The Beginning of Wisdom Is Never Calling a Patient a Borderline;

or, The Clinical Management of Immature Defenses in the Treatment of Individuals With Personality Disorders

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In individual psychotherapy of personality disorders, patients' uses of the less mature ego mechanisms of defense can detrimentally affect the intersubjective field. The diagnostic epithet "borderline" often reflects unconscious countertransference more than it does diagnostic precision. Psychotherapists can avoid the deleterious effects of such countertransference by being attentive to the ways their patients' defensive styles affect the therapeutic dyad and by learning to collaborate with self-help groups. The author discusses strategies for managing in individual psychotherapy seven immature or image-distorting defense mechanisms: splitting, schizoid fantasy, hypochondriasis, projection, turning against the self acting out, and neurotic denial.

The treatment of personality disorder is far less easy than the treatment of neurotic conflicts. The defenses of patients with personality disorders have become part of the warp and woof of their life histories and of their personal identities. However maladaptive their defenses may be in the eyes of the beholder, they represent homeostatic solutions to the inner problems of the user. Neurotics suffer from their defenses (which may include repression, isolation, reaction formation, and displacement) and thus welcome insight and view interpretation of their defenses as helpful. In contrast, the defenses of patients with personality disorders often only make others suffer; the owners view interpretation of their defenses as an unwarranted attack.

Nevertheless, if psychiatry, psychology, and general practice are to help their most difficult patients, the immature defenses such as projection, hypochondriasis, dissociation, fantasy, acting out, splitting, and turning against the self—the building blocks of Axis II disorders—must be understood. The appreciation of immature defenses is essen-

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tial to reaching the hypochondriacal help-rejecting complainer, the wrist-cutting borderline, the injustice-collecting litigant, the devaluing eccentric, and the noncompliant sociopath—in short, the denizens of any urban emergency room on a Saturday night. However, by carelessly threatening an immature defense, a clinician can evoke enormous anxiety and depression in the patient and rupture the therapist-patient relationship. Indeed, there is the rub. Any attempts to challenge immature defenses should be mitigated by strong social supports (e.g., Alcoholics Anonymous), or else the patient's defense needs to be replaced by alternative defenses, usually from the neurotic or intermediate level. For example, fantasy can evolve into isolation; projection can evolve into reaction formation; and hypochondriasis can evolve into displacement.[1]

But helping a patient alter defenses at the immature level is easier said than done. William James spoke of character as being "set in plaster"; Wilhelm Reich, one of the early therapeutic pioneers of personality disorder, spoke of "character armor"; and Anna Freud spoke of the "petrification" of defenses. The early psychodynamic investigators of character disorder (e.g., Reich, Glover, and Abraham) provided much that was of theoretical interest but little that was of practical clinical value. Advocating longer and longer psychoanalyses hardly offers a panacea to the overworked urban social worker, parole officer, or emergency room physician.

Rather, it was as psychoanalysts entered prisons (e.g., Adler and Shapiro[2]), public hospital inpatient units (e.g., Havens[3]), and general hospital wards (e.g., Kahana and Bibring[4]) that practical help was provided to our management of the immature defenses. Such help meant that the Freudian models of drive psychology and ego psychology had to be modified. The ego and drive models are particularly well adapted to the analysis of neurotic defenses, but the analysis of immature defenses requires conceptual models that focus more on object relations. In the symptomatology of personality disorder, scripts, role-relationship models,[5] and internalized beloved and hated people play as crucial a part as do conflicts over forbidden desire and rage.

Each therapist-patient dyad must collaboratively develop a meaningful common language. This common language, like poetry, must lead toward a mutually understood reconstruction of the patient's inner life and of the patient's internalized relationships. Appreciation of the metaphors of immature defenses plays an important role in this reconstruction.

However, the therapy of personality disorders requires a broad, not a constricted, view of competing models of defense mechanisms. Steven Cooper,[6] a Boston psychoanalyst, describes some of these competing models succinctly: "One group of theorists, including Brenner, Kernberg, Schafer, and Kris, despite important differences in their theories, define defenses within a strictly intrapsychic context. Other theorists, such as Laplanche and Pontalis, Modell, and Kohut, emphasize that the function of some defense mechanisms is to maintain or preserve an object relation that, without it, would signify overriding anxiety" (p. 866).

Cooper goes on to point out that in contrast to Anna Freud,[7] who proposed a classification of defenses according to the source of anxiety (such as the superego, the external world, or the strength of instinctual pressures), many object relations theorists have minimized drives. For example, Cooper quotes Modell[8] as maintaining that "affects are the medium through which defenses against objects occur. Once affects are linked to objects, the process of instinct-defense becomes a process of defense against objects" (p. 879). In his efforts to help personality-disordered individuals, Kohut moved still further away from the defenses-against-drive model. Kohut[9] maintained that the whole concept of defense-resistance is dependent on the overemphasis by classical psychoanalysis on the mechanics of mental processes

to the exclusion of the patient's self-experience.

FIRST PRINCIPLES

I believe that therapists of personality-disordered patients can use help from every competent theorist they can find. Drives, people, reality, and culture are all significant. Psychoanalysis, family systems theory, cognitive therapy, and behavior modification can all play valuable roles. In this article, however, I wish to focus solely upon the clinical management of immature defenses in the treatment of individuals with personality disorders. I will begin by outlining three broad principles for enabling patients to replace immature defenses with more mature defenses: stabilizing the external environment, altering the internal environment, and controlling countertransference.

Stabilizing External Environment

First, an effective way to alter a person's choice of defensive style under stress is to make his or her social milieu more predictable and supportive. That is why Kohut's theories have seemed so useful to clinicians working with personality disorders. We are all a little schizoid and paranoid when among strangers whom we fear may treat us harshly. We are all more adept at altruism, suppression, and playful sublimation when among friends who are empathic toward our pain. Thus, in the consulting room, schizoid and paranoid personalities are rarely attractive, but they respond better to our empathy and forbearance than to our confrontation or rejection. Indeed, Kohut's views on the treatment of personality disorders remind me of the old fable of the wind and the sun competing to see who can make a traveler remove his overcoat. The harder the wind blew, the more tightly the man defended himself with his overcoat. Then, it was the sun's turn; and when the sun shone down, of course, the man grew warm and cast his outer garments aside. Similarly, the more the drive-oriented psychiatrists tug at their patients' mantle of defenses, the more they will see the immature defenses exaggerated. In contrast, the "Winnicottian" or "Kohutian" who strives empathically to be a good enough mirror or selfobject for the patient will find personality-disordered patients using more mature and less pathologic defenses—until the patients leave the consulting room and cloak themselves once more to meet the chilly gusts of the cold, outside world.

