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Countertransference and its Influence on Judgements of Fitness for Analysis

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IN THIS ESSAY, I DO the following: first, I differentiate those characteristics of the borderline and the narcissistic personality organizations which, I believe, contribute to important variations in the transference-countertransference matrices typically established by one and the other type of patient. This will include comments on the Kernberg-Kohut controversy. Secondly, I consider how the countertransference difficulties generated by the massive resistances of the borderline patient might induce psychoanalysts to disqualify such patients as analyzable, or to otherwise mistreat them.1

In responding to an earlier draft of this paper, some colleagues challenged the premise that persons can be meaningfully differentiated into one or another of such personality organizations, raising larger issues concerning the pitfalls of diagnostic labeling.2 Once we pin a label on a person, or accept a label as given—and this can begin, of course, with the label, 'patient'—we may be led easily to think of the person as some-*thing*-known. And, this may stimulate in our thoughts, a process which begins with depriving the patient of his personhood and ends by negating his therapeutic need to be understood as fully as possible in his own terms.

It is, therefore, necessary always to monitor our diagnostic thinking lest we reify our patients or our psychoanalytic constructs. (Feiner 1970), (Schafer 1979) Still, mindful of such cautions, I find the distinction between these two character constellations meaningful, substantively and heuristically. I have found the following to be true, in my own practice, and in an even larger number of cases reported to me in supervision and in case seminars: (1) that there are some patients whose transference patterns in the therapeutic interaction closely correspond to those Kohut has described in connection with the narcissistic personality organization (Kohut 1971), (1978); and (2) that there are other patients whose transference patterns correspond to those described by Kernberg (Kernberg 1975) in connection with the borderline personality organization; and (3) that the therapist's countertransference experience in response to the transference behavior of one or the other type of patient corresponds as well to that which has been described by these writers.3

It is, in fact, the quality of the transference/countertransference matrix which mainly determines whether I think of a patient as having a borderline or a narcissistic character structure or as being in a borderline or narcissistic ego state. I believe these distinctions to be important only in so far as they guide the therapist in his handling of the treatment process.

This brings me to a brief discussion of the essential disagreement between Kernberg and Kohut and of some points of disagreement which I have with each. Kernberg disputes Kohut's conception of the narcissistic personality organization as well as his treatment recommendations, dismissing, in effect, the therapeutic progress evidenced in Kohut's case material.4 Kernberg states:

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[1]The original version of this paper was read on September 23, 1978 at a National Psychological Association for Psychoanalysis symposium on "Some contemporary issues in countertransference".

[2]I wish to thank Drs. J. Cohlers, I. Hirsch, and A. Issacharoff for critically evaluating this paper in the course of its development.

[3]Also see Wolf (1979) for an extended discussion of transference and countertransference in the analysis of disorders of the self.

[4]Extensive clinical material illustrating Kohut's treatment approach is presented by his associates in a casebook edited by Goldberg (1978).

From a dynamic viewpoint, pathological condensation of genital and pregenital needs under the overriding influence of pre-genital (especially oral) agression characterizes narcissistic personalities as well as borderline personality organization in general. …

The difference between narcissistic personality structure and borderline personality organization is that in the narcissistic personality there is an integrated, although highly pathological grandiose self, which … reflects a pathological condensation of some aspects of the real self ("specialness" of the child reinforced by early experience), the ideal self (the fantasies in self images of power, wealth, omniscience and beauty which compensated the small child for the experience of severe oral frustration, rage and envy) and the ideal object (the fantasy of an ever-giving ever-loving and accepting parent, in contrast to the child's experience in reality; a replacement of the devalued real parental object). … Theintegration of this pathological, grandiose self compensates for the lack of integration of the normal self-concept whichis part of the underlying borderline personality organization …" (Kernberg 1975, p. 265–266)

Thus, Kernberg views that Kohut calls the narcissistic personality organization as a defense, overlaying what is essentially borderline pathology. The technical implications of this view is that the narcissistic patient should be treated with the strict interpretative approach Kernberg recommends for the borderline patient (Kernberg 1975). This involves the "systematic elaboration of the manifest and latent negative transference without attempting to achieve full genetic reconstructions on the basis of it…", and "confrontation with and interpretation of those pathological defensive operations which characterize borderline patients, as they enter the negative transference."[5](Kernberg 1975 p. 72)

Kernberg, in other words, views the narcissistic patient's autoplastic behavior, such as hypersensitivity to slights, hypochondria or depression, and alloplastic behavior, such as, perversion, delinquency or addiction (Kohut 1978), as negative therapeutic reactions based on unconscious negative transference. They are manifestations of primitive ego-splitting and projective processes which are powered by destructive impulses.

