Six Steps in the Treatment of Borderline Personality Organization

The Therapist's Therapeutic Regressions and Countertransferences

Vamık D. Volkan

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The Therapist's Therapeutic Regressions and Countertransferences

THE ANALYST'S BACKGROUND

In working with borderline patients I discovered that my personality was compatible with theirs. I was born in Cyprus to Turkish parents, a replacement child named after an uncle idolized by my mother and grandmother, who gave me multiple mothering. My mother was the oldest child in her family, and one of her brothers had mysteriously disappeared while a university student in Istanbul, some six years before my birth. A body believed to have been his was found in the Sea of Marmara and was buried before being definitely identified; his brother, also a university student, identified the clothing found on the dead man and kept by the authorities. Nonetheless, a myth that my uncle might still be alive was fostered in the family, and my grandfather is supposed to have consulted a Cypriot Greek psychic to learn from his dead son what had happened to him. The psychic told my grandfather that six friends of my uncle had been involved in his disappearance. My grandmother kept some things that had belonged to him as "linking objects." Much later I described such objects as magical things a mourner keeps and uses as an external place in which the dead person's representation and related affects can meet the corresponding representation of the mourner and related affects (Volkan 1972, 1981c).

Although I had no conscious understanding that the idealized representation of my uncle had been deposited in me, I do recall comparing my pictures with his when I was a teenager. In one, in which he wore a high school soccer uniform, I thought he looked very much like me, as if I could see my representation in his photograph. I wanted to be on my high school's soccer team but was an utter failure in the sport. In retrospect I think my failure might have been in the service of an unconscious effort to rid myself of my dead uncle's idealized representation, but I think that in general I identified with it, though I had never seen him, and thus expected much from myself.

For some unknown reason I chose to write early on in order to sublimate the handling of object relations conflicts. When I began at the university in Turkey at the age at which my uncle had died, his

representation in my identity system became bothersome, and I tried to externalize the consequent conflict by writing a play about a Cypriot Turkish student (myself) who went to the university in Turkey to look for six men who had murdered his uncle years earlier. When, after graduating in medicine and coming to the United States, I put together an album of pictures of my life before emigrating, I put on the first page a picture of my Uncle Vamik in the company of six unidentified university friends. Later it occurred to me for the first time, that in a sense, I "killed" him during my analysis in my own way, but I think I continued many aspects of his representation by making them mine.

As a replacement child I was obliged to soothe the grief of my mother and grandmother, to be the "savior" of women with complicated mourning and elements of depression. I had grown up with rescue fantasies and have written elsewhere (Volkan 1985c) about their influence on my choice of a career.

Olinick (1969) wonders why an adult should devote energy to years of arduous study in order to spend his days, hour after hour, with only a small handful of patients in what had been called an impossible profession (Freud 1937, Greenson 1966). Olinick wrote:

> I suggest that a powerful motivation for the psychiatrist dedicating himself to the psychoanalytic relationship is the genetic effect of a rescue fantasy having to do with a depressive mother, the latter having induced such rescue fantasy in her receptive child. . . .
>
> For such relatedness of mother and child to be formative, it must be early, though the necessary duration is not clear (see, for example, A. Freud 1954b, 1963, and Ferenczi 1923, 1933, especially 1933, p. 165). It seems that depression or sadness alone is not sufficient; in addition, the maternal character must be at least in certain aspects alloplastic. Often there is an effort by provoking guilt to force the other to rescue, such enslavement also confirming one's lovableness. [pp. 12-13]

Olinick adds that he does not mean anything as naive as that the analyst's "work ego" is nothing but a child playing at rescue; and I certainly do not say that my perceived compatibility with regressed or undeveloped patients should be reduced to the effects of being a replacement child. Olinick (1969) writes that what distinguishes the psychoanalytic psychiatrist is the degree in which he accepts regression "in the service of the other" (p. 14)—the patient—as contrasted with the absence of such regression. The analyst's St. George complex is sublimated, becoming part of his character without leading to regressive decompensation. But other factors also help analytic therapists to be able to tolerate therapeutic regressions of their own in order to "meet" regressed or undeveloped patients on their own territory. Such meetings are necessary in the type of treatment I describe here if the therapist is to help

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his patient travel on a progressive road and rise to a higher level of psychic organization. The more severely regressed and undeveloped the patient is, the more the psychoanalytically oriented therapist needs to regress more deeply in his psychoanalytically oriented treatment.