Altering Internal Environment

Second, facilitating internal as well as external safety remains a cornerstone of the treatment of personality disorders. We can also help patients abandon immature defenses by altering their internal milieu. Toxic brain syndrome makes almost anyone project. Intoxication with alcohol and unlanced abscesses of grief and anger lead to fantasy, to rage turned against the self, and to acting out. We are all better at sublimation and reaction formation when we are not hungry, not tired, and not lonely. Often, adequate pharmacotherapy of affective spectrum disorders can ameliorate symptoms of Axis II disorders that are secondary to affective illness.

In addition, if we attempt to challenge patients' defenses, we must be sure that we have their permission. If in the course of examination we ask our patients to remove their protective clothing, we must protect them with something else. Psychopharmacology alone is rarely specific enough to provide such protection. Too often, psychiatrists forget that the brain was designed to process information and not as a series of mere chemoreceptors. The limbic system was neurobiologically designed to be comforted by friendly people and not by chemistry. Either we must offer these personality-disordered individuals ourselves—a luxury rarely available to busy doctors—or we must offer them alternative social systems and facilitate their use of more adaptive defenses.

Controlling Countertransference

Third, if we are to manage our patients' immature defenses, we must manage our own countertransference. I believe that almost always the diagnosis "borderline" is a reflection more of therapists' affective rather than their intellectual response to their personality-disordered patients. That, perhaps, is why up to 90% of patients diagnosed "borderline" can also be assigned another, usually more discriminating, Axis II diagnosis[10,11]; and even when carefully applied, the DSM-III-R criteria for borderline personality disorder are extremely overinclusive and lacking in specificity. For years I have demonstrated to our own residents the subjective nature of the epithet "borderline" by asking each of them to list what they considered the six most salient characteristics of the borderline. Year after year there is little consensus. As with beauty, the definition of "borderline" lies in the eye of the beholder. For, as a function of personality-disordered persons' need to establish object constancy, their immature defenses have an uncanny capacity to get under the skin of some observers. To circumvent such subjectivity in working with patients who use immature defenses, it behooves the therapist to use the surgeon's favorite defense of isolation and to try to identify the patient's defensive style as precisely as possible.

When I am invited to other centers as a visiting professor, I always ask to interview a "borderline." My task is to endeavor to offer an alternative, more rational diagnosis. At such clinical conferences, as an outsider, I am often impressed at how irrational the ward staff have become in the prolonged presence of their character-disordered patients' provocative behavior. Helping staff to intellectualize about the defenses of such patients allows the clinicians to appreciate the invasive, infuriating, separation/individuation-defying contagion of the immature defenses. Such intellectualization helps staff to regain the sane, calm reflection with which an outsider can approach the "biggest borderline" on someone else's inpatient unit.

If our inner worlds include relatively constant people toward whom in real life we have had relatively unambivalent feelings, then our external relationships will remain relatively assured, loving, autonomous, and well demarcated. However, the internalization of stable and loving people is not the lot of individuals with personality disorders. The interpersonal relationships of such individuals remain perpetually unstable and entangled. It is often in an effort to preserve an illusion of interpersonal constancy that individuals with personality disorders unconsciously deploy immature defenses. These image-distorting defenses permit ambivalent mental representations of other people to be conveniently "split" (into good and bad) or moved about and reapportioned. Too often, clinicians unconsciously, then, label the immature defenses of such patients as perverse or taboo; for, once touched, observers can rarely separate themselves from immature defenses completely.

Put differently, immature defenses are contagious. The contagion of immature defenses does much to account for the inhumanity of man to man that is seen throughout our criminal justice system. The hypochondriac provokes our passive-aggression, and in the presence of an acting-out drug addict liberals become prejudiced. When baited by their adolescent children, even the most reasonable and staid parents become hopelessly overinvolved and unreasonable. In such instances, we are hard put to distinguish "normal" countertransference and "pathologic" projective identification.[12] And yet the process by which our patients get under our skin is subtle; and the tumult, if noticed, seems quite mysterious to an outsider. Recently, I was fascinated to note that when I asked our residents to describe their own countertransference to their "borderline" patients, they collectively, but unwittingly, provided the DSM-III-R polythetic definition of borderline personality disorder. In short, the diagnosis "borderline" describes an enmeshed clinical

dyad in which at least the inner experience of both participants can begin to meet the criteria for the disorder.

I remember consulting on a hypochondriacal patient who had been admitted to a general hospital for the 37th time. When I asked the medical resident for the patient's present illness, the resident replied mysteriously, "She was admitted for multiple stab wounds...inflicted in the emergency room." The explanation was that the patient, a known hypochondriac—which is the internists' pejorative epithet for the "borderline"—had come in complaining of chest pain. Unable to send the patient home, the exasperated staff tried to put in a subclavian intravenous line on her right side. They missed the vein and tried to insert the line on her left side and missed again. Then, furious and disgusted, they had to admit their wounded patient.

The real moral of the story, however, was that the patient greatly benefited from her week in the hospital. Her heart was healthy; it always had been. The "stab wounds" were irrelevant; she had been wounded often before in the past. But her hospitalization reduced her problem list from 20 problems to 3. What she benefited from most was her first bath in a month, the comfort of clean sheets, and the restoration of her internal milieu by intravenous fluids. For, in response to her abusive home life, she had been continuously vomiting for a week. To understand her illness it was necessary to look behind her hypochondriacal camouflage and behind her help-rejecting reproach that made her doctors so reflexively enraged. The true source of her pain was an abusive spouse who was identified nowhere in her three-volume hospital record. In her 36 prior admissions the hospital staff had been consistently misled by this hypochondriacal patient who always insisted that her social history was noncontributory. In their anger, the staff were only too ready to remain blind to her real pain. Only recently have psychiatrists appreciated how appropriate it may be to rediagnose many "borderlines" as having post-traumatic stress disorder.[13]

By necessity, the effective therapy of personality-disordered patients requires that the therapist avoid becoming enmeshed in the patient's own issues surrounding separation/individuation. It is well for clinicians to begin by acknowledging what the family therapists have always known; namely, separation/individuation is a lifelong process. Just as war is too important to be left up to the generals, individuation is too complex to be left up to toddlers. In other words, the purpose of the immature or image-distorting defenses is to manage internal and external object relations in adults as well as in children.

