Psychotherapy with Borderline Patients

An Overview

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Review of the Literature

The main question raised in the literature on intensive psychotherapy with borderline conditions is whether borderline 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.

Gill (13, 14) has clarified this issue in delimiting classical psychoanalysis from analytically oriented psychotherapies. He states that psychoanalysis, in a strict sense, involves consistent adherence by the analyst to a position of technical neutrality (and neutrality, he rightly states, does not mean mechanical rigidity of behavior with suppression of any spontaneous responses). He believes that psychoanalysis requires the development of a 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 transference neurosis, and they do not imply resolution of the transference on the basis of interpretation alone.

Eissler (8) has further clarified this issue in his discussion of the "parameters of technique," which imply modifications of the analytic method 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. Additional clarifications of the differences between psychoanalysis and other related psychotherapies can be found in papers by Stone (69), Bibring (3), Wallerstein and Robbins (78), and Wallerstein (75,77).

From the viewpoint of Gill's delimitation of psychoanalysis, 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 analyzed while others would require expressive psychoanalytic psychotherapy; also there are those who do not sharply differentiate between psychoanalysis and psychoanalytic psychotherapy.

The early 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 (67, 68) recommends an expressive approach, with the constant focus on the transference rather than on historical material, and with constant efforts to reduce the clinging, childlike dependency of these patients 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 a capacity to establish a transference neurosis similar to that of the usual analytic patient. Schmideberg (63) recommends an approach probably best designated as psychoanalytic psychotherapy.

Knight's (39, 40) 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 defenses; 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 program for such patients.

At the other end of the spectrum are a number of analysts influenced to varying degrees by the so-called British school of psychoanalysis. 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 assumption about the possibility of treating most borderline patients with psychoanalysis and with many of their theoretical assumptions in general, I believe that the findings of these analysts permit modifications of psychoanalytic psychotherapies specifically adapted to the transference complications of borderline patients. I am referring here especially to the work of Bion (4, 5, 6), Khan (37), Little (42, 43, 44), Rosenfeld (60, 61, 62), Segal (65), and Winnicott (79, 81).

In this country, Boyer and Giovacchini (7) also recommend a nonmodified psychoanalytic approach to schizophrenic and characterological disorders. Although Giovacchini, in chapters dedicated to character disorders, does not refer specifically to borderline conditions (in contrast to severe character pathology in general), his observations focus on the technical problems posed by what I think most authors would consider patients with borderline conditions.

Somewhere toward the middle of the spectrum are the approaches recommended by Stone (70) and Eissler (8). 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. In following Eissler's and Stone's approaches, various authors in this country have recommended a modified psychoanalytic procedure or expressive psychotherapeutic approach to borderline patients that has influenced and is related to my own treatment recommendations that are outlined below.

Frosch (10, 11) has spelled out the clinical approach to borderline patients within a modified psychoanalytic procedure, and summarized his overall strategy of treatment with these patients. Greenson (17, 18, 19) proposes a similar approach, illustrating his modified psychoanalytic technique with clinical cases. Both Frosch and Greenson stress the importance of clarifying the patient's perceptions in the hours, and his attitude toward the therapist's interventions. Their approach (with which I basically agree) implies a neutral technical position of the therapist, and only a minimum deviation from such a position of neutrality as might be necessary.

In contrast, other psychoanalytically derived psychotherapeutic approaches to borderline conditions involve more modifications of technique. Thus, Masterson (49, 50, 51) designs a special psychotherapy as specifically geared to the resolution of the "abandonment depression" and the correction and repair of the ego defects that accompany the narcissistic oral fixation of these patients by encouraging growth through the stages of separation-individuation to autonomy. He proposes that psychotherapy with borderline patients start out as supportive psychotherapy and that intensive reconstructive psychoanalytically oriented psychotherapy is usually an expansion and outgrowth of supportive psychotherapy. He stresses the importance of the

analysis of primitive transferences, and has expanded on the description of two mutually split off part object relations units (the rewarding or libidinal part object relations unit and the withdrawing or aggressive part object relations unit) thus combining an object relations viewpoint with a developmental model based upon the work of Margaret Mahler.

Rinsley (57) and Furer (12) are other authors among a growing group of psychoanalytically oriented therapists who are combining an ego psychological object relations theory with a developmental model stemming from Mahler's work (45, 46, 47, 48). Giovacchini (15), Bergeret (2), Green (16), Searles (64), and Volkan (74) have also been applying object relations theory derived models, and Searles, particularly has focused on the understanding of the characteristics of transference and countertransference developments in the treatment of borderline and psychotic patients. Comprehensive overviews of some of these approaches can be found in Hartocollis (21) and Masterson's (51) recent book.

While the American authors just mentioned base their approach on an essentially ego psychological model that incorporates recent developmental findings and ego psychological object relations theories, the British school of psychoanalysis (that was originally identified with certain object relations theories) has continued to influence the technical approaches to borderline patients. Little's work (42, 43, 44) focuses mostly on technique. Although she assumes that the patients she describes are mostly borderline conditions, her implication that her patients presented a lack of differentiation between self and object, and her technical proposals for helping them develop a sense of uniqueness and separateness, seem to focus on the pathology of the early differentiation subphase of separation-individuation. Her views are somewhat related to those of Winnicott, but her patients seem to be more regressed than those described by him.

Winnicott (80) stresses the need to permit the patient to develop his "true self" by avoiding an "impingement" upon him at certain stages of therapeutic

regression. Winnicott has described the optimal attitude of the therapist under these conditions as a "holding" object, a function akin to basic mothering for patients for whom, for whatever reason, normal mothering was lacking. At such moments, Winnicott suggests, a silent regression takes place to what amounts to a primitive form of dependency on the analyst experienced as a "holding mother." At such times, the analyst's intuitive, empathically understanding presence may be sufficient, in contrast to the disturbing, intrusively experienced effects of verbal interpretation.

