Narcissistic/Borderline Couples:

A Psychodynamic Approach to Conjoint Treatment

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> There is a common aphorism that when people marry they become one. But no one ever explains what kind of a "one" they become: a healthy "one," a symbiotic "one," a fused "one," or a parasitic "one."
>
> J. L.

Although a voluminous amount of material has been written on narcissistic and borderline disorders and many authors have increased our understanding of narcissistic vulnerabilities, few have explored what happens when a narcissist and a borderline personality join together in a marital bond or "bind." In fact, an individual with a borderline character is inclined to *attract* as an object choice a narcissistic personality, and vice versa. In *The Narcissistic/Borderline Couple: A Psychoanalytic Perspective on Marital Treatment* and earlier contributions (Lachkar, 1984, 1986, 1992), I have described the particular kind of couple I have clinically observed and called the narcissistic/borderline couple.

What is it that attracts, bonds, and keeps these individuals together? This is the pivotal question a clinician must ask when dealing with the narcissistic/borderline relationship. When paired, these oppositional types appear to maintain a bond in which their repetitive behaviors appear as the enactments of many unresolved wishes and childhood dreams. These two personality types enter into a psychological "dance" in which each fulfills the other's unconscious needs. The revelation is that each partner needs the other to

play out his or her own intern object relations drama, as each stirs up some unresolved conflict in the other. For example, when the borderline person is in the presence of his or her object choice, the narcissist, the borderline person experiences that partner as the source of all psychic pain. The borderline person holds to the fantasy that if only he or she were better, the other would meet his or her needs.

DSM-IV AND THE NARCISSISTIC/BORDERLINE COUPLE

Narcissistic/borderline couples present specific vulnerabilities whereby either one or both partner may meet the criteria for a DSM-IV personality disorder. The DSM-IV (American Psychiatric Association, 1994) is designed to categorize individuals and does not offer a classification for couples or for a "couple diagnosis." This chapter, therefore, attempts to fill the gap by providing clinicians a treatment procedure for couples insofar as narcissistic personality disorders and borderline personality disorders are concerned.

Although narcissistic and borderline characteristics, traits, and states tend to shift back and forth between individuals or even within an individual over time, discussion would be impossible without making certain delineations from which to view these conflictual and complex relationships. The therapeutic challenge is to differentiate a "collective couple diagnosis," to determine whether individuals within the couple (dyad) suffer from more severe pathology stemming from

infancy or whether their momentary relational conflicts are less chronic and relate only to neurotic aspects of personality functioning. The goal is not only to understand the dynamics of what occurs when a narcissistic and a borderline person join together, but also to diagnose and organize a suitable treatment program. Some couples will benefit from short-term treatment, whereas others may require long-term conjoint therapy concomitant with in al psychotherapy.

Exhibits 13.1 and 13.2 provide DSM-IV criteria for Narcissistic Personality Disorder and Borderline Personality Disorder (American Psychiatric Association, 1994).

Exhibit 13.1
DMS-IV DIAGNOSTIC CRITERIA FOR NARCISSISTIC PERSONALITY DISORDER
(American Psychiatric Association, 1994)

A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy [in the patient], beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)

2. Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love

3. Believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)

4. Requires excessive admiration

5. Has a sense of entitlement, i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations

6. Is interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends

7. Lacks empathy; is unwilling to recognize or identify with the feelings and needs of others

8. Is often envious of others or believes that others are envious of him or her

9. Shows arrogant, haughty behaviors or attitudes

Exhibit 13.2
BORDERLINE PERSONALITY DISORDER
(American Psychiatric Association, 1994)

A pervasive pattern of instability of interpersonal relationships, self-

image, and affects, and marked impulsivity [in the patient], beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. **Note**: Do not include suicidal or self-mutilating behavior covered in Criterion 5.

2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation

3. Identity disturbance: markedly and persistently unstable self-image or sense of self

4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). **Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.

5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.

6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)

7. Chronic feelings of emptiness

8. Inappropriate, intense anger or difficulty controlling anger (e.g.,

frequent displays of temper, constant anger, recurrent physical fights)

9. Transient, stress-related paranoid ideation or severe dissociative symptoms

The Narcissist

To meet the criteria of Narcissistic Personality Disorder, the following characteristics are described (American Psychiatric Association, 1994). The narcissist is overpreoccupied with self, has an exaggerated sense of achievement and talents, is engaged in fantasies of unlimited success, power, brilliance, beauty, or ideal love. To an unusual degree, these patients exhibit a need to be loved and admired by others. The narcissist has an exaggerated sense of entitlement and unreasonable expectations of others and may take advantage of others to achieve or attain his or her own self-serving interests. The narcissist is lacking in empathy and is unwilling to recognize the needs of others.

At an interpersonal level (Lachkar, 1992), the narcissistic lover is the "entitlement lover," in love with self, one who cannot imagine that the needs of the other exist. When not properly mirrored or when their personal sense of pride has been threatened, narcissists respond with rage or withdrawal. One can imagine what this withdrawal does to a borderline partner, who already has a thwarted sense of self. On a deeper level, narcissists are unable to form healthy dependency

bonds and confuse normal states of vulnerability with imperfection. Narcissists have more integrated superegos and better impulse control, responding more to interpretation than to confrontation. Narcissists are quick to become bored and restless when their accomplishments wear thin and, very often, are considered to be dependent because they need so much attention from others.

