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The Theory of Psychoanalytic Psychotherapy

Curative Factors in Dynamic Psychotherapy

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The Theory of Psychoanalytic Psychotherapy[1]

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Historical Roots of Psychoanalytic Psychotherapy

Psychoanalytic exploration of the defenses and resistances, the transferences and drive derivatives of patients with severe character pathology and borderline personality organization has shown that the intrapsychic structural organization of these patients seems very different from that of better functioning patients. This finding has imposed serious constraints on the traditional theory of psychoanalytic psychotherapy. Of particular concern is that the structural characteristics of borderline patients defy applying the model of psychoanalysis to psychoanalytic psychotherapy, unless the model is modified. Yet many studies of pathological early development and object-relations theory that aim to understand severe psychopathologies recommend—implicitly or explicitly—only standard psychoanalytic techniques. We seem to have, on the one hand, a theory of psychotherapy that is not applicable to many patients in psychotherapy and, on the other hand, theories of pathological development and severe psychopathology that might require new models of psychotherapy, but are presented in terms geared mostly to psychoanalytic technique proper. One purpose of this chapter is to try to resolve this paradox.

Gill's (1954) definition of psychoanalysis as the establishment of a therapeutic setting that permits the development of a regressive transference neurosis and the resolution of this transference neurosis by means of interpretation carried out by the analyst from a position of technical neutrality contains two important implications for the theory of psychoanalytic psychotherapy. First, if the analyst's position of technical neutrality, the use of interpretation as a major psychotherapeutic tool, and the systematic analysis of the transference define psychoanalysis, then psychoanalytic psychotherapies may be defined in terms of modifications in any or all of these three technical essentials. In fact, I think the definition of a spectrum of psychoanalytic psychotherapies, ranging from psychoanalysis to supportive psychotherapies, is possible in terms of these three basic features.

Second, it needs to be stressed that the analysis of the transference is simultaneously the analysis of instinctual urges and defenses against them, and of a particular object relation within which these instinctual urges and defenses are played out. As Glover (1955) pointed out, all transference phenomena must be analyzed in terms of the principal stage of libidinal investment activated and the principal identification involved. Both contemporary ego psychology and object-relations theory take their departure from this dual nature of the transference.

It seems to me that modern ego psychology's major contributions to the

theory of technique—in contrast to theories of development and psychopathology—stem from Wilhelm Reich's *Character Analysis* (1933-1934) and Fenichel's *Problems of Psychoanalytic Technique* (1941). These works expanded the analysis of resistances—including the transference as a principal resistance and source of information in the psychoanalytic situation—into the detailed analysis of the resistance function of pathological character traits. These contributions also pointed to the intimate connection between the predominance of character defenses in cases of character pathology, on the one hand, and the activation of these defenses as part of the prevailing transference resistances in all analytic treatments, on the other.

The analysis of character may well be the most dramatic practical application of psychoanalytic technique to the treatment of the neuroses. Psychoanalytic character analysis is a fundamental challenge to the traditionally pessimistic attitude of psychology and psychiatry toward the possibility of changing personality structure. From the early focus on reaction formations and inhibitory character traits to the later focus on impulsive character traits and impulse-ridden characters in general, it was only a small step to the present psychoanalytic focus on the nature of global ego "defects"—and on the puzzling relationships between ego defects and character defenses and resistances (is an ego defect a complex character resistance, or does a character resistance reflect an ego defect?).

The ego-psychology theory of psychoanalytic psychotherapy as proposed by Gill (1951, 1954), Stone (1951, 1954), Eissler (1953), Bibring (1954), and others may be defined as a psychoanalytically based treatment that does not attempt to systematically resolve unconscious conflicts, and therefore, resistances, but rather, to partially resolve some resistances, and reinforce others, with a subsequent partial integration of previously repressed impulses into the adult ego. As a result, a partial increase of ego strength and flexibility may take place, which then permits a more effective repression of residual, dynamically unconscious impulses, and a modified impulse-defense configuration that increases the adaptive—in contrast to maladaptive—aspects of character formation. This definition differentiates psychoanalysis from psychoanalytic psychotherapy in terms of both goals and the underlying theory of change reflected in these different goals.

Wallerstein formulated this difference when he proposed (1965) that the procedural stance of psychoanalysis is characterized by its lack of a specific goal (in terms of the open-ended nature of analytic work), that it aims instead at fundamental character realignment. In contrast, psychoanalytic psychotherapy focuses on certain individual circumscribed goals in that it aims for desirable modifications of behavior and character structure, without the broader goal of resolving character pathology.

The techniques employed in psychoanalytic psychotherapy were all

devised to facilitate these goals and to bring about a partial shift of the dynamic equilibrium among the tripartite structures. I would modify Bibring's (1954) description of psychotherapeutic techniques to include, first of all, partial interpretation, meaning both preliminary interpretations that would remain limited to conscious and preconscious areas (or clarification), and full interpretations of some limited intrapsychic segments (leaving other segments untouched). The effect of these techniques would still be "analytic" in a strict sense, that is, at least partially uncovering unconscious motives and conflicts.

Abreaction, another psychotherapeutic technique, would permit the expression of suppressed and repressed emotions in the therapeutic situation, thereby presumably reducing intrapsychic pressures, owing to the patient's sense of being accepted by the therapist as a tolerant and empathic parental figure and, in this connection, by means of other transference gratifications as well. Suggestion, comprising a broad spectrum of psychotherapeutic techniques, includes rational counseling, advice, and emotional suggestions (e.g., hypnosis). Its effectiveness would be due to the transference implications of direct support and command from an important parental figure, the reinforcement of adaptive characterological solutions to intrapsychic conflicts, the (at least temporary) decrease of superego pressures (by their externalization, and, in this process, modification), and the facilitation of identificatory processes with the therapist's active and

supportive stances toward the patient.

