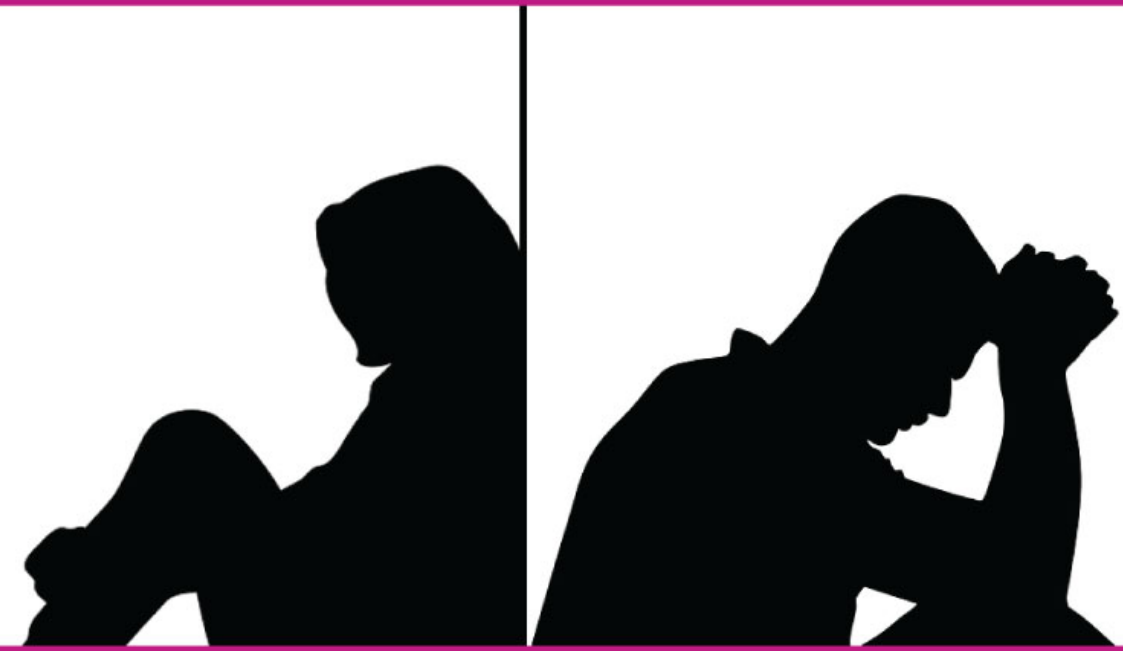
Narcissistic/Borderline Couples:



A Psychodynamic Approach to Conjoint Treatment

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In narcissistic/borderline relationships, pain stirs up an amalgam of unresolved developmental issues as both partners need each other to play out their intern drama. Ultimately, this is done in the effort to get in contact with some split-off undeveloped part of themselves. Paradoxically, within these primitive unions the very same elements that bonds/binds such individuals may also be the very elements that perpetuate the conflict between them. It is not unusual when in this state, couples often panic and have great difficulty tolerating the confusion and chaos. "Should we stay? Should we leave? What must be conveyed is that while in this mental state of disarray, it is virtually impossible to make decisions and to know what "to do," let alone to get a sense of what is real and what is not real. The nature of primitive defenses and level of their defensive structures makes it infeasible to get a sense of the "real relationship"[1]. As Goethe once said, "It's difficult to know what to do at this point, especially when there is so much blaming and attacking going on!"

Couple Transference

The couple transference does for the couple what transference does for the individual, but is slightly more complex. Couple transference interpretations are derived from the analyst's experience and insights designed to produce a transformation within the dyadic relationship (Lachkar, 1997). To understand its complexity, I have integrated the notion of intersubjectivity, a well-known construct elaborated by many contemporary psychoanalysts (Brandchaft &

full erection, although he claimed he was never impotent prior to that time. This failure was felt as a severe blow to his self-esteem and produced intense anxiety within him. In addition, he expressed growing resentment toward his wife, had difficulty taking a stand with her, and saw any expression of desire or need for her as a losing proposition.

Simultaneously, he complained about his wife's withholding of sex, blaming her for his impotence and fearing that she would, one day, banish him. He believed that they had a good marriage in the early days before his wife began to reject him. Now, "all she expects is for me to pay the bills," he confided.

