

**THREE THEORETICAL PERSPECTIVES ON THE IMPASSE WITH  
THE BORDERLINE PATIENT**

by

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**Three Theoretical Perspectives on the Impasse with the Borderline Patient**

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## ABSTRACT

Impasse is one of the frequent problems therapists face when treating borderline patients. This thesis explores the mechanisms of impasse in the treatment of borderline patients and the possible approaches to resolve the therapeutic stalemate. It expands on Chessick's (1989) idea of multiple channels of listening. When the process has reached an impasse, the therapist's interventions are no longer effective. The choice of alternative interventions depends on the therapist's capacity to listen to the patient through different channels. When the therapist can listen through a number of channels, his understanding of the patient becomes deeper and more complex and determines the choice of more effective intervention. Three object relations perspectives on borderline pathology were reviewed – Steiner's theory of pathological organizations, Kernberg's conflict theory and Adler's deficit theory. The clinical approaches based on these theories were discussed in the context of a clinical case. A supportive approach, relying on containing and facilitating the patient's selfobject transference was recommended as corresponding more closely to the patient's needs in the initial stages of therapy. Interpretations and limit setting were seen as necessary interventions when the patient's behaviour appeared to act systemically against the therapeutic goals.

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## **Chapter 1**

### **Introduction**

The purpose of this thesis is to explore how the impasse that may occur in the treatment of borderline patients can be understood from different theoretical perspectives, to compare these perspectives, and suggest in what way each one of them may be helpful for resolving such an impasse.

Impasse is a frequent and complex problem that may occur in the treatment of patients with borderline pathology. Every clinical approach designed or adapted to work with borderline patients, views and deals with situations of impasse in different ways, consistent with the theory on which it is based. I was particularly interested in the psychodynamic and psychoanalytic therapies and I chose to review and compare three psychoanalytic theories about the borderline pathology. The three psychoanalytic perspectives about the borderline pathology I compare in this paper, are the British object relations theory, particularly John Steiner's view of pathological organization, Otto Kernberg's "conflict" theory and Gerald Adler's "deficit" theory. These three theories can be described as object relations theories as they are concerned with the borderline patient's internal object relations and their influence on the way the patient perceives and participates in his/her relationships in the present. The choice of psychoanalytic frame of reference reflects my curiosity in this particular way of approaching patients and listening to their stories and my acceptance of the psychodynamic idea that therapeutic change occurs in the context of a human relationship as a result of a new experience with another human being and from the process of exploration, understanding and communication of the patient's inner world. There is also a growing support for the effectiveness of modified psychoanalytic therapy in the treatment of this type of personality

disorder (Stevenson and Meares, 1992, Bateman & Fonagy, 1999, 2000, 2001, Kächele et al., 2000). The committee of experts appointed by the American Psychiatric Association, has recently issued a new guide (2001) for the treatment of borderline personality, recommending psychodynamic therapy, along with dialectical behavior therapy, as a particularly effective treatment for patients with borderline pathology. If psychoanalytic psychotherapy is considered a method of choice in the treatment of borderline patients, then it is important to refine our understanding of the problems that arise in this particular therapeutic setting and our methods of dealing with them.

Psychoanalytic psychotherapy is based on a continued relationship between patient and therapist; it is rather unstructured, and the therapists attempt to follow to a different degree the principles of abstinence, neutrality, and anonymity. These aspects of the therapeutic setting are particularly challenging for the borderline patients, given their difficulty with intimacy and separation, and with handling their anxiety in an unstructured situation. This is the reason borderline patients are often considered suitable for more structured and supportive forms of psychotherapy than classical psychoanalysis. On the other hand, these challenging aspects of the setting constitute what the patient needs to learn in the course of his/her therapy: how to tolerate intimacy and separation and how to handle his/her anxiety more effectively. The argument is (Chessick, 1993, Kernberg, 1975, 1978) that it is worth involving the borderline patient in this type of therapeutic relationship, because it can lead to deeper and long-lasting changes in the patient's personality than supportive therapy. However, the contradiction between the patient's low capacity to tolerate closeness and uncertainty, and the characteristics of the psychoanalytic psychotherapy setting (involving a certain degree of intimacy and uncertainty) create tensions in the treatment that may

contribute to the development of an impasse. It is not my goal to question the usefulness of the psychoanalytic setting in the treatment of borderline patients; rather, I focus on the processes that occur within this type of setting and the interventions that may be used if an impasse is reached.

Impasse can be defined as an arrest of the therapeutic process: for a period of time there seems to be no progress towards the goal of therapy, that is, towards psychological change. Impasse means that the therapeutic relationship has lost its therapeutic quality. The therapeutic setting may be preserved for a long time: the participants keep meeting in the role of patient and therapist, but what happens between them does not have therapeutic results. If impasse is not resolved, therapy either ends unsuccessfully and prematurely, or continues formally but the therapist can not relate therapeutically to the patient: a perversion of the therapeutic process sets in, in which the similarity to therapy is preserved but the open communication is hindered. In psychoanalytic terms what happens between the two participants when the process has reached an impasse, is often defined as a transference and countertransference acting out (Chessick, 2000, p.195): instead of exploring the patient's inner world, the participants start to act out their emotional states, which may establish itself as a pattern.

This brings us to the question about what creates the impasse: can it be explained with the patient's pathology or is it a problem of the therapist? The use of the diagnosis "borderline" to describe the patient's problems, as well as the use of any other diagnosis, is more compatible with a linear rather than with a circular view of the client; diagnosing is an act that is more characteristic for the modern than the postmodern discourse. In the modern discourse the use of a diagnosis is related to the assumption that the self is structured in a

certain way as a result of the unique way the person's early experiences with important others combine with the person's innate tendencies. The patient brings that self to therapy and the experienced clinician can recognize the pathological patterns by making careful observations from a position of neutrality: he can allow the transference patterns to emerge without interfering with them. The relationship with the therapist is seen as asymmetrical, a relationship between an observer, or expert, and an object of observation. Neutrality is about not allowing one's own values and idiosyncrasies to interfere with the process of observation. This view is based on the premise that there is an objective reality that can be grasped by the observer and that the observer is relatively capable of perceiving that objective reality, in this case, the personality of the patient as it really is.

The works of Maturana and Varela (1980), von Foerster (1981) and others, strongly challenged the idea of the objective observer. Maturana came to the conclusion that the only way the human being can know the world is subjective. Our biological body (our brain) is structured in such a way that it precludes an accurate perceptual representation of the outer world. The reality as we know it, is a construction created as a result of our idiosyncratic way of organizing information, not an accurate, universally true representation of the world. Accordingly, there is no absolute, objective way the personality of the patient is. Neutrality, in the modern sense of this word, is never obtained because there is no way for the observer/therapist, to perceive the patient without being influenced by his own values, theories and emotions, or more precisely, without using the values, theories and emotions to create a representation of the patient. The concept of neutrality can still be used, but with a different meaning. The therapist attempts to be neutral by constantly examining his or her role in constructing the reality observed in the therapeutic system. That includes awareness of the

theoretical perspective, values, and personal experience and beliefs that all determine the way he generates meaning and participates in the interaction. Cecchin (1987) defines neutrality as curiosity about multiple perspectives. If we apply that definition to the work with one client, we can say that neutrality means listening to the multiple perspectives of the client, the perspectives of the therapist, and their dance with each other. This constitutes the postmodern perspective, which influenced significantly the psychotherapists' stance regarding knowledge, truth and therapy. Seen from that postmodern perspective, the impasse is not caused by the patient, neither by his quality of "borderlineness." It is not caused by one of the participants but it is a state of the process between the two of them, a result of a pattern of communication that gradually becomes established between them. Both therapist and patient contribute to the establishment of that interactional pattern. Each of them becomes stuck in a rigid way of experiencing themselves and the other, which constitutes the therapeutic stalemate. That experience is either largely unconscious for the participants, or they can be partly aware of it; however, they do not see any other choice how to communicate differently. According to Schwaber (1995), who wrote of her understanding of the causes and mechanisms of impasse in the course of analysis, the impasse begins when the process of listening starts to fail. When the therapist's awareness of his participation begins to decline, the therapist may feel that he "knows" the patient (or even that he does not want to know the patient). The therapist loses his curiosity about the patient's version of reality, and begins to privilege his version of reality over the patient's; he is no longer neutral in the postmodern sense of that word. The corollary of this postmodern position is that the therapist can introduce change in the therapeutic system (that includes the patient, too) by changing and refining his/her own way of listening.

On the other hand, patients displaying a set of behaviours that can be classified as borderline may present these “pathological” behaviours from the very beginning of the contact with the therapist as well as with most of the people in their life. The patient tends to bring certain patterns of relating and experiencing into the encounter that mirror his difficulty to be in a relationship, to be intimate with and separate from the other. It is considered (Kernberg, 1989, Chessick, 1993) that these patterns become expressed at some point in therapy, regardless of the therapist’s communications and the therapist’s personal characteristics, given that the therapy is not too structured or too dominated by the therapist’s countertransference. Therapists often find it difficult to maintain their capacity for therapeutic listening when treating borderline patients. The intensity of the patient’s emotions, his tendency to act instead of reflect on them, his need to control the relationship, and the intense countertransference reaction provoked by the patient’s behaviour, contribute to the difficulty of listening and intervening therapeutically. In other words, it is hard to attribute all the difficulties in the relationship with this type of client to the idiosyncratic way client and therapist relate to each other. Kernberg (1992), for example, who is familiar with the postmodern perspective, is of the opinion that the more severe the personality disorder, the more the reactions of the therapist, that is, his countertransference, have an “objective” quality: the therapist’s countertransference tells more about the patient than about the therapist; the therapist can first of all treat his countertransference as a mirror of the patient’s internal objects or aspects of the self. The corollary of this position is that it is possible to establish certain guidelines about the therapeutic behaviour with this particular type of patient.

Therefore, both the postmodern and the modern perspectives seem useful in describing the complexity of the impasse with borderline patients. The impasse can be seen in a linear way, as related to the borderline patient's difficulty with intimacy and separation, which puts a lot of strain on the therapist to preserve his therapeutic stance and to maintain the relationship within therapeutic parameters. Impasse can also be understood as a collapse of the therapist's neutrality, that is, the therapist's capacity to listen therapeutically. Although the patient may have initiated the dysfunctional pattern that leads to impasse, and may have had the major contribution for its establishment in therapy, still the only aspect the therapist has the power to change is his or her own input in the interaction. This input is determined to a large extent by the way the therapist constructs the patient and the therapeutic relationship between them. A therapist who privileges a single perspective of her own (that is, is entrapped by her countertransference), loses empathic connection with the patient's experience, loses her "neutrality" and curiosity about the patient. To resolve the impasse the therapist needs to restore the therapeutic quality of the encounter with the patient by listening to the patient in a different way that allows for communication of different meanings. In order to be able to listen to the patient, the therapist needs to understand herself better. Only then can she prevent her own acting out and utilize her emotional reactions and fantasies to deepen her understanding of the client. Along with this emotional work, there is an intellectual work involved. It includes the effort to understand the client's communication through a number of different theoretical perspectives. The therapist's perspective determines the range of meanings he/she can assign to the patient's communication, and therefore, also the way of relating to the patient and the interventions in terms of focus, level, wording and attitude they convey. Listening from a number of perspectives, particularly when they are

different or contrasting, is what helps the therapist (Chessick, 1989) to be more flexible and eventually more receptive to the meaning of the patient's communication; this type of listening would help the therapist to achieve a more complex perspective on the client that will enable him to connect with the patient on the level the patient needs to connect. The therapist's interventions are also an integral part of the circular process of listening: by intervening the therapist influences the patient and the patient's response that the therapist listens to, and so on. The observation about the impact of the therapist's interventions on the patient is a constant process that is particularly important, and must be restored when there is an impasse.

That is why in my thesis I will approach the impasse that may occur in the psychoanalytic treatment of borderline patients by focusing on the process of therapeutic listening. This will include a review of the three psychoanalytic perspectives I have chosen and the interventions they recommend. At the end I will try to suggest which intervention for what kind of impasse may be helpful. The assumption behind this, is that by changing the channel of listening and attempting a different intervention, we open opportunities for different meanings to be communicated, which restores the therapeutic quality of the therapeutic process and "resolves" the impasse.

In the next chapter (chapter two) I will discuss how the concept of borderline pathology was developed, how it is used in the current psychotherapeutic discourse, and what difficulties the therapist encounters in conducting psychotherapy with this type of patients. Chapter three presents each of the three psychoanalytic perspectives on the borderline structure. In chapter four these psychoanalytic perspectives are applied to a clinical case, in which the therapeutic process has reached a state of impasse; the purpose is to elicit the

differences among them regarding the processes that lead to a therapeutic stalemate and the interventions that can be used. In chapter five I discuss the strengths and weaknesses of the three perspectives and their role in dealing with impasses.

## **Chapter 2**

### **The Borderline Construct**

The literature on the treatment of borderline patients is abundant and the authors use different diagnostic criteria to determine whether the patient's pathology belongs to that category. In order to clarify that confusion, I will review the emergence of the concept in its historic context, and its meanings both within the current American classification of mental disorders (DSM-IV) and within the psychoanalytic theories about the psychic structure.

#### **Historic Review**

McWilliams (1994) presents a thorough review of the historic context in which the concept of borderline emerged and evolved. Her review starts with Freud's distinction between two levels of disturbance: neuroses and psychosis. She clarifies that in his writings, Freud preserved the general distinction suggested by Kraepelin between the levels of pathology. The primary distinction in Kraepelinian classification was between neuroses and psychoses. His neurosis-versus-psychosis model reflected a dichotomic view about the person's psychological functioning, according to which one is basically either "sane" or "insane"; either mildly disturbed, or severely disturbed. Following Freud, the analytically influenced therapists in the beginning of the century differentiated only between neurotic and psychotic levels of pathology. The major distinction between the two was the relation to "reality." In neurosis there was general appreciation of reality and in psychosis there was at least a temporary loss of contact with it.

With the accumulation of further analytic experience, it became evident that a simple distinction between two levels of pathology was not sufficient to capture the essence of all the patients' disturbances. It did not take long before other distinctions between different

levels of pathology were introduced first of all within the neurotic category. W. Reich's distinction between symptom neurosis and character neurosis seemed to describe in a useful way the difference among patients who would ordinarily be labeled neurotics. The diagnosis "symptom neurosis" was given to patients whose neurotic symptoms appeared in the context of an otherwise healthy personality (neurotic symptoms appeared usually after some precipitating event), while the diagnosis character neurosis was preserved for patients whose character seemed permeated by neurotic patterns (they seemed to accompany the person through most situations in his or her life and were established relatively early on in one's individual development). Certainly, this distinction had concrete implications for treatment and prognosis (McWilliams, 1994). Symptom neurosis implied that something in the current life had activated an unconscious infantile conflict and the patient was using infantile defensive mechanisms to cope with it, which had been adequate in the past, but in the present they created more problems. The therapeutic task in this case was to identify the conflict and help the patient to process the associated emotions. Once this was accomplished, the patient was more inclined to use more mature defenses and find new solutions to her troubles. The therapeutic alliance with these patients was expected to be strong and to survive the turmoil of transference and countertransference reactions. If the patient's difficulties were related to character neurosis, then the therapeutic task was a much more ambitious one: it involved restructuring of the patient's personality. The therapeutic alliance was expected to be problematic for many reasons. In order to establish a therapeutic alliance, the therapist first had to create the conditions under which it could develop. Often the whole course of therapy was about creating the conditions to establish good contact with the patient. While people with symptom neuroses were considered to be on the therapist's side in opposing the

problematic part of their personality, those with character neurosis were not, and had to learn a new way of thinking about their whole personality in order to join the therapist and allow for change to occur.

For a long time the constructs of symptom neurosis, character neurosis and psychosis constituted the main constructs by which diagnosticians understood personality differences among people on the dimension of severity of disorder, where the symptom neurosis was the least serious condition, and character disorder and psychosis more serious to a different degree. Over time however, it appeared that this classification did not describe in a satisfying way the variety of phenomena clinicians encountered in their practice. There were neurotic reactions that were related to a much more decreased capacity of adapting to life than some character disorders. On the other hand, some character disorders involved disturbances that could not be easily classified as neurotic but seemed closer to psychosis.

These were the grounds on which the concept of borderline was introduced. The idea that we can discern a personality organization somewhere in the middle ground between neurosis and psychosis took shape around the middle of the 20<sup>th</sup> century. The very word "borderline" concerning a particular category of patients was first introduced by psychoanalysts in the 1920s and 1930s when a number of analysts were confronted with a situation where patients came for analysis and seemed to meet the criteria for analytic treatment but soon after they lay on the couch, they began to experience overwhelming difficulties with the analytic process, including psychotic reactions. Freud's criteria for the indications for psychoanalytic treatment included high motivation for therapy, good ego integration, ability to free associate and to develop transferences. The patients developed transference neuroses and their psychopathology could be conceptualized in terms of

conflicting intrapsychic forces, that is, as a conflict between their ego, id and superego. The analysts, however, came across patients who presented transferences and evoked countertransference reactions in the therapist that could not be readily explained within the neurosis-vs-psychosis model. Their problems seemed to reflect a much deeper disturbance than the one expected from a neurotic. Although these patients did not report hallucinations or delusions and could not be classified as psychotic they lacked the stability and predictability of the neurotic patient. Their problems seemed more difficult to understand and put into words than the ones neurotic patients had. These patients could sometimes become temporarily psychotic when they were in treatment, while outside the consulting room they could function with some stability even if it entailed reliance on pathological patterns of relating to people and to oneself; other patients would come to therapy seemingly on the verge of psychosis or even psychotic, and would restore their link to reality surprisingly quickly.

Therapists began to suggest new diagnostic labels that captured the quality of these people whose pathology was neither neurotic nor psychotic. Among these new labels is the borderline neurotic of Stern (1938), Helene Deutsch's "as if personality" (1942), Knight's "borderline states" (1953), Frosch's "psychotic character" (1964); also, O'Shaughnessy's notion of defensive organization (1981), Steiner's "pathological organization" (1982) and Rosenfeld's narcissistic organization (1984). Kernberg (1975), Masterson (1976), and Stone (1980) developed the concept of borderline level of personality organization in detail based on clinical experience and research and it attained widespread acceptance particularly in the American psychoanalytic community. In 1980, the category "borderline" became sufficiently legitimate to appear in DSM-III as a *type* of personality disorder. This step was both

recognition of the general category of borderline level of personality organization and a displacement of its original meaning, since in DSM-III and the subsequent editions this label represents a type of pathology rather than a level of pathology (McWilliams, 1994).

Therefore, borderline pathology is currently constructed in two different ways. One, as a type of disorder, as it is presented in some of the current classifications of mental disorders, for example in DSM-IV; the other, as a particular structure of the personality, reflecting a certain developmental level, as it is used in the psychoanalytic discourse.

