Clinical Observations and Theoretical Considerations

BORDERLINE PERSONALITY ORGANIZATION

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Six Steps in the Treatment of Borderline Personality Organization

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e-Book 2016 International Psychotherapy Institute

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Because the subjects in this book are mainly "psychosis-prone" (Gunderson et al. 1975, Boyer 1986) borderline patients, it would be well to discuss at the outset what is meant by *borderline personality organization*. The term has had considerable attention in the literature of psychoanalysis and psychiatry since the late 1960s. Here I limit discussion to the ways in which this type of psychic organization appeared in the background of the patients whose treatment I report.

Classification by Structural Configuration

Kernberg (1967, 1975) holds that the borderline patient has a *specific* and pathological personality organization, and suggests that this diagnosis be arrived at according to the structural configuration of a patient rather than according to his symptoms and personality traits, even when the latter are highly suggestive. He classifies patients according to the two tasks of the early ego: to differentiate self- and object representations, and to integrate the differentiated self- and object representations. These are initially polarized, influenced either by libidinal drive derivatives, in which case they are "good," or by aggressive ones, in which case they are "bad" (Jacobson 1964). Neurotics, or those with an advanced level of ego organization, have accomplished both of these tasks; psychotic patients have accomplished neither.

Kernberg notes that patients with borderline personality organization are those who have accomplished the first, but not the second, of these tasks and thus cannot synthesize opposing self- and object images or representations and the affective states associated with them. Especially important is his explanation that this lack of integrative capacity is used defensively by the ego of the patient with borderline personality organization. He calls this *defense splitting* and considers it the dominant defense of such patients. Splitting occurs naturally in the course of an individual's development; the infant cannot at first mend (integrate) those self- and object images having libidinal drive investment with those having aggressive drive investment. This developmental splitting disappears as the ego of the

child slowly develops integrative functions. Most observers suggest that mending begins at about 6 months of age and is completed, for all practical purposes, around 36 months of age. Kernberg emphasizes that when something interferes with the integrative ability, splitting continues, but it now becomes a defense mechanism. Other defenses often used by persons with borderline personality organization—such as primitive idealization, primitive forms of projection, denial, devaluation, and omnipotence—are centered around splitting. Thus the ego is protected from object relations conflict "by means of dissociating or actively keeping apart contradictory experiences of the self and of significant others. These contradictory ego states are alternately activated, and, as long as they can be kept separate from each other, anxiety related to these conflicts is prevented or controlled" (Kernberg 1980, p. 6).

One of my patients illustrated in a clinical setting the way in which contradictory experiences are kept separate.

> Many months into his treatment he began coming to his sessions 25 minutes late. He was seeing me four times a week and using the couch. I tolerated his tardiness for nearly a month before confronting him with it. It then became clear that he did arrive at my office building on time, but upon arrival went into the lavatory adjoining my office, where for 25 minutes he created in his mind a "bad" image of me and a corresponding "bad" one of himself to interact with it. Then he would make his way to my office, where the door always stood open for him and where I sat waiting. Lying on the couch, he would smile in a reflection of his good image and induce a pleasant sensation in me that reflected a good image of me. Then he would start the session—or what was left of it—by saying, "...and another thing, Dr. Volkan!" as though one "good" session were the continuation of another. His opposing experiences with me, as well as his own opposing self-image, all of which had been the subject of rumination in the lavatory, were altogether apart from the pleasurable experience taking place in my office.

Although this vignette exemplifies the way splitting appears in a clinical setting, we must remember that the splitting of self- and object images does not occur automatically, but that each of the images involved in this process has its own developmental history and is connected with affective states and infantile pathogenic fantasies. The patient who activated images of himself and me in the lavatory had been greatly overprotected in childhood by his mother. She had given him frequent enemas from the time of his early infancy, not for constipation but as a way of allaying her anxiety over perfect cleanliness, and he had been unable to integrate the image of a devoted mother with that of one so physically intrusive. It is not surprising that while being treated by me he showed marked splitting.

Classification by Ego Defenses

Classification of patients may also take into consideration the use of ego defenses. Kernberg is very specific about separating high- and low-level defense constellations. Neurotics, or those with high-level defense operations—such as reaction formation and rationalization—center around the dominant mechanism of repression. Those with borderline personality organization use low-level defenses such as primitive projections and denial, all of which center around splitting.

