Six Steps in the Treatment of Borderline Personality Organization

Patients Prone to Psychosis

THE BORDERLINE SPECTRUM

Vamık D. Volkan

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THE BORDERLINE SPECTRUM

Although Kernberg's description of borderline personality organization is clear, even a cursory review of the literature will indicate that there is no consensus as to what is "borderline." Stone (1980) offers a review of the ways in which the term has been applied, and, what is more important here, compares "borderline" as used in recent work with the concept of the state as articulated in the American Psychiatric Association's *Diagnostic and Statistical Manual #3* (DSM-III). The "official" diagnosis refers to a broad definition including not only patients of the type Kernberg would call borderline, but also those in the Gunderson (1977) system.

Emphasis on borderline psychopathology seems to vary from one psychoanalytic writer to the next. Rather than offer a detailed review I will give selective references here. For example, Searles (1977) emphasizes unconscious processes of dual or multiple identity, seeing them as a fundamental feature of borderline ego functioning. This view, I believe, is echoed in the remarks of Abend and colleagues (1983) that identification with greatly disturbed parents plays a prominent role in the development of a borderline condition. They do not speak directly of identifications that are contradictory, that cannot possibly be brought together, or that tax the individual's integrative functions (I emphasize the importance of contradictory identifications), nor are they particularly impressed with the existence of splitting in adult life—it must be remembered that their patients were healthier borderline individuals.

Giovacchini, known, like Searles, for his analytic work with the severely regressed, offers a different definition of borderline disorder from Kernberg's, pushing "the fixation point somewhat further back, but not by much" (1986, p. 44). He notes that Kernberg views the fixation point of the borderline individual as being at the stage of beginning separation-individuation, and stresses the patient's poorly formed self-representations: "I agree that these patients do, indeed, have problems in their identity configuration, but I would add that their egos are more amorphously organized than the psychic structure that characterizes beginning separation-individuation—Mahler's (1972) hatching phase" (p. 44). Thus,

patients diagnosed as borderline by Giovacchini are more regressed, their adaptive functions more primitive, and their dealings with reality more inadequate. Such patients "make borderline adjustments to the external world, in that their adaptations are inadequate to cope with the complex demands of reality and . . . may lose their psychic equilibrium and become psychotic" (p. 45).

Kernberg (1975) divided those with narcissistic personality disorder into high-, middle-, and low-level categories, the first of which includes persons with effective adaptation on the surface, and the ability to gain success in their social lives and to influence external sources to provide them with a dominant role over others (Volkan 1980a, 1981b, 1982b, Volkan and Itzkowitz 1984). Those at the lower level are closer in function to persons with borderline personality organization. Although Kernberg refrains from categorizing borderline patients as high- or low-level borderlines, some of his work suggests that he sees possible diversity among borderline patients in spite of the fact that they all exhibit splitting and related primitive defenses, unintegrated concepts of the self and other, ego weaknesses as previously defined here, and so forth. It is when he speaks on the treatment of borderlines that he becomes aware of the possibility of regarding those on one side of the spectrum as being "healthier" or more "analyzable" than those on the other. In general, Kernberg (1975) does not regard borderline patients as analyzable, and the main goal of his expressive, psychoanalytically oriented treatment is to strengthen the patient's ego rather than emphasize the total and systematic resolution of his conflicts. He notes, however, that there are different levels of borderline patients: "In every patient presenting a borderline personality organization, at one point during the diagnostic examination the question of analyzability should be considered and psychoanalysis should be rejected only after all the contraindications have been carefully evaluated" (p. 107). Kernberg (1984) later became more optimistic about the analyzability of some borderline patients having a certain degree of superego integration and few antisocial trends and evolving to the point at which neurotic transference is possible. (As I have indicated, my observation has been that aspects of neurotic transference appear from the beginning of work with all borderline patients, but it is a technical mistake to focus on the neurotic transference in the initial phase of treatment.)

I believe that we can see within the general developmental and metapsychological guidelines of Kernberg's formulation, "psychosis-prone" personality organizations (Gunderson et al. 1975, Boyer 1986), some of which are less stable than others. Such patients know where they end and others begin;

they all have psychic boundaries that, while not intact, remain distinct when close to those of others, although with drugs or some other regressing influence, representations of others sometimes flow into the self-system through boundary flaws. The regressing influence may be psychological since these patients are quick to develop transference reactions to others. A female friend, for example, may very quickly become almost altogether a mother representation, and when this occurs, the patient may lose his psychic boundary to a considerable extent when relating to her, although he maintains it in less critical relationships. Such persons can be expected not only to exhibit psychotic behavior, therefore breaking with reality, but to develop psychotic transferences if their treatment permits therapeutic regression.

NINE PATIENTS

During the last twelve years I have treated nine psychosis-prone borderline patients. Although I may from time to time, for the sake of simplicity, use the masculine pronoun in speaking of the genus *patient*, six of the nine persons in this particular study were women.