Kohut, on the other hand, views these symptomatic behaviors as signs of losses of self-cohesion in reaction to some disappointment or wounding by the analyst which has not been registered in consciousness. The technical task therefore, is, first, to understand that such is the case and, secondly, to communicate the probable sequence of events to the patient, thereby, putting him in touch with both his experience of hurt and disappointment and the source of it. From Kernberg's point of view, Kohut's treatment approach would amount to little more than supportive therapy, shoring up the patient's defensive superstructure. The underlying psychopathology would not be touched.

I have not found Kernberg's view of what Kohut calls the narcissistic personality organization to be valid. I have found Kohut's understanding of the patient's behavior as well as the treatment recommendations he makes to yield progressive andenduring therapeutic results, similar to those reported by him and his associates (Kohut 1978), (Goldberg 1978).

In fact, I have come to a conclusion somewhat in opposition to that of Kernberg regarding the severity of psychopathology in these respective personality organizations. I have found that as the primitive defense-resistances of the borderline patient are worked through, he gradually emerges from and outgrows his borderline ego state. His behavior in the therapeutic interaction increasingly takes on the features of Kohut's narcissistic patient. He becomes highly vulnerable to slights and disappointments issuing from empathic failures in the clinical situation as well as in his outside life. From this I would conclude that the analysis has at that point become a good-enough holding situation for the patient and has strengthened his ego sufficiently to enable him to present his true and vulnerable self to the analyst. In Winnicott's words, "the false self hands over to the analyst. This is a time of great dependence, and true risk …" (Winnicott 1955-56, p. 297).

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[5]In an earlier paper (Epstein 1979) I have suggested that Kernberg's strict interpretative approach to the borderline patient's negative transference is likely to be at worst psychonoxious or at best less effective than a more maturationally oriented approach which aims at *resolving* instead of *overcoming* the patient's resistances (Spotnitz 1969), (1976); (Searles 1978)

While Kernberg negates Kohut's view of the narcissistic personality organization and his therapeutic approach, Kohut disqualifies as unfit for psychoanalysis those patients with more primitive personality organizations. He defines the borderline state as follows: "Permanent or protracted break-up, enfeeblement or serious distortion of the self, which is covered by more or less defensive structures." He states that this form of psychopathology along with the psychoses and the schizoid and paranoid personalities "are in principle not analyzable, the diseased (or potentially diseased) sector of the self does not enter into the limited transference amalgamations with the self-object imago of the analyst that can be therapeutically managed by interpretation and working through" (Kohut 1978).

I believe that both Kernberg and Kohut have committed serious errors of overgeneralization. Kernberg overgeneralizes his concept of borderline pathology and his treatment approach to include the narcissistic patient. Kohut overgeneralizes the psychology of the self and his treatment recommendations for the narcissistic patient to include all "analyzable" patients; those patients who do not respond to *his* treatment approach are declared unanalyzable.

The explanatory power of the psychology of the self derives from the careful and patient study of the narcissistic patient in the clinical situation. I am hopeful that the theory can be expanded to apply more successfully to the treatment ofpatients with more primitively organized personality structures. This can only come about through a more carefulstudy of clinical situations involving such patients than I believe has been made by Kohut and his associates.

Because Kohut's conclusion so severely restricts the range of analyzable patients, I have surmised that this view is in fact erroneous. I suggest that unconscious countertransference difficulties play a significant role in influencing an analyst's decision to declare a patient fit or unfit for analytic work.

Let me now describe more specifically what I have in mind when I refer to the borderline patient. He is usually brought to therapy by feelings of intense dysphoria. He suffers from chronic dissatisfactions either with himself, others or his life in general. He presents massive resistances to the therapeutic process. On the one hand he exerts an intense pressure on the therapist to serve and anticipate his every wish and need; on the other hand, in one way or another, overtly or covertly, he rejects all that is offered. Because he has a strong aversion to understanding anything about himself, he rejects almost all interpretative interventions. He rejects as well the limits of the therapeutic setting, sometimes demanding, with varying degrees of insistency, that we give him extra time, give him special favors, that we reveal facts about our personal lives, engage in physical contact, etc.