This conception is related to Bion's theory that mother's intuitive daydreaming (or "reverie," in Bion's terms) permits her to incorporate the projected, dispersed, fragmented primitive experiences of the baby at points of frustration, and to integrate them by means of her intuitive understanding of the total predicament of the baby at that point. Mother's intuition, Bion says, thus acts as a "container" which organizes the projected "content." Similarly, Bion goes on, the dispersed, distorted, pathological elements of the regressed patient's experience are projected onto the analyst in order to use him as a "container," an organizer, one might say, of that which the patient cannot tolerate experiencing in himself.

In short, both Winnicott and Bion stress that it is very important for the therapist working with borderline patients to be able to integrate both cognitive and emotional aspects in his understanding of the therapeutic situation, and while Bion focuses on the cognitive ("containing") in contrast to Winnicott's emphasis on the emotional ("holding"), these seem closely related aspects of the analyst's attitude.

In recent years, there has been a gradual shift away from the recommendation that borderline patients should be treated with supportive psychotherapy, and Zetzel (83) and Grinker (20) seem to be the last proponents of the purely supportive approach to the psychotherapy of borderline conditions that was so predominant twenty years ago. Zetzel recommends regular but

limited contact (very seldom more than once a week) with these patients in order to decrease the intensity of transference and countertransference manifestations, and a stress on reality issues and structuralization of treatment hours, all of which constitute jointly an essentially supportive approach. Zetzel acknowledges that, with that approach, it may be necessary for many borderline patients that the therapist remain at least potentially available over an indefinitely extended period. The implication is that this supportive approach, while effective in permitting the patient to adjust better to reality, may contribute to an interminable psychotherapeutic relationship. Zetzel and Grinker share the fear expressed in earlier literature regarding the presumed "frailty" of the defensive system, personality organization, and transferences of borderline conditions. Implicitly, this fear is also reflected in various psychoanalytically based but operationally manipulative approaches, such as those of Marie Nelson (53) and Arlene Wolberg (82).

In summary, a majority of clinicians who have worked intensively with borderline patients have been shifting in recent years from a supportive approach inspired by Knight's earlier work to modified psychoanalytic techniques or psychoanalytic psychotherapy for most patients, while: still considering the possibility that some patients may be treated by nonmodified psychoanalysis from the beginning of treatment and others with a modified psychoanalytic procedure which might gradually evolve into a standard psychoanalytic situation at advanced stages of treatment (11, 19, 26, 70).

My own work in this area fits clearly within this overall approach (28, 30, 32, 33, 35). I think that, while some borderline patients may respond to a nonmodified psychoanalytic approach, the vast majority respond best to a modified psychoanalytic procedure or psychoanalytic psychotherapy which I shall describe in detail below. I believe that for some borderline patients a psychoanalytic approach—standard or modified— is contraindicated, and that these patients do require a supportive psychotherapy (that is, an approach based upon a psychoanalytic model for psychotherapy relying mostly on the supportive

techniques outlined by Bibring (3); Gill (14); and Zetzel (83). I also think that psychoanalysis and psychotherapy should be most carefully differentiated, and I follow Gill (14) in this regard.

In addition, I think that much of what appears as "ego weakness," in the sense of a defect of these patients, turns out, under a psychoanalytically based exploration, to reflect conflictually determined issues. Obviously, this conviction underlies my stress on the value of an interpretive, in contrast to a supportive, approach with borderline patients. A major source for this conviction stems from the psychotherapy research project of The Menninger Foundation (36), which revealed, contrary to our initial expectations, that borderline patients did much better with an interpretive or expressive approach, and much more poorly with a purely supportive one.

Outline of Psychoanalytic Psychotherapy With Borderline Patients

If psychoanalysis is defined by 1) a position of technical neutrality, 2) the predominant use of interpretation as a major psychotherapeutic tool, and 3) the systematic analysis of the transference, psychoanalytic psychotherapies may be defined in terms of changes or modification in any or all of the three technical paradigms. In fact, I think the definition of a spectrum of psychoanalytic psychotherapies, ranging from psychoanalysis, on the one extreme, to supportive psychotherapies, on the other, is possible in terms of these three basic paradigms.

Within an ego-psychological approach, psychoanalytic psychotherapy may be defined as a psychoanalytically based or oriented treatment that does not attempt, as its goal, a systematic resolution of unconscious conflicts and, therefore, of all impulse/defense configurations and the respective resistances; rather, it attempts a partial resolution of some, and a reinforcement of other resistances, with a subsequent, partial integration of previously repressed impulses into the adult ego. As a result, a partial increase of ego strength and

flexibility may take place, which then permits a more effective repression of residual, dynamically unconscious impulses, and a modified impulse/defense configuration (that increases the adaptive—in contrast to maladaptive—aspects of character formation) . This definition differentiates psychoanalysis from psychoanalytic psychotherapy, both in the goals and in the underlying theory of change reflected in these differential goals.

Regarding the techniques employed in psychoanalytic psychotherapy geared to the achievement of those goals, and the differences between such techniques and those of psychoanalysis proper, the ego-psychological approach defines two major modalities of treatment based upon the psychoanalytic framework: 1) exploratory, insight, uncovering, or, simply, expressive psychoanalytic psychotherapy, and 2) suppressive or supportive psychotherapy.

Expressive psychotherapy is characterized by the utilization of clarification and interpretation as major tools, and, in this context, also abreaction. Partial aspects of the transference are interpreted, and the therapist actively selects such transferences to be interpreted in the light of the particular goals of treatment, the predominant transference resistances, and the patient's external reality. Technical neutrality is usually maintained, but a systematic analysis of all transference paradigms or a systematic resolution of the transference neurosis by interpretation alone is definitely not attempted.