Four of the women were between 19 and 23 when they came into treatment; two were in their late twenties. One man was in his early twenties, one in his early thirties, and the other just past 40. I saw one of these patients five times a week, the others four. Pattie, whose entire case is reported in Part II, reduced her sessions from four to three a week during the latter part of her treatment. Except in the first part of what I call Step One, all used the couch. The average length of treatment was six years, save one of the older women patients, who terminated after two-and-a-half years in spite of my efforts to analyze her resistance.

I consider her case as a failure on my part, in spite of her having been very ill at the time she began treatment, and, by most standards, unanalyzable. In retrospect I feel that I was technically in error for failing to make adequate preparation in Steps One and Two before actively confronting her with her conflicts and before systematically interpreting her genetic material. Since she works near my office, is reliable at work, and associates with people with whom I have professional contact, I do know that after her treatment of two-and-a-half years she was able to organize herself on a higher level, and I intuit that she has established a stable satellite state. This state was originally described as referring to a special compromise solution for problems of separation-individuation (Volkan and Corney 1968) in which the

adult continues orbiting around the mother's representation. In the case of this patient I believe that I was such a representation. She stayed close to me, but not too close, handling the pull toward engulfment and that toward (pseudo) independence by becoming a satellite, like a moth circling a flame. I suspect that this woman uses much energy maintaining her satellite state, which enables her to be to a considerable extent free from object relations conflicts so she can manage her life.

Another woman, seen four times weekly, remained in treatment for more than six years before we agreed on termination. She had definitely improved, especially in that she no longer experienced temporary periods of losing touch with reality. I do not, however, consider her treatment very successful; before long she required treatment for alcohol addiction. Since certain members of her family had had an indirect influence on my personal life and on the life of friends of mine, I must conclude in retrospect that unresolved countertransference issues complicated my work with her, especially in the termination phase. Her case illustrates the difficulty of treating anyone connected with someone uniquely important to the therapist. There remained some loose ends in our work when we separated, and ten years later she sought me out to deal with them, although by then she was living at some distance. We had two sessions to review the loose ends, and these were the most moving sessions of my long professional life. My patient in turn expressed great pleasure and relief derived from them. Although I have heard nothing of her for nearly three years, I like to think that she continues experiencing benefit from those two encounters and the work we accomplished in them. As far as I could tell, the outcome of treating my other seven patients was successful.

In general, the nine patients exhibited intolerance of frustration, and most were involved in chaotic and rather short-lived relationships. Any long-term relationships were sadomasochistic. The man in his early twenties and the one in his early thirties were married; the others were unmarried but involved in temporary, stormy relationships with members of the opposite sex. The wife of one of the married men seemed rather well organized on the surface, but while treating her husband I learned of her masochism, which made the continuation of her marriage possible; they had no children. The wife of the other married man was as primitive as he. They had one child, but divorced, the divorce so distressing to the husband that he sought treatment with me. The couple had undergone supportive therapy previously; indeed, six of my nine patients had had various kinds of treatment, some protracted (see the account of Pattie's earlier treatments in Part II, for example).

Splitting was evident in the way these patients related to other people; their self-representations were split as well, and they suffered from identity diffusion. At the lowest level of the borderline spectrum, they evaluated reality in primitive ways, unable at times to distinguish between an inner wish and an outer reality. Their omnipotent expectations of themselves and others would rapidly give way to feelings of helplessness and rage. All had poor work records.

All nine of the patients under discussion, including the two whose treatment I considered unsuccessful, showed drastic improvement; from a metapsychological point of view the seven whose treatment I did consider successful resolved their object conflicts, moving up in treatment to oedipal-level issues, tolerating oedipal passage as well as oedipal competition, and developing high-level defenses that they began using adaptively. All seven attained stable goals in their relationships and in their vocations and learned to tolerate being alone.

Two of the women needed hospitalization during the first years of their treatment with me; one was confined twice, for periods of a few weeks, while the other had one hospital stay of two months. The confinement of both was necessitated by rage and self-destructive behavior, which we discussed during their sessions. I arranged for them to enter the hospital, and I saw them regularly in my office while they were inpatients; when on suicide alert they were brought there by a nurse, who picked them up 50 minutes after delivering them to my door. I did not get involved with such aspects of their hospital stay as medication or the time for their discharge. I prescribed no medication for the nine patients at any time, but the inpatients were given medication while on the ward.

PROGRESS NOTES

I have for many years taken extensive progress notes on patients I am treating, and I followed this practice with the nine, although I did this *during* sessions with only five, making notes on the other four after their hours were over. I now make notes during all sessions, eschewing the use of electronic recording because I find my own notes a more satisfactory and creative way of reflecting what takes place. I have become so accustomed to doing this that it does not interfere with my hearing the patient, with my own regressions, with my observation of my affective experiences with my patients, or with my ability to formulate the meaning of what is taking place.

