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THE BORDERLINE PATIENT

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Development of the Concept

The concept of the borderline patient, poorly understood and vague, has become lost in a semantic morass; it well illustrates the poor quality of much psychiatric and psychoanalytic literature. Authors combine clinical description and dynamic formulations and using the method of psychoanalytic reconstruction have paid little attention to what others have already included under the term "borderline." As Grinker et al. point out, ". . . the reports are repetitive, discursive and not well documented by empirical references."

Nevertheless, the concept of the borderline patient appears worthwhile and can be saved from the semantic morass. It represents a frequently encountered type of patient in our era, posing special problems for the psychotherapist, the general physician, and for those interested in the etiology and nosology of mental illness.

Although the term "borderline" appears from time to time in the classical psychiatric writings, major credit for delineating the concept and

making it clinically respectable goes to Stern. In three papers, the first in 1938, he painted the clinical and psychodynamic picture, and discussed special problems in the treatment. He regarded "narcissism" (used by him according to the Freudian definition) as the basic underlying character component of these patients, leading to the development of a person with typical personality features. These are: (1) "psychic bleeding"— the patient goes down in a heap at each occurrence of stress in his life; (2) inordinate hypersensitivity—the patient is constantly insulted and injured by trifling remarks; (3) rigidity; (4) "negative therapeutic reaction"—a response of depression and anger to any interpretation, which is experienced as an injury to the patient's self-esteem; (5) feelings of inferiority and lack of self-assurance; (6) "masochism and wound-licking"—a tendency to self-pity and depression; (7) a strange "pseudo-equanimity" or outward calm, in spite of the inward chaos, may be present (although not always); and (8) a tendency to use projection, especially with people in authority, and corresponding peculiarities in reality-testing. Stern regarded the entire problem as a developmental injury caused by lack of spontaneous affection from the mother. Such patients were described as "traumatized pre-oedipal children," with a profound "affect-hunger."

The second author to make an important contribution to the subject was Deutsch, who—without reference to Stern—described the "as-if" personality. The "as-if" patient is a subclass of the borderline patient group. In

general, he is an extreme caricature of Riesman's "other-directed" personality. Although he appears outwardly amiable, he has no identity of his own and is not capable of forming any genuine emotional attachment to people or moral principles. While there is a poverty of object relationships and much narcissism, no obvious defect in reality-testing is present—yet these patients certainly do not belong in the typical clinical "neurotic" category. Deutsch was suspicious of a "schizophrenic predisposition," but admitted that the relationship of "as-if" patients to neurotic and psychotic patients was not clear.

The subject of the borderline patient gained tremendous prominence due to the introduction of a number of new terms by well-known and highly respected authors. The first of these was the concept of "pseudoneurotic schizophrenia," introduced and investigated by Hoch and his co-workers. Patients suffering from this disorder are characterized by "pan-anxiety"—they are made anxious by everything conceivable—and "pan-neurosis"—they present all varieties of neurotic symptoms, shifting back and forth over our nosological classifications. Furthermore, they may at times show clear-cut psychotic manifestations and even psychotic episodes, but these do not last and the patients as a rule *do not* deteriorate into chronic schizophrenic psychoses.

Grinker et al. point out that Hoch vigorously opposed including

pseudoneurotic schizophrenic patients among borderline patients. He considered them a variety of paranoid or catatonic schizophrenia, and opposed the use of the borderline concept altogether. However, clinical experience and common usage have tended to include "pseudoneurotic schizophrenic" patients among borderline patients because their pan-anxiety and pan-neuroses make it impossible to classify them as either neurotic or psychotic and, more importantly, because these conditions usually do not deteriorate into schizophrenia, indicating a certain remarkable stability to the condition. The same narcissism and poverty of object relations previously described for "as-if" and borderline patients are typically present in these patients. Since little further work has been done on this concept, except for Weingarten and Korn, and since the term is used in such different, vague, and general ways, it is perhaps best to drop it altogether.

At this point, it is possible to see how the concept of borderline patient may become confused with "ambulatory schizophrenia" or "latent schizophrenia," and many other such terms, generally designating schizophrenic patients who are not so sick as to require hospitalization. Thus, ambulatory or latent schizophrenics show the typical symptoms of schizophrenia, except to a less obvious degree; careful clinical examination may be necessary to pick up the classical schizophrenic syndrome, and a diagnosis can then be accurately established.

