Six Steps in the Treatment of Borderline Personality Organization

Two Styles of Treatment

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THERAPEUTIC REGRESSION

In view of our examination of the ability of an analyst or analytically oriented therapist to have deep therapeutic regression in the service of his patient, it is not surprising that some who experience anxiety in meeting a patient at the patient's regressive position advocate methods of treatment that discourage him from regressing therapeutically and avoid his own regression as well. However, with undeveloped and/or already severely regressed patients, the issue of the patient's therapeutic regression should be considered separate from the therapist's own ability to regress.

Two Treatment Styles

Here we face certain theoretical and clinical dilemmas outside the therapist's personality makeup. For the purpose of a discussion of this dilemma I am dividing intensive treatment approaches in such cases into two opposing styles, although such division cannot be observed entirely in practice.

The first supports keeping the patient at a level at which he can function without further regression, while at the same time providing new ego experiences in the therapeutic setting calculated to help him integrate his opposing self-representations and corresponding object representations. Therapists endorsing this style hold that if these already regressed or undeveloped patients further regress, they will become psychotic and beyond the reach of "the talking cure."

The second view holds that such patients need to experience further—now controlled—regression, and hence that the therapist should not interfere with his regressing to a level lower than the chaotic one already exhibited. Accordingly, after regressing so low in a therapeutic setting, the patient will progress through healthier developmental avenues toward psychic growth, much as a child does when in a suitable environment. Those advocating this approach know that already regressed and/or undeveloped borderline patients may exhibit transference psychosis when regressing further, so they embark on the treatment expecting to continue working through the patient's psychotic transference in

hopes of his becoming able to recognize a new and healthier psychic structure.

Both styles are justifiable. A proponent of the first will point to the role of primitive pregenital aggression in borderline patients and the possibility of its reaching unmanageable intensity with further regression, perhaps turning inward or calling for the destruction of others, the term *destruction* being used here in a general sense that includes the ruining of the therapist's efforts. In other words, the therapeutic regression may lead to a reaction that is not therapeutic (Olinick 1964). Knight's pioneering work (1953) suggests that in "borderline states," the weaker the patient's ego, the more necessary supportive treatment becomes. His view proposes mixing psychotic and neurotic features in borderline states with a surface picture that disguises deeper psychopathology. His idea is that in stressful and unstructured situations, psychotic traits would emerge; thus his emphasis is on supportive measures. Some analysts continue to advocate supportive treatment for borderline patients (Zetzel 1971, Wallerstein 1986), but Kernberg (1984) holds that this is contraindicated and suggests instead what he calls "expressive psychotherapy." In spite of this, for reasons I will clarify, I classify his style with the first type. He maintains therapeutic neutrality, which he rightly emphasizes while by no means excluding empathy: "Technical neutrality means maintaining an equal distance from the forces determining the patient's intrapsychic conflicts, not a lack of warmth and empathy" (p. 103). He is aware that aggressive acting out or other behavior that threatens the treatment (or life itself) sometimes interrupts the therapist's neutrality but advises his returning to it as soon as possible.

Kernberg's technique mainly depends on the utilization of clarifications and interpretations. He agrees with Frosch (1970) that patients with severe psychological illness can understand interpretations; but, he adds, such patients, including those considered borderline, either distort interpretations because of their psychodynamics or cannot put them to use. Thus, according to Kernberg, "Clarification takes precedence over interpretations. This technical demand creates quantitative differences between expressive psychotherapy and psychoanalysis" (p. 103).

Kernberg clarifies for the patient the way he is using splitting and other primitive mechanisms of defense and distorting his perceptions while in treatment. However, what Kernberg interprets is *not* the reason for his borderline patient's splitting his self- and object representations, and he does not focus on genetic connections, which await advanced stages of the treatment. Kernberg focuses first on the

elaboration in the here-and-now of his patient's *negative* transference, and he is criticized for his selectivity by Abend and colleagues (1983), who hold that "such predetermined selectivity produces an artificial interruption of free associations and constitutes a preplanned approach" (p. 196). They believe that patients with borderline psychopathology have equal difficulty dealing with libidinal impulses.

