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Adolph Stern

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PSYCHOANALYTIC INVESTIGATION OF AND THERAPY IN THE BORDER LINE GROUP OF NEUROSES

BY ADOLPH STERN (NEW YORK)

I

It is well known that a large group of patients fit frankly neither into the psychotic nor into the psychoneurotic group, and that this border line group of patients is extremely difficult to handle effectively by any psychotherapeutic method. What forced itself on my attention some three or four years ago was the increasing number of these patients who came for treatment. My custom was not to treat them analytically, except when they were suffering acutely from neurotic symptoms (i.e., anxiety, depression, etc.) and required immediate therapy. With these I tried the usual analytic therapy but in the large majority of the patients, after a more or less lengthy course of treatment, I had to stop treatment leaving them not much benefited. In the case of the 'neurotic character', which makes up a very large proportion of this border line group, much more often than not I attempted no treatment at all, for the simple reason that I had learned from experience that our knowledge of analytic therapy as employed with the psychoneurotic patients was insufficient to achieve good results with this group, especially when their suffering was not acute enough to justify immediate therapy.

In the last three to four years, these patients have increased in numbers; those that I took for treatment were in the main acutely sick and had to be treated. Repeated failure in the past taught me that the knowledge we possessed was not adequate to treat these people. The inevitable happened: it was

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clear to me that though I had handled thoroughly enough the object libidinal phenomena in these patients they nevertheless remained sick, while a straightforward psychoneurotic similarly treated did well. I therefore studied my patients more closely to see what aspects of the clinical picture were unaffected by methods successful in the usual run of psychoneurotics. The results I propose to give in the following pages.

This border line group of patients shows a fairly definite clinical picture and fairly definite clinical symptoms. This has facilitated their presentation from two angles: The first avenue of approach is the historical, as given by the patients and developed in the course of the treatment. The second avenue of approach to the understanding of this border line group is by the investigation of the events in the transference situation; here we find fairly pathognomonic phenomena that enable us to see the differences between them and such phenomena as occur in the transference situations in the usual run of psychoneurotic patients.

The clinical symptoms which I enumerate and describe below come under the heading of reaction-formations or character traits. While all of them are not peculiar to the border line group, some of them are, and others are more pronounced, constant and difficult to influence by psychoanalytic therapy than is the case in the psychoneuroses. They are as follows:

1 Narcissism.

2 Psychic bleeding.

3 Inordinate hypersensitivity.

4 Psychic and body rigidity—'The rigid personality'.

5 Negative therapeutic reactions.

6 What looks like constitutionally rooted feelings of inferiority, deeply imbedded in the personality of the patient.

7 Masochism.

8 What can be described as a state of deep organic insecurity or anxiety.

9 The use of projection mechanisms.

10 Difficulties in reality testing, particularly in personal relationships.

1 Narcissism.

That these patients in the border line group belong to a large extent to the narcissistic neuroses or characters, I think is generally known. My patients, as indicated above, constitute a large indefinite group between the psychoses and the transference neuroses, partaking of the characteristics of both but showing frank tendencies in the direction of the psychotic; and we are accustomed to speak of certain psychoses as the 'narcissistic neuroses'. This border line group shows the presence of narcissism to a degree not present in the usual run of neurotic patients. It is on the basis of narcissism that the entire clinical picture is built. In the psychoneuroses we are accustomed to look for basic causes in the disturbances to which childhood sexuality was subjected. With this in mind, an investigation of the earliest narcissistic periods in very early childhood discloses factors adversely affecting their narcissistic development. In at least seventy-five per cent. of this group, the histories show that one or more of the following factors were present from earliest childhood. The mother was a decidedly neurotic or psychotic type, in more than one instance developing a psychosis or psychotic episodes of short duration. These mothers inflicted injuries on their children by virtue of a deficiency of spontaneous maternal affection: among them were mothers who showed much over-solicitude and over-conscientiousness; they were meticulous about the child's habits, food and behavior, but they lacked a wholesome capacity for spontaneous affection. There were in the family, extending over years, many quarrels between the parents and repeated outbursts of temper between parents or directed at the children. In some of the families, before the patients were seven years old, divorce, separation of the parents, and in one case, desertion by one of the parents, acted as added sources of great insecurity at a time when these children were already in a state of affective deprivation because of discords between the parents before the separation took place. All of my patients as children remained then with their mothers, not one of whom before the separation was really an adequate

mother from the point of view of her capacity for simple, spontaneous affection for her children. Actual cruelty, neglect and brutality by the parents of many years' duration are factors found in these patients. These factors operate more or less constantly over many years from earliest childhood. They are not single experiences.