Psychotics also use primitive defense mechanisms, but, according to Kernberg, they do so mainly to protect themselves from further disintegration of the boundaries between self and object; then the potential for fusing the self-experience with the experience of important others is reduced. Volkan and Akhtar (1979) describe how splitting as a defense is not crystallized in the schizophrenic, and how other primitive defenses such as the projection of self- and object representations (externalization) do not provide lasting comfort, because schizophrenics can *identify* themselves with whatever they have externalized more readily than can borderline patients. *Projective identification*, as this process is usually called in psychoanalytic writings, is a rather stable defense in those with borderline personality organization who maintain obligatory contact with the object into which they project their intrapsychic experiences, and then try to control it as though to keep from having to take back what has been projected. They empathize with and identify to some degree with the object. Quick identification dominates in schizophrenia; what is projected is soon felt within the subject, and this precludes taking any lasting comfort from the maneuver. The thrusting out and externalization of unwanted units, and their subsequent replacement within, differs from one patient to another and prevails among schizophrenics without providing significant comfort. It gives borderline patients a more stable defense against anxiety. This process may result in fusion, defusion, and refusion of self- and object images or representations. According to Kernberg, such states are typical in schizophrenia, but they appear only briefly and temporarily in patients with borderline personality organization. Kernberg makes a clear distinction between the borderline and the psychotic individual.

Volkan and Akhtar (1979) see defensive qualities, however extremely primitive, in fusion, defusion, and refusion. Some fusion relates to very primitive pathogenic fantasies that are libidinally determined. The patient "consumes" the representation of a good object in order to experience ecstatic

union, but in patients like schizophrenics, any good object, whether fused with the subject or not, can quickly turn into a bad one.

Paradoxically, most fusions in schizophrenia seem to interrelate with aggressive fantasies. The patient "kills" a terrifying object image by fusing with it—consuming it—but then he feels terror within because of the fusion that has taken place. No satisfactory solution is achieved; externalization of the terrifying unit follows, and the patient seems to be arrested in a fusion or defusion cycle and to be using very primitive defenses against object relations conflict.

Ego Weakness

Kernberg also describes patients with borderline structure from the standpoint of ego psychology, speaking of the *relative* strength as well as the weakness of their egos. Such patients are relatively intact in reality testing and thought processes. Because of their relatively sound adaptation to reality and interpersonal relations, they may seem fairly normal, but it should be remembered that their state is only relatively normal and may, as I will show later, give way to brief psychotic moments in regression. Kernberg emphasizes, however, that such patients tend to maintain their relative strength over time, and because of their comparatively sound capacity for reality testing and interpersonal relations, borderline patients should not be confused with the truly psychotic.

Ego weakness in the individual with borderline personality organization includes poor tolerance of frustration, poor impulse control, and proclivity to use primitive ego defenses and identity diffusion.

Identity Diffusion

Kernberg uses Erikson's term (1950, 1956) *identity diffusion* (see Akhtar 1984, for a concise review of this syndrome) to describe the basic problem of the patient with borderline personality organization— the absence of an integrated self-concept and an integrated concept of others. This shortcoming is reflected in a chronic subjective feeling of emptiness, a shallow and contradictory perception of oneself and others, and an inability to integrate emotionally behavior patterns that are contradictory.

Pregenital Aggression

Kernberg holds that the ego's second task—to integrate self- and object representations formed under the influence of libidinal drive derivatives and their related affects with the corresponding self- and object representations—is not accomplished because of a pathological predominance of pregenital aggression, especially oral aggression. Such aggression "tends to induce premature development of oedipal strivings, and as a consequence a particular pathological condensation between pregenital and genital aims under the overriding influence of aggressive needs" (Kernberg 1967, p. 681).

In indicating why some people develop a borderline personality organization, then, Kernberg points to a failure to develop and complete the integration of opposing representations of self as well as opposing representations of their respective corresponding affective states.

