My Work with Borderline Patients

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Chapter 9

Image of the Therapist
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in the Patient
The Development
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and of this book.

Touched upon here have also been dealt with in chapters 1, 2, 3.

I shall discuss here some of the difficulties
It seems widely agreed that the borderline patient, until he is relatively far along in therapy, has difficulty in maintaining a stable, internalized image of the therapist between sessions. LeBoit (1979) makes a statement which, although perhaps considerably oversimplified, is relevant here:

A number of authors now hold the position that the process of cure with the borderline patient comes about through the introjection of a healthier object, replacing the pathological parental object. As the patient will not surrender his internal bad objects until the analyst becomes a sufficiently good object for him, the success or failure of the treatment hinges upon this transposition. . . . The analyst . . . serves . . . not only as a transference object, but also as a new parental model for the patient to identify with and to internalize (p. 24).

On the one hand the borderline patient is spared, by his lack of well-established internal images, from normal grieving; as one man was able to say still, after several years of treatment, “I don’t miss anybody. . . . I never miss people. . . . I don’t feel unhappy when I’m away from anyone.” But on the other hand, such a patient’s lack of a firmly internalized image of the therapist makes the patient prone to feelings of panic lest the absent therapist has gone out of existence entirely. Such patients tend typically to make between-sessions telephone calls to the therapist, for needed external feedback affirming for the patient that the therapist still exists in the patient’s external, if not internal, world. Similarly, when the patient arrives for a session after a brief interruption in the therapy, he has difficulty in shaking off a sense that the situation, and the therapist, are strangers to him.

It is similarly widely agreed that, in the context of the session itself, such a patient needs relatively much visual and auditory feedback to sustain his tenuous internalized image of the therapist. But it is in the context of the sessions that therapist and patient have their best opportunity to explore the largely unconscious internal contents, in both participants, related to the patient’s difficulty in this regard.

The Patient’s Split-Off Hatred Toward Any Nascent Internalized Image of the Therapist

When one man said, “I hate myself; . . . I feel like chewing myself up and spitting myself out!,” I heard this as an expression of unconscious ambivalence toward not only his “self” but toward such internalized images of me as he had so far developed; on the one hand he wanted to chew them up (as if to ingest them), but on the other hand he wanted to spit them out. When, a few days later, he said, literally hissing with intensity, “I look at myself and I can’t stand it! I just wanta spit myself out!”, I felt I was seeing something of the intensity of the hatred still directed at his internalized images of me, such that these images did not survive well the interims between sessions, nor survive reliably during the sessions themselves.

One woman would turn and look at me before leaving, at the end of each session, in a strange fashion which gave me to feel that she was mentally photographing me, as if to hold me, thus, in her mind until the next session. Another woman said, “The only way I know a person is there—that a person exists—is, I have to keep a person in mind, or the person dies, the person disappears.”
The Patient's Subtly Autistic Unrelatedness; Unintegrated Oedipal Rivalry as One of the Determinants of This

These patients have learned, long since, to pretend to participate in interpersonal relationships much more fully and consistently than is actually the case, and have become so skillful in so doing that it is difficult for the therapist to discern those times when the patient has taken refuge, unconsciously, once again, in autistic unrelatedness. The patient may manifest his less-than-full relatedness by arriving late and then referring, significantly, to himself as being late, still many minutes along in the session after his actual arrival—indicating that, although physically present, he has not yet arrived fully, in a psychological sense.

In one's work with a borderline patient who has become, at a conscious level, relatively well related with the therapist during the session, but who experiences the times between sessions as being stretches of bleak unrelatedness with anyone, I have found this understandable in terms of the splitting so characteristic of borderline patients: the unrelatedness which is being dissociated during the session itself is displaced into the interim between sessions, and needs to become discovered by the two participants as being at work, subtly, during the sessions themselves, sessions in which both patient and therapist have felt, heretofore, that they were involved in a relatively strong, and even intense, interpersonal bond with one another.