In looking over the histories of the general run of neurotic patients, such data as those above given play a decidedly less frequent rôle. Our patients suffer in the psychic field what David M. Levy has termed 'affect hunger', much the same as food deficiencies leave behind them evidence of physical hunger, that is, nutritional disturbances. Because of the above experiences this group never develops a sense of security acquired by being loved, which is the birthright of every child. These patients suffer from affective (narcissistic) malnutrition. In this connection, however, it might be advisable to raise the question, to what degree a peculiar constitution or endowment, and how much environment *per se,* or a combination of both is responsible for the clinical picture. I have no answer to this question.

On the basis of an injured, starved narcissism the clinical picture develops. Normal narcissistic gratification, normal self-preservative needs in the psychic sphere, are not adequately provided for. The roots of neurotic character traits, and in some patients also neurotic illness, are buried deep in these very early periods of psychic starvation and insecurity due to lack of parental, chiefly maternal, affection. Hence it might be inferred that a disturbance in the narcissistic development of the very young is responsible in this group for neurotic character traits or neurotic illness, just as disturbance in the sexual (object love) development is at the root of the psychoneurotic disturbances.

As Freud states, all neurotic symptom formation is an attempt on the part of the ego to minimize or eliminate the intolerable distress produced by anxiety. In the psychoneurotic group the anxiety develops on the basis of the infantile sexual impulses; in our group, in the main, on the basis of the infantile narcissistic impulses. Narcissism is present in this border line group as the basic underlying character component. It is the soil in

which the phenomena to be described later take their origin, on which they depend for their form and the functions they serve. Having in mind that anxiety is the motor for defense in the formation of neurotic character traits and symptoms, I will describe in detail the above enumerated character traits as seen in the border line group.

2 *Psychic bleeding.*

The picture of a psychic bleeder is a familiar one. Instead of a resilient reaction to a painful or traumatic experience, the patient goes down in a heap, so to speak, and is at the point of death. There is immobility, lethargy instead of action, collapse instead of a rebound: a sort of playing 'possum. In this quiescence the patient is reflexly in a state of self-protection, necessitating a minimum of functioning, and exhibiting complete relaxation in order to counterbalance the great demands made on the organism by danger. Paralysis rather than flight or fight is the reaction. The state of collapse in a sense represents a reflex defense in the form of preparation for recuperation.

3 *Inordinate hypersensitivity.*

Psychic hypersensitivity is perhaps comparable to the physical hypersensitivity of the very young to physical sensory stimuli. That this hypersensitivity serves reflexly, automatically, as an exquisite receptive apparatus or instrument to detect danger readily and to take appropriate precautions is clear enough. That it has no reality function is as true of this as of any other neurotic symptom. But from the neurotic point of view of the patient, the hypersensitivity is a logical symptom or character trait. It is in keeping with a deeply rooted insecurity, which necessitates undue caution and awareness to danger, in this sense clearly an advantage as is any other neurotic symptom. This hypersensitivity, in many of the patients, comes close to the mechanism by means of which the paranoic develops his ideas of reference. My patients are constantly being deeply insulted and injured by trifling remarks made by people with whom they come in contact, and occasionally develop mildly paranoid ideas.

4 Psychic rigidity. 'The rigid personality'.

This is one of the most fascinating mechanisms to investigate, see in operation and in resolution; for one can modify 'a rigid personality' through psychoanalytic methods. If we keep in mind that anxiety is the motor stimulating action on the part of the ego for its own defense, the rigid personality becomes understandable to us. Further, as I indicated before, and shall again when discussing the transference phenomena, reactions of defense in this border line group of patients is almost of a reflex nature. The body is brought into an attitude of protective behavior because of anxiety arising from danger within or without. In the transference neuroses, on the contrary, the defense mechanisms have to a much greater extent psychological explanations and values. In evaluating the significance of the rigid personality, I have in mind by way of comparison the rigid abdomen and the rigid knee as reflex responses to inflammation in the respective areas. An extreme picture again for the sake of comparison is the rigid catatonic. With his shifting, watchful, alert eyes and the rigid picture of his body, a connection between the two, on the basis of protection against danger, becomes clear enough. In the patients under consideration, psychic rigidity and often enough physical rigidity, are constantly present phenomena, reflexly protective in nature. What I have not been able to settle in my mind is the time when such phenomena take form. In some it appears that the rigidity is present in the earliest years, before four or five, increases at important periods, as for example, puberty, and with important (to the patient anxiety-producing) experiences. Maturing for these individuals is fraught with great danger (anxiety) against which protection through psychic and physical rigidity goes forward apace. The recognition of the defensive purposes of this rigidity gives the clue to its therapeutic handling, just as it does in instances of handling defenses in the transference group.

