FROM ANALYZING JENNIFER TO ANALYZING PERSONS WITH BORDERLINE PERSONALITY ORGANIZATIONS

When I first saw Jennifer, she was trying very hard to hold on to her grandiose self, but her attempts were severely limiting her interpersonal relationships. Those with narcissistic personality organization split a grandiose self from the hungry one, as examined in my book, *Psychoanalytic Technique Expanded: A Textbook on Psychoanalytic Treatment* (Volkan, 2010, 2011). In typical cases, the grandiose self is well established and stable and the individual holds it close, while externalizing as well as denying the hungry one. When Jennifer had a therapeutic regression, she behaved as if she were a tailor sewing two pieces of cloth together. In her preoccupation with two pieces of cloth, she behaved like a person with a borderline personality organization. Jennifer was a borderline-near person with narcissistic personality organization. She was successful in sewing the two pieces together. She emerged from this experience after nine months by developing an integrated self-representation.

In this book, I use the term borderline personality organization in a specific manner. It does not refer to a phenomenological understanding of a patient, but to a psycho-structural understanding of the patient's internalized images of the self and others, regardless of the surface clinical picture. However, as expected, there is some correlation between the surface picture and the patient's personality organization.

In her daily life, a typical person with borderline personality organization is preoccupied with two pieces of cloth—often called "good" and"bad" pieces in the psychoanalytic literature. Metapsychologically the two pieces represent the individual's unmended self- and object images separated by splitting. None of the split parts of persons with borderline personality

organization is as stable as a grandiose self can be. In individuals with borderline personality organization, externalization and internalization of split parts occur often, sometimes within an hour, within a day, within a week or month. The general stability of such a patient in daily life depends on how much the person can slow down this externalization-internalization cycle.

We should also differentiate the inner structure of an individual with borderline personality organization from the inner structure of another individual with a psychotic personality organization. In persons with psychotic personality organization, self- and object images are not simply split into two basic camps. The internal worlds of persons with psychotic personality organization are fragmented, and the fragmented self- or object images can be included in constant and very quick externalization and internalization cycles unless the individual develops a chronic psychotic condition such as schizophrenia. In persons with psychotic personality organization, at times such images also merge, making their reality testing highly defective.

I suggest that those individuals who have multiple personality organization (Brenner 2001, 2004) exhibit an advanced version of psychotic personality organization or a specific version of borderline personality organization according to the nature of their fragmented self-images and corresponding object images. These images have evolved to possess distinct characteristics and have become stable enough for the individual to sense them, as if various identities (personalities) exist within the individual. The person usually gives them names—one is Madeline, the other one Grace, and still another one Fatima. One of these personalities, if advanced enough, does not recognize the lower-level ones, since the function of repression is available to it. Meanwhile, the lower-level personalities, without the benefit of repression, may be aware of the existence of the highest one and sometimes each other.

Now let me ask a question: Can we analyze individuals who possess borderline personality organization?

Preparation for Analysis

In 1912, Freud predicted that with time and experience advances in the psychoanalytic field would lead to a consensus about the most expedient techniques. In 1919, he was ready to admit that psychoanalytic understanding was incomplete, and that methods could be altered as more was learned. He expected improvements in analytic technique. As new theoretical orientations evolved his followers did call for new technical approaches and, as expected, treating patients with narcissistic or borderline personality organization required new theoretical and technical considerations. Here I offer illustrations from my experiences with such patients, using my way of relating to them in a therapeutic setting. I ask readers to compare their way of analyzing such individuals. Meanwhile, I agree that, “Variation in technique has its usefulness, but variation from analyst to analyst must be appraised and evaluated with a sound understanding of the theoretical basis for such technical innovations, deviations, or maneuvers” (Lorand 1963, p. 192).

Historically speaking, when analysts began to apply the classical analytic technique to patients formerly considered unapproachable due to their ego weaknesses or ego deficiencies, in general they resorted to supportive measures. They called such approaches a "preparation for analysis" (Rapaport 1960). The idea was that through supportive measures the patient's ego would be strengthened, and after this strength had been established, the patient would be ready for “real” analysis. This idea still exists. When I visit different psychoanalytic institutions in

the US and other countries, often I notice many analysts working with borderline patients for months or years before putting them on the couch.

While some analysts' ideas about supportive measures are dominated by sound theoretical principles and are directed toward increasing the patient's ego functions, sometimes—with or without acknowledgment—the idea of supportive measures leads the analyst to become a manager of the patient's life. For example, one analyst knowing that his patient had difficulty controlling his spending impulses arranged to have a joint bank account with his patient. The patient could not withdraw money from the bank without his analyst's signature. Theoretically speaking, the analyst became an external ego/superego. In this "technical maneuver" there was little or perhaps no psychic space between the patient and his analyst—space where the therapeutic work which holds the possibility of changing a patient's psychic structure—is done. In order that the patient truly identify with the analyst's impulse-controlling function, an intrapsychic examination of this function within the therapeutic space between analyst and patient must take place. There must also be a struggle for and against the identification with the analyst and the analyst’s therapeutic function prior to its assimilation in the patient's sense of self.