Abend, Porder, and Willick

Abend and colleagues (1983) provide a thoughtful review of the concept of borderline personality, as well as a study of Kernberg's formulations. Their monograph is based on the work of the Kris Study Group of the New York Psychoanalytic Institute, on extended discussions of four analyzed patients diagnosed as being borderline, and on a lengthy exchange with Kernberg. In reviewing the literature, these writers found substantial agreement among various descriptions of borderline cases. Nonetheless, they remain dissatisfied with the accuracy of the term *borderline* to indicate a specific diagnostic category and see variables in respect to specific individual characteristics. Thus they prefer to diagnose each case according to the patient's specific psychic structure, using such terms as *severe sadomasochistic character disorder.* They disagree, then, with Kernberg's belief that all who have a borderline personality organization share such features as similar internalized object relations, similar dominant defenses, or similar ego structures.

Basing their findings primarily on observation of the four analyzed patients discussed at Kris Study Group meetings, Abend and colleagues suggest that oedipal-phase conflicts play an important role in the object relations of these cases, and that profound identification with disturbed parents contributed significantly to the personality development of the patients under study and helped determine their character traits, thought processes, and symptom formation. Stating that oedipal-phase conflict is often

neglected or minimized in the literature dealing with the development of borderline psychopathology—including Kernberg's contribution—they were impressed by the influence of oedipal-level conflicts in the pathological features of the four cases studied. These cases exhibited preoedipal conflicts as well, but they "could not specify that the crucial etiological determinants for the development of all borderline patients took place between the ages of 8 months to 18 months" (p. 107). They do not, therefore, subscribe to the idea that the main etiological factor is preoedipal fixation. Regression from oedipal-level issues seems to them a more acceptable explanation, one at least as important as preoedipal factors.

Finally, Abend and colleagues disagree with Kernberg in respect to the defensive constellations of these patients. They feel that defenses in general should not be described as either primitive or advanced, and that any defense should be evaluated according to the total ego organization of each patient. Borderline patients, they suggest, use all kinds of defense mechanisms including repression. Although they agree that a toddler may "split" the mental representation of the mother into all-good and all-bad segments and displace all-bad feelings onto another object in order to preserve the good relationship with his mother, they believe "that such 'splitting' does not represent an immutable fixation which persists unchanged into adult mental life" (p. 165).

OBJECT RELATIONS THEORIES

Kernberg (1976a) described at least three types of object relations theory. The first broadly concerns the understanding of present interpersonal relations in terms of past ones (something that applies to virtually all psychoanalytic approaches, in which we examine the mental structures that preserve past interpersonal experiences and the relationship between such structures) and derivatives of instinctual needs in the psychosocial environment.

The second theory, at the opposite extreme, is based on the concepts of Melanie Klein and W. R. D. Fairbairn. The third theory is one that Kernberg himself endorses, acknowledging his debt to such theoreticians as Edith Jacobson, Margaret Mahler, and Erik Erikson. His theory of object relations assumes that

> . . . the earliest internalization processes have dyadic features, that is, a self-object polarity, even when self- and object representations are not yet differentiated. By the same token, all future developmental steps also imply dyadic internalizations, that is, internalization not only of an object as an object representation, but of an

interaction of the self with the object, which is why I consider units of self- and object representations (and the affect dispositions linking them) the basic building blocks on which further developments of internalized object and self-representations, and later on, the overall tripartite structure (ego, superego, and id) rest. [Kernberg 1980, p. 17]

The object relations theory described by Kernberg is not an additional metapsychological insight but, rather, an integral part of ego psychology. Kernberg (1984) states that "internalized object relations constitute substructures of the ego, substructures that are, in turn, hierarchically organized" (p. 5). I have examined the relationship between this object relations theory and the overall structural theory (Volkan 1981a), pointing out the close relationship between the maturing ego and the establishment and differentiation of self- and object representations. This relationship is not unlike the reciprocal benefit that plants receive from the very soil they are sown to enrich. As object representations are successfully formed and some of them are assimilated into self-representations by means of identification, the ego gleans enough nourishment to continue to differentiate from id, and, in turn, to further yield mature object relations.

