that there exists one group of indications for psychoanalysis which may be called "heroic indications". This indication is for patients in whom, although it seems more or less doubtful whether psychoanalysis would be of help, it seems reasonably beyond doubt that any treatment other than psychoanalysis would not be of help. Narcissistic personalities are part of this group. There are other authors who also feel that psychoanalysis is the treatment of choice for these patients, and who have contributed decisively to our understanding of the dynamics of these patients and the technical difficulties in their analyses **(Kohut, 1966)**; **(Rosenfeld, 1964)**. In every patient presenting a borderline personality organization, at one point during the diagnostic examination the question of analysability should be considered and psychoanalysis should be rejected only after all the contraindications have been carefully evaluated.

This paper attempts to outline a general psychotherapeutic strategy with patients presenting borderline personality organization. The danger of such an outline is that it may be misinterpreted as a set of fixed rules, or that because of its necessarily comprehensive nature, it may appear too general. It is hoped that this outline may contribute to the overall frame of reference for therapists who are working with these patients and who are, therefore, well acquainted with the complex tactical therapeutic issues that each patient presents.

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