In the early sessions of the therapy, Mr. D wanted to blame his wife. Any attempts by the therapist at addressing the issues of his own internal world were to no avail. His response to the therapy induced in the therapist powerful countertransference reactions, causing her to offer quick remedies to provide immediate relief for his overwhelming anxiety. When these quick-fix solutions proved ineffective, Mr. D would have intense and sudden outbursts. He began to demand that his wife participate in the therapy, an apparent replication of his demands for her to have sex. He worried that his attempt to have his wife join him in therapy would end up as fruitless as asking her for sex. On an unconscious level, Mr. D was enacting the helpless, impotent mother role, projecting onto his spouse his "bad" dependency needs, which met with rebuffs. This cycle threw him into a whiny, desperate-baby position as an impotent husband. The therapist, failing in her efforts to encourage Mr. D in dealing with his internal issues, succumbed to his wishes and invited his wife to join the therapy.

Mrs. D did agree to come to some sessions on the basis that the problems in the marriage had nothing to do with her and in the hope that her attendance would facilitate her husband's improvement (the narcissist's need to hold on to the "perfect self"). According to Mrs. D, the problems began soon after the wedding when Mr. D's desire for intimacy diminished gradually (the diminishment of idealization). She felt he did the opposite of what she requested: "If I asked him to rub my back, he would pinch or pull at me. He hurt me, so, of course, I withdrew. " She revealed that she no

longer wanted to have sex with him because he was insensitive when they had sex, almost as if he hurt her "on purpose."

Mrs. D described her mother as a very domineering, religious, and rejecting mother, and her father as passive, cold, and detached. She recalled being the special child until her baby brother was born then, at his birth, she felt that she had been dethroned and replaced by her new sibling. Mrs. D was left with deep feelings of never being special enough: "I spent the rest of my life trying to prove to my parents how perfect I was, and would do anything for their attention." This loss became an unforgettable, narcissistic injury, from which she had no opportunity to recover. She recounted how her mother never supported her burgeoning femininity, but favored her brother. So, she became "a tomboy," eschewing playing with dolls. "Eventually, I learn I didn't need anyone. Even when I got my period, my mother ignored me and never offered any help, advice, or concern

Mr. D's poor male identification made him feel uncertain about his role as a husband and father, and Mrs. D suffered the contrariety of gender and identification (Benjamin, 1988). Ultimately, she disidentified with her mother and fused with her father, either by becoming competitive with him or by taking on his cold and detached ways. Both of these states became intolerable for her needy and insecure husband (the "rejected self").

Discussion

In their "dance," Mrs. D became the "dead" parent whom Mr. D tried desperately to revive. Similarly, Mrs. D took on the role of an unavailable mother, intoxicated with her own self-involvement. Mr. D's needs became the "disgusting" split-off part of his wife's original dependency, the feminine part of her that yearned for a special place with a parent, of which she had been deprived. In this

scenario, Mr. D's "normal" requests for sex were felt to be rebukes of Mrs. D's sense of self and how she viewed herself as a woman. Because of her guilt and anxieties about her own sexuality, Mrs. D projected her guilt onto Mr. D, which in turn ignited his shame (the delusion that dependency needs are dangerous or "bad for one's health"). Conversely, Mr. D projected his envy and shame back onto Mrs. D, along with feelings of guilt, of being less than perfect, and of normal femininity being a sign of imperfection, the disfigurement of a woman.

As their psychological dance unfolded, we could see Mr. D fusing with his mother's/wife's body, living psychically within her. His need became insatiable and his sexualization often became linked to perversion (the pinching and the hurting). In this early stage of treatment, Mrs. D continued to rebuff Mr. D's sexual advances, inducing in him increased desperation and neediness: "If she loves me, she will have sex with me. If she doesn't, she won't. She makes me feel as if I don't exist."

As the therapy advanced, there was an opening of the therapeutic space as bonding developed with the therapist. Both partners began to tolerate states of confusion, "not-knowing," and healthy dependency on the therapist. The therapist took on a more active role, using interpretation, confrontation, and management techniques. The major shift for Mrs. D was in the gradual diminishment of her omnipotence, her all-knowing attitude that conveyed, "I just know what he's going to do and say." Once she could grasp the idea that her "absolute knowingness" of

her husband as forever being a nothing, and that "nothing will ever change," Mrs. D was quite relieved to find how her omnipotence actually worked against her. During the next few months, Mrs. D began to feel some assurance in her newly acquired sense of being a feminine woman, the result of her preliminary identification with the therapist's qualities of sensitivity and vulnerability. Her developing capacities to tolerate her own "imperfections" and those of her husband, her feeling that she could get mad at him instead of projecting onto him and then rejecting him, contributed greatly to her feeling of increased security and the knowledge that the marriage was of paramount importance to her.