It is not uncommon that the narcissist was once mother's special child until the birth of a sibling. Suddenly, this child's position is usurped and he or she grows up perceiving the parents as cruel and rejecting. To find refuge, such persons tum to valued parts of themselves: "I'll show them. I'll become famous, and they'll be sorry." Mothers lacking in attunement will minister to the infant's physical needs, but are unable to attend to the emotional needs. The following case illustrates this injury.

> A couple in their mid-50s, each with grown children from their first marriages, are having dinner with the wife's adult children. The husband accuses the wife: "Susan, you gave everyone at the dinner table something to eat first, and you totally ignored me. You gave your son a chicken breast, and what did you give me? You gave me the backs!"

In this scenario, the borderline wife has unconsciously communicated to her narcissistic husband that he is not entitled to "the breast," this enactment playing into his original narcissistic in that he was not entitled to his mother's breast after his baby brother was born

In couples treatment, the narcissist cannot allow the kind of dependency the

borderline partner yearns for because the exposure would make him or her feel fragmented and too vulnerable. Narcissists become libidinally connected to those who mirror their beauty, success, or achievement or will offer them any semblance of power, fortune, or fame.

To maintain their ties with their archaic objects, narcissists form idealized relations and attachments. Their emotional life is shallow, as they obtain very little satisfaction in life other than from the adulation they receive from others. Unlike the borderline person, the narcissist believes the world owes him or her something; thus, many narcissists are unable to achieve their lifelong goals and dreams. They are dominated by such defenses as projection and withdrawal in response to their feelings of shame, guilt, omnipotence, and grandiosity. Because they must struggle against the impact of their harsh and punitive superegos, they become obsessed with perfectionism. Narcissists are markedly different from their borderline counterparts in that borderline partners fuse with the object, while narcissists critically withhold or withdraw from the object.

The Borderline Personality

To meet the criteria of Borderline Personality Disorder, the following characteristics are described (American Psychiatric Association, 1994). Borderline persons have a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and

present in a variety of contexts, as indicated by at least some of the following: (1) they are frantically invested in avoiding real or imagined abandonment, (2) they exhibit an array of unstable interpersonal relationships characterized by alternation between extremes of idealization and devaluation, (3) they have marked identity confusion and low self-image, and they are impulsive and self-damaging (in the areas of spending money, sex, substance abuse, binge eating, etc.), (4) some exhibit recurrent suicidal behaviors, gestures, or threats, or self-mutilating behavior, (5) they suffer from chronic feelings of emptiness and display inappropriate anger or difficulty in controlling their temper, often with recurrent physical fights.

In interpersonal terms (Lachkar, 1992), the borderline person is one who does not have much of a sense of self, does not feel entitled, and will do anything to feel a semblance of bonding or relatedness. Borderline persons defend against intolerable shame and abandonment by splitting or projection, fearing that if their real needs are expressed they will be ridiculed, ignored, betrayed, or rejected. Typically, borderline persons have been abandoned by absent parents, alcoholic parents, abusive parents, psychotic parents, or emotionally unavailable parents. As a result, they remain forever faithful to an allegorical world of lost mothers, fathers, and abandoned babies.

As a consequence, they exhibit poor reality testing and impaired judgment, have poor impulse control, and tend to fuse with their objects. They frequently

perpetuate the cycle by getting themselves into abusive, controlling, addictive, or other maladaptive relations. They have difficulty with setting boundaries, as they lack the self-regulatory mechanisms to self-soothe, self-regulate, and self-affirm (Manfield, 1992). In severely disturbed relationships, the borderline person's love feelings intersect with aggression, unconsciously converting love into a malignant experience instead of one of intimacy and bonding.

Unlike narcissists, who withdraw when injured, borderline persona fuse or merge when injured and respond with splitting or projective defenses. Some may spend the rest of their lives getting back or getting even, using their hurt to spur attacks of shame and blame on their partner (Lachkar, 1984, 1986, 1992, 1997, 1998). One such patient remarked: "He's always working, and when he's off, he's always with his friends. He never has time for me, and when I ask him to spend more time with me, he claims I'm too needy or too demanding. This is where I lose it and go crazy. I start to eat, binge, and stuff myself to pieces. At other times, I scream, yell, or else I just go along and pretend that everything is fine."

Just as the narcissist is trying to prove a special sense of existence, the borderline person is trying to prove his or her existence as a thing in itself. The borderline person, like a chameleon, develops a persona, a false self, to shield the true self from real desires, needs, feelings, and yearnings which he or she has learn will not be met.

THEORETICAL CONSIDERATIONS

Drawing from various theoretical frameworks, mainly concepts from classical psychoanalysis, including Freud (1914), self psychology (Kohut, 1971, 1977), object relations (Klein, 1935, 1936, 1937, 1940, 1946, 1957a, 1957b), Fairbairn (1952), Winnicott (1953, 1965), Bion (1959, 1962, 1967), group psychology (Bion, 1961), and psychohistory (Lachkar, 1993), and more contemporary theorists such as Grotstein (1981, 1987) and Kernberg (1990, 1991, 1992), I have attempted to integrate the complements of these theories into a viable treatment process applicable for narcissistic/borderline couples. Object relations is extremely effective in helping couples face their internal deficits and conflicts and can offer invaluable contributions to marital treatment. Self psychology has been found to be valuable in working with narcissists, whose exaggerated entitlement fantasies and search for approval make them more responsive to empathy, introspection and interpretation.

