*Borderline Psychopathology and its Treatment*

# Treatment of the Primary Sector of Borderline Psychopathology

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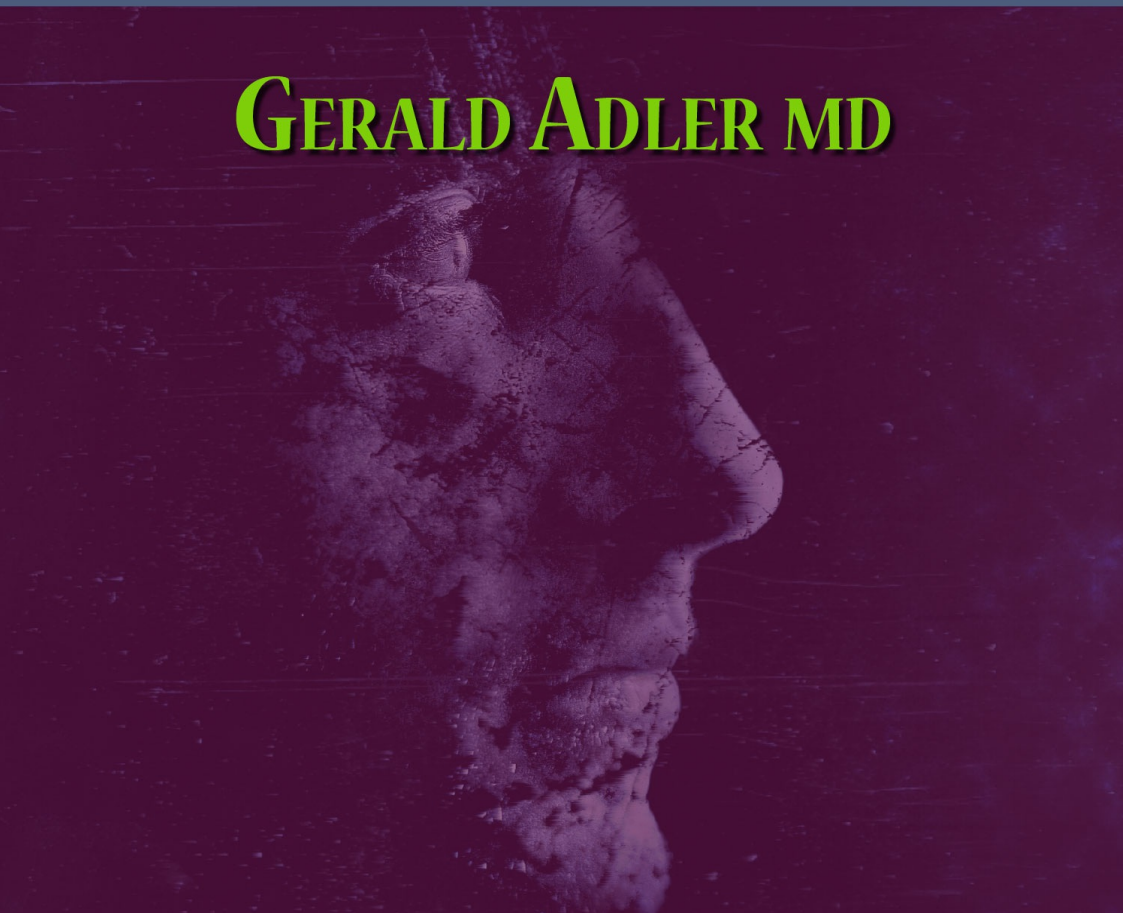

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# Treatment of the Primary Sector of Borderline Psychopathology

Definitive treatment of the primary sector of borderline psychopathology involves three successive phases. In this chapter I shall outline the work involved in each, and illustrate it with aspects of a clinical case. Because the narcissistic sector can bear in a particular way on the primary sector, it is also noted.

## Phase I: Inadequate and Unstable Holding Introjects

The primary aim of treatment in the first phase is to establish and maintain a dyadic therapeutic relationship in which the therapist can be steadily used over time by the patient as a holding selfobject. Once established, this situation makes it possible for the patient not only to develop insight into the nature and basis of his aloneness but also to acquire a solid evocative memory of the therapist as sustaining holder, which in turn serves as a substrate out of which can be formed adequate holding introjects. That is, developmental processes that were at one time arrested are now set in motion to correct the original failure. This process would simply require a period of time for its occurrence were it not for certain psychodynamic obstacles that block it in therapy just as they block it in life. These obstacles must, therefore, receive intensive therapeutic attention. They are consequences, or corollaries, of aloneness. The inevitability of rage is one such corollary that interferes with the process of forming holding introjects. This rage has three sources for the borderline patient:

1. Holding is never enough to meet the felt need to assuage aloneness, and the enraged patient is inclined to vengeful destruction of the offending therapist, of a fantasied eviction of the therapist from the patient's psychic inner world. Under these circumstances the patient feels as if he imminently will, or even has, lost or killed the therapist. In addition, the patient expects to lose the therapist through the therapist's responding to his rage by turning from "good" to "bad" in reaction to the patient's hostile assault and rejection.

2. The holding selfobject that does not meet the need is not only the target for direct rage but is also distorted by means of projection of hostile introjects. Thus the patient carries out what he experiences as an exchange of destructiveness in a mutually hostile relationship; subjectively, the inevitable resuit of this projection is the loss of the good holding object.

3. The object that is so endowed with holding sustenance as to be a resource for it is deeply envied by the needy borderline patient. This envy necessarily involves hateful destructive impulses.

Any of these sources of rage can lead to the state of recognition memory rage or diffuse primitive rage, with transient loss of holding introjects or object representations or even loss of use of transitional objects. At such times the patient is subject to the terrifying belief that the therapist has ceased to exist. When that occurs all possible support of the holding-soothing type may be required to maintain his psychic integrity and stability.

There is another corollary to aloneness that acts as a serious impediment to the process of forming a holding introject. It is the intensity with which the borderline personality must employ incorporation and fusion as a means of experiencing holding with a selfobject, an intensity that involves oral impulses as well as experiences of psychological merging. Belief in the imminence of destruction of the selfobject, the self, or both, demands that the borderline patient distance himself from his selfobject to such an extent that the subjective experience of holding-soothing is not adequate to promote the needed development of solid holding introjects.