In Chapter 1, I mentioned that whereas in some borderline patients, symbiotic processes predominate, in others, subtle autism is more dominant. Thus, one woman patient is silent for long stretches of time while lying on the couch, for the reason, so it becomes evident, that she has become fused with me in my silence. And on the other hand, a relatively talkative man is belatedly discovered to be subtly exiling me upon his assuming the couch, such that throughout the session itself, at an unconscious level he is alone in the room throughout.

In Chapter 5, I have pointed out that the borderline patient's autistic non-relatedness, in the transference, has one of its etiologic roots in his oedipal rivalry: he has fostered, unconsciously, a state of unrelatedness between himself and the therapist such as prevailed—so his oedipal ambitions would have it—between his own two parents whenever those two were alone in a room together. One such patient said, "I just can't picture my parents together; they never seem to be on the same wave-length" (Searles 1979a, p. 362).

The Therapist's Struggle to Develop a Stable, Internalized Image of the Patient

It seems to me unrealistic to expect the patient to develop a stable, internalized image of the therapist unless, and insofar as, the therapist has proved able, first, to have developed such an image of the patient. For a variety of reasons, this is a formidable task for the therapist.

The patient's need to project his own dissociated internal contents into the therapist is so intense as to interfere not only with his own development of a stable, internalized image of the therapist, but also with the therapist's developing a comparable image of the patient. One of the reasons why this need to project is so intense is that much of the patient's dissociated experiences, or introjects, have important roots in his preverbal history. These experiences are so verbally-inarticulable that the patient can communicate them, predominantly, only by projecting them into the therapist and giving the latter, thus, to experience them at first hand. To the extent that this aspect of the therapeutic inter-
action succeeds, the therapist with his relatively strong ego becomes able to experience these in awareness, and express them in appropriate words, as relevant analytic data for shared work with the patient. Many of these feeling-states are so strange, so complex and paradoxical, that, the therapist finds, even a relatively healthy person can scarcely, if at all, find words to express them. In my work with such a patient, whereas for years I used to be intensely exasperated with her for being able to say only that she felt “nervous,” as I came to experience within myself the indescribable feelings she was largely warding off and projecting into me, I came fully to appreciate why she had felt so helpless to articulate what she, on occasion, was experiencing.

I hope to be conveying, here, something of how the patient’s need to project into the therapist, as a primitive means of communicating these primitive feeling-experiences, works powerfully against the therapist’s being able either to remain steadily available for the patient’s developing a durable introject of him, or to develop a stable, realistic, internalized image of the patient. One could surmise, also, that the patient’s mode of communicating thus has, as one of its additional determinants, the effort to ensure that the therapist not durably exist, in psychological reality, for such introject-formation. We glimpse here, I believe, how very ambivalent is each of the two participants concerning the development of an internalized image of the other one.

The unaccustomed, for the therapist, nature of many of the borderline patient’s transference-reactions and -attitudes toward him is another major difficulty in the therapist’s development of a stable internalized image of the patient. These transference-phenomena are often so threatening to the therapist that he tends unconsciously to flee from the developing transference-role in question or, if he starts to become aware of it, to interpret it prematurely as putting this hot potato, which he himself cannot endure, back into the patient’s lap, as it were.

My (Searles 1960) first book, The Nonhuman Environment in Normal Development and in Schizophrenia, describes as a universal human struggle the endeavor to become subjectively human, as distinct from the surrounding nonhuman environment, and to become able to differentiate one’s fellows as human, also. The borderline individual, like the frankly psychotic one, is much involved in such an identity-struggle and, in his typical transference-responses to the therapist, invests the latter with various of the patient’s own subjectively nonhuman personality components. Thus, in one’s work with the borderline patient, one finds that the patient’s transference-reactions are not predominantly to one as being a single and whole and alive and human being, but rather to one as something less than, or other than, human. Margaret Little (1966), in her paper, “Transference in Borderline States,” says of one of her patients that “in fact to her I was her eczema, the source of all her troubles and the prime cause of the general ineffectiveness, loneliness and despair which had brought her into treatment; I was the loneliness itself, and also, as appeared later, her mother’s loneliness, anxiety and despair” (p. 476).