Within DSM-IV, the borderline pathology is included as the diagnostic category "Borderline Personality Disorder" (BPD). DSM-IV definition states that BPD is:

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behavior covered in criterion 5.

2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.

3. Identity disturbance: markedly and persistently unstable self-image or sense of self.

4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behavior covered in criterion 5.

5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.

6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).

7. Chronic feelings of emptiness.

8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).

9. Transient, stress-related paranoid ideation or severe dissociative symptoms. (DSM-IV, p. 710)

The criteria that constitute the diagnosis borderline personality disorder within DSM-IV were formulated solely on the basis of descriptions of observable behavior. This definition reflects an effort to construct criteria that have no allegiance to any particular theory and thus

can serve well researchers and practitioners who belong to different schools of thought. In contrast, the act of making a psychoanalytic diagnosis is overtly not atheoretical; rather, it is based on theories of psychological development and dynamics of the unconscious mind.

In the psychoanalytic discourse the term “borderline” was invented as a result of the clinicians’ continuous efforts to make diagnostic distinctions between people regarding the depth of their difficulties: to cover the middle ground between the “deepest” disturbance – psychosis and the “mildest” - neurosis. The diagnosis “borderline personality” within the psychoanalytic paradigm is a structural diagnosis: it is constructed on the basis of particular assumptions about the interrelationship between the individual’s early experiences and the development of psychic structure. In the current psychoanalytic literature on diagnosis and treatment, the personality structure of the patient is understood and described in two distinct and interacting dimensions: the developmental level of personality organization and the defensive style within that level (McWilliams, 1994).

Identifying a person’s developmental level has become a critical part of diagnosing him or her. If the person’s psychological development can be described as a process of achieving one’s individuality (autonomy) then psychopathology can be seen as the degree of individuation one has achieved. Further, the process of individuation is often conceptualized in terms of the boundaries between self and object, the degree of integration of self and object images and the level of ego development with its characteristic defenses, capacity to contain affect and the relationship to reality. Four levels of development (individuation) are distinguished and currently used in the psychoanalytic discourse in North America and England to some extent: psychotic, borderline, neurotic and “normal” (McWilliams, 1994). In that continuum the borderline level of individuation constitutes the lower part, the gray

area between psychotic and neurotic, suggesting that people who function at this level have serious problems of different degree with their autonomy.

The second dimension in which the patient's character structure is usually described identifies his or her type of character, that is, in what particular way is the person handles his anxieties, strivings and object relations. Different types of personality are distinguished that correspond to the diagnostic categories in the psychiatric classifications (paranoid, schizoid, depressive, antisocial, histrionic personality). This distinction accounts for descriptions of patients with borderline personality organization as being histrionic, schizoid, paranoid, etc. (McWilliams, 1994)

The four levels of dynamic diagnosis (psychotic, borderline, neurotic and normal) have implications for what are the expected developments in therapy and the expected outcome, and also what kind of therapeutic approach is expected to be most beneficial for the patient. Each level is considered to be associated with unresolved difficulties at a particular stage of the individual development. Often the psychotic is described as psychologically fixated on the issues of the early symbiotic phase; the borderline is seen as preoccupied with separation-individuation issues and the neurotic can be understood as having difficulties on the Oedipal level. There is a consensus that the borderline pathology is pre-oedipal (McWilliams, 1994), which means that the patient's problem is located in the dyadic relationship with his primary object, the mother, and the person is preoccupied with issues of separation from that object. The father as a structuring force has not yet entered the child's psychological field, and when working with a patient at a borderline level of personality organization one does not basically expect to come across conflicts and anxieties typical for

the Oedipal complex, or rather they appear heavily influenced by unresolved issues in the primary relationship with the mother (McWilliams, 1994, Chessick, 1993, Kernberg, 1975).

Westen (1990), who discussed the theories of borderline object relations from the point of view of the accumulated empirical research, suggested that the person's psychological structure does not reflect a single developmental line but multiple discrete and interacting developmental lines. Consequently, the patient who functions primarily at the "borderline level" will present a complex picture of developmental achievements and arrests in the different areas of his psychological functioning. Object relational development, argues Westen, continues throughout childhood and adolescence and even enduring object relational structures can be affected at any point by significant experiences. Westen points out however, that the earlier the trauma, the more damaging the effect of it, because it happens at a time when the structuralization of the psyche is not advanced. Particularly, "the affective quality of the object world and the capacity to invest in other people are fundamentally shaped in the pre-oedipal years" (p.689). In other words, although the therapist may diagnose a pre-oedipal, borderline level of personality structure, that structure is always more complex, involving conflicts characteristic for all levels of psychological functioning and developmental arrests; on the other hand, the conflicts and arrests related to earlier developmental levels are usually more challenging therapeutically than the ones related to later developmental levels.

The therapeutic relationship with a patient with a pre-oedipal disorder has certain characteristics that make the course of therapy remarkably difficult. Compared to other people that enter therapy who have less problematic attitude towards life, and who seem to be more integrated and flexible, borderline patients suffer in a way which taxes the therapist's

own flexibility and integrity, and her stance as a therapist. With the borderline patients the therapist may expect difficulties in all aspects of the therapeutic situation: it may be hard to establish and sustain the boundaries of the therapeutic setting, to facilitate the development of a working alliance, to utilize the transference and countertransference reactions, and above all, it may be impossible at times to be understanding, accepting and empathic. The therapist working with a borderline patient is quite often pressed to revise her stance and choice of techniques and has to work perseveringly if she wants to keep the patient in therapy and create the conditions for therapeutic change to occur. A more detailed review of the difficulties patient and therapist encounter in the therapeutic process follows.

### **Most Often Encountered Problems in the Treatment of Borderline Patients**

Therapists have difficulties handling their clients' attitude towards the therapeutic setting, the intense transference, the fragile therapeutic alliance, and their own intense countertransference feelings.

### **Relationship to the Therapeutic Setting**

With the borderline patient the setting frequently becomes a problem: very often the patient tries to transgress the agreed upon boundaries that constitute the setting. The transgression of boundaries may take the form of a variety of acting out behaviours like missing hours or coming late, refusals to pay for the sessions, innumerable telephone calls, or seductive insistence on outside therapy relationship with the therapist. The acting-out behavior may threaten the viability of the treatment process itself when the patient who is angry with the therapist chooses to quit therapy instead of discussing his feelings with the therapist. The acting-out outside of the therapeutic context like engaging in self-destructive or criminal behaviour may endanger the patient's health, life and social future. These

behaviours replace the verbal communication to the therapist and often dominate the interaction, which is an obstacle to the goal of exploration and understanding.

### **Transference**

Although the content of the transference with its meanings, feelings, desires, fantasies, and images, is unique for every person in therapy, the transference of the individuals with borderline personality structure has certain characteristics. One of the distinct features of the transference is that it is intense and can dominate the interaction from the very beginning of the contact with the therapist. The early phases of the therapy may be particularly stormy and seriously threaten the therapeutic relationship.

Frayn (1990) uses the term “archaic” or “regressive” transferences. According to him, archaic transferences are reenactments of the preverbal level of experiencing. It is not transference in the classical sense i.e., a return of the repressed: the patient does not remember, free associate or think about it. He needs to act out his experiences. The therapist is treated as an object that is either complementary or obstructive to the fulfillment of the patient’s needs. The patient makes intense and insistent demands for gratification that are much stronger than his or her desire to know and understand. Although the patients may flood the session with dreams, fantasies, and memories about early traumas, or with hints about their transference reactions, they may not experience the feelings associated with these fantasies and memories, and do not integrate this material. It seems as if it is left only for the therapist to feel the unbearable feelings, think the unthinkable thoughts, and integrate them for the patient. Characteristic is not only the acting-out of the transference feelings within the treatment, but also the fact that the efforts to deal with it by interpretation alone are ineffectual; the patient’s demands for gratification can become overwhelming and may

completely block the therapeutic work. In that way the archaic transferences become “formidable resistances to the development of therapeutic alliance or meaningful interpretation”, and therefore to therapeutic change (Fray, 1990, p.50). On the other hand, if transference acting out and negative transference remain uninterpreted, the therapeutic relationship becomes emotionally shallow and does not touch upon the most important areas of the patient’s suffering and pathology; their avoidance induces a stalemate in the therapeutic process.

Another way to describe the transference is that it may become highly negative or erotic, sometimes from the very beginning of the treatment. The erotic pre-oedipal transference may be very difficult for the therapist to work with, although it may bear some resemblance to the positive and to the erotic Oedipal transference. It is usually the patient’s negative transference however, his chronic rage, hostility and hatred, that becomes central problem in the process of therapy (Chessick, 1989, Kernberg, 1989). The patient may not be able to see anything positive about the therapist and her rage at the therapist or her more enduring attitude of hostility, hatred and suspiciousness regarding the therapist’s motives and trustworthiness may become too much for the therapist’s capacity to bear. This may seriously undermine the therapist’s ability to function as an understanding and helping professional. The attitude of hostility and hatred to the therapist, is related to the person’s character structure, i.e. it represents the habitual way in which the person relates to most of the people in her life. Knowing that, however, does not help the therapist always keep his presence of mind in the face of a patient who seems to reject, mock and depreciate every intervention the therapist tries to make. The configurations in the negative transference may constantly shift from a powerful and threatening therapist in a relationship with a patient-victim to a

powerful, despising patient and a helpless and vulnerable therapist (Kernberg, 1975, Meissner, 1993). In the same way the therapist may quite unexpectedly lose his pleasant role of being special and omnipotent and become worthless and impotent in relation to a grandiose and entitled patient. (Meissner, 1993).

### **Therapeutic Alliance**

The alliance with the borderline patients is often described as unstable and fragile. The patients' transferences and the patients' need to distance from any close and meaningful relationship are seen as the major reason for the instability and disruptions in the alliance. According to Meissner (1993) pseudo-alliances are also common: that is, the more subtle, difficult to detect, and persistent "distortions" of the alliance. The relationship may look collaborative and positive but it may be based on the patient's compliance; the compliance is disguised as agreement with and respect for the therapist's judgment but it is essentially a sign of crippled autonomy (Meissner, 1993). Another form of pseudo-alliance, which is considered characteristic for the borderline patient, is what Bion calls "reversible perspective" (in Etchegoyen, 1999). The patient who uses reversible perspective is in apparent agreement and hidden fundamental disagreement with the therapist regarding the goals of therapy. He sees everything that happens in the process from a different perspective, which he does not reveal to the therapist. It is as if the patient makes a parallel, hidden contract in which all the experiences will be reinterpreted according to another frame of reference. The patient begins therapy with an "unconscious, rigid, parallel contract, which is to be applied without concessions" (p.897). The patient is seemingly in therapy to understand his problems but on a deeper level, his goal is to restore a previous balance lost as a result of changes in his relationships, or to prove that he does not need therapy. Etchegoyen (1999)

emphasizes that even when the therapist is very perceptive and recognizes such subtle alliance distortions, he/she may not be able to alter them significantly. Constant interpretive focusing on them may not produce the desired transformation and they usually return disguised in different forms, and remain a source of difficulty and impasse for long periods of the therapy.

### **Countertransference**

Countertransference reactions accompany every therapeutic work, but the work with a borderline patient is known to stir intense and usually problematic countertransference reactions. The position most clinicians take regarding the treatment of borderline patients is that an intense countertransference involvement is inevitable with this type of patients. The power and the range of the therapist's countertransference may be such that they even suggest that the countertransference reactions may be the most reliable guide to making the diagnosis borderline personality disorder (Kernberg, 1975, Gabbard & Wilkinson, 1994). The problem in the treatment of the borderline patient, just as with any other kind of patient, is that the therapist may act out her countertransference feelings before she is able to reflect on them and understand what they reveal about her own unconscious dramas and what they hint about the patient's unconscious communication. Perhaps, in comparison with the more neurotic patients, the therapist working with a borderline patient is more prone to acting out. Borderline patients are believed to evoke enactments through the unusual power (the "archaic" nature) of their transferences, which demand satisfaction, and through the confusing mixture of exceptional amount of aggression and the profound need for a devoted Other. Their way of communicating is believed to involve sensitivity to and exploitation of the therapist's vulnerable areas, and the therapist's personality is in the spotlight (Chessick,

1977). When treating a borderline patient, the therapist may be surprised by aspects of herself that become activated, and she may need to start or resume her own therapy, which is one of the features that make this enterprise so challenging and intriguing.

The most common and most problematic countertransference reactions in relation to a borderline patient are the therapists' hatred, the feelings of helplessness and worthlessness, the state of constant anxiety they have to struggle with, and the feelings of guilt (Gabbard & Wilkinson, 1994). The therapist's defenses against her countertransferences preclude her understanding of the process and facilitate her acting-out, particularly transgressions of the professional boundaries. Chessick (1996) describes the most often used defenses that account for the countertransference acting out: the therapist may repress his feelings, particularly his anger and hatred of the patient, which often leads to a state of boredom, restlessness, or inattentiveness; other possible defensive reactions may be turning against the self in which the therapist feels low self-esteem; a reaction formation of overconcern, maternal love, and fantasies of rescuing the patient; projection of the feelings of anger and hate, manifested by a fear that the patient will commit suicide, hurt himself, or leave treatment; and finally, a distortion of the therapist's reality testing to validate the countertransference hatred, in which the patient is devalued as hopeless or dangerous.

Most often it is the initial stages of therapy that are most vulnerable to impasses and ruptures because of difficulties to address the paradoxes in the area of therapeutic alliance, transference and countertransference reactions.

## Chapter 3

### Three Theoretical Perspectives on the Borderline Structure

I will review three of the theories that have distinctive ideas about the borderline condition: Steiner's theory of "pathological organizations," Kernberg's "conflict model," and Adler's "deficit model." The purpose of that review is first of all to link the ideas of the three theories about the meaning of the patient's behaviour with the problems that arise in the therapeutic process with borderline patients; then, to compare how the clinical approaches based on these theories attempt to restore the therapeutic work. In this comparison I will focus mainly on the differences among the three approaches.

The three theories can be described as object relations theories. They all share the assumption that the psychic structure is formed out of the constant interaction of the individual with his objects throughout the first years of his life. It is the British Object Relations School that first began to view the infant not only as seeking gratification but as inherently object seeking (Greenberg&Mitchel, 1983). The implication of this shift is that the person is always seen in relationships with objects in his external world. These relationships correspond to the structure of the individual's internal world: the internal world is also structured as relationships of the self with a certain objects. Kernberg's theory emerged from the marriage of object relation theories and classical drive/structure theory. Adler's theory combined ideas from the object relations theories, Kohut's self-psychology and Piage's developmental theory. As a result, Steiner, Kernberg and Adler's theories differ from one another in their assumptions about the role of the early experiences for the development of the individual's psychic structure and the elements of this structure. Steiner and Kernberg's models can best be described as *conflict* models. They view the borderline pathology as an

intrapsychic defensive structure that was established as a result of the child's need to deal with drives, emotions and object relations experienced as threatening to the self. Adler's model can be described as a *deficit* model because he sees the borderline pathology as a result of environmental failure to provide the necessary developmental experiences, which leads to deficits in the patient's self. Since the British Object Relations School has a pioneering role in introducing and developing the idea of object relations, I am presenting it in a greater detail than the other two theories.

### **British Object Relations School. Steiner's Concept of Pathological Organizations**

The British Object Relations school includes a number of theories ranging from Klein's preoccupation with life and death instincts and their intrapsychic elaboration as internal object relationship, to Fairbairn's and Winnicott's emphasis on the real relationships with the parents and their influence on the internal structure. I chose to review one of these theories, namely, the work of Steiner on pathological organizations because it deals specifically with the problem of understanding and treating borderline patients. Steiner's theory is rooted mostly in the Kleinian tradition. Kleinian theories deal with primitive (i.e. very early and intense, detached from reality, unsophisticated) psychotic states of anxiety, and, because of that, seem particularly applicable to people who struggle with such intense anxieties, like psychotic and borderline patients. Steiner's theory is both representative of the Kleinian school of thought, and unique in stressing some aspects of the borderline pathology.

In the following pages I will present both Steiner's view and the Kleinian ideas on which his theory is built.

Steiner (1982) sees the borderline patient as residing mainly in an inner place where he/she does not feel anxiety of any kind, a place he named "psychic retreat." This state of

inner quietness is achieved through an excessive use of primitive defenses. These defenses are glued together into a tight and highly rigid defensive structure. This defensive structure is what Steiner called "pathological organization of the personality," because it attempts to suppress and silence any signs of emotional life of the person, not just a single emotional aspect.

Steiner defines the pathological defensive organization as different from, yet related to, the depressive and the paranoid-schizoid position. According to him, the individual is trying to stay away from these two basic positions, since the emotions of both the paranoid-schizoid and the depressive spectrum are too threatening and unbearable. The person is struggling to distance from either of them and as a result is stuck somewhere in the borderland between them.

Steiner (1993) suggests that there are many varieties of pathological organizations, and each person has his or her own idiosyncratic methods of attaining emotional stasis, but he emphasizes the general characteristics of the personality structure that make it pathological. Typical for the personality structure is that it involves object relations with a weak healthy part snared by a strong, dominant, tightly organized group of bad internal objects. In the context of the individual's history, this organization was established as a result of the patient's efforts to handle an excess of death instinct and envy within herself. The excess of death instinct and envy threatened the very existence of the individual's inner world. The individual's strivings to bind, control and evacuate this destructiveness resulted in a rigid defensive personality structure. The "bad self" emerged as part of the personality that had to contain large quantities of death-instinct impulses, and which, because of that, was very destructive.

This complex view of the borderline structure is constructed in the context of the Object Relations perspective about the psychological development and the structure and functioning of the mind. It is rooted in the works of Melanie Klein (1935), Wilfred Bion (1957), Hanna Segal (1972), Susan Isaacs (1948), Herbert Rosenfeld (1971), Donald Meltzer (1968) and others, who developed an elaborate system of ideas about the content of the inner world and its dynamics and development. A review of the basic concepts within the Kleinian theory follows.

### **Kleinian Notion of Structure and Development**

#### **Unconscious phantasy and internal objects.**

The Object Relations' view is that the structure of the personality is determined by the constant and enduring unconscious phantasies the ego has about itself and about the objects it contains. The concept of "unconscious phantasy" occupies a central position in the Kleinian theoretical system.

The unconscious phantasies are concerned with relationships among internal objects and they are always active in the individual, underlying every mental process. All mental activity, including perception, takes place on the basis of phantasized relations with objects. In other words, the notion of the Unconscious in the Object Relations School is substituted by the concept of unconscious phantasy; the unconscious is made up of phantasized relationships with objects.