I do not suggest that every analyst take notes during a session, as it may interfere with its benefits, but I am not the only one who follows this practice. Searles (1976) tells how the notes he took in the treatment of "a borderline paranoid woman" became a transitional object for each member of the dyad. In this situation, his own analysis of the meaning of the notes was necessary to prevent an impasse, but notes are clearly very useful therapeutic tools, over and above any psychological symbolism they may hold for analyst and patient. Greenacre (1975) speaks of the utility of certain kinds of notes, and Boyer (1986) states that his keeping "copious progress notes" make "review dependable when I remain confused following a session or series of sessions, which, I believe, reduces the number of analytic impasses. This viewpoint has enabled me to be more objective while simultaneously emphatic" (p. 27).

I read and study my progress notes whenever I feel confused or whenever I have not seen the patient for a time. When during session after session a patient refers to a particular dream, it is most helpful to have notes on its first—and subsequent—appearances in his disclosures.

Progress notes are also useful in research and teaching (Dewald 1972, Volkan 1984). My notes on the nine patients here, for example, make it possible for me not only to provide accurate material about the early environment of each but also to provide data reconstructed in the analytic process.

THREE TYPES OF EARLY ENVIRONMENT

I classified my nine patients into three categories according to the first few years of life of each patient, placing emphasis on factors found within the child's interaction with the early environment that influenced integrative functions of the ego. I accept the idea of psychobiological givens in each case, believing, for example, that some children are born with less tolerance for anxiety than others, while some are more prone than others to exhibit derivatives of the aggressive drives. Allowing for this, we should examine the child's experience in the formative years in order to understand better why certain persons are prone to continue splitting after becoming adults.

My experience with patients other than the nine under discussion here suggests that the three types of early environment I indicate also concern patients with higher-level borderline personality organization and narcissistic personalities. Therefore, we need to look to factors (i.e., constitutional)

other than the nature of the family background in order to evaluate why some patients are more regressed and psychosis-prone than others. All such patients have had difficulty mending (integrating) their opposing self- and object representations.

The First Type of Patient: Single-Parent Relationships

The first type of patient has had early one-to-one interaction with his mothering person, but difficulties in this interaction kept him from completing the mending of opposing self-representations and internalized object representations at the normal age of 36 months. The mothering person may, for some reason, perhaps her own immaturity, have been incompetent in certain mothering functions; consequently, her child was exposed to repeated frustration and intense aggression. This kind of background corresponds to Kernberg's account of the genetic-dynamic analysis of borderline patients. The original pathology is oral; oral-sadistic impulses combined with anal-sadistic ones so greatly load the bad self- and object images that their integration with libidinally determined good images is hard to accomplish. Furthermore, the mothering person may have lacked aspects of ego function, so her child could not acquire them by identifying with her and accordingly had a deficiency in integrative activity and reality testing. The case of Pattie (Part II) exemplifies this: During her treatment she told of the frustration she had experienced as a little girl, and throughout her life she maintained oral images of herself that were greedy, voracious, and murderous, like the animated mouths of the video game "Pac-Man." In time she came to understand that her mother had certain ego weaknesses, as when she continued to see a certain tree as living long after it died.

On the other hand, the mother may have been able to provide a model for her child in respect to reality testing and integrative activities but because of illness or some other circumstance she was unavailable. Or she may have been burdened by another pregnancy in the first year of the patient's life, or by an ill child. In such cases the patient might accumulate oral envy and aggression and have in consequence bad self- and object images heavily laden with aggressive drive derivatives and experience difficulty trying to mend his aggressively and libidinally contaminated self- and object representations.

To summarize, the first type of patient develops a borderline personality organization because of early noxious elements in his one-to-one interaction with his mothering person, and possibly because of

a deficiency in his innate ability (a constitutional factor) to tolerate anxiety and to integrate opposing elements of the self and object. Six of my nine psychosis-prone borderline patients were in this category. In my supervisory experience I have encountered many others of this type.

These six patients came to the oedipal age with unresolved object relations conflicts that contaminated the father's image. I found the subsequent development of borderline personality organization among these children to be greatly affected by the father's role in maintaining unmended structures; they certainly brought to the oedipal level a lot of untamed aggression. On the other hand, the fathers had failed to help their children absorb the excessive aggression, reduce the ferocity of castration anxiety (in boys) and penis envy (in girls), and deal with the child's fantasy of murdering the parent of the same sex and being killed by him (her) in retribution. The sibling rivalries of these patients were also contaminated with intense aggression, and they never formed realistic representations of brothers and sisters.

In only one of the six cases completing treatment was regression from oedipal to preoedipal issues clear; preoedipal difficulties dominated in the rest, and this accounted for developmental failure and fixations. However, I found in treating them some elements that suggested original progress to the oedipal level with subsequent regression to the preoedipal level, in moves the patient involved customarily adjusted to. Such regressions were condensed with the original preoedipal fixations. The one individual whose regression from the oedipal level was clear in certain areas had oral frustrations and had displaced her dependency needs from her mother to her father, who not only met these needs, taming her aggressive drive derivatives, but helped her to evolve oedipal and even postoedipal configurations. However, his marriage deteriorated while his daughter was in latency, and he began stimulating her psychologically to a dangerous degree, taking her to the country as a wifelike companion, swimming with her in the nude, and so on. He left the family, as it happened, at the time she had her first menstrual period, when she was in adolescent turmoil, and when she was in charge of a depressed mother. She began to regress and to separate good and bad images of her father, winding up with so much splitting of images of her self- and mother representations that she exhibited marked borderline relatedness.