Just as neurotic mechanisms of defense (e.g., displacement, isolation, and repression) transpose feelings, immature mechanisms (e.g., splitting, projection, and hypochondriasis) magically maneuver both feelings and their objects. Psychotherapists are no exception. Almost by definition, work with a personality-disordered patient creates a psychological "umbilical" link between patient and therapist. This psychic fusion, often unconscious, violates the ideal of a therapist who first provides the patient a neutral blank screen and then wisely interprets the patient's conflicts projected or transferred onto that screen. The technical but difficult-to-define term "projective identification"[14] captures more abstractly the back-and-forth transfusions of affects and introjects that threaten to disrupt effective psychotherapy with patients afflicted by personality disorder.

By recognizing that the invasive, contagious quality of personality disorder "infects" and produces reciprocal projective identifications in the therapist,[12] I am not saying that the phenomena that we associate with patients whom we label "borderline" are iatrogenic. For as Brandchaft and Stolorow[15] warn, "conceptualizing borderline phenomena as arising in an intersubjective field is *not* equivalent to claiming that the term 'borderline' refers to an entirely iatrogenic illness" (p. 1117). Rather, I am simply noting

that in the presence of a patient who deploys image-distorting defenses, the therapist may unwittingly accept the patient's projections. Thus, in the blurring of ego boundaries that often accompanies the essentially dyadic process of projective identification,[16] the therapist may forget that "borderlines" can be stabbed by the very hand held out to comfort them.

Countertransference in Clinical Practice

Inadvertent countertransference has led to four popular approaches for managing personality-disordered patients: psychopharmacology, mothering, limit-setting, and interpretation. These four approaches, if pursued too enthusiastically, are more likely to lead to disaster than to success.

First, psychopharmacology is often overused in managing difficult borderline patients. Borderline patients seek pills; they demand pills; they abuse pills; they try to kill themselves with pills; and they try to punish their therapist by taking too many or too few pills. In response, their therapists—urged on by hopeful advertising and their own frustration—try one after another of the latest pharmaceutical agents. The results at best are like playing roulette, and at worst such polypharmacy leads to iatrogenic multiple drug abuse. If one takes the long view, personality-disordered patients—in sharp contrast to patients with schizophrenia and major depressive disorder—fare better as Christian Scientists or as members of any group that provides patients a holding environment while simultaneously forbidding their use of psychopharmacological agents. By these words of caution I am not criticizing the use of carbamazepine, lithium, or low-dose neuroleptics[17,18] to control unmanageable behavior in selected patients with personality disorders. Nor am I suggesting that antidepressants cannot play a critical role in ameliorating affective spectrum disorders,[19] which may present as personality disorders. Rather, I am only asking clinicians to wonder, each time they reach for their prescription pads, "Will my prescription reflect scientific pharmacotherapy or countertransference?"

A second equally dangerous response to personality-disordered patients is the impulse to be the "good-enough mother" that the patient never had. Responding to their idealized understanding of the wise techniques of Heinz Kohut and Margaret Mahler, such therapists try to mother, mirror, and love their patients. Borderline patients take the promise of mothering as seriously as they do the promise of a magic pill. Again, the results are often antitherapeutic. When you really need a mother—during August vacation, at three o'clock in the morning, and on Christmas day—would-be therapist-mothers, unlike real mothers, are never available. The patient, often an already angry and formerly abused child, takes such a seeming breach of faith by an allegedly kind clinician as a justified opportunity to bite the hand that feeds him. Therapists regard such treatment by their patients as ungrateful and respond by condemning their patients as having too much "innate aggression" or as being afflicted with "malignant narcissism." The fight is on. Instead of finding a good mother, the patient experiences another blow to self-esteem, hardly what the doctor wished to order.

This sequence of events may explain the transferential sequence of events that Gunderson and Zanarini[20] have described as pathognomonic of a "borderline" diagnosis: "When the borderline person senses a supportive relationship with another person (or within the structured, warm 'hold' of institutional settings), he or she is likely to experience sustained dysphoria and a lack of self-satisfaction. When such a relationship is disrupted by the threat of separation or the withdrawal of reassuring nurturance, there is a shift to angry, hostile affect accompanied by highly characteristic manipulative, self-destructive actions" (p. 5).

Instead of helping young adults with personality disorders to find mothers, the therapist should encourage such patients to be

surrogate mothers, both to others and, equally important, to their own "inner child." Little is gained by forcing the personality-disordered person into the confining role of sick patient. Rather, self-esteem is enhanced by allowing the patient to be of appropriate help to others who are more needy. Furthermore, reaction formation and altruism are less troublesome ego defenses than acting out. In other words, pill-taking is rarely helpful for personality-disordered patients, but anybody's sense of object constancy, self-esteem, self-efficacy, and empowerment is often helped by giving pills to others. But such surrogate responsibility for others must occur within the matrix of a holding environment. Often this holding environment entails an institution; for institutions, like real mothers, remain at home during August, at 3 A.M., and on Christmas day. The 12th-stepper cares for others within the fellowship of AA; the former delinquent cares for others within the matrix of a fire department; the former narcissistic playboy, St. Francis, cares for others within the holding environment of a monastery.

Third, perceiving the need for limits in personality-disordered patients, many writers recommend a punitive, authoritarian Nurse Ratchet (from *One Flew over the Cuckoo's Nest*) approach. Once again, this approach is encouraged by the patients themselves. Many personality-disordered patients have "thrown stones at the jailhouse door" in order to obtain the limits that they feel they need. Yet to be inside a jail or a restricted psychiatric ward is as noxious for a personality-disordered patient as is too ready access to alprazolam or to the cheat of being promised, after age 21, a good mother. Instead of providing limits from above, the therapist should encourage peer support. Effective, structured social supports—whether Overeaters Anonymous, group therapy, or a Hell's Angels gang—render the patient's social world safer and thus reduce the need for maladaptive, image-distorting defenses. Besides, it is the presence of social support that distinguishes limits from punishment, a delicate but vitally important distinction. Although punishment is useless in mitigating personality disorders, limits, like scientific pharmacotherapy and holding environments, can be lifesaving. Sensitive individual psychotherapy can help to build an intrapsychic analogue to the external holding environment that is created by a receptive peer group.