Before the reality principle is established, the unconscious phantasy is omnipotent, that is, there is no distinction between phantasy and reality: what is experienced in phantasy, is believed to have actually happened. Because of that, when the ego uses defensive mechanisms to reduce its anxieties, the changes in the internal objects as a result of these

defensive operations, are experienced as real. A complex internal world is constructed in this way. The structure of the personality is determined by the most constant and enduring phantasy that the ego has about itself and the objects it contains.

This is particularly important to understand how the primitive defenses against the inner destructiveness (death instinct) affect the psychic structure of the individual. What from an observer's position is a defensive maneuver to deflect the inner destructiveness, in the unconscious phantasy is experienced as expelling, taking in, annihilating, which alter decisively the contents of the internal objects. In that way, the primitive defensive operations give rise to an actual alteration of the ego (Hinshelwood, 1989). Pathological organizations are a result of primitive omnipotent defensive operations, which create an internal world where the bad objects rule.

### **Death instinct, psychotic anxieties and primitive defenses.**

Klein's notion of the death instinct is based on Freud's view of the clash between life and death instincts. For Kleinians there is a fundamental conflict between the desire to know, change and move, and the desire to enter a state of oblivion, silence and numbness. In Freud's view, this conflict between the forces of life and death, creativity and destructiveness is at the core of the individual development. The death instinct is a primary source of destructiveness, directed inwardly, to the self. This is so threatening that from the first moments of life, the death instinct calls for the use of the first defensive operations to deflect it from the self and to modify it. Paul Hoggett describes it in the following way (Hoggett, 1997):

This [conflict] is basic to the human condition. In other words, terror has an existential status. The death instinct is a drive towards death; it is directed inwardly, attacking the life of the subject and his desire to live. It is inner destructiveness. We cannot ask, "what is this terror of?" It has no locus that can

be pinpointed and at first it is attached to no object or structure. It is a self-reproducing, silent, deathly force. The process of projection that Klein speaks of is equivalent to the process of converting an internal terror into an external and identifiable threat. "I fear" becomes "I am frightened of" and "I hate." In other words, because of our terror we are capable of hate.

According to Hanna Segal (1957, in Hinshelwood, 1989), the baby's first experience of his needs lead to two alternative reactions: to satisfy the need which involves object seeking and love under the influence of the life instinct, and to annihilate the need, the perception of it, or the ego that needs, under the pressure of the death instinct. Normally the death instinct is in a state of fusion with the life instinct, and the healthy development implies that in this fusion the life instinct predominates over death instinct. In these cases, it is said that the death instinct is clinically silent, that is, does not have a symbolic expression in one's symptoms and dreams. In pathological conditions though, the death instinct may be prevailing in this fusion; then the operation of the death instinct becomes apparent and determines the destructive style of the personality.

The operation of the death instinct within the organism, is experienced as a fear of annihilation (Rosenfeld, 1971). It calls for the mobilization of primitive defensive mechanisms. Primitive or psychotic defense mechanisms are those mobilized against the death instinct, or more precisely, against the anxieties arising from the activity of the death instinct (Hinshelwood, 1989). In other words, they are defenses against sadism and destructiveness. In contrast, the neurotic defenses (repression) are used against the libido. Typically, the anxieties arising from the death instinct take two forms: paranoid anxieties of being attacked and falling apart and depressive anxieties that include guilt over the harm done to the object. The two forms of psychotic anxieties evoke different sets of defenses. The defenses against persecutory anxiety are annihilation of the persecutors, expulsion –

projection and projective identification, denial, flight to the good object, and splitting. The defenses against the depressive anxiety are omnipotence, denial, triumph and contemptuous control.

### **Positions.**

Klein postulated that early development is comprised of two distinct but overlapping developmental positions, called paranoid-schizoid and depressive positions. Originally she saw them as developmental phases, both part of the oral stage, with the paranoid-schizoid prominent in the first 3-4 months, followed by the depressive position, which is gradually achieved during the second half of the first year. Later on, she adopted the term “position” to move away from the idea of phases, since their characteristics tend to fluctuate and overlap. For Klein these positions are in essence mental states, configurations of psychic phenomena, which include particular predominating psychotic anxiety, defenses against the anxiety and phantasy of a specific set of object relations (Greenberg & Mitchell, 1983).

The process of individual development is generally a progression from paranoid-schizoid to depressive position that goes through many fluctuations from one to the other and back again. The most significant process that happens in the infant’s inner life is the transformation of object relations towards increasing integration of the internal objects and the self. The infant’s mental life begins with a state of unawareness of persons as whole objects, the paranoid-schizoid position, in which the inner world is populated by part-objects. Through a process of gradual integration, a sense of wholeness both in the self and in object relations develops and flowers during the depressive position. Along with this transformation comes a shift from preoccupation with the survival of the self to a concern for the object and recognition of one’s dependence on the object (Weininger, 1984).

For Klein, the ultimate source of our distress are the psychotic anxieties. Much of what happens in the individual is a result of defenses erected against the psychotic anxieties, so that we do not have to endure them consciously. Both paranoid-schizoid and depressive anxieties come from a fear from one's own destructive impulses (fear of the death instinct). In Kleinian terminology, both the persecutory and the depressive anxieties are psychotic anxieties.

Bion suggested that normally, we constantly shift between the two positions as part of our moment-to-moment fluctuations in everyday life; our inner states oscillate easily and frequently from the one to the other. As opposed to that inner mobility, in the case of pathological organization there is very little movement of emotions and perspectives and the patient is stuck in the retreat.

### **The Borderline Position**

As mentioned earlier, Steiner suggests that the patient uses a system of defenses to ensure that she does not experience the terror of persecution and fragmentation of the paranoid-schizoid position or the guilt and responsibility of the depressive position; she'd rather feel nothing, be emotionally dead. Steiner defines this state of the mind as a third position, a psychic retreat, which is related to but distinct from the first two. A retreat is a state in which the patient is hidden behind a powerful system of defenses. The defensive system serves like a protective armor for the patient, a shell, from which the patient emerges occasionally only to hide once again as soon as she experiences pain and anxiety. The patient needs her defensive organization to protect herself from experiencing intolerable anxiety.

These organized defenses are to be contrasted with the defenses that are part of the normal development. Characteristic of the healthy functioning are constant oscillations between the paranoid-schizoid and depressive positions; the anxieties and the concomitant

defensive operations shift over and over again in our everyday life. Normally, the defenses are unorganized, transitory to a greater or lesser extent, and recurrent. As such they reflect flexibility in the individual's perspective on his or her situation and a considerable capacity to be in touch with reality. In contrast, the defensive organization is a fixation: it is stable and not changing in relation to the changing circumstances. It is a system of defenses, built on one another to ensure that no emotions are experienced. It represents a deep preoccupation with internal sources of threat for the individual and much less contact and appreciation of the external reality.

Steiner ties the establishment of defensive organization of the personality to the operation of the death instinct within the person. "Defensive organizations serve to bind, to neutralize, and to control primitive destructiveness whatever its source" (1993, p.4). Trauma and deprivation intensify the state of inner destructiveness or death instinct, and thus may lead to pathological organization of the personality. Object Relations school sees destructiveness (death instinct) as part of the inner world of every person, but the psychotic and borderline patients are seen as having rather significant troubles with their destructiveness. That is why in these patients the defensive organization comes to dominate the psyche.

The defensive personality structure is determined by the use of two central defensive mechanisms: pathological splitting and pathological projective identification. Projective identification is a complex defensive mechanism in which a part of the self is split off and projected into an internal or external object. This part of the self is attributed to the object and the fact that it belonged to the self is denied. Then the object is no longer seen as separate from the self, having its own qualities different or resembling those of the self. The

individual relates not to an object per se but only to the aspects of the self that he/she put into the object. It is as if the person relates only to him/herself. In that way, a narcissistic type of object relationships is established.

The person deals with his or her excessive destructiveness by splitting off the destructive parts of the self and by evacuating them through projective identification into internal objects. These internal bad objects become characterized with ruthlessness and cruelty; they are assembled into an internal group, a “gang,” or inner “Mafia,” which idealizes violence and brutality. The “inner Mafia” part of the personality completely dominates and drives into hiding the other part that longs for “freedom and beauty” (Waddell & Williams, 2001). The patient may identify with one group or the other, oscillating between victim and oppressor, or he may feel like a helpless observer of his own behaviour, rather than an agent. He cannot change or “leave” this internal situation because he has projected (and lost) too many elements of himself. The organization prevents the needy and dependent parts from contact and communication with the real people the person needs, including the therapist. Thus the most important feature of the borderline structure is that there is a part of the personality, which is dedicated to destructiveness. Steiner suggests that the bad internal objects and their destructiveness towards the self and others are idealized –a defensive maneuver that helps the person live with the part of him that terrifies him. This structure accounts for these patients’ tendency to experience the world as malevolent and their proneness to inflict pain on the self and others without feeling guilt, remorse and care. According to Steiner, the death instinct can even become erotized, so that living in a world of violence becomes both a terrifying and appealing experience.

Steiner also suggests that along with, and in relation to, the excessive amount of death instinct, infants struggle with issues of separation and dependence and it seems that projective identification is a solution to the pain and anxiety related to both. According to him, one of the most difficult facts of life the child has to accept, is that the main source of goodness and survival is the breast, which means that it is outside the infant and outside the infant's control, in the external world. Awareness of one's separateness from the breast leads to awareness that one is dependent on the breast. Dependence entails feeling of love and recognition of the goodness of the object, but also pain and rage when the object is missing, envy and urge to destroy the good object because the good object withholds its riches and deprives the self of them. In order not to experience anxiety, anger and envy the infant denies its separateness from the object and resorts to a narcissistic phantasy that it is the infant who creates the good breast, that the breast is inside her and under her control. When there are too many traumatic experiences with one's parents, which significantly prevail over the good experiences, the need for control over the object and the defensive fantasy that the breast is inside the self, which denies any dependence on the object and the hope to be nurtured, tend to prevail in the person's internal world. It is also almost impossible for such a person to recognize that the mother that hurt him is also the mother who had the desired goodness, so the splitting between them is reinforced.

This structure of bad objects ensures protection to the individual so he does not experience anxiety of neither persecutory nor depressive type. As Steiner (1993) noted, the organization "contains" the individual's anxiety as it presents itself as a protector to the vulnerable self. This containment is different from the containment, which takes place in a healthy relationship between a baby and his mother (Bion, 1959). Bion 1959, (in

Hinshelwood, 1989) suggested that projective identification could be categorized into normal and pathological, depending on the degree of violence with which one projects the unwanted part of the self and the aim of that defense. In pathological projective identification the individual is attempting to violently evacuate a painful state of mind, forcing the threatening part into the object (make the therapist feel what the patient feels) in order to experience relief and to exert control over the object. The object now carries a part of the self, and because of the patient's persistence and control, the object starts to identify with the patient's part projected into him: the result is a fusion between self and object, and so, this becomes also a defense "against separateness, need and envy" (Hinshelwood, 1989, p.91). In normal projective identification, the individual is trying to communicate with the object about his state of mind by making the object experience what the person experiences. For Bion (1959), when the baby is overwhelmed with anxiety, she communicates her state of distress by means of projective identification to her mother. If the mother recognizes the emotion, and is not overwhelmed by it, she "digests" it and detoxifies it; then she does or says something, returning the affect in a shape, which the infant can handle with her weak ego. In both cases the anxiety is handled through the use of projective identification but the quality of the internal relationship and the end results are totally different. When containment is done by the mother, it creates a healthy situation that promotes integration and growth, when it is done by the self as a defensive evacuation, it still ensures survival, but it is at the cost of surrendering oneself to the destructive part of the personality (Steiner, 1993). Steiner adds that although this organization is introduced to avoid catastrophe, it is the organization itself, which becomes a chronic catastrophe.

Steiner suggests that all people can reside temporarily in each one of the three positions: not only in the two basic positions but also in the borderline position. It only becomes a pathological state when the patient is stuck in one of the positions. The work with the borderline patient requires a precise assessment in which position the patient is located at any particular time (1993). Both paranoid-schizoid positions and depressive positions are characterized by intense anxieties and they seem to be fertile ground for interpretation. The consequence of the pathological defensive organization for the therapeutic relationship is that the patient is withdrawn from the emotional contact with the therapist. The patient who struggles to protect herself from experiencing intolerable anxiety by remaining untouchable in the area of the retreat poses significant obstacles to the process of therapeutic change.

### **Projective Identification, Mourning and the Goals of Therapy**

Projective identification has a central role for the creation of the pathological organizations. Along with the evacuation of intolerable experiences, it sustains the fantasy that the object is not lost as a result of one's destructiveness, but is under the subject's omnipotent control. Accordingly, the therapy has to deal with the issues of containing the patient's destructiveness and with the anxieties about separation from the object. Since both are defensively handled by means of projective identification, a major therapeutic task is to facilitate its reversal.

Normally, the projective identification would be reversed, meaning that at some point the person would withdraw the projections from the object and own the unacceptable parts of him/herself. The boundaries between the self and the object would become clearer as the person gradually distinguishes between the characteristics that belong to him and those that belong to the object. The withdrawal of one's projections is a part of the process of

mourning. This process of mourning and boundary delineation is provoked by an experience of loss (Steiner, 1993).

In the case of a pathological system of defenses, the withdrawal of the projections from the object is hindered, because in order to recognize what truly belongs to him/her, the person has to let go of the omnipotent control of the object, in other words, to experience the loss of the object and to mourn it. This is particularly problematic when the threatening phantasies are projected into a group of objects rather than a single object. The self has to separate from any single object by withdrawing one's projections from that object, facing its difference and mourning its loss. This is difficult to accomplish when the object is linked to other objects in an organization since the individual needs to keep the organization intact. The person still needs the organization as a whole because it provides containment, although this containment is pathological (provided by a group of dangerous objects). On the other hand, people with borderline personality have significant difficulties with accepting their separateness from the object. At a primitive level the experience of separateness is felt like a loss: separation is the same as death of the object. Moreover, if too much is projected into the object and the object is lost, then a part of the self is lost too. The person clings onto the object and denies the loss. If the individual has the capacity to acknowledge the reality of the loss, to relinquish his control over the object, it means that he has differentiated from the object.

[Mourning] involves the task of relinquishing control over the object and means that the earlier trend which was aimed at possession of the object and denying reality, has to be reversed. In unconscious phantasy this means that the individual has to face his inability to protect the object. His psychic reality includes the realization of the internal disaster created by his sadism, and the awareness that his love and his reparative wishes are insufficient to preserve his object, which must be allowed to die

and with the consequent desolation, despair and guilt. This process involves intense mental pain and conflict, which are part of the function of mourning to resolve. (Steiner, 1993, p.61)

Within the object relations framework, the therapeutic aim is to help the person go through the process of mourning to enter the depressive position and endure its pain. It involves the difficult task of facing the reality of who the object is and its separateness from the subject, going through the painful recognition of what belongs to the object and what belongs to the self. The individual becomes more capable of withstanding the guilt and pain of the depressive position. Technically, it is the process of delineation of one's boundaries that has to be assisted in therapy, and the dynamics of this process is called mourning.

Initially, the contact with the patient is in the focus of the therapist's attention. Every opportunity for contact and emotion is to be used when the patient emerges from her retreat for interpretation, and hopefully, insight into her inner world and her participation in the relationship. The therapist has to attend to the subtle changes in the emotional contact the patient establishes anywhere on the continuum from painful feelings to retreat. It is usually through interpreting the process, the here and now of the therapeutic session, that insight and structural changes are facilitated. The therapeutic task is complicated not only because of the complexity and the extent of projective identification that is to be reversed, and the amount of losses to be mourned, but also, by the perverse nature of the relationship the patient establishes with the therapist. There is perversity in the fact that the patient attends therapy but uses it to support the continuing lack of insight and to reposition herself into the retreat; the therapist wants to know and offer understanding, the patient needs to deaden her emotions. The therapist believes that the patient's pain needs understanding, while the patient has learned to receive gratification from her misery and deadness. Then, the problem for the

therapist is how to enter and participate in the patient's world in a non-perverse way and at the same time preserve the relationship with the patient.

### **Kernberg's Conflict Model of Borderline Pathology**

Kernberg (1975) offers a perspective on borderline personality organization that springs from his conceptual model, which integrates the theory of object relations with the drive theory. According to Kernberg what is characteristic of the psychic structure of the borderline patient is the lack of integration of positive and negative introjects. He considers this structure a result of pathological use of splitting mobilized to handle excessive amounts of aggression.

### **Development of Psychic Structure**

Kernberg preserves to a significant extent the language of the drive model; he proposes a structure of the mental apparatus, which resembles on a superficial level Freud's structural model, consisting of id, ego and superego. His ideas however, about the origin and the development of these structures are significantly influenced by the object relations theory. A central position in his theory about the origins and development of the psychic structure has the concept of affect. For Kernberg affects are the primary instinctive components of our experience, inborn dispositions, common to all individuals:

[T]hey emerge in the earliest stages of development and are gradually organized as part of early object relations into gratifying, rewarding, pleasurable affects or libido as an overarching drive, and into painful, aversive, negative affects which are organized into aggression as an overarching drive. Within this conceptualization, affects are inborn, constitutionally and genetically determined modes of reaction that are triggered first by various physiological and bodily experiences, and then by the development of object relations from the beginning of life on.  
(Kernberg, 1995)

According to Kernberg, elation is the basic affect of libidinal drive and rage is the basic affect of aggressive drive. The intimate bodily contact with mother is a source of pleasure for the infant, and the child experiences it as a state of elation. Rage is a reaction to frustration and it is at the core of the feeling of hatred and envy, and also of anger and irritability as attitudes present everywhere in one's relationships.

Kernberg (1995) suggests that aggression is a major inner problem the person has to deal with, which plays a central role in the development of severe psychopathology. Kernberg assumes that some infants have inborn disposition to more intensive aggressive affect reactions and lower threshold of the aggressive affect activation than others. If the infant's limited cognitive capacity is additionally genetically or constitutionally impaired, he or she may be more inclined to react with rage when in situations of uncertainty and separation. Traumatic experiences like physical and sexual abuse, and other forms of severe pathology in early object relations activate aggressive affects and determine the overall predominance of aggressive over libidinal attitude. When aggression predominates the child's experience, she attempts to deal with it with all the means at her disposal, which results in conditions of severe psychopathology.

Kernberg (1975) suggests that the individual's structure of the mind crystallizes as a result of an internalization of the early relationships between the infant and her caretakers. The result is a complex inner world of representations which gradually becomes reorganized and assimilated to form the structure of the ego and id and later, the superego. The first representations reflect what the baby makes of its relationships with a real external object. Thus the experience with that object precedes the structuralization of the ego (although the

capacity to experience means that there is something that can experience, a precursor of the ego).