The belief that such patients make inadequate transferences for the purposes of psychoanalysis originated, of course, with Freud and for many years among classical analysts has remained unchallenged dogma. Yet, the transference projections of the borderline patient are no less adequate for psychotherapy than are those of more integrated patients. They do, however, pose special problems because the major functions of these transferences are those of defense and resistance. More specifically, they serve to defend a maturationally deficient ego organization against the consequence of its own destructive aggression, and they serve to resist the catastrophic loss of a passionately cherished, compensatory infantile omnipotence.

Because the borderline and the narcissistic patient are arrested at the narcissistic level of development, they have many features in common. The borderline patient, however, has a special problem with hate and destructiveness. Because of this he is forever plagued with a sense of his own badness. I want to make it clear at this point that I make no attributions to constitutional factors. I make the assumption that all psychopathology begins with the developing self's attempts at coping with chronic parental failures to meet its particular constellation of maturational needs. I do not believe that it is necessary to assume that the borderline patient's problems with hate, aggression and badness are caused by an excessively strong primary aggressive drive. I prefer to think of such problems in Kohut's terms, as disintegration products derived from severe maturational deficiency.

The borderline personality organization has failed to develop a unified self which is felt to be good-enough vis-a-vis representations of parental images which are also valued as good-enough. The relations between the self and its objects are hateridden and persecutory, making the borderline patient's internal world a strife-torn battle-ground pervaded by a sense of badness. In contrast, the narcissistic personality organization is not beset by problems of hate and aggression. In the course of his development the patient has not internalized persecutory and embattled relationships between the self and its objects. His internalizations involve a self which is inadequately nourished and lacking in resiliency, and objects which ultimately fail and disappoint.

The maturational deficiency of the borderline patient is greater than that of the narcissistic patient. He is farther from being organized as a separate person. Interpersonal situations have a more exciting effect on the borderline personality organization than on the narcissistic personality organization and other more integrated personality structures. The analytic situation is likely to be especially agitating. A complex of contradictory impulses and highly ambivalent feelings is aroused. The potential freedom of the other to disregard, reject, go away, and otherwise be himself arouses intense abandonment anxieties which rarely cross the threshold of consciousness. Instead they drive the borderline patient to annihilate otherness by means of aggressive fusions and incorporations. The borderline patient's emotional dependency on the analyst may arouse unbearable feelings of abysmal inferiority and destructive envy along with frustration aggression, compensatory omnipotent strivings, and grandiose fantasy. To rid the psyche of painful affects and unwanted self and object parts, and to achieve a more tolerable, equitable distribution of goodness and badness and power and weakness, primitive defensive processes are called into play, *i.e.*, externalization, denial, splitting and projection. All this spills over into compulsively repetitious behavior which is aimed at emotionally dominating and controlling the object of the borderline patient's attachment needs. Language becomes primitivized. It loses its primary function to communicate symbolic understanding. It becomes an instrument for the urgent evacuation and transfer of accretions of psychic disturbances, for the creation of impervious barriers to the communication of meaning, and for the actual destruction of meaning (Langs 1978). Truth and understanding are dreaded because they are expected to reveal to the borderline patient his vulnerability, his impotence, his inferiority, and his essential badness—now heightened by his penetrating assaults on the therapist's essential goodness.

The push-pull of his contradictory and conflicted unconscious feelings and impulses leave the borderline constantly frustrated and hopelessly struck. His destructive nullifying interactions with others perpetuate his sense of badness, in this way justifying the hateful attacks which his internalized persecutory objects make on the self.

I want to consider now the possible unwitting reasons why many analysts relegate the borderline patient to the realm of the unanalyzable. This issues mainly, I believe, both from an inadequate understanding of the countertransference experience generated by the borderline patient, and from a shared conception of what constitutes the necessary conditions for analysis to take place. More specifically, I am referring to how the analyst may believe he should feel and function with his patient so as to qualify, in his own mind, as a 'good analyst' and, further, to that behavior on the part of the patient which qualifies him in the analyst's mind as a good patient.

What conceptions do analysts share of "the good analyst"? Despite differences in training, we have all learned that our proper function with the analyzable patient is to understand the derivatives of ongoing unconscious or pre-conscious processes and to communicate this understanding to the patient in a way which takes adequate account of his anxiety and his resistances. Our stance should be essentially empathic. When the patient permits us to function in this way we are able to sustain what I call the "good-analyst-feeling." This may be possible, however, only if the patient is capable of forming an authentic therapeutic alliance.

