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PSYCHOANALYTIC TREATMENT
An Intersubjective Approach

Robert D. Stolorow
Bernard Brandchaft
George E. Atwood

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Treatment of Borderline States

The borderline concept has, in recent years, achieved enormous popularity within psychoanalytic and psychotherapeutic circles. Despite this rise to stardom, vast differences of opinion and numerous unresolved questions continue to exist concerning just what, if anything, the term "borderline" describes. We shall not attempt to cover the voluminous literature on this subject here (see Sugarman and Lerner, 1980, for an excellent review). Instead, we offer a critique of the currently prevalent view that the term "borderline" refers to a discrete pathological character structure, rooted in specific pathognomonic instinctual conflicts and primitive defenses. An alternative understanding of borderline phenomena emerges when they are viewed from an intersubjective perspective. Our focus will be on the intersubjective contexts in which borderline symptomatology takes form, both in early development and in the psychoanalytic situation.

The term "borderline" is generally used to refer to a distinct character structure that predisposes to faulty object relations, in which the fundamental difficulties are ordinarily attributed to the patient's pathological ego functioning. Typically the borderline personality organization is pictured as a direct structural consequence of the patient's use of certain primitive defenses—splitting, projective identification, idealization, and grandiosity—to ward off intense conflicts over dependency and excessive pregenital aggression (which dependency presumably mobilizes). But what is the clinical evidence that supposedly demonstrates the operation of these primitive defenses? And what is the meaning of the excessive aggression to which primary etiological significance is ascribed in the genesis of borderline psychopathology?
THE QUESTION OF SPLITTING

The experience of external objects as “all-good” or “all-bad” is generally regarded as a clear manifestation of splitting, resulting in sudden and total reversals of feeling whereby the view of the object is shifted from one extreme to the other. Oscillation between extreme and contradictory self concepts is similarly seen as evidence of splitting. This fluid and rapid alternation of contradictory perceptions of the self or others is seen as the result of an active defensive process whereby images with opposing affective valences are forcibly kept apart in order to prevent intense ambivalence. But is this assumption warranted clinically? Splitting as a defense actively employed to ward off ambivalence conflicts can come into play only after a minimum of integration of discrepant self and object experiences has been achieved through development (Stolorow and Lachmann, 1980). A defensive split into parts presupposes a prior integration of a whole. It is our contention that such a presupposition is not warranted when treating patients who are ordinarily diagnosed “borderline.” Their fragmentary perceptions do not result primarily from defensive activity, but rather from an arrest in development, which impairs their ability reliably to synthesize affectively discrepant experiences of self and other. Their rapidly fluctuating views of the therapist, for example, do not primarily serve to prevent ambivalence toward him. They are, in part, manifestations of a need for the therapist to serve as an archaic containing or holding object whose consistently empathic comprehension and acceptance of these patients’ contradictory affective states function as a facilitating medium through which their varying perceptions and feelings can eventually become better integrated (Winnicott, 1965; Modell, 1976; Stolorow and Lachmann, 1980).

It is our view that the lack of synthesis of self and object experiences characteristic of so-called borderline states is neither defensive in nature nor central in the genesis of these disorders. In our experience, the intense, contradictory affective states that these patients experience within the transference, and in particular their violent negative reactions, are indicative of specific structural weaknesses and vulnerabilities rooted in specific developmental interferences. Archaic mirroring, idealizing, and other selfobject needs are revived in analytic
transferences, together with hopes for a resumption of development. When these needs are responded to, or understood and interpreted empathically, intense positive reactions occur. Similarly, when these needs are not recognized, responded to, or interpreted empathically, violent negative reactions may ensue. If these angry reactions are presumed to represent a defensive dissociation of good and bad aspects of objects, this in effect constitutes a covert demand that the patient ignore his own subjective experiences and appreciate the “goodness” of the analyst and his interpretations. It precludes analysis of the patient’s subjective experience in depth, the elements that go to make it up, and their special hierarchy of meanings for the patient. In contrast, when we have held such preconceptions in abeyance, we have found that the intensity of the angry reactions stems from the way they encoded and encapsulated memories of specific traumatic childhood experiences.

**The Case of Jeff**

A clinical vignette illustrates our idea of a specific vulnerability. When Jeff, a young man of 23, entered treatment, he was in a state of marked overstimulation. He could not sit still for more than a few minutes at a time; his eyes darted from object to object; and he spoke under constant pressure. Although enrolled in college, he had not been able to attend classes or concentrate on his work. Increasingly frightened when alone at night, he had recently begun to take to the streets. There he had been approached for homosexual purposes several times, and this made him more fearful of his own unrecognized wishes and heightened his agitation. In the sessions he gave the impression of wanting desperately to cling to something around which he might begin to reorganize and restructure himself. Consequently, during the first months of treatment it was very difficult to bring any session to a close. His initial resistances centered on fears of being used to fulfill the analyst’s needs. When these were interpreted, an early idealizing transference developed. This enabled Jeff to confront the area of primary defect—a failure to have attained a cohesive self and a vulnerability to recurrent states of protracted disorganization. The analysis thus resumed a developmental process that had been stalled.

Jeff’s relationship with his father had always presented difficulty for him. The father reacted to any weakness or shortcoming in his son
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with impatience and contempt. This situation directly entered the analysis because Jeff's father had assumed financial responsibility for the treatment. The arrangement became a source of greater and greater tension between the two, for the father resented the burden of payment, as well as what he saw as evidence of his son's weakness and simultaneously a source of shame for himself. The difficulties in this area increased whenever Jeff made it clear that the analysis was not leading in the direction of making Jeff the son his father had always wished for, but was instead increasing Jeff's determination to develop in his own way.

Although the analyst realized the complications that might ensue, after two and a half years he notified Jeff that he was raising his fees generally. He wanted to discuss the matter with Jeff to see if and how it might be worked out. The request came at a time when Jeff's relations with his father were already strained, though it did not appear likely that this would change within any foreseeable period of time. Jeff's initial response was one of some anger about the unfortunate timing, followed by a remark to the effect that of course he knew how the analyst felt because everything was going up in price. Recognizing Jeff's frequent tendency to substitute an understanding of someone else's position for an expression of his own, the analyst interpreted this, together with Jeff's fear of the analyst's reaction to his expressing his own feeling. (We would emphasize that in our experience such genuine emotional expression is always obstructed, and with it an essential aspect of an authentic relationship, when a patient's affective states are incorrectly interpreted as defensive transference distortions.)