Knight gave impetus to the serious psychoanalytic investigation of borderline cases, by discussing them in terms of a variable impairment of ego functions. This provided a partial theoretical explanation for the nosologic confusion, although his term, "borderline schizophrenias," again tended to blur the distinction between borderline patients and ambulatory schizophrenia patients. At any rate, in the borderline patient, as Knight put it, "the ego is laboring badly." The superficial clinical picture of a variety of neurotic symptoms, etc., "may represent a holding operation in a forward position, while the major portion of the ego has regressed far behind this in varying degrees of disorder." The great danger to the clinician is to misunderstand these "forward holding positions" as constituting the illness, and attempt to treat them—when they represent the healthiest part of the patient's ego functioning! Knight emphasizes the major point that only a careful face-to-face clinical examination, sometimes consisting of several interviews, in contrast to quickly putting such patients on the couch at one extreme, or quickly coming up with psychopharmacologic remedies on the other, will enable the physician to assess the *"total* ego functioning" of the patient. He offers details on how to conduct such an examination.

The final major accretion to the concept of borderline patient was added by Boyer, Bender, Schmideberg, and others. Not only may the borderline patient show a variety of neurotic symptoms, but he may show a variety of delinquent, or "acting-out," or "pseudopsychopathic" symptoms, involving

him in all kinds of difficulty with society. This would be logically expected if the condition, as explained by Knight, represented the impairment of various ego functions. Such patients, for example, may involve themselves in all sorts of delinquent activity at various times in their lives, ranging from business chiseling to overt theft and criminal behavior, but it is unusual to find them engaged in major brutal crimes. In our era, they most typically appear in the general physician's office due to the syndrome of "periodic hyperingestion," as described by Chessick. To the despair of their physicians and the panic of their families, these patients may consume large quantities of substances or combinations of substances, including opiates, barbiturates, marijuana, meprobamate, various phenothiazines, and other "tranquilizers " mescaline, alcohol, amphetamines, and food. At other times, there may be complete or almost complete abstention.

Certain physical and psychic symptoms may periodically become intense; these include aches and pains, gnawing and weird abdominal sensations, insomnia, anxiety attacks, epileptiform seizures, tics and twitchings, and depression. They are sometimes followed by an explosion of hyperingestion in which the patient is functionally partly or completely paralyzed and concentrates all his energy on a compulsive "stuffing in" of various substances while other activities are neglected. The substances hyperingested may vary from episode to episode, and the diagnosis of alcoholism or addiction may be mistakenly made at this point. However,

although the patient may shift back and forth, he is on the whole able to function reasonably effectively in society and does not deteriorate.

A clear clinical delineation of the borderline patient emerges from this historical review. It includes the following characteristic features:

1. Any variety of neurotic, psychotic, psychosomatic, or sociopathic symptoms in any combination or degree of severity may be part of the presenting complaint. Either a bizarre combination of such symptoms cuts across the standard nosology, or the relative preponderance of any given symptom group is constantly changing or shifting. Thus, at least two and preferably three diagnostic interviews at intervals of at least a week apart are mandatory in establishing the diagnosis, in addition to a careful history-taking, including details of all symptoms and their vicissitudes. The "psychosomatic" symptoms must be taken seriously, as irreversible tissue damage can occur if proper treatment is not instituted promptly. They should never be dismissed as "merely hysterical."

2. Vagueness of complaint or even a bland, amazingly "smooth," or socially successful personality may be encountered. Careful investigation in such cases will reveal a well-hidden poverty of genuine emotional relationships, behind an attractive and personable social façade. Thus, the patient may present either a very chaotic or stormy series of relationships with a variety of people, or a bland and superficial but relatively stable set of relationships; in both cases, a lack of deep

emotional investment in any other person may be carefully, consciously or unconsciously, concealed.

3. The capacity for reality-testing and the ability to function in work and social situations is not seriously impaired, although the degree of functioning may vary from time to time. On the whole, these patients are able to maintain themselves, raise families, and otherwise fit into society (or even the prison environment). They do not present as drifters, chronic hospital or long-term prison cases, totally antisocial personalities, or chronic addicts. On the other hand, they may have tried everything, and may present a variety of sexual deviations, but they are not functionally paralyzed by these or by their neurotic symptoms or anxieties, at least not for long periods of time.