5 Negative therapeutic reactions.

Such phenomena are regularly observed in this group of patients. One notes depression, readily aroused anger, discour-

agement and anxiousness as responses to any interpretation involving injury to self-esteem. Since the handling of anxiety is attempted essentially through defensive measures, it becomes clear enough that any interpretation that impairs the neurotic defense at the same time releases the anxiety which determined the patient to resort to protective devices for a feeling of security, so that a depression ensues, or discouragement, anger, etc. The margin of security of these patients is extremely narrow, and an enlightening interpretation throws them, at least for the moment, into despondency, so that only rarely does one notice a favorable reaction to discoveries. Furthermore, in estimating the significance of the negative therapeutic reaction one must bear in mind that the marked immaturity of these patients, and their insecure, depleted narcissism impel them to react to interpretations as evidence of lack of appreciation or love on the part of the analyst. With these patients analytic therapy is like a surgical operation. The surgical operation is a therapeutic measure, in itself traumatic but necessary. Care then must be exercised that the operative technique be adapted to the particular patient at that particular time and not to the illness. Good judgment based on clinical experience, is of inestimable value here. A negative therapeutic reaction is nevertheless inevitable; in some the reaction is extremely unfavorable and, cumulatively, may become dangerous; patients may develop depression, suicidal ideas, or make suicidal attempts. In these negative therapeutic states the necessarily dependent attitudes are exaggerated, and the demands for pity, sympathy, affection and protection made on the analyst are extremely difficult to handle; the transference situation, complicated as it necessarily is, becomes even more so. Ordinarily such patients' relationship to people in authority is determined by their need of love and protection, to be obtained by them through infantile methods, especially obedience, compliance, and insistent demands for tender gentle handling. The same attitudes are operative in the transference, and the patients, though they understand the interpretations, at the same time react neurotically (i.e., through the negative therapeutic reac-

tions) as though they were rejected. The result is an increased clinging to the analyst as a parental figure.

6 Feelings of inferiority.

In connection with these phenomena, as with the others mentioned, I attempt no explanation of their origin. My object is to show their clinical function as a logical part of the pathology of the illness (neurotic character), and to demonstrate here too that a symptom is evidence on the part of the organism, the ego, of an attempt to combat anxiety. In these patients the feelings of inferiority are pervasive, including almost the total personality. Essentially the feelings of inferiority are accepted by the patients as unpleasant but logical and inevitable for them. There is no questioning on their part as to the validity of their judgment in this respect. One gets the impression of a delusional coloring to this. The patients are convinced of their inferiority, lacking *in toto* insight in the symptomatic nature of these feelings. Not a few of my patients have become successful in their chosen fields of endeavor, have acquired excellent general and professional educations; not a few have prepossessing physical and psychological characteristics—but none of their accomplishments, nor the sum of all of their accomplishments, in the least influences them in their judgment as to their being inferior people. A close approach to this picture is the delusional self-depreciation of the melancholic.

These border line patients are cases of arrested development and patently show infantile character traits. From this point of view, as I shall try to show in some of their transference phenomena, it is quite logical from the premises of the patients that they feel inferior—immature, young, weak, timid, unworthy, never loved, etc. These feelings of inferiority are used in the service of overcoming anxiety whenever action or thinking is required of the patients that might demand of them the exercise of adult functioning. The discrepancy between adult functioning as they see it and what they feel themselves capable of doing is sufficiently great to precipitate enough anxiety to make the patients recoil and slump into inaction,

acutely conscious at such time of feelings of inferiority. Assurance against recurrence of anxiety is obtained, unsatisfactory as it may be to the healthy judgment of the patient, by remaining inactive and loudly proclaiming his inferiority, with the hope that instead of being pushed to adult behavior, he will be consoled, pitied, or allowed to remain dormant. The conviction of being an inferior individual influences the patient against active behavior and is pleadingly proclaimed to the analyst (paternal figure) in order to achieve the same objectives (to bring out the parental rôle). It is among these patients that one frequently finds (the bane of the analysts' existence) those who get a thorough psychoanalytic education through being analyzed and remain quite sick people. They have the intellectual equipment to accumulate knowledge and unless the analyst is on his guard, will use this knowledge not to unravel sources of their feelings of inferiority, but neurotically to bolster up their ego, with pseudo-therapeutic results.