There is yet one more impediment to the use of the therapist as a holding selfobject. It is a primitive, guilt-related experience that involves the belief by the patient that he is undeserving of the therapist's help because of his evilness. The patient's response is akin to the negative therapeutic reaction (Freud 1923) in that it can lead to the patient's rejection of all therapeutic efforts, as well as his rejection of the real relationship with the therapist, in the service of self-punishment. In extreme situations it can lead to suicide attempts. Primitive guilt can generally be traced to an archaic punitive superego.

Acquiring insight into and working through the impeding corollaries of aloneness—threats posed by rage from various sources, incorporation and fusion, and primitive guilt—are necessary in order for the borderline patient to be in a position to use his selfobject relationship with the therapist over time to develop a stable evocative memory for and introject of the therapist as holding sustainer. Treatment in phase I, therefore, focuses on these dynamic impediments to the use of the selfobject therapist for attaining the desired intrapsychic development for experiencing stable holding-soothing. Each of these impediments must be worked with in the standard ways as it manifests in transference, through use of

the therapeutic maneuvers of clarification, confrontation (see Chapters 7 and 8), and interpretation. Once insight is gained, each aspect requires working through. This treatment must be conducted in an adequately supportive therapeutic setting, one that attempts insofar as possible to help maintain the tenuous holding introjects and internal objects, hence keeping annihilation anxiety within tolerable levels and maintaining cohesiveness of the self. The amount of support may considerably exceed that involved in most psychotherapies. To some extent the therapist in reality acts as a holding selfobject. Transitional objects (for example, vacation addresses and postcards), extra appointments, and telephone calls reaffirming that the therapist exists are required at various times, and, for the more severely borderline personalities, one or two brief hospitalizations may well be expected. At times, in the interpersonal setting of the therapy hour, the therapist must vigorously clarify, interpret, and confront the patient with reality, especially around matters of the therapist's continued existence as a caring object, his not resembling the hostile introjects or identifications that the patient projects, and the patient's minimization of dangerous situations in which he may, through acting out, place himself when struggling with these issues. When splitting of the type Kernberg (1967) describes occurs acutely with the danger of serious acting out, it requires priority attention for correction.

The outcome of this work with the impeding corollaries of aloneness is this: The patient learns that the therapist is an enduring and reliable holding selfobject, that the therapist is indestructible as a "good object" (Winnicott 1969), that holding closeness gained by incorporation and fusion poses no dangers, and that the patient himself is not evil.

Indeed, the initial increments in development of a holding introject take place as the patient begins to believe in the survivability of the therapist as a good object. Hope is aroused that the relationship and the therapeutic work, involving understanding of object and selfobject transferences plus genetic reconstructions, will open the way for psychological development and relief. Once the holding introject gains some stability, a positive cycle is induced that results in a diminution of the intensity of aloneness and, along with it, a diminution of the corollary impediments; this in turn allows for further development and stabilization of holding introjects.

The healing of longstanding splitting (of the type Kernberg [1967] describes)—in the relationship with mother, for example—must await this formation of stable holding introjects. *Efforts to bring together*

*the positive and negative sides of the split can be therapeutic only after development of more stable holding introjects along with correction of distorting projections that have acted to intensify the negative side of the split.* Development or recognition of realistically based love on the positive side of the split is also helpful in healing it. With these therapeutic developments, the external and internal resources for love and holding become sufficient to endure the acknowledgment that the loved and hated object are one and the same and that the loving and hating in one's self toward the object must be reconciled.

**CLINICAL ILLUSTRATION**

Mr. A. began treatment in his mid-twenties when, as a graduate student, his lifelong sense of depressive emptiness grew dramatically more intense and he was progressively enveloped by diffuse anxiety, issuing in suicidal feelings. He had been very successful in his field of study and was highly regarded by his professors and peers, but he had no truly close friends. Those who did gain some intimacy with him found themselves repeatedly rebuffed as he time and again withdrew on some pretext into an irritated reserve, often then drawing closer to someone else. The person who most often occupied his mind was his mother, usually with a sense of rage. He respected his father as a hardworking, semiskilled man with principles. In his own pursuits as a student he was rather like him, but his father was a reserved man who was dominated by his wife and related to the patient mostly at a distance. His mother was often emotionally involved with the patient, but always in terms of her own wishes and needs and rarely, if ever, in terms of him as a separate person with his own identity. Alternately she was either intensively close or preoccupied with herself to such an extent that she appeared to have forgotten him. She involved him in sensuous body closeness, only to repel him in disgust when he responded. When angry she would declare that she had made him and she could kill him, and as a child he believed it. She also had clinical episodes of depression, during which she would take to bed and become literally unresponsive to everyone. Nevertheless, she was a compelling person for the patient. She was beautiful, and the positive times of closeness with her were heavenly. She gloried in his high intelligence and always backed his efforts to achieve academically.

From early childhood, at least from age 3, he was repeatedly sent by his mother to live with her childless sister for periods of weeks, up to a year. At times her motivation seems to have been the need to ease her burdens while having a new baby. The aunt and uncle were kindly and quiet but did not relate

well to the boy. He felt desolate, describing these visits away from his mother as like being stranded on a frozen desert. Sometimes he could manage his feelings with blissful fantasies of being harmoniously close to his wonderful mother, but he could not sustain them.

As twice-a-week psychotherapy deepened over a period of months, the patient felt increasingly dependent on the therapist. Looking forward to seeing him began evolving into an urgent sense of missing and needing him between hours. Longing was mixed with anxiety; by the time a year had passed, he began to express anger that the therapist was not with him enough and did not care enough. The transference evolved into a clear projection of his introjected relationship with his mother, which was clarified and interpreted. Insight was of little value, however, as he began to experience times with the therapist as wonderfully helpful and times away from him as a desert-like isolation where, despite continued good academic performance, all other involvements most of the time seemed meaningless.

As rage with the therapist intensified, the patient stopped looking at him. For the next two years, he never looked directly at the therapist, finally explaining that he was so full of hate toward him that he felt that his gaze would fragment the therapist's head into slivers of glass.