Finally, a fourth popular treatment for personality disorder is insight-oriented psychotherapy. Once again, a treatment that seems promising to patient and therapist alike is often disappointing. The efforts of psychotherapists to interpret their patients' projection, splitting, and hypochondriasis may be disastrous. In response to psychoanalytic interpretation, neurotic patients are grateful and often decide to become psychotherapists themselves. In contrast, interpretation of the defenses of personality-disordered patients can make them feel disgusted, angered, or ashamed. If a therapist points out that a hypochondriac's help-rejecting complaining is defensive, the interpretation will result in the patient's accusing the therapist of being heartless, unfeeling, obtuse, and stupid. To tell another person that he or she is paranoid and prejudiced results in being called a bigot yourself. To point out to patients that they use schizoid fantasy is as comforting as explaining to them that their chief defect is loneliness. To tell someone in the middle of a tantrum that he or she is acting out is like trying to pacify a raging ocean by flogging it. In contrast, empathy, mirroring, and what Leston Havens[3] calls "making contact" are most useful and allow the patient to shift from immature to neurotic defenses.

In other words, although immature defenses can be understood and managed, they can rarely be interpreted. Rather, the therapist should inquire about, and help patients to think through, the consequences of their actual or intended actions. The Socratic method stands the personality-disordered patient in better stead than all the good advice and dynamic interpretations in the world.

Thus, the rest of this article will focus on helping the psychotherapist to manage, rather than to interpret, immature defenses.

Besides employing the Socratic method and facilitating his or her patients' discovery of peer supports, the therapist does well to empower patients toward developing more mature defenses. By this advice I mean that the therapist should help the patient evolve along a developmental continuum: for example, hypochondriasis can lead to reaction formation and then to altruism; fantasy can lead to isolation of affect and then progress to sublimation; sadistic passive-aggression can lead first to displacement and wit, and then to humor. Sigmund Freud summed the whole process up with his sexist quip, "A young whore makes an old nun."[21]

Put somewhat differently, patients should be supported to provide—rather than receive—the pills, the mothering, the limits, and the psychotherapy that borderlines seek. We should remember that it is not an accident that Florence Nightingale and Mary Baker Eddy were once themselves severe hypochondriacs. Nor should we forget that, in AA, a definition of a "pigeon" is "someone who came along just in time to keep their sponsor sober." We should not forget that, like a small child's mother, the physician's beeper is there to assert his or her value 24 hours a day. Lastly, more than one very gifted psychotherapist has met the criteria for personality disorder—once upon a time. Such a person's own transformation from patient to clinician was often catalyzed by his or her own individual psychotherapy—a psychotherapy that permitted projection to evolve into altruism, fantasy into sublimation, splitting into humor, and so on.

MANAGEMENT OF INDIVIDUAL DEFENSES

If we fail to recognize and to understand the immature defensive processes of our patients, we run the risk of taking these defenses personally and of condemning them. Therefore, I shall shift from discussing immature defenses collectively and examine them one at a time. Readers should translate my terms into their own language. The formulations presented below will be in the language of psychoanalytic psychiatry, but the language can be translated into principles consistent with cognitive and behavior therapies. Because the problems presented by personality disorder are ubiquitous, I shall use examples from the emergency room and from medical and psychiatric inpatient units as well as from psychotherapy. In general, I shall use the terminology for defenses popularized by the Freuds,[1] but I will suggest instances where Kleinian terms like devaluation, idealization, and omnipotence could be substituted.

Although patients with personality disorders may be characterized by their most dominant or most rigid mechanism, each person usually deploys several defenses. Indeed, personality-disordered patients are often called "borderline"—if they tend to deploy a wide variety of immature defenses. Thus, in treating a patient with personality disorder, it may seem reductionistic to focus upon one or two defenses. However, sometimes in working with very provocative people, keeping it simple is helpful. Always, empathy toward immature defenses rather than countertransference is essential in creating a holding environment within the consulting room. For if the individual psychotherapist can understand the patient's defenses and avoid reactive contagion, the patient feels empathically understood and held.

Splitting

A defense mechanism commonly seen in patients with personality disorders is splitting. Instead of synthesizing and assimilating less-than-perfect past caregivers and instead of responding to important people in the current environment as they are, the patient divides ambivalently regarded people, both past and present, into good people and bad people. For example, in an inpatient setting

some staff members are idealized and others are mindlessly devalued. The effect of such defensive behavior on a hospital ward or in a therapeutic group can be highly disruptive and often provokes the staff to turn against the patient. Splitting is best mastered if the staff members anticipate the process, discuss it at staff meetings as an intellectually interesting topic, and thus use the defense of isolation to reduce their own irritation.

In a psychotherapeutic setting, to dismiss the patient's split positive and negative affects as "just transference" is to miss the point. The therapist must work to create an atmosphere that is conducive to letting the patient experience simultaneously positive and negative aspects of important relationships, including the relationship with the therapist. Unconditional positive regard, safety, and firmness are necessary—all within the same session. This process necessitates a psychotherapeutic "container" analogous both to a Winnicott holding environment and to the kind of secure containment necessary to create energy from nuclear fusion. This is no easy task. Although it requires greater clarity of formulation, the task necessitates the same self-restraint and empathy that therapists use when supporting patients in acute grief. Splitting can evolve into its more mature counterparts of undoing and humor if the therapist helps the patient recall past loves as well as more recent resentments.

Fantasy

Many persons, especially eccentric, frightened persons—who are often labeled schizoid—make extensive use of the defense of fantasy. They seek solace and satisfaction within themselves by creating an imaginary life and imaginary friends. Often, such persons seem strikingly aloof. One needs to understand that such unsociability rests on a fear of intimacy. The clinician should maintain a quiet, reassuring manner with schizoid patients and convey interest in them without insisting on a reciprocal response. Recognition of their fear of closeness and respect for their eccentric ways are both useful. As trust develops, the schizoid patient may, with great trepidation, reveal a plethora of fantasies, autistic relationships, and fears of unbearable dependency, even fears of merging with the clinician. Imaginary friends should never be made fun of or even mentioned to the patient without the patient's tacit permission. The patient may vacillate between fear of clinging to the clinician and fears of fleeing through fantasy and withdrawal. Always, therapists must beware of projecting their own loneliness that the schizoid person may engender in them. They must remember to treat the schizoid character as if he or she were frightened rather than lonely.