One woman reported a dream of a woman who seemed to alternate between being dead and being alive; and in the session, her associations made clear that this woman represented me in the transference. Another woman, whom I interviewed before a group of psychiatric residents, replied, when I asked her something about her mother, “The first thing about my mother is that she’s dead,” and, although this was literally now the case, several of the residents present had the sense, as did I, that the patient had perceived the mother so even while the latter had been alive. When I asked a man, during one of his analytic sessions, whether
he had ever confided in his much-elder sister anything of the area of concern which he was presently exploring, he reacted with a degree and kind of shock which helped me to realize that, for him during his childhood, his sister had been psychologically dead, and that many of our more moribund sessions had to do with his transference to me as being that “dead” sister.

Many borderline patients have had a parent who was frankly psychotic. One such woman reported to me, several years along in her analysis, that the thought had just occurred to her that “Maybe you’re *not* crazy, after all.” For years, theretofore, I had had to live, alone, with the knowledge of her unconscious transference to me as being crazy; only now did she realize that she had unconsciously so regarded me, all along.

As I described in Chapter 4, the borderline patient’s ego-functioning tends to be, at an unconscious level, dual or multiple in nature; hence many of his transference-reactions cast the therapist as being two or more persons simultaneously. I customarily sit in a corner, in analytic or therapeutic sessions, behind the couch, and I found it notable when one woman reported a dream in which she was in a bus station where “over in one corner there was this, uh, man and woman, ...”. A man, while lying on the couch, was reporting a dream in which, “... I really thought these two men back of me were going to catch me, ...”

Another category of borderline transference-phenomena involves the therapist’s being one or another of the patient’s psychopathologic symptoms. One man said, on the couch, “There’s this load on my back [sic] of murkiness about my future years, this cloudiness, this terrible suspense....” Earlier in the session he had reproached me for my sitting silently, back there, while he was having to do all the work. Another man who likewise lay on the couch while I was sitting behind him, was saying of his life at home currently,

“The depression just sort of sits there and sooner or later overwhelms me.”

A woman reacts to me, unconsciously, as being the carbuncle which, in childhood, had afflicted the back of her neck and nearly killed her, and which she is afraid will materialize there again.

A man says, consciously referring to his relationship with his eldest son, “I’ve never seen a father-son relationship like this [N.B.]-it’s already dead; it just sits there....”

Another man unconsciously equates me with his electric blanket which, during the night, he can turn up or down; this is in line with Modell’s (1968) description of the borderline patient’s transference to the analyst as being a transitional object, and is one of many clinical examples, in my experience, in which the therapist is unconsciously equated with, or perceived as fused with, some inanimate object. Such “inanimate” transference-perceptions are referable in part, of course, to the patient’s unconscious identity-aspects as being subjectively inanimate. One woman gave a fleeting glimpse of her own subjectively inanimate identity in saying, with a tone of futility, “I can’t see my way out of this situation at the office; it’s up to other things [N.B.; then, as if to obscure what she had revealed, she added hastily]—and other people, ...”

A man in reporting a dream detailed that “while I was on a bus, it just abruptly switched to you—we were facing each other and you said, ‘Now, Bill....’ When he said “it just abruptly switched to you,” he clearly meant, consciously, that the focus of the dream had switched to me; but what he conveyed, unconsciously, at this moment in the dream-narration was that the bus had switched to—that is, turned into—me. His need for me to serve as a firm holding environment (such as a bus) was evident many times over the years of my work with him.

Another man reports, in the present tense, a dream in
which he inadvertently causes some damage to the building in which my office is located, “and I'm in a panic that you're gonna be enraged and the building is gonna be enraged [my italics] and everything. . . .” His phrase, “the building,” evidently is consciously intended as an abbreviated way of saying, “all the people in the building”; but the affective tone of his italicized statement conjures up, nonetheless, the sense of an erstwhile holding environment (the building) which has become murderously rageful toward him.

I hope that the presentation of these typical examples of borderline transference, presented here in an inevitably relatively glib and superficial manner, something like a stroll through a zoo, will nonetheless serve to convey something of how intensely uncomfortable, for the therapist, are such transference-roles, especially when—as happens more often than not—they are the product of intense and sustained, dissociated emotions on the part of the patient. It is important to realize that, when the nature of the transference eventually emerges with the kind of clarity I am describing in these examples, the therapist has reason to feel much relief that long-subterranean responses on the patient's part have surfaced at last, into a relatively conscious realm where they can at last be seen by both participants, and explored mutually.