7 *Masochism.*

It is not very clear how this fits in as a defensive, corrective or protective phenomenon. That it is present is clear enough and easily verified. In this class of patients, self-pity and self-commiseration, the presentation of a long suffering, helpless picture of the injured one, are regularly met; also what I call wound-licking, a tendency to indulge in self-pity. All these roughly but not very clearly may be considered as agents for obtaining a compensation for what the patients, and some of them justly, regard as not being or having been sufficiently loved in their childhood, a sort of unspoken plea for help and love as a needy child seeks it. There is no doubt that such patients suffer much. Many tend in the direction of depressions and some of my patients in this group came with acute depressions; and masochism is of very frequent occurrence. The latter is demonstrated clearly enough in their dreams, their symptoms, their lives. They hurt themselves in their business, professional, social, in fact all affective relationships.

Masochism is in itself a phenomenon so malign, that it seems

futile to ascribe to its constant presence in these patients a remedial or defensive purpose. In respect to the other character traits, it is comparatively easy to see such a purpose.

8 'Somatic' insecurity or anxiety.

In a sense, the use of the word anxiety with reference to this particular clinical symptom is a misnomer, for the simple reason that anxiety as such is not a constant phenomenon, nor do these patients by any means regularly complain of its presence. On the contrary, many present to immediate observation, a placid, perhaps better put, a stolid physical and mental equanimity. They strike the observer as not enough disturbed by difficult situations. In the course of analytic investigation it becomes apparent that an inordinately adequate system of defenses had been established by means of which this pseudo-equanimity is maintained. A knowledge of this on the part of the analyst is of benefit both to him and to the patient. It should guide the procedure to undo as little of the patients' defenses at a time as possible. For these patients are capable of releasing unpleasant, at times dangerous quantities of anxiety in the course of analytic therapy, so that as the analyst pursues his efforts at investigation and therapy simultaneously, he becomes familiar with this elaborate defensive system. With treatment a clearer picture of a deep underlying insecurity is unfolded, stretching back to earliest childhood, its roots penetrating to periods beyond memory. Instead of the fairly common clinical picture of traumatic experiences in childhood, with which we are more or less familiar in our neurotic patients, it seems as though insecurity always existed or was dissipated by some device. One rarely gets an impression that these patients at any period in their lives possessed self-assurance or self-confidence, unless the environment in some form or other gave it to them for the time being through approval, or when some experience gave them a temporary feeling of being completely adequate. Self-assurance usually was an evanescent experience, rather than one gained through a process of growth, maturity, experience, reality testing. That

is, in an individual of ordinary self-assurance, an unfortunate or stupid experience is regarded by him as a thing *per se,* to which he reacts as such. To an individual in our group, one such experience is interpreted to mean that he is thoroughly unfortunate or stupid and he suffers a total depreciation of his ego (self-esteem), or the reverse, an elation, or an exaggerated self-esteem from one successful experience. These individuals give an 'all or none' reaction. It is in connection with this deep insecurity that early parental love seems to play an important rôle. Those doing work with children are in a position to test directly the value of observations made in the case of these adults. I wish to say that my interest in the possible causes of these phenomena in the adult was aroused by reading material on this subject written by Dr. David M. Levy, and through talks with him. On the basis of these observations, it seems of value to keep in mind that a sense of security, of self-assurance, is developed in children on the basis chiefly of spontaneous maternal affection and to a minor degree paternal love. These children, deprived of something as essential to adequate psychic narcissism as food is to the body, meet experiences later in life already burdened with pathological insecurity, that is, they show a proclivity to develop anxiety. Sexual experiences or anything that is in their opinion disapproved of by authority, or which may involve danger, or put them to a test, are approached in their peculiar but to them logical way. Because of their, as they see it, already precarious state, anxiety in great quantities is ever ready to be mobilized, for disapproval or danger threatens to make an already insecure position still more so. Defense reactions are set into operation, those described above in particular. These adults in their childhood as a rule were inordinately submissive and obedient through fear and need. They clung to parents and substitutes with the desperation of the greatly endangered. In the female, penis envy and in the male, castration anxiety play considerable rôles. Anxiety because of the sexual impulse also plays a considerable rôle. The œdipus complex most assuredly does. But in connection with these facts, one thing must be kept in

mind: that antedating, or coincident with the above, there is a degree of immaturity and insecurity that is not present in the ordinary transference neurosis with which we are familiar; and this deep insecurity stems from disturbances in the narcissistic needs.