As his wife became more receptive to him and committed to their relationship, it came as quite a shock to Mr. D that he was not so much interested in intimacy and making love as he was in using sex as an act of aggression (a perverse use of love) against his passive, self-involved mother/wife. His striving for bonding transcended sex, as sex had served as the substitute for emotional contact and responsiveness. As he began to comprehend his own true dependency needs, he not only began to appreciate his wife's vulnerabilities, but displayed an increased capacity for abstract thinking ("thinking about" feelings and needs instead of "acting them out"). Mr. D became intrigued with his new thinking tools, was astonished to learn how his bonding needs became intertwined with aggression and persecutory anxieties. Even more notable was his newly gained tolerance for ambiguity, the notion of many forces operating simultaneously within him and around him. He didn't have to "abuse," "seduce," or demand; he

could simply ask.

In the final phase of treatment both partners expressed a desire for reparation. Mrs. D observed how her underlying fears of deficiency not only related to the difficulties in her marriage but impacted every area of her life, including her career and her children. Her defenses of withdrawal, isolation, and the demands for perfection, for "flawlessness," had given her a false sense of power, but ultimately kept her unprotected in a hostile intern world. Within the couple transference, the working through of Mrs. D's desire for special treatment manifested itself in several ways, such as insistence on fee reduction, changing hours to suit her schedule, or "perfect understanding." Mrs. D came to understand that just as her husband substituted sex for intimacy, she substituted omnipotence and control for dependency. She also noticed how anxious she felt whenever she had to take in nourishment from the therapist. She defended against this by being the one who had to know it all or being the one with all the answers. This need for perfect mirroring is exemplified by the following exchange:

Mrs. D: You don't understand. I was not mad, I was infuriated.

Therapist: So, you were angry.

Mrs. D: No, I was not angry, I was frustrated.

When the therapist brought up important issues, Mrs. D accused her of an "agenda" mother; when she was more silent and reflective, she was accused of

being the passive, impotent father. When the therapist tried to point out specific issues that Mr. D needed to deal with, he accused her of "ganging up on him."

Still, it was very affirming for Mr. D when the therapist could see positive aspects of his impulsive outbursts, that they really were representative of his wish to feel alive, to exist, and to feel loved, rather than to destroy or mutilate his mother/wife. Mr. D came to understand and appreciate how another part of him had a genuine need to depend on his wife and to love her. As he began to feel more contained, his ability to encompass ambiguous states and tolerate and consider ideas increased. Mrs. D was also moved and impressed by the notion that needing was not disdainful/sinful and would not necessarily result in abandonment. Gradually, both realized their true needs could actually enhance their relationship rather than diminish it. The conjoint sessions ended with Mrs. D requesting to see the therapist in individual sessions, and Mr. D requesting a referral to a male therapist for analytic work.

Summary

In the case of Mr. and Mrs. D, issues clearly centered around dependency needs. Working within the milieu of the couple transference and the dual projective identifications, the therapist gradually diminished the defenses against dependency by moving the couple away from shame/blame/ attacking defenses to that of healthy dependency needs (bonding with the therapist). For Mr. D, to need

represented an anguished tormented part of himself, subject to disapproval and rejection, and linked with aggression and persecutory anxieties. For Mrs. D, dependency represented disgust and disdain against a rebuffed feminine side of herself she equated with impotence and rejection. As treatment continued, the work consisted of showing how each projected and identified with each other's negative projections (dual projective identification). Mr. D, the borderline husband, felt he existed solely through his wife's affection and affirmation (living inside the object), and that it was his insatiable needs that actually drove her away. Mrs. D projected her shameful feminine side onto her husband to ward off her own inadequacies, compelling him to become even more needy, attacking, and sadistic. Mr. D. identified with Mrs. D's projection that it was bad to be vulnerable, equating femininity with an early narcissistic injury (birth of a brother). Eventually Mrs. D was able to relinquish some of the guilt and shame surrounding her dependency needs as she began to bond and identify with the therapist's "femininity." As the therapist was able to provide important selfobject and containing functions, they both began to feel more alive. Mrs. D. was reassured that giving her husband attention was also a way of giving her attention, and was not denigrating her, rebuffing her, but, in fact, supportive of her. As Mr. D became more observant of his earlier aggressive assaults, he became aware of how they had stripped him of his inner resources, making him feel emotionally impotent. He felt more contained and that there was someone to listen to him, to understand his pain (did not have to "act out" to get the attention he needed). Finally, both