Kernberg (1998) maintains that relationships are internalized at two levels, depending on the intensity of the emotions. The first level of internalization occurs when emotions are not at their peak. Through this process of internalization of the ordinary interchanges with the parents in the context of low affective levels, the child gradually learns more about the world around him. The second level of internalization occurs in the context of intense emotions. The experience of peak emotional states (positive and negative) has deep impact on the child. Because of the intensity of the affect, these representations of the self, the other and their relationship are so prominent and vivid in the child's mind, that they become crucial in organizing the mind. They determine the way the child sees herself and her relationship to her significant others.

The most important internalized relationship is the relationship with the mother. Images of interactions with the mother at the moments of most intense affect are created and become the building blocks of the personality structure. Each internalized object relationships has three parts: object image (the image of the external object), self-image (the image of the self in interaction with the object), and affective coloring (reflecting either libidinal or aggressive drive which was active at the time of the interaction). In other words, the earliest structure is comprised of dyadic representations, each one created and given meaning within a particular emotional context. The perception of an external object relationship is linked to the perception of an internal emotional state, representing the drive.

The process of internalization of the relationships becomes more elaborate in the course of individual development. This refinement in the process of internalization corresponds to a gradual development of the ego (Kernberg, 1975).

The earliest, most “primitive” level of the internalization is introjection. What is being internalized by the baby, are undifferentiated and loosely organized images of the self and the object in the context of the most tempestuous and extreme emotional experience. The interaction between baby and mother, in which the baby experiences pleasure and love is introjected as a unit: self-mother-good feeling, and becomes a good internal object. When the baby experiences frustration and aggression in the interaction with the mother, he internalizes the relationship as a different unit: self-mother-bad feeling, which becomes a bad internal object. The positive and the negative introjects are split and held separate at this level of development, because the ego is too immature to integrate states, which are contradictory. The introjects structured around hostile feelings are held apart from each other, while the positive, libidinal introjects are integrated into a primitive ego-core.

A more mature level of internalization is “identification.” It happens when the child is capable of appraising the role she plays and the role the object plays in the interaction; the child becomes capable of making much finer distinctions in one’s own states and the states of the object. This system of internalized object relationships consists of image of the object in particular role, image of the self in a complementary role and the emotional coloring, determined by the drive active at the time of the interaction. Emotions are not that intense as they were at the earlier stages but modulated to a certain degree by the developing ego.

The most mature level of internalization is ego-identity. Kernberg uses this term to designate identifications and introjections that are organized by the synthetic function of the

ego. The level of maturity of the ego makes it less likely for splitting operations to continue. The result of the process of synthesis is a mature, consistent, integral idea about the object world, and a feeling of consistency of one's self. The opposite valence self and object images become integrated into whole, good and bad, images of self and other. At this level the earlier levels of internalization are organized and integrated with each other. Ideal self and object representations are also formed and eventually become ego ideal. In other words, for Kernberg the ego comes into being as a result of the process of introjection and subsequent consolidation of these introjects. The first representations reflect what the baby makes of its relationships with a real external object. Thus, the experience with this object precedes the structuralization of the ego. It begins with the first interpersonal relationships, which are internalized, although the capacity to experience means that there is an agency that can experience, a precursor of the ego.

When the ego becomes more integrated, it tends to use repression and other higher level defenses to deal with aggression and other threatening experiences. In Kernberg's view the ego represses what it cannot tolerate into the consciousness and the repressed content becomes the dynamic unconscious of the person, the id. It means that for Kernberg the dynamic unconscious consists of self-object-affect configurations, which are too intense and dangerous for the ego; this is a view that very much resembles Fairbairn's view of the unconscious as created through repression of the bad object.

The synthesis of self-object-affect configurations with opposite affect valences leads to drive neutralization. Kernberg sees drive neutralization as the most important source of energy for repression. Once the individual starts to use predominantly repression to deal with

upsetting experiences, her personality organization is no longer borderline, but becomes neurotic.

The development of the superego follows the same line as the ego. It begins with early, hostile object images – the most primitive, early form of the superego. Then ego ideal is added, consisting of ideal self and object representations that balance the presence of hostile superego images. Finally, realistic images of the child's parents and particularly their values, prohibitions and demands, are created, which is the most mature level of the development of superego.

The trajectory along which Kernberg places the development of the mental structure is from unorganized dyadic introjects, which reflect the specifics of the earliest relationships, to a coherent, smoothly functioning system, where the object representations lose their specific qualities: a process similar to the process of digestion and metabolization of food (Greenberg & Mitchel, 1983). In contrast to the food metabolization, the mental metabolization is reversible even with people who have achieved a significant integration and transformation of their early introjects. This kind of structural demetabolization is what is expected to happen in the course of one's analysis: what the patient initially experiences as his own demands and prohibitions (from his Superego), gradually come to be experienced as an attitude expressed by his parents in the context of a particular interaction with them. The structure of the neurotic patient is considered to be fairly integrated into three systems: id, ego, and superego. That is why with them the process of structural demetabolization (transference) typically takes a long time to develop.

The patients with borderline personality structure did not have an adequate metabolization; no coherent structure was developed to handle the patient's experiences. As a

result, the patient tends to act out again and again his contradictory internalized relationships, instead of processing them (Greenberg & Mitchel, 1983). According to Kernberg (1975), these patients remain pathologically fixated to an early stage of the development of their personality structure, with an ego that splits the experience into “good” and “bad.”

### **Borderline Personality Structure**

Characteristic for the borderline personality structure, or "borderline personality organization" (Kernberg, 1975) is that the good self and object representations are held separate from the bad self and object representations. This internal situation, which is normal at a particular stage of individual development, is pathologically fixated and persists into adulthood.

Splitting, which is a normal defensive mechanism in the initial stages of individual development becomes pathologically reinforced. As a result, the individual does not develop an integrated ego-identity but tends to experience contradictory ego states. Other primitive defenses based on splitting (primitive idealization, denial, omnipotence and devaluation, projection and projective identification) are also used to protect the ego from conflict by keeping apart the contradictory experiences and images of self and others. Primitive idealization is a mechanism through which the person exaggerates the good qualities in the other, excluding from one's awareness the negative traits of the object. No signs of imperfection in the other can be tolerated by the subject. Idealization easily switches into devaluation of the other. The use of the mechanism of denial makes it possible for the person to recognize that her experience at one point may be completely different from her experience at another point, without experiencing any conflict and anxiety, and without any movement towards integration when the contradictory experiences are recognized. Projective

identification in Kernberg's view is a mechanism of projection that remained incomplete, a more primitive form of projection, performed by an immature ego, in which an impulse is projected onto the other person while the self continues to experience the projected impulse. It leads to fear of the other person who is seen as having the dangerous impulse and a need to control the other by making him/her react in a way that validates the projection.

The development of the superego is also hindered. It has reached a stage where ideal object images are created to balance the presence of hostile object images but the mechanism of splitting keeps them apart. As a result, the superego is composed of nonintegrated sadistic all-bad object images and ideal object images. As the integration of good and bad introjections does not occur, the energies of the libidinal and aggressive drives do not neutralize each other. Since the ego needs neutralized energy for its functions regarding reality testing, control of impulses and containing of anxiety, the lack of neutralization leads to a weakened ego with characteristic reliance on primitive defensive operations, failure to develop a stable ego identity, low anxiety tolerance and lack of impulse control.

Kernberg sees psychotic structure as a result of developmental problems that occur earlier than the ones that gave rise to the borderline structure. The psychotic individual failed to differentiate self images from object images, and in particular to separate intrapsychically from their mother. Borderline individual has been able to accomplish this task to a major extent but failed to accomplish the next developmental task: to integrate diverse and contradictory object and self images created in different contexts into a whole image.

Borderline structure is created as a result of defensive operations, namely spitting and other primitive defenses. The major problem the patient tries to defend against is her excessive aggression. For Kernberg aggression is the core difficulty of the borderline patient.

Kernberg considers some of the other characteristics of the borderline personality, like lack of libidinal object constancy, sense of emptiness and dependence upon external objects for a variety of functions, secondary consequences of one's attempts to deal with her primary aggression.

The more aggression the patient has to contain, the more extreme the defenses are, and, as a result, the more severe the psychopathology. Still, the patient's excessive aggression is not lost as a result of the defensive operations but is expressed in the form of hatred and envy (Kernberg, 1995). Kernberg considers hatred connected to an unconscious desire to control and destroy the bad object. Hatred is not transitory like rage, but is chronic and stable because it is embedded in a particular structure consisting of representations of self and object in a sadistic relationship. The person usually feels that her hatred is justified reaction to a frustrating object and so she feels entitled to revenge. Envy as a manifestation of primitive aggression is a view, which Kernberg borrowed from Klein. In envy, there is a wish to destroy the good object precisely because it is good. The infant experiences the absence of the good breast as if the breast withheld itself. This provokes an angry attack of the object, which is thought to have all the good things the child desires. Underlying hatred there is a fantasy of destruction of an object which when frustrates the subject is perceived as sadistically attacking the self. Envy is a form of hatred of an object, which in fantasy is seen as sadistically or teasingly withholding what the person needs or desires (1995).

### **Clinical Manifestations**

The borderline personality organization is reflected in the patient's predominant characteristics. The patient has a certain degree of identity integration, certain level of defensive operations and certain capacity for reality testing, different from those in neurotic

and psychotic personality organization (Kernberg, 1984, 1989). Characteristic for the person with borderline personality organization are identity diffusion, primitive defenses and preserved capacity for reality testing.

Additional secondary structural characteristics are manifestations of ego weakness that include lack of impulse control, lack of anxiety tolerance and lack of channels for sublimation, and superego pathology, revealed in the immature value systems, contradictory moral demands or antisocial features of the personality (1989).

Identity diffusion is revealed, according to Kernberg (1989), in the patient's contradictory self-perceptions, contradictory behaviour, severe mood swings, the experience of chronic emptiness, contradictory perceptions of others, and the tendency to describe the others' and the person's relationships with them in a superficial, shallow way.

Characteristic for the borderline (and also psychotic) level of organization is the use of primitive defenses, centering on the mechanism of splitting, while in neurotic personality organization predominate high-level defensive operations, centered on the mechanism of repression.

Kernberg defines reality testing as "the capacity to differentiate self from nonself and intrapsychic from external origins of perceptions and stimuli, and to evaluate one's own affect, behavior, and thought content in terms of ordinary social norms" (1989, p.7). The capacity for reality testing in both neurotic and borderline personality organization is preserved. This capacity is lost to a different degree in psychotic personality organization.

### **Therapy**

In the Kernberg's conceptual framework, the goal of therapy is "to enhance the borderline patient's ability to experience self and others as coherent, integrated, realistically

perceived individuals, and to reduce the need to use defenses that weaken the ego structure by reducing the repertoire of available responses” (Kernberg, Selzer, Koenigsberg, Carr & Applebaum, 1989, p.8). The structural change therapist and patient are striving to attain, is to integrate the split positive and negative introjects. In that way, a stronger ego, capable of better management of affects, anxieties and impulses emerges.

Kernberg recommends a modified form of expressive psychoanalytic psychotherapy as more suitable for the patients with borderline personality organization (Kernberg, 1978). In this approach, the goal of the therapy is achieved through *systematic* confrontation and interpretation of the patient’s defenses. Ego weakness is not a sign of insufficient defenses; on the contrary, ego weakness is seen as a result of the operation of powerful and rigid system of defenses. This systematic interpretation of the patient’s defenses is in contrast to expressive psychotherapies with better functioning patients where only some of the defenses are interpreted, while others, which are more adaptive or not relevant to the therapeutic focus, are left untouched. Only through the systematic interpretive focus on these defenses as they appear in the context of transference, can the therapist unchain the process of ego growth (Kernberg, 1978). Since the primitive transferences are immediately available and function as resistances to the process of understanding and integrating, they also have to be focused upon and interpreted immediately. However, in contrast to psychoanalysis, transference interpretation is not systematic. It is based on the predominating transference paradigm and the prevailing conflicts in immediate reality, but it is limited by the specific goals that emerge in therapy, like dealing with the acting out behaviour, and with the alarming disturbances in the patient’s external reality (Kernberg et al., 1989). Although Kernberg’s treatment approach has a supportive effect, namely, introducing structure at times

when interpretation is insufficient to limit the acting out behaviour, or in the case of psychotic breakdown, Kernberg emphasizes that it does not include supportive techniques. Therapeutic change comes about as a result of “purely expressive, meticulously analytic approach” (Kernberg, 1978, p.86), which ultimately relies on interpretation, insight and learning.

Therapeutic change emerges as a result of continuous clarification and interpretation of dissociated psychological elements, which bring together the aggressive and libidinal aspects of the personality to make up total self and total object representations. Once such profound transformation of the internal world is achieved in the context of his current relationships with the therapist and significant others, the patient can be helped to come to terms with the figures from his past.

### **Gerald Adler's Deficit Model**

Kernberg believes that the core problem of the borderline patients is the conflict between positive and negative introjects which makes the process of their integration difficult. Adler, in contrast, believes that the core problem of these patients is their inability to adequately establish a specific kind of positive introject, namely the holding and soothing introject. Adler’s understanding of the borderline pathology is influenced by Winnicott, Kohut, Mahler and Piaget’s theories of psychic development.

### **Borderline Personality Structure**

In his work on borderline pathology, Adler (1985,1993) focuses on the issue of dependency on the primary object as central to the understanding of these patients. He uses an object-relations framework to define the structure underlying the borderline pathology. According to him, the core problem of the borderline patients is their inability to rely on their

own internal resources to hold and soothe themselves when faced with separations. Adler and Buie (1993) ascribe this deficit to the insufficiency and instability of certain kinds of introjects that are needed to sustain the person's psychological self. These introjects internally "hold" and soothe the self, creating a feeling of psychological security. Although in the case of borderline structure some introjection of holding and soothing experiences has happened, giving rise to holding and soothing introjects, these introjects remain both insufficient in number and unstable, liable to regressive loss of function when the individual faces changes, tensions or losses in his or her relationships (Adler, 1985). There is a major defect in the psychological structure: it is not that the positive introjects are spit off and kept apart from the negative ones, as it is according to Kernberg; the positive introjects are outbalanced by negative ones. Thus, the experience of aloneness is structurally embedded, arising from the lack of an internal figure, a lack that leaves an internal void; aloneness is considered by the author the central problem that has to be addressed in the treatment of borderline patients.

The patient's failure to internalize soothing and holding objects is a result of the early experiences with parental figures. For the most part these experiences include abandonment, neglect, and emotional, physical or sexual abuse. Their objects were not "good enough," to put it in Winnicottian terms (Winnicott, 1986), since they generally failed to provide the child with sufficient love, safety, and holding. The patients' childhood environment was not sufficiently safe and predictable to give them opportunity to internalize interactions with loving and reliable parental figures who were in tune with the biological unfolding of the child's cognitive and structures and emotional needs. As a result, under the stress of separation, the patients cannot count on the holding and soothing introjects they do have.

They regress at those times to experiences of panic and a sense of inner emptiness, which Adler and Buie call borderline aloneness or annihilatory anxiety (Adler, 1993).

Along with the lack of holding and soothing introjects, borderline patients may experience the internal presence of negative, hating, and attacking introjects. While positive representations and introjects depend on the positive experience of being held and soothed, negative representations and introjects are constructed out of the child's rage and hostility, projected into the external object (Adler, 1985). Adler noted however, that this hostility is reactive, due to the lack of holding and soothing maternal presence. When feeling intense rage, the patients may imagine themselves attacking and destroying the images of people who have previously been seen as positive and have been among the holding and soothing introjects. In other words, the patient does not have or cannot count on her holding and soothing introjects particularly when her murderous rage appears, and on the other hand she is overwhelmed by her negative introjects. What complicates significantly the problem is the omnipotent quality of these phantasies, so that when the borderline patient is angry, she experiences it as if she is actually killing the positive introjects (Adler, 1993).

### **Development of the Borderline Structure**

Adler related patients' difficulty with separations to the child-development literature and in particular to the achievement of object permanence: he bridged psychodynamic theories with theories about the normal maturational processes. In his view, the work of Piaget, Fraiberg, Winnicott, and Mahler regarding the capacity for object permanence seemed related and fit his definition of the borderline structure.

For Adler the process of internalization of the object and achievement of object permanence parallels the development of memory capacity. He is particularly interested in

the development of the so-called recognition memory (the capacity to recognize an object as familiar) and evocative memory (the capacity to evoke an object without being reminded of its existence by external cues). Recognition memory makes possible the beginning of object representations that can provide a sense of inner soothing, and evocative memory allows for the establishment of continuously available object representations, that is, for object permanence. With the attainment of recognition memory at about 10 months, and if there has been good-enough mothering, the child can begin to use transitional objects to provide the holding and soothing that previously were provided only by the physical presence of the mother. When the child's evocative memory develops, the mother with her functions of holding and soothing is introjected and from that point on, the child can perform himself to some extent what he had expected from his actual mother or from his transitional object. Eventually, identification with the functions of the holding introject and the people from the individual's environment occurs and it leads to integration of these functions into the ego. The individual becomes less dependent on his environment to provide him with a sense of security and comfort.

The developmental failure that occurs in the borderline patient's history appears to be a result of a mothering that is not good enough during the phases of separation and individuation at the second and third year of age on Mahler's developmental scheme. The references to Winnicott and Mahler, place the origins of the deficit at the time when the child separates from the mother and the child's boundaries and individuality are negotiated in relation to her. Adler's understanding is that in order to separate from the mother, the child needs to securely internalize her presence and care, that is, to achieve object permanence.

In that period of negotiating his/separateness from the mother, the child needs the mother's physical and emotional presence and comfort until the internal object is permanently established. This requires also a certain level of neurobiological maturity that is attained at about 18 months of age. Borderline patients have not achieved solid evocative memory of significant objects and, when under stress, they tend to regress to recognition memory or earlier stages. Holding introjects of present and past figures are functionally inadequate because there were not enough good experiences with the mother to remember/internalize. Adler assumes that in most of the cases the child has been neuropsychologically ready to form representations and introjects, but the environment did not facilitate this process. When the mother is not securely introjected as alive and caring, the child and constantly needs transitional objects to maintain the memory of her. Later, the adult remains dependent on external self objects to provide the necessary holding and soothing.

For Kernberg, the experience of inner emptiness follows an aggressive attack on the object in reality or in fantasy: the person withdraws from the intrapsychic representation of the needed but feared object in order to avoid the experience of its loss. The primary issue is to keep apart introjects with opposite valence, which means that there is an assumption that a considerable amount of positive introjects has been created around which the self is organized. The patient's inner world is far from empty, relatively rich in introjects of a positive and negative quality. For Adler, in contrast, the experience of inner emptiness is not secondary to the expression of one's aggression, but primary. It reflects a relative absence of positive introjects, and the self is organized in these conditions of lack: this situation creates a true inner emptiness, a fragile self, incapable of dealing with the patient's reality. Adler agrees with Kernberg that borderline patients experience difficulty in integrating good and

bad self-images and object images, but he believes that this problem arises at a later point in development and arises later in transference. The problem related to the functional insufficiency and instability of the holding introject arises earlier in one's development and are at the core of borderline pathology.