Supportive psychotherapy is characterized by partial use of clarification and abreaction and the predominance of the use of technical tools of suggestion and manipulation. Bibring (3) defined these techniques and illustrated their technical utilization. Insofar as supportive psychotherapy still implies an acute awareness and monitoring of the transference on the part of the psychotherapist, and a careful consideration of transference resistances as part of his overall technique in dealing with characterological problems and their connections with the patient's life difficulties, this is still a psychoanalytic psychotherapy in a broad sense. By definition, however, transference is not interpreted in purely

supportive psychotherapy, and the utilization of technical tools such as suggestion and manipulation implicitly eliminates technical neutrality.

The major problem with this psychoanalytic theory and technique of psychoanalytic psychotherapy has been the contradiction between the theoretical model from which it stems and the structural intrapsychic organization of many patients with whom it has been used. The theoretical model underlying this approach holds remarkably well for patients with good ego strength. In contrast, however, the application of this psychoanalytic psychotherapy model to patients with severe psychopathologies— particularly the borderline conditions—has led to puzzling and contradictory findings.

First, these patients present a constellation of primitive defensive mechanisms centering around dissociation of contradictory ego states rather than on repression. Second, the transferences of these patients have peculiarities that are very different from the more usual transference developments in better functioning patients. Third, and most importantly, their primitive impulses are not unconscious but mutually dissociated in consciousness. In this connection, the evaluation of defense-impulse constellations often does not permit a clarification of what agency within the tripartite structure (ego, superego, and id) is motivating and activating a defense against what impulse within what other agency. In other words, the transference seems to reflect contradictory ego states that incorporate contradictory, primitive internalized object relations within an overall psychic matrix that does not present a clear differentiation of ego, superego, and id.

This leads to an additional, specialized psychoanalytic approach that attempts to deal with the phenomena just described, namely, psychoanalytic object relations theory.

Within an object relations framework, intrapsychic conflicts are conceptualized as always involving self- and object representations, or, rather, as

conflicts between certain units of self- and object representations under the impact of a determined drive derivative (clinically, a certain affect disposition) and other, contradictory or opposite units of self- and object representations under the impact of their respective affect dispositions. Unconscious intrapsychic conflicts are never simply conflicts between impulse and defense, but, rather, the drive derivative is represented by a certain primitive object relation (a certain unit of self- and object representation) , and the defense, as well, is reflected by a certain internalized object relation. Thus, all character defenses really reflect the activation of a defensive constellation of self- and object representations directed against an opposite and dreaded, repressed self-object constellation. For example, in obsessive, characterological submissiveness, a chronically submissive self-image in relating to a powerful and protective oedipal parental image may defend the patient against the repressed, violent rebellious self relating to a sadistic and controlling parental image. Thus, clinically, both character defenses and repressed impulses involve mutually opposed internal object relations.

From the viewpoint of object relations theory, the consolidation of the overall intrapsychic structures (ego, superego, and id) results in an integration of internalized object relations that obscures the constituent self representation-object representation-affect units within the overall structural properties of the tripartite system (33) ; the psychopathology of the symptomatic neuroses and less severe character neuroses is produced by intersystemic conflicts between such integrated ego, superego and id systems. In contrast, in the psychopathology of borderline personality organization, such an integration of the major intrapsychic agencies is not achieved, and conflicts are, therefore, largely or mostly intrasystemic (within an undifferentiated ego-id matrix). In severe psychopathologies—particularly the borderline conditions—early, primitive units of internalized object relations are directly manifest in the transference, in the context of mutually conflictual drive derivatives reflected in contradictory ego states.

In these cases, the predominance of a constellation of early defense mechanisms centering around primitive dissociation or splitting immediately activates, in the transference, mutually contradictory, primitive but conscious intrapsychic conflicts (30). What appears on the surface as inappropriate, primitive, chaotic character traits and interpersonal interactions, impulsive behavior and affect storms actually reflect the fantastic, early object relations derived structures that are the building blocks of the later tripartite system. These object relations determine the characteristics of primitive transferences, that is, of highly fantastic, unreal precipitates of early object relations that do not reflect directly the real object relations of infancy and childhood, and that have to be interpreted integratively until, by reconstitution of total—in contrast to partial or split—object relations, the more real aspects of the developmental history emerge (31). In the treatment, structural integration through interpretation precedes genetic reconstructions.

Let me now spell out a proposal for an integration of ego psychological and object relations theory derived conceptualizations geared to outlining a theory of psychoanalytic psychotherapy for borderline conditions.

Because primitive transferences are immediately available, predominate as resistances, and, in fact, determine the severity of intrapsychic and interpersonal disturbances, they can and need to be focused upon immediately, starting out from their interpretation only in the "here and now," and leading into genetic reconstructions only at late stages of the treatment (when primitive transferences determined by part object relations have been transformed into advanced transferences or total object relations, thus approaching the more realistic experiences of childhood that lend themselves to genetic reconstruction). Interpretation of the transference requires that the therapist maintain a position of technical neutrality for the reason that there can be no interpretation of primitive transferences without a firm, consistent, stable maintenance of reality boundaries in the therapeutic situation, and without an active caution on the part of the therapist not to be "sucked into" the reactivation

of pathological primitive object relations by the patient. Insofar as both transference interpretation and a position of technical neutrality require the use of clarification and interpretation and contraindicate the use of suggestive and manipulative techniques, clarification and interpretation are maintained as principal techniques.

However, in contrast to psychoanalysis proper, transference interpretation is not systematic. Because there is a need to focus on the severity of acting-out and on the disturbances in the patient's external reality (that may threaten the continuity of the treatment as well as the patient's psychosocial survival) and, also, because, as part of the acting-out of primitive transferences, the treatment easily comes to replace life, transference interpretation now has to be codetermined by: 1) the predominant transference paradigm, 2) the prevailing conflicts in immediate reality, and 3) the overall specific goals of treatment.

