Six Steps in the Treatment of Borderline Personality Organization

Six Steps in Treatment

Vamık D. Volkan

Six Steps in the Treatment of Borderline Personality Organization

Vamik D. Volkan

e-Book 2016 International Psychotherapy Institute

Table of Contents

Six Steps in Treatment

This chapter will examine the six steps in sequence, although it must be remembered that either internal or external events may cause the temporary reappearance of one already completed (or aspects of it). Sequential consideration makes for an overall picture of the total treatment process and illustrates the ways in which characteristics of each step often dovetail with those of another.

STEP ONE: THE ESTABLISHMENT OF A REALITY BASE

After the diagnostic interview(s) I explain to each patient that we will meet four or five times a week, that I will not prescribe drugs, and that he or she will before long be expected to lie on the couch. I further explain that the patient should feel free to communicate whatever comes to mind and whatever bodily sensations are experienced in any session.

The patient with borderline personality organization comes to treatment with many fantasies about the analyst, some of which are primitive, and many transference expectations. Even at the outset he contaminates the analyst's representation alternately with externalizations of good and bad self- and object images. After the first hours, in which patient and analyst are face to face, the former comes to recognize the latter as unchanging over time and tends to correct, to some extent, his initial distortion of the reality of the analyst and the analyst's therapeutic commitment and aims. A precursor of the representation of the analyst as "a new object" (Loewald 1960) or an "analytic introject" (Giovac-chini 1972) appears in the patient's mind during the very first sessions. Many of my patients have told me late in treatment how important my initial attitude was to them. I hope that, as treatment starts, my attentive but relatively unchanging presence gives a reality base for the intensity of introjective-projective relatedness in the transference still to come.

Therapeutic Alliance

I try to focus on issues to help develop the core of a therapeutic alliance. For example, I tell the patient that his symptoms or behavior patterns must have meanings, and that we will try to understand

them; however, I offer no overt advice or information about myself except to say that I am available during the sessions, promising no overt support. I see the undertaking of treatment as *the* most important step in a patient's life, and being so convinced of this myself, I usually have no difficulty in convincing him, even if he denies my commitment on the surface.

Initial Nondrastic Limit Setting

Whenever a patient looks at my books, or asks to borrow some, I say that we are embarking on a long journey together and I find it natural that he should be curious about me, but that if he were to try communicating with me by handling my books I would find it hard to be sure about his message. Although I know I will find his nonverbal communications significant, I indicate that in the analytic setting I will depend on what he tells me verbally. I do not chitchat with a patient, and I make it clear that my restraint in this regard is due to my desire to understand him rather than to be mysterious. If at the close of a session a patient asks to use my telephone, I explain that although there is nothing special about my telephone, I would rather he find another because I would not know the meaning of his using mine were he to do so. Then, during the next session, I search for his response to my setting of limits. For example, one patient whom I denied the use of my telephone opened his next session with a story about a rigid, ungenerous, and bad person. After letting him finish this story, I explained again why I did not allow him to use my telephone—my "rigidity" was in the service of our working together. Thus I differentiated myself—and, through this, an image of myself—from his image of the rigid, ungenerous character in his story. The verbal outline of what constitutes an analytic setting is important in working with borderline patients; neurotic persons take it for granted, but it is often necessary to push the borderline individual to adjust to it.

The Analytic Image

During Step One I emphasize my differentiation of my image as an analyst, hoping not to overdo it as an educational ploy but to give the patient an image of me as "a mattress to fall on" when he later becomes anxious in his complicated transference relationship with me. I follow certain routines from the very beginning, even if the patient presents a crisis such as losing his job. I may remark that his crisis may have something to do with our starting to work together, if this seems reasonable, but offer no crisis

management.