I have stated (1981a) that structural theory is still the best instrument for understanding the psychopathology of patients with fully differentiated id, ego, and superego, and for success in handling transference-countertransference manifestations in their treatment. I agreed that this theory is not, however, very useful when applied to the treatment of patients whose dominant psychopathology reflects the reactivation of primitive internalized object relations. I went on to indicate, as I had previously noted (Volkan 1976) that once a patient in treatment resolves the psychopathology that reflects his reactivation of primitive internalized object relations, he moves on to exhibit conflicts best understood and interpreted with the use of structural theory. In a sense I saw a hierarchical model in the process of understanding a patient's psychic experiences as he matures. This idea parallels Gedo and Goldberg's argument (1973) for limiting consideration of the tripartite model to psychopathology exhibited at a higher developmental level.

SPLITTING AND AMBIVALENCE

In 1976 I observed that when patients with borderline personality organization commence treatment they exhibit a dominant reactivation of their primitive internalized object relations and in doing so use splitting as described by Kernberg. Abend and colleagues (1983) imply that there is no

difference between intense ambivalence and splitting, but I hold that there is a difference that can be understood by examining the ego's integrative function. The sicker the borderline patient is, the more his "ambivalence" corresponds to Kernberg's definition of splitting. Buie (1985), in reviewing the book by Abend and colleagues (1983), concludes that they studied only four patients healthy enough for classical analysis. Moreover, certain clinical phenomena are imprecisely classified when the concept of ambivalence is used and are better understood with the concept of splitting. Dorpat (1976) endorses Buie's assertions, referring to Burnham's "object need-fear dilemma" (1969) as an example. A schizophrenic has a need for and a fear of support from others. His excessive need for objects makes him fearful since these objects can destroy him through abandonment. Objects can make or break such a patient. They are either all needed (good) or all rejecting (bad). Dorpat suggests that this clinical phenomenon cannot be described by the concept of ambivalence.

I believe the concept of ambivalence also cannot explain the "little man phenomenon" (Kramer 1955, Niederland 1956, Volkan 1965); however, the concept of splitting is highly informative here. The "little man phenomenon" explains how an unintegrated self-representation (the little man) remains separate from the rest of the self-representation. I suggest, contrary to the conclusions of Abend and colleagues, that splitting can remain unchanged into adult life. I believe this is so because in my work with borderline or severely regressed patients, these patients exhibited their splitting behavior in such a way that it dominated the transference phenomenon. More importantly, at one point in their treatment they mended their split psychic experiences after identifying with the analyst's integrating functions and after enriching their egos. I have given clinical examples of this elsewhere (Volkan 1975, 1976, 1982a), and I give further examples in my description of Pattie's progress in Part II of this book.

Buie (1985) also maintains that the borderline patient develops ambivalence *in* treatment. This development of true ambivalence occasions great distress and anxiety, with guilt and turning of hate onto the self, often with suicidal intent. My findings support Buie's observations, but I must add that the better the patient is prepared therapeutically for the occasion of mending, the more a process like mourning, though with less guilt, replaces a process like depression, with guilt, at the time of mending.

DEVELOPMENTAL SPLITTING

I agree with others (e.g., Berg 1977) that mending of the *developmental* splitting is never totally accomplished (Volkan 1981a), although, as I have stated, we expect a child whose developmental course is uncomplicated to complete the mending process *for all practical purposes* by the age of 36 months. What happens to the unmended good and bad self-representations? Kernberg himself (1976b) answered this question, suggesting after van der Waals (1952) that with the newly developed—or more precisely, increased—repression some unintegrated representations are pushed into the id, making that portion of it an "ego id."

Integration of opposing representational units brings about a feeling of loss; when this happens to a patient in a clinical setting he experiences a sense of mourning. The child reacts to the "loss" of his good units by establishing a new set of representations. These are idealized as unmended good units, but are not, like his good units, absolutely good, being more closely connected with realistic aspects of objects and the self. In turn, these idealized images coalesce through identifications into superego identifications. Since the precursors of the superego contain some unmended and excessively bad images, the new images help tame the ferocity of the superego.

The Child's Externalizations

In examining what happens to our unintegrated self- and object images, I have suggested (Volkan 1985a, 1985b, 1986) the presence of a phenomenon with cultural, social, and political implications, and have offered the view that under the influence of mothering persons, the child deposits, through externalization, some of his unmended self- and object representations and their accompanying feeling states into certain reservoirs in the environment. I call these reservoirs, which are stable, "suitable targets of externalization." Familiar aspects of the child's home or neighborhood, that is, the ethnic soup or other possessions indicative of bonding that Mack (1984) calls "cultural amplifiers," become targets upon which the child externalizes his unmended aspects of himself for "safekeeping." There are reservoirs for good unmended aspects as well as for bad ones. When these reservoirs are stable, they can contain the child's externalizations for a long period of time, perhaps even a lifetime, in order to help him to keep more integrated self- and object representations within himself and to avoid object relations conflicts.