4. These patients do not deteriorate. The borderline patient suffers from a relatively stable and enduring condition. He may suffer transient psychotic episodes either for no apparent reason or as a result of stress, alcohol, drugs, improper psychotherapy, etc., but he does not remain psychotic for long. He "snaps out of it"; often, he learns what will "snap" him out of it and administers a self-remedy. At times, this remedy simply consists of dropping out of an improper psychotherapy; at other times, it involves all varieties of bizarre rituals or behavior. Sometimes, his marital partner or friends know about this and will even apply his self-remedies for him; they consider this just his "hang-up."

Similarly, when the borderline patient is in one of his pan-neurotic, pan-

anxiety, hyperingestive, or psychopathic states, he causes tremendous alarm in those around him, and appears to be in a terrible condition. At the same time, he may frustrate all efforts to "help" at that point, or if "helped" he may show a surprising lack of gratitude. Those borderline patients who suffer from various dramatic transient episodes soon acquire a reputation in the family and are often rejected by physicians as "crocks" or bad patients. They stimulate many unconscious and not-so-unconscious maneuvers by both family and physicians to get rid of them, for example, by sending them to a "sanitarium" for a "rest."

Further outstanding descriptions of the borderline patient are best found in literature, for example in the characters of Sartre or Camus or, as Litowitz and Newman point out, in the "theatre of the absurd."

Recent Areas of Investigation

Four recent areas of investigation of the borderline patient may be called to the attention of the interested reader. These involve more profound recent psychodynamic studies, sociocultural considerations, clinical-descriptive research, and possible biological determinants.

The first current area of investigation involves the use of the psychoanalytic method to develop an increasingly profound understanding of the psychodynamics and genesis of the borderline patient. One of the

pioneers in this study was Albrecht Meyer who presented at least two papers on the subject, which to my knowledge have never been published (although mimeographed copies are available), and who organized the study group of psychoanalysts from the Chicago Institute for Psychoanalysis, now headed by Gamm. Some of the findings of this group have been reported by Grinker et al., and by Chessick. Meyer was impressed by the work of Leuba on what was called the "phobia of penetration," later described in a different terminology by Little as "psychotic anxieties" regarding annihilation, identity, and existence itself. Because of this, for example, the patient may either pretend to get well or leave treatment, in order to avoid the resurgence of these fears in the transference.

Meyer also called attention to the work of Odier who presented a little-known but major contribution to understanding the borderline patient in his concept of the "neurosis of abandonment." Odier emphasizes the role of anxiety as described above, which he maintains is directly proportional to the amount of insecurity in early childhood, and produces regression to the prelogical stage of infantile thinking. He describes the magic thinking in detail as involving either (a) objectification of fear—"whatever threatens me is wicked and whatever protects me is good"; (b) objectification of anger—toward animistic malevolent objects, as chosen; and (c) identification with the aggressor. The "objectification" is the magical defense, placing the anxiety and fear and anger *outside* of the psyche onto external objects, as in phobias,

or onto fantasy objects, as in nightmares or religion.

In the "neurosis of abandonment," the anxiety is objectified onto a human being, instead of a cosmic image or a transitional object, who is then given the power of creating or abolishing abandonment, insecurity, and helplessness. This individual is seen as all-powerful, sometimes benevolent and sometimes malevolent. In this situation, the oscillation between love and hate, security and insecurity, dependency and paranoia, and the rapid transitions from euphoria to depression, all as a function of the minor provocations or reassurances from the chosen object, lead to the typical picture of the borderline patient.

Modell, without reference to Odier, developed the same theme. He stressed the importance of a core of positive sense of identity, of "a sense of beloved self," which develops in infancy as a response to adequate mothering. Without this inner sense—which is probably related to Saul's recent concept of "inner sustainment"—thinking remains magical and object relations remain primitive, just as described by Odier. These defects soon become manifest in psychotherapy in the relationship to the therapist, and represent the fundamental problem in the healing process, described in detail by Chessick.

These concepts are placed into formal psychoanalytic terminology in an

important paper by Murray, who stresses the deep narcissistic "sense of entitlement" that pervades the thinking of the borderline patient. The patient lives in a "narcissistic world of omnipotence, with its unlimited power of magical thinking and unlimited entitlement to the lusts and destructions of pregenital excitements." A classic description of this may be found in the progressive deterioration of the heroine as portrayed in Tolstoy's *Anna Karenina.*

The most profound and thorough current attempt to delineate the borderline patient in classical psychoanalytic terminology is presented by Kernberg. He stresses the patient's lack of anxiety tolerance, lack of impulse control, and lack of developed sublimatory channels, and contends that oral aggression plays a crucial role in the psychodynamics. There is a premature development of oedipal conflicts as an attempt to escape from the oral rage, with a subsequent condensation of pregenital and genital conflicts. There is a "pathology of internalized object relationships" and "an intensification and pathological fixation of splitting processes" in the ego functions of these patients, as well as a lack of sublimatory channels.