To some extent her treatment differed from that of the other eight patients; she went more quickly

through the initial stages of treatment and developed a full-blown transference neurosis, which for a long time was dominated by reactivation of her original relationship with her father, her defenses against aspects of it, and her fantasies connected with it.

Typically, all six patients showed elements of oedipal-phase conflict, but it is significant that they were influenced by dominant preoedipal conflicts and that their reactivation was used to defend against anxiety if "hotter" preoedipal conflicts were relived. It was always necessary in treatment to deal with earlier conflicts before working on oedipal issues.

Many studies have added to our knowledge of how the family contributes to the development of a borderline personality organization in a child (Zinner and Shapiro 1972, Berkowitz et al. 1974, Shapiro et al. 1975, 1977). I believe that the patient groups in these studies represent the prototype of borderline patients, or Type 1. They note the failure of the family to provide a "holding environment" (Winnicott 1960) to facilitate the child's integration of positive and negative constellations, and they note that parents chose their borderline child to participate with them by means of projective identification (a feeling of being identified with the other, attributing to him his own qualities) in a relationship that embodies the aggressively contaminated self- and object representations they would deny.

These investigators speak also of regression in the establishment of the borderline personality organization, referring to the whole family group's regression to such preambivalence that each member seems single-minded in relation to the borderline child, even when he is adolescent and is forced, as it were, to absorb aspects of parental conflicts denied and projected onto him.

The Second Type of Patient: Multiple Mothering

This patient's background is characterized by multiple and contradictory manifestations of parenting that evoke multiple and contradictory identifications. The first type of patient, who typically has had a one-to-one relationship with one mother, may, of course, form multiple identifications with her representation because of inability to integrate pleasurable and unpleasurable experiences with her, but with the second type, experiences leading to multiple contradictory identifications are complicated by

the *actual* existence of multiple parent figures. Cambor (1969) was, as far as I know, the first analyst to write on the influence of multiple mothering on a child's ability to integrate:

> There is . . . a greater tendency for a delay in the establishment of stable object representations, and this delay may be reenforced by interference with the process of fusion of good and bad maternal object representations. This interferes both with the process of separation-individuation and the progressive maturation of identification processes, and encourages the regressive wish for fusion with the idealized good mother only. [p. 91]

In a one-to-one relationship with one dominant mothering person, a child experiences loving and frustrating experiences and so learns that the mothering person is sometimes good and sometimes bad in terms of gratification. If not exposed to excessive frustration, the child then becomes able to integrate opposing representations of her and begins relating to her with ambivalence.

The child to whom more than one mothering figure is available may move from one who frustrates him to another and thus need not experience pressing frustration from any one individual. Thus it is hard for him to see any "mother" as a total individual; if his caretakers differ significantly from one another or are inconsistent, integration becomes even more of a problem. Kramer's case of Simon (1986), an adopted 6-year-old, is a good example of this formulation.

> I know that the outcome of multiple mothering was far worse in Simon than in most children who receive their major care from someone other than the mother. But I conjecture that a split in the self image because of partial identification with two competing care givers may occur in other instances where the pathology and hostility of the care givers are of great magnitude. [p. 170]

The child with multiple mothering experiences his contacts with one "mother" after another as a kind of loss-and-gain phenomenon accompanied by sad and elated affect. As an adult, the second type of borderline patient repeats in daily life and in treatment various changes of affect as he reactivates in the here-and-now his relationship with his early environment. Such patients are occasionally diagnosed inaccurately as being manic depressive; examination of their mood changes discloses a rationale of loss or gain. An experienced analyst or therapist can then understand how such loss or gain relates to reactivation of the internalization of experiences with the childhood environment. With proper psychological treatment these patients respond positively to the clarification and interpretation of their mood changes. Patients who related to an adoptive as well as to a biological mother provide examples, but there are variations on this theme. For example, if the child had had an opportunity to establish

object constancy with a mother who died, he may keep the idealized representation of her with which he identified. Then, if he has a stepmother, he will form a representation of her that in many ways is contrary to that of the dead mother; then the child identifies with both but is unable to integrate the two. This situation often is a significant cause of lifelong activation of the splitting mechanism.

One sees somewhat the same phenomenon in the case of a white child reared in the South by a black "mammy," as he assimilates their warm relationship with his self-system. As he identifies with his white mothering person, who, consciously or unconsciously, may regard the black mother as inferior, he will find it difficult to meld his self-system with his internalized object world. Smith (1949) has suggested that the Oedipus complex of a southern white child mothered by both a white mother and a black mammy requires adjustment that is simple compared to that involved in the early dual relationship. I suspect that a similar influence has been the way in which the British aristocracy, among others, gave the care of their young children over to nannies and had only limited contact with them themselves.