Traditionally, because most of the "preparation for analysis" period was non-analytic, the analyst identified the treatment of such patients by names such as psychoanalytic psychotherapy or intensive psychotherapy. In general, in these situations, there was a tacit acknowledgment that further regression in these already-regressed patients was bad. In my thinking, without therapeutic regression, the technique cannot be psychoanalytic. I am *not* against activities in an analyst’s office that prepare a person with borderline personality

organization for analysis. What I am suggesting is this: If the analyst thinks and plans to put such a patient on the couch in the future, the technique utilized for this preparation period should be understood by implementing a sound theory that envisions preparing the patient for the development of a workable *split transference* and preparing the analyst to tolerate it. Because in an analysis of such an individual, workable split transference and the analyst's response to it will be *the* relationship between the two people in the analyst's office for a long time before the patient reaches a level where crucial juncture experiences begin.

Two Styles of Treatment and Countertransference Issues

When analysts accept individuals with borderline personality organization for individual analysis, my observations suggest that analysts' approaches still can be divided into two opposing styles, although not strictly. In practice, analysts utilizing the first style sometimes borrow the technique of analysts who utilize the second style, and vice versa.

1. The first style attempts to maintain a level at which the patient, who is already in a severely regressed state, can function *without* further and major regression. The analyst utilizes suggestions, clarifications, limit-setting and interpretations that aim to reduce the patient's anxiety. The repeated experiences with the analyst's gentle but steady confrontations with the splitting provide new "ego experiences" within the therapeutic setting, which may help the patient. Analysts endorsing this style hold that if their already regressed or undeveloped patients regress further they will become psychotic. This idea is justified by the role of primitive aggression in patients with borderline personality organization. Further regression may induce unmanageable aggression that, in turn, may destroy the therapeutic efforts.

2. The second view holds that such patients need to experience further—now controlled—major therapeutic regression. Hence, the analyst, at the appropriate time, should not interfere with the patient's regressing to a level lower than the split level 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 are aware of the patient's aggression and thus "prepare" the patient for a therapeutic regression. Once they regress further, such patients will exhibit temporary transference psychosis (fragmentation of self- and object images and/or a fusion of self- and object images). Then the analyst embarks on the treatment, expecting to continue working through the patient's psychotic transference in hopes that the patient will gain the ability to organize a new and healthier structure.

The *countertransference* issue becomes a crucial one in the second style of treatment. The analyst will need to participate intensively in the patient's externalization-internalization cycles and in “offering” him- or herself and the therapeutic functions as identifications that will enrich the patient’s internal world. Such a process will induce intense countertransference responses, because the patient’s externalization-internalization cycles are strongly contaminated with aggression and because, before identifying with the analyst as a new analytic object and with his or her therapeutic functions, the patient will test the analyst again and again to be sure that the analyst is not like the patient’s archaic objects. Furthermore, the analyst needs to regress "in the service of the other" (Olinick 1964, 1980) in order "to meet" the patient at a regressed level. The resumption of progressive development made possible by regression is therapeutic.

I suspect that the key deciding factor for choosing the first or the second style of treatment comes down to the analyst's own sense of how much will be required in order to tolerate the countertransference issues while working with any such patient. If we assume that analysts functioned on a neurotic level or with high-level character pathology before their training analyses, we will expect them to have become familiar with their own transference projections and reintrojections as well as their analysts' reactions to them. Thus they "learn" through identification with their analysts how to remain in the therapeutic position when subjected to these projections and reintrojections. Such tolerance is part of the analyst's professional identity. In short, properly trained analysts are more familiar with and more tolerant of a patient's transference projections, introjections and displacements than they are of patient's transference externalizations and internalizations that are accompanied by denials, idealizations, and extreme devaluations contaminated with primitive aggression. Some analysts, due to personal life-experiences, can sense whether they wish to work with individuals with low-level personality organization analytically or not. One of my late mentors, who made a career of putting patients with borderline and psychotic personality organization on his couch and treating them successfully, once told me that when he was a child his mother had a psychotic personality organization. "I am familiar with the internal worlds of my patients with primitive internal organizations. I can be with them therapeutically without anxiety." Then he asked me what the important thing was in my background that allowed me to put individuals diagnosed as suffering primitive mental conditions on my couch without much anxiety. I thought about this seriously. Unlike him, I had a rather nice childhood. But, my paternal grandfather who was a farmer in Cyprus used

to thresh wheat using a wooden board with sharp flint stones attached underneath (known as a "threshing sledge"). He and I, when I visited him in my childhood, would sit together on the wooden board pulled by two donkeys or cows to thresh the wheat. My children in the United States are very good with computers. I figured out that my experiences in life include activities connected with both the Stone Age and the modern world. I can regress to the Stone Age and then come back to modern times. Accordingly, I thought, this is the reason why I felt rather comfortable meeting my patients on the couch in their extreme regressions and fixations. Every analyst knows what kind of patients he or she chooses with the expectation of success. Obviously, proper supervision, consultation, and serious studies help expand an analyst's comfortable and successful work with a variety of mental conditions.