Conversely, object relations proves beneficial in working with the abandonment anxieties of borderline persons and in meeting their containing, holding, soothing, and bonding needs. Self psychology techniques may be misperceived by a borderline person as the therapist's weakness, with the therapist being seen as a "pushover," not a "hard enough object" to deal with the aggressive forces the borderline partner may act out within the dyad. As clinicians, we must be empathic with the borderline person's vulnerability, but not

to the aggression. To empathize with the borderline person's pathology is a collusion, a grave clinical error that can lead only to further destructiveness: the tendency to find fault/blame for all the shortcomings in the relationship.

There are distinct differences, however, in the way each one of these theoretical perspectives arrives at truth or psychic "reality." The methodology for the self psychologist is via intrasubjectivity and introspection, whereas for the object relationist it is via the patient's projections, splitting mechanisms, and other primitive defenses emanating from infantile fantasies. In self psychology, one strives to understand the interpersonal experience of patient and therapist, whereas in object relations, the patient's distortions, projections, and misperceptions are considered to shed light on important intrapsychic processes. Unwittingly, many self psychologists gratify the patient's distorted needs in order to allow a selfobject transference to emerge. So as not to lose sight of these distortions and delusions, the therapist must have a good grasp of normal development, keeping a clear image of how a healthy couple would respond. In healthy relationships, both spouses are mutually invested in the same goals. Aggression and other conflicts do not destroy or overcome the desire for love and intimacy. But in unhealthy relationships, love, hate, envy, control, and other aggressive forces divert the relationship away from love (Kernberg, 1990, 1991, 1992; Lachkar, forthcoming); conflict overcomes the relationship.

What is most helpful in terms of marital treatment? The therapist should not

take the position of deciding who is right or who is wrong; doing so will only foster further delusions of grandiosity in the narcissist and further feelings of shame in the borderline partner. Instead, the therapist must create a holding environment in which each partner's issues can emerge safely. Such a therapeutic space will allow each partner the opportunity to experience an abundance of his or her own subjective experiences, leading to an understanding not only of those affectual experiences, but also of those of the partner.

THE DANCE

In narcissistic-borderline relations (Lachkar, 1992), the metaphor of "the dance" is used to explain why couples stay in painful conflictual relations, a choreographic web of entanglements, behaviors, and interactions that are circular —like a rondo—destructive, and never ending. Each borderline person needs a narcissist, and each narcissist needs a borderline partner to play out their dramas, to "do the dance."

In this psychological dance, the borderline partner attacks, the narcissist withdraws. If the narcissist feels guilty for abandoning the borderline partner, he or she cannot tolerate the guilt and returns. To woo the narcissist back, the borderline partner promises, "I'll do anything, I'll be anything you want me to be, just don't leave! For a short while the borderline person can playact at being the perfect mirroring object for the narcissist, but because of the lack of impulse

control, inability to contain, hold, or sustain, or because of recurring and uncontrollable rages (Lachkar, 1984 forthcoming), the borderline partner cannot maintain the fulfillment of the promise. Feeling seduced by the partner's "promises" (the false self), the narcissist finds that such pledges are meaningless. The cycle repeats, the narcissist demanding to have perfection mirrored, the borderline partner feeling persecuted by the repeated need to comply with the narcissist's demands. Their interactions culminate in repeated object failures and disappointments.

WHY DO COUPLES STAY IN PAINFUL CONFLICTUAL RELATIONSHIPS?

Why is it that partners involved in primitive bonds find it so difficult to heed the clinician's advice? Why is it that even after a divorce or a separation these individuals maintain a bond, albeit a destructive one? Are they crazy, perverted, sadomasochistic? Any attachment is better than no attachment at all. There are those individuals who cannot feel a semblance of aliveness unless they are fused in a maladaptive attachment. Although this situation may be enraging to such patients, at least they feel a sense of aliveness instead of deadness (Kernberg, 1991).

Fairbairn (1952) more than anyone helps us to understand painful relationships, why people stay attached to a "bad" rejecting object (a tantalizing, tormenting, or unavailable object) over a prolonged period of time. It is the parent

who promises, disappoints, and frustrates the child over a prolonged period of time. The parent who is loving and kind is also the same parent who can be cruel and sadistic. Although Fairbairn did not talk about narcissistic and borderline relationships, his conception of how the ego splits and subdivides into several parts crystallized the notion of traumatic bonding. The borderline person will remain forever attached to an unavailable, abusive, or an aloof object, such as a narcissist, who stirs up hope for a connection to his or her earliest craving (the deprived or lost self). Grotstein (1989) maintain the borderline person will stay because the pain is still preferable to the emptiness, the black hole, the meaninglessness, or the dread. It is therefore the "meaninglessness that epitomizes states of terror more than the deprivation itself." (p. 4) Borderline patients often develop a preoccupation with pain as expressed through psychosomatic illness, additions, suicidal ideation, or form sadomasochistic attachments as a means of parasitic bonding with their objects. "When I burn myself with a cigarette, then I know I'm alive. I exist! Now, he'll be sorry." Anything is better than facing real needs-drugs, alcohol, or even this relationship!" Many narcissistic/borderline relationships border the fringes of perversity dominated by the need for excitement and eroticism as the surrogate for a real loving and intimate bond (perversion is the confusion between what is good and what is bad). It is primarily part object thinking, shielding one from getting too close to the "good thing." Eroticism then becomes the replacement for love, an emotional insurance policy again vulnerability of the "real relationship."