The mothers of borderline patients have been described by a variety of the clinical authors mentioned above. In general, they are described as intelligent and overfeeding mothers, who were able to hide the emotional impoverishment of their personalities behind pseudo-giving. This is

combined with a stern, almost cruel, often unverbalized demand that the child live up to their expectations. This combination of overfeeding and pseudo-giving accompanied by the hidden stern demands produces a chaos in the child's mind that Leuba has called "deception" and Chessick a "pre-verbal disaster," leading to severe defects in ego development and an immersion in narcissistic consolation fantasies. These fantasies can pervade the patient's entire behavior, producing a sharp clash with reality, as magnificently portrayed in many of the plays of Eugene O'Neill. The further understanding and delineation of the borderline patient remains an important current area of psychoanalytic investigation.

A second recent area of investigation is a byproduct of the current interest in "social psychiatry." The impact of social conditions upon the development of the personality is given major emphasis in this kind of investigation, in contrast to the psychoanalytic focus on the mother-child interaction. An important pioneer in this area is Wheelis who, building on Riesman and others, emphasizes the major change in presenting symptomatology found in psychoanalysts' offices over the recent years. Nowadays, the presenting complaints deal with "vague conditions of maladjustment and discontent"—in short, they sound more like the borderline patient and less like the "classical" neuroses. The lack of identity in these patients is linked to the collapse of institutional absolutes and values, leading to a sense of futility, emptiness, and longing. Chessick also emphasizes

the mechanism of externalization as underlying the "existential anguish" commonly presented by these patients.

There are many theoretical and methodological difficulties in this kind of approach, since the "linkage" between cultural-social and psychological systems remains unclear. Grinker et al. devote a chapter in their book on the borderline syndrome to the questions: "Are there some factors in our rapidly changing western society and/or culture which spawn or facilitate the development of the borderline? Do these act directly on the developing personality at various critical periods such as adolescence or young adulthood or indirectly by influencing the maternal child-rearing practices or both?" They are unable to go beyond what might be called an "educated guess" that "in some way social and cultural conditions plus some other variables contrive together to produce the overt syndrome." The opportunity remains for much neglected and much needed interdisciplinary co-operation in understanding the borderline patient.

It is important to keep in mind that the complaints of the borderline patient often resemble a caricature or exaggeration of the complaints and behavior of so-called normal people in our current society; in fact, many "as-if" and other borderline patients are quite successful in the superficial social and business world. This is in marked contrast to the "latent" or "ambulatory" schizophrenic whose complaints are more bizarre and who is usually a

generally unsuccessful person, by society's standards of "success."

Grinker et al. and a corroborative study by Gruenewald, from the same institution, have pioneered another area of investigation of the borderline patient, that might be called "clinical-descriptive research." In this study, *hospitalized* patients with the diagnosis of "borderline" were observed by various personnel, and the behavioral observations were rated for specific variables chosen "within an ego-psychology framework" and in terms of "allocated ego-functions." Obviously great care and attention by a team of experienced investigators were given to developing the methodology of this project. The ratings were then analyzed statistically in a sophisticated manner, resulting in a definition of the borderline syndrome and its subcategories.

The over-all characteristics found were: (1) anger was the main effect experienced by such patients; (2) a defect in affectional relationships was present—"these are anaclitic, dependent or complementary, but rarely reciprocal"; (3) indications of consistent self-identity were absent; and (4) depression was based on loneliness rather than guilt. Four subgroups were further delineated.

The investigators consider the borderline syndrome to be based on "the basic defects in maturation and early development expressed in ego-

dysfunctions," discussed in psychoanalytic detail by Wilson. A variety of factors are believed to contribute to the development of this defect, but cannot be elucidated at this time. The results of the study show an excellent clinical "fit" with the psychoanalytic office practice concept of the borderline patient described above. This kind of study, which much needs repeating in other institutions and in outpatient settings, helps to distinguish the borderline patient from the "latent" or "ambulatory" schizophrenic patient, and from other conditions.