Manipulation would affect the intrapsychic balance of forces by indirect means, such as fostering a more favorable social environment for the patient, eliminating or controlling regressive and conflict-inducing situations in the environment, and favoring derivative expressions of the patient's unconscious needs by providing specific social outlets or situations.

Some common mechanisms by which all of these psychotherapeutic techniques may affect the patient in psychoanalytic psychotherapy have been described in the literature; for example, the "corrective emotional experience" implied in the positive human relationship developed in the course of psychoanalytic psychotherapy; the particular transference gratifications symbolically achieved in the course of the therapist's suggestive, manipulative, abreactive, and even clarifying and interpreting interventions; and, most important, the activation of identification processes in the patient by means of all of these interventions—adaptive ego identifications with the therapist would increase ego strength directly.

Combining the techniques employed in psychoanalytic psychotherapy, the ego-psychology approach defined two major modalities of treatment. The first is exploratory, insight-oriented, and uncovering—in short, expressive psychoanalytic psychotherapy; the second is suppressive, or supportive,

psychotherapy.

Expressive psychotherapy is characterized by the use of clarification and interpretation as major tools. The therapist actively and selectively interprets some aspects of the transference in the light of the particular goals of treatment, the predominant transference resistances, and the patient's external reality. For the most part, technical neutrality is maintained, but neither a systematic analysis of all transference paradigms nor a systematic resolution of the transference neurosis by interpretation alone is ever attempted.

Supportive psychotherapy does use clarification and abreaction, but suggestion and manipulation predominate. Insofar as supportive psychotherapy still implies that the psychotherapist is acutely aware of and monitors the transference, and carefully considers transference resistances as part of his technique in dealing with character problems and their connection to the patient's life difficulties, it is still a psychoanalytic psychotherapy in a broad sense. By definition, however, the transference is not interpreted in purely supportive psychotherapy, and the use of suggestion and manipulation implicitly eliminates technical neutrality. A comprehensive overview of the ego-psychology theory of psychoanalytic psychotherapy can be found in Dewald's (1969) textbook.

All the ego-psychology theoreticians I mentioned earlier have stressed the difference between the structural change achieved in psychoanalysis and the more limited changes achieved in psychotherapy. Structural change as obtained in psychoanalysis implies a radical change in the equilibrium of conflictual forces involving the tripartite structural system—that is, reduction in superego pathology and pressures on the ego, reduction in the rigidity of the ego's defensive structures, sublimatory integration of previously repressed unconscious impulses, and significant increase in the scope and flexibility of adaptation to internal and external reality derived from such changes in inter-systemic equilibrium.

In contrast, the changes effected by the psychotherapies would be largely behavioral. Increased adaptive functioning of certain impulse-defense configurations would predominate in the outcome of these psychotherapies. Instead of obtaining structural intrapsychic change on the basis of an interpretive approach, the therapeutic changes would be in large part adaptive, obtained, at least partly, by environmental "structuring" (in the sense of manipulation) that would help the patient deal with a more manageable environment, or by consistent "educational" guidance toward better ways of adjusting to the environment.

As suggested earlier, the major problem with this technical theory of psychoanalytic psychotherapy has been the contradiction between the

theoretical model from which it stems and the structural intrapsychic organization of many patients to whom it has been applied. Thus, the ideal indication for psychoanalytic psychotherapy would be for mild cases where the "major surgery" of psychoanalysis is not warranted, and, in its supportive modality, for those with serious psychological illness (e.g., severe character pathologies) where psychoanalysis seems contraindicated (Wallerstein and Robbins, 1956). Psychoanalytic psychotherapy with patients who have relatively mild psychological illness is indeed highly effective; even brief psychoanalytically oriented psychotherapy or "focal" psychotherapy (Balint, Ornstein, and Balint, 1972) with patients who have good ego strength and motivation can be effective. The theoretical model underlying this approach holds remarkably well, then, for patients with good ego strength.

The application of this psychoanalytic psychotherapy model to patients with severe psychopathologies, however, yielded findings I have described elsewhere (Kernberg et al., 1972): Patients with ego weakness who were treated with supportive psychotherapy—following the traditional idea that such patients need to reinforce their defenses and that, therefore, resolution of resistances by interpretation is risky—did rather poorly. In contrast, borderline patients treated with expressive psychotherapy sometimes did remarkably well. As predicted, however, borderline patients treated with unmodified, standard psychoanalysis did rather poorly. In addition, the psychoanalytic exploration of defenses and resistances—particularly the

transference of borderline patients—revealed findings that were hard to reconcile with the classical tripartite structural model (Kernberg, 1975).

First, these patients presented a constellation of primitive defense mechanisms centered on dissociation of contradictory ego states—or splitting—rather than on repression. Second, the transference of these patients had peculiarities that seemed very different from the more usual transference developments in better-functioning patients. Third, and most important, primitive impulses were not unconscious, but dissociated in consciousness. In this connection, the evaluation of defense-impulse constellations often did not permit a clarification of which agency within the tripartite model was defending against which impulse within which other agency. The transferences of these patients seemed to reflect contradictory ego states that incorporated primitive internalized object relations within an overall psychic matrix that did not present a clear differentiation of ego, superego, and id. In short, the cases for which the ego-psychology approach had modified classical psychoanalytic technique and formulated a theory of change by less than strictly psychoanalytic means did not seem to fit the structural theoretical model on the basis of which the psychotherapy of these cases had been conceived.

This leads us to a new psychoanalytic approach (in addition to the classical and contemporary ego-psychology ones) which attempts to deal

with the phenomena just described, namely, psychoanalytic object-relations theory. As I said before, it is paradoxical that object-relations theories offer answers to problems that originally developed within ego-psychological psychoanalytic psychotherapy while many object-relations theoreticians, particularly those of the British schools, steadfastly refuse to consider any theory of technique or technical approach for patients with severe character pathologies and ego weakness other than psychoanalysis proper. What follows is an application of psychoanalytic object-relations theory to a theory of the technique of psychoanalytic psychotherapy.