Hypochondriasis

This mechanism of defense, also called "help-rejecting complaining," is commonly seen in patients with Axis II personality disorders—especially those with a borderline or self-defeating diagnosis. Hypochondriacs, in contrast to the usual supposition, do *not* make their complaints for simple secondary gain. A moment's reflection reveals that a hypochondriac's complaints can rarely be relieved. Often, the hypochondriac's complaint that others do not provide help conceals bereavement, loneliness, or unacceptable aggressive impulses. In other words, hypochondriasis disguises reproach and permits patients to covertly punish others through frustrating their desire to relieve the patient's own pain and discomfort. Hypochondriacs are people who bite the hands that feed them; they are not people, like conversion hysterics, who gratefully bask in the warmth of special attention. The initial response of clinicians to the hypochondriac is often guilt at their own failure to relieve suffering. This response is followed by anger and rejection on the part of the clinician, which only amplifies the patient's now vindicated reproach. Depending on the medical specialty of the caregiver being reproached,

the hypochondriac may present unrelievable complaints of somatic pain or of suicidal ideation. The clinician's inadvertently angry response to this reproach may be polysurgery or polypharmacy, or intensive psychiatric treatment followed by abrupt discharge or transfer.

Instead of trying to gratify or to diminish the hypochondriac's complaints, the caregiver should follow five rules.[22] First, the clinician should acknowledge that the hypochondriac's pain or insoluble dilemma is as severe as any the interviewer has ever seen. Such amplification of the manifest complaint is an approach that, paradoxically, leads hypochondriacal patients to moderate their complaints. At last, someone has appreciated the pain of past trauma or unspeakable abuse that the hypochondriac has been unable to reveal or to emphasize. Thus, the treatment of hypochondriasis becomes an acknowledgment of the intensity and genuineness (rather than the site) of the pain. Instead of offering reassurance, the clinician should turn the "volume" of suffering up even further. Statements such as "I don't know how you stand it," or "It must be awful to have to endure such terrible pain," are much more useful than "I hope it feels a little better today." The effect of this seemingly paradoxical approach is often startling, especially when a clinician tries it and discovers, often for the first time, the beginning of a real rapport with the patient. When thus validated, the hypochondriac's painful anger can again become the patient's own responsibility.

Second, the clinician should make some symbolic effort to meet the hypochondriac's overall need for dependency, rather than attend to the specific complaint. For example, inexplicable complaints of abdominal pain should not be met first by reassurance and then by a covertly vindictive laparotomy. Instead, the prescription might be three days of strict bed rest, a special diet, and a careful, noninvasive physical examination of the *whole* patient. Willing offers of concern, return visits by appointment, physical therapy, and diphenhydramine rather than alprazolam are helpful. However, hypochondriacal demands—in psychiatric practice these are often suicidal threats—will increase if the patient senses a withholding of treatment or an implication that the clinician believes that the pain is imaginary.

Third, instead of retaliating against the helplessness and anger that hypochondriacs engender in their caregivers, clinicians need to wonder, "Why is this patient so angry?" A careful social history may provide the answer. By including a legible psychosocial history in a prominent place in the patient's record, the clinician can remind future caregivers of the most likely source of the patient's pain. Reminding future clinicians that the patient is a survivor of Buchenwald or a victim of child abuse may be more useful than providing a chart full of negative laboratory results or of psychodynamic ruminations about the last two weeks of "borderline" inpatient behavior.

Fourth, as the clinician plays detective, he or she should never regard misleading information as lying. Most hypochondriacal misinformation is as innocent and as unconscious as that of a patient with coronary disease who complains of terrible arm pain. The hypochondriacal complaint is, after all, an effort to get the doctor's attention, to validate past trauma, and to displace rage rather than an effort to obtain secondary gain or a quick fix. The need of Coleridge's "Ancient Mariner" to repeat his tale of woe provides an analogy. In acknowledging and validating past unspeakable trauma, the therapist will ultimately serve the so-called borderline, who may in fact suffer from post-traumatic stress disorder,[13] far better than if the therapist were to maintain too close an adherence to the theories of Mahler and Melanie Klein. Validation of past trauma is essential to the creation of a stable sense of self.

Finally, in caring for a hypochondriacal patient perhaps the most useful technique is to use the metaphor inherent in the patient's pain to link physical or self-abusive complaint

to affect. A hypochondriacal patient who complains of chest pain, and who is unreassured by a normal ECG, may be comforted if the clinician says, "One thing is sure; the pain in your heart is real." Or when a patient provocatively mentions his suicidal ideation yet again, the caregiver can respond with: "I can see that things have been terribly painful for you; you must be furious that others have helped so little." In both cases the clinician, by responding with metaphor, not logic, opens the way for a broader consideration of life's pain.

These five principles permit a useful modification of the clinician's own need for omnipotence. Clinicians must become able to accept that they are not going to cure the hypochondriacal patient, just as they accept that they are not able to cure a mourner after a funeral. Rather, our task with hypochondriasis, as with the other immature defenses, is to decipher it so that we may remain sensitive to the patient's pain, not so that we can abolish it.

Many patients who use fantasy and hypochondriasis are pejoratively labeled "narcissistic." This is because both fearfulness and poor self-esteem are shored up by schizoid or hypochondriacal pretense of omnipotence. To the casual observer and to the unempathic clinician, such self-centered behavior may be erroneously labeled vanity, grandiosity, and entitlement. An effective way of surmounting the pejorative connotations of the term "narcissism" is to translate that multisyllabic epithet into the simpler and more empathic phrase "in pain."

Patients who use splitting, fantasy, and hypochondriasis may also be unusually critical of (i.e., devalue) the clinician. Some patients may even suggest that a therapist pay for the privilege of caring for them. In response, the therapist may become defensive, contemptuous, or rejecting. Nobody likes being belittled. Clinical progress is facilitated if, instead of belittling patients or defending themselves, clinicians understand that the Kleinian defense of devaluation is a less mature cousin of the Freudian defense of undoing. What this means is that such patients are contemptuous of their clinicians precisely because the patient also feels reluctantly loving toward or admiring of them. The paradoxical contempt and envy induced by perceiving one's therapist as lovable can only be transformed into gratitude by sustained Rogerian unconditional positive regard and by Kohutian mirroring. No easy task.