A final important contemporary area of research concerns the biological determinants of mental illness, especially possible genetic links between schizophrenic and borderline conditions. A problem similar to that found in studying sociocultural factors also exists in these areas of research—to develop a "linkage" between the various factors. Rosenthal, for example, presents several "models" of the "heredity-environmental interaction" that leads to the clinical picture of schizophrenia. He distinguishes between monogenic-biochemical theories of the etiology of schizophrenia, life-experience theories, and diathesis-stress theories, and points out that, "those who emphasize the genetic contribution seldom consider in earnest the role that environment might play, and environmentalists usually pay lip service to the idea that hereditary factors may eventually have to be considered as well."

It is the diathesis-stress theories that bring in the concept of the borderline patient. In this view, a constitutional predisposition to schizophrenia is seen as being inherited, usually on a polygenic basis. An extreme example of this is presented by Heston who utilizes the concept of "schizophrenic spectrum" to include schizophrenia, schizoid conditions, ambulatory, latent *and* borderline schizophrenias. He considers the borderline area around schizophrenia to be clinically fuzzy because it is "biologically unreal," since "schizoidia" and "schizophrenia" are genetically linked conditions. This interesting concept deserves further investigation, but it should be clear from the previous discussion that the borderline patient, as here described, *cannot* be lumped under the "schizophrenic spectrum" and does not belong under "schizoidia." Otherwise, as some authors argue, there would be no point in retaining the concept at all and it would be indistinguishable from "latent" or "ambulatory" schizophrenia, etc.

However, both psychoanalytic clinical research and clinical descriptive research strongly support the presence of a large group of borderline patients who are clearly distinguishable from both ends of the "schizophrenic spectrum" on the one hand, and from the neuroses on the other. Perhaps Stern's original concept of these patients as "traumatized pre-oedipal children" is still valid, if one is willing to accept the psychoanalytic idea that the classical neuroses are based primarily, although certainly not entirely, on disasters during the oedipal period of development. The presence or absence

of genetic and biochemical factors in the etiology of these disorders remains unknown and much less investigated than in schizophrenia.

Treatment of the Borderline Patient

There are almost as many varieties of recommendations for the treatment of the borderline patient as there are authors on the subject. General agreement is found only on a few basic issues. First, ordinary encouragement or supportive therapy as practiced in the general physician's office produces either no effect at all or a dramatic remission soon followed by relapse with the same or new symptoms, accompanied by the angry demand for more magic. Second, the typical administration of various psychopharmacological agents to these patients often complicates the situation in many ways. They abuse the dosage instructions, and the side-effects produced by improper dosage complicate the symptom picture. They collect medication from various physicians and take these in varying amounts and combinations. Suicide attempts with these medications pose a definite risk.

Consultation of an understanding psychiatrist is mandatory in the management of these patients. It is obvious how intensely frustrating they can be, in spite of the best efforts of the well-intentioned physician. Either the patient is shifting back and forth between a puzzling variety of neurotic and

psychosomatic symptoms with possible lapses into delusional material, such as ideas of reference accompanied by the realization that his suspicions "can't really be true," or he is shifting back and forth into various sociopathic behavior forms with the possible additional complication of periodic hyperingestion.

These rapid shifts, with all the excitement, storm, and panic they cause the patient and those around him, usually accompanied by either the missing of appointments, failure to pay the bill, or spending session after session in talking about various symptoms, and the constant introduction of new problems and extraneous matters, can soon make both physician and patient feel that no progress is being made. There is typically an increasing exasperation on the part of the therapist, as well as a developing barrage of complaints about the treatment from the patient, which usually leads to an impasse and a referral either for chronic hospitalization or to a psychiatrist "who works with addicts." A variety of ways are employed to get rid of these patients.

However, if one is willing to put up with a great deal of frustration and disappointment, it is possible to successfully treat many borderline patients. Four basic approaches to the psychotherapy of the borderline patient are found in the literature. It is assumed that the treatment is carried out either directly by an experienced psychiatrist or under careful supervision. There

are great opportunities for doing harm, as well as an ever-present serious suicidal risk that must be recognized and cannot be avoided by constant hospitalization. As Little eloquently points out, "Analysis of these patients is a life-and-death matter, psychically, and sometimes somatically as well. The analyst, or some extension of him is all that stands between the patient and death; and at some point he has to stand aside, and simply be there, while the patient takes his life into his own hands, and becomes a living human being—or a corpse."