In the severe psychopathologies, early, primitive units of internalized object relations are directly manifest in the transference as conflicting drive derivatives reflected in contradictory ego states. In these cases, the predominance of a constellation of early defense mechanisms centering on primitive dissociation, or splitting, immediately activates contradictory, primitive but conscious, intrapsychic conflicts in the transference. What appear to be inappropriate, primitive, chaotic character traits and interpersonal interactions, impulsive behavior, and affect storms are actually reflections of the fantastic early object-relations-derived structures that are the building blocks of the later tripartite system. These highly fantastic, unrealistic precipitates of early object relations, which do not directly reflect the real object relations of infancy and childhood and which must be interpreted until the more realistic aspects of the developmental history

emerge, determine the characteristics of primitive transference. In the treatment, structural integration through interpretation precedes genetic reconstructions (Kernberg, 1979).

The interpretation of primitive transferences—which includes the systematic interpretation of splitting mechanisms and other primitive defenses—requires special psychoanalytic methods. First of all, the dangers of severe acting out and of blurring the boundaries of the psychoanalytic situation may necessitate establishing parameters of technique and/or structuring the patient's external life in order to protect the psychoanalytic situation.

Second, since verbal communication is often disturbed at primitive levels of fixation or regression, and since severe psychopathology is typically expressed nonverbally (as is all character pathology to a certain extent), the analyst's focus may have to shift from the content of free association to the total material expressed in the patient-therapist interaction, including the patient's experience of and reaction to the psychoanalytic setting, which frequently becomes a major channel of expressing the transference.

Third, under these conditions, the immediate meaning of the interpersonal relation in the transference—in terms of the activation of primitive transference dispositions—has to be interpreted with a special

consideration of the patient's predominant unit of self- and object representations reflected in such interaction. Some authors have used the notion of psychoanalytic "space" (Winnicott, 1958, 1965, 1971; Bion, 1967, 1970) to refer to this translation of nonverbal interaction into a primitive object-relations structure. They have stressed the integrating function of the analyst's cognitive and emotional absorption and tolerance of the patient's chaotic material as well as the analyst's subsequent use of the integrated material in interpretive comments.[2]

Fourth, countertransference dispositions are particularly pronounced in these cases and require particular methods so that the analyst's emotional reactions can be controlled and therapeutically used.

In contrast to the facilitation of integrated ego functioning by means of the ego's overall defensive structure in patients with good ego strength, primitive defensive operations in patients with severe psychopathology have a serious ego-weakening effect. Therefore, interpretation of primitive defensive constellations such as splitting, projection, projective identification, denial, omnipotence, idealization, and devaluation improves ego strength and permits the gradual development of an observing and integrated ego function (Kernberg, 1976). Thus, within an object-relations framework, both the interpretation of defenses as clinical resistances and the interpretation of transferences as internalized object relations may—and actually should—be

applied throughout the entire spectrum of psychopathology. Jacobson (1971), for example, has applied her findings regarding the psychopathology of depression and depressed borderline patients to the psychoanalytic treatment of these conditions.

While Jacobson, Mahler, and other theoreticians oriented to ego-psychology object-relations viewpoints have generally been careful in their selection of cases for psychoanalysis and have questioned the indiscriminate application of the same psychoanalytic technique to all patients, the British object-relations group, particularly the Kleinians, have applied the same unmodified technique to all patients. In the light of much accumulated clinical experience, I consider the latter approach a mistake and think that it can lead to disastrous results.

In contrast, Little, Guntrip, and, to some extent, British "middle group" clinicians in general, have tended to blur the distinctions between psychoanalysis and psychoanalytic psychotherapy, a position which can lead to considerable confusion. The approach of the British school represents precisely the other side of the paradox mentioned earlier, namely, that the theoretical and technical contributions of most interest for the psychoanalytic psychotherapy of patients with severe psychopathologies have been developed without regard for the theoretical and technical differences between psychoanalysis and psychotherapy.

I think it is possible to formulate a theory of psychoanalytic psychotherapy that uses the concepts derived from both ego psychology and object-relations theory.

A Theory of Psychoanalytic Psychotherapy

At all levels of psychopathology where psychoanalysis or psychoanalytic psychotherapy is clinically indicated, symptoms and pathological character traits reflect intrapsychic conflicts. These conflicts are always dynamically structured, that is, they reflect a relatively permanent intrapsychic organization of contradictory or conflicting internalized object relations. At severe levels of psychopathology, such dynamic structures are dissociated, thus permitting the contradictory aspects of the conflicts to remain in consciousness. Here, the interpretation of defenses and primitive transferences fosters ego integration, the consolidation of the tripartite structure, and the simultaneous transformation of primitive transferences into advanced or typically neurotic ones. Under these conditions, interpretation of the transference may bring about an alteration of the equilibrium of the forces in conflict, as well as structural intrapsychic change in the sense of integrating part object relations into total ones, consolidating ego identity, and reinforcing the boundaries of ego, id, and superego. The analysis of the transference is carried out by a direct analysis of the total analytic situation, with particular emphasis on the psychoanalytic setting and

its relation to reality.

At less severe levels of psychopathology such as one finds in the standard psychoanalytic patient, the dynamically structured intrapsychic conflicts are unconscious, and are manifest largely in intersystemic conflicts between ego, superego, and id and their typical defense mechanisms. Here, the interpretation of defense mechanisms induces a partial redissolution—or rather, a loosening and shifting of the boundaries—of the tripartite structure, which facilitates both the establishment of a regressive transference neurosis and the gradual unfolding—by means of the systematic analysis of ego and superego defenses—of a regressive transference, that is more integrated than those initially formed in patients with severe psychopathologies. The analysis of the transference in patients with well-integrated tripartite structure is facilitated by the patient's observing ego and the related therapeutic alliance. The analyst must focus chiefly on free association and its distortions by the manifestation of various defense mechanisms; the focus on the analytic setting itself recedes into the background. The integration of complex repressed impulses reflecting entire constellations of repressed object relations (especially the Oedipal constellation) permits an enrichment of ego functions and experiences, as well as a reduction in the rigidity and constraint of ego defenses and superego pressures.