The suitable targets of externalization sponsored for children by the important others in their group (i.e., ethnic, national) who share identical investment in them, make the children alike inasmuch as all draw from the same reservoir. I have noted elsewhere how such inanimate shared reservoirs might be the psychological beginnings of concepts of an ethnic or nationalistic group's enemies (bad suitable targets of externalization) and allies (good suitable targets of externalization) in the social and political sense.

Children externalize their unmended bad self- and object units in accordance with the pleasure principle, since it helps them retain the mended (realistic) as well as good and idealized representations of important others. But we must ask why children also externalize their good unmended self- and object images, and why they may share a reservoir to contain such good units for such a long period of time, indeed, throughout life. Why, for example, do Finnish children invest the sauna with such good units and with higher symbolic meanings (Tahka et al. 1971)?

It seems that the inevitable frustrations a child experiences may load the representation of his experiences, especially the representations of people involved in them, with the derivatives of the aggressive drive. In a sense, the child does not want to experience contamination of some of his good units by his aggressive ones and may seek to protect them. Under the direction of important others, his real experiences make him "think" that certain things "out there"—the ethnic soup, the sauna—can absorb and protect his good units. Such good, inanimate, suitable targets seem always to contain aspects of a good mother.

I have described only briefly my ideas on suitable targets of externalization (for an elaboration see Volkan 1985a, 1985b, 1986). I emphasize here that splitting, in an unchanged as well as a changed manner, finds expression in adult life, and that we all make use of it; it is not limited to the borderline individual. For example, we are likely to think in terms of black and white when in reality, expressions of our own ethnicity, nationality, and so on, should in all fairness be compared with those exhibited by a common enemy, and be seen as competing. Disregard for the realities of the other side is considered normal if sanctioned by one's own ethnic or national group.

DEFENSIVE SPLITTING

The difference between neurotic patients and those with a high-level ego organization is apparent insomuch as splitting is used as a defense mechanism. I agree with Abend and colleagues (1983) that borderline patients, even schizophrenics, "use a good deal of repression, even though in acute regressive states formerly repressed instinctual drive derivatives may emerge." They also state, "We found repression operating along with other defenses in our patients" (p. 155). In many, perhaps all, patients we see the simultaneous operation of splitting and related mechanisms, and repression and related mechanisms. In 1984 I described the entire analysis of a patient who, in addition to utilizing sophisticated defense mechanisms, used splitting; splitting was particularly marked whenever he regressed therapeutically. This patient, however, was not considered to be borderline, although he had borderline characteristics among his many neurotic psychopathological and higher-level (obsessional) personality traits.

Object Relations versus Structural Conflict

Patients with borderline personality organization tend to use splitting and related mechanisms when there is urgent conflict, particularly when it is an object relations conflict and not structural. They use repression and related mechanisms when the conflict is not urgent, especially if it is a structural conflict.

Dorpat (1976) offers a way of differentiating object relations conflict from structural; he holds that the general application of the tripartite (id-ego-superego) structural model to all developmental levels tends to obliterate important differences among psychopathologies at various developmental levels. Dorpat assumes that not all psychic conflict is of the type that involves the tripartite structure. Object relations conflicts involve a less differentiated psychic structural antecedent to an advanced id-ego-superego differentiation. Describing what he considers the *crucial difference* between structural conflict and the conflict of object relations, he says

> . . . in a structural conflict, the subject experiences (or is capable of experiencing if some part of the conflict is unconscious) the opposing tendencies as aspects of himself. . . . In the object relations conflict, the subject experiences the conflict as being between his own wishes and his representations (e.g., introjects) of another person's values, prohibitions, or injunctions, [pp. 869-870]

He adds that conflicts concerning dependency and independence, and closeness to and distance from objects, are little understood without the concept of object relations.