The first type of psychotherapy recommended is advocated, for example, by Schmideberg. She emphasizes a very authoritative and directive approach, with much psychological pushing and shoving of the patient "to get him moving." She makes it a point to appear involved and "nonprofessional," and emphasizes controls, socialization, and reality-testing. This reminds one of the "total push" type of treatment often used for schizophrenics; it deals mainly with the symptoms and tends to produce an "as-if" personality who modifies himself either to please the therapist or to escape the psychotherapy. Unless interminable contact is maintained with the patient, relapse is to be expected, especially when life stress arises. If this approach can be made to work, it is certainly quicker and cheaper than the long-term intensive therapies.

The second type of approach is formal psychoanalysis. Some argue this

to be the treatment of choice, for example, Boyer and Giovacchini, while others see it as a desperate "heroic" measure. Most psychotherapists reject this approach out of clinical experience in which many borderline patients show a complete intolerance to the ordinary psychoanalytic situation, reacting with suicidal attempts, transitory psychoses, or dramatic and chaotic symptoms and acting out that finally interrupt the treatment. Even placing such patients on the couch where they cannot see the psychotherapist may produce an explosive reaction, although in certain cases it may be surprisingly beneficial, as illustrated in Chessick's series of patients. To say the least, a formal psychoanalysis of the borderline patient should not be attempted by anyone except the most experienced and well-trained psychoanalyst who is willing to assume great risks.

The third type of psychotherapy attempts to combine an uncovering psychotherapy with providing a direct "corrective emotional experience" for the patient. This "corrective emotional experience" can range from taking the patient's hand to examining the patient in the nude or letting her bite and suck on the therapist's hand, in a direct attempt to provide better mothering experiences within the particular psychodynamics of the patient. Needless to say, the danger of massive countertransference acting out is quite acute in these situations, and the most hair-raising and destructive behavior by the therapist can be excused as attempting to provide a "corrective emotional experience." Here, again, considerable training and experience is necessary

for the psychotherapist to know what he is doing, and repeated consultation with colleagues is required.

From a theoretical point of view, there is the important additional danger that the use of such heroic measures, which must invariably be experienced as primary-process interchange, works directly against the stated aim of converting the patient's ego functioning away from primary process and towards secondary process based on thinking and behavior. The patient, as in the directive and authoritative psychotherapies, can become easily "hung up" on the primary-process gratifications involved, leading to a demand for more, and subsequent stalemate. I have seen this occur repeatedly when attempted by inexperienced or poorly trained psychotherapists.

However, the line between primary-process phenomena and secondary process is not an easy and distinct one, and, "Primary-process phenomena are not necessarily pathological, nor are they always maladaptive," as Arlow and Brenner point out. There are undoubtedly times in every psychotherapy when this type of communication makes all the difference, and fear of such communication can lead to a rigid and withdrawn psychotherapist who surely will fail with border line patients. Self-understanding, training, and experience are the crucial factors in success or failure with borderline patients who are generally less forgiving of pathology in the therapist than

most patients.

Except for the unusually qualified therapist, the treatment offering the greatest potential with the least serious risk for borderline patients goes under the various names of “psychoanalytically oriented psychotherapy” or “psychoanalysis with parameters,” the latter a controversial and horrendous term. The most complete and thorough review of “psychoanalysis with parameters” for the borderline case has been presented by Kernberg and summarized by Wilson. Chessick has explored the psychoanalytically oriented psychotherapy of the borderline patient in a less formal language. I will conclude this chapter by reviewing the psychoanalytically oriented psychotherapy of the borderline patient, which is often a face-to-face psychotherapy, depending on the anxiety level of the patient. In this therapy, the proper understanding and management of the transference is critical, and poses many special problems.

The initial problem of the therapy is getting the patient to form a therapeutic alliance, in spite of all the *Sturm und Drang* which his symptoms can provide for the relationship. In fact, the patient must first be very tightly locked into the therapy, in order to enable him to maintain it when terrific anxieties of abandonment and annihilation arise and must be worked through. A very long period of “being there” from a psychotherapist with a high empathic capacity and great frustration tolerance is necessary before the

patient begins to build a sense of confidence and becomes locked into a symbiotic relationship with the therapist. This is facilitated by concentration on reality problems, instead of getting lost in fancy or highly intellectual dream interpretations or psychodynamic formulations, and also by a certain "deep inner attitude" towards one's patients, which is difficult to characterize in detail.