In addition, technical neutrality is limited by the need to establish parameters of technique, including, in certain cases, the structuring of the patient's external life and the establishment of a teamwork approach with patients who can not function autonomously during long stretches of their psychotherapy. Technical neutrality, therefore, is a theoretical baseline from which deviations occur again and again, to be reduced— again and again—by interpretation. One crucial aspect of psychoanalytic psychotherapy with patients presenting severe psychopathology is the systematic interpretation of defenses. In contrast to expressive psychotherapies in better functioning patients—where certain defenses are selectively interpreted while others are not touched—the systematic interpretation of defenses in severe psychopathology is crucial to improve ego functioning and to permit the transformation and resolution of primitive transferences.

Therefore, the similarity between expressive psychoanalytic psychotherapy and psychoanalysis is greater in the case of severe psychopathology than in the case of patients with milder psychological illness. One might say that, in

psychoanalytic psychotherapy of borderline conditions, the tactical approach to each session may be almost indistinguishable from psychoanalysis proper, and that only from a long-term, strategic viewpoint do the differences between psychoanalysis proper and psychoanalytic psychotherapy emerge. By the same token, the cleavage between expressive psychotherapy and supportive psychotherapy is sharp and definite in the case of patients with borderline conditions, while it is more gradual and blurred in cases with less severe illness. In other words, it is not possible to bring about significant personality modifications by means of psychoanalytic psychotherapy in patients with severe psychopathology without exploration and resolution of primitive transferences, and this requires a purely expressive, meticulously analytic approach, although not psychoanalysis proper.

Manipulative or suggestive techniques destroy technical neutrality and interfere with the possibility of analyzing primitive transferences and resistances. Such analysis is the most important ego strengthening aspect of the psychoanalytic psychotherapy of borderline patients. Technical neutrality means equidistance from the forces codetermining the patient's intrapsychic conflicts, and not lack of warmth or empathy with him. One still hears comments implying that borderline patients need, first of all, empathic understanding rather than a precise theory and cognitively sharpened interpretations based on such a theory. All psychotherapy requires as a base line the therapist's capacity for authentic human warmth and empathy; these qualities are preconditions for any appropriate psychotherapeutic work.

Empathy, however, is not only the intuitive, emotional awareness in the therapist of the patient's central emotional experience at a certain point, but must also include the therapist's capacity to empathize with that which the patient can not tolerate within himself; therefore, therapeutic empathy transcends the empathy involved in ordinary human interactions, and includes the therapist's integration, on a cognitive and emotional level, of what is actively dissociated or split in borderline patients.

In addition, when serious distortions in the patient's reality testing in the psychotherapeutic hours evolve as part of the activation of primitive transferences and primitive defensive operations (particularly that of projective identification), it may be crucial for the therapist to start out his interpretive efforts by clarifying the reality of the therapeutic situation. Such initial interventions often require a great deal of active work on the part of the therapist, a direct dealing with what the reality is in the sessions or in the patient's external life, that may be misunderstood as a technically supportive, suggestive, or manipulative intervention.

Strategy and Tactics of Transference Interpretation

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 patient.

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. 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 (23).

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 of predominantly 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 is suggested as a crucial factor in the severe regression that soon complicates the premature transference developments.

Once a borderline patient embarks on 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 (38) and others, namely, Heimann (24), Money-Kyrle (52), Rosenfeld (59), and Segal (65). Projective identification is a primitive form of projection, mainly called upon to externalize aggressive self- and object-images; empathy is maintained with real objects onto which the projection has occurred, and is linked with an effort to control the object now feared because of this projection

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 behavior, at the same time, tends to provoke from the therapist counteraggressive 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 (52, 55).

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 (27), 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" (55).

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 (24) has illustrated these vicious circles of projective identification and distorted reintrojection of the therapist in discussing paranoid defenses. Strachey (71) 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.

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 a 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 as a "transference psychosis" is reached.

"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. 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 (25, 41, 56, 58, and 76). Control of transference acting out within the therapeutic relationship becomes of central importance.

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 (66), who demonstrates how to deal with acute episodes of anxiety.

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 extratherapeutic interactions. The patient's acting out at the regressed level overruns the therapist's effort to maintain a climate of abstinence.

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 behavior or experience, is questionable insight. 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 following general principles summarize what has been said in this section.

1. The predominantly negative transference of these patients should be systematically elaborated only in the here and now, without attempting to achieve full genetic reconstructions. The reason is that lack of differentiation of the self concept and lack of differentiation and individualization of objects interfere with the ability of these patients to differentiate present and past object relationships, resulting in their confusing transference and reality, and failing to differentiate the analyst from the transference object. Full genetic reconstructions, therefore, have to await advanced stages of the treatment.

2. The typical defensive constellations of these patients should be interpreted as they enter the transference; the implication is that the interpretation of the predominant, primitive defensive operations characteristic of borderline personality organization strengthens the patient's ego and brings about structural intrapsychic change which contributes to resolving this organization.

3. Limits should be set in order to block acting out of the transference, with as much structuring of the patient's life outside the hours as necessary to protect the neutrality of the therapist. The implications

are that, although interventions in the patient's external life may sometimes be needed, the technical neutrality of the therapist is essential for the treatment; moreover, it is important to avoid allowing the therapeutic relationship, with its gratifying and sheltered nature, to replace ordinary life, lest primitive pathological needs be gratified in the acting out of the transference during and outside the hours.

4. The less primitively determined, modulated aspects of the positive transference should not be interpreted. This fosters the gradual development of the therapeutic alliance; however, the primitive idealizations that reflect the splitting of "all good" from "all bad" object relations need to be interpreted systematically as part of the effort to work through these primitive defenses.

5. Interpretations should be formulated so that the patient's distortions of the therapist's interventions and of present reality (especially of the patient's perceptions in the hour) can be systematically clarified: one implication is that the patient's magical utilization of the therapist's interpretations needs to be interpreted.