My initial work with borderline patients uses a technique much like Kernberg's, but I prepare myself and my patient for further therapeutic regression, whereas he tries to effect fusion of split self- and object representations without the benefit of a transference psychosis. He takes his patient from a chaotic state and helps him integrate his self- and object representations by using clarifications, interpretations, and, it seems to me, confrontations. Abend and colleagues (1983) also see in Kernberg's work "a consistent and persistent confrontation of the contradictions within the patient's productions" (p. 194). The loop consisting of therapeutic regression is bypassed.

Kernberg speaks of the gradual increase of the frequency of advanced transferences in borderline patients, but does not explain in detail what he does with the transference neurosis once it evolves. His main goal is the integration of self- and object representations and the consequent integration of the total world of internalized object relations, along with the integration of affects with the patient's relationship, whether real or fantasied, with significant objects. One gets the impression that once he has achieved these goals he considers his therapeutic work finished. He says, "At this point, the borderline patient may be helped to come to terms with the past more realistically, in the context of profound transformations in his relation to the therapist and to significant others in his current life" (Kernberg 1984 p. 107).

It should be understood that this technique is for those borderline patients considered good candidates for expressive psychotherapy, and that Kernberg has written extensively on the management of sicker borderline patients in a hospital setting. I suspect he might not consider psychosis-prone borderline individuals like those described in Chapter 2 good candidates.

A Rationale for Therapeutic Regression

"Getting well" does not always require regression. Boyer (1983) illustrates this in a clinical experience with an adult patient in which stable externalization and projection were employed. Once

unwanted aspects were controlled and kept in a reservoir, the patient experienced and sustained better psychic health.

> While working as a hospital psychiatrist during his service in the army, Boyer was assigned the care of a man admitted to the hospital in a strait-jacket. At the time, Boyer was extremely busy with other patients; since he could not give enough attention to the man, he released him from the strait jacket and asked him to write down the experiences he wished to communicate. A week later, when the patient arrived for his appointment at the psychiatrist's office, he presented Boyer with two thick notebooks filled with handwritten descriptions of his aggression-laden hallucinations and accounts of his delusional experiences. Although the patient had received no medication or intensive treatment, he appeared to have recovered. He showed surprise when Boyer asked what, in his opinion, had contributed to this sudden turn-around, and he explained that his recovery was due to his having given his crazy parts and ideas—written in the notebooks—to the psychiatrist. He watched Boyer carefully while explaining his recovery, amazed that he was not visibly affected by having become a target for the man's externalization and projection. It seems that he was using the psychiatrist as a repository. He wrote to Boyer 10 years after this episode, assuring him of his continued good health and asking after that of the psychiatrist.

Boyer nonetheless agrees that we see in daily work with deeply regressed individuals the beginning of a lasting structural change when regression to earlier levels occurs, initiating a restorative move. Early in his career of almost four decades, he came to believe (Boyer 1985) that therapeutic regression is necessary for the establishment of structural changes in the patient's personality, and I have been influenced by his work.

It seems that Boyer, Giovacchini, Searles, and other American analysts who have had long therapeutic interaction with psychotic patients and who have tolerated and responded therapeutically to their transference psychoses, favor the second style of treatment for borderline patients, advocating the need for therapeutic regression leading to structural change, even for those who are psychosis-prone. I belong in this group.

As Jacobson (1964) and Kernberg (1975) demonstrate, there "normally" occurs a developmental split between libidinally and aggressively invested representations of the self and object; ultimately, the "normal" child becomes able to tolerate ambivalence. In a sense, this kind of splitting persists in people with borderline personality organization, but its function is altered and it becomes the dominant mechanism of defense. By using *defensive splitting*, this type of patient keeps his contradictory ego states and their affective investments separate from each other. Anxiety arising from object relations conflict is controlled at the expense of splitting (and related defense mechanisms), leaving the ego weak.