In narcissistic/borderline relationships, pain stirs up an amalgam of unresolved developmental issues as both partners need each other to play out their intern drama. Ultimately, this is done in the effort to get in contact with some split-off undeveloped part of themselves. Paradoxically, within these primitive unions the very same elements that bonds/binds such individuals may also be the very elements that perpetuate the conflict between them. It is not unusual when in this state, couples often panic and have great difficulty tolerating the confusion and chaos. "Should we stay? Should we leave? What must be conveyed is that while in this mental state of disarray, it is virtually impossible to make decisions and to know what "to do," let alone to get a sense of what is real and what is not real. The nature of primitive defenses and level of their defensive structures makes it infeasible to get a sense of the "real relationship"[1]. As Goethe once said, "It's difficult to know what to do at this point, especially when there is so much blaming and attacking going on!"

Couple Transference

The couple transference does for the couple what transference does for the individual, but is slightly more complex. Couple transference interpretations are derived from the analyst's experience and insights designed to produce a transformation within the dyadic relationship (Lachkar, 1997). To understand its complexity, I have integrated the notion of intersubjectivity, a well-known construct elaborated by many contemporary psychoanalysts (Brandchaft &

Stolorow, 1984). The couple transference refers to mutual delusions, distortions, or shared couple fantasies, which are projected onto the therapist. Frequently, a couple will "invite" the therapist in by trying to draw the therapist into the "dance," that is, projecting into the therapist feelings of confusion and inadequacy. For example, two spouses may share a mutual fantasy, that if they begin to depend on the therapist, he or she will "abuse" or take advantage of them. Couples need to learn that dependency needs enhance the relationship, do not destroy, are normal, and when negated or denied, stir up fierce anxieties. (*Maybe you worry that if you both become dependent on me or begin to form a close attachment, I will take advantage or mistreat you as others have done in the past.*)

The notion of the "couple/therapist" transference within the matrix of a couple transference opens up an entirely new therapeutic or transitional space in which to work. It is within this space that "real" issues come to life.

PSYCHODYNAMICS AND PRIMITIVE DEFENSES

Not only is there a "dance" between the couple, there is also a dance between their psychodynamics, between guilt and shame, between envy and jealousy, between rejection and withdrawal. Both narcissists and borderline persons have a fragmented sense of self, both have been traumatized in early life (known as archaic injury), both suffer from feelings of displacement, annihilation anxieties, and preoedipal strivings. Even though there is some overlap, there are

distinct qualitative differences in the way each experiences anxiety related to these archaic injuries and dynamics and the way each idiosyncratically identifies with the negative projections of the other (Lachkar, 1984, 1985, 1986, 1992, forthcoming). Becoming aware of these qualitative differences is invaluable to the clinician treating such couples.

Primitive defenses consist of a predominance of splitting and projection. Extensions of these primary defenses are projective identification, loss of identity, boundary confusion, lack of differentiation between self and other, shame/blame/attacking, omnipotent denial, idealization, and magical thinking. The primitive mind cannot hold onto both the good and bad parts of self, and so must shift back and forth between these unmentalized states. The very nature of primitive defenses obscures thinking, along with establishing a propensity for intense exaggeration and the distortion of reality. These states, in turn, lead to further denial and devaluation of the self (the tendency to turn against the self and/or feel responsible for all the shortcomings in the relationship). It is for this reason that we not only need to address with these narcissistic/borderline couples their conflicts, pain, and sufferings, but also to acknowledge and make use of their virtues, strengths, and sensibilities.

Projective Identification

Projective identification is a concept devised by Melanie Klein (1957a) as

identifying a primitive form of communication. It is an unconscious psychic process whereby one disclaims some unwanted or disowned aspect of the self, and translocates it to the other. It is the nature of projective identification that weakens the self, not strengthens it. Put another way, it makes one feel internally helpless. Under the influence of projective identification, the one receiving the projection becomes vulnerable to the coercion, manipulation, or control of the person doing the projecting (Bion, 1962, 1967; Grotstein, 1981).

Dual Projective Identification. Dual projective identification is a term I originated to understand the projective/introjective process as it occurs in conjoint therapy. It is designed to zero in on what happens when both partners project back and forth as they identify with each other's negative projections. As projective identification is a one-way process, it does not explain the mutuality of shared projections Dual projective identification is a two-way process whereby the partners project back and forth as each identifies with the negative projections of the other (Lachkar, 1992, 1997, forthcoming). It is a state of fusion, where both partners lose all sense of boundaries between self and other. In marital treatment, one partner (the narcissist) may sit impatiently silent, unconsciously compelling the other (the borderline) into taking on a caretaking role. "Whenever he acts like this, I always feel it is up to me to be responsible for everything!" Given such vigorous psycho-aerobics, this concept is particularly useful in sorting out very complex mental states, especially when there is a preponderance of primitive defenses. These projections are felt to be so intense that even reality testing does

not relieve them. Instead, reality is replaced by infantile enactments of the primary loss of self. In normal bonds, it is the reverse, as reality testing does offer relief (Vaquer, 1991). Later in this chapter, the case of Mr. and Mrs. D. illustrates the power of dual projective identification.

THERAPEUTIC FUNCTIONS

Containment

Bion's conception of the container and the contained is perhaps one of the most useful and all-inclusive concepts of the function provided by the therapist for the patient. The importance of the therapist as both the mirror and the container becomes even more vital in the conjoint setting, because the central issues revolve around confusion, ambivalence, dependency, and aggression. The mother/therapist not only teaches the baby/patient to learn to tolerate and process frustration, but the mother/therapist serves as a filter, transforming affect back to the baby/patient important meaning, detoxifying the bad into something good or meaningful. A child needs an object who can contain destructiveness. If baby feels that his rage destroys his objects, he then becomes addicted to the fantasy that he can control the object (the spouse, the therapist). The mother/therapist, who is able to withstand the child's/patient's anger, frustrations, and intolerable feelings becomes the containing mother. This will be a new experience for the narcissist or the borderline partner.