Gradually, over the course of the next few sessions, Jeff was able to come out with his feelings—feelings of hurt, disappointment, and violent anger. The hurt seemed to center on the analyst's failure to ever (Jeff's words) consider him first, and the extent to which this experience revived feelings of always having been a burden, a supplicant, someone standing in the way of other people's plans or enjoyment. Jeff was a twin, and he recounted a welter of experiences in which his twin had preempted his parents' attention by being exactly the child they wanted and one who caused them no difficulty.

Jeff's anger at the analyst was related mostly to the poor timing and what that meant to him. He spoke of the bind the analyst's request put him in. Things were already going badly between him and his father.
Jeff had started a new job and had been forced to ask his father for money for new clothes. Each encounter of that kind was humiliating for Jeff. Now he would have to face a review of how long he had been in treatment and how much longer it was to continue. How could the analyst, knowing all this, choose to put Jeff through it?

Frequently, after expressing himself unabashedly, Jeff would huddle up, as if in a corner, his arms protectively wrapped around himself. In response to questions, he confirmed that he was terrified. He was certain that the analyst would be furious with him, call him selfish, and berate him for his lack of appreciation for the analyst.

There now emerged a host of memories in which the timing of Jeff's life (and, indeed, his life itself) had to conform to someone else's wishes. He had to go to bed when his father told his mother he should. He had to wait until his father was done with the evening news before speaking to him, and then he could only talk about what his father was interested in. Monday night, football night, was especially sacrosanct—not an occasion when a pleasurable interest might be shared, but one more occasion when Dad was not to be disturbed.

Jeff's mother told him when, what, and how to eat. She chose his clothes for him, where and how he was to sit or stand. He was not to sit on the couch lest the cushions be messed up, nor on his bed for similar reasons. He had to renounce his own inclinations and adopt her wishes regarding what music he was to like. Always before the family left on an auto trip, he was instructed to urinate, and his mother checked to make sure he didn't put anything over on them. Otherwise they might have to stop along the way. And Jeff recalled that whenever he attempted to protest or assert himself, perhaps because something was especially important to him, he was squelched, accused of selfishness and a lack of consideration. He was told that his father wouldn't want to come home at all if he kept this up.

For Jeff, the most significant aspect of these repeated experiences was a feeling of absolute powerlessness. Once, when he could not stand it anymore, he went to his room and packed an overnight bag. When he appeared in front of his parents to declare he was running away, no one said a word or made a move to stop him. He then realized that he was stuck—that no one else would want him and that he had to give in.

These experiences formed the background of Jeff's reaction to the analyst's request for an increase. Jeff retained, in its most imperative form, the longing that someone would put his wishes first, and he was
THE QUESTION OF PROJECTIVE IDENTIFICATION

Considerations similar to those we have discussed for splitting apply to the view of projective identification as a primitive defense, characteristic of borderline patients. In projective identification there is a blurring of the distinction between the self and the object in the area of the projected content. Such states of self-object confusion are presumed to be the product of an active defensive effort to externalize all-bad, aggressive self- and object images. Once again, we question whether this assumption is clinically justified.

Projection as a defense actively employed to ward off conflict can come into play only after a minimum of self-object differentiation has been reliably achieved (Stolorow and Lachmann, 1980). Defensive translocation of mental content across self-object boundaries presupposes that those boundaries have been for the most part consolidated. Our experience contradicts such a presupposition for patients diagnosed “borderline.” Their states of self-object confusion arise primarily from a developmentally determined inability to maintain the distinc-

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These repeated experiences ice, when he could not stand ed an overnight bag. When are he was running away, no .im. He then realized that he m and that he had to give in. sund of Jeff's reaction to the ined, in its most imperative t his wishes first, and he was highly sensitive to the specific configuration of others' needs being put before his own. He therefore responded acutely and intensely to that configuration when it entered the transference. This response was covered over by a more moderate reaction, in which he apparently at tempted defensively to "synthesize" good and bad object concepts. What was crucial, however, was for Jeff to recognize the underlying inten-sity of his hurt and the experiences behind it, rather than having his reaction regarded as an instance of splitting or a lack of apprecia-tion for the analyst. This recognition opened up an entire area of the transference to analysis and ultimate resolution. Jeff and the analyst came to see clearly the extent to which Jeff had found it necessary to define himself around what was expected, what would please, and what would not offend in order to maintain his object ties. They were able to comprehend the threat constantly posed by any authentic experience of self—the threat of estrangement and isolation Jeff had en countered whenever he asserted himself or attempted to act on his own behalf. The analysis, then, brought out into the open and allowed Jeff to work through the enormous resentment such subjugation of self had aroused.
tation between self and object. In the treatment context it is not useful to view such states as examples of either defensive projection or general ego weakness. Instead, these partially undifferentiated states are best understood as manifestations of revivals with the therapist of a specific need for immersion in a nexus of archaic relatedness, from within which formerly thwarted developmental processes of self-articulation and self-demarcation can be revitalized and once again resumed (Stolorow and Lachmann, 1980).

Frequently we have encountered in the literature a second, and to our minds even more questionable, use of the term "projective identification." There is presumed to be not only a projective distortion of the patient's subjective experience of the object, but also a purposefully induced alteration in the external object's actual attitude and behavior toward the patient. The patient is said to put split-off, disavowed parts of himself inside the external object. This formulation is based on the observation that intense reactions frequently occur in analysts who are treating borderline patients. Because such reactions are experienced similarly by most "reasonably well-adjusted therapists," the reasoning goes, "countertransference reactions in these cases reflect the patient's problems much more than any specific problems of the analyst's past" (Kernberg, 1975, p. 54). It is also suggested that if the analyst is reacting intensely to the patient, such countertransference is a clue to the patient's hidden intention. Kernberg (1975), for example, writes:

If the patient systematically rejects all the analyst's interpretations over a long period of time, the analyst may recognize his own resultant feelings of impotence and point out to the patient that he is treating the analyst as if he wished to make him feel defeated and impotent. Or when antisocial behavior in the patient makes the analyst, rather than the patient, worry about the consequences, the analyst may point out that the patient seems to try to let the analyst feel the concern over his behavior because the patient himself cannot tolerate such a feeling [p. 247].