Certainly not all children who have multiple mothering will develop borderline personality organization or a narcissistic personality, but I suggest that multiple mothering tends to foster such personality organization and has been seen to lay the background for pathology. Some children are more adaptive than others to dealing with multiple mothering and do not show adverse effects. One of my analysands, a painter, illustrates this. Seeing his work and listening to his free association about his paintings made it clear that his paintings were psychological links between his early identifications with two mothering figures. The creativity and ability to form psychological links that he had possessed even as a small boy enabled him to manage his object relations conflicts. He was able to progress rather positively through the oedipal phase and did not exhibit a borderline or narcissistic personality organization, although he had neurotic problems and an obsession to be a peacemaker.

In traditional extended families such as those in rural Turkey, the classic child-mother relationship is enlarged to include experience with other "mothers." The child may not, however, experience one mother as incompatible with another, but rather as a continuation of the same mother. Even if the child does perceive his mothering contacts as different, Turkish culture absorbs the ramifications of this, so as an adult the individual fits cultural expectations and does not have a pathological personality

organization. It is beyond the scope of this book to examine cultural phenomena that parallel clinical pathological phenomena; the reader interested in this comparison may turn to writings by Ozbek, Cevik, and myself (Ozbek and Volkan 1976, Volkan 1979a, Volkan and Cevik 1989).

The father's influence is as important with Type 2 individuals as with Type 1. For example, Kramer (1986) tells how Simon's father was too weak in reality, as well as in the representation Simon introjected, to "wrest Simon from the two mothers" (p. 170).

Two of the nine patients in my study were Type 2 individuals, and I saw others in my supervisory work. One such individual was a man named Clark.

> As a child, Clark had "many mothers" and multiple fathers, and the effect of this on his personality organization and behavior became clear during his analysis. He was a 27-year-old university student when he began analysis. He was married but had no children. He sought treatment because of a sense of dissatisfaction with his "inner balance," having "lost himself' from time to time when experiencing feelings of panic. He thought his main problem concerned his relations with others, which he tried in a primitive way to control. For example, he experienced his extramarital sexual adventures as being split off from his marital life, and at times he lost the boundaries between his self-representation and the representation of a woman. Although he would experience this as "a mystical, blissful union," he was very aggressive with his wife and occasionally beat her. These presenting symptoms suggested object relations conflicts, difficulty in integrating opposing self- and object representations, and a susceptibility to having brief, psychotic experiences of fusion.
>
> An illegitimate child, he had lived with his biological mother for his first 13 months. Although his father had rejected him and the mother, he was adopted by a childless, married brother of the father, after which time he had no further contact with his biological mother. His biological father became his "uncle" and lived nearby, although remaining emotionally distant from the child. While in his early teens, Clark learned of his parentage from his adoptive father, whom he continued to call "Father," and to whom I will refer likewise.
>
> His adoptive mother died of cancer when Clark was three and a half, and he brought to treatment some memories of her as she had been in her terminal illness. She seems to have been musical and of a warm temperament, and when she died, Clark grew close to his father. But when Clark was 5, his father married a beautiful girl 15 years his junior, who took no interest in the boy. The second marriage had a bad effect on the father, who became withdrawn, easily provoked to anger, and a heavy drinker. When Clark became adolescent, his father's young wife became "repulsively seductive" toward him. The boy excelled in elementary school and was a favorite of his teacher. He was a lifelong student but felt disappointed in not achieving more. He married a social worker but continued his extramarital affairs.
>
> By having relations with many women he was repeating his childhood experiences with multiple parents. Just as he kept his several parenting persons compartmentalized in his mind, he kept his women separate, on occasion fusing himself with the representation of one, and then with that of another. Once in his analysis he also split off the representation of his analyst. He sometimes experienced his analyst as a teacher who was idealized, but then as one who was devalued. Sometimes the analyst definitely became the precursor of a bad superego, or a rejecting object representation, and at such times Clark would refer to him as "an analyzing machine." He told the analyst how his image of him changed frequently. When it was bad, Clark would behave

as though he did not hear him or accept what he had to say. This behavior, I believe, reflected Clark's defense against introjecting the bad analyst (his voice).

After Clark had been in treatment for two years, his wife bore a son, Sam. By focusing on the new father's reactions to his baby son, and the fantasies he had about him, we may grasp how his own early experiences influenced his personality organization, and how Clark reactivated those early experiences, which were contaminated with wishes, fantasies, and defenses. Although he had been rather calm during the pregnancy, he told the analyst that the expected baby would somehow be in danger. After Sam's birth, Clark formed through projective identification "immediate contact" with him; in his mind, the baby was, alternately and simultaneously, Clark himself. Both young parents became hypochondriacal about the infant, having him checked and rechecked by physicians.