The Role of Noticing or not Noticing "Anchoring Points"

In the usual analytic setting, the transference projections on the analyst are anchored in some real event. Even though the analyst may have an emotional reaction to such a projection, the recognition of this *anchoring point* (Volkan 1981) tames the analyst's counterresponse. This can be much more difficult when the analyst becomes the target of an externalization without a clear anchoring point and it may, in turn, evolve the analyst's counterresponse to an uncomfortable level. Let me first give an example of a patient with a neurotic personality and his involvement in a transference projection, my noticing the anchoring point, and how this removed my discomfort.

Spence had a dominant mother who had routinely denigrated her husband. The father was accordingly perceived as ineffectual and my patient, in spite of his considerable professional accomplishments, considered himself to be ineffectual as well. His analysis revealed

that this identification with the degraded image of his father also 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 projection and displacement onto me of his attitudes and feelings toward this stronger father. As might be 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—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. This is because my experience as an analyst had made me familiar, in the course of my professional development and practice, with being considered a castrator at some time or other by patients with neurotic personality organization.

One day, while lying on the couch at this stage of his analysis, Spence calmly told me how amazed he was to recognize the pattern of the radiator grill in my office. He said that his father, who had been a mechanic, had made grills and had made a beautiful one exactly like mine for his own office. Spence thus acknowledged that his father's manual skills made him appear 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 of 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 with a quickened heartbeat and sudden sweat. Regardless of this natural human response, my emotions did not lose their signaling function and thus I was able to

think through Spence's use of the radiator grill 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 grill in my office and its actual or fancied resemblance to the one in his father's office provided an *anchoring point* for the interaction that took place between us. Within minutes I was in command of my counteremotions. I chose not to tell Spence about them, since such knowledge would burden him unnecessarily, but in due course the process was repeated and then I interpreted it 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 one-time counteremotion with what we regard as a manifestation of a full-blown countertransference. I use it here simply as a microscopic example of a collection of such events, the macroscopic correlate of which is the full-blown countertransference reaction to a patient's transference.

When they are the subject of the externalizations of a person with borderline personality organization, analysts may lack the advantage of having an observable anchoring point in reality, which precipitates or accompanies such processes. Then analysts are more at the mercy of what their patients attribute to them, but they will come to understand more of what is going on as the therapeutic process advances and as they gain secondary process understanding of the affect-laden sensations they experience as the recipient of their patient's split-off self- and object images. Most of us feel comfortable in the treatment situation when we see a patient's low-level behavior pattern such as a hallucination, 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 patient's observably unusual pattern. We do not identify ourselves with the patient's experience of something beyond the range of our usual way of life. However, to be a target for the externalization of the patient's representational units that are connected with untamed affects is something altogether different. I recall literally almost choking early in my career when working with a patient with borderline personality organization 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 since 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-image 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. First I would accept her externalizations long enough for her to realize that I could tolerate them, so that through her identification with me as someone who can tolerate such feelings, she could re-internalize and hopefully also assimilate them. Then I would tell her, if she had enough ego function to grasp my interpretation, that she wanted me to have a firsthand experience of the intrusive mother.

When a workable split transference is established, it is not enough for the analyst to think that “now a ‘good’ image is being externalized onto me and then a ‘bad’ one." Each such dominant image has its own developmental history and collections of affective experiences related to it and, accordingly, a *specific context* which the analyst must understand. Although they ultimately will be interpreted to the patient, what counts *initially* with such patients is not making genetic interpretations of context. Instead, the analyst should make an interpretation of the same context in current terms as it appears, with careful consideration given to the eventual basic aim of helping the patient to integrate the split-off representation and to advance toward a more realistic self-concept and a more realistic internalized object world. The psychoanalyst's examination of the countertransference will yield important clues to the understanding of the specific context of the patient's image units as they are being externalized onto the analyst.

In my book *Psychoanalytic Technique Expanded: A textbook on Psychoanalytic Technique* (Volkan, 2010, 2011) I look closely at the second style of analysis applied to patients with borderline personality organization on an analyst couch.