His intense yearning for the presence of the therapist contrasted with his increasing aloofness in the hours. The distancing behavior extended further. On entering and leaving the office, the patient began walking along a path that was as far away from the therapist as the room contours and the size of the doorway would allow. Whenever the therapist moved forward a little in his chair, the patient with a look of fear moved as far back in his chair as he could. Clarification of his apparent fear of closeness led first to emergence of overt fear that on entering and leaving the office he might fall into the chest of the therapist and disappear; similarly, he feared the therapist's leaning forward in his chair because it felt like the therapist could fall into the patient's chest and be totally absorbed. None of these fears were at the level of delusion, but the fantasy was so intense that it dictated behavior. Tentative interpretations of the possibility that his fears involved a wish led to emergence of overt cannibalistic impulses, first discovered in a dream that involved eating meat, which he recognized as the therapist, and later emerging in a dream of the therapist as a large-billed bird who was going to eat the patient.

As rage with the therapist mounted, the patient began acting out in consciously self-destructive

ways. He started drinking straight whiskey in bars noted for homosexual perversion and violence, thinking about the therapist and saying to himself, "I'll take what I have coming!" It was in this part of therapy that he experienced nearly intolerable times when he could not summon any memory image of the therapist beyond a vague inner picture. He could not sense the feeling of being with the therapist; he described these times as very frightening periods of belief that the therapist did not exist. On one such occasion he drank heavily and in a rage of aloneness and annihilation panic recklessly crashed his car into the side of a bridge. The therapist responded with added vigor in interpreting the patient's transient incapacities to know that the therapist existed. He insisted that at such times the patient must not act on his fear and rage but must instead telephone the therapist and, if necessary, make extra appointments. The therapist emphasized that in this way the patient would have a chance to learn that the therapist did continually exist, did continually remember the patient, and really was available to him. The patient did as the therapist urged, contacting him with brief calls and occasionally seeing him extra times as a means of managing these crises. (For a more detailed account of this episode, including a fuller analysis of Mr. A.'s homosexual feelings, see Chapter 7.)

In these ways the therapist was attempting to help the patient bear and understand his aloneness, rage, regressive memory loss, and frightening belief that closeness meant mutual destruction through incorporation and fusion. The clear transference to the therapist as a seductive and abandoning mother led to genetic interpretations and insight. But it also was essential that the patient repetitively have the opportunity to learn that despite his rageful attacks on the therapist, the therapist remained a caring person who consistently tried to help. For example, the patient spent 40 minutes of one hour verbally assaulting the therapist. He hated him intensely and wanted to kill him. He was certain the therapist did not understand what he was going through, that he couldn't understand how he felt because he did not care—he only collected the fee. He absolutely wanted to kill the therapist, to crash into him, drive his car into his house and smash it, rip it apart as though it were canvas. He hated the patient who preceded him and thought that she was in analysis, getting a higher form of caring than he was. He wanted to run over people in the neighborhood with his car and run over the therapist. He knew the therapist's family was there in the house, and he wanted to kill them too. He expressed all this with great intensity, feeling at the time that he really meant it. But with the therapist's persistent attitude of attentive acceptance, the patient in the last 10 minutes grew calmer, saying finally that his problem really was that he wanted to

possess his therapist completely, literally to swallow him whole.

With all of these efforts the patient gained a steady capacity to remember the therapist and to feel what contact with him was like at times between hours. He stopped having to make emergency telephone calls. His rage diminished. He began looking at the therapist, and he developed comfort with his wishes for incorporative and fusion closeness.

He told about a fantasy that he had had since childhood and now attached to the therapist. He was quite fond of it. It first developed after he learned about slaughterhouses for cattle. What he yearned for was closeness with the therapist gained through their each having been split down the abdomen so that their intestines could mingle warmly together. It was clear from the way he told it that this was a loving fantasy.

### Phase II: The Idealized Holding Therapist and Introjects

In general the holding introjects established in phase I are considerably unrealistic, in that they are patterned in part after qualities of whatever positive introjects were formed in early years. As such they are idealized in a childlike manner. The selfobject transference is strongly colored by projection of these idealized introjects, and introjection of this transference experience results in formation of an idealized holding introject that the patient takes to be a homologue of the holding qualities of the therapist. Were treatment to stop here, the situation would be quite unstable, for two reasons. First, the unrealistic idealization of the holding introjects, along with the projections of them onto persons who serve as holding selfobjects, would continually be confronted by reality and would inevitably break down. Second, at this point the patient is still heavily dependent on a continuing relationship with holding selfobjects (including the therapist), as well as holding introjects, for an ongoing sense of security; this is not a viable setup for adult life, in which selfobjects cannot realistically be consistently available and must over the years be lost in considerable number.

The therapeutic work in phase II parallels that described by Kohut (1971) in treating the idealizing aspects of selfobject transferences with narcissistic personalities. (Indeed, the introjects of interest here are idealized not simply in the area of holding, but also in terms of worth. For purposes of

this discussion, the two qualities that are idealized are artificially separated, and the one concerned with worth is addressed in a later section.) Kohut describes the therapeutic process as "optimal disillusionment," and the term is applied in this section to idealization in the area of holding-soothing as he uses it in the area of self-worth. No direct interventions are required. The realities of the therapist's interactions with the patient and the basic reality orientation of the patient always lead to the patient's noticing discrepancies between the idealized holding introject, based on the therapist and reflected in the transference, and the actual holding qualities of the therapist. Each episode of awareness of discrepancy occasions disappointment, sadness, and anger. If each disappointment is not too great, that is, is optimal, a series of episodes will ensue in which insight is developed and unrealistic idealization is worked through and relinquished. (Any disappointments that are greater than optimal precipitate recurrence of aloneness and rage in a transient regression that resembles phase I.) Ultimately the therapist as holding selfobject is accepted as he realistically is: an interested, caring person who in the context of a professional relationship does all that he appropriately can to help the patient resolve conflicts and achieve mature capacities. Holding introjects come to be modified accordingly.

**CLINICAL ILLUSTRATION**

At this point, Mr. A. was preoccupied with interrelated idealized holding introjects based on good childhood times with his mother and unrealistic beliefs about the therapist. Directly and indirectly he declared strongly positive feelings for his therapist. He was not concerned about vacations, because he knew the therapist kept him very much in his thoughts. He fantasied their hugging in greeting when the therapist returned (something that he in fact never attempted). At the same time he reminisced tearfully about the passive bliss of being with his mother at the times she cared for him. He referred to her by her first name, Joanna.