A woman says uneasily, at the beginning of a session, “I dunno; as I was lying down, I had some sense of your being like an apparition—spooky, in some sorta way. . . .” She went on to describe that, during the previous night, she had awakened, screaming for help. Another woman, after reporting an unearthly kind of dream, sensed me as being (there behind the couch) an unseen, malevolent deity, bent upon destroying her. A man, lying uncomfortably on the couch, was talking in an attemptedly philosophical, but actually whistling-past-the-graveyard manner, and said, “There's always the death in the background. . . .” I had reason, from many quarters, to hear this as an unconscious reference to me, sitting behind him.

Various patients have conveyed in various ways that I, sitting behind them, personify their past, or attributes of their past. One woman said, “I didn’t have the guts to burn the bridges behind me.” Another says, “Whenever I feel at all nostalgic, I try to put it completely behind me.” A man, long involved in an unhappy marriage, says, “My past has always been a ball and chain I’ve had to drag along behind me.”

Another man is saying, of his troubled relationship with his son, “. . . I don’t want my anger at him—[pause]—to get in the way of his developing more self-confidence. . . .” Various clues too numerous to present here indicated to me that, at this juncture in the work, I represented to him, unconsciously, his unwanted anger at his son.

A woman clearly manifested, in one session after several years of analysis, a transference to me as being her feelings—not merely certain of her feelings, not only her unconscious feelings, but all of her feelings. My notes state that “Part of the data was that, without me—I'll be away tomorrow—she has submerged panic lest she lose all feelings, and she reports ‘an urge to grab you’ in order to be able to feel.” This woman and I had accomplished much together, by then, and I felt that she had progressed farther, at this point, than an early borderline patient of mine who had reported happily, one morning upon coming to her session (now many years ago), that she was carrying her feelings with her, in her purse. I do not believe I had dared, at that relatively early time in my psychoanalytic career, to become as important to her, and know that I had become as important to her, as was the case in my work with this much later patient, all of whose feelings I personally had come to embody, for her, in the transference.

Another woman, who had progressed far in her analy-
sis, said, in a light, chatty manner, while I remained silent, “One thing I like about coming here is that it makes my mind work. My mind is inclined to sit back and do nothing— whoops! [brief, amused laugh]—not you—Are you my mind?

A man, whose language showed many identifications with that of his immigrant father, reported to me, sitting behind him, “I was thinking in back of myself [my italics; he clearly meant this, consciously, as equivalent to “in the back of my mind”]. ‘Why are you having such a hard time getting this [legal] brief written?’”

**The Patient’s Defensive Splitting Is Opposed to the Two Participants’ Developing Stable, Internalized Images of One Another**

The splitting which is generally agreed to be among the borderline individual’s major defenses is another factor which works against not only the patient’s development of a stable, coherent, internalized image of the therapist, but the therapist’s development, similarly, of such an image of the patient. The following clinical examples are intended mainly to highlight the impact, upon the therapist, of the splitting in the patient’s transference-reactions to him.

One man brought to me a gift of two matched drawings he had done, prior to framing them, and set them up across the room. I commented admiringly about them and, for reasons which I shall not attempt to detail here, chose to accept the intended gift of them. A couple of weeks later he brought in one of them, framed, and put it on view in the same general location as before, across the room, and assumed the couch. The feeling-atmosphere between us seemed genuinely friendly; but I interrupted his reporting, not many minutes along in the session, by commenting, “You know, I’m sitting here looking at that drawing over there, and I’m thinking, it’s very beautiful—but where’s the other half of it?” His friendly demeanor immediately vanished: he expostulated, violently, “You son of a bitch!—I knew you’d say that!” This led, naturally enough, into a further exploration of some of his less positively-toned transference reactions to me. Seldom have I found the split-off “half” of a patient’s transference-reaction to emerge so neatly in response to a technical intervention of mine. Only as I write this do I see that here, now, he gave me a truly worthy psychoanalytic gift.