Empathy/Mirroring Versus Containment

Alongside containment, there must be empathy and mirroring responses. As clinicians we need to know when and how to offer containing functions, when to offer empathic interpretations versus offering mirroring responses. When do we contain and when do we mirror? When do we confront? Narcissists are more in need of mirroring. Borderline patients are more in need of containment or a hard object to stand up against. Many borderline patients become confused with empathic responses, misperceiving them as collusion or lack of clear boundaries. These patients need distinct boundaries. They need clarity. The therapist must be able to speak directly to the heart of the issue and stand up to this patient's distortions, delusion, and aggression.

Selfobject Functions

Some therapists believe it is the task of the therapist to "teach" selfobject functions. I believe, instead, that providing selfobject functioning for the patient is one of the primary tasks of the therapist, especially in treating narcissistic and borderline couples. While partners are in primitive bonds, they do not have the capacity to perform selfobject functions for each other. To "teach" prematurely can recreate an old scenario, reinforcing compliant, "false self" enactments or instigating a rapprochement crisis.

Selfobject is a term devised by Kohut referring to an interpersonal process

between the therapist and the patient. These are basic functions designed to make up for psychological disturbances caused by failures from early caretakers (those who were lacking in mirroring, empathic attunement, and had faulty responses with their children). "*You'll never amount to anything*!" The purpose of the selfobject is to repair defects in the structure of the self. In the service of development, the function is of a revival nature, with the intent to reconstitute an arrested or thwarted self. There is ongoing discussion among therapists as to whether it is up to the couple to provide selfobject functions for one another. Although Kohut reminds us that some individuals may need selfobjects the rest of their lives, my view is that while couples are in the early phase of treatment, it is impossible for them to provide selfobject functions. This is the task of the therapist! To enforce this may reenact the false self, a self which belies the true self, one forced to grow up much too quickly and much too soon.

Psychoanalytic technique and theory are meaningless unless they are artistically, emotionally, and creatively executed. Every psychological movement, like every step of a dance, must be sensitively expressed with meaning, purpose, and conviction. The therapeutic task is to link what occurs externally with the internal life of the patient(s). The following case of a narcissistic/borderline couple shows in-depth the creation of a therapeutic space and the treatment that was offered within that space.

THE CASE OF MR. AND MRS. D

The case of Mr. and Mrs. D not only portrays what transpires in these beleaguered narcissistic/borderline relationships and how the "dance" is played out, but also serves as an example of how the therapist works within the "couple transference."

> Mr. D, 50 years old, attractive and well-dressed, is an engineer, a borderline personality who initiated treatment complaining of marital difficulties. He presented the problem of a sexually unavailable wife who withholds time, attention, and affection. Mrs. D, the narcissistic wife, is a 40-year-old, pretty, slim, and impeccably dressed schoolteacher. The couple have been married for 10 years and have two children. Mr. D was seen individually until Mrs. D was "invited" into treatment, which is when conjoint treatment began. In borderline/narcissistic relations, it is the borderline partner who typically seeks help, as narcissists rarely offer themselves willingly to marital treatment. The couple therapy of Mr. and Mrs. D continued over a period of a year and a half, along with concomitant individual psychotherapy sessions for each.
>
> Mr. D, the borderline husband, showed a marked degree of destructive behaviors and primitive defenses, as compared with Mrs. D, the narcissistic wife, who operated at a more developed level of superego functioning, which critically withheld from the object (the "withholding self").
>
> Mr. D was an only child whose father died when the boy was 10 years old. His mother was an alcoholic. She remarried but divorced shortly thereafter. Although Mr. D did have some male conn in his formative years, he unconsciously blamed his mother for his father's death and his subsequent poor male bonding experiences. He felt very insecure about his role as husband and father, identifying with his helpless mother. At first, he was thought to be an obsessive-compulsive personality, but upon further exploration he revealed a typical borderline personality structure.
>
> In the months before treatment began, Mr. D became unable to maintain a

full erection, although he claimed he was never impotent prior to that time. This failure was felt as a severe blow to his self-esteem and produced intense anxiety within him. In addition, he expressed growing resentment toward his wife, had difficulty taking a stand with her, and saw any expression of desire or need for her as a losing proposition.

Simultaneously, he complained about his wife's withholding of sex, blaming her for his impotence and fearing that she would, one day, banish him. He believed that they had a good marriage in the early days before his wife began to reject him. Now, "all she expects is for me to pay the bills," he confided.

In the early sessions of the therapy, Mr. D wanted to blame his wife. Any attempts by the therapist at addressing the issues of his own internal world were to no avail. His response to the therapy induced in the therapist powerful countertransference reactions, causing her to offer quick remedies to provide immediate relief for his overwhelming anxiety. When these quick-fix solutions proved ineffective, Mr. D would have intense and sudden outbursts. He began to demand that his wife participate in the therapy, an apparent replication of his demands for her to have sex. He worried that his attempt to have his wife join him in therapy would end up as fruitless as asking her for sex. On an unconscious level, Mr. D was enacting the helpless, impotent mother role, projecting onto his spouse his "bad" dependency needs, which met with rebuffs. This cycle threw him into a whiny, desperate-baby position as an impotent husband. The therapist, failing in her efforts to encourage Mr. D in dealing with his internal issues, succumbed to his wishes and invited his wife to join the therapy.