The Noisy Phase

When the patient first takes the couch, I try to note his anxiety level, exploring the possibility that my being out of sight might give him the idea that I had disappeared—or even that he had "murdered" me. I observe such clues as his keeping a foot on the floor while reclining on the couch, excessive pulsation of the carotid artery, pallor, and the like. When indicated, I calm him down with noncommittal sounds in response to what he is saying, and in this way reassure him that I am still there. Boyer (1967) speaks of "the noisy phase" of regressed patients, including schizophrenics, who will not tolerate silence on the part of the analyst. I agree and find that my noncommittal sounds keep a patient from feeling deserted, or thinking me a victim of murder at his hands. Moreover, for the patient who perceives his analyst as all bad, such sounds "tame" the bad image, and the patient on the couch does not feel himself to be in the presence of an unseen monster. Likewise, if the analyst is perceived as good, his throaty utterance modifies his ideal image, and the patient does not feel that all he need do is to lie silent on the couch and bask in the sunshine of a quickly idealized analyst.

Clarification and Suggestion

I make reference to what I suspect is causing his anxiety, clarifying what is happening in the here and now rather than interpreting genetic material and transference displacements. When his defenses fail, the patient becomes anxious, and clarification, with suggestions about the therapeutic alliance, usually helps him continue treatment.

During the first step my main aim is to establish the core of the therapeutic relationship. For example, a patient might report at the start of his hour that he had seen a skunk and then mention that he had applied more than his usual amount of deodorant while dressing. At this point he is calm, but he refers again to the skunk, with which he seems preoccupied. He then places one foot on the floor, as though to rise and escape from the couch, and makes other anxious gestures. I ask him to consider the possibility that revealing things to me may be difficult, especially if what he has to convey could be considered by me as "stinking." I explain that we are working together and that I am willing to listen to

anything he is able to share about what is passing through his mind.

The Patient's History

As indirectly as possible, and with few questions, I collect as much historical data about my patient as I can in the first step; I refrain from making interpretations about the disclosure of his history. Although I am well aware that there are likely to be discrepancies between what he tells me and his actual history, his narrative is important to my initial formulation of his dynamics and supportive to me in the development of an empathic attitude toward him. Obviously, as time goes on, the patient and I may change our understanding of his history. Step One concludes when I sense that my patient experiences me as one committed to treating him and relentlessly protective of the therapeutic setting and my method of conducting our sessions.

STEP TWO: THE FIRST SPLIT TRANSFERENCE

The second step is established usually within the first few months when the patient comes to his session because he wants to use the analyst as the target of his alternating good and bad self- and object representations. Not only libido, but aggression also binds him to his analyst (Pao 1965), who maintains therapeutic neutrality. This is not to imply that the analyst fails to convey empathy or other feelings for or about the patient, but that he refuses to gratify his infantile wishes. A breach of therapeutic neutrality will have a more devastating effect on an already regressed and/or undeveloped individual on the borderline spectrum than on a less regressed neurotic patient. It seems as though the neurotic person can "forgive" the analyst for a mistake, but those with borderline personality organization find it harder to be generous toward him.

It is usual to see a chaotic picture when the patient uses defensive splitting and other primitive mechanisms and relates to the analyst with introjective-projective relatedness. The patient makes the music, but the analyst is the conductor, correcting gross misperceptions, misinterpretations, and obvious distortions of his remarks and making it clear that the patient has resorted to these to fend off anxiety. This interchange involves what might be called "miniconfrontations." I allow major confrontations in respect to only two issues: the protection of the therapeutic setting and the schedule of sessions; and the

prevention of the patient's acting out in a way destructive to himself or me. If a woman announces that she has a gun in the purse she is clinging to while on the couch, I tell her that one anxious person is enough in my office and that she must leave the room and return without the gun. I also terminate the session of a patient who arrives under the influence of drugs or alcohol.