6. The highly distorted transference (at times, of an almost psychotic nature), reflecting fantastic internal object relations related to early ego disturbances, should be worked through first, in order to reach, later, the transferences related to actual childhood experiences. All transferences, of course, recapitulate childhood fantasies, actual experiences, and defensive formations against them, and it is often difficult to sort out fantasies from reality. However, the extreme nature of the fantasied relationships reflecting very early object relations gives the transference of borderline patients special characteristics, our next issue.

The Transformation of Primitive into Advanced or Neurotic Transferences

The ordinary transference neurosis is characterized by the activation of the patient's infantile self, or aspects of that infantile self linked to or integrated with his infantile self in general, while the patient reenacts emotional conflicts of this infantile self with parental objects that are, in turn, integrated and reflect the parental figures as experienced in infancy and childhood. In contrast, the

nonintegrated self- and object-representations of borderline patients are activated in the transference in ways that do not permit the reconstruction of infantile conflicts with the parental objects as perceived in reality, and rather, the transference reflects a multitude of internal object relations of dissociated or split- off self aspects with dissociated or split-off object-representations of a highly fantastic and distorted nature.

The basic cause of these developments in borderline patients is their failure to integrate the libidinally determined and the aggressively determined self- and object-representations (27, 29 and 36). Such a lack of integration derives from the pathological predominance of aggressively determined self- and object-representations and a related failure to establish a sufficiently strong ego core around the (originally nondifferentiated) good self- and object-representations. However, in contrast to the psychoses, in which self images have not been differentiated from object images, in borderline patients there has been at least sufficient differentiation between self- and object-representations for the establishment of firm ego boundaries. The problem with borderline patients is that the intensity of aggressively determined self- and object-representations, and of defensively idealized, all good self- and object-representations makes integration impossible. Because of the implicit threat to the good object relations, bringing together extremely opposite loving and hateful images of the self and of significant others would trigger unbearable anxiety and guilt; therefore, there is an active defensive separation of such contradictory self and object images: in other words, primitive dissociation or splitting becomes a major defensive operation.

The overall strategic aim in working through the transference developments of borderline patients is to resolve these primitive dissociations of the self and of internalized objects, and thus to transform primitive transferences —that is, the primitive level of internalized object relations activated in the transference—into the transference reactions of the higher level or integrated, more realistic type of internalized object relations related to real childhood

experiences. Obviously, this requires intensive, long-term treatment along the lines I have suggested (31), usually not less than three sessions a week over years of treatment. The strategy of interpretation of the transference of borderline patients may be outlined into three consecutive steps. These three steps represent, in essence, the sequence involved in the working through of primitive transference developments in patients with borderline personality organization.

The first step consists in the psychotherapist's efforts to reconstruct, on the basis of his gradual understanding of what is emotionally predominant in the chaotic, meaningless, empty, distorted or suppressed material, the nature of the primitive or part-object relation that has become activated in the transference. He needs to evaluate what, at any point, in the contradictory bits of verbal and behavioral communication, in the confused and confusing thoughts and feelings and expressions of the patient, is of predominant emotional relevance in the patient's present relation with him, and how this predominant material can be understood in the context of the patient's total communications. In other words, the therapist, by means of his interpretive efforts, transforms the prevalent meaninglessness or futility in the transference—what literally amounts to a dehumanization of the therapeutic relationship—into an emotionally significant, although highly distorted, fantastic transference relationship.

As a second step, the therapist must evaluate this crystallizing predominant object relation in the transference in terms of the self image and the object image involved, and clarify the affect of the corresponding interaction of self and object. The therapist may represent one aspect of the patient's dissociated self and/or one aspect of the primitive object representation; and patient and therapist may interchange their enactment of, respectively, self or object image. These aspects of the self and of object representations need to be interpreted and the respective internal object relationship clarified in the transference.

As a third step, this particular "part-object" relation activated in the

transference has to be integrated with other "part-object" relations reflecting other, related and opposite, defensively dissociated "part-object" relations until the patient's real self and his internal conception of objects can be integrated and consolidated.

Integration of self and objects, and thus of the entire world of internalized object relations, is a major strategic aim in the treatment of patients with borderline personality organization. Integration of affects with their related, fantasied or real, human relation involving the patient and the significant object is another aspect of this work. The patient's affect dispositions reflect the libidinal or aggressive investment of certain internalized object relations, and the integration of split-off, fragmented affect states is a corollary of the integration of split-off, fragmented internalized object relations. When such a resolution of primitive transferences has occurred, the integrative affect dispositions that now emerge reflect more coherent and differentiated drive derivatives. The integrative object images now reflect more realistic parental images as perceived in early childhood.

Arrangements and Difficulties in the Early Stages of Treatment

A major question in the early stages of treatment is to what extent an external structure is necessary to protect the patient and the treatment situation from premature, violent acting out that may threaten the patient's life or other people's lives or threaten the continuation of the treatment. When the treatment starts out right after a recent or still active psychotic episode (which borderline patients may experience under excessive emotional turmoil—under the effect of drugs, alcohol, or in the course of a transference psychosis), there may be indication for a few days to a few weeks of hospital treatment, with a well-structured hospital milieu program and clarification of the immediate reality and a combination of an understanding and clarifying and yet limit-setting milieu approach. A generally chaotic life situation, particularly when complicated by the patient's difficulty in providing meaningful information about his life to the

psychotherapist, may represent another indication for short-term hospitalization. Severe suicidal threats or attempts, a deteriorating social situation, or severe acting out with involvements with the law, are all typical examples of situations which threaten .lie patient's life or the continuation of treatment. Under such circumstances, short-term hospitalization may be necessary, simultaneously with the beginning or continuation of intensive psychotherapeutic treatment along the lines mentioned before.