These formulations fail to take into account that when the analyst, in his interpretations, insists that the patient's difficulties arise from vicissitudes of aggressive-drive processing, the only alternatives open to the patient are to agree with the premises being put forward or to find
himself in the position of inadvertently making the analyst feel defeated and impotent. To us, this state of affairs seems to reflect the extent to which the analyst's self-esteem depends on the patient's acceptance of the correctness of his theoretical position, rather than necessarily reflecting any unconscious hostile intention on the part of the patient. Similarly, the analyst's concerns about a patient's antisocial behavior seem to us to reflect the analyst's difficulties in sufficiently demarcating himself from the patient so as to be able to devote himself to the investigation of the meaning of the actions in question.

A description of a typical clinical application of the concept of projective identification is contained in Kernberg's (1975) reference to Ingmar Bergman's movie Persona:

A recent motion picture... illustrates the breakdown of an immature but basically decent young woman, a nurse, charged with the care of a psychologically severely ill woman presenting what we would describe as a typical narcissistic personality. In the face of the cold, unscrupulous exploitation to which the young nurse is subjected she gradually breaks down. She cannot face the fact that the other sick woman returns only hatred for love and is completely unable to acknowledge any loving or human feeling toward her. The sick woman seems able to live only if and when she can destroy what is valuable in other persons, although in the process she ends up by destroying herself as a human being. In a dramatic development the nurse develops an intense hatred for the sick woman and mistreats her cruelly at one point. It is as if all the hatred within the sick woman had been transferred into the helpful one, destroying the helping person from the inside (pp. 245-246).

We hold that conclusions such as this are unjustified and that the underlying assumptions are unwarranted and antitherapeutic. In the first place, there is no evidence that the sick woman is "able to live only if and when she can destroy what is valuable in other persons"; there are only indications that the sick woman does not respond in a way that the nurse-therapist wants or needs. We are familiar in our own practices with many cases in which patients who have recently experienced traumatic loss and disintegration resolutely protect themselves against any involvement until some spontaneous recovery has set in. Second,
there is no evidence that "the hatred within the sick woman has been transferred into the helpful one, destroying the helping person from the inside." There is, instead, every indication that the patient's responsiveness was required in order for the nurse to maintain her own self-esteem and to regulate her own psychological functioning. When frustrated, the nurse demonstrated her own narcissistic vulnerability and propensity for rage reactions. We have observed such factors at work in ourselves and regard them as to some degree universal in therapeutic relationships. In our view, their near universality does not warrant their being ignored as originating in the personality structure of the therapist. Nor does it warrant the assumption that these responses are an indication of pathological projective mechanisms on the part of the patient. We have found that the assumption that the patient wishes the therapist to feel impotent or infuriated is much more often than not directly contradicted in our own work. Such wishes, we suggest, occur only when the patient's disagreements, assertions, and primary wishes to have his own subjective experiences empathically understood have been consistently unresponded to. Far more often, the patient's fear of the analyst's narcissistic vulnerability and of being held responsible for the analyst's feeling of frustration constitutes a severe resistance to free association and is a prominent motive for defense.

The concept of projective identification is used extensively by analysts to explain any fear that is not readily intelligible as a response to a real danger. It is consistently invoked to explain why patients are so regularly afraid of their analysts. We have found, however, that the analyst's insistence that negative reactions in analysis are to be explained by the patient's innate aggression or envy, or by his projection of aggressively distorted internal objects, can be damaging to the patient, to the unfolding selfobject transference, and to the analysis (Brandchaft, 1983).

The application of the theory of projective identification carries with it the real danger of depriving patients of a means of defending themselves when they feel that the analyst is cruel, distant, controlling, or demeaning. This danger is increased if the analyst, for whatever reason, is unable or unwilling to become aware of his actual effect on the patient, or if he minimizes that effect because of a conviction that he has the ultimate best interests of the patient at heart. Frequently, this conviction in the analyst takes the form of a conception
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of a "more normal dependent" part of the patient, which is being domi
nated and excluded by the aggressive part. Such unwarranted, if
reassuring, concepts notwithstanding, the tendency to fall back on in
terpretations of projection to the detriment of the subjective experi
ence of the patient, even where such mechanisms exist, can in practice
be shown to foster a dependence on the analyst's perceptions at the ex
pense of the patient's. These interpretations encourage, indeed re
quire, a pro forma belief in the analyst's "goodness" and correctness at
the expense of the self. They impair the patient's sense of his own self
and belief in himself, and they encourage an agreement that necessary
and understandable efforts to protect a vulnerable self are indicative of
severe pathology and should be given up.

FURTHER MISCONCEPTUALIZATIONS

Closely allied with the developmental disturbances discussed so far
are the idealizations and grandiosity that often pervade the treatment
of patients who are called "borderline." Such perceptions of the self or
others are regularly interpreted as being defensive against dependency
and the attendant subject-centered or object-centered aggression. Our
experiences indicate that most often the idealizations and grandiosity
are manifestations of selfobject transferences (Kohut, 1971, 1977).
They are not pathological defenses, but rather revivals with the therape
ist of the archaic idealizing and mirroring ties that were traumatically
and phase-inappropriately ruptured during the patient's formative
years and on which he now comes to rely for the restoration and main
tenance of his sense of self and for the resumption and completion of
his arrested psychological growth.

Having argued that much of the clinical evidence cited for the oper
ation of primitive defenses is actually evidence of needs for specific
archaic selfobject ties, and of disturbances in those ties, how shall we
understand the "excessive pregenital aggression" that many authors
believe is the etiological bedrock of borderline pathology? We contend
that pervasive primitive aggression is an inevitable, unwitting, iatrogenic
consequence of a therapeutic approach that presupposes that the psycholog
ical configurations we have been discussing are in their essence pathological defenses against dependency and primitive
aggression. A patient revives an arrested archaic state or need, or at-
tempts a previously aborted developmental step within the therapeutic relationship, and the therapist interprets this developmental necessity as if it were a pathological defense. The patient then experiences this misinterpretation as a gross failure of attunement, a severe breach of trust, a traumatic narcissistic wound (Stolorow and Lachmann, 1980). When vital developmental requirements reexperienced in relation to the therapist once again meet with traumatically unempathic responses, is it surprising that such misunderstandings often bring intense rage and destructiveness in their wake? We are contending, in other words, that the pervasive aggression is not etiological, but rather a secondary reaction to the therapist’s inability to comprehend the developmental meaning of the patient’s archaic states and of the archaic bond that the patient needs to establish with him (Kohut, 1972, 1977; Stolorow, 1984a).