Holding Environment

The importance of this constellation is that it provides a facilitating or holding environment (Winnicott 1960, Modell 1976) that supports the patient's regressive state without necessarily inducing further regression. Without making genetic interpretations, the analyst calls attention to his patient's psychic operations in the here and now. I call interpretations made at this point linking interpretations, borrowing a term from Giovacchini (1969). They link events in the external world to the patient's inner psychic productions. The process is like showing a patient how day residue appears in a dream. If a female patient fantasizes seeing blood on the ceiling of my office (my extension) as she lies on the couch and during the same hour speaks of having her menstrual period, I link the two communications for her. Similarly, I might link a patient's psychosomatic reaction to his having seen a threatening policeman on his way to my office. This approach shows the patient that there are psychological connections in the products of the mind and psychological influences on behavior patterns. It could be said I am making the patient more psychologically minded.

Chaotic Splitting

I call this chaotic second step the first split transference. Transference manifestations will inevitably include the splitting of representations of the analyst along affective lines, contaminated with the patient's archaic self- and object representations and interaction between these split representations of the analyst and corresponding split self-representations of the patient himself. It is not possible to interpret systematically the first split transference, because at this time it is rather chaotic; manifestations are not yet able to effect, in the service of structural change, the mending of what has been split. They are repetitious in the sense of failing to accomplish any new level of mature relatedness.

I bring this type of split relatedness to the attention of the patient in connection with some event

outside the treatment itself that both the patient and I have noted and understood. For example, in our case it was very easy for a female patient to observe that when she spoke of her mother as a good person she referred to her boyfriend as a bad person and vice versa. When derivatives of a split transference are manifested they are explained to the patient not in the way of an aggressive confrontation or of an order to him to mend his opposing self- and object representations and affects connected with them, but in a way so as to increase his observing capacity. The analyst helps the patient to see how certain events, perceptions, and feelings are connected with or influenced by the inner and outer flow of aggressively or libidinally tinged self- and object representations. For example, when a patient externalizes an aggressive unit on the analyst, he may exhibit anxiety about coming to the next session and lying on the couch. This phenomenon is then clarified for him.

Unrepressed Oedipal Material

I have also observed that during the second step of treatment the patient with severe borderline personality organization offers rather unrepressed oedipal material and incestuous fantasies. This does not come, however, in any systematic way, and it cannot be systematically studied in the therapeutic setting. In fact, patients who function on a low level of ego organization and who have split or fragmented self- and object images use oedipal material as "upward resistance" (Volkan 1976). I usually pay little attention to such material at this point in treatment except to make note of it as a form of resistance—usually against conflicts of early, primitive internalized object relations. I agree with Rosenfeld (1966), Boyer (1967, 1983), and Ornstein and Ornstein (1975) that premature oedipal interpretations—indeed, any direct attention to such issues—preclude the development of the preoedipal transferential state that must be worked through before the patient can reach a steady and classical transference neurosis. It is clear that this approach is different from that offered by Abend and colleagues (1983). As Winnicott (1956) notes, the natural evolution of the transference will occur without the analyst's interfering except to protect the therapeutic alliance and its setting, and without the analyst's attempting to teach the patient or to support him in his real life problems. Within a year or so, the third step of the treatment begins.

Dreams

I pay attention to dream reports throughout the second step, as I do in others. Perhaps because of my interest in their dreams, all of the previously mentioned nine patients reported them abundantly. In this step I locate the day residue and note ego defenses reflected in the manifest content. The patient invariably begins to see that different characters in the dream represent important persons from his childhood as well as different representations of himself, and that his interaction with them profoundly affected him. I refrain from agreeing with his designation of some of his important childhood objects as bad and some as good, but I help him see that he relates to the images of important others in his mind as he relates to important others now.

Identification with the Analyst's Analyzing Functions

Throughout this process the analyst notes his patient's attempts to identify with him. Since such identification in this step includes what the patient has already put into the analyst, it may lead to a vicious cycle. Thus, through miniconfrontations the analyst will help his patient to modify an identification with him that he considers nontherapeutic. For example, if the patient views the analyst's curiosity as aggressive because he projects aggressive drive derivatives onto the analyst, he may then identify with aggressive attitudes. This will cause him to exhibit aggressive curiosity and try to needle the analyst, gossiping about him and following him around at any encounter in a public place. The analyst must make it clear to his patient that he is curious about him and his verbal and nonverbal productions during the sessions only because he seeks to understand them, and that this kind of curiosity is different from a destructively aggressive one.

