Borderline Psychopathology and its Treatment

The Myth of the Alliance

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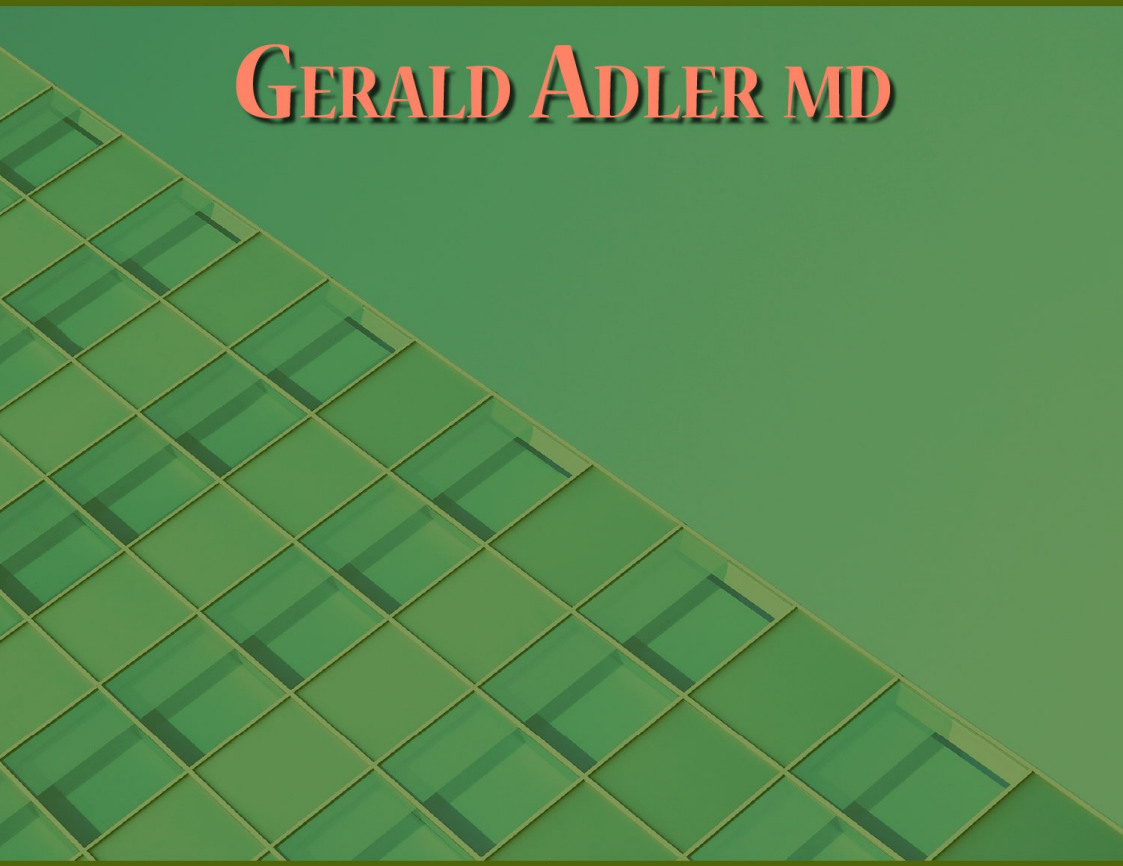

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In clinical work with borderline patients, we are frequently impressed with the rapid breakdown of what seems to be a tenuous, or sometimes even more solid, alliance. Desperate borderline aloneness can emerge when unbearable affects appear in the therapy or when the therapist makes a response that is unempathic or perhaps incorrect. Similarly, when we examine the narcissistic personality disorders with their stable selfobject transferences, we can ask whether a therapeutic alliance exists or whether these primitive transferences themselves allow the patient to be sustained in the treatment. Although we invoke concepts of alliance and make statements about building alliance, it seems probable that the empathic support and optimal frustration offered by the therapist provide the empathic framework that the patient needs in order to sustain himself with a selfobject transference; the therapist can mistake this stable transference for an alliance.