AN INTERSUBJECTIVE VIEWPOINT

At this point we are in a position to formulate our central thesis regarding the borderline concept. The psychological essence of what we call “borderline” is not that it is a pathological condition located solely in the patient. Rather, it refers to phenomena arising in an intersubjective field—a field consisting of a precarious, vulnerable self in a failing, archaic selfobject bond. In order to elaborate this thesis further, we must clarify the nature of the self disorder that contributes to the emergence of borderline phenomena.

We view the various disorders of the self as arbitrary points along a continuum (see Adler, 1981) rather than as discrete diagnostic entities. The points along this continuum are defined by the degree of impairment and vulnerability of the sense of self, the acuteness of the threat of its disintegration, and the motivational urgency of self-reparative efforts in various pathological states. The degree of severity of self disorder may be evaluated with reference to three essential features of the sense of self—its structural cohesion, temporal stability, and affective coloration (Stolorow and Lachmann, 1980).

In certain patients, the sense of self is negatively colored (feelings of low self-esteem) but is for the most part temporally stable and structurally cohesive. One might refer to such cases as mild self disorders. In other patients, the sense of self is negatively colored and its organiza-
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tion is temporally unstable (experiences of identity confusion) but,
notwithstanding fleeting fragmentations, it largely retains its struc-
tural cohesion. These cases might be called moderately severe self dis-
orders. In a third group of patients, the sense of self is negatively
colored, temporally unstable, and lacking in cohesion and thus subject
to protracted structural fragmentation and disintegration. Such cases
can be termed very severe self disorders. Roughly speaking, patients
who are called “borderline” fall within the moderate to severe range of
self disorders.

Our concept of self disorder as a continuum or dimension of psychopathology is somewhat at variance with Kohut’s (1971) early view of
“borderline” as a discrete diagnostic entity that is sharply distinguish-
able from the narcissistic personality disorders. The borderline per-
sonality, according to this view, is chronically threatened with the
possibility of an irreversible disintegration of the self—a psychological
catastrophe that is more or less successfully averted by the various pro-
tective operations characteristic of borderline functioning. This vul-
nervability to a permanent breakup of the self is the product of a
traumatically crushing or depriving developmental history that has
precluded even minimal consolidation of the archaic grandiose self
and the idealized parent image. Consequently, unlike the narcissistic
personality, the borderline patient is unable to form a stable mirroring
or idealizing self-object transference and is therefore unanalyzable by
the classical method.

In contrast with Kohut’s conceptualization, our observations are
consistent with those of other analysts who have reported analyses of
borderline personalities in which the therapist was eventually able to
help the patient form a more or less stable and analyzable self-object
transference (Adler, 1980, 1981; Tolpin, 1980). It is true that the
self-object ties formed by those patients who are called “borderline”
tend initially to be far more primitive and intense, more labile and vul-
nerable to disruption, and therefore more taxing of the therapist’s em-
pathy and tolerance (Adler, 1980, 1981; Tolpin, 1980) than those
described by Kohut as being characteristic of narcissistic personalities.
Furthermore, when the selfobject ties of a patient with a moderate to
severe self disorder are obstructed or ruptured by misunderstandings
or separations, the patient’s reactions may be much more catastrophc
and disturbed, for what is threatened is the patient’s central self-
regulatory capacity—the basic structural integrity and stability of the
sense of self, not merely its affective tone (Adler, 1980, 1981; Stolorow and Lachmann, 1980). Nevertheless, when their archaic states and needs are sufficiently understood, these patients can be helped to form more or less stable selfobject transferences, and, when this is achieved, their so-called borderline features recede and even disappear. As long as the selfobject tie to the therapist remains intact, their treatment will bear a close similarity to Kohut’s descriptions of analyses of narcissistic personality disorders (Adler, 1980, 1981). When the selfobject tie to the therapist becomes significantly disrupted, on the other hand, the patient may once again present borderline features. What we wish to stress is that whether or not a stable selfobject bond can develop and be maintained (which in turn shapes both the apparent diagnostic picture and the assessment of analyzability) does not depend only on the patient’s nuclear self pathology. It will be codetermined by the extent of the therapist’s ability to comprehend the nature of the patient’s archaic subjective universe (Tolpin, 1980) as it begins to structure the microcosm of the therapeutic transference.

The Case of Caroline

Our conception of borderline as phenomena arising and receding within an intersubjective field is exemplified by the case of Caroline. The “borderline” symptoms that led Caroline to enter analysis were immediately precipitated by severe disturbances in her relationship with her husband. In other words, they arose within a specific intersubjective field—that of a precarious, vulnerable self in a failing, archaic selfobject tie. The analyst, however, did not sufficiently recognize this when the treatment began, and his lack of understanding complicated and prolonged the treatment. We have since observed that most often patients enter treatment when there is a breakdown in an archaic selfobject bond, which has hitherto served to maintain, however precariously and at whatever cost, the structural cohesion and stability of the self and the patient’s central self-regulatory capability.

1In a personal communication (1981), Kohut stated that he had long held views compatible with those developed here. He wrote: “Insofar as the therapist is able to build an empathic bridge to the patient, the patient has in a way ceased to be a borderline case . . . and has become a case of [severe] narcissistic personality disorder.”
Caroline's two previous attempts at treatment had not materially affected the underlying defect in her self-structure. When she entered the analysis described here, she was 42 years old. Her last analysis had ended about three years earlier when her analyst told her he didn't feel he could do any more for her. Since that time she had thrown herself into various pursuits. She had returned to school to finish her education, which had been interrupted many years before when she married. In addition, she had involved herself in some charitable and social activities in an attempt "to feel useful" and to keep herself occupied.

Caroline spoke with a Southern accent, which became more pronounced when she was tense. She was somewhat overweight and attempted to cover this with loose-fitting clothes, which only made it stand out more. For some time she had been in a state of more or less constant anxiety, at times hyperactive and at other times withdrawn, apathetic, and unable to get moving. Early in her treatment, she displayed a frightened, little-girl look, expressing her evident discomfort and not infrequently her terror. She avoided the analyst's eyes almost completely. In the first weeks, she openly voiced her disbelief that anyone could help her and said she saw no way out of her difficulties.