The positive identifications with the analyst's curiosity and other analyzing functions that occur at the end of this step have a sobering effect on the patient, and the sessions become calm. During this time the patient will offer insight that is clearly genuine; it is accompanied by unexaggerated but deeply moving and appropriate affects about his interaction with his parents and important others as a child, and appreciation of the conflicts in his object relations. My experience has shown that at this point in treatment patients exhibit therapeutic regression.

STEP THREE: FOCALIZED PSYCHOTIC TRANSFERENCE LEADING TO REACTIVATED AND TRANSFERENCE-RELATED TRANSITIONAL PHENOMENA

After going through the long preparation of Steps One and Two, patients with low-level borderline personality organization exhibit further regression and offer psychotic *therapeutic stories* (Volkan 1984). One such story is offered by a patient who, becoming preoccupied, continues disclosures of an event involving transference session after session. It becomes an affectively lived drama, a here-and-now version of a real or fantasized event in the past, which it may now be possible to deal with in a different way. Such stories involve considerable action inside and outside the sessions, action that turns passivity into activity. One can expect the therapeutic story of a patient with psychosis-prone borderline personality organization to include manifestations of transference psychosis and delusional relatedness. With successful treatment up to this point, the psychotic transference is tolerable for both partners.

In Step Three the patient usually goes through a regressive therapeutic story within a few weeks or months. With effective interpretation of this regression, in hopes of resolving unfinished business from childhood, the patient moves into a progressive development to a new step, and eventually mends his opposing self- and object units, becoming able to experience a transference neurosis. What is interesting here is that such patients develop "new" transitional objects or phenomena (Winnicott 1953), which have the potential to become a new bridge to reality (Greenacre 1970). The patient might return in Step Four to regressive therapeutic stories, but if handled properly, each regressive movement has the potential to help the patient achieve better organization once he returns to progressive development.

Clark, whose case was reported earlier, began his third step after his analyst's interpretation that his wish to have fellatio while in warm water was a wish to keep a bond to his biological mother, and after he had abandoned his "Samiosis" (his pun on the word "symbiosis" that he used to describe his pathological relationship with his son, Sam) he was by then more than two years into analysis; thus, it is usual for the second step to end with the patient's first genuine emotional understanding of the genetic factors responsible for the fixation of splitting good and bad self- and object relations. The patient then seems sober, and his grasp clearly real, neither distorted nor denied. Sometimes an external event will promote the repetition and working through of some childhood memory, stimulating a therapeutic regression to the conclusion of Step Two. The therapist contributes to the interpretation of the drama. In Clark's case the useful external event that led to reactivation and observation of his object relations

conflict was the arrival of a son and his interest in caring for him. One day after the end of his "Samiosis," Clark babbled like a contented infant on the couch. His analyst was aware of Clark's therapeutic regression, which continued from session to session, and unconsciously he himself had a corresponding therapeutic regression meeting his patient at his regressed level and experiencing a symbiotic relatedness to him. He felt drowsy and even fell asleep for a moment. He was alerted by the feeling that he did not know whether words that came into his mind had been uttered by his patient or had occurred to himself in a dream. Both were caught up in this symbiotic relatedness and were reluctant to have to end the session and face the reality of separateness.