### **Characteristics of the Structure**

For Adler the experience of aloneness is at the core of the patient's subjective being. He contrasts his notion of aloneness with sadness and loneliness where the external object is missed and desired; loneliness implies that the internal object is present and alive and there is a sense that the longed for real person exists somewhere in the world. In other words, the experience of loneliness is only possible for a person who has a stable and functional holding introject. Aloneness implies that the holding introject is not adequately functioning. There is internal emptiness underlying the experience of aloneness. It is experienced as a panic that the self will cease to exist, or as vague feeling that one is not really alive, a sense of deadness or emptiness. The patient needs to replace the missing introject with a real holding selfobject.

The borderline structure is characterized by its instability and the fact that it dooms the individual to dependence on other people: borderline patients depend on a permanent basis on external objects to deal with their anxiety and to maintain in that way their psychological stability. The other people function as auxiliary egos for the borderline patient. Adler uses Kohut's term selfobject to designate the people who perform these psychological functions for the patient (selfobject, because they are objects, people, experienced as part of the self and functioning as part of the self). While the narcissistic patient is described by Kohut and Adler as relying on selfobjects to maintain his sense of self-worth (selfobjects provide him with a mirroring function and are available as objects of idealization), the

borderline patient is described as relying on selfobjects to provide holding and soothing function. The therapist always is used as a holding selfobject by the patient.

Under normal circumstances, when their life is structured and without surprises in the interpersonal field, the borderline patients can maintain sufficient interaction with holding selfobjects to maintain a sense of psychological integrity. However, when the selfobject fails to perform his holding function, the patient feels abandoned, and reacts with rage. Her rage is accompanied with fantasies of destruction of the object, which under the primary process thinking is felt as if the object is really destroyed. In the patient's inner world too the corresponding introject is lost. At first, the evocative memory for the holding selfobject is lost: the patient cannot remember the therapist's voice and face and the way the therapist's presence is felt outside the therapy hours. As a result the holding introject, corresponding to the selfobject is also lost. Still, the patient can make use of the external holding selfobject and the transitional object for holding and soothing. If the feelings of abandonment and rage intensify even more, further regression in one's cognitive capacity ensues. Recognition memory is also lost. The amount of hate can be so extreme, that the patient may not recognize the therapist when she sees him. The external object is no longer recognized as a selfobject that can potentially provide for holding and soothing; transitional objects also become meaningless.

### **Therapy**

The aloneness issues are expected to arise in the treatment of all borderline patients, as soon as some level of trust and dependency is achieved. These aloneness issues have to be addressed by providing the patient with an opportunity to create the missing holding introject. Adler's clinical theory is highly influenced by Kohut's ideas of the therapeutic

process, particularly Kohut's notions of self-object transference, idealizing transference and transmuting internalization. For Adler, the structural defect becomes gradually repaired in the context of a therapeutic relationship that allows for stable selfobject transferences.

Adler describes the treatment as proceeding through three phases. The task in the first phase is to establish a therapeutic relationship in which the therapist can be used by the patient as a holding selfobject. This prolonged experience, along with the insight into one's aloneness, is a basis for the formations of adequate holding introjects. "That is, the developmental processes that were at one time arrested are now set in motion to correct the original failure" (Adler, 1985, p.50).

The second phase is the gradual resolution of the patient's idealizing transferences. Since the selfobject transference is strongly coloured by projection of idealized introjects onto the therapist, they give rise to a formation of an idealized holding introject. This introject is based on idealization, and because of that it is vulnerable to the disappointments, which reality inevitably brings. What has to happen is a process of "optimal disillusionment," that occurs naturally as the patient perceives the discrepancies between idealized holding introject and the actual holding qualities of the therapist and goes through the feelings of disappointment, sadness and anger.

Finally, the task in the third phase is to help the person love him/herself and experience genuine love for the object and sadness in the face of the inevitable losses. Structurally this stage involves changes in the in the ego and the superego. The qualities that have been internalized as characteristics of the internal introject, become gradually assimilated and integrated with the ego through a process of transmuting internalization, to become ultimately functions of the ego. In that way the person develops autonomous

capacities for soothing and holding herself, for appreciating her personal qualities, and for loving herself (Adler, 1985).

## Chapter 4

### Case Illustration

In the case fragment taken from Gabbard and Wilkinson (1994), which I chose as a base for comparing the three theoretical perspectives, the impasse is a product of the way patient and therapist relate to each other regarding the patient's negative transference. The negative transference is a particularly important clinical problem that arises in the treatment of practically every patient with borderline pathology. No matter what role different theories assign to aggression in the etiology of the borderline personality structure, they all consider it an essential part of that structure. That is why the negative transference needs to be addressed as a part of the process of therapy, and it represents one of the most difficult for the therapist aspects of the treatment, which often becomes a source of impasse in the therapeutic work.

In order to be able to apply the three theories freely, as equally legitimate perspectives on the case material, which would lead to different developments in therapy, I deliberately left out the second part of the case vignette as it was presented in Gabbard and Wilkinson, because it focused on the way the therapist resolved the impasse and opened a discussion about the patient's conflict (Gabbard and Wilkinson, 1994).

Mr. S, high level borderline patient, began seeing Dr. H in four-time weekly psychoanalysis after his previous analyst had left town. He began the analysis with almost immediate feelings of contempt toward Dr. H.

Mr. S: I know you think I'm assaultive, but it is because of the way you treat me. You charge me, you even bill me when I choose to take vacations, you don't give me answers to any of my questions and you rigidly enforce the end of the hour even if I'm in the middle of a thought. I see you as assaultive, so I react with hostility.

Mr. S reacted with scorn when Dr. H would suggest that much of the venom Mr. S directed toward Dr. H was a displacement that actually belonged with the memory of his last analyst. Mr. H suggested that Dr. H was trying to pass the buck to someone else for his own failings.

Dr. H felt that Mr. S had a point. Mr. S had indeed been tuning in to Dr. H's attempt to sidestep the heat of the transference by deflecting it elsewhere. Dr. H had grown increasingly frustrated with the absence of analytic space in which the two of them could look at what was being re-created in the transference as a repetition of past relationships. Confronted with no gateway to forging a viable working relationship with the patient, Dr. H was attempting to develop an alliance by encouraging Mr. S to direct his wrath elsewhere. If Dr. H had succeeded, he could have empathized with the hatred Mr. S was feeling toward his previous analyst and, in so doing, could have formed an alliance around the shared anger toward an "outside enemy."

Dr. H's primary reaction to Mr. S's intense hatred was to feel falsely accused because the anger did not belong to him. He occasionally felt some relief when his patient would regard him briefly as an idealized object but this turn of events led Mr. S to hate all the more because envy then emerged.

Mr. S: I see all your books on those shelves, and I feel a sense of loathing toward you. I could never read that many books. I can't ever hope to have the amount of knowledge that you have. I feel like getting up and tearing down all your bookshelves.

Mr. S often would pound his fist lightly on the wall adjacent to the couch as he railed against Dr. H. He would exert some control over the pounding so that it would stop just short of being a disturbance to the occupant of the office next door. Dr. H could never be certain, however, and Mr. S's behavior placed his analyst in a disturbing dilemma. If Dr. H did nothing about the pounding, he felt like he was colluding with this "acting in" by allowing Mr. S to disturb his neighbor. If, on the other hand, Dr. H told Mr. S to stop the pounding, he worried that he would be allowing himself to be manipulated by his patient into a nonanalytic posture in which Mr. S could then rightly view Dr. H as attempting to control him. This was only one of the many dilemmas Mr. S presented when Dr. H felt damned if he did and damned if he didn't.

Mr. S would repeatedly try to maneuver Dr. H into a corner where the analyst would wittingly or unwittingly imply that he hated the patient. The barrage of contempt day in and day out took its toll on Dr. H, as he was not always able to contain the patient's projected contents adequately. Dr. H would occasionally make sarcastic, contemptuous, or counterattacking comments as he sought to survive in the lion's den that Mr. S had created in his office. On one particular day Mr. S accused Dr. H of not empathizing with his point of view. Dr. H responded with some exasperation in his voice.

Dr. H: You treat me with contempt and then expect me to empathize with you. I wonder if this is a part of a larger pattern of expecting others to love you and take your side without earning their regard.

Mr. S: So you do hate me. I knew I could get you to admit it.

On another occasion the following exchange occurred:

Mr. S: I don't understand why you give me no credit whatsoever for being able to hate you. Don't I get two points for expressing my anger?

Dr. H: What do you see as positive about that?

Mr. S: Because all my life I've suppressed my anger. Now I'm finally getting it off my chest.

Dr. H: You are speaking of a side of you that I haven't seen. All I have seen is unrelenting hostility.

Mr. S: Then you must hate me! You can't handle me! I'm too tough. I get a thrill out of triumphing over you and being the only patient of yours, who will not get better, who won't change in the way that you want me to.

Mr. S had made a couple of good points. Indeed, Dr. H did feel sometimes that he could not handle Mr. S and he certainly did hate him at times. One of the most distressing aspects of the analysis for Dr. H was that Mr. S appeared completely uninterested in receiving help from him. The patient confirmed the accuracy of this observation when the analyst pointed out to him that he repeatedly defeated any effort on the analyst's part to help him understand himself. Mr. S's response was explosive:

Mr. S: I don't fucking want your help! I want you as a target! I attempt to provoke you. I have a fantasy of throwing up on your floor or shitting on your couch. I want to rid myself of all this. I hate it when I can't provoke you into taking my anger. Then I have to take it. I need a place to dump. I have been using you like a pay toilet. (pp. 102-104)

From the very beginning of this fragment and from the beginning of the therapy, the patient comments on the relationship between him and the therapist, which reveals an early intense transference. The transference is manifestly negative and it prevents the development of a therapeutic alliance, which becomes the primary concern of the therapist and is an ingredient of the state of impasse that is gradually established. Another aspect of the process that needs attention and becomes a source of difficulties that lead to impasse are the patient's envy, his acting out behaviour, and his surprising lack of desire to understand his own psychological functioning. Clearly, the therapist's countertransferential hatred contributes significantly to the arrest of the therapeutic process.

### **Object Relations Perspective. The Patient who Needs a Container**

We can attempt to understand the negative transference from the point of view of Steiner's theory by asking what is the position of the client: is it a paranoid-schizoid position, a depressive position or is the patient in a psychic retreat, out of real contact with the therapist, struggling not to experience anything? This question can be answered by paying close attention to the nature of the patient's defenses, the underlying anxiety and quality of the relationship with the therapist.

The attitude of contempt for the therapist, mentioned in the first paragraph may be understood as a manic defense. In the internal world this defense corresponds to a relationship of contempt for an object that is needed, admired and loved, so that the loss of that object is not experienced as important, and the dependency on the object is denied. This represents an attempt to evade the intense pain of guilt in the early depressive position, in which the anxiety is that one's destructive and envious impulses had hurt or destroyed the good object. The presence of manic defenses against the depressive anxieties does not mean that the patient is in a depressive position. He seems to be oscillating between paranoid-schizoid position, where he feels attacked mercilessly by the therapist and a psychic retreat where he is out of real contact with the therapist and does not have feelings of his own, except his hostility, which for him is only as a reaction to the therapist's assaultiveness.

The first statement of the patient in the presented case fragment about his own and the therapist's assaultiveness, is an example, I believe, of projective identification. The patient projects the assaultive part of the self in the internal object, (which in the transference is the therapist) and feels that this part then, attacks him back. He recognizes that part in the therapist (the therapist is seen as assaultive) and tries to control the therapist through that

projection (by eliminating from the relationship any possibility of receiving something positive, helping or new from the therapist).

From the point of view of Steiner's theory, the patient is struggling with excessive amounts of inner destructiveness. The amount of personal aggression or death instinct the patient has to contain is overwhelming. The choice for him is either to feel that the guilt and responsibility that he can injure (depressive position) or the fear that he can be attacked viciously (paranoid-schizoid position); he is either persecuted internally by a gang of hostile objects (created by his projections), or surrounded by objects that are injured, dying or dead as a result of his murderous attacks. In any case, it is a world he cannot and does not want to face. That is why he needs the other, the therapist, to achieve some peace of mind by placing the badness or vulnerability into him as if in some kind of a safety deposit box. In the internal world, that containing relationship corresponds to an unconscious phantasy of a relationship with an object, in which the boundaries between the self and the object are obliterated.

So, if the therapist listens through that channel, he can hypothesize that what this patient finds unbearable about his inner destructiveness, is the phantasy that he destroyed his good internal object (and therefore the good therapist, too): it is the pain of the depressive position that he attempts to avoid. Since his anxiety and the guilt are unbearable, Mr. S needs to project into the therapist the destructiveness, which he cannot contain within himself. The major defensive mechanism he uses for that purpose is projective identification. This is what the therapist encounters from the beginning of the therapy: to be used as a toilet: a container for the bad and unacceptable parts of the self.

What would be a good containing in this case? To accept the projections placed into him, without trying to deflect them, retaliate or return them to the patient prematurely.

Eventually the therapist is supposed to return to the patient what was projected into him only when he was able to detoxify it for the patient: to turn the poison into food. The patient at this stage does not have a capacity for handling his anxiety in any other, more sophisticated, way. Containing takes into account when and in what form the patient can take some of the projected material back and start reintegrating it. For prolonged periods of time, the therapist has to keep to himself the unpleasant feelings like guilt, hatred, shame, fear of separation and so on, before suggesting that they actually have something to do with the patient's state of mind, his feelings and intentions. The patient does not want to own these bad parts and be responsible for what happens in the relationship. If the therapist returns the projections prematurely, the patient learns that his psychological contents are indeed intolerable. As a result, he may double his efforts to evacuate these contents instead of developing a capacity to keep them for himself and taking responsibility for them. Neither Steiner, nor Bion, who invented the idea of containing, offer a "protocol" about how to contain the patient's anxiety. It is an emotional process that most of all includes recognition of the patient's state of mind and, importantly, the therapist's state of mind, too. I suppose that with Mr. S the process of containing the patient's destructiveness may look like a careful exploration of his experience and view of the therapist. When did Mr. S feel for the first time the therapist was assaultive? What did he think of that? How did that make him feel? At the least one of the messages is that the therapist is not frightened from the assaultive part; neither is he rejecting it. However, the therapist has to refrain from interpreting, as interpretation may lead to forcing the patient to accept responsibility for the badness in the therapeutic relationship (Steiner, 1993). This is in contrast with Kernberg's approach (who interprets relatively early in the treatment in order to undo the negative transference) and with Adler's approach (who

interprets the negative aspects of the transference as a reaction to disappointment and a defense that prevents the development of self-object transference). Based on Steiner's recommendation for prolonged containing and refraining from patient centered interpretations, I assume that the therapist could start exploring the patient's relationship to his aggression while the aggression is still seen as carried by the therapist. In that way the separateness between self and object is not forced into the patient's awareness and neither is the responsibility about his murderousness. It seems in that approach the most powerful defense is not challenged for a while, until the need for that defense decreases as a result of a new experience provided by the therapist's containment.

The problem in this part of the interview and the impasse coming with it is the therapist's difficulty to contain the hatred projected onto him. "You can't handle me" is a sign that the patient perceives insufficient containing. Part of the patient's anger at the therapist comes from his feeling that his projections were not contained. Trying to deflect the negative transference to a third imaginary party is also a problem of containing, indicating that the therapist cannot bear the badness placed onto him. Therapist's desire to be seen by the patient as a good object is an acting out of the therapists' anxiety about that badness. Casement (1985) states that in order to become eventually situated in the patient's internal world as a good object, the therapist need not to try to become a good mother, no matter how tempting this idea may seem. The good object in therapy is not someone who is better than the original object. Rather, it is someone who survives being treated as a "bad object," without collapsing under that experience or retaliating because of it (Casement, 1985, Winnicott, 1971).

In the context of this view of the patient's unconscious dynamics, the lack of some degree of positive feelings towards the therapist and the lack of a therapeutic alliance,

revealed in Mr. S's refuse to work together with the therapist to understand his own conflicts, is a problem that cannot be fixed easily with one intervention, even if it is a very clever one. Mr. S has a much more serious need: to handle his own murderousness. This requires the therapist to be a container into which he can dump what he cannot handle himself. A strong therapeutic alliance will emerge only when the patient feels sufficiently contained and understood. In that sense, the emergence of a good therapeutic alliance with this patient should be considered an achievement of therapy.

The situation of impasse is also related to the patient's envious relationship towards the therapist and his acting-out behaviour; his envy and acting out strategies need to be understood and addressed by the therapist. Mr. S's envy explains why the positive transference is scarce. Envy, according to M. Klein implies that the self recognizes that the object is good and nourishing, but cannot stand to know that this goodness belongs only to the object, not to the self, and destroys it even if it means that he deprives himself of the good breast that feeds him and loves him. So, envy tries to obliterate awareness of one's separateness from the object. In the Kleinian tradition envy is considered at the root of the negative therapeutic reaction and therapeutic impasses. Steiner does not specifically address this issue but it seems that the negative therapeutic reaction cannot be resolved with containing and perhaps a more Kleinian approach in which envy is always interpreted, is applicable.

Mr. S's pounding on the wall and repeated railing at the therapist can be seen as acting out in the transference. They are both examples of acting out, since they are behaviours that replace the talking about the patient's feelings. Acting out represents an attack on the therapeutic task of communicating with the therapist and understanding

(Etchegoyen, 1999). Steiner suggested that the patient might need to organize his relationships in such a way as to evade any meaningful contact with the therapist, which may expose the vulnerable dependent self of the patient. Then the purpose of the acting out can be seen as a way to withdraw in the retreat that leaves the therapist helpless to intervene; the meaning is that the patient avoids contact, any contact that would open him to the reality of another person and disturb his well-guarded equilibrium. The pathological organization of defenses makes his world orderly and predictable, while contact means an exposure to the threatening unknown.

It is said in the description of the case regarding the acting out that the therapist felt placed in a paradoxical situation, where whatever he did was wrong. It seemed that there was no good or right choice. From the object relation perspective it may mean that the purpose of Mr. S's communication to the therapist was above all to try to force the therapist into passivity and paralysis, to have him end completely under control. This can be seen as the power of the pathological organization, which tries to destroy and undermine the therapeutic process in order to prevent contact and development. The patient needs the object paralyzed to prevent any surprises; he has to control the object completely in order not to feel separation and loss. Thus, the client's withdrawal from contact and struggle to control the therapist constitutes a major part of the situation of therapeutic impasse that the process has reached. Steiner does not address this issue directly, but it seems to me that the therapist's way to address this could be to interpret the meaning of the acting out and function of the paradoxical communications of the patient in the service of avoiding contact.