In this chapter I shall delineate a developmental sequence that culminates in the patient's capacity to form a therapeutic alliance. I hope thereby to expand our understanding of the concepts of transference, real relationship, and alliance in all patients, based upon examination of the recent literature about borderline and narcissistic personality disorders and clinical experiences with them. In particular, I shall be considering the primitive or selfobject transferences (Kohut 1977) these patients form and their relationship to the evolving capacity to observe and utilize the objective qualities of the therapist ultimately to develop a mature therapeutic alliance that can withstand the vicissitudes of intense affects, impulses, wishes, and conflicts. I shall then discuss the relationship of these selfobject transferences to the analysis of all patients and the formation of the usual neurotic dyadic and triadic transferences.

The concepts of alliance, transference, selfobject transference, and real relationship are complex, interrelated, and often confusing. It is generally acknowledged that alliances derive from transference and relate to certain successful childhood experiences and developmental achievements, which obviously include relationships with people, both past and present. Because the separation of these concepts is important theoretically and clinically, I shall define the ways in which I shall use some of

these terms.

Definitions

Transference is the experiencing of affects, wishes, fantasies, attitudes, and defenses toward a person in the present that were originally experienced in a past relationship to a significant figure in childhood (Greenson 1965). As a displacement of issues from old relationships to present ones, transference is always inappropriate to the present. It can also be conceived as a projection of inner or internalized or partially internalized superego (Zetzel 1956), ego ideal, id, or ego aspects onto the present person. Selfobject transferences are transferences in which the therapist and patient are variably fused along a complex continuum in which the therapist performs certain functions for the patient that are absent in the patient. The therapist's performance of these functions is necessary for the patient to feel whole and complete, while experiencing these therapist functions as part of himself. As defined by Kohut (1971, 1977), the narcissistic patient needs the therapist's mirroring responses and his acceptance of the patient's idealization. The borderline patient, as we have seen, needs the therapist to perform holding-soothing functions. Dyadic and triadic transferences are those transferences most often found in neurotic patients and are usually related to the transferences in the transference neurosis. They imply solid self and object differentiation as well as minimal use of projection and projective identification such that these defenses do not significantly interfere with reality testing. The further distinctions between selfobject transferences and dyadic-triadic transferences will be discussed later.

I shall use alliance in the usual sense of Zetzel's (1956) therapeutic alliance and Greenson's (1965) working alliance as derived from Sterba (1934), an alliance between the analyzing ego of the therapist and the patient's reasonable ego. It involves mutuality, collaboration, and the mature aspects of two individuals working together to understand something and to resolve a problem. Although it derives from and relates to earlier kinds of relationships that can be considered precursors or aspects of alliance, my utilization of the term stresses mature collaboration.

By real relationship I am referring to the actual relationship between patient and therapist, which is based upon the patient's perception of the objective attributes of the therapist as they are distinguished from transference. To perceive the real attributes of the therapist, the patient must have

achieved a significant degree of self and object differentiation and must not utilize projection and projective identification to an extent that they obscure the therapist's objective attributes. The real relationship is also referred to as the personal relationship between patient and therapist (A. Freud 1954, Lipton 1977). The personal relationship is generally used to mean the way the therapist utilizes his personality and human qualities to relate to his patient, and includes such qualities as his flexibility, warmth, and openness. For this personal relationship to be synonymous with the real relationship in the patient's eyes, the patient should have achieved sufficient self and object differentiation and concomitant capacity to test reality to perceive this personal relationship in objective terms, that is, as separate from transference. The real relationship must also be distinguished from such concepts as "the therapist's being more real." The latter is often used to describe issues such as the amount of activity by the therapist and his sharing of personal information in response to his perception of the patient's needs or demands. It may or may not coincide with the patient's objective perceptions of this activity at the moment or at some other time, again based upon the degree of the patient's self and object differentiation and uses of projection and projective identification at the moment, which in part may be determined by the intensity of the transference.