Projection

Another defense commonly encountered in patients with personality disorders is projection. Excessive fault-finding and undue sensitivity to criticism on the patient's part may seem to the observer to be prejudiced, injustice-collecting projection. But projection, however blatant, should not be met by interpretation, defensiveness, or argument. There is usually a grain of truth in most projection! Instead, even minor mistakes on the part of the clinician and the possibility of future difficulties should be frankly acknowledged. The epithet "paranoid" should be replaced with the more empathic "hypervigilant." Strict honesty, real concern for the patient's rights, and maintaining the same formal, although concerned, distance as one would with a patient using fantasy are helpful. Confrontation guarantees a lasting enemy and an early termination of the interview. Therapists need not agree with their patients' injustice-collecting; instead, they should ask respectfully whether they can agree to disagree.

The technique of counterprojection[3] is especially helpful. In that technique, the clinician acknowledges and gives paranoid patients full credit for their feelings and for their perceptions. Further, the clinician neither disputes the patient's complaints nor reinforces them; rather, he or she acknowledges that the world that the paranoid describes is imaginable.

There are several components to counterprojection. First, the clinician aligns him

or herself beside, not opposite, the patient. Eye contact and confrontation are avoided and replaced with the interactive mode of a traveling companion who is trying to view the world from a similar vantage point. Both clinician and patient look out of the same bus window, as it were.

Second, empathic counterprojective statements must encompass, without necessarily agreeing with, the patients' distress. Thus, Havens uses the example of a patient stubbing his toe, to which the therapist responds, "That damned old chair!" rather than "That must have hurt."

Third, the point of counterprojection is not to agree with the patient, but only to get out of the way. Thus, the therapist would not say, "The doctors in this hospital are sadists," but "It must seem as if the doctors here were trying to make you suffer." In so doing, the clinician distances him or herself from the patient's tormentors. The interviewer can then talk about the patient's real motives and feelings, even though they are initially misattributed to someone else.

Fourth, unlike the case with hypochondriasis, where metaphorical speech is important, with paranoid patients precise speech is helpful. In addition, a statement—what Havens[3] calls "making marks"—is more revealing and less annoying than a question. Whereas the interrogatory "When were you born?" will meet with a rebuff, the statement "I expect that you are a Gemini (or born in June)" will elicit "No, I was born in September."

The clinician must remember that trust and tolerance of intimacy are troubled areas for paranoid patients. Courtesy, honesty, and respect are the cardinal rules for the treatment of any such patient. If the clinician is accused of some actual inconsistency or fault, such as lateness for an appointment, an honest apology serves better than a defensive explanation or an analytic "Mmm?"

Individual psychotherapy requires a professional and not overly warm style on the therapist's part, and argument over trustworthiness is futile. For example, consider the following dialogue:

PATIENT: I am sure this room is bugged.
THERAPIST: To the best of my knowledge it is not.
PATIENT: I could not trust a psychiatrist who bugs his office.
THERAPIST: Any sensible person would mistrust a psychiatrist who bugged his office. I expect it's a waste of time, but, if you wish, you can look for bugs. On the other hand, you may have some other topics you would rather talk about.

Too zealous a use of interpretation—especially interpretation concerning deep feelings of dependency, sexual concerns, and wishes for intimacy—significantly increases the patient's mistrust. Clinicians can often address the concerns concealed behind projection if they wait until the patient brings up these concerns in a displaced manner; for with maturation, projection evolves naturally into displacement and reaction formation.

At times, the behavior of paranoid patients becomes so threatening that it is important to control or set limits on it. Delusional accusations must be dealt with realistically but gently and without humiliating the patient. When disorganized by high levels of anxiety, paranoid patients can be reassured by the clinician's involving security personnel. However, it is profoundly frightening for paranoid patients to feel that those trying to help them are weak and helpless. Therefore, a clinician should never threaten to take over control unless willing and able to do so.

Acting Out

Antisocial personalities are especially prone to use acting out. Acting out represents the direct expression through action of an unconscious wish or conflict in order to avoid being conscious of either the idea or the affect that accompanies it. Tantrums, apparently motiveless assaults, child abuse, and

pleasureless promiscuity are common examples. To the observer, acting out often appears to be unaccompanied by guilt, but acting out is not that simple. As with conversion hysteria and its accompanying *belle indifference*, anxiety and pain also exist behind the cool indifference of acting out. In responding to such behavior, the clinician should remember the maxim "Nothing human is alien to me."

Glover[23] has said of the sociopath: "In addition to his incapacity to form deep personal attachments and his penchant to cause suffering to those who are attached to him, the psychopath is essentially a non-conformist, who in his reaction to society combines hostility with a sense of grievance" (p. 128). But the "incapacity" of sociopaths to form attachments represents defensive process, not inability. Close relationships arouse anxiety in them. Terrified of their own dependency, of their very real "grievances," and of their fantasies of mutual destruction, sociopaths either flee relationships or destroy them.

In trying to treat the antisocial personality, the clinician must remember that these persons uniformly lacked benevolent, sustained relationships with their parents. They are afraid of intimacy and of assuming responsibility for it. They cannot believe that others can tolerate their anxiety, and they devoutly fear responsibility for achieving success by open competition. They can neither identify with authority figures nor accept their criticism, and they resent any thwarting of their actions, even when such intervention is clearly in their interest. Their consciences are too rigid, not too lenient; and so, rather than experience their own punitive self-judgment, they reject all moral standards and ideals. The eye-for-an-eye morality of street gangs, of terrorist organizations, and of the jailhouse subculture make Calvinist morality seem libertine by comparison.

Bowlby[24] has suggested that mourning in childhood is characterized by a persistent and unconscious yearning to recover the lost object. The persistent crime and multiple drug abuse of the chronic user of acting out often represents a similar quest. Bowlby tells us that in lieu of depression, bereaved children, like sociopaths, exhibit intense and persistent anger that is expressed as reproach toward various objects, including the self. However, Bowlby notes that such anger, if misunderstood, seems often pointless enough to the outsider. Finally, sociopaths, like children, often employ secret anodynes to make loss unreal and overt grief unnecessary. Their need for secrecy is based on the fact that "to confess to another belief that the loved object is still alive is plainly to court the danger of disillusion" (p. 519). These defensive maneuvers, then, serve to hide the child's and the sociopath's depression from our psychiatric view. Persistent, seemingly mindless delinquencies make symbolic sense if interpreted dynamically—as one might interpret misbehavior in a dream or in a child's play therapy. In short, I believe that the incomprehensible behavior of acting out is a product of a well-defended ego and of a strict, albeit primitive, conscience. Cleckley[25] is wrong. Acting out is no mere "mask of sanity," but it is often a mask to grief.[26]