Although individual considerations always have priority in determining

the type of treatment, generally speaking, psychoanalysis is the preferred treatment for patients with milder forms of psychopathology, except when special circumstances warrant brief psychotherapy or psychoanalytic psychotherapy. For patients with good ego strength, I would recommend psychoanalytic psychotherapy as originally defined by the ego-psychology writers I referred to earlier, as well as the combined use of various expressive and supportive techniques.[3] The following three paradigms—(1) the principal technical tools (clarification and interpretation versus suggestion and manipulation), (2) the extent to which the transference is interpreted, and (3) the degree to which technical neutrality is maintained—jointly define the nature of psychotherapy within the expressive-supportive range of treatment.

In cases of severe psychopathology—with a few exceptions where, for well-documented individual reasons, psychoanalysis is indicated and feasible —the preferred treatment is expressive psychoanalytic psychotherapy. Expressive psychoanalytic psychotherapy with such patients differs, however, from that attempted with better-integrated patients. Maintaining the three basic paradigms upon which differentiation of psychoanalysis proper from psychoanalytic psychotherapy can be established, psychoanalytic psychotherapy for severe psychopathology might be described as follows.

Because primitive transferences are immediately available, predominate as resistances, and, in fact, determine the severity of intrapsychic and interpersonal disturbances, the analyst must focus on them from the start, by interpreting them in the "here and now." Genetic reconstruction should be attempted only at later stages of treatment (when primitive transferences, determined by part object-relations, have been transformed into advanced transferences or total object-relations, thus approaching the more realistic experiences of childhood that lend themselves to genetic reconstructions). The analyst must maintain a position of technical neutrality in interpreting such primitive transferences. He must establish firm, consistent, stable reality boundaries in the therapeutic situation, and avoid getting sucked into reactivated pathological primitive object relations. Insofar as both transference interpretation and a position of technical neutrality require the use of clarification and interpretation, and contraindicate the use of suggestive and manipulative techniques, clarification and interpretation remain the principal therapeutic techniques.

In contrast to psychoanalysis proper, however, the transference analysis is not systematic. Because of the need to focus on the severity of the acting out and on the disturbances in the patient's external reality (which may threaten the continuity of the treatment as well as the patient's psychosocial survival), and also because the treatment, as part of the acting out of primitive transferences, easily comes to replace life, transference

interpretation now has to be codetermined by (1) the predominant conflicts in immediate reality, (2) the overall specific goals of treatment—and the consistent differentiation of life goals from treatment goals (Ticho, 1972), and (3) the material immediately prevailing in the transference.

In addition, technical neutrality is limited by the need to establish parameters of technique, which sometimes include structuring the patient's external life and using a team approach to help the patient who cannot function autonomously during long stretches of psychotherapy. Technical neutrality is therefore a theoretical baseline from which deviations occur again and again, to be reduced by interpretation. The therapist's interpretation of the patient's understanding (or misconception) of the therapist's comments is an important aspect of this effort to reduce the deviations from technical neutrality. Further exploration of the differences between expressive psychoanalytic psychotherapy with patients presenting ego weakness and that with patients having good ego strength requires a sharper focus on both the mechanisms of action and the effects of psychotherapeutic techniques—our next issue.

The Therapeutic Action of Psychoanalytic Psychotherapy

It is interesting that little concern was expressed in the 1950s about the potentially contradictory effects of combining various interpretive and

supportive techniques. Although psychoanalytic psychotherapies were classified along a spectrum ranging from the purely expressive to the purely suppressive, it was assumed that a mixture of supportive and interpretive techniques and effects was perfectly harmonious.

In retrospect, a mixture of supportive and expressive techniques does seem feasible for patients with good ego strength. For example, a therapist's suggestive and manipulative interventions in the course of an exploratory psychotherapy that focuses mostly on transference developments and their relation to the patient's immediate reality may not unduly distort such transference developments, although they naturally reduce the intensity of transference regression (particularly in driving underground the severer aspects of the negative transference dispositions, or in displacing them toward other objects). Indeed, the therapist's empathic attitude in helping the patient deal with an immediate real-life problem may lead to a favorable ego identification, without activating a primitive, pathological idealization of the "good" therapist as a defense against the activation of paranoid fears of the "bad" therapist (the potential receptacle for projected early sadistic superego forerunners). In other words, ego identification with the therapist and transference gratification may take place in the context of a mixture of supportive and expressive technical approaches with patients who have sufficiently good ego strength to be able to perceive, understand, and integrate the more positive aspects of the therapeutic relationship in spite of

the underlying ambivalences in the transference.

On the other hand, this combination of expressive and supportive techniques and the respective mechanisms of their action may not work for patients with severe psychopathology. In patients with predominantly primitive transference dispositions reflecting part object-relations, all these psychotherapeutic techniques (except interpretation per se) and the mechanisms by which they are supposed to bring about therapeutic change raise new questions.

First, selectively interpreting some resistances while leaving others untouched in order to protect ego integration runs counter to the clinical observation that the predominant constellation of primitive defense mechanisms in such cases has ego-weakening effects, and that the systematic interpretation of such defenses—largely manifest as transference resistances—has an ego-strengthening effect.

Second, the very fact that the conflicting impulses—the pathologically condensed sexual and aggressive drive derivatives expressed in dissociated or split-off part object-relations—are conscious makes it imperative to deal with them: ignoring such exigent needs and impulse expressions in these patients only increases their fear of their own impulses, and displaces the most significant instinctual conflicts from the transference situation onto

other relationships, thereby increasing acting out.