One possible conclusion regarding the therapist's approach is that there are aspects that are better not interpreted, and others that are better to be interpreted. In terms of the need

for a container for contents the patient needed to evacuate, it is better to postpone the interpretation until that need decreases in the context of a reliable containing relationship. On the other hand, there are aspects of the patient's behaviour that if not discussed could seriously disturb the therapeutic process. Interestingly, from what was said above about projective identification, envy, acting out and psychic retreat, it seems that the patient's anger itself is not such an obstacle. But the patient's need for complete control over his object/therapist, as well as the need to be unreachable for contact, seems to be aspects of the negative transference that the therapist has to address directly in interpretation; if not, the result may be paralysis of the process.

At the point when the therapist would wittingly or unwittingly implied that he hated the patient, Mr. S's projective identification had succeeded; the therapist's empathic abilities were clearly eroded and the patient felt relieved from the burden of his own hatred. The paranoid-schizoid mode of functioning is highly contagious and eventually the therapist's ability to oscillate between the paranoid-schizoid and depressive positions became impaired: the therapist seems to reside in the paranoid-schizoid more than it is healthy for the relationship. The therapist identified with a hating and revengeful object in himself and in the patient's invasive projections into him, and his interventions became acting out of his countertransference hate.

An interesting aspect of Mr. S's view of the relationship with Dr. H is his statement he expected praise and respect from his therapist for being able to hate the therapist. From Steiner's theoretical perspective, this may be seen as a manifestation of the perverse side of the patient's personality, namely, a strange persistence and pleasure in doing what is known to be wrong and bad: a direct expression of the part of the personality dedicated to

destructiveness. It is interesting what the therapist's intervention would be if he sees that statement as a manifestation of the perversity of the client, given that he tries to refrain from taking the role of the patient's superego and telling the patient what is right and good to do. I think that what can guide the therapist is idea of the containing function of the therapist. In this case the containment could be conveyed to Mr. S not by focusing on the perversity of the solution to his destructiveness, but in the form of empathy with the patient's need to see the therapist as not scared by the patient's hostility (it does sound like the patient's need for the therapist to accept his aggression). What is being contained is the patient's pain and fear, as opposed to focusing on the pleasure from the gratification of his aggressive impulses.

The patient's statement at the end of this fragment surprisingly resembles the Kleinian vocabulary and her notions of projective identification and laboratory transference. Throwing up on the floor and shitting on the couch represent the bad substances the patient is getting rid of, which if kept internally would torment him. If the patient believes that he is putting vomit and shit in the therapist, the therapist needs first of all to see them as such, that is, recognize the primitive dimensions of the patient's experience, without being disgusted by the patient or hate the patient for that. So, it seems that the therapist can transform the patient's experience first of all by recognizing his countertransference hatred and disgust and not act it out. In other words, what can be transformed in the beginning are the therapist's feelings about what the patient is putting into him. That transformation has to precede the interpretation, if interpretation is given at that point.

Finally, the situation of impasse is created by the discrepancy between Dr. H's idea of what the therapy is about and Mr. S's uses of the therapy. The paradox of this therapeutic situation is that the patient wants to regain his equilibrium by getting rid of the deeply

disturbing parts of himself and withdrawing to a psychic retreat, while the therapist wants to help the patient emerge from his retreat and understand how his mind works in order to allow his development to resume. The therapist may see that as a perverse side of the patient, which hates to be understood and hinders communication. This situation creates a lot of discomfort in the therapist and although the patient is probably aware of this discomfort, he does not want to accept his role in the creation of the therapist's state and does not want to focus on his own internal problems. The patient is afraid to examine his own mental processes because it would mean to entertain the idea that they belong to him - a thought so deeply threatening that any space for further thinking and reflecting is obliterated. The patient uses his words not to communicate, but to have an impact on his object, the therapist; his words are intended as actions that affect the analyst and his state of mind so that he ultimately becomes the object the patient wants him to and thus becomes completely predictable and under the patient's control (projective identification). The analyst's words are also experienced as actions indicating something about the analyst's state of mind rather than offering insight to the patient. The therapist and the patient have different agendas about the therapy: the analyst believes that his task is eventually to help the patient gain understanding, and the patient cannot tolerate or does not want understanding. Consequently, the therapist interventions are never heard the way they are intended to be heard and the therapist remains helpless until he is aware of the patient agenda and the motivation behind it. This is what Bion calls reversible perspective and it is one of the major reasons for the state of impasse in Mr. S's therapy.

How does this perspective on the patient's dynamics inform the therapist's actions?

From Steiner's perspective, the approach to this situation should be to keep a delicate balance all the time: if the therapist insists too heartily that the patient has to gain insight and develop,

the withdrawal to the retreat may become obstinate, if he becomes passive, the patient may see him as completely controlled or intimidated by the pathological organization, and therefore, incapable of introducing any difference in the patient's psychic life. Steiner (1993) suggests that the patient may not be interested in understanding himself, but he still wants to be understood by the analyst. The therapist has to choose on whose state of mind to focus: on the patient's or on his own. Steiner indicates that the patient, at least initially, is concerned with the way his objects behave, with what the therapist thinks and feels, not with the functioning of his own mind. It can be said that interpretations then, have to take into account the patient's state of mind and put into words the situation as close as possible to the way the patient sees it. An interpretation, is often formulated as "You experience me as...", "You are afraid that I..." "You were relieved when..." (p.133). This gives the patient the experience of being understood. Steiner calls this type of interpretations analyst-centered, as opposed to classical interpretations, which he calls patient-centered. If the therapist gives a patient-centered interpretation, it implies that the patient is responsible for what happened between the two participants. It creates so much guilt that the patient withdraws in the retreat or paranoid-schizoid position. At this stage it is more productive to concentrate on the patient's view of the analyst and avoid making links between the two.

To summarize: the goal is that the patient feels understood and contained. Successful containment leads to integration and the experience of being understood provides a context where further development is possible. Steiner (1993) emphasizes however, that while containing brings relief for the psychotic and borderline patients, it cannot be expected to lead directly to growth and development in them. It is because the reduction of one's anxiety depends on the presence of the containing object; the capacity to contain is not yet

internalized, as the separateness from the object is not acknowledged and tolerated yet.

Because of that even if the therapist is functioning sufficiently as a container, he can expect that Mr. S would still deal with his inevitable experiences of separateness by projective identification, trying to exert omnipotent control over the therapist, in order to make him absolutely predictable and controllable.

The therapist who does not collude completely with the patient's projections is capable of temporarily stepping aside from the patient's omnipotent control, which leads to achievement of some degree of separateness. Although the patient's further development in therapy is based on containment, it is not in any way limited to it: insight and understanding are necessary to help the individual start using his own mind to know himself and to contain his feelings. Evidently, this is the task that has to be accomplished at the first phase of Mr. S's therapy.

It is a fundamental shift for the patient to become interested in understanding himself and it implies a grown capacity to be alone, to perform functions which were formerly performed by his objects. This requires a capacity to tolerate mental pain and is associated with a move from paranoid-schizoid to depressive position. While the ultimate goal is to help the patient enter the depressive position and achieve separateness from the object, the task in the beginning of the therapy is to create the conditions, under which the patient can emerge for contact and utilize these "islands" to interpret his unconscious phantasies. The therapist, on the other hand, also has to try to maintain his depressive position perspective that would allow him to see the patient as a whole person, not as a totally bad part object with evil intentions towards the therapist.

## **Kernberg's Theory: Undoing of the Negative Transference**

From the perspective of Kernberg's theory, the negative transference is an expected development in the therapy of a patient with borderline personality organization. It is the systematic focus on and elaboration of the manifest and latent negative transference, which is one of the main characteristics of the psychotherapeutic process (Kernberg, Selzer, Koenigsberg, Carr & Applebaum, 1989).

Initially, the therapist diagnoses each primitive part-object relationship revealed in the transference by trying to determine what the patient's fantasy about the momentary relationship between patient and therapist, the dominant affect, and the self- and object-representations are. Kernberg assumes that a particular dyad is alternately projected onto the therapist, so that for a time the therapist is experienced as the part object, and then, as the part self. The therapist working within Kernberg's paradigm expects a constant shifting between mutually dissociated states, between hating and idealizing transferences, as evidence of the excessive use of the mechanism of splitting.

In the case fragment, the transference seems to be dominated by a negative transference. The patient, Mr. S, can be seen from the conflict theory's perspective as struggling with his excessive aggression through splitting himself and his object into all good and all bad, and projecting into the therapist the bad self or object images, linked with an aggressive drive derivative. Then the patient reintrojects an image of the therapist as hating and dangerous, which easily becomes a vicious circle of projection and reintrojection.

Kernberg (1975) also draws attention to what he calls the borderline patient's need to defend against his/her negative transference, which seems relevant to the case of Mr. S. According to Kernberg, the emergence of primitive, especially negative, transference

reactions that occurs in the transference regression, is particularly threatening for the patient. The patient increases his/her efforts to defend himself against them, which greatly contributes to the difficulties in the treatment. The patient uses the same defenses that reinforced his ego weakness in the first place (splitting, projection and projective identification, denial, omnipotence and devaluation) to evade the negative transference he begins to experience in relation to the therapist. Mr. S's communication from the very beginning of the case fragment reveals an extensive use of projective identification, which we can assume, is mobilized to protect him from his negative transference. He feels mistreated, attacked by the therapist, while at the same time he has "empathy" with the projected intense aggression: although he is aware of his own hostility, he feels that he is only responding to the therapist's aggression; he is justified to be angry and aggressive towards the therapist and is compelled to exert powerful control over the him with all means available.

In order to undo the vicious circle of projections and reintjections of the bad self and object representation and to affect change the therapist has to interpret the negative transference. On the level of interventions this is the most prominent characteristic of the Kernberg's approach that distinguishes it from Steiner and Adler's approaches. Kernberg (1975) emphasizes that it is lethal for the process if the therapist tries to evade or deny the negative transference in order to build a therapeutic alliance with the patient. It creates emotional shallowness, pseudosubmission to what is seen as therapist's demands, severe acting out or interruptions of the treatment. In other words, the evasion of the negative transference instead of helping the establishment of an alliance, leads to a therapeutic impasse and rupture. On the contrary, the focus on and the interpretation of the negative

transference are essential when the therapist tries to build a therapeutic alliance with the patient. Kernberg (1975) affirms that consistent undoing of the negative transference is indispensable prerequisite for broadening of the observing ego and for consolidating the therapeutic alliance. The observing ego is relatively absent in the borderline patient, as a part of the general ego-weakness. But the excessive defensive operations mobilized to protect the patient from his/her negative transference further prevent the emergence of the observing ego in the therapy. It is the observing ego that establishes a therapeutic alliance with the therapist, but this becomes impossible when the therapist is seen as a powerful, dangerous enemy. Particularly when the negative transference is strong from the very beginning, an early interpretation may be indicated to prevent its disruptive effects on the therapeutic alliance. For Kernberg (1989), interpretation is the fundamental technical tool of the expressive therapy with borderline patients. Taking into account that an interpretation is effective when the patient is emotionally prepared for it, he recommends that the context for an interpretation is created at first by clarification and confrontation.

Clarification involves "invitation to and request of the patient to explore any data that are vague, puzzling or contradictory" (Kernberg 1989, p.16). In the case of Mr. S the therapist may focus the patient's attention on the fact that the patient had agreed in the initial contract to the same conditions he was later complaining about and invite the patient to associate and think about the emergence of his negative feelings regarding these conditions. This not only aids the patient in his reality testing, and thus reduces the heat of the negative transference, but also actively attempts to involve him in a process of exploration of his behaviour and psychological functioning. Clarification brings out new elements in the patient's communication, which may help the therapist understand previously inexplicable,

or annoying behaviour and help the patient create a more complex version of the therapeutic situation that is more difficult to be interpreted in a black-or-white fashion. Clarification can be made from a position of knowing or from the position of not knowing. The not-knowing position is preferable, because the therapist is more open to hear unexpected elements in the patient's story. Clarification may help the therapist avoid the aggravation of his own countertransference reactions, as they are based both on the therapist's fantasies and identifications with the patient's material. Clarification, with its potential to bring out new information, elucidates the differences between the patient and the therapist's projections onto him, which allows for revival of empathy.

Confrontation is the next step in the preparation for an interpretation. The aim of the confrontation is to make the patient aware of the conflictive and inconsistent aspects of his/her communication. This is particularly important with a borderline patient who makes extensive use of the mechanism of splitting. Confrontation brings together conscious and preconscious material, or two contradictory mental states, which may coexist in the patient's consciousness without influencing each other. Regarding what is described as an envious attack in the case of Mr. S, the therapist may explore what the books represent for the patient and confront him with the fact that the feeling of loathing and the impulse to tear down all the therapist's bookshelves came after the patient felt that he received something positive from the therapist.

After careful and persistent preparation the therapist will interpret Mr. S's negative transference. The interpretation would be based on the therapist's perception of the transference and the defenses against it (the projective identification). As a result, the use of primitive defensive operations will diminish and the ego strength will increase.

Kernberg insists that the interpretation of the negative transference should stop at the level of the here-and-now or only references should be made to the patient's past history, and no speculations about the original unconscious conflicts of the childhood. According to Kernberg, the more disturbed the patient is, the more complex and indirect the relation between past and present becomes. Particularly with borderline and narcissistic patients, it appears that after years of treatment the therapist may discover that the past history was completely different from the one told in the very beginning of the treatment. The present psychic structure revealed in transference does not directly tell the therapist how the structure was established and developed over time, or what was the actual childhood history that provided the context for the development of that structure. That is why the links to the "real" history are highly speculative and uncertain and should be avoided. At the same time Kernberg recommends that the interpretation of the negative transference be completed by a systematic examination and analysis of the manifestations of the negative transference in the patient's interpersonal interactions outside the therapeutic relationship. This fosters the patient's reality testing and responsibility and helps ventilate and disperse the intense negative emotions.

From Kernberg's perspective acting out behaviour also calls for immediate attention and interpretation, since it both reveals important information about the patient's conflicts and, at the same time, prevents insight and change by its defensive function. Kernberg's recommendations regarding the acting out are clear and systematic; they represent one of the strongest elements of his approach. Kernberg recommends that acting out be systematically explored and resolved by interpretation. According to him however, the effort to deal with the acting out behaviour with interpretation alone, frequently fail. It is partly because of the

loss of an observing ego through projective identification and the loss of ego boundaries and reality testing that goes with it. But the acting out behaviour is resistant to interpretation also because it gratifies the instinctual needs of those patients particularly regarding their intensive preoedipal aggression. This gratification of instinctual needs represents a major transference resistance: because the patient discharges all his instinctual tensions, his/her anxiety disappears and he can present a composed side of himself outside therapy. Kernberg suggests also, that satisfaction of the sadistic needs of the patient makes working through the transference impossible because it provides far more gratification than any understanding or resolution of the transference may provide. Therefore, the therapist does not need to hesitate to interpret the acting out if he understands it, or limit it, particularly when it provides more instinctual gratification than the search for understanding. Mr. S's pounding on the wall can be seen as an expression in the transference of a sadistic or teasing internalized object relationship, but an interpretation and involvement of the patient's in a process of reflection on that may not be possible. The patient's statement that he expected praise and respect from Dr. H for being able to hate him can be seen along the same lines of transference acting out that provides him with instinctual gratification of pathological, aggressive needs. Kernberg points out that some patients obtain much more gratification of their pathological instinctual needs in the transference than would ever be possible in their extratherapeutic interactions, and because of that, they tend to choose the transference acting out over the exploration and understanding.

In this case, Kernberg advises that the therapist introduce some structuring parameters to control the acting out. He thinks that the therapist has to take a firm stand and create a structure within the therapeutic situation, which he/she should not abandon. Dr. H could

insist on limiting the amount of insults and railing at him permitted in the hours, so that the aggression would enter the transference; he could also suggest or insist that instead of pounding on the wall the patient try to give words to his feelings. From Kernberg's perspective, the therapist must present it as a condition for continuing the treatment that Mr. S exercises some degree of control over the form and degree of expression of his feelings in the sessions. The goal of this structuring is to help the patient become more reflective and also to prevent the therapist from acting out his countertransference, especially the chronic countertransference reactions which tend to develop in the intensive psychotherapy with borderline patients.

Kernberg (1989) suggests that only if interpretations fail repeatedly to reduce the acting out behaviour, should the therapist instruct the patient to stop the behaviour. When the therapist introduces new "parameters of technique" in that way, he always interprets the potential meaning of the acting out behaviour and explains why he had to stop it. This is related to the issue of technical neutrality: Kernberg suggests that the therapist have to be particularly careful not to move away from technical neutrality. For Kernberg technical neutrality "refers to the therapist's position of equidistance from the emotional forces in conflict in the patient - the id, superego, external reality, and acting (in contrast to the observing part of the patient's ego)" (1989, p.23). The therapist should try to function as both a participant and an observer, aligned with the patient's observing ego. Any interpretation of the transference is ineffective if made outside the position of technical neutrality. When in the work with borderline patients, the therapist chooses to introduce "parameters of technique," that is, temporary modifications of the technique that move the therapist away from the position of technical neutrality, he always has to resolve these modifications and

reinstate his technical neutrality by interpretative means, namely, interpreting and explaining what made him move away from his technical neutrality. Parameters of the technique are only a temporary measure, and as soon as they fulfill their function, therapy has to proceed without them.

The statement of Mr. S that he does not want the therapist's help to understand himself can be seen as reflecting the relative absence of an observing ego. To seek satisfaction and relief instead of understanding is a form of acting out and so it has to be addressed as an acting-out behaviour. Kernberg repeatedly stresses the need to facilitate the emergence of an observing ego. This is achieved through interpretation and undoing of the negative transference, blocking of the transference acting out and direct focusing on the observing functions of the ego. These also represent the fundamental conditions for change and growth in therapy (Kernberg, 1975).

In other words, from the point of view of Kernberg's theory, the impasse in the therapy with Mr. S is a result of insufficient interpretation of the patient's defenses against the negative transference and envy and the therapist's hesitance in introducing parameters of technique, which would limit the acting out behaviour and restore the therapeutic work of exploration.