He grieved repeatedly as he recognized, little by little, that the idealized images of Joanna and the therapist were unrealistic. This work required no active stimulus from the therapist; reality intruded on idealizing illusion enough to keep the work going. The therapist helped the patient bear his grief and put it into perspective by empathically staying with him, by providing clarifications and interpretations about dynamic and genetic bases for his disappointments, and by avoiding any confrontations that would intensify his disappointments. The grief process consisted of sadness, crying, nonmurderous anger, and

relinquishment of impossible yearnings.

For example, for several weeks the patient had talked tearfully about how beautiful life had been with Joanna. She was everything to him, and he would do anything for her. He also spoke of the solidity he felt in his relationship with the therapist. It was like the large oak trees that stood outside his office. Then in one hour he related a dream in which he was descending the stairs of an elevated streetcar station. There were several people on the ground waiting for him, including a woman and the therapist. He noticed that the stairs ended several feet above the sidewalk and he was expected to jump. The people could have made it easier by catching him, but it was safe enough; so they simply stood by watching. He was angry, jumped anyhow, and was all right. After reporting the dream he said that he had been wishing the therapist would talk to him more. He didn't know much about the therapist personally and really longed to know more. He felt deprived, and he was angry about it. He felt jealous of other patients and the therapist's family; they all got something special from the therapist. He wanted to be like a man in a recent movie who lived to be adored. He wanted all his therapist's adoration. He wanted him to smile affectionately, touch him, clean him all over, touch and clean every crevice of his body, like a mother would her baby. He was jealous of people whom he fantasied the therapist to be close to sexually. The wonderful thing the therapist had to give was like two golden pears in his chest. He yearned for them so much and did not get them. He was furious about it, felt like destroying them. Then he became sad, and tears streamed down his cheeks. He felt badly about his anger because he knew that what he wanted was unreasonable. The therapist said to him that it was like his dream. He wanted to be held in his jump to the sidewalk although he knew he actually didn't need it. His anger arose not because a need to be saved was ignored, but because he wasn't receiving something he very much yearned for. Mr. A. agreed that this was the meaning of his dream and was the way he felt.

The excerpt that follows is taken from the last portion of Phase II. The patient said:

> I feel like I'm missing Joanna, like I'm looking for her everywhere, and she ought to be all around, but she's not. [He looked mildly depressed and sad.] I miss her. I miss her, and you can't bring her back, and nobody can. It's like she died. [He began to laugh.] I wonder what the real Joanna is like. The Joanna I yearn for isn't the real one at all. It's some ideal Joanna I'm wanting, someone very wonderful and very exciting. A Joanna like that never really existed. [He grew sad, but retained his humor.] You know, the trouble is that I don't see people and places for what they really are because I keep looking for Joanna there. There are lots of girls I know but haven't ever appreciated because I haven't really related to them. I've missed out on them. I had a dream. All I remember is that there was a wonderful celebration for me, but I couldn't enjoy it because Joanna wasn't there. It's like part of me has died, but it's not so much that I can't do okay without it. It's really as if she's

been everywhere or is everywhere. She's part of me, and it's awfully hard to give her up. [With good humor, slightly hypomanic.] It feels like I can peel Joanna off now, that it's like a layer of skin. And when I do, most of me is still left there very solid.

## Treatment of the Narcissistic Sector of Borderline Personality Psychopathology

The majority of borderline personalities also exhibit serious pathologies of narcissism of the type Kohut (1971,1977) and Goldberg (1978) describe, manifested in everyday life by grandiosity and narcissistic idealization of others and in psychotherapy by apparently stable selfobject transferences of the mirroring and idealizing types. I shall be discussing the relationship between narcissistic and borderline psychopathology in greater detail in Chapter 5. For now it is enough to note that by and large the modes of treatment delineated by Kohut are applicable to treatment of the narcissistic sector, but that the therapeutic work is complicated by the interrelationships of pathological narcissism and pathology of holding-soothing the self. There are three concerns here:

1. Narcissistic grandiosity and idealization can substitute for holding-soothing in effecting a subjective sense of security. Some borderline personalities make significant use of this substitution as a regular part of their character functioning; others temporarily resort to it as a means for feeling secure at times when use of holding selfobjects is compromised. Perhaps this substitution is effected through the medium of the satisfaction and pleasure inherent in possessing or partaking of perfection, as well as through the assurance and security offered by the sense of invulnerability that accompanies narcissistic grandiosity and idealization.

2. Cohesiveness of the self depends upon maintaining equilibrium in the areas both of narcissism (Kohut 1971) and of holding-soothing.

3. Although dynamically different, undermining of pathologically maintained narcissism can be a life-and-death matter, as can the loss of the borderline personality's means of maintaining holding-soothing of the self. Undermining of grandiosity or idealization can precipitate a subjective experience of worthlessness that is unbearably painful. By itself it does not, as aloneness does, portend danger of annihilation, but it can prompt serious suicidal impulses as a means of gaining relief and/or punishing whoever is felt to be responsible (Maltsberger and Buie 1980).

The importance of pathological narcissism for maintaining a subjective sense of security and self-cohesiveness and for avoiding unbearable worthlessness bears greatly on the timing of therapeutic

approaches to narcissism in the borderline personality. Insofar as possible, pathologically maintained narcissism must not be weakened during phase I of treatment, when holding-soothing security is so vulnerable and the risk of aloneness, with annihilation anxiety and loss of self-cohesiveness, is so high. In phase II, narcissistic idealization and grandiosity are often interwoven with idealizations of the holding type. At this time therapeutic disillusionment can often be successful in both areas, provided it remains optimal for both. It may be necessary, however, to delay definitive treatment efforts with the narcissistic sector until after the work of phase II is accomplished in the primary sector of borderline personality psychopathology. Timing must, of course, vary from patient to patient. The guideline is that narcissistic issues can be approached only insofar as a stable holding selfobject transference and adequately functioning holding introjects are firmly enough established to prevent regression into insecurity and loss of self-cohesiveness.

For Mr. A. narcissistic pathology was not extreme. It was expressed in phase II especially in the context of the idealized holding selfobject transference—in feeling and wanting to feel adored. Optimal disillusionment in the area of holding proceeded hand in hand with optimal disillusionment in the area of narcissism.