The Transference-Alliance Literature

Zetzel (1956) is credited by Greenson (1965) with introducing the term therapeutic alliance into the psychoanalytic literature, although the alliance concept was implicit in the work of others. Fenichel (1941) describes the "rational transference," and Stone (1961) writes about the "mature transference." Greenson's (1965) working alliance is similar to Zetzel's but emphasizes the patient's capacity to work in the psychoanalytic situation.

Friedman (1969), in his scholarly discussion of the therapeutic alliance, delineates the complexities and paradoxes in Freud's development of the concept of transference and its link to the idea of alliance. Freud (1910a, 1910b, 1912, 1913) was aware that transference was not only a resistance, but also a helpful bond in keeping the patient in treatment. He attempted to resolve the contradiction by ascribing the resistance to negative feelings and defenses against unconscious erotic feelings toward the analyst. The positive bond was strengthened by the patients "conscious" and "unobjectionable" feelings.

The interrelationship of transference as a resistance to treatment and transference as an ally of the therapist and motivating force in treatment is a theme throughout Freud's writing, as Friedman describes. Freud, in his last attempts to address the transference and alliance dilemma (1937), utilizes the structural theory. He writes of "an alliance with the ego of the patient to subdue certain uncontrolled parts of his id, i.e., to include them in the synthesis of the ego" (p. 235), and states that the positive transference "is the patient's strongest motive for the patient's taking a share in the joint work of analysis" (p. 233). Here, too, transference and alliance seem inextricably intermeshed.

In all this work, Freud rarely discussed the real relationship between patient and analyst. Lipton (1977) attributes this omission to the fact that Freud was describing technique and, for example, the neutrality required in it. The personal relationship was obviously present and obviously important, as Freud's notes of his work with the Rat Man (1909) reveal, and as confirmed by reports from Freud's former analysands (Lipton 1977).

Perhaps we can sort out some elements in the use of transference and alliance in Freud's technique papers by examining the various functions of transference and alliance in therapy and the therapist's and patient's different uses of them. The positive transference, which keeps the patient in treatment, is primarily experienced by the patient as something he feels when he thinks about the therapist or is with him. The alliance, in contrast, is utilized by the therapist to help the patient look at something, including the experience of transference (P. G. Myerson, personal communication, 1978), and is felt by the patient as an awareness that the therapist's actions are motivated by the patient's best interests (Myerson 1964). The alliance aspects support looking, reflecting, examining, and insight. The transference supports attachment and emotional involvement. However, a careful examination of these distinctions clinically can sometimes reveal the lack of a clear difference between them: Sometimes what appears to be an alliance is compliance on the part of the patient; the patient may wish to please the therapist in order to get gratification or avoid fantasied punishment—in short, the transference can be confused with the alliance (Greenson 1965; P. G. Myerson, personal communication, 1978).

In a recent paper Gutheil and Havens (1979) draw heavily upon Friedman's work to delineate transference and alliance concepts. Utilizing Friedman's descriptions they categorize many varieties of alliance. Although they tend to allow a blurring between transference and alliance to remain, they

provide an interesting lead into new territory. They attempt to validate their complex categorization of forms of alliance by seeing whether they can apply their categories to Kohut's writing, using one of his major works, *The Analysis of the Self* (1971). They believe that Kohut himself confuses transference and alliance; Kohut emphasizes that stability in analysis occurs when the narcissistic (1971) or selfobject (1977) transferences that develop in narcissistic personality disorders are allowed to emerge through the therapist's empathic understanding. These transferences especially flourish when there are no intrusive alliance-building statements or specifically defined countertransference difficulties that can disrupt their appearance and solidification. Once these selfobject transferences are established in the narcissistic personality disorder, Kohut states, the framework for a stable clinical analyzable situation exists.

As Gutheil and Havens point out, however, Kohut also speaks of the alliance in narcissistic personality disorders in a statement that is reminiscent of Sterba:

> The observing segment of the personality of the analysand which, in cooperation with the analyst, has actively shouldered the task of analyzing, is not, in essence, different in analyzable narcissistic disorders from that found in analyzable transference neuroses. In both types of cases an adequate area of realistic cooperation derived from positive experiences in childhood (in the object-cathected *and* narcissistic realm) is the precondition for the analysand's maintenance of the therapeutic split of the ego and for that fondness for the analyst which assures the maintenance of a sufficient trust in the processes and goals of analysis during stressful periods (Kohut 1971, p. 207).