Splitting and Repression in the Borderline Individual

Persons with borderline personality organization are especially likely to use splitting, denial, primitive forms of projection, devaluation, idealization, and omnipotence to deal with anxiety stemming from object relations conflicts, but this does not mean that they will not repress aspects of a structural conflict. Although impulse-defense constellations often afford "no clear delineation of which agency within the tripartite structure (ego, superego, or id) was defending against which impulse within which other agency" (Kernberg 1980, p. 4), some of the conflicts of those with borderline personality organization can be conceptualized in structural terms. For example, we see in such persons repression of both an incestuous wish and any expression of guilt feeling it awakens. We can say that the patient is experiencing a structural conflict if, during analysis, he experiences his incestuous wish as coming from himself, and by identifying with it *owns* an object representation that acts either as a superego forerunner or as a primitive superego punishing him for his wish.

Kernberg seems to say that those with borderline personality organization do not experience guilt in a way that neurotics experience it, since the superego in the former is not yet a solid structure. I, however, have seen manifestations of very strong guilt feelings in patients with borderline personality organization under the influence of primitive superegos that are *owned* by them. What is typical to the borderline individual is the rapid disappearance of strong guilt feelings as he disowns the primitive superego and changes it into an unmended internalized or externalized bad object representation; when this occurs, he experiences struggle and tension between such an object representation and his self-representation, instead of having feelings of guilt.

Further evidence that patients with borderline personality organization utilize more splitting than repression comes from examining the total treatment process of such patients. One notices that, after mending takes place during treatment, the patient becomes "forgetful" of previously recalled childhood events; in other words, one observes newly established repressive functions. This may indeed be very dramatic. In treating neurotic patients, we see more and more derepression as the treatment approaches

the termination phase. Borderline patients may also exhibit derepression, since along with splitting they also use repression. However, unlike neurotic patients, they exhibit "new" repressions in the treatment process.

New Developments for the Future

Many analysts have observed defensive splitting in borderline patients, and I make no attempt here to review their findings to offer further "proof" of Kernberg's formulation on this issue. Their observations are usually based on clinical findings. We need to develop vigorous and systematic psychological test procedures to prove the existence of splitting among borderline individuals, but I know of only a few attempts in this direction by psychoanalytically informed psychologists. For example, a Rorschach scoring system based on Kernberg's theoretical formulations has been developed to assess the specific defenses of splitting, idealization, devaluation, projective identification, and denial (Lerner et al. 1981, Lerner and Lerner 1982). These investigators conducted studies in which independent samples of borderline patients were compared with samples of neurotic and schizophrenic patients. They contended that "borderline patients present an identifiable constellation of defenses, different from that of neurotic and schizophrenic patients," and that "the scoring system is a valid means of identifying these defenses" (Lerner and Lerner 1982, p. 111). Schulz (1980) is developing a clinical scale for the assessment of the psychotic patient's ability to differentiate between self and object; this will further differentiate, from an object relations perspective, patients with borderline personality organization from those who are schizophrenic.

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OEDIPAL AND PREOEDIPAL: AN ISSUE OF ETIOLOGY

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Abend and colleagues (1983) would like to see greater emphasis placed on oedipal-phase conflicts in borderline patients. They state that Kernberg largely neglected this issue, but a reading of his work indicates that he does say a lot about the oedipal conflicts of the borderline patient. For example, he refers to premature oedipalization of preoedipal conflicts that lead to the development of a terrifying representation of the oedipal rival. There occurs a condensed father-mother image of an unreal kind. He also explains how, when oral-aggressive conflicts are displaced from mother to father, the boy experiences increased castration anxiety, and the girl increased penis envy and related distortions.

I believe that the issue on which Abend and colleagues (1983) differ from Kernberg is that of etiology. The former, while acknowledging the role of preoedipal factors in the development of a borderline personality organization, insist on the importance of the influence of triangular (oedipal) conflicts. Kernberg, on the other hand, clearly holds that the beginnings of that personality organization lie in the preoedipal area, especially during the first 18 months of life. The controversy, then, is the determination of what is dominant—fixation at the preoedipal level or regression to it. The oedipal-preoedipal dilemma has had considerable attention in psychoanalytic writings; Greenspan (1977), for example, asks how a *regressive* preoedipal conflict situation can be distinguished from a *pure* one.