A patient’s split-off negative-transference image of the therapist is assigned, frequently enough, to a spouse to feel in awareness and to vocalize. For example, one woman reported as she turned up for a long-acclimatized Saturday morning analytic session—reported in a relatively friendly and reasonably affable tone, as usual with her—that her husband had snarled at her, as she was leaving the house to come to her session, “As you still seeing that bastard?”

A man described his having shown to his wife, with warm pride, a copy of my first book. He reported to me, dutifully, that his wife had glanced at the book and retorted, curtly, “Searles is a charlatan; I can’t believe he can write any better than he can analyze people.”

Another man achieved, after a number of years of psychoanalytic therapy, sufficient integration of previously-split transference-images of me to be able to say, in one breath, “I can’t tell you how much I love you or how much of a shit I think you are.” But each of the two affective tones in the two halves of the sentence—the one intensely loving, indeed, and the other equally intensely harsh and rejecting—was undiluted by the other, and the whole statement was jolting in its over-all impact upon me.

A man who split off, for years, his feelings of unrelatedness during the session, displacing these onto situations be-
tween the sessions, one put it that “The time I spent here used to feel like the only time I was alive—the rest of my life was kinda dead,” and described that still (after years of therapy), “What a let-down it is each time I go to work from here. The Bureau [where he was working] is so empty and meaningless. Relationships go from something to nothing. You talk about having some relationship for the rest of your life; but, for me, it doesn’t happen like that. To me, there is no such thing; this relationship [for example] can disappear at any moment, and there would be no trace of it anyone can see. But that’s how it is: every day I leave here and there’s nothing left, and in its place is the Bureau—only it’s not in its place; it’s [that is, the Bureau is] no good as a replacement...”

The patient who is involved in a split-transference toward the therapist, and who therefore conveys totally opposing demands upon the latter—for example, to be silent and to speak, or to be at one and to be, simultaneously, apart and unrelated—is basically dissatisfied for the reason that he wants the therapist to heal the unconscious split within him, the patient.

The Therapist Feels This Transference-Role to Be His Only Link with the Patient

The therapist who is working with a borderline patient is given to sense that this transference role, which the patient unconsciously perceives him as occupying, in his—the therapist’s—only means of relating to the patient. Another way of thinking of this is to conceive that the patient is projecting one of his introjects into the therapist, and the therapist senses that this introject, which he personifies to the patient, is the only possible person he can be in relationship with the patient. This involves the borderline person’s existing in accordance with the pars pro toto principle—that is, that this present part of his over-all potentially possible ways of relating with the therapist is the totality; his experience has not given him to realize, as yet, that this is only part of a many-faceted totality, a totality which contains within it many different, potentially more gratifying, ways of relating.

For example, one woman said, “At work it seems to me that I just live in terror of being asked to do something that’s not in my power to do.” The words she emphasized were said in a tone which conveyed that she is really living only when she is in terror. When she said this, I was reminded of a patient whom I had interviewed (in teaching-interviews) who had given me to know that terror, or even panic, was preferable to their boredom, and of one who agreed when I suggested that he felt alive only when he felt in imminent danger of being murdered. Such patients give the therapist to sense that being in relatedness with the patient requires that the therapist be perceived, by the patient, as terrifying. All this has to do with the patient’s inability to experience in awareness, at this point in his ego-development, anything like the full gamut of human feelings. One man phrased it that “I don’t feel sadness; sadness isn’t something I feel. I understand devastation, and I understand rage.” A woman described that the emotionality of her older sister (who had served as mother-figure for her) had been limited to “shocked and stunned,” and hence she—the patient—had become considerable of a daredevil in childhood, in order to get the only available kind of emotional response from her sister.

One sees this same principle, as regards severely limited possibilities for relating, in work with frankly psychotic patients also. In a paper wherein I (Searles 1977a) described some aspects of my work with a chronically schizophrenic man, I reported that “It required some years before I
realized, sitting in one of the silences which still predominated during our sessions, that it had now become conceivable to me to be tangibly related to him without my having to either fuck him or kill him” (pp. 18–19).