9 The use of projection mechanisms.

We know the wide use made of projection mechanisms in the psychoses. In our patients projection mechanisms are in common use; this is one of the phenomena which links this group with the psychotics. The use of these mechanisms implies the existence of a piece of defective judgment, which gives the patient's ego a more ready handling of his neurotic anxiety. The causes of his anxiety are projected to the world outside; he sets defensive behavior into operation at the cost of insight. The immature, narcissistically needy person can thus more easily protect himself from what he considers a hostile environment, through defensive measures (rigid personality, introversion, psychic and physical withdrawal, mild delusional systems, etc.). He is, however, unable to recognize that his insecurity is inwardly determined, for that would necessitate internal psychic changes in the direction of maturity and self-confidence which he cannot attain. The easier path is to explain his difficulties on the basis of a hostile attitude of the environment towards him and the inordinate difficulties that his conception of reality present, particularly in relationship to people, chiefly people in a position of authority.

10 Difficulties in reality testing.

This will be described in part II, in connection with treatment of the transference situations.

II

The development of the illness as manifested in the course of the transference affords an intimate bedside opportunity, so to speak, for appreciating the differences between the clinical picture of this border line group and the picture of the frank

psychoneuroses. I have attempted to show in part I of this presentation the very important rôle that narcissism plays as an etiological factor in the border line group: this causative factor necessarily operates in the clinical picture both as the patient presents it upon examination and also as he evinces it in the unfolding of the transference relationship.

Because of the preponderant influence upon the clinical picture of narcissism the therapeutic handling of the pathologically affected narcissistic impulse becomes a problem that is not present to an equal degree in the transference neuroses. On this basis some modification of the psychoanalytic technique is a logical procedure.[1]

Let us keep in mind the broad picture given in part I. Just as in the transference group, so in this also, prevention of

[1] It is in this connection that what I called above a modification in the application of psychoanalytic therapy is indicated. Really there is no change; my experience has taught me several things in the matter of this extreme, desperately clinging and dependent transference situation. These patients need much more supportive treatment than the usual run of psychoneurotic patients. Among the border line group of patients, those who come with an acute neurosis, chiefly depression and generalized anxieties, or those who develop disturbances in the course of therapy, which is the case with most, we find to be very sick people, much sicker than those in the psychoneurotic group. This latter group regularly presents a less grave picture. So that, just as in the field of physical medicine, the very sick are coaxed along, so to speak, by all manner of supportive treatment while medical measures are concurrently applied, and radical measures put off until the patient's powers of resistance are adequate. In this field too, supportive treatment over long periods is an essential preparation for the time when psychoanalytic technique can be applied. Because these patients are gravely ill and because work on the transference relationship, acting as a frustrating agent, is borne badly by these patients, greater attention to supportive therapy marks one modification of technique. A second modification consists in a rather constant occupation with the transference relationship to the apparent neglect of the historical material and interpretations. The affectively immature attitudes, which manifest themselves for long periods and in great quantities, make intelligent work impossible, except for that which the analyst can, so to speak, force the patient's healthy ego to accomplish in the understanding of his dependent attitudes incident to his narcissistic needs. At first this, as one patient put it, cutting 'across my path' is a disturbing process, for it necessitates frustration to the patient; and this is something these patients find difficult to tolerate. However, careful handling will materially diminish the persistent impulse to cling, and a certain amount of healthy intellectual functioning becomes available for work on the historical material and interpretations.

anxiety is the motor for the neurotic behavior. That the transference situation is a miniature neurosis is well enough known. The particular mechanisms used by the patients in handling anxiety that develops in the transference situation give us a clue to a diagnosis and prognosis, so that as we watch the transference phenomena develop we are in a position to estimate where we are and what we need do.

In studying the transference relationship in this group, first and foremost we see established a relationship to the analyst of extreme dependence. These affectively immature people cannot form an affective relationship on any other basis. Since the need for protection is great, we note in these patients, as evidence of dependence, a strict adherence to rules, an obedience, at times something like a compulsive application to the analytic job, and efforts to win approval, commendation, emphasis on trouble and suffering to arouse the protective sympathy of the analyst. So intense an affective involvement can this attachment become that attention to this aspect of the transference relationship takes up an inordinate amount of time, much more than in the work with less immature people.