Gradually it was reconstructed that her present intractable state dated from about 10 years earlier and had followed a deterioration in her relationship with her husband (to whom she had then been married for about a dozen years). Although Caroline had been a reasonably attractive young woman, her shyness and lack of confidence, in concert with a puritanical upbringing, had constricted her social and sexual development. Thus, her husband was the first man with whom she had had a serious relationship. She had been an outstanding student—her remarkable intelligence was to become clearer as the treatment progressed—but she left college when she married, in order to support and further the career of her husband, then in law school. Subsequently, when he set up practice, she kept house for him, assisted him in many ways, reared their child, and operated a small business so that they could prosper financially. In spite of this, their relationship became more strained and conflicted, as her husband became ever more displeased with and critical of her—of her accent, her weight, her anxiety and depression. This culminated in a "borderline" state, with progressive lethargy, hypochondriacal symptoms, feelings of deadness that began in her extremities and threatened to engulf her...
whole body, and frightening delusions about her husband harming, poisoning, or killing her.

Caroline recovered from this early episode in a matter of weeks, but many of the symptoms recurred (though not the delusions) and other symptoms took hold. She began to eat compulsively, and there were periodic withdrawals during which she remained preoccupied with puzzles or needlework for long periods of time. In the early months of treatment, Caroline appeared so distraught and disorganized that the analyst believed that only by seeing her six times a week could he avert a prolonged hospitalization or suicide (to which she made several references).

Whatever the content of the sessions, Caroline reacted to their ending with enormous anxiety and clung to the analyst as the hour drew to a close, speeding up her associations so that he could not interrupt her. When he succeeded in calling the session to a halt, she either continued the conversation until he closed the door behind her or, enraged by his interrupting her, walked out in a sullen pout. Weekends and more prolonged separations produced severe regressive states and numerous dreams filled with disaster—floods and drowning, houses perched precariously on a cliff edge, supports crumbling, black men pursuing her, and imagery involving a variety of mutilations.

In the first dream that Caroline reported in the analysis, she described her husband and her analyst sitting in the living room. She went to the freezer and took something out. It was the trunk of a frozen corpse with no limbs. She showed this to the men, but they began to have sport with it—tossing it around and laughing.

The early sessions were marked by an almost uninterrupted stream of associations. The analyst found it hard to think, let alone formulate a coherent understanding of any underlying meaning. As this continued for some time, it was difficult for the analyst to escape the conviction that she was projecting her anxiety and helplessness into him in an attempt to rid herself of these feelings.

Gradually, however, it became clear that she was terrified of the analyst and the treatment—terrified that she would be treated cruelly, driven mad, or abandoned as a hopeless case. These fears were interpreted to her as indications of a lack of trust and reluctance to depend on the analyst. Such interpretations seemed for a time to calm her, and they evoked memories of her early experiences.

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ried when her mother was approaching 40. Her father, four years older
and a widower with two teen-aged sons, was a hard-working account-
ant who needed someone to take responsibility for their upbringing.
As a young woman, Caroline’s mother had wanted desperately to es-
cape from the drudgery of her small town life, and her love of music
seemed to offer her the opportunity. But she realized rather late that
her hopes of becoming an opera singer or the coach of an operatic
prodigy were destined to disappointment. By that time her chances for
a good marriage had passed her by, and she settled on Caroline’s fa-
ther, more with resignation than ardor, a bird in no gilded cage.

Caroline was born two years later, after what she was repeatedly
told was an extremely difficult labor. Three years after her birth a
brother was born. This birth was even more difficult and resulted in se-
vere damage to the mother’s pelvic tissues. Afterward the mother took
to her bed in a depression that lasted for many months during which
time she was preoccupied with an assortment of hypochondriacal
and somatic symptoms. When she recovered, she treated Caroline as if the
little girl were an extension of her own defective, diseased self. She re-
acted to every sneeze as if it were a harbinger of death, took Caroline
from doctor to doctor, and kept her out of school for two years. As
Caroline and her health became her mother’s sole preoccupation, in-
tense conflicts arose. These centered on what foods Caroline was to
eat, how much and at what intervals she was to sleep, and especially
her bowel habits.

As the treatment progressed, the analyst noted that Caroline was
somewhat better as each week proceeded, but then regressed toward its
end. Weekends remained disasters, with the patient unable to think or
function except at a minimal level. The analyst thought that the mate-
rial indicated Caroline’s inability to retain any image of a good object
built up during the sessions—she and it underwent a nearly complete
deterioration during separations. When she returned to analysis, it
was in a state of helplessness. Repeatedly, she then complained that
the analysis was not helping her, and frequently, apparently forgetting
her condition when she entered treatment, she angrily asserted that
the analyst was responsible for her pain and lack of progress.

It was easy for the analyst to conclude that the archaic states of con-
fusion and disintegration into which Caroline lapsed came about be-
cause of persistent splitting, that her good internal objects were being
kept widely apart from the bad, that synthesis was being actively pre-
vented from occurring, and that she could not simultaneously accept
the analyst's goodness and his separateness. She reacted to his un-
availability on weekends and to what he believed were thoughtful and
helpful interpretations as if they were purposely meant to make her suf-
fer. Attacking him in that way, she anticipated being attacked in re-
turn. And she experienced every attempt on his part to explain this
situation to her, no matter how cautiously, tactfully, and empathically
phrased, as a renewed attack on her.

Another "symptom" appeared in Caroline's treatment. One day, in
striking contrast to her usual outfit of jeans and tennis shoes, she ap-
peared in a lovely skirt and jacket, a pretty blouse, and fashionable
shoes and purse. Greatly embarrassed, she revealed that she had gone
on a spree, bought three outfits, several pairs of shoes, and an assort-
ment of matching accessories. She confided that she did this every
once in a while, in spite of herself. She knew that when she went home
she would have to hide all the things she had bought and might never
be able to wear them, for her husband would be furious with her. He
would be frightened and horrified by her excesses. He maintained ab-
solute control over the family finances and regarded her buying binges
as symptoms of insanity or as inconsiderate breaches of contract.
Moreover, now he would have further grounds for his understandable
concern over her treatment.

The analyst felt that if her purpose was to project into him her anxi-
ety over behavior for which she wished to escape responsibility, she
could not have devised a more effective means. He was also struck by
the excess, the suddenness, and the lack of control, and he tried, with-
out success, to investigate the spree from that perspective. He was to
learn later that Caroline did not buy another stitch of clothing for
three years.