**CLINICAL ILLUSTRATIONS**

Ms. B., a 25-year-old social worker, by documented history had since infancy suffered intermittent rejections by her immature and volatile mother, as well as excessive verbal and physical abuse. She exhibited in her history and in therapy a narcissistic developmental arrest of the type Kohut describes, along with the elements of a borderline personality. She was especially fixated at the level of a grandiose self through having been very important to her mother as an idealized selfobject. For her mother's sake and her own she needed to be outstandingly bright and popular. In late grade school the equilibrium between them began to disintegrate under the impact of her real position vis à vis her peers and teachers. The intense urgency and importance of her needs had made her a socially awkward girl, and the tension lest she fail to achieve perfection had immobilized her in academic competition. As her position with teachers and peers deteriorated, she tried to meet her mother's and her own needs by lying to her mother, conveying fantasies of achievements and popularity as if they were facts. Eventually her gullible mother learned the truth, and the narcissistic equilibrium of each was permanently shattered.

Treatment in phase I was more difficult with Ms. B. than with Mr. A. In addition to problems with aloneness, she was subject to desperate feelings of worthlessness when her selfobject means of maintaining narcissistic equilibrium were threatened or interfered with. This added extra dimensions of intensity to the therapy, including greater levels of rage and envy, and at times the therapist had to provide vigorous support to her fragile sense of self-worth. In phase II she worked through her idealizations of the therapist as selfobject holder and modified her introjects accordingly. Thereafter some effective work was done with her pathological narcissism; in phase III it became possible to modify her need for grandiosity by substituting self-worth derived from effective involvement in personally meaningful pursuits and achievements. Although at termination narcissistic pathology still persisted significantly, follow-up has shown that the process that began in treatment continued. Successful life experiences made possible further replacement of the grandiose self and idealizing transferences with realistically rewarding career achievements and more realistic involvements with worthwhile people.

Certain patients who are insecure because of relative paucity of holding introjects and relative inability to use holding selfobjects may exhibit considerable pathological narcissism yet require little direct therapeutic work with it. These are patients who use pathological means of maintaining narcissism as a substitute form of security that supplements their inadequately available means of maintaining holding security. A third case illustrates this pattern.

Mr. C. was a successful historian whose background included marked deprivation of security from the time of infancy. He was a brilliant man, however, and he possessed outstanding charm of a mannered sort. He was preoccupied with this image of himself and loved to indulge in fantasies of being Henry VIII and other magnificent men of history, often in affairs with great women of the past. But all his relationships were emotionally shallow, and his mannered charm obscured the fact that he had no close relationships, including with his wife and children. They often entered into playing out his fantasies of being a king whom they obediently revered. The magnetism of his personality was such that a great many people quite willingly provided the mirroring admiration that he needed to maintain his fantasy life.

Mr. C. was able to live well financially by virtue of an inheritance; this was a most important prop for his grandiosity. When the money ran out, he decompensated into a prolonged phase of severe

depressions alternating with mania, at times exhibiting evidence of delusions. On several occasions he attempted suicide. Finally, he began psychotherapy with the aim that it be definitive. He desperately reached for closeness with the therapist, probably for the first time in his adult life, and soon was involved in the therapeutic situation that has been described for phase I. Concomitantly he reconstituted his old grandiosity, using the therapist as a transference mirroring selfobject. As with Ms. B., this part of the psychopathology was not worked with and was not challenged in phase I. When he entered phase II, he was in a well-established selfobject transference of the holding idealization type. Unlike Ms. B., however, he now altogether discontinued his transference use of the therapist, or other people, to support his pathological narcissism. At the same time more realistic modes of maintaining self-worth emerged. Prior to his decompensation he managed the primary sector of his borderline psychopathology by maintaining a guarded distance in all relationships and by supplementing the inadequate resources for holding in his inner and external worlds with substitute security derived from maintaining a grandiose self. Once an adequate stable idealizing transference of the holding type was established in phase II, he was able to and did essentially dispense with his grandiose self (apparently permanently) because he no longer needed it for security.

### Phase III: Superego Maturation and Formation of Sustaining Identifications

To become optimally autonomous—that is, self-sufficient— in regard to secure holding and a sense of worth requires two developments: (1) A superego (as an agency comprising both the conscience and the ego ideal) must be established that is not inappropriately harsh and that readily serves as a source of a realistically deserved sense of worth. (2) The ego must develop the capacity for pleasurable confidence in the self (the heir to grandiosity) and for directing love toward itself that is of the affectionate nature of object love.[1] This development of the capacity to love the self in the manner of object love contributes not only to enjoyment of being one's self but also makes possible a reaction of genuine sadness in the face of losses that involve the self— accident, disease, aging, approaching death—a grief that is homologous with that experienced with object loss. Without this ego development, the reaction is instead one of depression, fear, and despondency, which typify "narcissistic" loss rather than object loss.

The therapeutic endeavors in phase III are based on the principle that capacities to know, esteem, and love oneself can be developed only when there is adequate experience of being known, esteemed,

and loved by significant others.

Once the inappropriately harsh elements of the superego (or superego forerunners) have been therapeutically modified, the process by which superego development is initiated in this phase of treatment is introjection, as described by Sandler (1960). Accordingly, early in this sequence of development, one can speak of superego forerunners that have the quality of introjects in the psychological inner world, that is, of being active presences that exert an influence on the ego. For example, a patient might state, "I can feel how my therapist would guide me and value me for this work." Such superego-forerunner introjects evolve into an agency, one that still functions with the quality of an introject; through a process of depersonification, however, it comes to be experienced as part of the self rather than as part of the inner world. One can now speak of a superego and illustrate this development by altering the example just given into, "My conscience guides me and gives me approval for pursuing this work well." Further development occurs through increasing depersonification and proximity of the superego to the "ego core" (Loewald 1962), along with integration of the superego with the ego. These developments can properly be subsumed in the concept of the process of identification (Meissner 1972), and it is in this way that superego functions are ultimately assumed as ego functions. Now the ego is no longer in the position of being responsive to the influence exerted by an agency external to it but, rather, becomes its own guardian of standards of behavior and its own source of a sense of worth. At this point the example under consideration evolves into, "I feel good about this work of mine which is in line with my values and meets my standards."