Therapeutic regression in such patients would involve regression at least to the level at which they experience their self- and object representations as undifferentiated, just as they would experience a transference psychosis. This would in turn be followed by progressive development in which self- and object representations would be differentiated, and the patient would experience *developmental splitting* in the transference instead of the previous defensive splitting. This would therefore give him a chance to mend his splitting as a normal child would do.

In my work with the nine patients, I sought to test my theory. My experience with them showed that a focal, controlled therapeutic regression in such patients during treatment is indeed possible, and that once it is accomplished they progress toward health. Our technique, then, should focus on ways of controlling this regression and minimizing the danger of global disintegration.

As Loewald (1982) states, "It is not regression per se which is therapeutic, but the resumption of progressive development made possible by regression to an earlier stage or to a 'fixation point'" (p. 114). Loewald goes on to say that we notice and analyze defense that interferes with this resumption. But he emphasizes that the analyst also *validates* the patient's regressive experience as a genuine one having its own weight, claim, and title "despite its incompatibility with the accepted normal organization of external reality, object relations, etc." (p. 118). To accomplish this validation, the analyst must have a corresponding "therapeutic" regression of his own, so that his patient is "not left alone" with his (p. 118). Loewald (1960) spoke earlier about the child-parent relationship that develops in the therapeutic process of borderline and psychotic patients on levels relatively like those of the early child-parent relationship. It is the regressive immersion of the analyst in the service of the other (Olinick 1969) that creates a dyad analogous in intensity and extended influence to that of the early mother-child unit and establishes a setting for a turn toward the resumption of ego development and maturation.

FIXATION POINT

At any given time, all levels of regression may occur in the patient, but we can refer to a fixation point in regression that is followed by progressive development, although the existence of such a fixation point has been widely debated (Lindon 1967). I am not speaking of those fixation points that might occur in response to the need to adapt to some specific trauma; my notion of a fixation point is more general,

involving a global response through the use of defensive (mal)adaptation to the accumulation of problems in the development process. Thus such points refer to the developmental level on which there remain some unfinished developmental tasks. Atkins holds a similar view (Lindon 1967), that although we sometimes look for some traumatic event to which a patient has regressed, such a search may be unrealistic:

> It is not necessarily a question of regressing to a trauma or a traumatic situation but could be a response to an earlier ego state of psychosexual orientation and it may not necessarily be to a traumatic experience. Also it can be a regression to a psychosexual, psychosocial crisis which has not been resolved. [p. 314]

As I have noted, it is possible for a patient's condition to improve if he can successfully externalize unacceptable conflicts, as seems to have been the case with Boyer's patient; or if he is repeatedly given new ego experiences, as is done in some supportive therapies to exert a psychological influence on the fixation. However, the analytic way to deal with the fixation point is to have the patient regress below it, or at least to its level, and then to unlock it, so the unfinished task is resumed and there is an opportunity for its successful completion, such as would occur in the development of a normal child. I agree with the clinical observation that each individual has a natural developmental push, and that a positive outcome can be expected if the psychological infection is removed and the developmental task put on the right track.

THERAPEUTIC REGRESSION AND PROGRESSIVE DEVELOPMENT IN THE TREATMENT OF SCHIZOPHRENIA

It is self-evident that fixation points in already regressed and/or undeveloped patients refer to complications in the early developmental process. The regression such patients display is not newly entered upon in the service of the resumption of development, but is a chronic regressive state referring to a defensive maladaptation to the fixation point, the resolution of the developmental task being blocked by unfinished business. Even in these patients, further therapeutic regression will be necessary. Searles (1966) suggests that this is true even for schizophrenics:

> Because the schizophrenic patient did not experience, in his infancy, the establishment of, and later emergence from, a healthy symbiotic relatedness with his mother such as each human being needs for the formation of a healthy core in his personality structure, in the evolution of the transference relationship to his therapist he must eventually succeed in establishing such a mode or relationship. . . .This means that he must eventually regress, in the transference, to such a level in order to get a fresh start towards a healthier personality differentiation and integration than he had achieved before entering therapy, [pp. 338-339]