Caroline's fears of the analyst and the analysis kept recurring. Her
dreams were filled with scalding suns, Chinese tortures, and mon-
strosely cruel people. Such images were generally interpreted as trans-
ference projections. And gradually some small progress seemed to
occur. Her anger subsided somewhat, her anxiety assumed more man-
gageable proportions, and she was able to read and to socialize to a
greater extent. Yet whenever her old symptoms returned, she thrashed
herself mercilessly. Repeated working through of these themes seemed
to the analyst to leave no alternative to the explanation that some-
thing in her was opposing success, making it impossible for her to bene-
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fit further from treatment, her marriage, and, indeed, her life. She
made many starts in many directions, but invariably her enthusiasm
disappeared, to be mourned and to become the focus of renewed dis-
pointment and anger with herself. It seemed that continued treatment
would only confirm an omnipotent fantasy that somehow some expe-
ience would magically solve her difficulties without her having to
change.

The analysis, then, appeared to have reached a stalemate. Although
basic problems had not been solved, the prospect of termination
loomed unmistakably, for it seemed to the analyst that more analysis
would only serve to keep Caroline from utilizing the considerable in-
sights she had attained. Rationalizations appeared like weeds after a
rain. After all, her background had left her with a considerable toll.
The difficulties of her attachment to or detachment from her husband,
especially at her age, were all but insurmountable. Her gains, looked at
in a certain light, were not negligible, and it seemed certain that she
was no longer so vulnerable to the threat of collapse that had brought
her into treatment.

In the fourth year of treatment, with many of Caroline's borderline
features still intact, the analyst decided to take one last look. It had
long been apparent that Caroline was disappointed and felt herself to
be a failure, but it was now also becoming clear that she felt that the an-
alyist was disappointed in her and that he considered her and himself
failures. This factor—Caroline's responsiveness to cues of the analyst's
feeling about her—had been grossly underestimated. In fact, as was
later understood, her imperative need to be liked and approved of and
the devastating effect on her of the analyst's disapproval, which she
sensed, had been crucial in structuring the first phase of treatment.
Her depression, her attacks on herself, and her lack of sustaining mo-
tivation all became understandable from this perspective. The analyst
could not continue to maintain that her perceptions of him were all
projection, for he began to recognize in himself what she had been re-
ponding to. This dawning awareness ushered in the second phase of
the analysis.

In a subsequent session, in response to Caroline's expression of wea-
riness and thoughts about terminating, the analyst commented that
he realized that the process was becoming wearing. But could they take
one more good look at what had been occurring before deciding to ter-
minate? Perhaps there was something he had not understood, some-
thing that might prove helpful. Perhaps he had conveyed an increasing
disappointment in her and in himself, especially around her continu-
ing symptoms, and perhaps that had contributed in an important way
to her dejection and disparagement of herself. Caroline responded en-
thusiastically. Yes, she exclaimed, she had felt awful about the ana-
lyst’s disappointment, which she had sensed. By this time she should
be able to feel better and to control her diet, for she had learned so
much. She had attacked herself mercilessly for not having tried hard
enough. She was weak and self-indulgent, she said, and must want to
spite both her husband and the analyst as she had always defied her
mother. When she was on her diets, she could somehow kill her crav-
ing for food and not be hungry. But something always happened and
she again felt the urge to eat. Then she felt she was a failure and tried
harder and harder. When she was finally unable to stick to her diet,
she hated herself, for she had let the analyst and her husband down.
Once that point had been reached she was absolutely unable to restrain
herself—the more alone she felt, the more she hated herself and the more she
felt compelled to eat.

The analyst was now able to glimpse the transference configuration
that had actually determined the course of Caroline’s analysis. To-
gether they began to look at what happened to her when she was
alone, paying increasing attention now to her subjective experiences
and trying to understand them in a different way. There seemed to be a
complex and thoroughgoing alteration of her state of mind—a slipping
away of self-esteem, feelings of accelerating disorganization and dis-
connectedness, an inability to concentrate, and increasing feelings of
deadness, involving coldness and loss of sensation in her limbs, so that
they no longer seemed to belong to her. All these symptoms the ana-
lyst came to recognize as signs of a fragmenting process and of an un-
derlying defect in her self-structure. It became apparent how much
Caroline had looked to the analyst to maintain her sense of self,
needing from him what had not been acquired in her childhood.
When the analyst had interpreted her archaic states and transference
needs as expressions of pathological splitting and projection, she had
become intensely ashamed and self-hating. In their impact on Caro-
line, the interpretations of pathological defenses had repeated the
fragmentation-producing effects of her mother’s view of her as defec-
tive and diseased.

It was especially important to Caroline that the analyst be pleased
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with her. She had tried valiantly to get this across to him early in the
analysis, but he had regarded this as defensive. He had not recognized
as primary her specific need to establish him as a selfobject who would
be a source of the mirroring, affirming responsiveness that her self-
absorbed, depressed, and hypochondriacal mother had been unable to
supply during her early formative years. Behind this specific need lay
the vulnerability to fragmentation that had pervaded Caroline's ana-
lytic experiences. When the selfobject tie to the analyst was disrupted
by a failure of the analyst to understand her subjective experience in its
essence or by a loss of connectedness during weekends or vacations,
she could not maintain the cohesion, stability, and affective tone of
her precarious self. She fell apart, eating compulsively in an effort to
strengthen herself and to fill the defect in her sense of self—trying to re-
cover through oral self-stimulation the feeling that she existed at all.

As the structural weakness was being worked through, Caroline real-
ized at one point that she was becoming addicted to television and ra-
dio. When she thought about the vague, apprehensive restlessness she
felt in the absence of sensory stimulation, she realized that "empty" did
not really describe her feeling. Rather, she recognized "a feeling of defi-
ciency, a lack of some very specific supporting structure which would
prevent everything from falling in—some essential piece of myself miss-
ing." When the analyst had taken her symptoms as a disparagement of
his efforts, as a defensive aggrandizement of herself, or as an indication
of greed, she had felt even worse. Feeling blamed, she had relentlessly
blamed herself.

As the disturbance in the transference tie was seen and analyzed in
this new way, with focus on the fragmented states and the underlying
structural deficit, Caroline became more alive, friendlier, much more
enthusiastic, and increasingly capable. Her desire to understand her
states of mind grew in direct proportion to her sense of the analyst's de-
sire to help her acquire this understanding. She expressed appreciation
that the analyst now recognized her vulnerability and the legitimacy of
her fears. "The first thing I had to get across to you," she explained
when she was certain that he would understand her, "was how impor-
tant what you thought of me was. Until that happened nothing else
could happen. I couldn't disagree with you because I was afraid of
worse consequences. So I tried to see and use and apply what you said,
even when it made me hate myself. I tried to think you were opening
up a new world for me, a new way of seeing things that would work out
better in the end. And when it wasn't working out that way, I blamed myself."