Often these patients also require help to gain the capacity to experience subjectively the factualness (validity) of their esteemable qualities, as well as the capacity to experience feelings of self-esteem. This process requires the transient selfobject functioning on the part of the therapist that will be described in the clinical section that follows.

In this phase of treatment, the ego evolves as its own resource for pride and holding through development of intrasystemic resources that are experienced as one part providing to another, both parts being felt as the self. These ego functions are developed through identification with the homologous functioning of the therapist as a selfobject. That is, the therapist, verbally at times, but largely nonverbally, actually does provide the patient with a holding function, a function of loving in the

affectionate mode of object love, a function of validating (enhancing the reality valence of) the patient's competences, and a function of enjoying the exercise and fruits of the patient's competences. To varying degrees these functions are internalized, first in the form of introjects, but in phase III they become depersonified and increasingly integrated with the ego, ultimately becoming functions of the ego by means of identification. This is the process that Kohut (1971) designates as transmuting internalization. The experiential quality of these newly gained ego functions might be expressed as follows: (1)"I sustain myself with a sense of holding-soothing"; (2)"I love myself in the same way that I love others, that is, affectionately, for the qualities inherent in me"; (3)"I trust my competence in managing and using my psychological self and in perceiving and interrelating with the external world; hence I feel secure in my own hands"; and (4)"I enjoy knowing that I am competent and exercising my competence."

The impetus toward effecting the introjections and identifications involved in these superego and ego developments arises out of a relinquishment of the therapist as an idealized holding selfobject, as well as a relinquishment of whatever use has been made of him as a narcissistic transference selfobject. Such relinquishment also involves homologous modification of introjects in the inner world that have been patterned after the selfobject transferences. Then the patient is forced by his needs to develop other resources for maintenance of holding security and narcissistic equilibrium. The introjections and identifications just described provide the necessary means for accomplishing this task. They also establish a stability of self in terms of holding and worth that is far greater than was possible before. The depersonified introjections and identifications are by their nature more stable and less subject to regressive loss under stress than the configurations and arrangements they replace (Loewald 1962).

Total self-sufficiency is, of course, impossible. For its healthy functioning the ego requires interaction with the other agencies of the mind as well as with the external world (Rapaport 1957), and no one totally relinquishes use of others as selfobject resources for holding and self-worth, nor does anyone relinquish using selected parts of the environment (art, music, and so forth) as transitional objects (Winnicott 1953). These dependencies are the guarantees of much of the ongoing richness of life.

It is only through the developmental acquisitions of phase III of treatment that the former borderline personality acquires genuine psychological stability. Of course, the degree to which it is achieved varies from patient to patient.

## CLINICAL ILLUSTRATION

Although superego development cannot be divorced from ego development (Hartmann and Loewenstein, 1962), for purposes of clarity a partial and artificial division of the clinical material will be made along this line.

### *SUPEREGO DEVELOPMENT*

In a time when nearly all hostile introjects had been altered and tamed in Mr. A., it became noticeable that one remained of a superego-like quality. It was like a harsh taskmaster that in fact overly dominated the conduct of Mr. A.'s work life. His associations included one of the dicta belonging to this introject: "You must sweep the corners of the room first; then you will be sure to clean the center." In fact his thoughts had been intrusively dominated by that maxim while cleaning his apartment the day before, and he hated the driven way he worked in response to it. It derived from his mother, being one with which she often regaled him. Further exploration revealed that nearly the entirety of the harsh taskmaster introject phenomenon under study was derived from interactions with this harsh quality of his mother. Although the genesis and present-day inappropriateness of this part of his inner world were clear to the patient, no modifications occurred. In a later hour the therapist, on a hunch, asked whether the patient would miss this harsh-mother-like conscience if it were gone. The question stimulated a mild grief reaction as the patient associatively discovered that he would in fact miss the felt presence of her that was the concomitant of the harshness. Indeed, it became clear that this introject partook of both negative and positive qualities of the interaction with his mother, and it seems for that reason it was the last significantly negative introject to go.

Thereafter a more mature superego began to develop. Mr. A. already possessed appropriate guiding standards as well as the internal authority to promote them (Sandler 1960). Therefore, some of the therapeutic work described above was not required. What he did need was a sense of satisfying and pleasurable self-value. Attaining it was a two-step process. To a degree he "knew" about many aspects of himself that were worthy of esteem, but he did not know them solidly and effectively so that his knowledge could carry the full value, or valence, of reality. The full reality of his positive qualities had, therefore, to be established first. This took place in the therapy through the process of "validation," by

which it is meant that the therapist reacted, verbally and nonverbally, to accounts of episodes in which esteemable qualities played a part in such a way as to convey simply that these qualities had registered in his mind as realities. Communication of this to the patient enabled him, then, to experience these qualities with a sense of realness himself. Validation is a selfobject function performed in this way by the therapist; the interaction provides an experience such that the patient can not only feel the realness of his qualities but also gain, through identification, the capacity to validate his qualities himself. The qualities thus covered in therapy by Mr. A. were myriad. His capacities as, by then, a college teacher of sociology constituted one such area. He was very successful with his students and with other faculty members. There were numerous events that demonstrated their appropriate esteem for him, but he was not in a position to understand and appreciate their expressions of esteem or to develop a similar sense of esteem for himself until he related it to the therapist. He could then gain a sense of the validity of their judgment.

The second step in acquiring a capacity for appreciating his own self-worth was facilitated by another aspect of the therapist's behavior when the patient related such episodes. The therapist responded with appropriate, subtle, but similar expressions of esteem. This directly promoted the patient's feeling an approving esteem for himself. Ultimately, through processes of introjection and identification, he developed a much improved capacity for autonomous self-esteem. He then no longer required it as a selfobject function from the therapist.

### *EGO DEVELOPMENT*

The patient required ego development that involved all the functions referred to in the brief theoretical considerations for phase III of treatment: (1) self-holding, (2) self-love with "object love," (3) trust and security in one's competence, and (4) prideful enjoyment in one's competence. Examples can be given of each.