I feel also that I can understand my patients' rather primitive communications on the basis of my own experience. Although I was a city child accustomed to the amenities of the city, I occasionally visited my grandfather, who lived in an earthen house, and saw wheat threshed by a cow's dragging over it a wooden plank studded with stones. I remember striking such stones together in the hope of making fire. Since my teenage son can operate a computer, I sometimes feel that the symbols and practices recalled in my mind span the millennium from the Stone Age to the Space Age; accordingly, a trip into the depths of the primitive aspect of a patient's mind is not altogether unfamiliar.

THE ANALYST'S PERSONALITY MAKEUP

Here we need to ask whether the analyst or analytic therapist, if he is to be successful in treating severely regressed or undeveloped patients psychoanalytically, must have a special background of early perceptions and conflicts that although sublimated, are kept accessible and familiar. Little (1981) considers the analyst's personality makeup to be important, and Giovacchini (1975) notes *common* factors, certain characterological features, among analysts that influence countertransference. Searles (Langs and Searles 1980), widely known for his work with the severely regressed and undeveloped, is more open than other psychoanalysts in discussing the relationship of his background to his development as an analyst. Boyer (1986) also refers to his childhood, writing of how his father left him with a highly emotional mother and a single sibling. He recalls how his principal rival for his mother's daytime interest was a dream book—a dictionary of arbitrary meanings attached to manifest content—that fascinated her and that he learned to read in order to share it with her. He holds this accountable for his fascination with symbols, his intense interest in folklore, myths, and religiomedical practices, and an unusual ability to work with regressed patients.

Boyer, however, no longer believes that the ability to work with regressed patients requires exposure to and mastery of conflicts engendered by actual experiences with important parental figures, and writes: "I have come to know several psychoanalysts who have consummate skill in treating such

patients and whose backgrounds were much more conducive to secure ego and superego development" (p. 13). Also, as supervisor of psychiatric residents and private therapists over three-and-a-half decades, he observed that "their personal analyses combined with teaching enabled them to develop a progressively greater capacity to work effectively" (p. xiii). I concur that a therapist need not have a special background with intense object relations conflicts, which he sublimates, in order to provide psychoanalytical treatment for schizophrenic, borderline, or narcissistic patients. After all, it is inevitable that all children have object relations conflicts as they climb the developmental ladder, and the ability to regress in the service of the other in order to grasp preoedipal ways of communicating is available to all. There are a number of factors to explain why some therapists can regress therapeutically more deeply than others, as is abundantly evident in supervising the psychoanalytic or psychoanalytically oriented therapy of either analyzed or unanalyzed practitioners.

Training analysis does not necessarily prepare for deep therapeutic regression, but it certainly helps. Assuming that the analyst functioned on a neurotic level, or with higher-level character pathology, before his training analysis, he can be expected to be familiar during his analysis with his own transference projections and his analyst's reactions to them; thus the candidate for training learns by identifying with his own analyst how to entertain these projections and still remain in the therapeutic position. Such tolerance is part of his professional identity. His own transference projections are on an oedipal level; when they include preoedipal concerns, these appear mostly as part of a defensive regression from oedipal conflict. Thus a neurotic or high-level psychoanalytic candidate may not have enough exposure to activation of primitive psychic constellations, chronic object relations conflicts, or the handling of such phenomena.

