CHAPTER 23

The "Unreasonable" Patient and the Psychotic Transference

Peter L. Giovacchini

THE "UNREASONABLE" PATIENT is a familiar example of a borderline personality disorder, although within that category there are many possible variations. Their common denominator is the psychotic aspect, which intrudes into the analytic setting. From a therapeutic perspective, this represents a reasonable consequence of the unfolding of the transference as primitive parts of the self are projected onto the imago of the分析师. Nevertheless, this progression in the context of the transference regression may cause serious difficulties for the therapist as he finds himself facing what appears to be an unreasonable patient.

THE UNREASONABLE PATIENT

Certain difficult situations in treatment may strain our capacities to preserve the analytic setting. This transference repetition is essential for analytic resolution, but with some patients its very nature seems to preclude analysis. These patients assert the right to be unreasonable. looked at in a certain light, this claim is reasonable, but it can be difficult to keep in mind.

For example, a young married woman from the very outset of treatment could not tolerate the idea of my ever leaving the city, for whatever reason. During one of our first sessions, she told me that she needed me to be around and that if I absolutely had to leave she would have to know far ahead of time—and even then the pain would be unbearable. I told her about my next trip, which was several months in the future, and she indicated that she was both angry and anxious about it. As the time approached she spent more and more time talking about my projected departure. During the session two
weeks before my leaving, she talked about nothing else. My trip entailed missing only one session, but the patient was furious.

The same pattern continued, although her feelings gradually became less intense. I had not appreciated the full meaning of her anguish until the following incident. At the time I was seeing the patient daily, except for Sunday. Quite unexpectedly, I had to be out of town. I had not told the patient ahead of time since I myself did not know I had to leave until the last minute. Anyway, I saw no reason to tell her because it made no difference in our schedule. I would be leaving after her last appointment on a Saturday morning and would return Sunday evening, before her next appointment on Monday. I also realized that I wanted to be spared her abuse. I was not, however, to be spared.

When she came in for that Saturday session, she immediately asked me where I was going. I was dumbfounded. I wondered how she knew! She replied that I was better dressed than usual, indicating that I had something else better to do than just seeing her. Furthermore, I had the look of anticipation of someone who was going to be involved in an activity that was different from the usual routine. She then went on to lecture and scold me for not understanding that she simply could not tolerate my being away and if I insisted on thwarting her she had to know exactly where I would be. With exasperation, I retorted that her attitude required that I remain in one place 24 hours a day, seven days a week. She calmly replied, "Of course."

Somehow her natural response forced me back into a therapeutic frame of reference. I realized that from her viewpoint, she was being quite reasonable. This was a woman whose structural defect made it difficult for her to form and hold mental representations without the reinforcement of the external object. The external percept of me in my office was one she could structure in her memory system, but having me away from the familiar environment created a decathexis of me as an internal object representation. Because this loss was equated with infantile abandonment, it could lead to uncontrollable rage and overwhelming terror.

This woman experienced both my leaving and my return as painful. It is understandable that the loss of a mental representation would be painful. However, my return was equally, and at times more, painful—then my presence was felt as assaultive and intrusive. For two reasons she found it difficult to form an internal object representation of me as I represented the analytic setting.

First, having lost what we might call the analytic mental representation, she no longer had any internal frame of reference that would permit her to integrate within her ego external percepts of the analytic interaction. Thus, she viewed me as a stranger, and an intruder, in much the same way as an infant reacts with stranger anxiety when facing a person other than his mother, a person for whom the baby does not have a corresponding internal object rep-

resentation. In a sense, my presence was incomprehensible—it took time and trust for it to be integrated within her ego system.

Second, in addition to not being able to integrate my presence, the holding quality (Winnicott, 1960) of the analytic interaction would also be lost. The holding environment that is the product of primary maternal preoccupation (Winnicott, 1956) is unwavering and constant. It surrounds the infant completely and is timeless. In fact, its continuity is assured because of its constancy. Any departure by the sustaining person is experienced as an irreparable breach of fundamental support. Even if my patient could accept my return, she could never feel secure that I would not abandon her again—an intolerable situation, reminiscent of the unpredictable abandonments of the infantile environment.