*Self-Holding*. Originally the patient worried fearfully about his health—signs of illness, being overweight, working too hard, and so forth. But there also was a real basis for his concerns. The therapist never responded with a similar worry, but he did show interest and a warm concern that carried with it the implied message that the patient should care for and take care of himself. Eventually this became the

patient's attitude, displacing the old fretful, nonproductive worrying. He began to care for himself with a sensible attitude toward himself; at that time the therapist stopped responding with a selfobject level of involvement. The patient then went on a diet, losing the weight he needed to lose, and he ordered his life better, for example, getting more nearly the amount of rest and relaxation he needed. All in all, it could be said that he developed an essentially autonomous caring about himself that effected a self-holding function.

*Self-Love with "Object Love."* In phase III especially, the patient related many stories of his work and personal life: how he managed a difficult committee problem, how he helped a student advisee who was in serious difficulty, or the conversational interchange with an old friend. Increasingly the full quality of his subjective experience in these episodes was regularly expressed in a spontaneous manner. The therapist in fact liked the patient very much, though he never said so. But his mostly nonverbal listening to these stories certainly conveyed his affectionate enjoyment of the companionship involved in his empathic vicarious participation. Eventually a new attitude emerged in the patient toward himself, one that was implied rather than explicitly stated. It was an affectionate attitude toward himself, one that partook of the quality of affection he felt for other people: his friends, students, and therapist. It was a self-love that mostly differed in quality from the holding form of caring about himself described above—it did not specifically involve concern for himself or taking care of himself, even though it could be combined with these. The therapist surmised that his own love for the patient had been important in the patient's coming to love himself, probably through the mechanism of identification. A further benefit of this development was that in loving himself the patient could more readily acknowledge and accept the love others expressed for him.

*Trust and Security in One's Competence*. Prior to phase III of treatment, the patient was always beset by doubts about his competence to do the task at hand, even though he nearly constantly was called upon, for example, to teach, give speeches, and organize meetings. He was never sure that he could express himself effectively, despite the fact that he never failed to do so. This doubt concerning his competence was present from the beginning of therapy and persisted unchanged for a long period. The therapist's function of validating seems again to have provided the necessary experience to bring about change. The therapist developed a realistically founded judgment that the patient was indeed solidly competent in a large number of ways, and by his attitude conveyed this judgment repeatedly to the

patient, although he rarely put it into words directly. Gradually the patient came to regard his competences as facts about himself; they had been validated by the therapist. It seems that the patient finally assumed the function of validation of his competence himself, probably through identification with the therapist's similar functioning. With this development his confidence in himself as he conducted day-to-day matters grew more solid; with it he seemed to gain a significant increment in his overall sense of security. It is as though he now could say to himself with authority, "I can handle what life brings me."

*Prideful Enjoyment in One's Competence.* The therapist enjoyed the patient's competence, and this, too, was subtly conveyed. As it was with establishing value through superego functioning, so it was with taking pleasure or pride in the exercise of his competence. First he had to know securely that it was "real," valid; then he was in a position to enjoy it. This capacity, too, developed over time in phase III.

## Psychotherapy or Psychoanalysis for the Borderline Personality

The ideas presented here apply mainly to treatment in the setting of two- to five-times-a-week psychotherapy. Some analysts report successfully using the psychoanalytic situation for treating patients broadly described as borderline. Chase and Hire (1966), for example, employ analytic techniques along with some parameters, and Boyer and Giovacchini (1967) restrict technique to classical procedures.

I believe that very important elements of the treatment are analytical: the development of stable transferences, the use of spontaneous free association along with clarification and interpretation for gaining access to unconscious content, and working through in the context of transference and the living of everyday life. But treatment of the primary sector of borderline psychopathology also requires actual selfobject functioning by the therapist in addition to facilitation of the use and resolution of selfobject transference. In phase I, when the patient transiently loses the capacity to conduct his life safely, the therapist must set limits and otherwise participate in protecting the patient. As regression deepens, there is a need for the therapist to confront the patient with the fact of the therapist's existence and availability, as well as to extend his availability outside treatment hours in order to provide additional actual psychological selfobject holding. Providing transitional objects may at times be necessary, the effectiveness of which may depend on the actual functioning of the therapist as a holding selfobject. In

phase III various kinds of subtle selfobject functions are necessary to provide the experience out of which the patient can through introjection and identification gain certain autonomous capacities: to guide and approve of himself according to his ideals, to experience the validity (realness) of his personal qualities, including his competences, to provide himself with a sense of security, and to love himself affectionately. All of these crucial selfobject functions of the therapist fall outside the realm of classical psychoanalysis. More important, these selfobject functions in large measure are effected nonverbally, especially through facial expression and body gesture. As such, the face-to-face context of psychotherapy is facilitating, and for some aspects of treatment essential. For this reason I advocate psychotherapy for phase I of treatment of all borderline personalities. The psychoanalytic format can often be instituted sometime thereafter, depending on psychological qualities of the patient, the therapist-analyst, and their interaction. For borderline patients of higher-level integration, whose holding introjects are more nearly stable, psychoanalysis might be used throughout treatment. In some cases it could even be the treatment of choice.

## Aloneness, Rage, and Evocative Memory

Because of their importance for my thesis, I should now like to restate my clinical findings in terms of three key concepts: aloneness, rage, and evocative memory. Aloneness usually begins to become manifest gradually in the transference as the patient finds the therapist to be a good sustainer or soother. The therapist need not make direct efforts in this regard, for the patient senses that the reliable capacity to sustain is an inherent part of the therapist's personality. The patient relinquishes some of the defensive distancing which he has maintained in various ways to some extent in all relationships. Because he needs to, and sometimes because he has a tenuous trust that it is worth the risk, the patient allows himself to depend on the therapist for sustenance of the holding-soothing variety. As he does so, the extent of his felt need—which corresponds to the extent of his vulnerability to feeling abandoned—comes forcefully to his attention. To varying degrees this need feels overwhelming and uncontrollable as his dissatisfaction emerges that the therapist cannot gratify the intensifying longings that occur in treatment. Usually this feeling begins as an aimless, joyless sense of something missing from his life in the intervals between therapy sessions. Ultimately it develops into episodes of aloneness, preceded and accompanied by a rage that may not be conscious and therefore not verbalizable, felt within himself and

in the surrounding environment. And when this experience is intense and accompanied by conscious or unconscious rage, it brings annihilation panic.

I have found that this escalating experience almost always centers around being away from the therapist; it reaches such proportions in an uncontrollable way because the patient finds himself unable to remember the soothing affective experience of being with the therapist, especially as his anger increases. Sometimes he cannot even remember what the therapist looks like. He behaves as if he has largely lost evocative memory capacity in this sector of his life.