To summarize: the task of the therapist in the initial stages of the therapy with Mr. S is to remove the defenses against the experience of negative transference and to constantly undo the negative transference. This is achieved with the use of clarifications, confrontation and interpretation aimed at reducing projective mechanisms and if necessary, by temporary introduction of a firm structure. The development of a therapeutic alliance and observing ego are actively encouraged indirectly by interpretation of the negative transference and by direct

focusing on them. Only at a more advanced stage of the treatment, the task becomes one of interpreting the split-off positive and negative introjects, as being defensively kept apart in order to protect the good relationship from contamination and destruction by the bad one. In other words, the therapeutic task at a later stage is to help the patient tolerate ambivalent feelings towards the same object and ambivalent images of the self. Initially, the interpretations focus mostly on the here and now as long as transference reactions remain primitive. Any premature genetic interpretations may foster intellectualization as a defense and at times may increase the confusion between past and present in the patient's mind, leading to transference psychosis. Insight into one's past and reconciliation with one's parental images becomes possible only after sufficient ego strength is achieved; and ego strength emerges as a result of a continuous process of integration and assimilation of dissociated introjects with opposite valence.

#### **Adler's Deficit Model. Facilitating the Development of Selfobject Transference**

Adler assumes that aloneness is at the core of the borderline patient's pathology. But the patient in this fragment does not speak of aloneness in the beginning of his treatment. What the therapist faces is rage and hatred without any sign that the patient needs him. Then, what are the sources of the Mr. S's rage? According to Adler's deficit model, the major structural characteristic of the borderline pathology is an insufficiency of the positive holding and soothing introject. Borderline patients are not seen as capable of solid evocative memory in the area of object relations and are prone to regress in this area to recognition memory or earlier stages when faced with certain stresses (Adler, 1985). Particularly, the patients cannot soothe themselves when facing separations.

Then, from the perspective of the deficit theory, the therapist can view Mr. S's rage as related to an experience of separation. At least two sources of the experience of separation can be discerned. One is related directly to the therapeutic setting. The establishment of the therapeutic setting represented by the therapist's fee policy, the time limits of the session, or therapist's abstinence are designed to introduce for the patient the experience of boundaries and separateness. Mr. S's transference rage at the therapist may be seen as related to the therapist's assertion of his separateness through the boundaries of the therapeutic setting. Underlying the rage, are probably both extreme dependency needs and fear of losing one's identity and separateness from the object. This is what Adler and Buie (1985) call need-fear dilemma that causes the patients to act out or withdraw from relationships, which, in turn, increases their feelings of aloneness and hunger for an object. The other source of separation experience is the termination of the previous analysis. It is mentioned that the patient's last analyst had left town and that the therapist interpreted the patient's rage as connected to that analyst. Then the patient's rage can be related to a feeling of abandonment and loss, which can partly be the reason for him starting new therapy. It may be hypothesized that the separation from the previous therapist has led to regression in the patient's psychological functioning: loss of the positive introject and loss or evocative memory about any caring attitude on the object's part. One can also hypothesize that the separation from the last therapist left the patient so hurt and angry, that he was determined most of all not to allow the new therapist to become important for him and seduce him into trust and dependency. Then, although the Dr. H's interpretation that the patient's anger belongs to the previous therapist may be correct, the patient has to reject it, probably because he needs to hate an object that is present, not one that is lost. He may reject the interpretation also because his aloneness and

vulnerability can be exposed if he admits his anger at the previous therapist, or in order to make sure that there would be no chance of positive feelings and attachment towards the new therapist. Another source of the patient's rage may be a more chronic feeling which pervades transference that the holding provided by the therapist-selfobject is never enough to mitigate the internal aloneness. The therapist or other holding selfobjects are insufficiently available relative to the patient's needs: the holding function is not performed to the degree it is needed. This is experienced by the patient as a threat to his "entitlement to survive" which provokes a deadly rage on his part. The rage is deadly because the person wishes to murder its object and under the primary process thinking he actually experiences the object as dead as a result of its attacks. "The urge to destroy the therapist is felt as an accomplished act" (Adler, 1985, p.35): in the inner world this contributes to the further sense of loss of the holding introject and the evocative memory capacity. In his rage the patient attacks the therapist and wants to destroy and expel him from the inner world. Mr. S may feel that he has lost or murdered the therapist particularly when the therapist under the pressure of the projective identification acts out his countertransference and thus from a patient's perspective turns from a good object into a bad one. The therapist is also distorted by projections of the patient's hostile introjects and by the patient's envy. Once provoked, his rage cannot be sustained without a regression and loss of the internal soothing and holding structure, because this structure is inherently fragile. Thus, at some point the patient is left without an internal capacity to soothe and reassure himself in the goodness of the external object - the new therapist, and his rage seems endless.

Adler's model suggests a particular perspective on the development of the therapy and the goals of therapy. Therapy is ultimately about curing the patient's aloneness. The

therapist expects that the aloneness issues will arise in treatment as soon as some level of trust and dependency is achieved. When the aloneness issues enter the patient's communication, the goal of the treatment becomes to address them properly, by providing the patient with an opportunity to create the missing holding introject.

Initially, the major goal of treatment is to establish and maintain a therapeutic relationship in which the therapist can be used over time by the patient as a holding selfobject. Only after this kind of relationship is established, the patient is able to develop insight into the nature of his/her aloneness and, most of all, to acquire a solid evocative memory of the therapist as capable of holding, which is the basis for the creation of a holding introject. In that way, the arrested developmental process is set in motion and the structural deficit is repaired.

In order for this to happen, the therapist has to be willing to become a selfobject, which offers continuous holding and soothing presence that manages to mitigate the patient's anxiety. Along with the therapist willingness, there are significant obstacles, part of the patient's pathology, which prevent the internalization of a holding and soothing object. These obstacles to developing selfobject transferences all spring from the experience of abandonment. The patient's rage is considered the most important and most powerful of these obstacles and it certainly makes up a significant part of the difficulties in the case of Mr. S. Rage is the first reaction to feeling abandoned by the therapist, because the therapist's holding is never enough to fill in the borderline person's aloneness and so reactions of rage are inevitable. In turn, the rage leads to fantasies that the therapist is killed or lost and further feelings of aloneness. Other possible impediments to the use of the therapist as a holding introject, not directly revealed in the material of the case but worth considering, are the

patient's fantasies of incorporation and fusion. Incorporation and fusion are also attempts to deal with aloneness, by taking the object in, or merging with it. That brings intense anxiety of losing one's subjectivity; either the self, or the selfobject, or both, are destroyed in that merger; in order to protect himself from the loss of subjectivity, the patient distances him/herself from the selfobject. Therapeutic work in the initial phases of treatment consists of constant focus, interpretation and working through of these obstacles. It seems that the Adler's model does involve interpretation at the initial stages of therapy, but the interpretative activity is limited to removing the obstacles that prevent the development of selfobject transference.

Mr. S's rage at the therapist is clarified and interpreted from the point of view of the hypotheses created within the model. His acting out behaviour has to be interpreted also, possibly as the patient's way of creating a distance from the therapist in order not to lose his subjectivity in the relationship under the pull of his needs for a selfobject. The same applies to the patient's envy emerging out of the need for an object that has everything the patient lacks: it needs to be interpreted, as it prevents the establishment of selfobject transference.

Adler, following Winnicott (1971), also underlines that in order for the patient to believe that he has a reliable and enduring selfobject the best the therapist can do, is to survive the attacks. Both the survival of the patient's murderous rage and the containment of the unacceptable aspects of the patient's psyche projected into the therapist, are supposed to create a holding environment in which interpretations of internal conflicts and phantasies becomes possible. Ultimately, these interpretations are considered the instrument for transformation and change.

In other words, the first stage of the analytic therapy involves insight into what prevents the patient from using the selfobject relationship in order to develop a stable evocative memory and to internalize a holding and soothing object. In order to achieve that, the therapist also attempts to create a supportive therapeutic setting; the amount of support needed for these patients may exceed that involved in most psychotherapies. Transitional objects are given during prolonged separations to maintain the frail evocative memory, extra appointments and telephone calls are allowed, which reaffirm the patient that the therapist exists.

At times it may be necessary to clarify, confront and interpret to the patient that the therapist is different from the hostile introjects or identifications that the patient projects. It is possible that Mr. S's behaviour presents a paradox, characteristic for the relationship most borderline personalities establish with the therapist in the beginning of the treatment. The patients seen from the deficit model perspective require a therapist who is warm, caring and willing to offer himself for selfobject transference. At the same time the patients' capacities to notice these qualities in the therapist, when they are present, are limited. Adler suggests that borderline patients have a capacity to see a relationship more realistically only when the selfobject transferences are firmly established. Mr. S came for therapy after he had lost an important selfobject relationship and was not capable of noticing the therapist's responsiveness and caring. That is why the therapist's behaviour may need to be more active in drawing the patient's attention to his willingness to be helpful, clarify, and explain in order to meet the patient's level of regression. The therapist's goal is to foster a therapeutic situation in which the selfobject transferences can emerge and the pathological aspects of the transference can be interpreted. To achieve this goal the possible excessive gratification must

be weighed against the patient's limited capacity to tolerate deprivation at any specific moment.

From the perspective of Adler's model, the lack of a therapeutic alliance in the case of Mr. S is characteristic for the relationship that borderline patients establish with their therapists. The patients do not usually experience a working collaboration: rather, they stay in therapy because they feel supported, understood and soothed. The therapist, who gives support, understanding and soothing, acts as a selfobject, and the patient is in a relationship, which involves some degree of fusion of the two participants. They do not establish a therapeutic alliance, since that implies a collaboration of two separate individuals and a capacity of the patient to separate his/her transference from the "real" relationship with the therapist. In other words, that means that although selfobject transference may look like a therapeutic alliance, which is a precondition for change and for establishment of a capacity for being in a collaborative relationship, the patient cannot yet participate in a therapeutic alliance. When the patient achieves a sufficient capacity to tolerate separateness, he/she becomes capable of a solid therapeutic alliance. At that point the patient has no more borderline or narcissistic disorder, but has advanced into the neurotic spectrum and is approaching the end of therapy. Borderline patients are not capable of a therapeutic alliance. That is why from this perspective it is dangerous to use alliance-building statements in the initial phases of therapy, as Kernberg suggests. These statements would convey that the therapist is unaware of the nature of the patient's relational needs. The task with Mr. S at this stage of the therapy is to create the conditions for selfobject transference by dealing with the patient's rage as a major obstacle to using the therapist as a selfobject.

From the three models presented here, Adler's approach is the most supportive, because it construes the patient as lacking certain structures that can only emerge after they have been provided by the environment; hence it is initially the role of the therapeutic environment to provide these functions to the patient. Although Steiner's model is a conflict model, according to which the central conflict of the patient is about his or her inner destructiveness, the clinical approach in the initial stage of the treatment relies on the containing relationship with the therapist, that provides a new experience for the patient necessary for the gradual establishment of this containing capacity in the individual. On this continuum from most supportive to less supportive, Kernberg's approach is the least supportive. He sees the weakness of the patient's ego and the patient's consequent inability to deal more effectively with his/her emotions as a result of early pathological solutions of conflicts about excessive aggression. The role of the healing environment (therapeutic relationship) is partly to insist that the patient abandon these early pathological solutions and replace them with more mature ones.

## **Chapter 5**

### **Conclusion**

I will start this conclusion by going back to the linear and circular, to the modern and the postmodern vision of the therapeutic work with borderline patients. The view that there is an entity that can be called borderline personality disorder, presenting itself as a set of rigid, unchangeable and unproductive patterns the patient brings to therapy, allows us to establish guidelines about which interventions work and which do not work with this kind of patient. This is what I will try to do in this chapter: to suggest which interventions for which situations of impasse may be effective.

The view that the self is a product of the encounter and the impasse is a result of a pattern of communication that was gradually established between therapist and patient and that is non-therapeutic, allows us to focus on the therapist and to discuss what may help him to maintain his therapeutic listening stance in the course of therapy.

I will focus on the impasse in the initial stages of the treatment, where the therapist has to deal with problems related to the borderline level of personality organization. This is based on the assumption made by each of the three theories that if the problems are successfully worked through, the patient will achieve a neurotic level of personality organization in the later stages of the treatment. Therefore, the issues raised in therapy and the nature of the impasse would be quite different from the ones that stem from a borderline level of personality organization. I will discuss in more detail what seem to be sensible interventions to some of the problems in the therapeutic relationship with a borderline patient, namely the negative transference, the unstable therapeutic alliance and the acting out behaviour.

When choosing an intervention the therapist needs to assess the problem that created the impasse and answer one or more of the following questions: To interpret or not to interpret? If not, what are the alternatives?

### **Negative Transference and Acting out**

If the negative transference is very intense from the beginning of the treatment and if it is in the context of what seems to be a complete lack of positive feelings towards the therapist, then it poses a threat of a therapeutic rupture.

The therapist has a choice to engage or not to engage with the patient's anger. One possible course of action that may be effective is the one recommended by Kernberg: to engage with the patient's anger by an early deep interpretation of the negative transference (preceded by clarification of reality and confrontation), in order to extinguish or reduce the destructive power of the negative transference. I believe that the interpretation at this stage should be limited only to these aspects of the transference that threaten the existence of the therapy and to the here and now experience in the relationship. Kernberg recommends an early interpretation of the powerful negative transferences to strengthen the patient's ego because such an interpretation clarifies the reality of the treatment and the therapist and the patient's distortions of that reality. In that way the transference is lessened and its disruptive power is reduced. At the beginning of the therapy when the goal is to keep the patient in therapy, these motives for interpretation seem appropriate. On the other hand, interpreting the early disruptive negative transference may also be seen as an appropriate containment of the patient at that stage of the therapy. The therapist functions as a container by not letting the patient's rage or hatred destroy his/her therapy and along with it destroy the patient's hope for growth and change. It is containing also because the interpretation is limited, focusing on

the aggression only in the context of its relation to the existence of the therapy, without any attempt to interpret completely (even if that seemed possible) the transference, which would force the patient to take back his or her projections.

Kernberg's approach of clarification of reality and systematic analysis of transference carries certain risks of making the patient feel under fire, and may encourage a paranoid view of the relationship. Kernberg's notion of patient's "transference distortions of reality" and confrontation of these distortions may introduce a false belief that there is a reality, which the therapist knows but the patient doesn't. This inequality between patient and therapist, introduced by the therapist, may provoke further anxiety and anger in the patient, and provoke the use of the "primitive" defensive mechanisms. So, the risk is that instead of bringing relief and better reality testing, this type of interpretation may provoke negative reaction. Kernberg does anticipate that this type of intervention may create additional problems: if the patient becomes more paranoid and angrier as a result of the first interpretation of the negative transference, Kernberg recommends that the therapist further interpret the patient's transference distortion of the meaning of the therapist's intervention. Kernberg does not tend to see problems with the power imbalance his approach introduces, and consequently does not consider the idea that the patient's anger might be justified. I believe that if the therapist chooses this intervention, he/she needs to be aware of the power issues that are involved. Perhaps the power imbalance cannot be resolved on verbal level at that point, and the possibility to convey equality is limited to the non-verbal domain. It is always better to interpret the negative transference when the therapist is not shocked by the patient's negative attitude and offers the interpretation tentatively, rather than from a position of a superior truth. The intense, highly disruptive transference at the beginning of the

treatment may be more manageable once the therapist diagnoses the borderline pathology. At the early stage of therapy, before the projective identification is firmly established in the transference with the accompanying confusion of boundaries and control on the therapist, there is less at stake for the patient and he/she may be more willing to review his/her perception of the therapist, and accept some responsibility for it. In other words, there are more chances that the intervention would work in the very beginning of the treatment. The likelihood of an overwhelming countertransference reaction and a countertransference enactment is less in the beginning of the treatment, too; that allows the therapist to assess the situation more clearly and intervene more effectively.

Another possibility to approach the early intense negative transference, consistent with Adler's perspective, is to see the anger as a response to experiences of frustration and/or separation, and to assume that these experiences were not assuaged because of the patient's relative lack of holding and soothing introjects. Then the therapist can decide not to engage with the negative transference at all, but instead to focus on and to explore the aspects of the patient's reality that have possibly contributed to the patient's state of heightened anxiety and anger. If the patient agrees to that dance, the beginning of the therapy may be smoother than the one that starts with an interpretation.

Clearly, of the two approaches, Adler's is much less challenging for the patient's capacity to handle anxiety than Kernberg's interpretative approach. Because of that Adler's model seems as a preferable way to start therapy. Kernberg's approach is more anxiety provoking; he assumes that the patient has a greater capacity to handle anxiety: this capacity is built by the very act that challenges it, the interpretation. It is a risky approach however, and I see it as a second choice when dealing with an early negative transference, if the patient

does not respond to the therapist's attempt to ignore the transference aspects of the anger and to explore empathically the current sources of stress in the patient's life.

Often the negative transference does not directly threaten the therapeutic process with abrupt termination but it is intense, unchanging and can dominate the interaction; interpretations do not seem helpful and tend to enrage the patient even more. What should the therapeutic stance be?

I want to suggest that when the therapist makes a decision whether to interpret or not, he/she needs to listen to the patient's capacity to tolerate separateness from the object (the therapist), and, connected to that, to tolerate knowledge (insight).

Insight, I believe, always involves repositioning of one's boundaries. It is important for the therapist to know how much insight into his or her separateness can the borderline patient tolerate. If by interpreting the therapist invites the patient to accept into the boundaries of the self the contents the patient is defending against, it makes sense that these contents have to become more tolerable for the patient. Steiner's approach, for example, suggests that the intolerable psychological contents have to be tolerated and transformed (their meaning) in the therapeutic relationship (through containing) before they could be accepted and integrated by the patient. Kernberg emphasizes early and systematic interpretation, to reduce the projective identification and other pathological defenses and to resolve the transference: the idea being that the ego has to become stronger to tolerate the intolerable psychological contents. Adler focuses on establishment of selfobject transference: clearly, the focus is not on the intolerable psychological contents, but on providing the experience the patient lacked in his/her childhood. Based on what I learned about the borderline patient's difficulties and the borderline structure from the three theories, I assume that an approach

that does not challenge too much the patient's capacity to tolerate separateness and insight has better chances to help: Steiner's and Adler's approaches fit this description.

Steiner's theory and Adler's theory suggest that there is a stage in the beginning of the treatment, preceding the emergence of the capacity for curiosity about oneself and the search for personal truth, when the patient needs to use the therapist, not to relate to him/her as a separate object. In that stage predominate what was described as archaic transferences: the patient assigns the therapist a real role in his/her life, which is different from the way the therapist traditionally sees his/her role – of facilitating understanding and integration, something that happens on the symbolic level of the person's functioning. Basically these two theories assume in different ways that the patient needs to function in a therapeutic environment where the separateness between patient and therapist is only barely if at all recognized by the patient. Both approaches take into consideration that incapacity in the beginning of the treatment to accept the separateness of the self from the object and recommend an adjustment of the therapeutic interventions accordingly, emphasizing containing/development selfobject transference. This is in contrast with Kernberg's approach, which constantly reintroduces in the therapeutic dialogue the issue of the separateness between patient and therapist by systematic interpretation of the primitive defenses and interpretation of the transference. On the other hand, reality has to be reintroduced eventually and the patient's separateness from the therapist reinstated. The advantage of Steiner and Adler's approaches is that the therapist's more supportive stance in the beginning prepares the patient for the subsequent work on the separation from the object. Of the two central to these approaches interventions (containing and encouraging the development of selfobject transference) I think that containing has more advantages because

it is a more complex, multilevel intervention, as it addresses both the intolerable content and the patient incapacity to tolerate this content as a part of the self.