The marriage foundered, and with Clark's reactivation of his early experiences, sexual activity came to a stop. He became a "good" mother and gave the baby motherly care, while his wife became the "bad" mother of the infant, who represented the needy infant Clark. He did not want her to look after their baby, and she became depressed and suicidal, eventually starting analysis herself. Against opposition, she continued to breast-feed Sam for 15 months. Clark, very angry, told his analyst of his desire to have breasts in order to be the perfect, idealized mother for his child. Unable to do this, he accused his wife (the antithesis of the idealized mother) of starving the baby.

During this phase of his analysis, he was helped to understand how multiple contradictory parental representations from his childhood, and corresponding representations of his own self as a child, were being reactivated. Clark came to believe that he had been breast-fed by his biological mother, and that, in an imaginative reversal, she had sucked his penis to give him pleasure. He began to speak more and more of the desire to experience fellatio while lying in warm water. This was connected with his adoptive father's oft-repeated account of his having wet the bed nightly after being adopted. His idea was that when he had been with his biological mother she had cared for him, changed his diapers, touched his penis, and made him feel warm and cozy. The analyst made the interpretation that his patient's wish to have fellatio while in warm water was a wish to keep a bond with his biological mother; before this interpretation was offered, a working through of the patient's childhood conflicts had obviously taken place, but it was the interpretation that moved him. He could now more clearly separate the representation of his biological mother from his internal gallery of multiple parents and could experience her in a more realistic and integrated way. In reviewing the knowledge he had of her, he no longer thought of her as either a whore or "eternally good," but as a young woman in a difficult life situation with an illegitimate son. He was now able to integrate more effectively, and in turn he could stop relating through projective identification to Sam, now a year old. When psychically separated from the baby, who was now better integrated in his mind, Clark could see humor (a good prognostic sign) in the previous pathological relationship between them. He called it his old "Samiosis," in a play on words related to symbiosis.

The Third Type of Patient: Deposited Representations

To me, he is the most fascinating. In this type, the ability to integrate opposing self- and object representations is taxed, because, as a child, the individual had experienced himself as a depository of a representation of someone else as it existed in the mind of his parents. I have compared the transmission of anxiety from mother to child with the transmission of germs that cause infection; and the passage of

unassimilated self- and object representations and their affect dispositions from parent to child, with the inheritance of genes (Volkan 1981c).

I deal for the first time with the concept of "generational continuity" in my book *Cyprus—War and Adaptation* (Volkan 1979a); I saw this phenomenon in myself as I watched a military parade with my little son during the first anniversary of the 1974 landing of Turkish troops from the mainland on the island of Cyprus, my birthplace. I then recognized that I was a link between the representation of my father, who had died during the turmoil between the two ethnic groups in Cyprus, and my son, the grandson he never saw. As I watched the Turkish troops parade, and the Cypriot Turks respond to them with joy and excitement, I sensed within myself a representation of my Cypriot Turkish father, not as an identification but as an object representation relating to his grandson, whom I also felt within me. I experienced my father's representation as if it were alive. It was freed from oppression, as in reality my father would now be, due to the changed political situation on the island. Although transient, this was a peculiar experience, and one that other second-generation people experience. Returning to this theme later (Volkan 1981c), I wrote of my patient Linda, who exemplified generational continuity in a longer-lasting and more complicated way. Her father was involved in complicated mourning over the death of his 7-year-old only son. Linda, a daughter of a subsequent marriage, had a mission to make him forget his grief; she kept within herself the representation of the dead boy, whom she had never seen, and identified with it to a considerable extent. When she had a son, who was now of the third generation, she perceived him, at least for a while, as a representative of her father's dead son, and as a solace to the representation of her dead father she kept alive within herself.

In neither my case nor Linda's did issues pertaining to generational continuity lead to the full-blown pathology of borderline personality. The representation of my dead father relating to that of his grandson was activated in an intensely emotional atmosphere and was temporary. In Linda's case, the representation of the dead boy was to a great extent depersonalized and absorbed through identification into her self-system. Although Linda appeared very feminine, she was a tomboy, and analysis of her tomboyish personality trait revealed that it was connected with her identification with the dead boy. When she had a son of her own, however, the dead boy's representation was no longer so much a part of her identification system, and it could now reappear as an object representation deposited in her newborn child.

Such observations led me to search for those deposited representations of others that remain unintegrated and do not become a part of an integrated identification system, which continue to have a life of their own. Such phenomena contribute to maintaining splitting of the child's self-concept if he experiences contradictions between his developing sense of self and the deposited representation.

The replacement child syndrome has been noted in the literature of psychiatry and psychoanalysis (Cain and Cain 1964, Green and Solnit 1964, Poznanski 1972) as occurring when a mother who has lost a child bears one to replace it. I have tried in my work to examine this syndrome above and beyond the phenomenological concerns, focusing on a metapsychological explanation of interactions between the dead child's representation, transferred from the parent to the living child, and the rest of the latter's self-system. When the child finds no creative ways to deal with his dilemma, a foundation for maintaining the splitting mechanism is strengthened. Furthermore, Zuckerman and I (1989) have shown that it is not only the representation of a dead person that can be transmitted to a child by its parenting figures. We offer the example of a woman who had developed kyphosis at puberty, along with many defenses and traits to deal with the intrapsychic ramifications of her physical deformity. For example, she was phobic about any deformed persons she might encounter; through displacement they represented her deformed self, and she avoided them. When she had a son, she deposited in him the representation of the straight spine she had lost but had not grieved over, with all its symbolic meanings (e.g., a phallus) and related affect. Her phobia then disappeared, but she developed a new symptom—exaggerated anxiety about the possibility that her son would not be straight. During her psychotherapy with Dr. Zuckerman, her transference neurosis included her expectation that she would damage her therapist by making him a reservoir of her deformity.