This phase of the transference relationship gives us insight into the degree of the patient's immaturity. It is startling at times to discover the naïveté with which the analyst is viewed and accepted as a personal, corporeal god and magician. Some patients, without any surprise or sense of the unreal, accept the analyst as some vague presence without definite form who must not even be looked at. The startling thing is not so much the existence of these phenomena, but that the patients never see that there is something odd and strange in their psychology to make such attitudes possible. They accept the giant size, omnipotence and omniscience of the analyst as children believe in fairy stories or in the omnipotence and omniscience of the parents or God. These patients cannot get or expect help or love or care (that is 'cure') from any but one who reproduces in fantasy the parental figure in all the exaggerated proportions of childhood. When these patients develop anxiety in the analytic situation through anything that disturbs this positive protective state, that anxiety is

great, directly in proportion to the protection destroyed or endangered.[2] Some patients state without any insight that they feel as secure and happy in the analysis as though they were in a Nirvana. They are just happy. One can easily picture the anxiety, the depression and defensive anger, when the naïvely accepted love giving object becomes hostile in the patient's eyes. When this pleasant Nirvana state changes, there comes a fairly well marked mental confusion, and anxiety-driven efforts to reconstruct the old situation. In these states little can be done in the way of analytic work. The patients need soothing and tentative attempts at explaining the change in their mood. Some of these patients come uncomfortably near to a psychotic state in such phases of their transference. In this state as a rule the patients make violent attempts to recapture the old beatific illusion. Often through the production of analytical material (association and interpretations or through emphasis on their sufferings) they seek to soften what they think and feel is the cruel attitude of the analyst. The disturbance of the sense of reality in so far as the rôle of the analyst is concerned is startling, particularly in that the patients accept the unconscious implications of the relationship as though it were reality. Interestingly enough, in the mildly disturbed transference states not infrequently the patients feel thus distressed only when in the analytic session. Many say that as soon as they enter the waiting room or at times even the building itself, an acute, uncomfortable sense of anxiety takes hold of them. Not one, to my recollection, has commented on this change as something for which he could not account, but instead accepted it as something wholly in keeping with his relationship to the analyst. As one put it, 'How else can I feel but in awe of you?'

To return to the topic of neurotic character traits (the tenth

[2] Among these patients one not infrequently finds those that demand and seek 'the very best and greatest' analyst as the only one that can help them. Offhand one might get the idea that their narcissistic love is what influences them in such ideas or quests. The fact is that it is not at all difficult to demonstrate that they have deeply suppressed feelings of great insecurity and inferiority, and that on this basis they need 'the best and greatest'. The ungratified and ungratifiable narcissistic needs are responsible for this demand.

on the list given in part I), disturbance of the sense of reality is a characteristic phenomenon in these patients in their relationships to the parental (imago) rôle of the analyst. Again it does not strike these patients at all strange that they attribute such gigantic proportions to this psychic and physical imago. The naïve acceptance of this is something to note; it may well warn the analyst to watch carefully for the effects upon the patient of what he says. To these people it is a god, a magician, an oracle that speaks with all the force that such beings possess for the very young; if these beings at the moment are favorably inclined to the patient as he at the moment feels, the influence upon the patient of information given by these imagos is of note. Such a process as good logical reality thinking is not to be expected under the circumstances. Sound common sense in the patient and reality testing are in abeyance, or should be expected to be. So also, when these imagos seem hostile to the patient, it is clear enough that anything savoring of criticism, as any interpretation is apt to be construed, has a most disturbing effect. Illusory improvement is a common phenomenon during the positive transference. The rise of self-esteem at what the patient interprets as approval, commendation or preference of him by the imago is marked indeed; it corresponds to the self-depreciation produced by what the patient interprets as criticism on the part of the imago. The affective immaturity of these patients precludes a transference that carries with it sufficient reality relationship to give the analyst a feeling of safety in relying to any great extent upon the patients' ability to use any but the smallest fraction of intelligence otherwise more or less competently operating in the patients' professional activities. More with these patients than with frank transference neurotics, is it necessary to watch closely the effects upon the patients of what the analyst says. For it is the imago that operates for a long time upon the psyche of the patient, rather than the analyst as a reality person. It is well known that at the outset of treatment such extreme distortions of the person of the analyst and of his functions are characteristic and expected phenomena in

the transference. What looks like improvement can then be better estimated, and sad disappointment to the analyst and depressions for the patient possibly avoided.

The negative therapeutic reaction is a constant phenomenon with these patients and constitutes a far more disturbing and important clinical symptom than in the ordinary run of patients. I should like to add some remarks to what has already been written about the negative therapeutic reaction based on its occurrence in and influenced by the transference. As is known, we have an expectation and assume that a patient will react favorably to some discovery made for him or by him in the course of the analytic work. Yet, are we justified in such an expectation? Certainly not when the discovery is first made. The negative therapeutic reaction in these patients is significant later, when in reference to the same piece of news or interpretation, a reaction of depression, anger, anxiety or discouragement takes place. That is to say, when some familiarity with the unpleasant material should have come about through reiteration, and some acceptance should have resulted, the patients for a long time react as though it were *de novo*. It seems to me that on the basis of the patients' premises such reactions are to be expected; for the negative therapeutic reaction means that the anxiety incident to facing a new situation of danger has been avoided at the expense of pain, i.e., depression. To admit to consciousness any painful concept is fraught with anxiety. This anxiety the patient must avoid; a successful avoidance is evidenced by a negative therapeutic reaction.