Regressive or Pure Preoedipal State?

My work with patients with borderline personality organization points to some answers. If the regression to the preoedipal level occurs after the patient has established an oedipal or postoedipal state so as to have had enough experience with it, his regression to a preoedipal level is likely to stay infused with oedipal-level defenses and adaptations, and he will exhibit a strong tendency to make a consistent, however silent, attempt to move up again. At the outset of their treatment such patients may seem regressed, but the experienced therapist "hears" the presence of oedipal and postoedipal assets and real evidence of their efforts to return to that level. Only a structural frame of reference need be used with such patients. When regression to the preoedipal level occurs early in the oedipal child's life, and if it is massive and involves many ego and superego functions, and if the child, for reasons such as being influenced by pathogenic fantasies or the lack of a supportive environment, cannot progress but can only chronically adapt to the regressive state, the difference between a regressive and a pure preoedipal state does not have practical significance. In such regressive situations, the child, when grown, will continue to use primitive defenses. The original oedipal trauma accountable for the massive regression can be disclosed and dealt with only in treatment. However, prior to this, the initial therapeutic work should focus on object relations conflicts, and the therapist may first need to consider a frame of reference pertaining to the internalized object relations theory (Volkan 1981a). I believe that regressive preoedipal and pure preoedipal conflicts can coexist. These patients enter the oedipal phase with unresolved preoedipal conflicts, which in turn color passage through the oedipal phase. They split the oedipal father's image as they did that of the preoedipal mother. Furthermore, in many areas the images

of father and mother are condensed. More importantly, I do not find it enough to deal only with the preoedipal conflict in treatment, and I do not consider the treatment completed until the oedipal transference configurations fully develop and are resolved. Further details of this process appear in Chapter 5. Like Boyer (1967, 1983) I emphasize *the upward-evolving transference* relationships that, in the long run, deal with pre-oedipal as well as oedipal issues.

REAL EXPERIENCES AND THEIR MENTAL REPRESENTATIONS

Meissner (1978) emphasizes that Kernberg's work concerns itself with *internalized* object relationships and not object relations in general. Kernberg's internalized object relationships "seem to come much closer to what had been described in other contexts as 'introjects'" (p. 588). Joining Meissner, Abend and colleagues (1983) point out that Kernberg does not give sufficient weight to the *real* experiences of the child with his parents, siblings, and so on, and that much of his work only emphasizes his hypothesis about intrapsychic development in very early life; the emphasis is on the developmental process and fixations within it. The developmental process will take its course, however, according to the nature of the subject's relationship with real objects, and it would be a mistake to consider that it takes place without such reference.

At times, in speaking about internalized object relations at professional meetings, I have noted a tendency for some practitioners to place unique emphasis on the developmental process of internalized object relations as though it does not take other processes and feeling states into account (i.e., historical events, unconscious fantasies). This is a rather mechanical way of seeing the internalization of object relations, and can lead to discussion of good and bad self- and object representations as though they had nothing to do with real human interaction. Were that true, all that would be necessary would be to help the patient to consider and confront both sides, and mend them! Thus it is important to remember that each good or bad image, each representation reactivated by the patient, has its own developmental history. To understand the patient, the specific nature of his preoedipal development and his oedipal passage must be examined; and the strength of his drive expressions, the formation of his self- and object representations, and identification with object representations at every level of psychosexual development should be considered. Internalized object relations, reactivated and dominating the patient's life as well as his posture in treatment, reflect a developmental response influenced by

interaction with real people. That is not to say that when our patients exhibit aspects of these internalized object relations in transference, they are simply repeating what actually happened when they were children interacting with parents, relatives, and friends. Adult expression of internalized object relations is not a replica of childhood interpersonal relationships. Such early experiences must be taken into account, of course, but we must remember that they persist into adult life colored by wishes and defenses belonging to each developmental level, by infantile pathogenic fantasies, by changes of function in psychic expression, and so on. Moreover, real experiences modify certain drive expressions and prepare a mechanism for keeping the child's ego weak—or enriching his repertoire of ego functions and his ego's relationship with id and superego.

It remains true, however, that to understand a patient we must first examine the history of his early life. I will elaborate on this in the next chapter.