Unlike conversion hysteria, however, acting out must be controlled as rapidly as possible. First, prolonged acting out is frightening to patient and staff alike. Faced with acting out—either aggressive or sexual—in an interview situation, the clinician must recognize that the patient has lost control. Anything that the clinician says will probably be misheard, and getting the patient's attention is of paramount importance. Depending on how threatened the clinician feels, the clinician's response can be, "You have acted in this manner because you can't pull that feeling up into your head," or, "How can I help you if you keep on screaming?" Or if the clinician feels that the patient's loss of control is escalating, he or she can respond, "If you continue screaming, I'll leave." Or, if physical violence genuinely seems a possibility, the clinician may simply leave and ask for help,

including the police. Invariably, acting out begets fear in the observer, and nobody working with psychiatric patients should bear this fear alone.[27]

Second, once acting out is no longer possible, the conflict behind the defense may be accessible. This is another reason that the clinician must find some way of limiting the patient's frightening but ultimately self-defeating behavior. To overcome the patient's fear of intimacy, the clinician must frustrate the patient's wish to run from tenderness and from the honest pain of human encounter. In doing so, the clinician faces the challenge of differentiating control from punishment and of differentiating help and confrontation from social isolation and retribution. Successful models of the controlling, helping, confrontational environment include halfway-house residences enforced by probation, "addiction" to methadone clinics, and the kind of therapeutic community behind bars that was devised for sociopaths at Utah State Hospital[28] and that was formerly achieved at the Patuxent Institute in Jessup, Maryland, and the Herstevester in Denmark. If those who use acting out are prevented from flight or tantrum, or if they are approached by understanding peers, instead of appearing incorrigible, inhuman, unfeeling, guiltless, and unable to learn from experience, they become only too human.

Third, chronic users of acting out should be encouraged to find alternative defense mechanisms. Play is always preferable to war. Displacement is the more mature cousin of acting out. As with a young child, the clinician should not just tell an antisocial person to stop doing something, but should point the patient toward an affectively exciting alternative. Acting out needs to be redirected, not forbidden.

Finally, once those who have antisocial personalities feel that they are among peers, they often find the motivation for change that they had lacked in other settings. Perhaps that is the reason that self-help groups have often been more effective in alleviating these disorders than have jails and psychiatric hospitals.

Turning Against the Self

A commonly seen mechanism in patients with personality disorders is turning anger against the self. In military psychiatry and DSM-III-R, such behavior is called passive-aggressive; in psychoanalytic terminology such behavior is most often described as masochism. "Long-suffering" and "self-sacrificing" are more empathic adjectives than "masochistic," which implies that the patient suffers because it is fun. The defense of turning against the self includes failure, procrastination, silly or provocative behavior, and self-demeaning clowning, as well as more frankly self-destructive behavior. The hostility in passive aggression and masochism, however, is never entirely concealed. Indeed, behaviors like wrist-cutting engender such anger in others that they feel that they themselves have been assaulted; thus, they come to view the wrist-slasher as a sadist, not a masochist. In Massachusetts, attempted suicide used to be classified as a felony.

The best way to deal with turning against the self is by helping the patient to ventilate anger and to direct his or her assertiveness outward rather than against the self. It is important to treat the suicidal gestures of passive-aggressive patients as one would any covert expression of anger and not as one would treat grief or primary depression. Antidepressant medications should be prescribed only when clinical indications are pressing and only when the possibility of overdose has been seriously weighed.

However, just as it is seldom wise to respond to angry suicidal patients as though they were simply depressed, it is seldom wise to isolate such patients in seclusion rooms for their angry gestures. As in the management of hypochondriasis, the therapist's task is to help patients acknowledge their anger, not to act out the patients' anger for them. The relief of tension that some patients obtain

from repeatedly cutting or burning themselves should be accepted as matter-of-factly by the clinician as the clinician would tolerate equally dangerous two-pack-a-day smoking in a colleague. Rather than treating self-inflicted cigarette burns as perverse or dangerous, staff members should say gently, "I wonder if there's some other way you could make yourself feel better. Can you put what you are feeling into words?" The clinician must continually point out the probable consequences of passive-aggressive behavior as they occur. Questions such as, "What do you really want for yourself?" may help to change the patient's behavior more than would a corrective interpretation or, as is all too common, instituting retaliatory suicidal restrictions.

Therapeutic techniques that help channel the patient's anger away from passive resistance and into more productive expression are very helpful. One means is to recognize that passive aggression can be channeled into displacement and humor. Instead of self-deprecatory clowning and sadistic hotfoots, wit, parody, caricature, even "guerrilla theatre" offer more acceptable ways of redirecting anger formerly turned against the self.

Behavioral therapy techniques, such as assertiveness training and the explicit setting of limits, are often useful. If stubborn, passive-aggressive patients are reluctant to help themselves, it is sometimes useful to take a time-out. Leaving the room or postponing the next appointment breaks the pattern of struggle and underscores the point that passive-aggressive struggles result in less rather than more attention. After a short time-out, the interviewer, too, is able to continue the relationship in a less angry and covertly sadistic manner.[29]

Recovery may be usefully presented to the long-suffering patient as a special additional task. Sometimes long-suffering, self-sacrificing patients are more able to cooperate in a medical regimen because of their readiness to add to the burdens that they carry rather than for the sake of benefits that might accrue to themselves. In every interaction with self-defeating patients, however, it is important to avoid humiliating comments about foolish, inexplicable behavior. Nobody's pride is easier to wound than that of a person who continually shoots him or herself in the foot.

Dissociation/Neurotic Denial

This defense (or these defenses) involves the patient's replacing unpleasant affects with pleasant ones. In its most extreme form dissociation is manifested by multiple personality disorder. In childhood and for short periods in adult life, such denial can serve to mitigate an otherwise unbearable affect. For example, if honest self-awareness and expression repeatedly brought down abuse from caretakers, dissociation allows abused children to remain separated from their emotional experience; but, of course, dissociation does not make problems disappear. Whereas the previously mentioned defenses tend to contaminate the intersubjective field by eliciting negative affects in the therapists, the danger of dissociation within the intersubjective field is countertransferential seduction. Dependent longing and unacknowledged grief are misperceived as sexual excitement or counterphobic exuberance.