Although the stable analytic situation in the treatment of narcissistic personality disorders arises from the emergence of the selfobject transferences, Kohut feels that these patients also have the capacity for realistic cooperation with the analyst, that is, they form alliances as well as selfobject transferences.

The problem with Kohut's statement lies in its lack of validation based upon clinical experience. In psychotherapeutic work with narcissistic personality disorders, we can observe that a stable clinical situation is present once the selfobject transferences emerge, but we find rational cooperation and an observing ego tenuous and easily lost. As Kohut himself points out, an empathic failure can rupture this rational bond to a degree not present in neurotic patients. Thus, patients with narcissistic personality disorders are capable of the capacities defined by Kohut to a relatively large extent once the selfobject transferences are firmly established and if not stressed too greatly by serious empathic failures or countertransference difficulties. Despite Kohut's inconsistencies about the interrelationship between

selfobject transference and alliance, as outlined by Gutheil and Havens, his descriptions of the stabilizing effects of selfobject transferences in the treatment of narcissistic personality disorders can provide the link in our discussion of the relationship of these transferences to other transferences, the real relationship with the therapist, and alliance formation.

Selfobject Transferences and Transference Neurosis

Kohut's selfobject transference concept, which he developed in his work with narcissistic personality disorders and which I have extended to borderline patients, is related to concepts utilized by other workers, especially when they describe the early phases of treatment of all patients. As Fleming (1972) states, the analytic situation is designed to shift the balance in the usual sources of comfort for a patient. All patients early in treatment tend to feel alone and wish to return to the security of the early mother-child relationship. The holding environment concepts of Winnicott (1960) refer to these same wishes and needs. Fleming (1972, 1975) stresses Mahler's (1968) symbiosis concepts as crucial in the early treatment situation. Erikson's (1959) basic trust concepts, Gitelson's (1962) discussion of the diatrophic function of the analyst, and Stone's (1961) descriptions of the "mother associated with intimate bodily care" are also related to the special issues of the early phases of treatment. Although these workers are using a variety of theoretical models and terms, I believe they are referring to a clinical situation early in the treatment of analyzable neurotic patients in which transferences emerge that may at times be indistinguishable from Kohut's selfobject transferences. In fact, a major task of the therapist or analyst in the early phases of treatment of all patients may be that of providing the setting, support, and clarifications and interpretive help that allow these selfobject transferences to emerge. The development of these selfobject transferences may coincide with the therapist's sense that the patient is "settling down" in treatment and is comfortable enough to be able to begin working collaboratively.

Obviously, the type of selfobject transference is largely determined by the specific needs of the patient. For this reason, the selfobject transferences that are present in neurotic patients may not be visible under ordinary circumstances. They may be established silently and unobtrusively in the therapeutic situation, in part through the consistency, reliability, and understanding that the therapist supplies from the beginning of treatment. The issues that are central to the selfobject transferences, that is, issues of self-worth and holding-soothing, are usually not major unresolved issues for neurotics. Thus,

neurotic patients do not generally return to these issues for further resolution as part of the unfolding transferences. Instead, these selfobject transferences provide the silent, stable basis for work on the more unsettled issues that make up the conflicts of the transference neurosis of many readily treatable neurotic patients.