*The Therapist's Unconscious Attempt to Flee from a Transference Role by Interpreting It Prematurely, or by Personal Reminiscences*

Therapists, including myself, tend frequently to interpret prematurely a patient’s transfere reaction wherein the patient has been projecting into the therapist some introject which has been giving the therapist to sense his own transference-role to be a most uncomfortable one. The therapist endeavors prematurely to highlight, for the patient, the role of projection in the way the latter has been perceiving him—confront the patient with the possibility that, to paraphrase, “The way you have been perceiving me is little if at all true of me, but is highly true of yourself, as regards one of your less palatable identifications with your father or mother.” My belief is that if the therapist has not yet come to find the transference-role in question reasonably tolerable to himself, he cannot realistically expect that the patient, whose sense of identity is less strong and well-integrated than his own, will yet be able to cope with this hot-potato kind of projected introject. When we try prematurely to unburden ourselves by such an interpretation, we usually do so with the implied denial that there is any reality basis for the patient's transference-perception of us and this, too, is to my way of thinking not rational. The patient needs to become able really to find, over the course of time, a sample of everything in the therapist.

In my own work, I find that not only do I tend prematurely to make transference-interpretations in such settings as those I have described briefly here, and, similarly, that I tend to make psychotherapeutic (rather than psychoanalytic) interventions precisely at points wherein the patient's long-held, previously unconscious, transference image of me as personifying the sickest aspects of his mother, or father, or whomever, is starting to emerge into better awareness on his part. That is, just when some long-manifested introject, which is at the basis of much of the patient's depression, for example, starts to become seen by him in me, then I experience an urge to make some explanatory, supportive, non-transference interpretation. Further, if I can manage to hold my tongue, then realize that this urge is based upon my wish to avoid emerging, in the patient's perception of me, as being very sick—as, in his childhood, he had abundant reason to perceive one or another of his mothering or parenting figures.

For many years I have been interested in the question of the degree to which a therapist can permissibly, and even usefully, convey to a patient information about the therapist's own life history. I am aware that this is a complex and difficult question. To my way of thinking, the therapist inevitably does convey much information about himself, much of it non-verbal and conveyed unconsciously—no matter how well analyzed the therapist has been. Further, I doubt that any therapist or analyst, no matter how classical in orientation, abstains totally from conveying consciously bits of his own personal history to the patient. I can well believe that such communications have a permissible and even, in aggregate, essential role in any patient's several-years-long experience with the therapist.

But I wish to call attention, here, to the likelihood that the therapist—and I know this to be true in my own work—will get into reminiscing to the patient about bits of the therapist's own past, in unconscious flight from some emerging transference-role which threatens the therapist's more
cherished views of his own identity. I shall give one example of this kind of interaction.

In a session during the closing months of my several years of work with her, a woman made relatively brief reference to a younger sister who was living the life of a recluse in New York City. Throughout the patient's therapy, she had made mention relatively infrequently of this sister, and had given me much reason to know that she had felt, in childhood and adolescence, intense jealousy of this then-beautiful girl. For many years now, she had felt remote from the sister.

Midway along in this session, quite some time after her having made some brief mention of that sister which highlighted, again, the latter's reclusiveness, she asked, "Do you enjoy what you do? Do you get fun out of it? Do you look forward to it?" and other questions in that vein. She asked these in a fashion so inviting that I felt a strong urge to confide in her my feelings at some length about this—excluding the most depressive among my gamut of feelings about my work. But I thought privately that by now, after about six years, she had had sufficient experience with me to have some fairly clear impressions, herself, as to the answers to these questions. I felt, nonetheless, in considerable conflict about this, for I was aware that she would be terminating (as agreed), in another few months, and there was much to be said on the side of her being given, at long last, a relatively generous amount of consciously verbalized information about me.

I replied in approximately these words: "I have a considerable urge to tell you in detail about myself, in response to what you've asked. But my better judgment is that there is something to analyze in this. You sound as though you know me scarcely at all, and I surmise that's about how you feel toward Hilda [the sister]."