Mrs. D did agree to come to some sessions on the basis that the problems in the marriage had nothing to do with her and in the hope that her attendance would facilitate her husband's improvement (the narcissist's need to hold on to the "perfect self"). According to Mrs. D, the problems began soon after the wedding when Mr. D's desire for intimacy diminished gradually (the diminishment of idealization). She felt he did the opposite of what she requested: "If I asked him to rub my back, he would pinch or pull at me. He hurt me, so, of course, I withdrew. " She revealed that she no

longer wanted to have sex with him because he was insensitive when they had sex, almost as if he hurt her "on purpose."

Mrs. D described her mother as a very domineering, religious, and rejecting mother, and her father as passive, cold, and detached. She recalled being the special child until her baby brother was born then, at his birth, she felt that she had been dethroned and replaced by her new sibling. Mrs. D was left with deep feelings of never being special enough: "I spent the rest of my life trying to prove to my parents how perfect I was, and would do anything for their attention." This loss became an unforgettable, narcissistic injury, from which she had no opportunity to recover. She recounted how her mother never supported her burgeoning femininity, but favored her brother. So, she became "a tomboy," eschewing playing with dolls. "Eventually, I learn I didn't need anyone. Even when I got my period, my mother ignored me and never offered any help, advice, or concern

Mr. D's poor male identification made him feel uncertain about his role as a husband and father, and Mrs. D suffered the contrariety of gender and identification (Benjamin, 1988). Ultimately, she disidentified with her mother and fused with her father, either by becoming competitive with him or by taking on his cold and detached ways. Both of these states became intolerable for her needy and insecure husband (the "rejected self").

Discussion

In their "dance," Mrs. D became the "dead" parent whom Mr. D tried desperately to revive. Similarly, Mrs. D took on the role of an unavailable mother, intoxicated with her own self-involvement. Mr. D's needs became the "disgusting" split-off part of his wife's original dependency, the feminine part of her that yearned for a special place with a parent, of which she had been deprived. In this

scenario, Mr. D's "normal" requests for sex were felt to be rebukes of Mrs. D's sense of self and how she viewed herself as a woman. Because of her guilt and anxieties about her own sexuality, Mrs. D projected her guilt onto Mr. D, which in turn ignited his shame (the delusion that dependency needs are dangerous or "bad for one's health"). Conversely, Mr. D projected his envy and shame back onto Mrs. D, along with feelings of guilt, of being less than perfect, and of normal femininity being a sign of imperfection, the disfigurement of a woman.

As their psychological dance unfolded, we could see Mr. D fusing with his mother's/wife's body, living psychically within her. His need became insatiable and his sexualization often became linked to perversion (the pinching and the hurting). In this early stage of treatment, Mrs. D continued to rebuff Mr. D's sexual advances, inducing in him increased desperation and neediness: "If she loves me, she will have sex with me. If she doesn't, she won't. She makes me feel as if I don't exist."

As the therapy advanced, there was an opening of the therapeutic space as bonding developed with the therapist. Both partners began to tolerate states of confusion, "not-knowing," and healthy dependency on the therapist. The therapist took on a more active role, using interpretation, confrontation, and management techniques. The major shift for Mrs. D was in the gradual diminishment of her omnipotence, her all-knowing attitude that conveyed, "I just know what he's going to do and say." Once she could grasp the idea that her "absolute knowingness" of

her husband as forever being a nothing, and that "nothing will ever change," Mrs. D was quite relieved to find how her omnipotence actually worked against her. During the next few months, Mrs. D began to feel some assurance in her newly acquired sense of being a feminine woman, the result of her preliminary identification with the therapist's qualities of sensitivity and vulnerability. Her developing capacities to tolerate her own "imperfections" and those of her husband, her feeling that she could get mad at him instead of projecting onto him and then rejecting him, contributed greatly to her feeling of increased security and the knowledge that the marriage was of paramount importance to her.

As his wife became more receptive to him and committed to their relationship, it came as quite a shock to Mr. D that he was not so much interested in intimacy and making love as he was in using sex as an act of aggression (a perverse use of love) against his passive, self-involved mother/wife. His striving for bonding transcended sex, as sex had served as the substitute for emotional contact and responsiveness. As he began to comprehend his own true dependency needs, he not only began to appreciate his wife's vulnerabilities, but displayed an increased capacity for abstract thinking ("thinking about" feelings and needs instead of "acting them out"). Mr. D became intrigued with his new thinking tools, was astonished to learn how his bonding needs became intertwined with aggression and persecutory anxieties. Even more notable was his newly gained tolerance for ambiguity, the notion of many forces operating simultaneously within him and around him. He didn't have to "abuse," "seduce," or demand; he

could simply ask.

In the final phase of treatment both partners expressed a desire for reparation. Mrs. D observed how her underlying fears of deficiency not only related to the difficulties in her marriage but impacted every area of her life, including her career and her children. Her defenses of withdrawal, isolation, and the demands for perfection, for "flawlessness," had given her a false sense of power, but ultimately kept her unprotected in a hostile intern world. Within the couple transference, the working through of Mrs. D's desire for special treatment manifested itself in several ways, such as insistence on fee reduction, changing hours to suit her schedule, or "perfect understanding." Mrs. D came to understand that just as her husband substituted sex for intimacy, she substituted omnipotence and control for dependency. She also noticed how anxious she felt whenever she had to take in nourishment from the therapist. She defended against this by being the one who had to know it all or being the one with all the answers. This need for perfect mirroring is exemplified by the following exchange:

Mrs. D: You don't understand. I was not mad, I was infuriated.