partners comprehended how they had disidentified with the parent of the same gender and identified with the parent of the opposite gender: Mrs. D had disidentified (Benjamin, 1988) with her mother, eschewing her feminine nature, and identified with her detached father, enacting that role within her marriage; Mr. D had disidentified with his father, who had abandoned him through death, and identified with his passive mother, becoming a demanding, insatiable infant with his wife. As Mrs. D embraced the feminine aspects of her nature and Mr. D reclaimed his masculine nature, their love life became a mutual experience of discovery, tenderness, and satisfaction.

THREE PHASES OF TREATMENT

Phase One: A State of Oneness—The Borderline Person Lives Within the Mental Space of the Narcissist (Fusion/Collusion)

During the initial phase of treatment, the borderline person often lives "inside" the emotional space of the narcissist, as in the case just introduced. It is a state of "oneness," of fusion/collusion (paranoid-schizoid position), which exhibits a propensity for living within the psychic space of the other (Lachkar, 1992, 1997, in press). Because of the predominance of primitive defenses, the major therapeutic task is to assist each partner in relinquishing blame, finding fault, omnipotent control, deciding who is right, who is wrong (the one responsible for all the shortcomings in the relationship). This is accomplished by gradually

"weaning" the couple away from their destructive, painful, and aggressive behaviors by bonding through their vulnerabilities. In this phase, there is much name calling, stonewalling, scapegoating, envy, jealousy, and guilt. There is not space for another person's ideas or feelings: "My needs are your needs!" The formation of parasitic ties are enacted repeatedly as each acts out unresolved unconscious infantile fantasies. ''I'll show him what it feels like to make demands on me!" Both partners show little awareness of the inner forces that pervade and invade the psyche via their splitting mechanisms, mutual and dual projective identifications.

Mr. D's defenses caused him to operate at the level of a primitive superego (persecutory and attacking), while Mrs. D's defenses of withholding and withdrawal operated at the level of a more advanced superego (critical, harsh, relentless). In this phase the therapist is often used as a "toilet breast" (Klein, 1940). The borderline partners typically cannot make use of the mother as a container, will display intense ruthlessness toward their objects (the therapist) in the effort to rid the psyche of the bad parts of the self.

Phase Two: A State of Twoness (Transitional Phase)

In the second stage of treatment, there is an emergence of twoness, a tentative awareness of two separate emotional states, even a feeling that treatment can be helpful. Couples begin to feel better without knowing why. The

reason is because they feel contained. There is greater tolerance for ambiguity, greater capacity to live within the space of "not knowing," and more awareness of conscious, unconscious, and other compelling forces. It is the beginning of their bonding with the therapist, of separation from living emotionally "inside" the object, and moving toward mutual interdependence. As the therapist emerges as both container and new selfobject, there is a broader range of experience, an opening of a new therapeutic space, or what Winnicott (1953) has referred to as the transitional space or holding environment.

This is the hopeful stage, there is a burst of new energy and feeling of excitement. There is a profound shift, a movement away from the act of doing toward acts of feeling, being, and thinking. Each partner begins to get a glimmer of the part each plays in "the dance." This is the transitional stage, and the beginning or the movement into the depressive position.

Phase Three: Awareness of Two Emerging Separate Mental States (Dependent and Interdependent)

The third phase of treatment marks the beginnings of the depressive position, where reparation occurs, a wish to "repair" the damage, to embrace guilt and pain, and to express remorse and sadness. It is a time where each partner comes to terms with uncertainty, ambivalence, and dependency needs, a time to heal, repair, and listen nondefensively to each other's hurts. There is new depth and richness to the work and an awakening to the depressive position, where true

reparation can take place. The couple begins to psychically live "outside" the mental space of the other, as two separate, yet connected, emerging mental states. For the first time, mutuality and movements between dependence and interdependence take place. Healthy dependency needs are recognized as each partner begins to respect the needs of both self and other. We see the gradual diminishment of repetitive negative projections along with a window of opportunity for further treatment in individual psychodynamic psychotherapy. This is the "thinking" and healing phase where expression of true feelings begin to replace the act of "doing" or "acting out" (as we saw in the case of Mr. D). There is less need to "spill over," evacuate, or "tell all" and greater capacity to contain. This is the weaning stage, away from the preoccupation with "the relationship" to concentration on self-development. Both partners begin to see that they have their own inner conflicts, and growing awareness of how they impact their relational bond (the "real relationship").