The Creation of a "New" Transitional Object or Phenomenon

I describe my fusion with a patient in Part II, and her creation of a "new" transitional phenomenon to effect differentiation. Coppolillo (1967), Kahne (1967), Kafka (1969), Fintzy (1971), Volkan (1976), and Volkan and Kavanaugh (1978) note that in some persons the transitional object or phenomenon persists into adult life, sometimes covertly, sometimes openly reactivated. I have found that most borderline patients persistently use active, covert, or reactivated transitional objects or phenomena. Perhaps this is why Modell (1963, 1968) suggests that borderline patients are arrested at the stage of transitional object relatedness, emphasizing that this relatedness has regressive and progressive sides that are directly correlated with the relative rejection or acceptance of the external object (see also Giovacchini's 1986 work on the transitional space in mental breakdown and creative integration).

I have shown how borderline patients also use their transitional objects to defend against object relations conflicts (Volkan 1976). However, the transitional object (or phenomenon) performs a progressive function in illuminating the bridge between mother-me and not-me (Greenacre 1970). The patient returns to it when ready to move out of the therapeutic symbiosis (the transference psychosis). In order to start moving again up the developmental ladder, he may create a new transitional object or use an old, persistent one with a new function. For example, one of my patients who always brought a bit of cloth to play with during her first year with me, resumed this habit in Step Three, but this time she would "lose" it on the couch and ask me to play with it. It belonged to both of us, and as we "played with it" (my play was only verbal), she began more and more to differentiate her representations of herself from her representations of me. Once the reactivated transitional object had fulfilled its function, she disposed of

her bit of cloth with a humorous comment, bringing instead a new dress to her session, the material of which looked somewhat like the discarded cloth—the transitional object.

Although the split transference that occurs during the second step is chaotic and impossible to study and interpret systematically, the split transference becomes in Step Four a part of the analytic working through, and it usually runs its course in a year or so. This split transference becomes the focus of the work and brings the possibility of mending the patient's opposing units.

When the borderline patient focuses on the second split transference, he pours out childhood memories, initiating affective discussions of the genetic determinants of what is going on in the here and now between himself and his analyst. Different images of the analyst, and corresponding split images of the patient himself, are visited or recalled.

Interpretation of the Genetic Material

In this step, the interpretation of the meaning of all-good or all-bad images includes genetic material as it appears in the transference and in the patient's daily activities. The three types of early environment noted in Chapter 2 come to the fore and the patient reviews his feelings, perceptions, and thoughts about the important characters in these backgrounds. The analyst's interpretations are retained with many effects on the psyche. Finally, the patient expresses frustration as he continues to use splitting in spite of his wish to "mend." The ways in which ferocious all-bad images bring annihilation anxiety at the time of mending is interpreted, and the analyst supports his patient's attempts to integrate opposing images.

Interpretation of Missing Hours

On a practical issue, I have found that borderline patients in this step are likely to skip some therapy hours if they split the representation of the analyst, seeking him out when he is good and "killing" him (by missing an appointment) when he is bad. When a like situation occurs during the first split transference in Step Two, I set limits, telling the patient I cannot work with him unless he comes to his appointments regularly. In the fourth step, however, I handle the question of missing hours by interpreting the anxiety pertaining to the integration of opposing affective images of the analyst.

Identification with the Analyst's Integrative Functions

In addition to interpretation in helping the patient to mend his split representations with their affective contamination is the patient's identification with the representation of the analyst as a new object. Although identifications with the representation of the analyst begin to occur much earlier, emphasis is now on identification of the analyst's *integrative* functions. When made the patient's own, these functions help glue the different, opposing representations of the patient together, like cement filling in the cracks and fissures of broken rock (Volkan 1982a). It is the analyst's task to monitor what the patient does with the analyst's "new" representation, which is now involved in an *exaggerated* introjective-projective relatedness. Although this representation is still contaminated with archaic good and bad objects, the patient is now ready to see it in terms of gray rather than in mutually exclusive terms of black and white. On the clinical level, the analyst will observe the patient's renewed and exaggerated interest in the extensions of the analyst such as the office furniture, pictures, and the like. For example, the patient may begin to refer in an accepting way to some picture on the wall formerly perceived as monstrous.