Regression in the Service of the Other

> Olinick (1969) describes regression in the service of the other: Immersion in the needs of a regressed or undeveloped person necessarily entails a regression, whether as parent, teacher, or therapist. Such regression in the service and interests of the other's development is controlled, partial, and reversible. It is concerned not with the patient's immediate gratifications but with his ultimate ones; not with the myriad secondary effects of frustration but with the development of tolerance for frustration … the analyst "serves," through the use of empathy as a by-product of a controlled regression, to comprehend the patient and to impart this understanding to him. [p. 8]

Introjective-Projective Relatedness

This is accompanied in the therapeutic setting by an introjective-projective relatedness between the analyst and the patient (Volkan 1968, 1976, 1981a, Olinick 1980). I use the term *introjective-projective relatedness* in a general sense to refer to all inner and outer flow. It includes introjection, projective identification (Klein 1946, 1955), introject formation, and different forms of identification. Conversely, it also includes externalization of self- and object images (Novick and Kelly 1970), and various levels of projections. Rapaport (1952) describes different conceptualizations of projection, envisioning a continuum…

> extending from the externalization of a specific type of tension in paranoid projections, to that of any kind of tension in infantile projection, to that of a whole system of attitudes and tension in transference phenomena, to where it imperceptibly shades into the externalization in the form of a 'private world' defined by the organizing principles of one's personality, [p. 463]

(See Volkan 1982a for a review of the many concepts pertaining to the term *introjective-projective relatedness*.)

The Question of Suitability

Some therapists and analysts simply do not feel comfortable working with patients who are extremely regressed and/or undeveloped, and who inevitably require in treatment a corresponding but controlled regression from the analyst or therapist and an intense involvement in introjective-projective relatedness. I strongly believe that not every analyst or therapist should feel obligated to work intensively with severely regressed persons.

> Most of us feel comfortable in the treatment situation when we see a low-level behavior pattern such as a hallucination in a patient, unless this behavior is accompanied by an emotion such as hostility directed toward us. One reason we can feel comfortable is that our own "normal" behavior pattern is so far removed from the observably "crazy" pattern of the patient. We do not identify ourselves with the patient experiencing what is beyond the range of our usual way of life. But to be a target for the externalization of the patient's representational units that are connected with untamed affects is something altogether different. Some therapists cannot "regress in the service of the other"—to use Olinick's phrase (1969)—when deep regression is required. Accordingly, some psychoanalytic therapists may be unsuited for treating borderline or schizophrenic patients in analytic ways that require their own regression, accompanied by an observing and therapeutic ego, in order to develop fully a therapeutic relationship that parallels the child-mother interaction. [Volkan 1981a, p. 445]

This child-parent relationship that develops in therapy with psychotic or borderline patients was described earlier by Loewald (1960).

The analyst or analytic therapist planning to work intensively with the severely regressed or undeveloped should have training and supervision before attempting such work on his own, even if he has a suitable personality makeup and the special background already mentioned. I agree with Boyer (1983) that an unsatisfactory state of teaching exists and that

> …many training institutions still teach candidates that psychoanalysis should be offered solely to patients with transference neuroses and that other patients should receive supportive therapy or diluted versions of psychoanalytic psychotherapy which largely exclude interpretation of the transference, [p. 196]

To be sure, the transference manifestation of those with object relations conflicts differs from that of those with structural conflicts. The countertransference of the analyst is different when he deals with the severely regressed or undeveloped from that appearing when he is treating neurotics or patients with high-level character pathology. If someone severely regressed and/or undeveloped reaches higher levels of psychic organization in his treatment, the emphasis in his transference manifestations will change—and the countertransference of the therapist will change as well.

TRANSFERENCE MANIFESTATIONS

We must remember that different terms are used in the literature to emphasize different transference manifestations of patients psychically operating at different levels. For example, those whose self- and object representations are not differentiated from each other exhibit transference manifestations as well as full-blown transference relatedness, and such terms as *transference psychosis* (Rosenfeld 1954, Searles 1963); symbiotic (Mahler 1963); and *psychosis* and *transitional object relatedness* (Modell 1968) are applied. Distortions in the transference are gross, and the patient's reality-testing ability relative to what the therapist represents to him seldom functions. The therapist merges as an external object and the target of the patient's externalization with other object and self-images.