Persons using dissociation often proclaim that they feel fine, although their underlying anxiety, depression, or resentment may be obvious to others. Because their troubling affects, impulses, and wishes are disavowed and actively pushed out of consciousness, users of dissociation have a tendency to feel accused and devalued if anyone points out their troubles. They are often seen as dramatizing, theatrical, and emotionally shallow. While they may often be labeled correctly as "histrionic" personalities, "captivating" is a less pejorative adjective. Their behavior is reminiscent of the stunts of anxious adolescents who, to erase anxiety, carelessly expose themselves to exciting danger. To accept such patients as enthralling and enthralled is to become blind to their pain

and neediness, but to confront them with their vulnerabilities and defects is to make them more defensive still.

Because patients who use dissociation seek appreciation of their attractiveness and courage and because they need some expression of prohibited impulses, the clinician should not be too reserved—only calm and firm. Reframing vulnerabilities as opportunities or potential strengths is often more effective than confronting such patients with their defects. Rather than lecture a "macho" coronary care patient, "Mr. Jones, you have had a very severe heart attack. You may die if you do not follow unit regulations," a better approach may be, "Mr. Jones, it takes real guts to put up with inactivity and the CCU routines, but remember, every day that you can tough out the pain of bed rest, your heart is getting stronger."

Such patients are often imaginative, if inadvertent, liars, but they benefit from having a chance to ventilate their own anxieties. In the process of free association they often "remember" what they "forgot," and through psychotherapy their self-serving lies can evolve into the acknowledgment of painful truths. Therefore, dissociation and neurotic denial are best dealt with if the clinician uses displacement and talks with the patient about the same affective issue but in a less threatening context. Empathizing with the denied affect, without directly confronting patients with the facts, may allow them to reintroduce the original painful topic themselves.

CONCLUSION

Let me close this discussion of immature defenses with four final suggestions on how to use an understanding of these defenses in individual psychotherapy.

First, defenses, especially immature (i.e., image-distorting) defenses, occur in a rich and complex interpersonal, intersubjective context. Such defenses encompass real past relationships and present if primitive transferences, as well as the realities of the current doctor-patient relationship. The simplified techniques outlined above for managing these defenses are offered only as suggestions and guides to the complexities of individual psychotherapy. Like all suggestions for managing intimate and intense interpersonal relationships, such suggestions must be carried out with sensitivity to context and mutuality.

Second, the greater the variety of immature defenses that patients deploy, the more likely they are to be labeled "borderline." I believe, therefore, that using that term will always obscure differential diagnosis. Worse yet, such name-calling leads to perceiving such patients' defenses as attacks on the clinician. If readers believe that they can use the epithet "borderline" while maintaining clinical objectivity, let me invite them to try the experiment of imagining that they found themselves described in their own therapist's notes as a "borderline." Instead of name-calling, therapists should always find something to admire in their patients' attempts to master past pain. In their formulations, if not in their diagnoses, therapists need to reframe the Axis II labels so that paranoid becomes "hypervigilant," narcissistic becomes "in pain," hysterical becomes "captivating," masochistic becomes "long-suffering," schizoid becomes "independent," and borderline becomes "post-traumatic stress disorder"—or "that patient who sure knows how to push my buttons."

Third, therapists should also always find something to admire in their patients' attempts to change and grow. Taking genuine pleasure in a patient's attempts to try out new, more adaptive behaviors is very rewarding for patient and clinician alike. Therapists must remember that the personality disorders are dynamic. Like adolescents, patients with personality disorders outgrow their difficulties with a little help from time and their friends. Paranoids can become reformers; hypochondriacs can become healers; and sociopaths can become enforcers of the law. In short, the therapy of personality disorder always proceeds more smoothly if we can remember our

own recovery from adolescence.

However, no defense can be abruptly altered or abandoned without an acceptable substitute. For example, abstinence from drugs is achieved through a process analogous to mourning: slowly the depended-upon substance is replaced with other loves. In similar fashion, successful treatment of personality disorder demands that the clinician try to help the patient develop a substitute for each defense.

Finally, in treating personality disorder we have to modify the conventional doctor-patient model. One-to-one therapeutic relationships by themselves are rarely sufficient to change severe personality disorder. Immature defenses repel, wound, and overwhelm the efforts of individuals; burnout is common. Only an extended family or self-help group can withstand such assault. In addition, the "borderline" needs to absorb more of other people than one person, no matter how loving, can ever provide. Nor can we look for help from drugs; there is no drug that can teach us Chinese or that can replace parents who were abusive or inconsistent throughout our childhoods.

Like adolescents, individuals with personality disorders need opportunities to internalize fresh role models and to make peace with the imperfect familial figures who are already within. A clinician, even five times a week, is not enough to satisfy an orphan. Especially at the start of the recovery process, only a church, a self-help residential treatment, or addicting drugs provide relief for a borderline's pain; all three provide an external holding environment 24 hours a day. On the other hand, individual psychotherapy, with its capacity to provide selfobjects and mirroring, may be more effective in modifying and enhancing those psychic structures that maintain an internal holding environment.

In other words, some form of self-help group is a useful adjunct to psychotherapy. To begin with, personality-disordered individuals, like the rest of us, need to find groups to which they can belong with pride. They often know only too well that they have harmed others; but they can meaningfully identify only with people who feel as guilty as themselves. They can abandon their defenses against grief only in the presence of people equally bereaved. Only acceptance by peers or a "higher power" can circumvent their profound fear of being pitied. Only acceptance by "recovered" peers can restore their defective self-esteem. A therapist's love is not enough.

There is another reason for combining peer groups with one-on-one therapy. Intensive individual psychotherapy seems most useful for people who (like many clinicians) have had too much parenting and for people who have learned from society not wisely but too well. In contrast, patients with personality disorders have experienced inconsistent or too little parenting. Because of defects in genes, socialization, and maturation, personality-disordered individuals have had difficulty learning what society wished to teach them. Thus, individuals with personality disorder often need care that is very similar to the care required by adolescents. Indeed, adolescents do not need therapy at all; they need a social group that offers them time, space, and safety to internalize the valuable facets of their parents and their society and to extrude the chaff. They need mentors and loves in order to catalyze the developmental transmutation whereby adolescent envy becomes adult gratitude. Object constancy—as defined by Kernberg,[30] not Piaget—is an essential ingredient of maturity; and object constancy is lacking both in adolescents and in personality disorder. The task of therapy for personality-disordered individuals, then, is to create such object constancy. For adults, groups and institutions sometimes provide this constancy and the opportunities for fresh identifications more consistently than can a single individual a few hours a week. At the same time, individual psychotherapy can play a vital role in the treatment of personality disorder. It is easier to walk with two crutches than with one.

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