My patient would frequently assert her "right to be unreasonable." In her outside life this would often create problems. Once, for example, she went to a party and locked herself in the bathroom and refused to leave. On another occasion she cut her blouse into strips and then locked herself in a closet. These were further examples in which, with the addition of some bizarre elements, she insisted on remaining in a particular setting, one in which it was unreasonable to expect to stay indefinitely.

She reminded me of patients I had seen in the past who described themselves as being empty and unable to fill the void they felt within themselves (Giovacchini, 1975, 1984). These are subjective states, but they are reflections of how the self-representation is formed and its comparative lack of psychic structure. Another patient, who was not as overt in her expression of voracious needs, summarized her psychic state in terms of privation.1

My patient stated that if one has never experienced gratification from a nurturing mother during infancy, an immense amount of giving will be required to make up for this primal deficiency. Together, we were able to formulate the situation with an elementary mathematical analogy: If we want to convert zero into a quantity, such as the number 1, we would have to multiply it by infinity. These are indeterminate relationships that simply translate into: If we want to get something out of nothing, we have to fill in nothing with everything. This zero-infinity sequence, in terms of psychic structure, expresses how the ego turns to the external world to cope with privation. The lack of internalization of satisfactory nurturing relationships creates an unbearable situation, which can be experienced in different ways. Rather

1 I use Winnicott's (1963) definition of privation as an early ego state that has experienced very little gratification of basic needs; consequently, there are very few memory traces of gratifying experiences. Winnicott contrasts privation with deprivation, the latter being an ego state that has fairly well-developed memory traces of such experiences. Thus, the infant feels frustration because he has known gratification. The infant in a state of privation cannot feel frustration because there is no internal registration of a satisfactory response that creates longing and is then thwarted. Privation can never be total; if it were, the infant could not survive.
than feeling frustration, which requires mental representations of at least partially satisfactory experiences, these patients describe an inner feeling of "disruptive emptiness." They are aware of an inability to be satisfied, but this takes peculiar forms. Some borderline patients describe an uncertainty about whether they are alive or dead. The capacity to receive satisfaction and the sense of aliveness are related.

Instinctual satisfaction and the endopsychic registration of satisfactory experiences lead to the acquisition of psychic structure, including the establishment and further structurization of needs. The needs of borderline patients are imperfectly developed, inasmuch as they suffer primarily from privation. Since they have little internalization of gratifying nurture, which includes all caretaking activities, basic needs as discretely felt impulses do not become established and undergo emotional development. Some borderline patients complain of not knowing what they feel. They cannot distinguish inner sensations. Many literally do not know whether they are hungry or thirsty, have sexual feelings, or need to defecate or urinate. Instead of being aware of the inner source of their perceptions, they simply experience a generally vague sensation of discomfort. Thus, their demands represent an attempt to achieve responses that might help them define their needs. To the outside world, this is puzzling because most of us are accustomed to the sequence of the need creating the response rather than the reverse, the response creating the need. From one frame of reference this strikes us as unreasonable, but for some borderline patients fixed at early psychopathological levels of privation, this is eminently reasonable.

As infants, borderline patients experienced an unreasonable and unpredictable world. It was unreasonable, in part, because it was unpredictable. The early world of the borderline infant was not ordered and organized around needs, which at the beginning were dominated by biologically determined circadian rhythms. In a sense, the child did not know what to expect and consequently developed no assurance of being able to contain feelings, which become painfully disruptive. What could have been the pleasurable excitement of anticipated gratification intensified to chaotic agitation.

The demand that the therapist be constantly available, besides being a need determined by the patient's inability to hold a mental representation without external reinforcement, also represents an attempt to maintain continuity and to make the external world predictable. This is a reparative activity.

