Six Steps in the Treatment of Borderline Personality Organization

A Psychosis-Prone Borderline Patient

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DIAGNOSTIC PROFILE

Pattie was 21 when she came to my office for the diagnostic interview that was to lead to six years and seven months in treatment. Although she lived about a hundred miles from my office, she came four times a week until, during her last two years of treatment, her added job responsibilities made it necessary to reduce her time with me to three weekly visits.

When I first saw her she wore a wrinkled shirt and cutoff jeans stained with dirt. She might have been considered pretty were it not for her aggressive expression. Her hair was uncombed, she was rather plump, and she walked with a masculine stride, holding her arms in a wrestler's defiant posture. Beneath her demeanor or fierce independence I sensed a frightened child asking for help.

She said that at age 14 she had been diagnosed as a schizophrenic and had presented so many problems at school that she had been sent to a school for the exceptional. She had seen a woman psychologist for therapy three times a week for four years before being admitted to a private hospital where she stayed for over two years, having therapy sessions with a woman psychoanalyst thrice weekly. When her hospitalization overtaxed her family's budget, she was discharged.

She and her family had heard of me through the psychoanalyst, whom I did not know, with whom I never spoke, and who seemed to have made little impression on Pattie, who seldom spoke of her during all our work together. She seemed not to have cathected to the lady analyst to any great extent. Pattie did report that during their face-to-face sessions this analyst had said very little, listening to her disclosures with eyes closed. Pattie retained a rather affectionate regard for her first therapist, however, feeling that she had tried to be helpful but had been handicapped by a lack of training. Pattie had lied to her psychoanalyst during her hospitalization, managing to keep from her an affair she was having with a troubled staff member, and the fact that toward the end of her hospital stay she had been pregnant and had undergone an abortion after being discharged.

Pattie's parents had bought a farm on which, besides the main house, was a cottage where there lived a young man and his wife who looked after the place and the few horses on it. Pattie's parents lived elsewhere, visiting the farm from time to time in expectation of moving there permanently after the father's retirement. Pattie went to this farm after she left the hospital; certain rooms in the main house were assigned to her, but it was understood that she enjoyed no ownership, and that she would get out whenever the family had houseguests. It was clear that she brought shame, anger, and frustration to her family, and that they were trying not to let her chaotic and eccentric lifestyle impinge on their orderly existence. I felt that she was perceived, in effect, as just another animal loose on the farm; apparently she also felt this, for she seldom slept in the house, preferring to bed down in the stable where she felt comfortable and could talk to the animals. On the few occasions when she did sleep in the house, she refused a bed, sleeping instead with her dog on a couch.

When she came to me she had been at the farm for more than a year, spending a great deal of time sleeping or dozing off. When she could afford it, she took drugs, and she went nightly to a nearby bar to pick up a stranger to bring home for a one-night stand, during which she experienced no orgasm. Many of these partners were truck drivers. Once the sex act was over, she would perceive her partner as threatening and evil and would become aggressive. Since she acknowledged that there were often fights, I felt that she was frequently in physical danger. It was her habit to return to the stables once her partner for the night had made his departure.

I noted that, in general, Pattie had psychic boundaries—she knew where she ended and others began. Her boundaries seemed, however, to be full of holes in spite of having two appropriately distinct surfaces on which these holes appeared. When under the influence of drugs and at such moments as she experienced intense need for nurturing objects, she merged with objects in the environment. She described inconsistent patterns of behavior and opposing aspects of an unintegrated sense of self, usually referring to herself as "a big bad blob." She had enough vanity, however, to feel that were she to take pains with her appearance, she would be a veritable femme fatale.

Her images of other people ranged from one extreme to the other; a "good" truck driver, for example, would suddenly become "a bad man." She described her parents as though they were fragmented. She was at a loss to describe the therapists she had had as total, integrated persons, and this

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was especially true of the psychoanalyst in the hospital. In respect to whatever was emotionally and symbolically rather neutral, her reality testing seemed unimpaired, but anything suggestive of psychic or physical intimacy made her so anxious that it blurred her perception of reality. She clung to aspects of her childhood omnipotence in order to deny danger; when she found herself with men who were drunk and armed with knives and pistols she chose to be oblivious to what was going on. When her omnipotence was threatened she used even more massive denial of the dangerous world. This maneuver seemed to account for her spending so much time during the day sleeping.