In these patients the problem of growing up is anxiety ridden. Being grown up is to these patients, especially in their relationship to people, a fantasy of perfection such as they ascribe to adults. In fantasy this can be attained, but behavior to prove it or test it out is anxiety ridden. Whenever he successfully attains adulthood, the patient has a secret idea that his performance was not real, and that he might easily be unmasked as a make-believe. To achieve a successful performance means to him a rather violent suppression of his neurotic

inferiorities, and the assumption (which might be detected) of the rôle of some highly envied omnipotent imago (father, mother). The patients correctly recognize in this a certain make-believe, though far too inaccurately and inadequately to be of service to them.

The transference situation offers opportunity for study of this: at the core of this situation is the enormous over-evaluation of the imago by the patient. Except through illusion, the patient cannot identify himself with the (imago) analyst; that is, the patient never identifies himself with the analyst but with his conception of him—through a process of projection of his own ego ideal as embodied in the gigantic size of the analyst (imago). It is this figure which talks to him. Therefore, when for instance, the patient is told that what he has just said indicates some suppressed hostility from childhood to an older brother or father, the patient collapses through fear of punishment by virtue of his having been discovered. This is approximately what such an interpretation means to these patients. Frequently the patient makes a vow to get rid of the hostility as soon as possible and may return to the next session feeling fairly satisfied with himself, and tell the analyst, with the hope of being approved, that he now has mastered this hatred and rid himself of it. Usually in a short time the same material returns and the same interpretation is made. The reaction is similar to the first—chagrin, guilt, fear of punishment, dread of not being approved, all are set going again because the major portion of 'seeing' has been illusory, due to an effort to win approval from the analyst, and to enhance the patients' self-esteem and self-assurance.

Another phase of this negative therapeutic reaction is that pertaining to failure when really success should be expected on the basis of the work done and the understanding which the patient exhibits. What should not be overlooked here is the fact, really the fact, that the patients' conception of reality behavior and accomplishment is too illusory. The very immature patient feels that to be able to live in the world of reality, as he sees it, he must be as he conceives his imagos to be.

Actually, the investigation of the transference phenomena informs us that as far as people go, these patients still live in a world of their own childhood—so that getting well and being adult are attained through *wishing* to be able to do what grown ups do, and this they dare not risk. In the imagination it is easy enough and while in the analysis, but independently the anxiety is too great.

Another prevalent phenomenon in the transference is the lack of contact of patients with the analyst (imago). The patients, particularly in periods of hostility and anxiety, are in a state of withdrawal. This is no light affair. One can sense that the patient has retired within his rigid protective covering and carries on his analysis from this position of security against the analyst. Most patients will talk on uninterruptedly as though oblivious of the analyst, but interruption of the flow of associations will bring about as a rule, anger or anxiety, and the information that the patient had in mind the possible influence upon the imago of the patients' effort to please or appease the anger of the imago. One notes such a tendency in other kinds of patients also but not to the degree and lengths to which our patients go. In fact, this mode of transference is typical and varies in degree with the quantity of narcissism involved (rigidity). One can ascertain that this exclusion of the analyst involves many factors, an outstanding one being the removal by the patient of himself from a hostile, critical, ridiculing parental figure. One gets the feeling about some of these patients that they crawl into their hole and pull it in after them (intrauterine state). The degree of immaturity and insecurity from which there patients suffer helps to understand the intuitive, archaic nature of this defense mechanism.

One notes readily that much of the work which these patients do is tendentious. Intellectual and superficial association, long descriptions, carefully selected words and sentences, well rounded out; a quiet, contained and constrained demeanor, the enunciation of words of anger, anxiety, love, without their emotional contents, a flatness, a monotone are what they present, regardless of the affects described. The absence of affect

from the transference situation is characteristic of much of the work. Of course, these individuals have that same demeanor in their daily life outside of the analytic situation.

Those patients who come into the analysis with an overt neurosis of which anxiety is the main symptom develop at the very outset of the treatment a violent, clamoring, grasping at the analyst in their great need for protection and assurance. They almost literally attach themselves by every childhood organ or sense of prehension. In the course of the analysis in those patients who come into treatment free from much anxiety because of successful repression, the anxiety becomes overt due to study of their defense mechanisms, particularly in the field of the transference, and the same picture as above described is initiated. In fact, successful treatment is characterized by precipitation of anxiety in the case of patients who have successfully repressed it. In some patients, when the anxiety is precipitated by an unfortunate current experience outside of the analysis, we get the same clinging attachment. Those patients who do not develop any acute anxiety present a stolid, at times solid immobile exterior, though they not infrequently describe disturbing sensations of anxiety in the chest, bowels, genitals, and scalp (as though it were being lifted off); only later in the analysis do these patients express affect through their voices. This last (stolid) group comprises at least fifty per cent. of the patients I am describing as belonging to the border line group.