If this locking in takes place, strong transference manifestations appear, affording the opportunity to correct the "pre-verbal disaster" without dangerous heroic measures. This correction takes place in the context of the transference through empathic understanding and interpretation by the therapist, as well as through a deep emotional interaction between therapist and patient, described in detail elsewhere. *Success or failure in the treatment depends on this process.* As one might expect, the transference manifestations can be extremely frightening and strong, so that the patient resorts to many unusual measures to deal with them.

Two of the most typical of these measures seen in the psychotherapy of the borderline patient are the "erotized transference" and the involvement of a third person in the transference, both of which must be quickly recognized and dealt with, or the treatment will be ruined. The erotized transference, which was recognized by Freud early in the development of psychoanalysis, manifests itself in borderline cases by the stormy demand for genital contact.

When this is rejected, the patient experiences deep and sincere hurt and humiliation. He does not accept interpretations and rather persists in the demands for gratification. Empathy, consistency of approach, patience in understanding the patient's sense of rejection, and not reacting with fear or hostility to his demands, can eventually lead to a resolution of the problem.

Similarly, borderline patients often cannot stand the intensity of their longings for the therapist in the transference, and they may quickly dump all of this on a third person, and engage in massive acting out. If this is not recognized and interpreted and stopped, sometimes forcibly, situations such as marriage or pregnancy may result. Alertness to the problem and consistent concentration on the patient's life situation are necessary. The use of a third person is not always undesirable to help the patient withstand the intense transference longings; it depends on to what extremes the patient has to go. Too energetic interpretations of transference longings can throw the patient into a chaotic panic and disrupt the treatment entirely.

If disruption does not occur, and the transference is properly understood and interpreted, the anxieties are gradually worked through, and in this protective atmosphere the patient is able to uncover his narcissistic core fantasies and sense of "entitlement" (Murray). Meyer's unpublished series of "fifteen to eighteen cases" psychoanalyzed by him demonstrated the presence of this narcissistic core fantasy when the fear of penetration was

reduced. This clinical experience was supported by findings from a series of twenty patients studied in psychoanalytically oriented psychotherapy by Chessick. The patient lives around a fantasy (or fantasies) which permeates and contaminates all the ego operations. This narcissistic fantasy, for example, being a famous professor or a saint of the church or a great artist, and so on, represents a consolation for the profound early and chronic deprivation of affect from the mother, and also attempts to produce the longed-for affect through satisfying her expectations. The patient often lives as if he has secretly accomplished these things, producing a set of unrealistic responses to life. Sometimes, these core fantasies are apparent even at the beginning of treatment, but direct assault upon them simply results in denial or break-up of the treatment, since they represent substitutes for gratifying human relationships and cannot be given up until the annihilation and abandonment fears are worked through in the transference.

It follows that the basic factor in the successful psychotherapy of borderline patients is how the psychotherapist responds to and handles the "crucial dilemma" (Chessick) produced by the intense transference longings and also the associated deep fears, and forcing the problem of "parameters"' upon the therapist. The therapist must have an empathic grasp of how the patient perceives and how he feels, and he must be able to both interpret in an empathic fashion and also emotionally respond to the patient, without using the patient to gratify his own needs. At the appropriate time, he must be

able to draw back and allow the patient to develop his own identity, providing throughout the psychotherapy Winnicott's well-known "good-enough holding situation."

Working with borderline patients is not easy, but it is extremely rewarding in many ways. It provides a deeper and deeper understanding of the development of ego functioning and warps in ego development that can be applied to all areas of psychopathology. It forces the therapist to constantly pursue and achieve a deeper understanding of himself and demands an ever-increasing maturity from him. Most important of all, when successful, it brings the patient back to life from a situation of psychic death, a state of unparalleled suffering portrayed with great skill in modem theater and literature, beginning perhaps with Dostoyevsky:

But it is just in that cold, abominable half despair, half belief, in that conscious burying oneself alive for grief in the underworld for forty years, in that acutely recognized and yet partly doubtful hopelessness of one's position, in that hell of unsatisfied desires turned inward, in that fever of oscillations, of resolutions determined forever and repented of again a minute later—that the savor of that strange enjoyment of which I have spoken lies. It is so subtle, so difficult of analysis, that persons who are a little limited, or even simply persons of strong nerves will not understand a single atom of it.

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