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Organismic Panic

Pao's ideas about "organismic panic" in schizophrenia (1979) may be useful to illustrate even better the therapeutic regression and the resumption of progressive development in already regressed or underdeveloped patients. (This refers to schizophrenics, whose usual regressed or undeveloped states are lower than the psychic organization of borderline patients.) We learn from Mahler (1968) that when a child's anxiety presupposes the existence of an ego adequate to handle it, organismic distress occurs. Prolonged periods of organismic distress over the mothering person's inability to function as an effective external ego make the child prone to experience organismic panic later in life. According to Pao, this experience shocks the future schizophrenic into paralysis of the ego's integrative functions; loss of the sense of self is painful in the acute phase of schizophrenia. The patient emerges from this experience of shock with a drastic change of personality that is a determinant of the diagnosis of schizophrenia.

I wrote about the treatment of schizophrenic patients with intensive psychotherapy, noting how crucial it is that, after years of work and the development of transference psychosis or symbiotic transference, the patient visit, as it were, the original organismic distress of his childhood and face the terrifying affects he had not previously been able to tolerate (Volkan 1985b). We can then say that he has regressed to his fixation point. Even though such regression may stimulate memory and/or reconstruction of a specific trauma (Volkan 1975), closer examination will disclose that the recalled or reconstructed trauma, like a screen memory, incorporates a more global experience of the patient's childhood. After reaching such a fixation point he experiences sad affect as a result of his loosening his ties to the earlier psychotic personality he had for so long maintained. Next, both patient and therapist experience pleasure with "mutual cuing" (Mahler 1968), and this leads to fresh, productive attempts of the patient to identify with the therapist, especially in those functions that were especially lacking in the person who mothered the patient as a child. This indicates that identification is a prerequisite for progressive development after therapeutic regression. The more regressed or, especially, undeveloped a patient is, the more noticeable is his identification with the therapist's representation a predominant curative factor.

> When some specific area in a child's interaction and experience with important mothering persons has been neglected, it is only in psychoanalytic treatment as an adult with a core deficiency that he can develop an ego formation that will enable him to deal effectively with this area. Thus, when we speak of identification with the therapist's representation as a curative factor, we refer to one or many different representations of the

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therapist dealing with one or multiple issues. [Volkan 1985b, p. 148]

I have written of a young woman unable to say "No" to anyone she thought of as deprived (Volkan 1982c). In her case, the deprived person represented the depressed early mother who, because of her state, could not function as an effective "frustrator" (Spitz 1957) for her child. It was in our mutual regression that, in transference-countertransference, I spontaneously frustrated our introjective-projective relatedness and became for her a frustrator with whose representation she could identify.

Since schizophrenic patients are involved at first in fusion as they begin treatment, as well as in separation and refusion of self- and object representations, they require a therapeutic symbiotic relationship with the therapist (Searles 1966) until their ability to differentiate between self and object is firm. While maintaining his observing ego as well as his "work ego" (Olinick et al. 1973, Olinick 1980), the therapist experiences a therapeutic regression of his own in order to allow a full-blown therapeutic symbiotic relationship—a transference psychosis—to develop. Once differentiation between self and object is well established, introjective-projective relatedness may permit the retention of certain representations of the therapist as a "new object" (Loewald 1960). It is at this time that the patient repeats and tolerates the childhood organismic distress that originally blocked much of his own ego development. This is then followed by further identifications with the differentiated therapist's representation in order to enrich the patient's ego functions.