One often misses, except later in the analysis, what we are familiar with as 'free associations' in the object-libido group of patients. One can gather from the trend of my presentation that the great need for these patients is protection to a degree that takes precedence over all others. One cannot therefore expect 'free associations' of a kind we get with the less immature neurotic. A difficult task for these patients is to release hostility. As one put it, 'It is bad enough as it is, how would it be if people sensed or heard my hostility?' Only as the immaturity particularly in the transference is gradually ameliorated, and the need for protection diminishes, does one get a transference picture comparable to that found in the

other groups of neurosis. Only then can the patient really make appropriate, adequate use of the historical material brought into the analytic work; only then can he really understand and incorporate (digest) the significance of much of the work (interpretations) done concurrently with the almost endless work on the transference relationship. Interpretations, though not in reference to transference, are frequently made to give the patient opportunity to exercise his intellect and to derive some ego satisfaction. Interpretations are made also with a view of giving the patient knowledge. All the while the analyst knows that much of this will have to be gone over after more maturity has been attained, so as to render the effects of interpretations that are not related to transference material less tendentious. With this class of patients it is of prime importance that the analyst be fully cognizant to what extent the patient knows what he knows. Only after the transference, established on this extremely immature basis has been well worked out, can the significance of parental attachments of the œdipus period, castration threats, the sexual impulse, its pleasures and dangers and a host of other phenomena become subjects for explanation with some expectation of their being adequately understood. Only then do these phenomena take their appropriate rôle as factors in neurotic etiology in this border line group. For the anxiety which seems to be the motor for symptom or defense formation is earlier in point of time than the castration anxiety of the transference group of neuroses; the transference situation in our group then has these basic early infantile colorings. It begins in a period which appears to antedate sexual development as the factor in neurotic illness. Not that this does not later appear in this capacity, only to add difficulties to the already overburdened child in its efforts to handle an insecurity already of great magnitude.

Summary

The shortcomings of this presentation are evident enough. A certain vagueness is at present unavoidable, because the material which this group offers for study runs so clearly in

two directions, namely, towards the psychotic and the psychoneurotic. Much more time and investigation are necessary to evaluate the rather obscure phenomena these patients present.

That they form a group by themselves, which one can designate as border line, is a justifiable assumption. On the basis of this assumption, one finds in this group characteristics which separate these patients from the ordinary run of psychoneurotics. These characteristics I have attempted to describe. This presentation had in mind a description from two points of view: first, the historical, as given by the patient, and then developed in the course of treatment and study, and second, study of these characteristics as they operate in the transference situation.

The latter approach offers opportunity for study of these character traits that has great advantages. One has an opportunity of seeing them mobilized by the transference situation, forming a 'miniature' neurosis, the elements of which can more easily be studied because they concern the patient and the imago (analyst); moreover, just as in the case of the transference situation of the psychoneurotics, this then tells the analyst what therapeutic measures to apply.

Since in this border line group, narcissism is the underlying material from which the symptoms (defense) originate on the basis of needs (anxiety), psychoanalytic measures are instituted just as is the case in the psychoneurotic in whom anxiety arises in connection with psychosexual impulses. However, in our group narcissism is the source of anxiety. Though we have long been familiar with narcissism, when it is present in large quantities as presenting phenomena such as our patients bring, an approach to it directly has not to any great extent been made. This presentation has as its object this aim: to show that narcissism is amenable not only to psychoanalytic investigation but to psychoanalytic therapy.

There is no doubt that these patients have not been adequately reached by methods more or less successful with the average psychoneurotic. The same psychoanalytic technique, with the variations indicated above, is applicable in cases of

the border line group except that, although attention to and treatment of the disturbed psychosexual impulses is included, there must be attention to and treatment of the disturbed narcissism as well.

As is the case in the psychoneurotic, so too in this border line group, whatever there is of healthy ego functioning not involved in the sickness is utilized by the analyst in his efforts to achieve results. It is clear, however, from the description of this border line group, that a great part of ego functioning is involved in the illness, a greater part than in the transference group. This is one important feature in the border line group that makes therapy more difficult, and the prognosis more grave, than in psychoneurotics.