The most important objective regarding the degree of structuring required is to set up an overall treatment arrangement which permits the psychotherapist to remain in a position of technical neutrality, that is, equidistant from external reality, the patient's superego, his instinctual needs, and his acting (in contrast to observing) ego (9). This objective can sometimes be achieved with less than full hospitalization, by means of the utilization of part-hospitalization arrangements, foster home placement, the intervention of a social worker within the patient's environment, etc. There are borderline patients who do not have a sufficient degree of observing ego for intensive, outpatient psychoanalytic psychotherapy; for example, many borderline patients with extremely low motivation for treatment, severe lack of anxiety tolerance and of impulse control, and very poor object relationships may require a long-term environmental structuring of their lives in order to make an expressive psychotherapeutic approach possible. Such long-term structuralization of their life may be provided by many months of hospitalization or a part-hospitalization environment, or by extra-mural social services which provide the necessary limit-setting in the patient's life or support of his family for this purpose. Severe, chronic acting out, suicidal or general self-destructive trends which the patient cannot control, and some types of negative therapeutic reaction, may require such a long-term external structuralization.

Many borderline patients are able, without external structuring of their lives, to participate actively in setting limits to certain types of acting out which threaten their treatment or their safety. At times the psychotherapist has to spell out certain conditions which the patient must meet in order for outpatient

psychoanalytic psychotherapy to proceed. The setting up of such conditions for treatment represents, of course, an abandonment of the position of technical neutrality on the part of the psychotherapist, and the setting up of parameters of technique. Such parameters of technique need to be kept at a minimum.

If a patient has a history of frequent suicidal attempts, or of utilizing threats of suicide to control his environment (including the psychotherapist), this situation needs to be discussed fully with him. The patient must either be able to assume full control over any active expression of his suicidal tendencies (in contrast to the freedom of verbally expressing his wishes and impulses in the treatment hours), or he must be willing to ask for external protection (in the form of hospitalization or part-hospitalization) if he feels he cannot control such suicidal impulses. In other words, several brief hospitalizations arranged by the patient himself, by his family or a social worker may provide an additional, external structure needed to maintain the treatment situation; this is preferable to the therapist changing his technique in the direction of relinquishing a primarily interpretive approach in the context of technical neutrality.

In contrast, many other potentially self-destructive symptoms may be left untouched for a long period of time, if they do not threaten the patient's life or treatment. For example, it may take years before a borderline patient with severe obesity may be able to control his obesity effectively; general failure in school or at work and interpersonal difficulties of all kinds may express the patient's psychopathology and a long time may elapse before they can be brought into the focus of the treatment.

When the patient consciously withholds information, or when he lies, the psychotherapist's first priority has to be to interpret fully and reduce this suppression of information by interpretive—in contrast to educational—means. This may take weeks or months, particularly in cases with antisocial features. However long it may take, full resolution of the reality and transferential implications of the patient's lying takes precedence over all other material,

except life-threatening acting out. However, because lying interferes with the psychotherapeutic approach toward all other problems including acting out, it may be preferable, if the patient who habitually lies also shows evidence of life-threatening or other treatment-threatening acting out, to start his treatment with sufficient structuring in his life, such as long-term hospitalization. Patients who lie habitually, and, therefore, give evidence of serious superego deterioration, tend to project their own attitude regarding moral values onto the psychotherapist as well, and to conceive of him as being dishonest and corrupt. The interpretive approach to the transference functions of lying includes, therefore, focusing on the patient's projection of his own dishonesty onto the therapist, and on the transferential implications in the "here and now'' of this development.

In some borderline paranoid patients conscious withholding of material is acknowledged by the patient as part of the expression of paranoid fantasies about the therapist; for example, one patient refused to give his real name over a period of several weeks. Whenever manifest paranoid ideation becomes predominant in the early hours of treatment, it is important for the therapist to evaluate carefully whether the patient is, indeed, a borderline patient, or whether the patient suffers from a paranoid psychosis. Since a psychotic paranoid patient might present serious aggressive acting out when transference psychosis develops, it is extremely important for the therapist to carry out an early, careful differential diagnosis, and not to initiate an intensive psychotherapeutic treatment without a clear understanding of all the implications of treating a psychotic patient. At times, when this diagnostic question cannot be clarified in the early treatment hours of a borderline paranoid patient, it may be preferable to start the psychotherapy with a concomitant period of brief hospitalization geared to evaluate the situation further. The long-range benefits of an early, brief hospitalization compensate for the increase of anxiety and transference distortions and other complications in these patients' daily life related to an early, brief hospitalization. In any case, it is important that the psychotherapist

not permit the patient to control the treatment situation in a pathological way, as this would affect not only the psychotherapist's technical neutrality, but his very availability, on a simple human level, to the patient. Sometimes it is preferable not to treat a patient at all rather than to treat him under impossible conditions.

In the case of borderline patients whose treatment is carried out, either initially or during later phases of the treatment, in combination with hospitalization, it is important for the psychotherapist to keep in close relationship with the leader of the hospital management team. This raises such issues as confidentiality, danger of splitting of the transference, and general coordination of hospital treatment and psychotherapeutic work.

In my experience, I have found it helpful for the psychotherapist to receive routinely full information regarding the patient's interactions in the hospital, and for the patient to be told about this. Thus, the psychotherapist can share significant information regarding the patient's interactions in the hospital with the patient himself and integrate it into his analysis of the transference. At the same time, the psychotherapist should inform the patient that he will keep confidential all information given him by the patient, except for specific issues which the therapist might wish to explore with the hospital team. But, before doing so, he would ask the patient specifically for authorization. In other words, general confidentiality should be maintained unless specific authorization is given by the patient for the psychotherapist to share certain information with the hospital team. Finally, I explicitly inform patients that I would not feel bound by confidentiality under circumstances which would involve threats to the patient's or other people's lives; again, under these circumstances, I would first share with the patient the nature of the information I feel needs to be talked over with the hospital treatment team.