Therapist: So, you were angry.

Mrs. D: No, I was not angry, I was frustrated.

When the therapist brought up important issues, Mrs. D accused her of an "agenda" mother; when she was more silent and reflective, she was accused of

being the passive, impotent father. When the therapist tried to point out specific issues that Mr. D needed to deal with, he accused her of "ganging up on him."

Still, it was very affirming for Mr. D when the therapist could see positive aspects of his impulsive outbursts, that they really were representative of his wish to feel alive, to exist, and to feel loved, rather than to destroy or mutilate his mother/wife. Mr. D came to understand and appreciate how another part of him had a genuine need to depend on his wife and to love her. As he began to feel more contained, his ability to encompass ambiguous states and tolerate and consider ideas increased. Mrs. D was also moved and impressed by the notion that needing was not disdainful/sinful and would not necessarily result in abandonment. Gradually, both realized their true needs could actually enhance their relationship rather than diminish it. The conjoint sessions ended with Mrs. D requesting to see the therapist in individual sessions, and Mr. D requesting a referral to a male therapist for analytic work.

Summary

In the case of Mr. and Mrs. D, issues clearly centered around dependency needs. Working within the milieu of the couple transference and the dual projective identifications, the therapist gradually diminished the defenses against dependency by moving the couple away from shame/blame/ attacking defenses to that of healthy dependency needs (bonding with the therapist). For Mr. D, to need

represented an anguished tormented part of himself, subject to disapproval and rejection, and linked with aggression and persecutory anxieties. For Mrs. D, dependency represented disgust and disdain against a rebuffed feminine side of herself she equated with impotence and rejection. As treatment continued, the work consisted of showing how each projected and identified with each other's negative projections (dual projective identification). Mr. D, the borderline husband, felt he existed solely through his wife's affection and affirmation (living inside the object), and that it was his insatiable needs that actually drove her away. Mrs. D projected her shameful feminine side onto her husband to ward off her own inadequacies, compelling him to become even more needy, attacking, and sadistic. Mr. D. identified with Mrs. D's projection that it was bad to be vulnerable, equating femininity with an early narcissistic injury (birth of a brother). Eventually Mrs. D was able to relinquish some of the guilt and shame surrounding her dependency needs as she began to bond and identify with the therapist's "femininity." As the therapist was able to provide important selfobject and containing functions, they both began to feel more alive. Mrs. D. was reassured that giving her husband attention was also a way of giving her attention, and was not denigrating her, rebuffing her, but, in fact, supportive of her. As Mr. D became more observant of his earlier aggressive assaults, he became aware of how they had stripped him of his inner resources, making him feel emotionally impotent. He felt more contained and that there was someone to listen to him, to understand his pain (did not have to "act out" to get the attention he needed). Finally, both

partners comprehended how they had disidentified with the parent of the same gender and identified with the parent of the opposite gender: Mrs. D had disidentified (Benjamin, 1988) with her mother, eschewing her feminine nature, and identified with her detached father, enacting that role within her marriage; Mr. D had disidentified with his father, who had abandoned him through death, and identified with his passive mother, becoming a demanding, insatiable infant with his wife. As Mrs. D embraced the feminine aspects of her nature and Mr. D reclaimed his masculine nature, their love life became a mutual experience of discovery, tenderness, and satisfaction.

THREE PHASES OF TREATMENT

Phase One: A State of Oneness—The Borderline Person Lives Within the Mental Space of the Narcissist (Fusion/Collusion)

During the initial phase of treatment, the borderline person often lives "inside" the emotional space of the narcissist, as in the case just introduced. It is a state of "oneness," of fusion/collusion (paranoid-schizoid position), which exhibits a propensity for living within the psychic space of the other (Lachkar, 1992, 1997, in press). Because of the predominance of primitive defenses, the major therapeutic task is to assist each partner in relinquishing blame, finding fault, omnipotent control, deciding who is right, who is wrong (the one responsible for all the shortcomings in the relationship). This is accomplished by gradually

"weaning" the couple away from their destructive, painful, and aggressive behaviors by bonding through their vulnerabilities. In this phase, there is much name calling, stonewalling, scapegoating, envy, jealousy, and guilt. There is not space for another person's ideas or feelings: "My needs are your needs!" The formation of parasitic ties are enacted repeatedly as each acts out unresolved unconscious infantile fantasies. ''I'll show him what it feels like to make demands on me!" Both partners show little awareness of the inner forces that pervade and invade the psyche via their splitting mechanisms, mutual and dual projective identifications.

Mr. D's defenses caused him to operate at the level of a primitive superego (persecutory and attacking), while Mrs. D's defenses of withholding and withdrawal operated at the level of a more advanced superego (critical, harsh, relentless). In this phase the therapist is often used as a "toilet breast" (Klein, 1940). The borderline partners typically cannot make use of the mother as a container, will display intense ruthlessness toward their objects (the therapist) in the effort to rid the psyche of the bad parts of the self.

Phase Two: A State of Twoness (Transitional Phase)

In the second stage of treatment, there is an emergence of twoness, a tentative awareness of two separate emotional states, even a feeling that treatment can be helpful. Couples begin to feel better without knowing why. The

reason is because they feel contained. There is greater tolerance for ambiguity, greater capacity to live within the space of "not knowing," and more awareness of conscious, unconscious, and other compelling forces. It is the beginning of their bonding with the therapist, of separation from living emotionally "inside" the object, and moving toward mutual interdependence. As the therapist emerges as both container and new selfobject, there is a broader range of experience, an opening of a new therapeutic space, or what Winnicott (1953) has referred to as the transitional space or holding environment.