IDENTIFICATION WITH THE ANALYST'S FUNCTIONS

Whether or not the patient makes progress after his therapeutic regression will depend on his ability to establish new identifications with the integrative functions of his therapist. Defenses that interfere with the resumption of progressive development and validation of his regressive experience should be analyzed. Our clinical observations indicate that introjective-projective relatedness in the psychotic assumes the dominance of defenses against anxiety; and among borderline patients, it parallels the use of defensive splitting, being a stale way of dealing with object relations conflicts. (However, once in psychoanalytic psychotherapy, the borderline patient, too, exhibits exaggerated introjective-projective relatedness.) The inevitable inclusion of the therapist's representation in this stale introjective-projective relatedness does not automatically promote ego-building activity, but the

therapeutic regression in such patients opens the way to new vigor and a change of function in their introjective-projective relatedness. Certain introjections of the therapist's representation may then be retained as identifications. Cameron (1961) speaks of finding therapeutically hopeful aspects in patients operating on archaic levels, noting that operation on such levels involves the equivalent of early partial identifications in ways unattainable by a more maturely developed psychic system. He added that these patients, although they are adults, could even internalize and assimilate new introjects (identifications) like infants. Hopeful processes do not, however, occur massively without further (controlled) regression, but unless preceded by regressive disorganization, they seem only to cover up object relations conflicts that may reemerge and continue to exert a pathological influence.

The Patient's Ego Organization

It is my assumption that introjective-projective relatedness appears in all psychoanalytic therapies but with differing clinical pictures and significance according to the degree of ego organization that the patient has achieved (Volkan 1982a). For example, if the patient is neurotic and has a cohesive self-representation, his introjective-projective relatedness is rather silent; it may appear openly in regression, but only temporarily, and usually it is accompanied by an observing ego; the neurotic patient does not fully experience it, as would someone with low-level ego organization. In analyzing a neurotic patient, the main focus is the interpretation of unresolved mental structural conflicts as they are related to drive derivatives and defenses against them that appear in the transference neurosis. In the background of this central endeavor, a "constant series of micro-identifications" (Rangell 1979) with the analyzing function of the analyst will take place. Rangell refers to them as being the same as Kohut's "transmuting internalization" (1971).

In fact, the introjection of the analyst in a gross and exaggerated way, involving a personified part representation, that is, one made up of the analyst's penis, nipple, face, or voice, is an unusual phenomenon in the treatment of neurotics (Rangell 1979), and the therapist should react to it as such and seek to learn the reason for its appearance. However, if the patient suffers from what Hendrick (1951) called "ego-defect" neurosis, that is, he has a psychotic, borderline, and/or lower-type narcissistic personality organization, one may expect to see in treatment the open and continued appearance of introjective-projective relatedness. The patient will refer openly to the therapist's representation, along

with—and in competition with (Abse and Ewing I960)—archaic representations. There will be a "therapeutic story" of imitation, introjection, projection, and externalization, accompanied by incorporative fantasies and leading to identifications that will alter the patient's psychic structure and change his self-representation.

Upward-Evolving Transference

I agree with Boyer (1971) that once a patient's ego organization matures and he forms a cohesive self and an integrated internalized object world, an *upward-evolving* transference relationship will appear. The development of more mature object relations with the therapist will occur in a transference neurosis, and introjective-projective relatedness will fall into the background of this relationship.

Of course, there is the danger that the "ego-defect" patient and his therapist will be arrested in the cycle of internalization and externalization and arrive at a therapeutic stalemate because both are using introjective-projective relatedness to defend against anxiety. The strength of this early mode of relatedness makes it difficult to move out of, and the therapist may be handicapped in trying to do so by lack of experience with patients of this type.

Projective identifications, which are sometimes accompanied by counterprojective identifications, induce exaggerated countertransference phenomena in the treatment of "ego-defect" patients. Unless these are understood and analyzed they make for failed therapy. Normally, however, the inclusion of the therapist's representation (when it has become an "analytic introject" [Giovacchini 1972]) initiates integrative function that enables the patient to mend fragmented and split self- and object representations and to attain a more cohesive identity.

The term *analytic introject* applies when the analyst's representation as taken in is not contaminated by externalization of existent object representations, fragmented self-representations, or archaic fantasies, but gives the patient a model of analytic attitude. One seeks its depersonification in order to involve its functions in an identification (see also Loewald's [1960] "new object").