Her real world was frustrating; indeed, she was playing a role in keeping it so. I sensed that she was creating and controlling something traumatic but familiar, and I recalled Giovacchini's remarks (1967) about how, to persons with character disorders, "The environment has to be constructed so that their total ego organization is maintained" (p. 579). (See also Jacobson 1964.) I thought also that the dangerous environment was a reservoir for Pattie's externalized and unacceptable self- and object images and her projected untamed impulses and her defenses against them. I began at once to check the accuracy of this conclusion.

She knew she was a woman, but her desire to be male was strong enough to suggest during her diagnostic interviews that she was not unlike the female borderline transsexuals I worked with at one time (Volkan 1974, 1980b, Volkan and Berent 1976, Kavanaugh and Volkan 1978). Indeed, from time to time she had given thought to having transsexual surgery but had never been obsessed by this possibility. The female transsexual typically has a troubled, usually depressed, mother whom as a child she had wanted to rescue from her depression for selfish reasons, clinging to and exaggerating her fantasy of having a penis. It is as though, were the little girl to have a penis, she could offer it to her mother, making her sufficiently happy to provide good mothering; but since mothering is frustrating, the little girl's fantasied penis is not always a loving one but is contaminated with derivatives of aggression. Having a penis differentiates the child from the depressed mother, who has none, and in this way, the possession of a penis is a defense against fusion with a bad mother.

In adolescence, after the oedipal father rejects his daughter, failing to disentangle her from her troubled relationship with her mother, the female transsexual feels her entitlement to an aggressive penis crystallize. Pattie had longed for a penis in adolescence, wanting it not for lovemaking but as a tool

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of aggression with which to protect herself from the dangers inherent in object relations. She reported that at age 11 or 12 she had tried to stab her mother with a kitchen knife as she lay in bed. The penis she wanted was like a kitchen knife.

As a small girl she had glimpsed the vagina of her menstruating mother and now thought of her own as ugly and dirty. I sensed that her desire to have a penis was, over and above the castration issues of a higher level, in the service of differentiating herself from her mother and thus protecting herself from a push toward engulfment by her (Socarides 1978). Even while presenting herself as a tough veteran of life, Pattie managed to tell me that she knew she was "in a mess" and that she often thought of suicide.

It took three diagnostic sessions for me to understand some of the basic reasons for Pattie's illness. I wanted to have a map, not too detailed at first, to give me some idea of where we would go if we decided to travel together in treatment.

In giving my formulation of her psychological problems, I calculatedly include here some information that was not available to me during these first three hours; her story and its meaning unfolded slowly over the years we were together, but to give the reader a comprehensive picture I include some later findings. Pattie came from an apparently prosperous family. Her father was co-owner of a textile plant, and her mother, a housewife, was involved in charitable and community affairs and had an active social life among "the people who count." Their oldest child was a girl five years Pattie's senior; their second, a boy, was four years older than Pattie. When she was two and a half, another sister, Mary, was added to the family. Although the latter developed normally over time, she had orthopedic problems as a child and had had to wear leg braces.

Pattie made it clear that Mary's lameness had injured their mother's self-esteem, and that the mother had devoted herself to Mary at Pattie's expense. Mary had had difficulty achieving separation-individuation from this solicitous mother, and it seemed to Pattie that she had so clung to her that Pattie herself was pushed aside. Thus she, too, experienced separation-individuation problems. Pattie remembered being quieted by a pacifier until she was about four and recalled the envy and rage she had felt over having to take second place.

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One day her mother struck a bargain with Pattie: she would get her a doll she wanted if she would give up her pacifier. To her surprise, her mother sealed the bargain by cutting up the pacifier when Pattie surrendered it; having believed that she could have both the doll and the pacifier, the child felt disillusioned. Later, while still a small child, she shoplifted a plastic baby bottle with which at one time she tried to nurse some baby rats, but which she used primarily as a replacement for the lost pacifier. It became a childhood fetish with which she could deal with her separation anxiety and even with transitional issues (Winnicott 1953). She could not part with it, and even as an adult she took it to the farm with her. When her pacifier was destroyed, she began having a repeated dream, which continually appeared during her treatment until its meaning was analyzed and, what was more important, until she developed more mature ego functions to deal with the issues in her dream. In this dream she had plastic-like chewing gum in her mouth and was unable to chew it; it stuck in her teeth, and she could neither swallow it nor spit it out. She would then awaken with anxiety. Her oral fixation was represented in this dream. Greatly desiring her mother's love (her breast), she dreaded the possibility that what she longed for might turn sour. Not only did her mother's preoccupation with Mary make her "bad," but Pattie's projections of her aggression onto her mother made her dangerous.