The therapist's recognition of these silent selfobject transferences, however, may be important for neurotic patients in at least two circumstances (D. H. Buie, personal communication, 1979): (1) a retreat by some patients to these selfobject transference issues as a defense against the onslaughts of a confronting therapist, and (2) difficulties in termination that may be related to unanalyzed selfobject transference issues that emerge during the termination process. When repeatedly confronted by a therapist with formulations that are beyond the patient's capacity to acknowledge at the time, or that may even be incorrect, the patient can regress defensively in a way related to Winnicott's (1960) descriptions of a false self. Under these circumstances an idealizing selfobject transference may be one of the ways the patient can protect himself from his therapist's intrusiveness, while sacrificing opportunities for constructive psychotherapeutic work. During termination it is possible that some of the expected reappearance of old symptoms and conflicts may also be related to unanalyzed selfobject transference issues that only now emerge when the selfobject bond between patient and therapist is about to be severed. Unless these are identified and examined, an opportunity for crucial therapeutic work can be lost. Finally, it is important to recognize that there is a large group of neurotic patients who require work at many points in their treatment on selfobject as well as dyadic-triadic issues. These patients have clearly advanced into the neurotic levels of unresolved conflict that becomes manifest in the transference neurosis. Yet there are sufficient unsettled earlier issues that require work on the level of selfobject as well as later transferences as the patient's material shifts from these different levels. Significant unfinished work can result from a focus on one rather than multiple levels of transference.

Relationship of Selfobject, Dyadic, and Triadic Transferences to Alliance

In contrast to the dyadic and triadic transferences, the selfobject transferences usually imply some degree of fusion of patient and therapist. Still, if we examine the full spectrum of selfobject transferences as Kohut (1971,1977) defines them, we see that they include both the most primitive varieties, with significant degrees of merger, and more differentiated ones that include complete separateness of

patient and therapist. For example, "the mirror transference in the narrower sense" is a variety of selfobject transference that Kohut describes as similar to the twinkle in the mother's eye as she admires her child. This form of selfobject transference, then, is one in which an interaction between two separate people is occurring. The selfobject transferences in which the patient and therapist are separate people, and which may include mirroring as well as idealizing varieties, seem to be a form of dyadic transference seen in neurotic patients. There thus appears to be a point in the continuum between selfobject and neurotic transferences in which there is no clear distinction between them—in which there is complete separateness of patient and therapist. At that point the transference may be said to be dyadic. Of course, not every dyadic transference is a more differentiated selfobject transference. Selfobject transferences by definition are related to issues of sustenance, grandiosity, and idealization. Therefore, they would not include dyadic transferences seen in neurotics that focus on, for example, struggles over control and power in relationship to the therapist as mother or father in the transference. But they would include the kind of silent transferences often present in neurotic patients that support emotional involvement with the therapist—the so-called positive transference.

Another quality that seems to distinguish selfobject and dyadic-triadic transferences is the patients' passivity or activity in these transferences (P. G. Myerson, personal communication, 1979). In the selfobject transferences patients more often wish to be held, fed, admired, and passively comforted, in contrast to the more active, assertive wishes and fantasies associated with the dyadic-triadic transferences. When frustrated or disappointed within the selfobject transferences, however, patients do experience an active anger that can be associated with destructive fantasies as well as with experiences of fragmentation.

The Real Relationship

Discussions about the real relationship in psychoanalysis and psychotherapy tend to occur most often among clinicians who work with borderline and narcissistic personality disorder patients. The emergence of several relevant issues in the treatment of these patients may help explain the interest in the real relationship: (1) This group of patients may complain with intensity that they need something more than the therapist is giving. (2) They may state specifically that the therapist is not real to them and ask or demand to know details about his life, or demand to have an extra-therapeutic relationship in

order to feel that the therapist is "real." (3) The therapist in working with these patients may feel both empathically and theoretically that these patients need something more than an approach that emphasizes clarification and interpretation.

These issues raise a major difficulty in discussing the real relationship. A patient demanding more from his therapist may be making a statement about intense transference longings, anger, or disappointments. Or the patient may be revealing a developmental failure on the basis of which he feels incomplete and requires some response to establish the situation that remedies this feeling, at least temporarily. At the same time, the patient may be pointing to an actual deficiency in a therapist who is failing to provide the necessary response either to the transference demand or to the requirements for a selfobject relationship that the patient needs in order to work with the therapist. If we use the term personal relationship to refer to the qualities of the therapist that objectively exist and that become a part of his interaction with the patient which the patient perceives objectively, we can more clearly separate transference issues from issues of the real relationship.