Third, the therapist's effort to provide a stable, reliable, and empathic parental figure who facilitates the patient's emotional growth by ego identification and transference gratification is often made impossible by the development of severely negative transferences reflected in paranoid dispositions. These paranoid dispositions must be dealt with to prevent the disruption of the psychotherapeutic relationship and to permit some semblance of therapeutic alliance to be established.

Fourth, and most important, the gratification of certain transference demands (usually stemming from the patient's need to protect the good, idealized transference relationship in the face of a threatening breakthrough of conflicts around aggression) significantly distorts the patient's perception of the therapist and of the therapeutic situation.

In short, the flexible capacity to take the best from the therapist, which patients with good ego strength have, and which, I think, has much to do with the fact that these patients respond favorably to a broad range of exploratory-supportive psychotherapeutic techniques, is missing in patients with severe psychopathology. In the latter cases, patients do not identify with the benign aspects of the psychotherapist, but rather, with highly idealized, projected forerunners of the ego ideal; because patients feel incapable of living up to

such idealizations, their autonomous growth is undermined. A related problem derives from the therapist's misunderstanding of the importance of empathy for patients with severe psychopathology, a subject which I have discussed elsewhere at some length (Kernberg, 1979).

For all these reasons, a supportive technique runs counter to the therapeutic needs of patients with severe psychopathology, particularly borderline cases, with whom a modified psychoanalytic procedure or psychoanalytic psychotherapy is attempted. These patients require a purely expressive approach. I shall now spell out the three technical paradigms that jointly define expressive psychoanalytic psychotherapy with the borderline personality as well as the specific effects of these techniques.

Interpretation

Interpretation is a fundamental technical tool in psychoanalytic psychotherapy with borderline patients; in fact, in order to protect technical neutrality as much as possible, suggestion and manipulation are practically contraindicated here, except when the potential for severe acting out requires structuring the patient's external life and using a team approach to set limits and make other interventions in the social field. Such socially structuring or manipulative efforts should be considered parameters of technique, to be interpreted as often and as comprehensively as possible in working toward

their gradual dissolution.

The following question has been raised: How is it possible that patients with severe psychological illness and ego weakness are able to respond to interpretation? Do these patients accept interpretations because of their actual meaning or because they are manifestations of the therapist's interest (that is, because of their magical, transference meanings)? Empirical evidence indicates that patients with severe psychological illness are indeed able to understand and integrate interpretive comments, particularly if their understanding of the therapist's interpretations is examined and interpreted in turn. In other words, the patient's difficulty in integrating verbal communication is itself a product of primitive defensive operations that can be interpreted, particularly as they are activated in the patient's reactions to the therapist's interpretations.

However, the need to explore fully the patient's understanding of the therapist's interpretations and to clarify consistently the immediate reality of the therapeutic situation—the meaning of what the therapist has been saying, in contrast to the patient's interpretation of that meaning—results in clarification taking precedence over interpretation. This technical demand creates quantitative differences between this kind of psychotherapy and psychoanalysis.

Maintenance of Technical Neutrality

This is an essential technical tool, an indispensable prerequisite for interpretive work. Once more, technical neutrality does not preclude an empathic, authentic, warm attitude on the part of the therapist, but, to the contrary, may best reflect such warmth and empathy under conditions in which the emergence of the patient's regressive aggression in the transference would naturally bring about counteraggressive reactions in the therapist. The therapist's emotional capacity to maintain an empathic attitude in such circumstances (the therapist's "holding" action) and his cognitive capacity to integrate ("contain") the fragmentarily expressed transferences are important components of such technical neutrality.

However, because the patient's potential for severe acting out and for developing life- and/or treatment-threatening situations may require structuring not only the patient's life but the psychotherapy sessions as well, technical neutrality is constantly interfered with, threatened, or limited, and a good part of the therapist's efforts will have to be devoted to reestablishing it, again and again. To put it differently, in patients with severe ego weakness or ego distortions where the nondefensive or observing part of the ego (which would ordinarily contribute to the therapeutic alliance or working relationship with the therapist) is not available, the provision of such auxiliary ego functions through clarification of the immediate reality shifts

the interpretations into clarifications and may bring about deviations from technical neutrality, requiring later reductions of such deviations by interpretive means. This quantitative reduction in technical neutrality implies another difference from psychoanalysis proper.

Transference Analysis

I mentioned earlier that transference interpretation is limited in these cases, that it is codetermined by a constant focus on the immediate reality of the patient's life and the ultimate treatment goals. Moreover, because the process of interpreting primitive transferences gradually integrates part object-relations into total object-relations and, correspondingly, transforms primitive transferences into advanced or neurotic ones, the transference of borderline patients is subject to relatively sudden shifts. Neurotic or advanced transferences, reflecting more realistic childhood developments, first appear infrequently, and then increasingly often throughout the treatment. As a result, the process of transforming primitive transference structures into their integrated counterparts evolves in discontinuous, qualitatively shifting phases throughout the treatment, which gives an overall timelessness to the genetic reconstruction and interferes with its historical placement (Kernberg, 1979). These developments require an atemporal, "as if" mode of transference interpretation over extended periods of time, an additional reason for regarding such transference interpretation as less than

systematic, and therefore different from that occurring in the standard psychoanalytic situation.

Nevertheless, while transference analysis is less than systematic under these conditions, the interpretation of defensive constellations is quite systematic. In contrast to expressive psychotherapy with better-functioning patients—where certain defenses may be interpreted while others are not touched—the systematic interpretation of defenses in severe psychopathology is of crucial importance in improving ego functioning and in permitting the transformation and resolution of primitive transferences. Therefore, the interpretation of the constellation of primitive defensive operations centering on splitting should be as consistent as their detection in the patient's transferences and extratherapeutic relationships permits.

The most important mechanisms of change implied in this approach (i.e., those effects that the interpretation of primitive transferences specifically attempts to achieve), are: the resolution of primitive defense mechanisms in the therapeutic situation; the integration of part object-relations into total object-relations; and the related integration and development of ego functions, particularly of ego identity, with the corresponding integration of the self concept and object constancy.