STEP FIVE: THE DEVELOPMENT OF TRANSFERENCE NEUROSIS

Once the ego organization moves from a lower level to one more integrated, the patient moves from a split transference to a transference neurosis, as indicated. I agree with those who hold that the upward-evolving transference relationship of the borderline patient is made possible by the development of increasingly mature object relations with the analyst. Kernberg's statement (1975) that narcissistic transference gives way to transference neurosis is, I believe, true for the borderline patient as well. At one crucial point, the deep admiration and love for the ideal mother and the hatred for the dangerous mother meet in the transference. Depression ensues, and the patient may even entertain suicidal thoughts, Kernberg says, because he has mistreated the analyst as well as other significant persons in his life and may feel that he has actually destroyed those whom he could have loved and who might have loved him. If this crucial point is watched by the therapist and properly interpreted to the patient, the latter is likely to experience only deep sadness instead of depression.

The vicissitudes of a genuine Oedipus complex are unmistakably present in this step. Although they may not emerge as completely as in a "classical" case, the patient now experiences the oedipal issue *for the first time with a mended inner structure*. Consequently, the experience of oedipal issues is fresh; they do not rise piecemeal from under a layer of repression. In a sense, these oedipal elements are like those the child analyst sees in children going through the Oedipus complex for the first time. Interestingly, with the development and resolution of these issues, the patient shows an increased capacity for repression, and some of the elements of split transference manifestations that are not mended are repressed.

STEP SIX: THE THIRD SPLIT TRANSFERENCE AND TERMINATION

The termination phase is extremely important in the analytic treatment of psychosis-prone borderline patients. If the "loose ends" are not tied, the patient might in the future, under certain circumstances, regress and stay regressed. By "tying the loose ends" I do not mean a rigid search for the perfect analysis, but only that there are last-minute secrets and/or activities that constitute a link to the regressive self and regressive operations. The termination phase allows such patients to bring these links to the surface and examine them, master the feelings they generate, and grieve over their surrender.

More than any other period of treatment, this sixth step approximates that of classical analysis in which the Oedipus complex has a "final" solution.

Little has been written about the termination phase of patients who had low-level character pathology at the start of their analytic treatment. Modell (1976), writing about the narcissistic patient, is exceptional. He divides the psychoanalytic process of patients with narcissistic character disorder into three phases. The last one, which ends with termination, approximates that of classical analysis in which the Oedipus complex is dealt with. Modell is quick to emphasize that the vicissitudes of the Oedipus complex may not emerge as completely as in a classical case and to say that, during this phase, the possibility of regressive movements is ever-present. To Modell's observations, I add (Volkan, 1979b) that the oedipal elements in the termination phase of narcissistic patients are often tinged with narcissistic glorification as the patient regards himself as "Number One" and thus behaves as though he is the only

oedipal child in the entire world.

I deal in other writings (Volkan 1975, 1976) with the termination phase of the psychoanalytic treatment of patients with borderline character organization. I suggest that, even after the borderline patient develops a transference neurosis, the background situation (splitting), so turbulent at first and now resolved as well as repressed, must continue to have attention. I suggest also that primitive splitting returns in the termination phase derepressed as though for review, ushering in a third split transference manifestation.

Because of the importance of Step Six, I will explore it here in some detail. I refer first to the termination phase of a neurotic patient and/or one with high-level character pathology and then I focus on the psychosis-prone borderline patient, comparing his termination phase with that of the former.