The patient who reacted violently when I took trips had never known continuity. Her early life had been characterized by a series of abrupt events; there was no bridge or transition from one experience to another. If she could perceive herself as being constantly with me, she did not lose her mental representation because I would in a sense be always there to reinforce it; but, at the same time, there would also be no discontinuity, since I would be constantly present. In an inconstant world, events are experienced as a series of impacts. In many instances, the unreasonable patient is trying to construct a predictable world out of a confusing and unpredictable one.

THE PSYCHOTIC TRANSFERENCE

The borderline patient's transference may have psychotic elements. The following case illustrates some pertinent features of the development of such a transference and can be considered an extreme example of an unreasonable patient.

The patient, a 30-year-old married woman, had been bedridden several months before our first appointment. She lay in bed all day, moaning and reproaching herself for her ineptness. She literally tore her hair as she wailed and lamented. When I first saw her, I knew nothing of the circumstances of her decompensation and was able to place them together only after several years of treatment. Briefly, an aunt who had been literally directing her life remarried and left the city, leaving her to rely on her own resources. Her almost total dependency on this aunt was far from obvious, and those close to her did not recognize how meaningful and life sustaining that relationship was for her.

The patient started treatment in a noisy, stormy fashion, pleading with me to help her, to save her. But, there was no substance to her questions and demands. Even if I had been inclined to respond, I would not have known how. I have discussed this type of patient in another context (Giovacchini, 1975, 1984), where I emphasized that the patient's basic helplessness, which causes the analyst also to feel helpless, derives from a lack of memory traces of satisfactory nurturing experiences—in other words, privation. This patient revealed that her mother had had a postpartum psychosis, which led to hospitalization, immediately after the patient's birth. The patient was reared by a series of cruel or indifferent maids, and she never saw her mother.

Probably she was somewhat autistic during her childhood. She was unable to remain in school and was sent to a residential treatment center. She had a total amnesia for her life up until early adolescence. Others told her that she did not talk until she was seven years old and was totally withdrawn from her surroundings. She did not relate to adults or her peers.

Her aunt entered the picture when she was hospitalized from the residential treatment center because she was starving herself to death, apparently suffering from anorexia nervosa. The aunt, a widow, took her out of the hospital and installed her in her house and vigorously looked after her.

This information was gathered in bits and pieces during treatment, and the sequence of her life events was to some measure repeated with me. For example, while being cared for by maids, she was reportedly uncontrollable. She cried all the time and could not be soothed. Her caretaker would not remain
very long, and another maid would soon take her place; she began treatment in a similar fashion, crying, screaming, and inconsolable. After infancy, she became autistic. The first period of treatment recapitulated the noisiness of infancy followed by a period with autistic features.

As she began, she thrashed around on my couch and frequently made sudden jerky movements that resembled convulsions. She demanded to be filled up; she felt as if she were an empty, hollow void that could never be filled. This noisy period continued for about six months and was followed by an apathetic, withdrawn state, that reminded me of her childhood autism. She acted and described herself as if she were numb. She still believed that her appointments were important but nothing really mattered. Rather than being depressed, she displayed a blunting of affect. She felt no pleasure, but she also felt no pain.

She had the following fantasy: She is on the moon and walking on a barren stretch of land. Finally, she is at the foot of a hill facing a cave. A hollow mysterious voice within the cave calls her name. She walks into the cave and tries to touch the owner of the voice, who she believes is God. However, she can hardly see him, for he is only a transparent mass of ectoplasm. He extends his hand to give her a loaf of bread, but she cannot grasp it because it is not solid; it is just an apparition.

The fantasy was with her practically all the time but it did not cause her to feel depressed. She was resigned to her fate and just felt numb. I pointed out to her how sad she made me feel by putting me in a position in which I could not help her. I could not symbolically nourish her. She was surprised that I would be sad. She acknowledged that I was failing her, but my caring about my failure was a new experience for her.

Gradually, after slightly more than a year, she began to show some feelings of comfort during our sessions. She revealed to me that previously she had vomited everything she ate, but now she was beginning to hold food down. I noted that she had gained a little weight and was showing some interest in eating. Apparently, she had become less helpless in the outside world and to occupy her time had joined a friend in opening a small boutique. She had affectionate feelings toward me and said that, for the first time in her life she knew what it meant to be gratified.