Elsewhere (1976, Chapter 6) I have described the interpretive steps

that gradually transform primitive transferences into advanced ones; steps that consist, first, in defining the predominant human interaction activated at any particular time in the transference; second, in defining the self- and object components and the affect disposition (reflecting libidinal or aggressive drive derivatives) linking them in this interaction; and third, in integrating the dissociated or split-off self- and object representations under the impact of, respectively, libidinal and aggressive drive derivatives.

This specific effect of interpretation, that is, transformation by integration, is supported by the relatively nonspecific one derived from the auxiliary ego functions carried out by the psychotherapist, particularly his emotionally and cognitive integrating function reflected in his capacity to tolerate what the patient originally could not tolerate in himself. This permits the patient to accept what was previously too painful to be integrated in his own subjective experience, and in the process, provides an implicit and silent assurance that, contrary to the patient's fantasies, aggression does not necessarily destroy love

TABLE 1 Psychoanalytic Psychotherapy

	MECHANISMS OF ACTION	
TECHNICAL TOOLS	*With Good Ego Strength*	*With Ego Weakness*
Interpretation	Reduction in defenses permits	Increases ego strength by resolving

	emergence of repressed material	primitive defenses
Transference analysis	Interpretation of selected transferences permits their gradual resolution	Interpretive integration of primitive into advanced transferences permits their eventual resolution
Technical neutrality	Fosters transference regression; permits interpretation by not gratifying transferences	Protects reality in the therapeutic situation; permits interpretation of primitive transferences

and the possibility of a deep and meaningful human relationship. These nonspecific effects may be considered "supportive," but then, all interventions are potentially supportive in their effects, as distinguished from being supportive techniques. It has been rightly stated that psychoanalysis is the "most supportive" form of therapy.

In summary, psychoanalytic psychotherapy with borderline patients uses technical tools that are similar to those used in psychoanalysis; the mechanisms of action of these tools, however, differentiate this treatment from expressive psychotherapy with patients presenting ego strength. These different mechanisms of action are outlined in Table 1.

There is one more dimension to consider in effecting therapeutic change in patients with severe character pathology and borderline conditions. This dimension has to do with the patient's increased capacity to experience subjectively what was previously dissociated and expressed in distorted

behavior in the interpersonal realm. In psychoanalytic psychotherapy with severely regressed patients, patients must become subjectively aware of their relation to the psychotherapeutic setting and integrate their former expression of the uncanny in the interpersonal field. This change is analogous to the incorporation into consciousness of repressed material in patients with well-integrated tripartite structure. Again, this is a particular effect of an analytic approach that quantitatively separates psychoanalytic psychotherapy with regressed patients from the standard psychoanalytic situation as well as from psychoanalytic psychotherapy with patients presenting good ego strength.

The differences between them notwithstanding, the similarity between psychoanalytic psychotherapy and psychoanalysis is much greater in cases of severe psychopathology than in cases of milder psychological illness. One might say that, with the former, the tactical psychotherapeutic approach to each session is almost indistinguishable from psychoanalysis proper, and only from a long-term, strategic standpoint do the differences emerge. However, although the technical approach to borderline patients resembles that of psychoanalysis, the therapeutic atmosphere is quite different: the predominance of nonverbal communication and of the examination of the total interaction over the patient's communication of subjective experiences and his intrapsychic life create a special therapeutic climate.

By the same token, the difference between expressive psychoanalytic psychotherapy and supportive psychotherapy is sharp and definite in patients with severe pathology, while it may be more blurred in the less severely ill. In simple terms, it is not possible by means of psychotherapy to bring about significant personality modifications in patients with severe psychopathology without exploring and resolving primitive transferences, and this requires an analytic approach (although not psychoanalysis proper). I think that in all cases it is very helpful to maintain a clear distinction between psychoanalytic psychotherapy and psychoanalysis.

There are patients with severe character pathology, narcissistic personality, or borderline personality organization for whom both psychoanalysis and expressive psychoanalytic psychotherapy are contraindicated, and in such cases I think that a strictly supportive approach is best. Such supportive psychotherapy requires, in turn, a very sophisticated approach in using suggestive and manipulative techniques and in dealing with primitive transferences noninterpretively. All our understanding regarding supportive psychotherapy may have to be reexamined and reformulated in the light of what we now know about severe psychopathology.

Clinical Illustration

The following segment from the psychoanalytic psychotherapy of a thirty-four-year-old single woman, a mathematician who had been unable to work for over six years and whose personality structure combined intense schizoid and masochistic features, occurred toward the end of the fourth year of treatment when, after significant improvement, a severe negative therapeutic reaction developed over a period of five months. During this time, the patient responded with subtle mockery and provocations to all of my efforts to clarify the meaning of her frequent silences, her emotional withdrawal from me, and her keeping me ignorant of important occurrences in her daily life. Over a period of months, she gradually became aware that the severe blocks and long silences in the hours reflected an internal prohibition against further improvement because of intense guilt caused by her sense that change could occur only at the cost both of her "real" mother's suffering and of the destruction and loss of her internalized mother.

On the surface, the patient's attacks on me were an attempt to make me withdraw emotionally and counterattack, which would then have permitted her to externalize her cruel internalized mother on me. In fact, there were times when a partial compromise solution took the form of her attacking me as a representation of her mother—thus partially rebelling against her—while maintaining a good surface relation with her mother in reality, thereby apparently submitting to her and keeping the treatment situation stable. She attacked her mother, bitterly complaining that her mother was cold,

domineering, and yet rejecting of her. Some of the patient's descriptions of her clinging to an overpowering and aggressive mother corresponded to actual aspects of her infantile past. But all opportunities in the therapeutic situation for a true dependency on me were internally forbidden and unavailable to the patient, for which she blamed me.