She replied, "I thought you were going to say my mother," and went into much pertinent transference-detail, then, about her mother and sister, dwelling particularly upon the latter. Her hatred and contempt for Hilda had never been so open and intense, over the years of the therapy, as now—and likewise her feelings of competitive triumph over her sister, whose days of glory had faded.

"Hilda was kinda one aspect of what Mother wanted to be. . . . Hilda was kinda one segment of that, and maybe I was another segment: not beautiful, but bright. . . . I always had the impression that Mother thought of herself as both bright and beautiful. . . ."

"The last time I really talked with Hilda was at Mother's funeral [a few years before] . . . and she seemed vacant. . . . It felt like I wasn't really talking to anybody—like there wasn't really anybody there. . . . Hilda was vacant; the inside of her had atrophied or hadn't been permitted to develop, and she was just a beautiful shell—(laughs)—I'll bet I just say that out of wild-eyed jealousy. . . ."

In hearing the last few of the statements she made, I felt shocked at the intensity of her hatred and contempt toward, and of her vindictive triumph over, her sister. The patient's laugh was a relatively light, good-natured, nonmalevolent-seeming one; but it did not fool me for a moment, for I had long known her to be an expert at carefully-practiced laughter in infinite variety. I heard her light-seeming laugh as a very clear attempt to gloss over the hatred that had become evident, for a few seconds, just before. Parenthetically, the agreed-upon, scheduled termination had been necessitated by factors outside the control of either of us. She had accomplished much in our work together but, as is obvious here, much remained unexplored.

At the end of this session, I did not feel fully confirmed
in the wisdom of the way I had responded to her questions to me. The atmosphere as she left was such that I didn’t know what her feelings were; it seemed to me as likely as not that an important opportunity for reality-relatedness between us had not been seized by me. But at least, I felt, this session had pointed up, in a way useful for me, some of the issues involved in the therapist’s conflict as to whether to tell the patient something of himself, or not, in response to the patient’s inquiry. In any event, I definitely felt that some of the power of my suppressed urge to tell her of myself was, in retrospect, my unconscious way of avoiding the transference-role of Hilda, perceived by the patient as being “vacant; the inside of her had atrophied or hadn’t been permitted to develop.” Had I told her what I felt so warmly invited to confide to her, of my experience of my daily work, I would have been reassuring myself that I am alive inside, but I would have made it appreciably more difficult for her to explore, in the closing months of our work, her transference to me as being her reclusive sister.

The Patient’s Experience of Attempted Transference-Interpretations as Being Paranoid Projections from the Therapist

I have had experiences with a number of patients which have helped me better to understand how difficult it is for a patient to associate at all freely, during the session, if he has a powerful transference to the therapist as being a highly paranoid parent-figure and as tending, therefore, to project, powerfully and tenaciously, repressed or dissociated inner contents upon, or into, the patient. Typically, the patient who is highly resistive to, or otherwise warding off, attempted transference-interpretations is protecting himself, thus, from the therapist’s perceivedly malevolent threat, in

the transference, to find in the patient, and to hold the patient totally responsible for, inner contents of the therapist’s own, which the therapist cannot consciously recognize, and accept personal responsibility for, as such.

I have come to understand this from my own feelings in being on the receiving end of powerfully-projected material from such patients. I find that, as such a patient walks in from the waiting room for the nth time, I am automatically battening down all my hatches, securing myself as an intendedly impregnable fortress—and I do see, here, the sexual connotation of the word “impregnable.” All this helps me to realize that such a patient, projecting into the therapist the patient’s own great need to project, must inevitably be highly constricted in the attempt at free association: he dare not reveal more than guarded bits of himself, lest all these projections come home to roose, projections perceived as originating from within the therapist.

In, again, my own experience with such a patient as he walks in from the waiting room, I find that I tend to take refuge in viewing him diagnostically, as predominantly afflicted with a character disorder of one sort or another, for example, for to the extent that I can maintain such a nosological view, I tend not to take personally his insulting, arrogant, infuriating, stinging, wounding, and what-not customary reactions to me.