The peaceful calm she experienced lasted only a few months. Her attitude toward herself and others, especially her business partner, changed from dependency and trust to anger and suspicion. She now complained constantly during her sessions. She found life increasingly difficult and talked incessantly about her inner pain. She began voicing her dissatisfaction with me because I was not helping her and protecting her from her partner.

One day she announced in an emphatic voice that this was going to be her last session. At first I was caught off guard, not knowing what was going on. She reviled me—I had been absolutely useless; I was selfish, insensitive, a chauvinistic misogynist, stupid and incompetent. Although in previous months she had expressed some negative feelings, the suddenness and intensity of her attack had an impact on me. She claimed that I had been especially remiss toward her because I had not foreseen how badly her partner would treat her.

She especially attacked me for not having dissuaded her from going into business with her partner. I should have foreseen what would happen. I realized that she was blaming me for everything that had happened to her. I tried to console myself by trying to understand her reactions as transference, but I found my anger mounting. I reached a saturation point and expressed my feelings.

I told her in an angry voice that I would not accept her accusations. I could perhaps understand her need to view me in such a destructive fashion, but I would not accept responsibility for all the pain and misery she had suffered throughout her life, I denied that I had been insensitive to her needs. She seemed to ignore what I said and rebuked me further for having failed. I ended the session by shouting that I did not want to put up with her provocativeness any longer (I probably called her paranoid). She was frightened and practically ran out of my office.

I tried to rationalize my loss of temper as having therapeutic benefit. I thought of it as something analogous to a transference interpretation. The patient would note that I could accept her projections only to a certain degree. My nonanalytic response would represent reality, a response to the irrationality of her allegations. She could then separate me into two components: the analyst who accepts her projections and the nonanalytic reality that does not. My being provoked also meant that I would not allow myself to be destroyed by her hatred by helplessly and passively accepting it. I would fight back and survive her. She would also know that she was capable of having an impact on me.

These explanations made me feel better, but, for the most part, they turned out to be incorrect. I was half-expecting her to return to treatment, but she did not return until a year and a half later, when she called and timidly asked for an appointment. I was immensely curious to know what happened to her during the last 18 months, and I was also eager to understand more about what had been going on in our relationship. I had stopped believing that my angry reaction had any therapeutic benefit whatsoever.

When she came in, she immediately reclined on the couch and began to tell me that she had missed her analysis. Then, somewhat to my surprise, she started reviling me for having failed her. Once again, she referred to my inability to protect her from her business partner and to my being the cause of all the pain she had experienced throughout her life. She was still in business with the same partner; nothing fundamentally had changed.

She insisted that I had failed her and that I was the cause of her pain. I re-
called how her mother had failed her by totally abandoning her. What she
now felt could be the repetition compulsion as it was recapitulated in the
transference. I also began to understand how her psychotic transference had
some foundation in the reality of our relationship. Prior to treatment she had
not experienced pain in an organized manner. She had felt agitated or numb,
but these were more primitive, amorphous feelings than anger. To feel pain
was an achievement of the analysis, but she could justifiably, in a sense,
blame the analysis for this achievement.

Since I had first introduced her to pain, I became the logical target of her
anger. True, during the session in which she terminated, I had reacted as she
might have feared to be the consequences during her childhood—that is, I
lost control and could have been viewed as dangerously destructive or as hav-
ing been destroyed. She was frightened by me, but her fear was only momen-
tary. She had faith in both of us surviving the episode, and she derived some
pleasure at being able to affect me to such a degree. This was markedly dif-
ferent from the vulnerable situation of infancy. She was in the throes of the
repetition compulsion, but she was also trying to master the helplessness she
had felt and to take further corrective steps by expressing an anger that she could
not, at that time, handle.