Kohut has referred to the "Zeigarnik Effect" to account for the narcissistic patient's compulsively repetitious attachment behavior. This behavior expresses an organismic need to resolve the tensions of an incompleted maturational task. By means of his mirroring and idealizing self-object transferences in the analytic situation, the narcissistic patient is attempting to complete himself. In the narcissistic patient, the apparent superiority and goodness of the analyst arouses admiration and the hopes and fantasies of greatness of the grandiose self. It induces the establishment of a *positive* self-object transference and sets the stage for optimal disappointment and transmuting internalization. The narcissistic patient enters an analysis ready to form a therapeutic alliance. The borderline patient, in the first and most critical phase of the therapy, is not yet ready to make *positive* self-object transference in the service of *his* need to complete himself. Instead he establishes a *negative-narcissistic transference*, and his therapeutic need is for the analyst to function as a *negative self-object*. The therapist, because he is the target of the patient's projective processes, cannot be his ally at this stage. At best he is an adversary. At worst he is an enemy or a potential persecutor. Under these conditions, the more the analyst attempts to function as a "good analyst", *i.e.*, as a sympathetic ally, the more the patient will be unconsciously driven to make him into a bad-or-no-good-analyst.

Let me recall the countertransference reactions we are likely to experience when we are the target of the borderline patient's projective processes. Depending on the patient's capacity to tolerate an awareness of his anger, hate and envy, the assaults he makes on our "good-analyst-feeling" will be delivered from higher or lower levels of consciousness. The less conscious the patient is of his feelings, the more covert his attacks. In these circumstances, we may be unable to see any direct connection between the patient's behavior and communications and whatever internal disturbances we may be experiencing. We may, for instance, experience a scrambling of our cognitive processes. The patient may be talking of things that we think should merit our interest, but despite our best efforts at concentration, we may be unable to assimilate what he is saying. Our mind wanders capriciously, we may have to struggle to stay awake. Our thought processes feel shallow and empty. We generally feel a growing pressure to think of something meaningful and worthwhile to say to the patient, yet nothing of value occurs to us. If the patient is sitting up and looking at us rather than lying down, we may often feel ourselves in danger of being caught at dozing-off or at being otherwise distracted. Our lapses may cause us to feel anxious and guilty, and we may find ourselves sneaking looks at our timepieces to find out how much longer we shall have to put up with the torture. If the patient is more in touch with his feelings, his attacks are more overt. He makes it clear that he feels desperate and hopeless, and that the therapy isn't getting him anywhere. He may denigrate us or our method, comparing us unfavorably with a friend's therapist who is more active, caring, stimulating etc. He might say he is thinking of trying hypnosis or Gestalt or bioenergetic therapy. Our reactions here are likely to be clearer and more focused. Depending on what we usually do with our agression we may hate either the patient or ourself or both. Either way we are likely to feel we have lost our analytic stance.

I believe that one of the special attractions that Kohut's work has had for many analysts is that it enables us to sustain or easily regain an empathic stance *vis-a-vis* the narcissistic patient. But the countertransference difficulties which are induced by the positive self-object transferences of the narcissistic patient are relatively minor and easily mastered. His sensitivity to slights and disappointments may cause him to use distancing security operations, but these usually serve defensive, not destructive aims. The basis for a working alliance is present from the outset and it is usually joined after the analyst proves himself capable of empathic understanding. What is important here is that since the analyst's empathy is highly valued by the narcissistic patient, the analyst is permitted to maintain an empathic stance. Even during the explosive rage reactions of the narcissistic patient, we can feel for him and understand his pain. In our countertransference we may be upset by his attacks, and we may feel ourselves to be at fault; yet we do not feel ourselves to be *transformed* into a bad person. We feel ourselves to be in a position to make reparation by means of empathic interventions, and the patient, sooner rather than later, responds positively to them.

When we are under the influence of the borderline patient's projective processes, and he is, at the same time, accusing us of being cold, unfeeling, depriving etc., our emotional situation can be quite confusing. We are, in fact, more likely than not, experiencing a coldness or rejecting feelings of varying degress of intensity. We might feel impelled by guilt to negate such feelings or, at best, to counteract them by offering the patient some sympathetically toned communication—perhaps conveying some understanding of his underlying defensive needs. The patient, however, is apt to sense the emotional inauthenticity of such interventions. On some level he may hate or scorn us for patronizing him. Should we persist in offering such emotionally inappropriate communications, an escalation of negative therapeutic reactions is likely to follow.