It is of the essence, in psychoanalytic therapy as in psychoanalysis, that the therapist facilitate, insofar as feasible and at such a pace as is appropriate for the patient’s current level of functioning, the patient’s coming to discover that the problems, conscious and unconscious, which impelled him into therapy are at work in the transference—are being manifested, that is, in his responses and attitudes toward the therapist. But if the therapist endeavors too frequently and too prematurely to call the patient’s attention to the likelihood that the patient, here and here again, is
responding to the therapist, at times when the patient has not been aware at all of doing so, it is easy for the patient to infer that the therapist is being what we would call essentially paranoid—self-referential, referring everything, or practically everything, to the therapist himself. If the therapist endeavors repeatedly to make plain, however, that much of the significance which he regards himself as possessing, vis-à-vis the patient, derives from his personifying, for the patient, significant persons from the patient’s childhood, the patient will be somewhat less likely to write off the therapist as being imbued with paranoid suspicion and grandiosity.

In my experience, it develops on rare occasions that the transference-countertransference emotions in my work with borderline patients become so intense that it feels to me all I can do simply to stay in the same room with the patient throughout the session—whether because I am finding him so infuriating, or insufferable, or disturbing in various other ways. Although I cannot report here with confident precision—for I have not kept sufficiently full research-notes upon the matter—I have the distinct impression that it is such patients whom, at the level of their internalized images within me between my actual sessions with the patients themselves, I experience as disturbing presences within myself. When I think back to the most disturbing periods of work I have done, with the most disturbing patients over the past years in my private practice, these typically have been borderline patients. I have found, further, that the work with any one of those most difficult patients has come to feel most unmanageable when I have become unable to know in surcease from the patient even between sessions, but have found him or her disturbingly present, in my memory and in my fantasies during sessions with other patients (as well as at home). In what feels to be quite a tangible sense, this disturbing patient, present at the level of an internal feeling-image within me while I am in a session with another patient whom I ordinarily have not found markedly difficult, threatens to overwhelm me, from within, in such a way that I shall become immersed imminently, here with this other patient, in essentially the same kind of transference-countertransference difficulties as those I have been finding too much for me in my work with the original so-difficult patient.

Surely, some of this involves my having identified with that so-difficult patient as an aggressor; hence I would tend to feel, and behave, like that patient in my work with all my other current patients. I cannot attempt to discuss these dynamics—essentially, I suppose, folie à deux dynamics—more fully here; but I hope to have succeeded, at least, in indicating how difficult it is for the therapist, in working with these so-trying patients, to develop a stable internalized image, within himself, of the patient. When one goes through experiences such as these, in the position of the therapist, one can now know, at first hand, something of why the patient—who projects into the therapist so much of his psychopathology—would become able only with great difficulty, and after many storms, to develop within himself a stable, internalized image of the therapist.

Summary

I have discussed some of the difficulties which the therapist and the borderline patient encounter in enabling the patient to develop a stable, internalized image of the therapist. The patient’s lack of such an image, in the early phases of the work, is evident both between and during therapy sessions; but his autism, in this connection, is often subtle and not easy, therefore, for the therapist to detect. The role of the patient’s split-off hatred toward any nascent internalized image of the therapist is touched upon here.

It is necessary for the therapist to lead the way, in
developing an internalized image of the patient, before the latter, partly by identification with the therapist here, can do similarly. The bulk of the chapter describes the therapist's own difficulties in this regard.

These difficulties are referable in part to the patient's projecting of his own introjects and other unconscious contents, in great abundance and with great intensity and tenacity, into the therapist. Further, and in consequence of this, the therapist finds himself in strange, oftentimes subjectively nonhuman, transference roles which are referable to very early stages of ego-development, on the patient's part, prior to the latter's individuation and prior, likewise, to his being able to distinguish between human and nonhuman, animate and inanimate, ingredients of the surrounding world. The patient's defensive splitting adds to the complexity and disturbing nature of the transference roles which beset, as it were, the therapist.

The therapist, in unconscious flight from one or another of these transference roles, tends to interpret them prematurely to the patient, or to launch into warmly human reminiscences.

In describing those instances in which the therapist finds particularly persecuting his internalized image of an extraordinarily difficult patient, some of the dynamics of folies à deux are touched upon.

References


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