The Termination Phase of the Neurotic Patient

The psychoanalytic literature suggests different criteria for starting the mutually agreed-upon termination phase of an adult patient who is neurotic or who has high-level character pathology. Glover (1955) asks a number of psychoanalysts for their criteria, asking if such criteria were (1) symptomatic, (2) psychosocial, or (3) social. Although all claimed to use all three indications, most admitted that they decided on termination on essentially "intuitive" grounds. Glover writes: "It would almost appear as if the use of systematic criteria were a source of guilt, as if only intuitive criteria were free of suspicion. This reintroduces the bugbear of unconscious and pre-conscious assessments of, and reactions to, the patient" (p. 327). Glover does not oppose an analyst's use of intuition but suggests that one should learn from experience the extent to which one could trust his preferred method, whether it arise from intuition or intellectual assessment, and devise suitable checks on his conclusions. Weigert's remarks (1952) on termination also take into account the analyst's self-observation, regarding the appearance of a freer and more spontaneous feeling toward the patient as an indication that the time is ready for termination. Criteria more readily examined systematically include the resolution of the patient's transference neurosis (Glover 1955, Hum 1970); the resolution of a specific area of the transference neurosis; the resolution of the Oedipus complex (Miller 1965); the patient's coming to experience his analyst as a "new object" (Loewald 1960); and others. In Freud's writing we can find remarks about the criteria for

"cure" in analysis, and for a healthy personality makeup, but he writes nothing about initiating the termination phase.

Novick (1982) criticizes those who hold that the termination phase proper begins when the transference neurosis—and, by implication, the Oedipus complex that was reviewed in the treatment—is resolved. He says, "If we wait until the transference neurosis is resolved, until all criteria of cure have been achieved, before starting the termination phase, then indeed there is nothing to do during the terminal phase" (p. 345). He suggests that the termination phase should begin at a point of maximum evolution of the Oedipus complex in the transference neurosis. According to this line of thought, much work remains to be done on the "final" resolution of the Oedipus complex during the termination phase. My experience supports Novick's views. In *What Do You Get When You Cross a Dandelion with a Rose?* (Volkan 1984), which is a true and detailed story of a psychoanalysis, I clearly show how much work was done in the termination phase to arrive at the "final" resolution of my patient's Oedipus complex. Thus I suggest that the termination phase of treatment of a patient who is neurotic or who has high-level character pathology should last for perhaps three or four months, which is a reasonable amount of time for mourning by both parties of the dyad.

Before setting a termination date I usually spend three or four months helping my analysand to take stock and arrive at a mutually agreeable time to terminate. Dewald (1972) has written on assessing structural change at the completion of an analysis, and his criteria can also be applied to stocktaking. I agree with Rangell (1966), Ticho (1972), and Novick (1982) that the termination phase should be divided into two subphases, in the first of which a decision that the analysis can and should end is reached, and in which both the patient and the analyst take stock. The second subphase begins with the decision about the termination date. I focus here on this second subphase, classically known as the termination phase proper.

I usually work for three to four months with a patient after setting the date for termination, although there are exceptions. For example, I reached an agreement with a patient for terminating in three months, but I later considered the agreement invalid and ended his analysis in an unusual way.

> The patient's father, a ranking military officer, had left his family for overseas duty for two years at the time my patient was approaching the oedipal age, and while awaiting her husband's return, his mother had

showered her child with affection. The oedipal boy then felt exaggeratedly competitive when his father came home. His mother would go into her son's bedroom, lock the door, and smoke while sitting on the child's bed as he tried to go to sleep. She would say, "My darling little boy, this [her smoking] is our secret; your father does not like me to smoke." For the child this was an oedipal triumph, and he symbolically kept it alive by keeping secrets, especially from father figures, for the rest of his life.

Once we had agreed on a termination date, he told me a secret he had previously kept from me. After discussing with him what he was repeating—a secretive oedipal triumph over me—we cancelled the termination date. I told him that after we had worked through the meaning of his "last" secret I would tell him when we would be through with his analysis. In a sense I was asserting the oedipal father's strength so that in turn he could identify with a strong oedipal father. I hoped that by doing this we would prevent his going through life feeling obliged to have symbolic secrets. I ended his analysis in the middle of a session after a few more months of work beyond the original termination date. I have a 20-year indirect follow-up on this case and hear that he is still doing extremely well.