The general implication of this approach is that if hospitalization is needed and carried out during psychotherapeutic treatment, the total treatment should be integrated; in practice, this should help reduce or prevent splitting operations

by which part of the transference is expressed to the hospital treatment team. In the case of outpatients where social complications, for example, pressures from the family, are expressed in the form of efforts of relatives or other persons related to the patient to establish direct contact with the psychotherapist, a social agency, or a psychiatric social worker might be asked to provide a structure which keeps the psychotherapist separate from the patient's external social environment, while still containing the overall treatment situation that has evolved. Again, under these circumstances the psychotherapist should maintain an open communication with the social worker who is seeing the family, but any information that the psychotherapist is planning to share with the social worker must be discussed with the patient.

Therapeutic Stalemates in Advanced Stages of the Treatment

Many borderline patients do not change significantly over years of treatment, despite the efforts of skilled therapists of various orientations. What follows are some general considerations regarding the issues frequently involved in lack of change in the treatment situation and some general requirements for the therapist which have seemed helpful to me in facilitating significant change in some of the more difficult cases.

The problem merges with that of the development of severe negative therapeutic reactions in the treatment of borderline cases. In fact, negative therapeutic reactions are a major cause of lack of significant change. However, in order to avoid an excessive broadening of the term negative therapeutic reaction, I think it preferable to discuss these issues in terms of lack of significant change.

I would restrict the meaning of negative therapeutic reaction to the worsening of the patient's condition, particularly as reflected in the transference, at times when he is consciously or unconsciously perceiving the therapist as a good object who is attempting to provide him with significant help. Such negative therapeutic reactions derive from 1) an unconscious sense of guilt (as in

masochistic character structures); 2) the need to destroy what is received from the therapist because of unconscious envy of him (as is typical in narcissistic personalities); and 3) the need to destroy the therapist as a good object because of the patient's unconscious identification with a primitive, sadistic object which requires submission and suffering as a minimal precondition for maintaining any significant object relation (as in some borderline and many schizophrenic patients who severely confuse love and sadism (30)). My findings seem consonant with those of other recent contributions to the psychoanalytic study of negative therapeutic reaction (1, 54, 60, 61, 62, 73).

I would like to focus on some common features of chronic stalemates in treatment. The situations most frequently met with are: 1) Unchanged grandiosity in severe narcissistic structures. Dehumanization of the treatment situation, amounting to a complete denial of any emotional reality in the transference, may appear even in narcissistic patients who seem to be functioning at a nonborderline level. 2) Severe masochistic acting out, related to the submission to and triumphant identification with a relentless, sadistic superego formation. 3) The even more primitive identification with a sadistic, mad object which provides love only under the aegis of suffering and hatred. Any satisfactory relation is thus equivalent to killing—and being killed by—the needed parental image, and, therefore, losing it, while the triumph over all those who do not suffer from such a horrible human destiny is the only protection from a sense of total psychic disaster.

4) The need, derived from all these situations, to neutralize or defeat the therapist's efforts may evolve into a malignant vicious circle. As the therapist persists in helping the patient in the face of obvious lack of response or even worsening of the patient's condition, the patient's envy and resentment of the therapist's commitment and dedication may reinforce the need to escape from what would otherwise be unbearable guilt.

In the middle of chronic therapeutic stalemate, patients may formulate

quite directly the angry, revengeful request that the therapist compensate them for their past suffering by dedicating his life totally to them. But, regardless of the extent to which the therapist might go out of his way to accommodate the patient's desires, eventually the following issues tend to become prominent. First, the patient may destroy time in the sense of losing his perspective on time; that is, he focuses on each session as if time had come to a halt in between the sessions, and, in a deeper sense, as if both patient and therapist would live forever.

Second, this destruction of time may be accompanied by a specific neglect and rejection of what otherwise would have to be perceived as manifestations of the therapist's concern for and dedication to the patient. It is as if the patient's suspiciousness and destructive disqualification of the therapist were geared to destroying love with cruelty, while projecting this cruelty on to the therapist. Relentless accusations implying that the therapist does not love the patient enough are the most frequent, but not the most severe, manifestation of this tendency. Uncannily, at times when the therapist may in fact be internally exhausted and withdraw passively from active attempts to work with the patient, the patient's accusations may decrease, and an eerie unconscious collusion fostering paralysis and emptiness in the psychotherapeutic situation ensues.

Third, the patient may attempt to convince the therapist that the patient is really not human, that ordinary psychological understanding and empathy have no place in this situation, and the therapist may be induced to replace his concrete understanding of the dynamics of the transference by more general formulations of ego arrests, lack of capacity for emotional understanding, cognitive deficits, and the like.

In short, something very active in the patient attempts to destroy time, love and concern, honesty, and cognitive understanding. I think that under these circumstances the therapist is facing the activation of the deepest levels of human aggression—sometimes hopelessly so. However, it is sometimes possible

to resolve these severe treatment stalemates with an essentially analytic approach, and it seems to me that some of the therapist's general characteristics and attitudes now become crucial. I shall attempt to spell out these attitudes.

First of all, it is helpful to combine an attitude of patience over an extended period of time with an attitude of impatience, of not accepting passively the destruction of concrete psychotherapeutic work in each hour. This approach is in contrast to a gradual giving up reflected in a passive wait-and-see attitude in each hour, while the therapist actually becomes more and more impatient and discouraged as time passes; he may even reach a sudden explosion point. The implication is that the acting out of severe aggression needs to be actively countered by the therapist. Activity does not mean abandoning the position of technical neutrality, a point I have explored in detail before.

It hardly needs to be stressed that the therapist should intervene only when he is not under the sway of negative, hostile affects toward the patient. Such aggression toward the patient may be a normal reaction under such extreme circumstances, but it usually becomes condensed with whatever potential for aggressive countertransference reactions exist in the therapist, and the therapist must contain this reaction in terms of utilizing it for his understanding rather than transforming it into action.