Within this overall context, the following episode took place. Following a stormy session, the patient sent me a letter. What follows is a summary of that letter and the two sessions we had after I received it. Because the treatment was bilingual and the letter itself was in a foreign language, the salient features of it will be paraphrased in translation.

The patient had left for approximately a week to visit her mother, who lived in a different state. She wrote the letter soon after her arrival there, and it reached me the day before our next session. The patient wrote that she was furious at me because she felt I was just "tolerating" her; she hated my sitting "patiently" through her angry outbursts and nagging demands. She was not denying her anger and demands, but all of this was made worse by what she experienced as my detached "professional" tolerance, which angered her even more. She had fantasies of making me suffer terribly, of hurting my feelings very deeply. Without any transition, she went on to tell me how much she hated me because I never gave her any credit for anything good that she did, and never made her feel good about herself in any way. She also felt that I

never acted as if we were working together, and I never showed any sense of accomplishment or pride in the progress that she had made. She felt that my emotional detachment was unfair because the progress in her treatment was not only her own work. She found my attitude one of artificial concern for her, as if I were giving her lessons in "positive feelings," and then added that one thing she hated about the treatment was that I never erred, that I never forgot that I was the therapist or slipped from that role.

The letter went on to say that she was perfectly aware what "transference" meant, that she would have to be mentally retarded not to understand this after years of treatment. But this did not take away her sense of loneliness, her sadness about not being involved in a satisfying and fulfilling relationship. And further, she added, when she did talk about this in the sessions, I twisted it around so that the problem always involved me, resulting in her feeling that I did not care at all. She really wanted to feel loved and appreciated, and instead of examining what she expected of the relationship, I only suggested endlessly that she did not appreciate what I had to give to her.

In an abrupt shift, she then wrote that instead of being angry at her parents directly, she felt angry at me for not fulfilling her parental ideals. She wanted to be loved and felt nobody loved her. In conclusion, she added that she also sometimes hated me for not being compassionate with her; she felt

reduced to self-pity. She really hated me, she wrote, for the pain I had caused her over the past years without thinking twice about it. Finally, she didn't think that I deserved any good feelings from her because I never gave anything back, and she didn't need lessons in expressing "positive feelings."

In spite of the intense anger the letter expressed, it also conveyed feelings of warmth and gratitude; I experienced it as a clear indication of the patient's increased tolerance of ambivalence, her awareness of the complexity of her emotional relation with me. In short, I was very touched by it.

In our next session, which occurred the day after I received the letter, the patient complained bitterly that I did not love her, that I was "professionally" objective and cool and had no real feelings for her. As these complaints were repeated insistently, I was struck first, by the patient's sadistic tone of voice and triumphant smile; and second, by my perception of a "frozen" quality inside myself, as if indeed I had no feelings for her, accompanied by a sense of guilt—as if I owed her some real feelings. This reaction was in striking contrast to the strong positive feelings I had experienced for her at the beginning of the session. Third, I was struck by the contradiction between her unusually clear, coherent, and modulated way of expressing herself, and the content of her angry accusations. In the past, great anger had had a disorganizing effect on her communications. Fourth, I noted her references to how angry she had been with me since the last session, and

how this anger had decreased only temporarily during the visit to her mother, after which she felt much better. She remarked, however, that her mother had told her she now looked "dangerously healthy" (!).

After attempting to stimulate the patient to explore how all the features I was observing might fit together, I realized that she was cutting me off every time I tried to speak, almost triumphantly making me shut up, and only remaining silent when I in turn remained silent. I told her I felt she was putting many of her internal conflicts into me because she could not tolerate them, and that she wanted to shut me up in order to avoid hearing about them. I said that behind her "simple" feeling that I had no feelings for her was a condensation of many conflicts and a fear that I would undo that condensation and face her with the conflicts that were buried in the middle of her assertion that I did not care for her.

The patient said she did feel afraid; I said that she felt afraid that I would attempt to help her understand what was going on, which was indeed very frightening. At the same time, I continued, one part of her also wanted to know what was going on, so that her fear expressed the struggle between the part of her which wanted to know and the part of her which simply wanted to get rid of her internal problems and of me.

Now the patient said she wanted me to tell her how I understood what

was going on (she no longer interrupted me). I said I felt there were several layers of problems expressed in her feeling that I did not care for her. First, she felt that I was like a cold and rejecting mother with whom she was enraged for not giving her any love; second, she was taking revenge against this mother by *becoming* an aggressive, sadistic, and triumphant mother who was accusing me (representing the frightened little daughter) of not having good feelings toward her mother to whom I (she) owed everything; third, in reenacting her relation with her mother with interchanged roles, she was also attempting to spoil the good aspects of her relation with me because she felt guilty about her improvement in psychotherapy—that is, in attacking me by accusing me of not loving her, she was able to protest against her mother while remaining submissive to her.

The patient's expression changed markedly at this point; she became sad and thoughtful. She said she knew her mother wanted her to stop psychotherapy and that her mother had accused her of having a much easier life than the rest of the family. What right did she have to continue spending so much money and time on herself when other members of the family had far greater problems? And she added that I must know that her mother was also friendly and loving, and at times warm and enthusiastic. I said that it was not I she was trying to reassure that her mother could have good as well as bad sides, but herself; and that it was because she was so afraid that her hatred of her mother would also destroy everything good that she had

received from her, and thus leave her completely alone, that she could neither acknowledge that hatred more directly nor accept the simultaneous existence of loving and hateful feelings for me (mother).

For the first time in several months, the patient was now able to explore further aspects of her relationship with her mother, her perception of the mother's personality, and her fear of becoming independent and grown-up.