The therapeutic task is to provide the patient with an interpersonal experience over time that will allow him to develop a solid evocative memory for the soothing, sustaining relationship with the therapist. Clarification, interpretation, and sometimes confrontation are necessary in order for the patient to gain understanding of his frightening experience and make intelligent use of the therapist's help. Most crucial is the provision by the therapist of adequate support to keep the experience of aloneness within tolerable bounds as the underlying issues, including the patient's rage, are examined. Brief telephone calls to augment a faltering evocative memory are often necessary. At times a patient may need to phone several times a day simply to reestablish on a feeling level that the caring therapist in fact exists. When evocative memory fails more completely, extra appointments are necessary. If the failure is extensive, a period of hospitalization with continuance of therapy hours is crucial.

Clinically the therapist must constantly assess the patient's capacity to tolerate his rage so as to prevent regression to recognition memory or an even earlier stage. Activity by the therapist that defines the issues, clarifies the meanings and precipitants of the rage, and puts it into terms the patient can discuss also demonstrates the therapist's availability, caring, concern, and reality as a person who has not been destroyed by the patient (Winnicott 1969). The therapist's repeated empathic assessment of the issues around the patient's rage, while simultaneously demonstrating his own survival and existence, supports the patient's faltering evocative and recognition memory capacities. Here, too, hospitalization may be required when the therapist's activities in this area are insufficient to stem the sometimes overwhelming regression into desperate aloneness.

There is yet another way available to the therapist for helping the borderline patient maintain

contact with an affective memory of him during absences. It is one that seems specifically indicated in developmental terms, namely, the provision of a transitional object, which is so important to the infant during the time between his recognition of separation from mother and his acquiring the use of evocative memory as a way of maintaining a sense of her soothing presence. Transitional objects specific to the therapist can be useful at these desperate times: the therapist's phone number on a piece of paper or the monthly bill (which the patient may carry in his wallet for weeks at a time). During vacations, a card with the therapist's holiday address and phone number usually are not used in order actually to contact the therapist but, rather, are carried as activators of memories of the absent therapist, just as the blanket is used as an activator for remembering the feel of mother by the infant who has as yet acquired only recognition memory. Fleming (1975) described how, in retrospect, she became aware that asking a patient to monitor his thoughts while he was anxious over weekend separations was a way of helping him evoke her image. I know of several patients who have spontaneously kept journals about their therapy. Through communicating with their journals they activated the feelings associated with being with the therapist.

Whereas Mr. A. could always recognize the therapist once he heard his voice or saw him, that is, he could regain his affective recognition memory of, and sense of support from, the therapist, some borderline patients regress to the point that even when they are with the therapist they are unable to feel, that is, to "recognize," his supportive presence—despite that fact that they can identify the therapist as a person. I have also noted that when treating a colleague's borderline patient during the colleague's vacation, my primary, often sole task is to help the patient retain evocative memory of the absent therapist through talking about details of the patient's experience with him.

The recognition memory-evocative memory framework can be a useful way of defining issues in the process of change in psychotherapy. It can be utilized to monitor a major task in psychotherapeutic work: the goal of helping the more primitive patient achieve a solid use of evocative memory that is relatively resistant to regression. Once the capacity for affective evocative memory for important relationships is firmly established, the patient may be considered to have reached the narcissistic personality to neurotic spectrum.

## Summary

In Chapters 1 through 4 we have seen that the primary sector of borderline pathology involves a relative developmental failure in formation of introjects that provide to the self a function of holding-soothing security. This developmental failure is traced to inadequacies of mothering experience during separation-individuation. Holding introjects are not only functionally insufficient but also subject to regressive loss by virtue of the instability of the memory basis for their formation. Because they are functionally inadequate to meet adult needs for psychological security, the borderline personality is constantly subject to degrees of separation anxiety, felt as aloneness, and is forced to rely on external holding selfobjects for enough sense of holding-soothing to keep separation anxiety relatively in check—to avoid annihilation panic. Incorporation and fusion are the psychological means of gaining a sense of holding security from selfobjects. Because of the intensity and primitive level of his pathological needs, the borderline personality unconsciously believes that incorporation and fusion also carry with them the threat of destruction of selfobject and self. This belief, along with vicissitudes of rage arising out of unmet need, makes it impossible for the borderline personality to maintain the kind of steady closeness with holding selfobjects in adult life that is necessary for developing a solid memory base for formation of adequately functioning holding introjects.

Psychotherapy for his primary sector of psychopathology proceeds in three phases. Phase I involves regression, with emergence of marked separation anxiety and rage, transient regressive loss of function of holding introjects and transitional objects, and emergence into consciousness of impulses and fears associated with incorporation and fusion. Clarification and interpretation, limit setting, actual provision of selfobject holding at a psychological level, and proof of indestructibility as a good object are the means by which the therapist enables the patient to understand and work through the impediments to the use of him as a holding selfobject. This accomplishment frees the patient to develop holding introjects based on experience with the therapist along with other past and present experiences with holding selfobjects. These introjects are, however, unrealistically idealized in terms of holding. Phase II is concerned with modification of this idealization through a series of optimal disillusionments with the therapist as holder-soother in the context of a selfobject transference. Relinquishing the idealization compels the patient to develop additional internal resources for security, ones that do not necessarily promote a feeling of holding-soothing but that provide various qualities of experience of self that contribute to a

sense of personal security. Through various forms of subtle selfobject functioning, the therapist provides the patient with experiences out of which he can, by introjection and identification, develop autonomous capacities not only for feeling soothed and held by means of his own, but also for feeling the reality of his personal qualities, sensing his own self-worth, enjoying his qualities and competences, and affectionately loving himself.

*Notes*

1 Object love is differentiated from narcissistic love in that object love is attached to qualities of the object that do not necessarily serve purposes for oneself and are not vicariously felt as if one's own; the reward of investing with object love is simply the experience of affectionately loving the other person. Narcissistic love centers around qualities of worth and survival that involve qualities of oneself, or qualities or functions of another person that are felt as enhancing personal value and survival. Although love feelings may be associated, narcissistic love is rewarding only insofar as self-experiences of worth and security are somehow enhanced.