A second major attitude of the therapist that might be helpful under conditions of therapeutic stalemate is to focus sharply on the patient's omnipotent destruction of time. The therapist needs to remind the patient of the lack of progress in treatment, to bring into focus again and again the overall treatment goals established at the initiation of treatment, and how the patient appears to neglect such goals completely while assuming an attitude that the treatment should and could go on forever. In this connection, the establishment of realistic treatment goals and their differentiation from the patient's life goals, as stressed by E. Ticho (72), become crucial.

The focus on the broad goals of the treatment needs to be complemented by a sharp focus on the patient's immediate reality. Usually, under conditions of extreme, prolonged stalemate, the patient also neglects his immediate reality situation and reveals what at times amounts to an almost conscious sense of triumph in defeating his own efforts; a triumph over the therapist, whose impotence is reconfirmed every day as impossible situations develop and disaster is courted. It is essential that the therapist interpret the unconscious (and sometimes conscious) rage at him expressed in the patient's playing Russian roulette in his daily life.

The patient will, in the process, have to reassume responsibility for his immediate life situation as well as for his long-range plans. This is a responsibility that I think we expect any patient who undergoes psychoanalytic psychotherapy on an outpatient basis to be able to assume, and it constitutes the reality baseline against which transference acting out can be evaluated and interpreted. In other words, acting out may take the form of burning all bridges with the present external life and with the future, with the implicit expectation that the therapist will assume full responsibility for these; this must be interpreted consistently.

Countertransference

I have suggested elsewhere (30) that one can describe a continuum of countertransference reactions ranging from those related to the symptomatic neuroses at one extreme, to psychotic reactions at the other, a continuum in which the different reality and transference components of both patient and therapist vary in a significant way. When dealing with borderline or severely regressed patients, as contrasted to those presenting symptomatic neuroses and less severe character disorders, the therapist tends to experience, rather soon in the treatment, intensive emotional reactions having more to do with the patient's premature, intense and chaotic transference and with the therapist's capacity to withstand psychological stress and anxiety, than with any specific problem of the

therapist's past. Thus, countertransference becomes an important diagnostic tool, giving information on the degree of regression in the patient, his predominant emotional position vis-à-vis the therapist, and the changes occurring in this position. The more intense and premature the therapist's emotional reaction to the patient, the more threatening it becomes to the therapist's technical neutrality, and the more it has a quickly changing, fluctuating, and chaotic nature—the more we can think the therapist is in the presence of severe regression in the patient.

The therapist normally responds to the patient's material with some affective reaction, which under optimal conditions, is subdued and minor, and has a "signal" quality rather than reflecting an intense emotional activation. At points of heightened transference reactions, or when countertransference reactions complicate the picture, the emotional intensity of the therapist's reaction increases and may interfere with his overall immediate understanding of, or internal freedom of reaction to, the patient's material. With borderline patient's not only is the intensity of the therapist's emotional reaction higher after relatively brief periods of treatment, it is also more fluctuating, and, at times, potentially chaotic. Obviously, rather than reacting to the patient under the sway of these affective reactions, the therapist has to be able to tolerate them and utilize them for his own understanding. Insofar as what the patient is reactivating in the transference and the analyst is perceiving in his affective response to it is not only a primitive affect, but a primitive object relation connected with an affect (that is, the therapist perceives a primitive self-image relating to a primitive object-image in the context of the particular activated affect) the therapist's diagnosis of his own emotional reaction implies the diagnosis of the patient's—often dissociated—primitive object relations in the transference.

Nowadays, the term countertransference is often used to refer to the therapist's total emotional reaction to the patient. For the most part, however, particularly for those with an ego-psychological approach, the term is still

reserved to apply to the therapist's specific unconscious transference reactions to the patient. In other words, this latter, restricted definition of countertransference focuses on its pathological implications, while the former, broader one focuses on the intimate relationship between the general affective responses of the therapist with his specific countertransference potential.

From the viewpoint of treatment of borderline patients it is an advantage to consider the total emotional reaction of the therapist as a continuum of affective responses from mild, realistic "signal" affects to intense emotional reactions which may temporarily interfere with the therapist's neutrality, and which constitute a compromise formation determined by the transference and specific countertransference reactions. In any case, the therapist needs to be free to utilize this material both for resolving analytically his own excessive reactions to the patient, and for diagnosing primitive object relations activated in the transference.

One important force active in neutralizing and overcoming the effect of aggression and self-aggression in the countertransference is the capacity of the therapist to experience concern. Concern in this context involves awareness of the serious nature of destructive and self-destructive impulses in the patient, the potential development of such impulses in the analyst, and the awareness by the therapist of the limitation necessarily inherent in his therapeutic efforts with his patient. Concern also involves the authentic wish and a need to help the patient in spite of his transitory "badness." On a more abstract level, one might say that concern involves the recognition of the seriousness of destructiveness and self-destructiveness of human beings in general and the hope, but not the certainty, that the fight against these tendencies may be successful in individual cases.

Realistic treatment goals involve the acceptance not only of unresolved shortcomings but of the unavoidability of aggression in ordinary life. The therapist's tolerance of his own aggression and that of the people he loves may make it easier for him to interpret the patient's aggression without being sucked

into the patient's conviction that his aggression is dangerous because it will inevitably destroy love, concern, meaning, and creativity. Therefore, the therapist's thoroughly understood awareness of the aggressive components of all love relations, of the essentially ambivalent quality of human interactions, may be a helpful asset in the treatment of extremely difficult cases.

The fact that the therapist can accept truths about himself and his own life may permit him to express in his behavior the conviction that the patient might also be able to accept truths about himself and his own life. Such uncompromising honesty in facing the most turbulent and painful of life's prospects may become part of very concrete interventions with patients having long-term stalemates in the treatment. The confidence that the patient can take and accept the truth about himself expresses at the same time a confidence in the patient's potential resources.

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