The perpetual chewing reflected Pattie's state of limbo in respect to her relationship with her mother, whose satellite she had become. The *satellite state* (Volkan and Corney 1968) occurs in maladaptation to separation-individuation difficulties; a person in this state is drawn to the mother's representation as a moth is drawn to a flame. Closeness (a pull toward fusion with the representation of the mother) creates danger, while distancing (individuation) brings loneliness for which the individual in question is unprepared. The end result is that he is doomed to circle around the mother or her representation.

Patients like Pattie usually stay near the parental home as young adults and alternate between closeness and distance in respect to the mothering person. Both parties to this peculiar attraction act in the real world as though they are endlessly involved in the separation-individuation process. In this sense the child and the mother, caught in a developmental struggle, are kept alive (reactivated daily) without any result.

Pattie's childhood habit of biting her playmates, and her early preoccupation with such images as

that of "Pac-Man," the devouring moveable mouth of the electronic game, directly expressed her oral sadism, which would be condensed later with anal and phallic sadistic impulses. She made a point of telling me that the knife with which she had tried to kill her mother (a phallic symbol) had "teeth," by which she no doubt meant that it had a serrated edge; in this remark one could sense the condensation of phallic and oral aggression.

When at first I learned during the diagnostic interviews about Pattie's mother having a disabled child for whom she had neglected Pattie, I had wondered whether this neglect alone could account for Pattie's psychopathological state. I could see no specific traumatic event save the destruction of the pacifier, but slowly I grasped that emotional poisons pervaded her family. She kept telling me that in spite of an outwardly stable appearance, her family was inwardly chaotic. As time went on I learned that the mother was fragile and had held second place with her tyrannical father, and she feared him even as an adult.

Pattie felt that her mother could function as a mother with only one child at a time and called her "The British Empire" because of something I said about the British maneuver of "divide and conquer." The sibling rivalry the mother had experienced was reflected in her own brood, and she could not face or control the sadistic competition among her own children. All of her children had problems. Her oldest daughter, who married a lawyer before Pattie became my patient, was her mother's extension, a favorite who had identified with her mother's rather narcissistic view of life. She was sadistic toward Pattie, whom she despised. Their brother struggled with obesity, and Mary had such separation anxiety that she too went into treatment.

The basic trauma Pattie had suffered at her mother's hands was not simply concerned with the destruction of the pacifier. We came to realize that the mother was deficient in certain ego functions such as the taming of affects, the integration of opposing elements, and some areas of reality testing in addition to being unable to help her children handle their rivalry. Pattie had not realized this until her own treatment progressed, and insight came to her suddenly after long preparation in therapy. When, with her father and a farmhand, Pattie was driving cattle one day into a corral, she saw her mother, dressed in street clothes, standing in the gateway of the corral, seemingly oblivious to the fact that she was obstructing the efforts of the others to get the cattle inside. Pattie had a flash of recognition that this was

the story of her childhood—having to silently deal with having her mother not only fail to appreciate her efforts but to have any idea of their meaning.

Once Pattie cut down a dead tree in front of the living room window in the farmhouse and was angrily reproached by her mother, who claimed that she had wanted to see her grandchildren climb on it. She knew that the tree was dead but failed to take that into account. By now Pattie was able to see, as she had not been able to do before her treatment, that her mother's behavior was not always rational.

Frustrated by her mother, Pattie had turned to her father, who had initially been warmly responsive to her. When she was 8, however, he was bypassed for a political appointment he coveted; she could recall his getting the news and becoming deeply depressed. His depression activated his complicated mourning over the earlier death of an army comrade of whom he had been very fond, and his manner toward Pattie then became rather cynical and rejecting. He remained depressive for the rest of his life. Her father's rejection dealt a severe blow to Pattie's blossoming femininity; she seemed to change overnight into the "big bad blob," but she tried at first to find other support for her self-esteem by idealizing a woman teacher, thus returning to the possibility of finding a good mother. Soon, however, this teacher became pregnant and left school, leaving Pattie rejected once again, by a mother figure who, like Pattie's own mother, gave attention to a new baby. Her history had repeated itself! She reacted by shoplifting again, in a sense making a store an instant gratifier (Volkan 1976), taking a lipstick from a shop with which her father had a business connection. Rejected by a mother substitute, she envisioned getting her father's attention by using the lipstick she had taken and showing that she was now a grown woman. She had once had high hopes of being his favorite. But the theft of the lipstick led to her detention by the shopkeeper. Her mother was summoned and expressed anger at her daughter, and overnight Pattie again became "a big bad blob." When shown a picture of herself taken before she was 8, Pattie did not feel as though it was she. It seemed that being rejected by the teacher she idealized had been destructive, and now her failed attempt to protect her self-esteem was the last straw. She experienced a kind of organismic panic (Pao 1979), or emotional flooding (Volkan 1976).