With the working through of her fragmented states in relation to their triggering experiences within a disrupted self/object tie, Caroline's borderline symptomatology and paranoid-like fears dropped away, together with what had previously been regarded as splitting, projection, and a failure to internalize a good object. She and the analyst could now better understand her dream of the frozen torso and her expectations of being laughed at. She had often been terrified as a little girl, but her fears had always been mocked. She could not, for example, let her mother bathe her or wash her hair, and her mother would be furious with her. No one understood why she was afraid of her mother—indeed, afraid of almost everything. She was teased mercilessly by her brothers for being so afraid. "Girls can't do anything," they would say.

As Caroline's vulnerability decreased, there were increasing signs that she was turning once more to the analyst to help her understand her early relationship with her mother, its effect on her, and how crucial elements were being replicated with her husband and the analyst. The analyst could now understand the symbolism of an earlier turning, which he had missed. Her buying binge had contained both her fear and her intense need to be noticed. As a girl, she had turned to her father to be noticed, for it was only through connecting herself to him that she felt she might be able to extricate herself from the traumatogenic enmeshment with her mother. "But he was remote and embarrassed by emotion—even by mother's emotion, and even though he loved mother," she remarked. "When feelings were expressed, he would look away. Then, after a point, he would introduce another subject, as if what had taken place before did not exist." Caroline remembered wanting her father to pick her up, but he never did, except as part of a game. She didn't play right, she felt, so she couldn't be held. And she so wanted him to want to be close to her. She realized now that when the analyst spoke to her gently and smiled when he greeted her, she felt real and warm, not frozen. If she had been feeling bad and hating herself, that made her feel all right.

Caroline had blamed herself when her father hadn't noticed her or loved her. In particular, she had blamed her anger. The anger evoked by her father's unresponsiveness had been enormously threatening to her because of her desperate need for him. Thus, she exonerated him and blamed her reactive anger for his faulty responsiveness. A similar
working out that way, I blamed fragmented states in relation to ruptured self-object tie, Caroline's oedipal fears dropped away, regarded as splitting, projection, etc. She and the analyst could be frozen torso and her expectation been terrified as a little girl. She could not, for example, let her and her mother would be further she was afraid of her mother — he was teased mercilessly by her to do anything," they would say. ed, there were increasing signs analyst to help her understand, its effect on her, and how crush her husband and the analyst.

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her father hadn't noticed her or her anger. The anger evoked enormous threatening to him. Thus, she exonerated him faulty responsiveness. A similar

sequence could be observed in reaction to unattuned responses from her husband and the analyst. Her idealizations were not primarily a defense against her anger. Rather, she preserved the vitally needed idealizations at the expense of her anger and of her ability to assert herself when her interests were disregarded.

Caroline had turned to her father not primarily as an oedipal love object, but as an idealized self-object whose responsive interest in her might open a compensatory path along which her thwarted development could resume. When this developmental thrust was revived in the transference, her associations led her back to her fourth and fifth years. Her memories clearly showed that what she most needed her father to notice and understand was what she was going through with her mother. In the analysis she realized that she had to return to that time because something had happened then that had made her life thereafter almost unbearable. She remembered herself before this time as a well-dressed little girl; afterward she felt like a ragamuffin.

When Caroline was four her mother, then recovering from a prolonged depression, had resumed her involvement with the church as an organist and choral leader. The church and the little girl largely made up the boundaries of the mother's restricted world. Even then her mother would often go to bed for the day, saying, "I know I can't get out today." Caroline remembered that during this period she had wanted to learn to play the piano. Taking affront that Caroline might want anyone else to teach her, her mother undertook the task. Caroline recalled that as with everything else, her mother insisted on a strict routine—first, months of finger exercises away from the piano, and only then the real thing. Her mother was an overwhelming teacher. When Caroline tried and pleaded, "I can't," her mother flew into a rage. Later, Caroline came to understand that the rage was toward her mother's own recalcitrant self, indistinguishable from that of her daughter. The mother desperately wished that her daughter would not give up, as she herself had done, that Caroline would not become a nobody doing the things in the kitchen no one else wanted to do. She insisted that Caroline did not care about her, did not value her. Caroline could see that her mother believed this, and it scared her. But then she told herself perhaps her mother was right, perhaps she would never be able to care for anyone (as she was also told) if she couldn't care for her mother. It was so frightening to think that her mother didn't understand her that she found it a relief to believe that she herself was bad.
Why couldn't she practice, her mother would ask. It was just a matter of moving her fingers. Her mother would demonstrate and then take Caroline's fingers and show her. It could only be rebelliousness, Caroline was always so stubborn. Then her mother would get out the whip as the little girl froze and cowered. It was a black, braided leather affair with a number of thongs, perfect equipment for not spoiling the child. Although it was only used three or four times, Caroline would remember her fear and humiliation for the rest of her life. That ended her career in music.

One of the most terrifying aspects of these childhood experiences was that something was glaringly wrong, but nobody seemed to know it or do anything about it. When Caroline went to her father, he would change the subject. When she went to the maid, she was told how it was to be an orphan as the maid had been. Caroline had to find some way to live with her mother, so she made herself responsible, telling herself that if she were better her mother would love her. "It is terrifying to be in the power of another person," she observed. The feeling that something was wrong and nobody seemed to know or do anything about it was replicated in the analysis when the analyst failed to respond to Caroline's assertions of the threat to herself posed by many of his interpretations.

There was something even worse than whipping, Caroline realized one day. One of the major methods by which her mother controlled her was by continuously threatening to leave her. That was always, and still remained, the ultimate whip, both with her husband and in the transference. She realized that the threat may have been completely false objectively, but it was very real to her. Even now, anyone she needed could reduce her to submission by threatening to leave her. Her mother had simply walked away from her when the little girl had "misbehaved" or acted cranky. "It is almost as if you have a choice of existing or your mother existing, but not both," Caroline explained. The meaning of a remark at the beginning of the analysis was now more understandable: "I have had to be able to hate my mother in order to stay alive!"