There are other controversies about how much time should pass in an analysis after the setting of a termination date. When symptoms return during this period, differing explanations are offered. Kubie (1968), for example, does not see the return of symptoms in this phase as an expectable, "normal" occurrence, holding that it is an indication of failure to resolve the transference. Miller (1965) believes it to be connected with the patient's attempt to retain the infantile fantasy of omnipotence. It is usual for my adult patients to exhibit some symptom revival, and I do not consider this an indication of failure; it is accompanied by an observing ego and does not lead to disorganization. Patients revive their symptoms in symbolic therapeutic stories. I see this as part of a last effort to take stock and, more importantly, part of the mourning process. Patients revive their symptoms in order to part with them.

Glover (1955) holds that the reactivation of symptoms at the end of the analysis is the patient's way of clinging to the analyst, and there is support for this concept in certain cases. Nonetheless, I find the formulation of clinging secondary to evidence of the mourning process.

The Termination Phase of Psychosis-Prone Borderline Patients

In the course of their improvement, psychosis-prone borderline patients develop a better ability to integrate and a better ability to repress. Their repertoire of high-level defense mechanisms improves. However, when they come to the termination phase, they face the biggest separation of their lives: the separation from their analyst and from the therapeutic process, which is closer to a parent-child relationship than the therapeutic relationship of a neurotic and/or a person with high-level character pathology. Borderline patients, like adolescents (Novick 1982), exhibit the recurrence of old symptoms

during the termination phase more often than do neurotic patients. They reexamine their object relations conflicts and, more importantly, revive old ways of controlling separation anxiety.

There is a longer time period between the setting of a date and the completion of treatment in the case of a borderline patient than with a typical neurotic; I usually plan for a period of six months to a year. When manifestations of the split transference reappear openly—and perhaps exaggeratedly—in the termination phase, I do not hasten to interpret them or to bring up genetic material reflected in recent interaction either within or outside therapy but exercise instead an attitude of *benign neglect* toward them. The patient then will inevitably interpret the appearance of primitive splitting and related defenses, make genetic references about it and, what is more important, acknowledge his clinging to it as a way of clinging to the analyst. This is more the case in borderline patients than in those who possess high-level character organization and are neurotic. However, borderline patients also reactivate their symptoms after the termination date is set, as part of their mourning process. I help the patient to face his own utilization of his observing ego in understanding the symptom revival and make him use his own integrative function with little assistance from me.

These patients strongly exhibit separation anxiety when coming to treatment, and they tend to use primitive and "magical" defenses against separation anxiety again when, after much work, they face the reality of terminating and leaving their analyst, who must be aware of this possibility. Even when his analytic treatment has given the patient experience in grieving, in a hidden and magical way he may want to control his grief over terminating, perhaps using secret "linking objects or phenomena" (Volkan 1972, 1981c) to try to remain in a state in which the option of either "killing" or "uniting with" the analyst always remains open. He will then choose an inanimate or nonhuman object (linking object) or an abstract symbol (linking phenomenon) through which to "connect" his representation of himself with the corresponding representation of the lost object (person), thus maintaining the illusion of being able either to bring the lost person back or "kill" him, although he does neither and stays in a state of limbo. Although not resolved, the separation conflict is controlled, at least for the time being.

The use of such magical links in the termination phase must be analyzed and dealt with properly. Since they are now considered to be fully adult, the analyst does not wean them but conducts his analytical business until the last moment.

"Review dreams" (Glover 1955) usually occur at this point as an indication to the patient that he can integrate opposing representations (Volkan 1976). What remains for him is to express genuine affection for and gratitude to his analyst as well as sadness over the end of their very long association.

After termination is effected, mourning is likely to continue until resolution. As Bird (1972) suggests, some patients cannot fully appreciate the reality of termination until after it takes place, and I believe that patients who undertake treatment in a severely regressed and/or undeveloped state usually fall into this category. The account of my work with Pattie, which appears in Part II, is designed to make the six steps described here come to life.