Her ego functions returned and she began to establish the best possible sense of self. She emerged from this experience with a personality change. Although Pattie did not go into a full-blown psychosis, she seemed to break out of her helplessness, finding support for her self-esteem and reorganizing a new

self. This occurred through crystallization of her “big bad blob” identity, which led her to think of herself as someone other than the child in the photograph. Her newly crystallized “bad” self did not, however, overcome her hopeful “good” self but put it in abeyance; it was better to have daily a “bad” self and a split off, hidden “good” self than to have no self at all. In order to support the “bad” self she tried to maintain, she began to play “games of being bad,” which were, paradoxically, the only way to get her mother’s attention and to identify with her crippled little sister, who in her mind, was bad. The games led her to break implicit family rules to respect what belonged to her siblings; to assume a tough, mean, masculine identity; and to split away from and hide her gentle and femininely seductive aspects. Although at one time she had shown affection for Mary, she soon came to feel rejected by her and added this supposed rejection to her reasons for being “a big bad blob.”

She forgot how to smile when she was eight, and she began wanting to be a boy, although there remained a hidden desire to save her father from his depression (condensed with her earlier savior fantasy about her mother) and a hope that some day she would regain his appreciation and love. Now her expectations of him were hidden behind constant bickering with him. As long as she fought with him she could hide her desire for his love; it was as though she felt that he would be nice to her if they stopped fighting but she was afraid to put this to a test for fear of being disappointed and so kept on being belligerent. Thus she kept the possibility of being either loved or rejected by her father in limbo just as she kept closeness and distance from her mother.

Much later she realized through her dreams that the truck drivers she picked up represented not only the nipple that had solaced her as a child and her “good” mother but also the “good” (saved) father. All of these consolations could suddenly cease to comfort—or even to be acceptable. By the time she was an adolescent she had become expert in finding reasons for her aggression toward and mistrust of others, and it was through such primitive mechanisms as splitting, denial, externalization, and projection she could so readily create a hostile environment. In all truth, the environment of her real world—her treatment at the hands of her older sister, for example—was hostile enough to be congruent with her pathological expectations. Unable to form mature relationships within her peer group, she suffered in mid- and late adolescence from massive identity diffusion, feeling alienated from other girls and boys. The world became dangerous in her view, and she tried to kill her mother.

Her parents sent her to a summer riding camp, where the discipline of riding well was beyond her. Feeling great anxiety, she withdrew more and more from people and began talking to the horses and hearing messages in the wind. It was soon after this that she began her first treatment with the psychologist.

After six years in treatment with two therapists, and after more than a year on the farm, Pattie came to me. Although consulting me had been discussed with her parents, I think it was the "accidental" killing of a kitten that precipitated her to visit my office. In panic she came for treatment. The death had made her very anxious, and in treatment I came to believe that it was an actualization of her unconscious fantasy of killing her younger sister.

PHENOMENOLOGICAL DIAGNOSIS

As a psychoanalyst I am more interested in making a psychological profile of my patient, and a detailed formulation of his psychodynamic processes and their psychogenetic determinants, than I am in making a diagnosis in a phenomenological sense. Here, however, I do diagnose in phenomenological terms according to DSM III (The Diagnostic and Statistical Manual of the American Psychiatric Association); such specificity is required now in order to qualify a patient for third-party underwriting in treatment. DSM III lists eight personality-trait determinants in diagnosing Borderline Personality Organization, in which five are required for a positive diagnosis. In terms of the DSM III, I saw Pattie as suffering from Borderline Personality Disorder (DSM III, pp. 322-323); she exhibited *all eight* of the determinants of this diagnosis:

1. She was impulsive and unpredictable in such matters as substance abuse, stealing, and overeating—aspects of potential self-destruction.

2. She seemed unable to control anger, appearing to be at times in the grip of murderous rage and at other times chronically angry.

3. Her interpersonal relationships were marked by attitudinal shifts involving both idealization and devaluation.

4. She had disturbance of identity, seeming uncertain about her gender identity and her body image.

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5. She had affective instability, being easily moved by either internal or external stimuli to anxiety, depression, and irritability. These affective states would run their course in a matter of hours, after which time she would present herself in a normal mood.

6. She could not tolerate being alone. When there was no one around she retreated into long hours of sleep or talked to the animals. Then she would frantically seek out people like the truck drivers, none of whom became friends.