Viewing her behavior in such an adaptive and constructive manner made it
much easier for me to deal with my countertransference feelings. Still, she
was, from time to time, able to irritate me—I occasionally felt impelled to
argue with her, usually when she reviled me for not having protected her
from her business partner. In general, I felt she was nagging me, but I could
maintain my therapeutic perspective as I saw this element of her psychotic
transference as representing a repetition of the failure of an early environ-
ment that should have protected her from external disruptions rather than
abandoning her. The situation became more bearable when I realized that
sometimes I was being reproached for not having said what I in fact had said.
She would, for example, lecture me by insisting “Well, you should have said
such and such,” and I would be astonished because I had said it and she was
using exactly my words and expressions. By now I had lost my inclination to
argue with her and protest that I had not been derelict, because this would
have been defensive and meant that I wanted her to stop criticizing me (which
to some extent was true). Rather, I marveled that she had been able to make
some elements of our interaction her own, that she had integrated them as
part of herself and lost sight of the external source.

I will not pursue further the course of this analysis except to report that she
was finally able to understand her feelings and attitudes in terms of the reper-
tition compulsion and her attempts to achieve mastery over the traumatic in-
fantile environment. When treatment was terminated, we were both pleased
with the very visible progress she had made.

DISCUSSION

The transference of patients similar to the woman I discussed repeat the
traumatic failures of childhood. This type of transference may have psy-
chotic features.

It may seem extreme that I imply that all patients suffering from primitive
mental states will develop psychotic transferences. This is a matter of degree
and depends on how real the feelings toward the therapist are to the patient.
Inasmuch as these borderline patients have poorly established boundaries
and time sequences are imperfectly perceived, frames of reference become
easily confused. The past and present are not well distinguished from each
other.

The transference can be separated into two components. Patients project
feelings, impulses, and parts of the self into the analyst. They then react to
the transference relationship with the help of infantile defenses and adapta-
tions. In order to do so, they have to create an ambiance that will support
these defenses. Elsewhere (Giovacchini, 1975, 1979) I have called the creation
of this ambiance externalization, which I contrast to projection.

From a technical viewpoint, the analyst makes himself available for the
patient’s projections. He does not require any special technique; he simply
maintains the analytic setting. The setting, however, clashes with the pa-

tient’s attempts to externalize the infantile milieu. As the patient learns to dis-

tinguish the analytic ambiance from the infantile ambiance, he is unable to
maintain his projections with any firm conviction. Instead, he analyzes them.
(We need not pursue this topic further because the working through process,
although still imperfectly understood, has been frequently discussed.) I am
emphasizing how the analytic setting, which is different from what the pa-

tient has ever known throughout the course of psychic development, causes
the infantile ambiance to stand out in sharp contrast. If the patient cannot
distinguish the two environments, then we are faced with a psychotic trans-

terence. Again, I remind the reader that this is a matter of degree. To some
measure, all patients want to merge the analytic setting with the world of
infancy. The extent to which they succeed will determine how psychotic the
transference is. The firm establishment of the past in the analytic present also
indelibly fixes the projection, and the analyst, in the patient’s eyes, really is,
at least functionally, the caretaking person who failed him.

CONCLUSION

I have focused on a type of borderline patient commonly seen in analyst’s
offices. These patients often tax the therapist's tolerance to the utmost be-
cause they vociferously claim their right to be unreasonable. Inasmuch as the infantile environment was unreasonable and unpredictable, they repeat these early constellations in the context of transference and the repetition compulsion.

The psychotic transference usually creates a difficult management problem. However, as is true of delusions in general, there was a core of reality to transference of the patient I described. She felt that I was the cause of all of her pain and misery and that I did not adequately protect her from being exploited by her business partner. Throughout the course of treatment, the patient developed a minimal capacity to experience gratification and was able to feel intense pain for the first time. From one viewpoint, she was correct when she accused me of being responsible for her pain.

The psychotic transference is bound to stimulate disruptive countertransference reactions. Whatever the analyst's particular character structure contributes to these reactions, the understanding of the adaptive features of the patient's transference attitudes makes it easier for the therapist to maintain his analytic identity. These difficult patients demand that we cling strictly to our belief in psychic determinism.

REFERENCES