In the following session, the patient began by saying she had left the last session feeling very sad, that she had cried on the way home and had gradually begun to feel that I had accused her of being cold and unfeeling. She said she thought that she was not cold and unfeeling and that I was accusing her of problems she had resolved long ago. She complained that I only saw her difficulties, that I could not acknowledge her improvement, and that in the middle of all of this I always maintained a self-satisfied and contented attitude stemming from my "happy satisfaction" with my own family at home. She also added that she knew that she exaggerated, but this was still the way she felt.

I told her that I understood this reaction to be a reversal of the earlier session, in which she had accused me of being cold and unfeeling, and in which I had interpreted her identifying herself with her mother in a self-satisfied, aggressive, and superior way, accusing me of being cold and

ungrateful in the same way her mother had accused her. I pointed out that, in accepting my interpretation, she had felt guilty for attacking me when she realized that I was really concerned and interested in her. I added that this feeling of guilt had then changed into her sense of being the impotent victim of a sadistic mother who accused her of being cold and unloving, a reversal to the childhood experience we had discussed earlier in that session (a change reflecting the reprojection of her sadistic superego). I added that while this was going on she was aware that there was something unrealistic about her reaction, that her perception of my comments as an attack reflected her own exaggerated, self-critical oversimplification of my comments, and that I felt that, in one part of her, she was still capable of maintaining a good image of me in spite of her anger and suspicion about me (implying that she was now better able to tolerate her ambivalence toward me).

The patient, much relieved, then said she felt it was much more important to discuss her sexual difficulties than to focus so much on her difficulties with her mother; there had been such emotional storms in recent hours with me that for several sessions she had not been able to discuss her relations with her boyfriend. She also said that I was unaware of how intensely sexual her feelings about me sometimes were.

I remained silent, with an attitude of expectation of further communication from her; but she also became silent, and I finally interpreted

her silence, saying that her conflicts with her mother were forcing themselves all over her mind, to such an extent that she did not have the internal freedom to explore her sexual difficulties. I also said that she might be attributing this interference to me, and that, ultimately, it was her internalized sadistic mother who was attempting to prevent her from describing her sexual feelings to me and from resolving her sexual inhibitions in the process. The patient replied that she understood better how several contradictory things were occurring in her mind, and that she had difficulty keeping them together, so that it was as if different people were experiencing different problems inside of her. I sensed considerable emotional warmth at the end of that session; the patient felt reassured by my interest and dedication without having to explore this issue verbally.

This session illustrates the persistence of the subject matter of the earlier one; the faster "replay" of the earlier resistances as part of working through; and the patient's growing awareness of the relationship between dissociative or splitting mechanisms, on the one hand, and the conflict with a sadistic primitive superego represented by her internalized mother, on the other.

Both sessions illustrate some technical characteristics of the process of structural intrapsychic change in the context of the working through of primitive transference paradigms. First, the initial manifestation of part

object-relations in the early part of the first session (rapid alternation between patient and therapist of the enactment of self- and object representations reflecting the conflicts with the mother in an overall confused or chaotic transference situation) changed rapidly in the second half of the first session and throughout most of the second one into the more organized transference disposition of a higher or "neurotic" level.

Second, the material illustrates how the painful experience of not being loved could be analyzed in its genetic components involving conflicts over both love and aggression. In other words, although the transference repeated an earlier experience of not being loved by mother, that earlier experience (as well as its repetition in the transference) reflected a more complicated state of affairs. The experience of not being loved was the final outcome of the combination of the patient's need for love, her envy and jealousy of mother, the frustration and aggression stemming from mother, the patient's counteraggression and its projection onto mother, and the spiraling effect of the projection of aggression onto the image of a frightfully sadistic and destructive mother. The therapist's availability as a real object permitted, as part of the total perception of the transference-countertransference situation, a diagnosis of these various components and their analytic resolution.

A contrasting approach would have been to gratify the patient's transference demands by indicating that she was, indeed, "special" to the

therapist, permitting her to think that the therapist liked her and that, in shifting from his position of technical neutrality into that of an orally giving parent, he acknowledged and responded to her needs. There are therapists, for example, who at such points might offer extra time, or express their positive feelings for the patient directly, or even hold the patient's hand. I think all these approaches are ill-advised and harmful in the long run; one pays a high price for the temporary relief that the patient experiences when his or her transference demands for love are met.

Third, the sequence illustrates the shift from a predominantly dyadic, pregenital transference into the beginning of a triadic, Oedipal one as the pregenital components are elaborated in the transference. The patient's envy and jealousy of the therapist's family contained elements of oral envy (the therapist prefers his children to the patient and feeds them with all his love) and also Oedipal elements (jealousy of the relation between the therapist and his wife and/or his adolescent daughter). In the second session the patient also directly referred to sexual fantasies and desires for the therapist, as well as expressing concern about her remaining sexual difficulties with her boyfriend.

Fourth, the overall sequence illustrates that the primitive transferences cannot be explored separately from the working through of ordinary neurotic transferences, and that there are repetitive cycles in which primitive

transferences dominate, are understood and worked through, and then shift into neurotic transferences with which they are genetically connected, illustrating the intimate relation between pregenital and genital conflicts in patients with severe character pathology.

Perhaps I should repeat that the sequence occurred after approximately four years of treatment and that the patient was quite obviously on the road to improvement in terms of symptoms, social functioning, and the development of the transference. In summary, the stalemate, reflecting the patient's submission to and identification with a sadistic, primitive, internalized mother, could be resolved analytically by working through the primitive transference reflecting this internalized object relationship.

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Notes

1 This chapter is an expanded version of a presentation at the panel "Conceptualizing the Nature of the Therapeutic Action of Psychoanalytic Psychotherapy," at the Annual Meeting of the American Psychoanalytic Association, Atlanta, Georgia, May 7, 1978.

2 In Winnicott's terms, the analyst's affective "holding" function; in Bion's terms, the analyst's cognitive "containing" function.

3 Gill (1978), however, has questioned the advisability of combining expressive and supportive techniques for patients with good ego strength, and has presented strong arguments for maintaining a strictly expressive approach with these patients.