There may be aspects of the patient's behaviour in the treatment that if not discussed or stopped will most probably lead to impasse. Two behaviours of this kind could be distinguished in the case of Mr. S: the behaviours defined as envy and acting out. Containing cannot limit these behaviours. Containing is relevant in the context of overwhelming psychotic anxieties; the purpose of the containing function is to transform the mental states that are intolerable to the patient. Envy and acting out are related to the psychotic anxieties the patient experiences, but they are not psychotic anxieties.

The patient's envy is a particularly interesting aspect of the negative transference. It is an important concept in the British object relations theory and in Kernberg's theory, where it is considered at the core of the negative therapeutic reaction and therefore the therapeutic impasse. Interestingly, although Adler mentions envy and negative therapeutic reaction, he does not particularly discuss them. Perhaps this is because of his emphasis on the development of self-object transferences that typically involve some degree of merger between patient and therapist. Envy is construed by British object relations theory and Kernberg's theory as emerging out of the realization that the other is separate from the self; it attempts to deny that separateness from the object. When the object is perceived as separate, there is an other to be envious of. It seems that envy occurs almost inevitably as part of the patient's experiencing of his/her separateness from the therapist; the acceptance of that separateness is an essential part of the therapy and therefore a constructive approach to envy is vital. I agree that once envy has emerged, it needs to be interpreted, because it acts against the therapeutic goals (separation from the object) as they are defined by the therapist from

the point of view of his/her perspective; if not interpreted envy undermines what is seen by therapist and patient as positive and good and thus prevents the patient from making any progress.

For the same reason I assume that the acting out also needs to be interpreted: because it replaces the communication to the therapist and acts against the therapeutic goal of understanding; if ignored, it will lead to therapeutic impasse. However, in the treatment of borderline patients the acting-out behaviour may occupy a significant part of the therapeutic time and often does not decrease as a result of interpretation. It seems to me that this is a clear indication that the therapist needs to set limits to this type of acting-out behaviour. Kernberg's approach provides the clearest guidelines in relation to setting limits to the acting out behaviour. Kernberg's idea of a contract regarding the patient's responsibilities in controlling his or her potentially destructive behaviour and the consequences of being unable to do so, seems most effective in that regard. In addition, there is another aspect of the acting out behaviour that Kernberg emphasizes, namely that it is extremely gratifying and because of that tends to perpetuate itself in the borderline patient. If there is an apparent pleasure in the acting out, I doubt that the patient would be willing to listen to interpretations and tolerate the pain of knowing his anxiety. In that case, again, Kernberg's recommendations regarding limit setting in order to reduce the secondary gain of the behaviour seem applicable.

### **Therapeutic Alliance**

There is an interesting difference across the three theories in the way they use the concept of therapeutic alliance. The British object relations theories do not use that concept, but focus on the developments of the transference and countertransference; Adler suggests that the type of collaborative relationship between two separate individuals, which the term

implies is far beyond to capacity of the borderline patient; Kernberg underlines that the development of a therapeutic alliance and observing ego need to be encouraged either indirectly by interpretation of the negative transference, or by direct focusing on them.

The difference among the three theories and the problems with approaching the issue of the therapeutic alliance in the case of Mr. S, raise the question if the concept is useful when we try to untangle the problem of impasse with the borderline patient. It is known that therapeutic alliance is usually difficult to establish with the borderline patient, and once established, it is unstable and fragile. The poor quality of the therapeutic alliance is usually attributed to the emergence of powerful archaic transferences. Working through these transferences allows the patient to establish him/herself as a separate person and to start relating collaboratively with another person. On the other hand, direct focusing on the therapeutic alliance as it is in the case of Mr. S seems unproductive and may be experienced by the patient as a lack of understanding of the deeper conflicts and deficits that are presenting themselves in the transference. In the case of Mr. S, the therapist's anxiety about the lack of a therapeutic alliance seems to be a result of expectations about how a patient should behave in therapy and acting out of the countertransferential feelings of helplessness and anger. On the other hand, there has to be some connection, some degree of positive relationship/libido invested in the therapist in order for the client to be interested in the therapeutic work. If there is no connection at any level, therapy would not be possible, the client would not have any hope for change; working towards a shared goal and positive attitude and sense of connection are important aspects of the therapeutic alliance. If both are absent at any level, perhaps the impasse is irresolvable. If there is a trace of collaboration or positive attitude, may be the therapeutic work can be resurrected. It seems to me that the

concept of therapeutic alliance is most useful for the therapist to observe the fluctuations in the therapeutic relationship and has little value if used in a direct attempt to improve the relationship. The therapist's goal is to eventually develop a therapeutic alliance with the patient. However, this goal is quite different from the goals of the patient, who is urgently looking for relief and balance in his life and is not interested in exploration and autonomy. That is why it makes sense to work towards the development of a therapeutic alliance by attempting to join the patient at the level he/she is ready to connect (which is consistent with Adler's approach).

In the context of the modern/postmodern debate regarding the therapeutic process and the impasse, the problem with the therapeutic alliance can be seen in different ways. The modern perspective is that the borderline patient has difficulty establishing a therapeutic alliance. A more circular perspective about the therapeutic alliance will take into account how the patient's attitude towards the shared goal changes when the therapist's attitude and interventions change as a result of a change in the therapist's perspective. This is the postmodern view that takes into account that the observer/therapist always participates in the act of observation and that by this very act he/she changes what is being observed. The therapist can observe the therapeutic interchange and attempt to note which of all the therapeutic interventions (not specifically the interventions that directly invite the patient to work more collaboratively because, as it was mentioned before, this approach does not seem to be effective) seem to be followed by an increase of the alliance. As I suggested above, the therapist needs both the modern and the postmodern perspectives on the alliance. The modern perspective offers security and predictability and the postmodern allows the therapist to open up to learning from the patient.

## Strengths and Weaknesses of Each Perspective

The perspective from which the therapist intervenes can have a powerful effect on the therapeutic process. It may affect the relationship between therapist and patient, the major themes that can be communicated and the way they are communicated. Even if all three approaches seem applicable to a particular therapeutic impasse, each intervention will most probably lead to a different outcome, and some outcomes are more desirable than others.

I would like to illustrate how each approach might look like in practice and the types of outcomes that might be expected with the following three imaginary dialogues:

Mr. S: I don't fucking want your help! I want you as a target! I attempt to provoke you. I have a fantasy of throwing up on your floor or shitting on your couch. I want to rid myself of all this. I hate it when I can't provoke you into taking my anger. Then I have to take it. I need a place to dump. I have been using you like a pay toilet.

Kernberg: I can see how using me as a toilet may provide temporary relief for your tension. However, I fail to see how it may help you in the long run. You have fantasies you need to get rid of; the question is what are these fantasies about. My impression is that you've been relating to me like a little baby to an unresponsive mother, overwhelmed by frustration and anger.

Mr. S: I am not interested in talking about my mother, she was a just fine.

Kernberg: When I offer you an explanation you tell me that you are not interested in listening, and hence, understanding. On the other hand, my responsibility is to help you understand why you have the problems that you have now with yourself. The only way I can do that is by helping you to explore the meaning of your behaviour. If you feel that you can't or you don't want to receive my help for exploration, then I will not be able to treat you. This brings us to the end of your therapy before achieving any sustained change in your problems.

Mr. S: Now you are threatening to throw me out because my needs are incompatible with your rules!

Kernberg: I am merely pointing out that you have agreed to certain responsibilities when we started therapy. They included, among other things, that you would try to talk about your feelings and fantasies no matter how difficult they were. If you feel that you cannot, or will not, fulfill these responsibilities it means that we cannot do therapy.

Mr. S: Fine! What do you want me to do?

Kernberg: I would like to draw your attention to how you reacted to my words just now. But first I want to clarify what I just did. I had to tell you

that we should stop your therapy in case you decided to keep acting out your anger instead of talking about it. I did that because you were destroying your therapy and your hope for a real change.

Mr. S: What shall we do now?

Mr. S: I don't fucking want your help! I want you as a target! I attempt to provoke you. I have a fantasy of throwing up on your floor or shitting on your couch. I want to rid myself of all this. I hate it when I can't provoke you into taking my anger. Then I have to take it. I need a place to dump. I have been using you like a pay toilet.

Adler: I can clearly see how angry you are at me at the moment. Looking back at how your anger started, I realize that you have felt some anger from the very beginning of our work together, and you have been quite open about that, I should say. What was not so obvious was your need to feel connected and soothed.

Mr. S: Connected and soothed? I don't need to feel connected and soothed, I just need to get rid of the shit that's inside me.

Adler: Sometimes it is more frightening to long to be held and soothed than to feel angry or hateful. You may be afraid that if you allow yourself to connect with me and to feel soothed, you will be abandoned sooner or later. That's why you need your anger to keep me at a distance.

Mr. S: Nobody can stand to look at all my needs. Sometimes I feel like a baby, flooded with feelings and completely helpless. People suffocate from my feelings and then flee. My anger keeps me together; it makes me feel that I am the one pushing the people away. If I give it up, I will disappear, scattered into pieces with nobody around to pick them up.

Mr. S: I don't fucking want your help! I want you as a target! I attempt to provoke you. I have a fantasy of throwing up on your floor or shitting on your couch. I want to rid myself of all this. I hate it when I can't provoke you into taking my anger. Then I have to take it. I need a place to dump. I have been using you like a pay toilet.

Steiner: It feels worse when I don't take your anger. When I become angry you feel better, because for you it means that the shit is no longer in you, but in me.

Mr. S: Well, in that way I am at least getting something for the money I am paying you. Plus, it's time for you to learn what I have to deal with every day! You did not seem to understand in any other way.

Steiner: For you there is no other way to make me understand what you feel. This is how you made me understand how helpless and terrified you are inside. Throwing up on my floor or shitting on my couch is about your fear that you are falling apart. You want it to happen on my floor and on my couch because you are hoping that somehow your ill, fragmenting self will be contained by me, by my couch and my floor.

Mr. S: You know, it is scary when you talk to me like that.

Steiner: In what way?

Mr. S: You are trying to seduce me into liking you.

Steiner: What would happen to you if you started to like me a little bit?

Mr. S: If you have to know, I suppose that it would make me very vulnerable to everything you decide to do to me. You could control me completely and I would be lost.

In each of the three imaginary dialogues therapist and patient reach a point from which the therapy can continue, as the first steps of resolving the impasse are made.

These dialogues convey my impression that Adler and Steiner's approach may inspire more sensitivity and empathy in the therapist than Kernberg's approach. On the other hand, I believe that this particular patient, Mr. S, cannot benefit from Kernberg's approach at this point of his therapy. The empirical research cited by Westen (1990) suggests that what is usually defined as a borderline level of object relations cannot be reduced to a single conflict or deficit in the patient's psyche; it always represents a complex structure involving both deficits and conflicts. Part of the therapeutic work with borderline patients is about tuning in to the patient's state of mind and attempting to determine whether the transference brings up unmet developmental needs or intrapsychic conflicts. It is possible that in the example above, Mr. S needs more sensitivity to his deficits than to his conflicts.

The therapist's listening is always enhanced when he attempts to listen through a number of channels. When the therapist listens through the channel of Kernberg's theory, he hears a story about excessive aggression and immature capacity to handle that aggression. On the other hand, Kernberg theory is the only one that does not suggest that the "good part" (good introject) in the patient is crippled. The theory emphasizes that the patient's concern is for his "goodness" - the good introjects inside him as threatened by his own excessive "badness" (his bad introjects). This, along with his view that the patient achieves enjoyment/gratification through his persistent and disturbing acting out behaviours, construe

the patient as potentially having much more strength and adaptability than the other two theories do. That, in turn, gives certain freedom to the therapist to relate to the patient as an adult, capable of functioning autonomously. What the therapist cannot hear listening through that channel is the weakness and neediness of the patient's child self. Adler's theory seems to complement this limitation of Kernberg's theory.

When the therapist listens through the channel of Adler's theory, the patient's communication reveals for him a wound, lack, or emptiness that is beyond interpretation. This makes him sensitive to these aspects of the patient's self that long to *experience* mother's holding and soothing presence and long to become complete and whole as a result of that experience. The advantage of listening through that theory is that the therapist can hear the patient's weakness, his needy and helpless self, and respond to that. What the therapist cannot listen to through that channel is the importance and meaning of the patient's aggression and his struggle to handle it so that he does not experience it as his own.

Steiner's theory with its emphasis on projective identification and containing focuses the therapist's attention on the *interaction* with the client as the two concepts describe processes that are both intrapsychic and interpersonal. It sharpens the therapist's perception of the circular aspects of the therapeutic interaction and hence his awareness of his participation and influence on the patient's symptoms and problematic behaviour in therapy.

Tuning our listening to hear the client's communication as coming from one of the three positions (paranoid-schizoid, depressive and borderline) also orients us whether to risk to interpret or to refrain from interpreting. The ongoing assessment of the current position from which the client relates to the therapist requires from the therapist to pay close attention to the minute-to-minute changes in the client. This in itself may increase the chance for the

therapist to hear something unexpected from the patient that does not quite fit into the perspective(s) the therapist currently uses. From that position of not knowing and awakened curiosity the bridge to the patient could be rebuilt.

The strengths of Kernberg's conflict model are that its emphasis on the patient's responsibility, which may be particularly helpful when the therapist feels that confusion of the boundaries (through projective identification and countertransference) makes the therapeutic work impossible. Characteristic for Kernberg's whole approach is that it does not encourage regression to the same extent the deficit model does with its emphasis on developing selfobject transference with the therapist. The assumption is that the pathological structure needs to be deconstructed in order to be reconstructed again into a more mature, reality-oriented organization. Systematic interpretations of pathological defenses and transference, and clarification of the patient's distortions of the reality of the therapist and the therapeutic relationship constantly reposition the patient as a subject separate from the therapist, and the therapist as a subject separate from the patient. In other words, Kernberg emphasizes most clearly the boundaries between the participants.

Kernberg's recommendations to interpret the transference and to introduce parameters of technique to limit the acting out behaviour, allow the therapist to make some symbolic space for him/herself by somewhat forcefully temporarily removing from the therapeutic arena those aspects of the patient's behaviour that seem to act against the therapeutic goals; he attempts to "pull" the patient into the symbolic field in which observing and understanding are possible. The therapist who is stuck and feels that the process is in impasse needs to reopen his or her own internal space for reflection; it is a space that easily collapses under the pressure of the patient's projective identification and the therapist's

countertransference. Since Kernberg's approach introduces reality and reinstates the therapist as separate from the patient, it allows him to earn some space for reflection outside of the patient's control. In this way it represents a good care for the therapist, and thus indirectly for the therapeutic process.

Kernberg's approach seems helpful when there is a crisis in which the therapy itself appears threatened by the power of the patient's transference process and defensive strategies (which involve functioning that disregards important aspects of reality related to the patient's or therapist's physical safety and the continuation of therapy). The risks involved in the Kernberg's approach are related to his disregard of the patient's view of the therapy and the relationship; this disregard is a result of his mostly linear way of seeing the therapeutic process.

The strong side of the Adler's theory is his emphasis on aloneness and the fact that it does not assume an inner badness in the patient. I believe that this facilitates the therapist's empathy with the patient, because it accepts the patients' feelings of emptiness and abandonment at face value, instead of seeing them as an inner result of the experience of anger and employment of primitive defensive operations. The approach based on that theory seem very respectful and accepting, because it does not press the patient to embrace their responsibility for having a bad part of themselves – something that is hard for most people, let alone a person whom we see as having a weak ego. It also implies that the merger, which the borderline patient seems to need and want, is positive and necessary within certain limits. Adler regards gratification as although not desirable, acceptable at times, when there seems to be no other choice. This may relieve the therapist from the guilt of yielding to the patient's insistence on some gratification.

Adler however does not seem too interested in the pathological solutions of the patient, which the other two theories regard as a significant part of the problem of the borderline structure and underestimates the role of the patient's aggression in maintaining that structure. There is also a risk, that the patient may become deeply disappointed and enraged when he/she discovers that the promise of a reliable, ever-present self-object cannot be fulfilled because the therapist's resources are never sufficient in the long run to satisfy the patient's insatiable need for such an object. That discovery of the therapist's (relative) unavailability and separateness may retraumatize the patient, and consequently the therapist who feels that is giving a lot, which sets the scene for an impasse in the therapy.

I find Adler's approach helpful in terms of forging the connection with the patient, which is particularly important in the beginning of the treatment, but it also involves certain risks of major disappointment for the patient and the therapist, or of colluding with the patient's defenses (that is, unwittingly agreeing not to be curious about certain aspects of the patient's behaviour).

Steiner's theory makes an invaluable contribution to the therapeutic work with the idea of containment. Containment seems to be at the core of every therapeutic work, regardless of the model one is following in their work with borderline patients.

It seems that in case of impasse, particularly one in the initial stages of the treatment, it is important step for the therapist to improve his/her containing function. The disadvantage of this focus on containment are at times it may justify passivity and masochism on the therapist's side and thus perpetuate an interpersonal pattern that works against the therapeutic goal of understanding and integrating.

The capacity to listen to the patient through all of these perspectives simultaneously may help the therapist maintain his neutrality - by making him more sensitive to the multiplicity of voices that the patient and the therapist himself bring in the interaction. The therapist also needs to create the conditions under which listening is possible; that is the reason I accept that there are behaviours in therapy that are better to be limited as is the case with the acting out behaviour.

In this thesis I discussed the problem of impasse that occurs in the treatment of patients with borderline personality organization. I suggested that the therapist needs to maintain a binocular view of the patient and the therapeutic relationship that enables him/her to construct the impasse as both a result of what the patient brings into therapy as his pathology and as an interactional pattern established between therapist and patient. This, along with listening to the patient's communication through a number of different theoretical perspectives, makes the therapist more flexible and open to new meanings, which is a necessary step to resolve the impasse. I reviewed three psychoanalytic theories that may inform the therapist's listening and I compared the clinical approaches based on them. I suggested that a more supportive approach that relies on containing what the patient cannot tolerate within him/herself has more advantages over early interpretation because it helps the therapist connect better with the patient in the early stages of therapy and prepares the patient to use interpretations at a later stage. Interpretations and limit setting were seen as necessary interventions in case the patient's behaviour appeared to act systematically against the therapeutic goals. An early assessment of the impasse, attention to the therapist's neutrality

and an early choice of an alternative approach are preferable, because that increases the chances of beneficial outcome of the impasse.

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