In reference to the treatment of borderline states, Tahka (1979) says, "The therapist's function, analogous to that of the primary object, is to provide the patient with useful identification models for a

belated ego building" (p. 130). In this paper, and later (1984), he emphasized the phase-specific psychoanalytic encounter of patients on different levels of pathology with corresponding arrests and disturbances in the structuralization of their personalities. He suggests, and I agree, that "therapeutic techniques which are based on established psychoanalytic knowledge of personality development and which have proved phase-specifically growth-promoting should be included in the technique of psychoanalytic treatment understood in a broad sense" (Tahka 1984, p. 133). The psychoanalytic treatment removes the obstacles so that the reactivation of the patient's *developmental push* is accomplished and promotes belated development within the limits of the patient's natural potential.

THE CASE OF JANE

The case of one of my patients, Jane, illustrates the raw introjective-projective relatedness of a chronically regressed patient and her attempts at identification with the analytic introject in an effort to consolidate her psyche on a higher level.

In her four-times-weekly treatment, Jane, who was in her twenties, began by referring to her inner world, which was populated with threatening animals or parts of them, along with parts of human bodies such as eyes, faces, detached penises, and nipples. Benign images moved in and out among the terrifying ones. Jane felt that she lived in a poltergeist world in which objects were moved about by some mysterious power beyond her control. Soon after starting treatment she would ask me when she was stressed to look first here and then there, to move toward or away from the light; then she would blink her eyes as though they were the shutters of a camera. In a crisis, she would, in effect, create an introject, "developing" in her mind a picture to soothe her when I was not there. (As an active object representation, an introject strives toward, but falls short of, assimilation into the self representation to form an identification. However, it strongly influences the self-representation and its relationship with other object representations.)

Jane then would use my introject, which was contaminated by her "all good" archaic introjects, as a child uses a mother—as an external ego-superego forerunner. At this point in her treatment, to "take my picture" was to remove me from the outer world, and this made her anxious. Moreover, my soothing image could readily be contaminated by her "bad" image and quickly shift from the "benign" camp to its

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opposite. In terms of my physical appearance, she was taking me in, in personified fashion, as a somewhat abstract whole or partial being. I was not yet being taken in in terms of my functions.

This patient's core difficulty was her inability to fully individuate. At the time of her birth her mother had been grieving over a slightly older child who was deformed and not expected to live. When this tragic child died, it was in the arms of her mother in a car taking them to the hospital, and Jane was there. Their mother's depression persisted, and her inability to be a "good-enough mother" dovetailed with the small child's sense of primitive guilt (a form of survivor guilt) to lay the foundation of her psychopathology. Like Berman (1978), I have described patients whose lives were organized around guilt over the death of infant siblings never seen (Volkan, 1981c). Jane's sense of primitive guilt was clear. She acted like a crippled baby for days during one period of her analysis and evoked intense "bad feelings" in me through projective identification. Since her mother had not been close to her in her childhood, her father had tried to compensate, but he unfortunately sexualized his interaction with her and overstimulated her, leaving her no choice but to be fixated in primitive object relations, with their attendant conflicts and primitive defenses.

As treatment progressed, her unavailable, early mother appeared in her mind in images of cancerous breasts, which contrasted with the images of good ones. Jane wanted to save me (Searles 1975) when I represented her grieving mother; she tried to leave peaches and apples in my parked car, which she found locked; thus, feeling unable to save me, she went into psychotic panic. She felt that the earth would crush, like an empty eggshell, if she stepped on it—that she would fall into a void inside. Acknowledging her desire to save, I thanked her and reassured her that I was in control of my faculties and that her notion that we were both without hope except for her efforts was a childhood fantasy. When she became able to hear and use what I said I made genetic interpretations of the fact that she was repeating an effort to repair her grieving mother by giving her her own breasts (the peaches and apples) in order to benefit from her mothering.