Having moved through the phases of treatment in the case of Mr. and Mrs. D, we can now apply some specific procedures to the treatment of narcissistic/borderline relationships.

GENERAL GUIDELINES

- The therapist must see the couple together before transition into individual therapy to form a safe bond. *Cautionary note*: Do not move into individual work until the couple is ready (separation too early can

induce a "rapprochement crisis").

- Be aware that couple interaction can diminish individuality. Avoid such phrases such as, "You *both* suffer from feelings of abandonment."

- Be aware that each partner experiences anxiety differently, and these differences must be respected (qualitative differences).

- A therapeutic alliance must first be with the narcissist (the tendency to flight/flee/withdraw can pose a serious threat to treatment). The borderline patient will be able to tolerate waiting as long as he or she knows therapeutic bonding is taking place. A further challenge is how do we provide empathic responses to the narcissist without betraying or abandoning the borderline patient?

- Be aware that development of the therapeutic alliance is slow and the creation of a secure framework (structure, boundaries, commitment) takes time. The more primitive the couple, the more we need to emphasize the need for commitment. As resistances unfold in the relationship, use these opportunities to wean them into the "couple transference."

- When individual treatment occurs in conjunction with conjoint treatment, the same basic guidelines apply. Privilege and confidentiality is still under the umbrella of conjoint treatment (Lachkar, 1986, 1992).

TREATMENT POINTS AND TECHNIQUES

Finally, we must consider some vital guidelines to technique.

- Do not be afraid to confront the patient's aggression. Speak directly to the aggression with technical neutrality by making clear, definitive statements. Be empathic toward the pain and the patient's vulnerabilities, but avoid getting drawn into the couple's battle.

- Continually set goals, reevaluating and reminding patients of treatment goals of why they came in the first place.

- Avoid asking too many questions and obtaining lengthy histories. Do not waste time. Start right in. The history and background information will automatically unfold within the context of the therapeutic experience and the transference.

- Avoid self-disclosure, touching or consoling the patient, and making unyielding concessions.

- Listen and be attentive. Maintain good eye contact, speak with meaning and conviction. Talk directly to the issues.

- Use short, clear sentences; keep responses direct; mirror and reflect sentiments with simple responses and few questions.

- Keep in mind a “normal couple” or "ideal couple." This image will sharpen your focus and safeguard you from getting lost within the couple's psychological "dance."

- Explain how one may project a negative feeling onto another person, but still understand why the other identifies with what is being projected (focus on the *dual projective identification).*

- Listen for themes. Be aware of repetitive themes. The subject and feelings

may change, but the theme is pervasive (betrayal, abandonment, rejection fantasies) .

- Help the couple to recognize "normal" and healthy dependency needs.

CONCLUSION

Narcissistic/borderline couples express their pain by repeating blindly their dysfunctional behaviors without learning or profiting from their experiences. The uncertainties of diagnosis have been acknowledged, as well as the difficulties in differentiating between borderline and narcissist states. I have discussed why partners in these beleaguered relationships are in complicity with one another through their psychological "dance."

Couples therapy is an experience that occurs among three persons: the two partners and the therapist. This is a deep emotional experience of intense communication and feelings that begins with the profound challenges of a primitive relationship and matures into the awareness of healthy dependency needs and mutual respect. With each session, the curtain opens, and the opportunity for a new experience begins.

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Notes

[1] The "real relationship" refers to the task-oriented couple, those who can learn from experience, see the relationship as it is (not as it should be, could be, or ought to be). This is in contrast to the "fantasized relationship," those who cannot learn from experience or cannot tolerate pain or frustration. The regressive couple are those who form collusive bonds, display a diminution of reality testing, have impaired judgment, and bond parasitically rather than through the maintenance of healthy dependency bonds (Lachkar, 1992).