7. She behaved in ways that jeopardized her physical wellbeing, although she had never attempted suicide in spite of thinking about it from time to time. On occasion she got into physical struggles with a truck driver, just as she had fought physically with her siblings and other children when a youngster. When she slept in the stable she exposed herself to injury, and had in fact been kicked and bitten by the animals.

8. She felt chronically empty and reported being bored and dissatisfied in spite of her alternating periods of dangerous activity and sleep.

Pattie had all eight of the characteristics of Borderline Personality Disorder to a marked degree. Her anger became murderous, she displayed transient symptoms of psychosis, and she could not maintain, even with her parents, the kind of relationship with others that would offer protection. I felt that her Borderline Personality Disorder was on the lowest level. Her shifts from one extreme of affect and attitude to another, and her frantic activities punctuated a customary state of being from which she operated from day to day; it was not a loving or idealized state, but one invested with hate in which she had an aggressively weighted self-concept and considered herself “a big bad blob.” Phenomenologically at least, her condition might be like Narcissistic Personality Disorder, which implies the day-to-day domination of the clinical picture by a “stable state of mind” in spite of a grandiose sense of self-importance and preoccupation with success, power, beauty, or ideal love. Unable to organize herself at this level, Pattie went to the opposite level; to her, a bad and negative identity was better than none at all. However, like a narcissistic person, she wanted to be “Number One” and tried in her customary state to be the worst person on earth, although her exaggeratedly bad stance and sense of self-devaluation were less stable than were she of the narcissistic type, which stoutly maintains its inflated self-importance.

DECISION FOR TREATMENT

I did not see Pattie as a candidate for unmodified traditional psychoanalysis, which is designed

basically to treat those who are neurotic and who have a high-level personality organization or high-level borderline personality organization. All indications pointed to her being very likely to exhibit transference psychosis, with acting out that could be dangerous to herself and others. During her stay in the hospital earlier, her analyst had probably tried the classical psychoanalytic approach, listening rather passively during their sessions to whatever Pattie had to say. Indeed, Pattie claimed that her analyst had made but few remarks during their two years of work together. During her four previous years in supportive therapy with a psychologist, she had received help in having some of her dangerous activities curtailed by the cultivation of a positive transference (which was never analyzed, nor was the negative transference), by consultation with her parents, and so forth. Such efforts had not been enough, however.

She was at a point where it seemed advisable to take a chance on using an undiluted version of psychoanalytic therapy that I had already tried with other psychosis-prone borderline patients, usually with success. I thought that if we did not take this chance, her life would be in danger, whether from a knife at the hand of one of her truck drivers, the kick of a horse, or injudicious use of drugs. Or she might wind up having to be repeatedly hospitalized, with someone to manage her life most of the time.

Arrangement to Pay for Treatment

I told Pattie that I would work with her and see her four times a week. I expressed some concern about her willingness to drive this often from a hundred miles away, but she replied that she did not mind driving and had been in any case thinking of moving to the city in which I work. During her final diagnostic session she reported that her parents wanted to meet with me. I told her I preferred having our work remain a matter between the two of us. Her father wanted to know the yearly cost of her projected treatment, and I came up with a figure allowing for the usual two months or so of my absence for academic meetings and holidays. I said that my academic duties made me somewhat less readily available than the average psychoanalyst in private practice.

Pattie was the beneficiary of a trust fund, but her father managed her income because she was thought to be sick. I suggested that she make her own financial arrangements with him about paying for her treatment and bring me checks she had signed herself. I explained our system of professional

reimbursement in the Medical Center but stressed that her bringing in payment for her bills herself would be an acknowledgment of her responsibility for her treatment. Later, when she began earning, she was able to shoulder this responsibility directly without consultation with her father.

Instructions

I told her that I did not give medication, and that we would work by her telling me whatever came into her mind and acquainting me with her bodily sensations during sessions. I also said I expected her to use the couch soon after we started. I told her that using the couch was productive, and my not being visible to her would, in the long run, help her to let her mind wander more freely. Also, it might make it easier for her to share and examine her fantasies about me and the treatment. Examination of such fantasies would be essential. A veteran of therapeutic work, Pattie knew about the customary use of the couch in psychoanalysis although she had not used one herself. I explained that it would be through free associations and reports of her bodily sensations that we would try to grasp how her mind worked and why it functioned as it did; thus in time she would come to see choices available to her in relation to her lifestyle, her relationships to others, and, most importantly, to herself.

She understood my instructions and expressed satisfaction in my refusing to meet her parents. She said she felt that I was taking my work with her very seriously.