Jane then went through a "therapeutic symbiosis" (Searles as was demonstrated by her belief that the couch was a swimming pool. She would lose the sensation of touch in parts of her body. Her body boundaries would disappear, and she would fuse with the analyst-mother (the couch). Such fusion with the analyst represented a therapeutic regression from clinging to fragmented good and bad images.

When, with therapeutic help, she came out of her therapeutic symbiosis, she seemed ready to work toward a healthier individuation.

In the third year of her treatment she had a dream that indicated that important structural changes were beginning to take place within her.

> "I was in a palace in front of a king. I told him I wanted to get married, and that he could help me. There were monks in the palace looking over old law books, one of which indicated that I could not get married. At this point I turned to the king and said, 'You are the king; why don't you decide whether or not I can get married?' Then a vent appeared in the floor and drew in the pages of the archaic law books by suction. They disappeared."

This dream came after her attempt to have her cat, Miss Kitty, put down. She had been using it as a *reactivated transitional object* (Volkan and Kavanaugh 1978), a bridge between mother-me and not-me (Greenacre 1970). I felt that her desire to kill the cat was in the service of intrapsychic separation from archaic mother representations. This dream had been preceded by one in which she killed her father, which she reported in the same session. In a sense, she was saying, "The king is dead. Long live the (new) king!" The new king represented the structural change toward superego characteristics taking place within her; the archaic law books pertaining to archaic representations were disappearing while the new king was being empowered to decide about such adult matters as marriage.

After telling her dream, she wept, indicating that she could now grieve over what she was leaving behind. Within a few days she moved out of her parents' house to an apartment of her own. Just before the new king dream, while still in her parent's home, she cooked her own breakfast for the first time. In the next treatment session, having moved into her apartment, she asked me for Turkish recipes. Since I am Turkish, she was in effect trying to internalize the "good therapist" via her incorporative wish. Instead of providing Turkish recipes I helped her understand her anxiety over the separation from her parental home and, with the achievement of her newly found inner structure, the prospect of new relatedness to the world.

Throughout the next month, I felt comfortably sleepy during most of the sessions. Finally I realized that she was speaking in an unusual, monotonous way. She was symbolically putting me to sleep with "lullabies." She was the "new" mother and I was the "new" baby. She spent hours in the kitchen of her new apartment baking pastries and thought of them as being made for me. During this time she

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described her schedule of four hours a week with me as being “like that of a mother nursing a baby on schedule.” Who was feeding whom was interchangeable in her mind. Sometimes she “fed” me and put me to sleep, but at other times I would perform these mothering functions for her in her fantasy. Such introjective and projective interactions were different from those that had appeared at the beginning of her treatment; they were much less contaminated with the absolutely “good” or “bad” images of her earlier introjective-projective relatedness. She was experiencing new objects in the service of healing and growth.

Soon her interest in me as an element to be introjected (eaten) changed from the crude and cannibalistic form it had been earlier. She became interested in me in more sophisticated and “grown-up” ways and identified with me on a different and higher plane. She began reading about my homeland and its people, taking a leap from eating to the cultural field. This led to her talking to me about the Middle East and Vietnam, where the war, to which she had previously made no reference, was taking place. She then began paying attention to world news, and developed what she called “adult interests.” Jane successfully completed her analytic work with me in a little over six years. She is now married and as far as I have been able to learn is an excellent mother to her two children and a supportive wife.

PSYCHOANALYSIS WITH FEW PARAMETERS

My work with the psychosis-prone borderline patients on the couch gave me an opportunity to systematize the process of their belated development. My technique prepares for entering into therapeutic regression and I consider it necessary for development through structural change, new identifications, and subsequent integration on a higher level. At first I called my method “undiluted/psychoanalytic psychotherapy,” but Boyer (1985) suggests the term *psychoanalysis with few parameters*; heated discussion of what should be called psychoanalysis can unnecessarily shift the focus from examination of the therapeutic process itself.

The following chapter focuses on the six steps of my treatment.