Patients with borderline personality organization as described by Kernberg (1967) exhibit *split transference* initially (Volkan 1981a), until their split self- and object representations are integrated. I

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have discussed the circumstances in which, because of splitting, the therapist can sense the presence in his office of four, rather than two, players; the patient's "good" self- and object representations are there as well as his "bad" ones (Volkan 1976). Operation above the borderline level, with splitting no longer a problem, produces the classical *transference neurosis* during analytic treatment.

Narcissistic Transference

Recent psychoanalytic writings also mention *narcissistic transference*, but not in the sense in which Freud described the withdrawal of the psychotic individual and his unrelatedness to the analyst. Today this term refers to the transference manifestations of the patient with narcissistic personality disorder. The nature of this personality disorder has led to the formulations of what are basically two schools, one championed by Kernberg (1975), the other by Kohut (1971). Kernberg describes, from the viewpoint of internalized object relations, the "grandiose self"—to borrow a term from Kohut. This grandiose self is a condensation of the real self, which reflects the specialness of the child and is reinforced by early experiences, and the images of the ideal self and ideal object. The grandiose self develops when integration of the self takes a pathological turn.

In this sense, a narcissistic organization falls between borderline and neurotic (or character pathology on a high level). In the narcissistic organization, primitive splitting also affects the transference. The grandiose self is split off from devalued self- and object images as well as from devalued external objects. In the narcissistic transference, the patient behaves as though he were the world's greatest inhabitant and as though it were the analyst's task to adore him. When he realizes that the analyst is not adoring him, he scorns him altogether. Kohut has beautifully described different manifestations of narcissistic transferences, except the reactivation of the rather hidden devalued self (see Volkan 1982b, Akhtar and Thomson 1982).

COUNTERTRANSFERENCE MANIFESTATIONS

Countertransference responses to psychotic patients may at first include the therapist's hesitation to be involved in the cycle of fusion or refusion (Volkan and Akhtar 1979). In 1961 Boyer made the then unpopular suggestion that a major cause of failure in the therapy of severely regressed or undeveloped

patients was the dilemma of unresolved countertransference. He later (Boyer 1971, 1977) joined others (Hann-Kende 1933, Fromm-Reichmann 1950, Racker 1968, Giovacchini 1979, Grinberg 1979, Searles 1979) in stating that the analyst's emotional responses can be used with great benefit in the service of the treatment.

Externalization

A paper by Novick and Kelly (1970) describes the countertransference phenomena of psychosis-prone borderline patients before they move on either to more regressive or progressive levels. Novick and Kelly use the term *externalization*, differentiating it from projection proper, which is used to defend against a specific drive derivative directed against an object. When treating neurotic patients we often see transference projections side by side with transference displacements. The patient directs a drive derivative onto his analyst, subjectively allocating it to him while experiencing himself as the object of that drive derivative.

Externalization is an earlier defense mechanism, one pertaining to aspects of the self as well as to internalized objects. Melanie Klein's term *projective identification* (1946, 1955) refers to something similar in the sense we speak of it here. When the child faces the very difficult task of integrating the various dissonant components of his developing self-representations as well as the internalized object world, some aspects are

> …valued through both the child's own pleasure and, more importantly, the parents' response to one or another aspect of himself. Those aspects which are not so valued may become dystonic. Their retention within the self representation will lead to a narcissistic pain such as humiliation. . . .One solution is to externalize that aspect of himself. [Novick and Kelly p. 83]

Ibelieve, as does Berg (1977), that all patients of the purely preoedipal type, once they are in treatment, initially include their analyst in their constant effort to externalize and reinternalize, making their analyst one split-off image and then another, while adopting for themselves one self-image after another, and so on. Externalization and reinternalization of self- and object images dominate in all preoedipal types, but the variety of such externalization and reinternalization depends on the degree to which the patient has an integrated self-identity and total object representations. Novick and Kelly always see "some degree of fit" in projection; they believe that what is projected always has a basis of

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reality. That is, the patient hangs his projections on some real event—a canceled therapy session, for example—and the projection of hostile impulses will always have some core of truth. This is particularly clear in the analysis of a child. Novick and Kelly see, however, and I am in agreement (Volkan 1979a, 1981a), that there may be very little fit between externalized dystonic ("bad") representations and reality; indeed, there may be no observable fit at all.