This is the hopeful stage, there is a burst of new energy and feeling of excitement. There is a profound shift, a movement away from the act of doing toward acts of feeling, being, and thinking. Each partner begins to get a glimmer of the part each plays in "the dance." This is the transitional stage, and the beginning or the movement into the depressive position.

Phase Three: Awareness of Two Emerging Separate Mental States (Dependent and Interdependent)

The third phase of treatment marks the beginnings of the depressive position, where reparation occurs, a wish to "repair" the damage, to embrace guilt and pain, and to express remorse and sadness. It is a time where each partner comes to terms with uncertainty, ambivalence, and dependency needs, a time to heal, repair, and listen nondefensively to each other's hurts. There is new depth and richness to the work and an awakening to the depressive position, where true

reparation can take place. The couple begins to psychically live "outside" the mental space of the other, as two separate, yet connected, emerging mental states. For the first time, mutuality and movements between dependence and interdependence take place. Healthy dependency needs are recognized as each partner begins to respect the needs of both self and other. We see the gradual diminishment of repetitive negative projections along with a window of opportunity for further treatment in individual psychodynamic psychotherapy. This is the "thinking" and healing phase where expression of true feelings begin to replace the act of "doing" or "acting out" (as we saw in the case of Mr. D). There is less need to "spill over," evacuate, or "tell all" and greater capacity to contain. This is the weaning stage, away from the preoccupation with "the relationship" to concentration on self-development. Both partners begin to see that they have their own inner conflicts, and growing awareness of how they impact their relational bond (the "real relationship").

Having moved through the phases of treatment in the case of Mr. and Mrs. D, we can now apply some specific procedures to the treatment of narcissistic/borderline relationships.

GENERAL GUIDELINES

- The therapist must see the couple together before transition into individual therapy to form a safe bond. *Cautionary note*: Do not move into individual work until the couple is ready (separation too early can

induce a "rapprochement crisis").

- Be aware that couple interaction can diminish individuality. Avoid such phrases such as, "You *both* suffer from feelings of abandonment."

- Be aware that each partner experiences anxiety differently, and these differences must be respected (qualitative differences).

- A therapeutic alliance must first be with the narcissist (the tendency to flight/flee/withdraw can pose a serious threat to treatment). The borderline patient will be able to tolerate waiting as long as he or she knows therapeutic bonding is taking place. A further challenge is how do we provide empathic responses to the narcissist without betraying or abandoning the borderline patient?

- Be aware that development of the therapeutic alliance is slow and the creation of a secure framework (structure, boundaries, commitment) takes time. The more primitive the couple, the more we need to emphasize the need for commitment. As resistances unfold in the relationship, use these opportunities to wean them into the "couple transference."

- When individual treatment occurs in conjunction with conjoint treatment, the same basic guidelines apply. Privilege and confidentiality is still under the umbrella of conjoint treatment (Lachkar, 1986, 1992).

TREATMENT POINTS AND TECHNIQUES

Finally, we must consider some vital guidelines to technique.

- Do not be afraid to confront the patient's aggression. Speak directly to the aggression with technical neutrality by making clear, definitive statements. Be empathic toward the pain and the patient's vulnerabilities, but avoid getting drawn into the couple's battle.

- Continually set goals, reevaluating and reminding patients of treatment goals of why they came in the first place.

- Avoid asking too many questions and obtaining lengthy histories. Do not waste time. Start right in. The history and background information will automatically unfold within the context of the therapeutic experience and the transference.

- Avoid self-disclosure, touching or consoling the patient, and making unyielding concessions.

- Listen and be attentive. Maintain good eye contact, speak with meaning and conviction. Talk directly to the issues.

- Use short, clear sentences; keep responses direct; mirror and reflect sentiments with simple responses and few questions.

- Keep in mind a “normal couple” or "ideal couple." This image will sharpen your focus and safeguard you from getting lost within the couple's psychological "dance."

- Explain how one may project a negative feeling onto another person, but still understand why the other identifies with what is being projected (focus on the *dual projective identification).*

- Listen for themes. Be aware of repetitive themes. The subject and feelings

may change, but the theme is pervasive (betrayal, abandonment, rejection fantasies) .

- Help the couple to recognize "normal" and healthy dependency needs.

CONCLUSION

Narcissistic/borderline couples express their pain by repeating blindly their dysfunctional behaviors without learning or profiting from their experiences. The uncertainties of diagnosis have been acknowledged, as well as the difficulties in differentiating between borderline and narcissist states. I have discussed why partners in these beleaguered relationships are in complicity with one another through their psychological "dance."

Couples therapy is an experience that occurs among three persons: the two partners and the therapist. This is a deep emotional experience of intense communication and feelings that begins with the profound challenges of a primitive relationship and matures into the awareness of healthy dependency needs and mutual respect. With each session, the curtain opens, and the opportunity for a new experience begins.

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Notes

[1] The "real relationship" refers to the task-oriented couple, those who can learn from experience, see the relationship as it is (not as it should be, could be, or ought to be). This is in contrast to the "fantasized relationship," those who cannot learn from experience or cannot tolerate pain or frustration. The regressive couple are those who form collusive bonds, display a diminution of reality testing, have impaired judgment, and bond parasitically rather than through the maintenance of healthy dependency bonds (Lachkar, 1992).