Caroline recalled that the family had a small house near the ocean, at the mouth of a river. Her mother was afraid Caroline would drown and so insisted on teaching her to swim—not in the small river but in the ocean. Yet her mother herself could barely swim. Caroline remembered her terror when her mother approached her. She couldn't let her
mother near her. She couldn't tolerate looking at her because she knew that just the touch or the look would immediately cause her to lose herself, not feel herself. Her mother frequently said, "If you could just see yourself through somebody else's eyes." Caroline realized how much she had needed for someone to see through her eyes. In the water she would scream, "I'll do it myself; please let me do it myself!" Her mother would stand over her, coldly retorting, "When are you going to do it? When are you going to do it?"

Caroline often imagined running away from her mother's ruthless training. One day, in the analysis, she spoke of this, remarking, "If I had had a father to run to, I would have." It was when she saw all her little friends playing and going places with their fathers that she began to feel like a ragamuffin. She remembered so much wanting to run away, but she was concerned about not having any food. She began to think about packing food in small packages. She collected Tarzan books, and she recalled being fascinated because he was able to survive in the jungle with only a knife; he didn't have to depend on or submit to anyone. Eventually, however, her daydreams of escaping from her mother collapsed. She was too aware of reality and knew that she would have to come back, so she made her peace.

At this stage of the analysis, Caroline remarked on a feeling of being better integrated. The analyst had allowed her to revive in the transference the longed-for selfobject bond to an idealized father, who would help her understand and separate from her pathological enmeshment with her mother. Everything she thought about now seemed more vivid, she commented. Her thoughts and feelings made more sense to her. She felt more self-confidence, although she was still worried that this would disappear and not return. Still, she felt she was stronger, as she put it, than the threat to her was. Moreover, she noted an increased ability to stick to her moderated diet. Slowly but noticeably, she began to lose weight. There was much more to be done, she realized, but she felt that a corner had been turned, as indeed it had.

To summarize this case: Caroline's adult "borderline" characteristics and paranoid-like distrust had arisen in the intersubjective field of her vulnerable, fragmentation-prone self within a failing, archaic self-object tie (with her husband). These borderline characteristics remained and were periodically intensified in the new intersubjective field of the psychoanalytic situation when the analyst's incorrect interpretive stance and faulty responsiveness unwittingly triggered and ex-
acerbated her states of self-fragmentation. The failures in her marital relationship and in the first phase of the analysis replicated the specific, traumatogenic selfobject failures of her early childhood years. Caroline had adapted to these failures by attempting to serve the archaic selfobject needs of her mother and pushing herself even harder when her mother found her wanting in that role. This was repeated with the analyst. In contrast, in the second phase of the analysis, when the analyst became able to comprehend the actual meaning of Caroline's archaic subjective states and needs, thereby permitting her to revive and establish with him the specific selfobject ties that she required, her so-called borderline features dropped away.

CONCLUSION

We have criticized the view that the term "borderline" designates a distinct pathological character structure, rooted in pathognomonic instinctual conflicts and primitive defenses. Instead, we propose an alternative conceptualization of so-called borderline phenomena from an intersubjective perspective. In particular, we believe that the clinical evidence cited for the operation of primitive defenses against pregenital aggression is better understood as an indication of needs for specific archaic selfobject ties, and of disturbances in those ties. As the case of Caroline suggests, the psychological essence of what is called "borderline" does not rest in a pathological condition located solely in the patient. Rather, it lies in phenomena arising in an intersubjective field, consisting of a precarious, vulnerable self in a failing, archaic selfobject bond.

We wish to clarify some potential sources of misunderstanding of our point of view. Conceptualizing borderline phenomena as arising in an intersubjective field is not equivalent to claiming that the term "borderline" refers to an entirely iatrogenic illness. As seen in the case of Caroline, the failing archaic selfobject bond is not always with a therapist or an analyst, although this will become increasingly more likely as the patient's selfobject needs are engaged in the therapeutic transference. More importantly, the claim of an entirely iatrogenic illness would be markedly at variance with our concept of an intersubjective field and would overlook the contribution of the patient's archaic states, arrested needs, and fragmentation-prone self to the formation
The failures in her marital analysis replicated the specific, early childhood years. Carl was attempting to serve the archaic ideal of the analysis, with the actual meaning of Caroline's army permitting her to revive and satisfy that she required, her soul.

The term “borderline” designates a phenomenon rooted in pathognomonic instances. Instead, we propose an understanding of borderline phenomena from a clinical perspective, as an indication of needs for turbulence in those ties. As the archaic essence of what is called archaic condition located solely in a arising in an intersubjective field in a failing, archaic sources of misunderstanding of borderline phenomena as arising in a claiming that the term “borderline illness.” As seen in the case of border illness is not always with a thercome increasingly more likely in the therapeutic transferarly iatrogenic illness as concept of an intersubjective field of the patient’s archaic self-prone self to the formation of that psychological field. If we view the therapeutic situation as an intersubjective field, then we must see that the patient’s manifest psychopathology is always codetermined by the patient’s self-disorder and the therapist’s ability to understand it.

Our claim is that borderline symptomatology is entirely iatrogenic, but that the concept of a “borderline personality organization” is largely, if not entirely, an iatrogenic myth. We believe that the idea of a borderline character structure rooted in pathognomonic conflicts and defenses is symptomatic of the difficulty therapists have had in comprehending the archaic intersubjective contexts in which borderline pathology arises.

We wish to emphasize that selfobject failures are developmentally codetermined subjective experiences of the patient and that therefore their occurrence in treatment is not to be regarded as an objective index of the therapist’s technical incompetence or inadequacy. They are revivals in the transference of the patient’s early history of developmental deprivation and interference. Thus, the therapeutic task is not to avert such experiences of selfobject failure but to analyze them from within the unique perspective of the patient’s subjective world.

From the standpoint of the archaic nature of the arrested needs revived in the transference, it is inevitable that the therapist will “fail” the patient, and that under such circumstances borderline symptoms may appear. In our experience, it is only when the subjective validity and meaning for the patient of these disjunctions and selfobject failures go chronically unrecognized and unanalyzed (often because they threaten the therapist’s self-organization requirements), and the reestablishment of the therapeutic bond is thereby prevented, that borderline phenomena become encrusted into what has been described as a “borderline personality organization.” This formulation of borderline symptomatology illustrates the general psychological principle that psychopathology cannot be understood psychoanalytically apart from the intersubjective contexts in which it arises and recedes.