One of my patients, Frances (Volkan 1981c), was a reservoir of the unassimilated and formed representation of her adoptive mother's dead brother. She was adopted as a newborn infant after her uncle's death. As a young woman this adopted child experienced herself as half dead and half alive; half in this world and half on another planet; half female and half male. She had, she thought, two layers of skin, and her body was sometimes invaded by "spirits" from another planet who were either all good or all evil. Although she'd exorcise them, she would await their return. She was obsessed with Poe's *The Masque of the Red Death* and felt at home watching movies like "Night of the Living Dead," in which eating (introjecting) the dead is graphically shown. I later saw a patient with similar psychodynamics,

one of my nine patients. However, I would like to report here the case of still another patient of this sort, Maria, who was treated by Dr. Gregory Saathoff.

A black-haired beauty in her late twenties, Maria was the daughter of a family from a South American country whose citizens considered themselves descendants of important historical figures. In a panic, she sought treatment after being abruptly rejected by a lover. She presented herself as an actress on stage and screen and an expert in pantomime; only after a few months did Dr. Saathoff realize that in reality she had never acted on any stage or screen. She had once gone to another city to take acting lessons, but after finding a drama teacher she developed stomach pains and went back to life in her parent's mansion. Even as a child she had acted as an entertainer for her parents, and as a teenager she assumed the identity of an actress from time to time. Dr. Saathoff saw her actress identity as a kind of armor protecting the real identity that underlay it. The writings of Deutsch (1942), Greenson (1958), and Searles (1986) on "as-if" personality are relevant here, as is Khan's paper on "the false self' (1974).

On the surface, Maria's actress identity seemed an attempt to play the role of a noble and wealthy woman in order to maintain the family's illusion of still living in royal splendor. In reality, the family did have a mansion, but it was no longer full of fine things, being, rather, an illusory skin concealing a certain shabbiness; Maria's assumption of an identity as an actress similarly covered up an inner deficiency. The lover who had rejected her had been involved with her in a kind of folie a deux, supporting her identity as an actress, and introducing her as such to people newly met. It was the loss of this support that had brought her to treatment. When she herself spoke of being an actress, she was animated and without any sign of depression, but underneath this armor she was fragile and very helpless, soft and feminine, and given to tears. She often spoke of feeling like a ghost, and having a sensation at times of sinking into the ground. Dr. Saathoff missed the deeper meaning of these remarks until, after six months in treatment, she revealed another "identity" than that of an actress, this time that of a daredevil. It surprised him to hear stories of dangerous escapades from the woman who had always seemed so fragile and delicate. He then learned that in reality she was a motorcycle racer, a truck driver, a white-water canoe guide, and a mountain climber.

Dr. Saathoff got the impression that her involvement in dangerous activities was accompanied by a sense of urgency and was a flirtation with death as well as a denial of it. "I can't imagine myself dying," she would say, and she behaved as though she were immortal; she seemed to be walking a tightrope between life and death. It was revealed, in fact, that she had had to deal physically with death: She had been employed in the transportation of corpses from isolated places by a jeep too small to carry a casket. As she sat in the driver's seat next to her helper, she had been practically in the arms of the dead body she was charged with taking into town. Dr. Saathoff sensed new meaning in her remarks about being a ghost and sinking into the ground. The story of her keeping the representation of a dead person within herself began to emerge.

Before her father married, his sister shot herself fatally in the stomach because their parents disapproved of the man she wanted to marry. The injured girl lived for a few days and would permit no one from her family except her brother to enter her hospital room; he was at her bedside until she died. We know nothing of the relationship between this brother and sister, or of what passed between them as she lay dying, but Maria had been told a family myth relating to the dead girl: Three days after her death a tree under which the girl would read was struck by lightning, and when her father went to assess the damage a scarf that had belonged to his dead sister blew out of a window in the house and wrapped itself around the tree. A week later a black cat appeared at the house for the first time, and the dead woman's mother comforted what she apparently thought of as a representation of her dead daughter. It then disappeared, but the myth of the wandering spirit of Maria's dead aunt had been established. In time, after Maria's father married and had his daughter, the representation of the dead woman was deposited in Maria, as clinical evidence demonstrated. Although the family kept the

dead woman "alive," on another level they regarded her suicide as a blemish on their long and noble family tradition and kept her story secret. Maria's father had pictures of his dead sister in the home he established, and Maria recalled often taking it out to look at in times of isolation. Hearing her parents whisper about the dead woman, she had fantasied as a child that she herself was a reincarnation of her aunt, whom she was told she greatly resembled. Her parents saw Maria as a representation of her dead aunt, and this gave the child a conflict in object relations.