Borderline and narcissistic personalities can establish both selfobject and dyadic-triadic transferences, although the intense transference demands of these patients usually relate to the failure of selfobject transferences to be established or maintained. The demands by the patient for the therapist to be more real often refer to these selfobject transference failures or breakdowns. If the therapist responds to these intense transference requests, for example, for more facts about the therapist, by sharing more about himself, a variety of results could occur. If the therapist's responses coincidentally help to establish or reestablish the selfobject transferences, the patient may become more comfortable and work more effectively in the therapy. On the other hand, when the therapist shares more about himself without clarifying or interpreting the transference, he may be felt unconsciously by the patient to be missing the essence of the patient's transference difficulties, and thus providing another disappointment; this disappointment can be followed by an angry escalation of demands for even more from the therapist. Thus, the correct assessment of the patient's demands may be crucial; if the issue is the breakdown of selfobject transferences, the work should involve clarification and interpretation; it may also include efforts to clarify distortions in the personal relationship between patient and therapist.

A paradox exists, especially with borderline and narcissistic personalities, in our understanding of

the personal relationship between patient and therapist and the patient's utilization of this personal relationship to facilitate the therapeutic work. At the beginning of treatment these patients often require an awareness of the person and personality of the therapist as someone appropriately interested, caring, warm, and wishing to be helpful in order to establish the selfobject transferences that stabilize the treatment and make optimal therapeutic work possible. Yet these same patients may have minimal capacities to define and observe these objective attributes in the therapist and utilize them for internalizations. The paradox relates to the fact that many of these patients have relatively secure capacities to see a relationship objectively only when the selfobject transferences are firmly established, that is, when they have regained functions previously present. These functions are transiently lost in the regression that often brings them into treatment, and that often involves a loss of a selfobject relationship or a loss of an activity that maintains self-worth. It requires the stability of the established selfobject transferences to reverse the *transiently* lost ability to observe clearly and define the personal qualities of the therapist. That is, the firmly established selfobject transferences, usually involving some degree of merger, allow the patient to regain concomitant capacities to appreciate the separateness of the therapist and the many areas of the patient's own separateness, which were transiently lost in the regression that usually leads these patients to seek treatment (and lost to a greater extent by borderline patients than by narcissistic patients as a general rule). With this appreciation, the patient can also begin to internalize objective qualities of the therapist that are missing in himself and idealized aspects projected onto the therapist as part of the selfobject transference. Patients with a borderline personality disorder, because of their occasionally tenuous self and object differentiation and primitive avoidance defenses that become most manifest as intense affects emerge, may have the most difficulty in perceiving and utilizing the objective qualities of the therapist. They therefore may require greater activity from the therapist in his demonstration of his willingness to clarify, explain, be helpful, and meet the patient's level of regression (P. G. Myerson 1964, 1976; personal communication, 1979). In making this statement, I am not minimizing the importance of an interpretive approach that focuses on transference and reconstruction. Nor am I unaware of the dangers of activity that may be perceived by the patient as smothering, engulfing, or seductive, or that may be a maneuver by the therapist to avoid the anger that the patient may be experiencing. Still, the therapist's goal is to foster a therapeutic situation in which the selfobject transferences can emerge and their pathological aspects can be interpreted. To achieve this goal, the possible excessive gratification brought about by the therapist's activity must be weighed against the

patient's limited capacity to tolerate deprivation at any specific moment.

In psychotherapeutic work with neurotic patients, the silent selfobject transferences are more readily established in the average expectable therapeutic environment. Neurotic patients can tolerate a wider range of styles and personalities in the therapist as part of their personal relationship with him, although there is an optimal spectrum within the wider range. They can also more readily perceive the objective qualities of the therapist and utilize these objective qualities therapeutically after the selfobject transferences and transference neurosis flourish.