Once a patient's analysis is under way and the transference neurosis is manifested, we can follow in the usual analytic setting the transference projections and displacements as they are anchored in some real event.

> A neurotic patient of mine had a dominant mother who had customarily denigrated her husband. The father was accordingly perceived as ineffectual, and in spite of his considerable professional accomplishments my patient considered himself to be ineffectual as well. His analysis revealed that this identification with the degraded image of his father had been a defensive maneuver to deal with castration anxiety. As his analysis advanced, memories that showed other aspects of his father as a stronger man surfaced. This new development went hand in hand with his transference displacement onto me of his attitudes and feelings toward this stronger father. As might have been expected, they were accompanied by references to castration anxiety. In other words, to see his father as stronger was to expect castration at his hands and through transference neurosis, at the hands of the "stronger" analyst. His references to this were initially tentative, and his view of me as a castrator did not induce in me any particularly strong emotional response since my experience as an analyst had made me familiar in the course of my professional development and practice with being considered at times a castrator by neurotic patients.
>
> One day this patient, while lying on the couch, calmly told me how amazed he was to recognize the pattern of the radiator grille in my office. He said that his father, who had been a mechanic, had made grilles and had made a beautiful one exactly like mine for his own office. The patient thus acknowledged his father's manual skills and made him appear to be a strong man. After a deep silence the patient suddenly broke into a loud outburst of hostility toward me in which he cursed and raved. He made it clear that during the silence he had felt fear toward me, thinking that I could hurt him and take advantage of him. His outburst was in the service of warding off my attack. Since he was usually obsessional and polite, his hostility took me by surprise, and I am sure I presented the appearance of someone under attack, having a quickened heartbeat and the sudden sweat of alarm. Regardless of this natural human response, my emotions did not lose their signaling functions; thus I was able to think through the patient's use of the radiator grille as a means of displacing behavior originally directed toward his father-castrator. His outburst was a protective maneuver against his projection of his own murderous impulses onto me. Moreover, it protected him from the possibility of homosexual surrender to his father. The reality of the grille in my office and its actual or fancied resemblance to the one in the office of his father gave an anchoring point for the interaction that took place between us. Within seconds I was in command of my counteremotions. I chose not to tell my patient about them since such knowledge on his part would burden him unnecessarily, but in due course the process was repeated and then was interpreted to him. This episode is but one example of many similar events that occur in our daily work.

I must emphasize that I do not equate this kind of counteremotion felt on one occasion with what we regard as a manifestation of a full-blown countertransference. I use it here simply as a microscopic

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example of a collection of such events, the macroscopic correlate of which is the full-blown countertransference reaction to the transference of a patient.

The Analyst's Tolerance of Externalization

The analyst who is the subject of externalizations may lack, especially initially, the advantage of having an observable anchoring point in reality which precipitates or accompanies such processes; he is more at the mercy of what is attributed to him by his patient. He will, however, come to understand more of what is going on as the therapeutic process advances, and as he gains secondary process understanding of the affect-laden sensations he experiences as the recipient of his patient's split-off self- and object representations. Even so, his countertransference responses are more likely to be generally unfamiliar to the analyst dealing with a patient who externalizes. Experience with such patients under supervision can, however, give the therapist familiarity with, tolerance of, and the ability to use such externalizations therapeutically. I would not advise anyone to undertake such therapies without first having had considerable supervised experience with them. I recall almost literally choking when working early in analytic psychotherapy with a psychosis-prone borderline patient whose behavior suddenly filled me with unbearable "bad" feelings; I felt it necessary for my survival that I flee into the fresh air and sunshine, and I could hardly wait for her to depart. It is not surprising that this patient's first remembered childhood dream was of her mother feeding her oatmeal and choking her with it. During the hour in which I felt choked I had become her helpless self-representation, and, identifying with the "bad" mother representation, my patient had choked me/her. Were such interaction to occur now, I expect that my emotional response would be tamer because I am now familiar with such externalizations. I would still feel it intensely if I were sufficiently regressed to accept her externalization, but I doubt that I would lose my objectivity. Moreover, I would find a suitable way to utilize my emotional reaction in the treatment process. After accepting her externalizations long enough for her to realize that I could tolerate them, so that in her identification with my analytic attitude such tolerance could be assimilated by her, I would tell her, if she had enough ego function to enable her to grasp my interpretation, that she wanted me to have a firsthand experience of the intrusive mother. As this microscopic example suggests, I use my countertransference responses more readily and openly in therapy with patients who activate unmended self- and object representations. Countertransference can