Since Maria's hair was lighter in color than her aunt's had been, they dyed it. They forbade her to eat mustard lest it eat the lining of her stomach; in a sense, they tried to prevent holes in her stomach since it had been a bullet hole in the stomach that had killed her aunt. Whenever Maria became anxious she had stomach pains.

As a child she had fantasies of having special powers and the illusion of being a great mimic, an entertainer. She wondered if she would ever die, and asked that if she did, her body be buried above ground rather than buried in it; this seemed to reassure her that she would never disappear. She told Dr. Saathoff, "I live under a curse passed from generation to generation."

When Maria reached adolescence, with its necessarily regressive position and second individuation (Bios 1968), the family myth that she was her aunt's reincarnation persisted. This interfered with her identification with her peer group, and, later, in late adolescence, with her formation of mature dyadic relationships. Overhauling her early self- and object relationships led to the crystallization of her identity both as her aunt and as an immature, fragile, and helpless "little daughter." Her real selves were composed of these two contradictory identities; the later identity as an actress, based on her fantasies of being an entertainer in childhood, was her false self, an artifact for linking the fragile child and the dead aunt identities, and concealing them. As an actress she could play both selves, without committing herself to either. Play acting lessened the tension of real confrontation between the two identities within herself.

As an adolescent she went to the place in South America where her aunt had lived, and was addressed in the street by a stranger who told her she was a perfect image of the dead woman. Her pretense—as an actress playing the role of her aunt—was threatened; she could be the dead woman! After this, she felt compelled to gaze for hours at her face in the mirror. The manifest content from her dreams at this time showed that she had two layers of "skin," like Frances, and they were in conflict. She tried to remove the skin she considered bothersome, or press the two together as if to make them one; this represented her wish to integrate contradictory identifications in order to resolve her object relations conflict. Whereas Frances, much more regressed than Maria, had hallucinations of being visited by spirits from another planet, Maria dreamt of spider-like entities from another planet who came to earth to paralyze their victims and devour them. In her dreams she would try to escape from them but would awaken and feel paralyzed.

In her late teens, Maria persuaded her parents to have a plastic surgeon operate on her nose, ostensibly to improve her appearance in order to become a movie actress; she was not conscious at the time of trying to expunge the "aunt identification" that bothered her, but while in treatment this motive dawned on her, and she said to Dr. Saathoff, "I still look at my aunt's pictures. She looks like the old me before my surgery."

Surgery for alteration of the body offers no solution for an internal conflict that is deep-seated and internally active. My work with borderline transsexuals who have had genital surgery shows this very clearly (Volkan 1974, 1980b, Volkan and Berent 1976, Kavanaugh and Volkan 1978). A male transsexual who becomes a "woman" after the removal of his penis and the alteration of his genital area

may have initial elation from feeling successful in uniting intrapsychically with the idealized version of his mother, but he is likely to dream of the reappearance of his penis, and this ruins the good effects of his surgery.

> Maria did not even have the luxury of initial elation, but had a feeling of horror when the bandage was removed from her nose and disclosed what she thought of as the face of a skeleton with two holes for nostrils. Instead of removing her resemblance to her aunt, thereby resolving her internal conflict, the physical intervention had made her look, she thought, more like the dead woman. She became deeply depressed and thought sometimes of shooting herself in the stomach, as her aunt had done. With the support of a series of male friends—who helped her keep one identity dominant, and the others suppressed—she was able to overcome her depression. When she became a daredevil, her co-worker, who was her lover, supported that lifestyle, and in that role she could be omnipotent and handle dead bodies and death in a counterphobic way, maintaining the illusion of her own immortality. When she separated from this man, she went home and spent her time with her father, who had retired, experiencing herself as a helpless little girl. Later her identity as an actress was supported for four years by the man whose rejection had made her turn for help to Dr. Saathoff. She told Dr. Saathoff that in her daydreams she performed the leading role only as a dark-haired tomboyish woman (the aunt) in a comedy (reversed affect). Then she would be world famous; everyone would recognize her and her talent as an actress. In other words, she would have the whole world to witness her reincarnating her aunt on the screen. Then she would abandon her career and retire to a farm that she described in idyllic terms as though it were a bountiful mother and live happily ever after.

I cite this case as an example of a third-type patient, and further mention only that in the second year of her treatment she became fully aware of her contradictory identifications, and, as though to rebury her aunt symbolically, she went to South America to see her aunt's grave. She was shocked to see her own birthdate, differing only in the year, on the tombstone, and realized that she had been born on an anniversary of her aunt's death. She had not been told of this and wondered if this were the reason her parents perceived her as her dead aunt's reincarnation. It seems probable that the birthdate was not the sole determinant, but that it likely had had an impact on the psyche of her parents and had made them deposit the dead woman's representation in her.