The Emerging Therapeutic Alliance

We can now discuss the relevance of all these considerations to the "myth of the alliance" with borderline patients. As Friedman (1969) and A. Ornstein (1975, quoted by Berkowitz 1977) note, the requirement that a patient establish or have the capacity to establish a therapeutic alliance at the beginning of therapy is the request for a capacity that is the end result of a successful therapy. In fact, the demand for an alliance may tax an already tenuous sense of psychological security in the patient. Yet clinically we attempt to assess such alliance potential in our diagnostic evaluations. If a patient responds with a confirmatory nod and amplification to a clarification that we present to the patient as something we can look at together, how can we know whether the patient feels supported by the empathic correctness of the statement or by its appeal to collaboration? Even if he responds to the "we" aspect of the statement, what does the "we" mean to him? Is it the collaboration of two separate people, or does he hear the "we" to mean the partial fusion of two people, that is, a statement supporting the formation of a selfobject transference?

My own work with primitive patients suggests that the "we" invoked by the therapist often makes the therapist more comfortable but is effective only when it coincides with the patient's feeling sustained through a selfobject transference. The patient usually does not experience the working collaboration; instead, he is held in the therapy by feeling supported, soothed, and understood. The therapist's activities in this regard help to create the selfobject transference. But they do not establish a therapeutic alliance, only its selfobject precursors, which ultimately can be internalized slowly as the primitive transferences are resolved and neurotic transferences become more solidly established. At the point that

the patient is capable of a solid therapeutic alliance, that patient no longer has a borderline or narcissistic personality disorder; in fact, he is well within the neurotic spectrum and approaching the end of therapy.

The therapeutic alliance in its mature, stable form is thus usually only present in a later stage of treatment, although precursors or unstable forms of it may be visible earlier. The therapeutic alliance derives from the resolutions of early (selfobject) and later (dyadic-triadic) transferences, and requires the patient's capacity to separate the personal relationship with the therapist from the transference. Internalizations that occur through resolution of the selfobject and neurotic transferences, which include internalizations of projections of the inner world or introjects onto the therapist, are part of this process that leads to the patient's increasing capacity to form a therapeutic alliance.

For all these reasons, there are dangers in using alliance-building statements at times when the alliance is not viable developmentally for the patient at a particular stage in therapy. These statements can be used to obscure the fact that the therapist is not empathically in touch with his patient and is appealing to reason when he does not understand the patient, leading to disruptions of the selfobject transference, as the following vignette suggests.

> A 35-year-old single woman who sought therapy for chronic depression and inability to maintain relationships with men was regarded by both her therapist and his supervisor as someone with a hysterical character problem. After nearly a year of twice-weekly psychotherapy, the patient remained essentially unchanged and felt that she was making little progress. The therapist focused his work on her disappointment in her relationship with her father and competitive feelings toward her mother. He also stressed the collaborative nature of their work and emphasized frequently that the two of them were looking at or could look at certain issues and feelings together.
>
> Following one of these exhortations about collaboration, the patient looked her therapist squarely in the eye and said, "Don't give me any more of that 'we' crap!" Although the therapist was momentarily stunned, he had no adequate response or explanation. It was only after careful review of his work with the patient that he concluded that he had been treating someone with a narcissistic personality disorder as a person with a neurotic character problem. His lack of understanding of the nature of the patient's despair and developmental difficulties was perceived by the patient as the therapist's empathic failure. Under those circumstances there was little to sustain the patient except for her perception that the therapist was occasionally empathically correct and struggled to understand her; nothing suggesting a therapeutic alliance, however, was ever present with her.

To summarize, I believe that a sequence occurs in the successful therapy of primitive patients: (1) the establishment of stable selfobject transferences that sustain them, (2) the increasing capacity to

appreciate the therapist as a real and separate person, and (3) the gradual ability to ally themselves with the therapist in the service of accomplishing work.

Using these formulations, the therapist has as a major task the clarification of where the patient lies in this continuum, what causes the patient's fluctuations within it, and what responses by the therapist will solidify the patient's achievements as he advances along it. Thus, the primitive patient's dissatisfaction that the therapist is not real to him may be viewed as the patient's failure to establish a sustaining selfobject transference at that moment. The therapist's formulations and empathic understanding determine his responses at different times and are specifically related to clarification or interpretation that addresses the appropriate point of the developmental sequence.