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in such cases more readily become a part of the therapeutic process than in the case of a patient with a structural conflict. However, I emphasize that I am not in the habit of burdening any patient by disclosing too much about my own reactions, or by reporting inappropriate material about myself.

Total Countertransference

Thus far I have described countertransference as the analyst's response to his patient's transference. In practice, of course, we deal with a "totalistic" form of countertransference (Kernberg that includes the analyst's total emotional reaction to the patient. There are other factors over and beyond a response to the patient's transference that influence how we feel about our patients. It should also be remembered that countertransference is unconscious; we know of its existence through self-analysis of its derivatives, by naming our feeling state, examining our fantasies as they appear in our sessions, observing our nonverbal gestures or bodily reactions, and so on.

Countertransference in the Treatment of Neurotic Patients versus in the Treatment of Borderline Patients

In comparing countertransference responses of a patient conflicted in object relations with the countertransference of a patient with structural conflicts, I do not mean to deny that problems of countertransference may sometimes be difficult in treating neurotic patients; prolonged issues of countertransference toward a patient at the neurotic level can bring an unwelcome stalemate; however, they differ from those typically experienced toward the patient who activates unmended split self- and object images and the affects associated with them.

Examination of the countertransference will yield important clues to the specific context of the patient's image units being externalized onto the analyst. Reference to the initial phase of Frances's treatment (see Chapter 2) illustrates this. Frances was in communication with both good and bad spirits "from another world," sometimes feeling them existent within herself and sometimes seeing them invested in me. Her self-concept was accordingly fragmented and aligned in two opposing ways: At times she thought of herself as an omnipotent savior, but at other times as dead. She was sometimes a woman, sometimes a man. Her psychopathology arose from her having been adopted as a newborn baby by a family that had lost a young male member and had been unable to complete their grieving for him. They

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had also lost to spontaneous abortion in the fifth month of pregnancy a child of the dead man's sister, so Frances was adopted and given the feminine version of his name, being viewed as his reincarnation. Thus she was perceived by those close to her in her infancy as half dead, half alive; half male, half female. These incompatible aspects of her concept of herself could not be integrated when she was a child, and my grasp of how it had been for her then was revealed by the externalizations she directed onto me. I felt numb and dead when the "dead" unit was in me, and enlivened and saved by her when her early mother's object representation was in me. My affective countertransference responses began making sense as I learned more about the details of her life.

There is yet another difference between the transference-countertransference phenomena in the treatment of a neurotic patient and that of a patient with conflicts in object relations. The notion that the neurotic transference is strongest at the time the patient enters treatment, and that a real relationship comes about at the end of the treatment, is erroneous. Anna Freud (1954), addressing this issue, states that the neurotic patient enters analysis with an attitude toward his analyst that is based on reality, but that this becomes secondary as the full-blown transference neurosis develops. When this is worked through, the figure of the analyst can emerge once again, but "to the extent to which the patient has a healthy part of his personality, his real relationship to the analyst is never wholly submerged" (p. 373). (This same comment can appropriately be made about countertransference.) This description cannot, however, be applied to those patients who activate primitive internalized object relations. In such cases, transference distortions may be extreme at the beginning of the treatment, and accordingly may induce "unfamiliar" and intense emotional responses in the analyst at the outset, bringing about a situation unlike that in work with the neurotic individual in which the transference-countertransference axis develops step by step.

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