The success of the therapy will depend almost entirely on our ability to fully admit to ourselves and claim our countertransference reactions, and thereby to gain sufficient distance from them to contain and process them as data. Achieving this we shall be in a better position to understand the meaning and function of the borderline's ongoing resistances and to formulate interventions and strategies for resolving them.

The particular content of our countertransference disturbances will, of course, reveal a great deal about our own residual psychopathology, providing us with excellent opportunities for self-analysis. I believe the major benefit to the patient, however, will issue from our efforts to understand *his* contribution to the ongoing countertransference experience.

Let me consider now some of the consequences that might result if an analyst believes he cannot function as a good-enough analyst unless he has a working alliance with his patient and unless he is able to feel predominantly positive feelings for him. With that as an orientation an analyst is likely to reject the borderline patient as unfit for analysis.

An analyst's decision to disqualify a patient may result from the unconscious operation of the Talionic principle. If the patient makes the analyst into a bad-or-no-good-analyst, the analyst makes the patient into a bad-or-no-good-patient. The borderline patient may be somewhat disappointed or discouraged, but he is rarely devastated when a therapist refuses to take him as a patient. It is more or less expected. For the borderline patient, being rejected often translates into getting himself rejected. As such, rejection may compensate him with masochistic and omnipotent gratifications.

He may be much worse off if he is accepted by a therapist who needs to have positive feelings for his patient and a working alliance. In such a case, the analyst may be more likely to negate the emotional realities of the transference-countertransference matrix and forge a more likeable, cooperative image of the patient in his own mind. I have known several psychoanalytic therapists in training who have done this in the name of Kohut and the psychology of the self, misapplying to the borderline patient the sympathetic empathic interventions which are appropriate and effective for the narcissistic patient. In such a case, the therapist, so as to rid the therapeutic dyad of hate, counter-hate, aggression and badness, unwittingly mirrors the primitive nullifying defense-resistances of t patient. Like the patient, the analyst denies the separate existence of the Other, changing him into a fantasied-object, more comfortable to be with. In this as-if context, the analyst's interpretations and inquiries, while delivered from the task-oriented sector of his self, are likely to be loaded with unconscious counter-hate and sadism (Epstein 1979).

The effects of all this on the patient and on the therapy will depend on the interaction of two factors: (1) the extent of the analyst's denial of the emotional realities and his projection of pseudo-goodness into the bipersonal field, and (2), the extent of the patient's tendency to reciprocate with false-self adaptations.

At best the patient may be repelled by the analyst's pseudo-goodness, perceive it as weakness or phoniness, and break off treatment. If he remains in treatment, he may be unconsciously driven to escalate his negative therapeutic reactions into treatment-destructive resistances—partly in order to make an appropriate emotional impact on the therapist, partly to stave off self-disintegration. The patient's establishment of a hostile-abrasive transference-countertransference matrix may constitute his only defense against a total loss of ego-boundaries (Epstein 1977). Should the analyst succeed in overriding this barrier, a psychotic merger transference may result.

Should it develop that the patient becomes engaged in a protracted pseudo-alliance—or misalliance (Langs 1975), the situation can become lethal. The unconscious collusion to disallow the playing-out of the patients hate-ridden and persecutory internalized self-and-object relationships in the interpersonal field may lock the patient's undischarged aggression into the self. I have known of one suicide, several near-suicides, and severe depressive and psychosomatic disorders to occur in such a context.

I have trained myself to develop a relaxed and detached attitude even toward severe disturbances of both cognition and concentration and toward intensely disphoric reactions. It helps me to stay awake, for instance, if instead of anxiously, guiltily fighting my sleepiness, I study it calmly and ask myself why I might be having this reaction at this particular time. Do I need sleep? Or is the patient using primitive communication? Should I intervene now with the aim of derepressing the thoughts and feelings that might be underlying the patient's primitive communication? Or should I study the situation further? This accepting-observing attitude helps reduce the intensity of feelings of strong dislike, even hate and disgust, while preserving the availability of such feelings as data for silent analysis.

The impact of borderline patient's defense-resistances is such, however, that my objectivity deserts me at such times. I am helped to regain my psychic balance and my analytic stance if I am able to remind myself that the patient, at this stage in the therapy, needs to have me as his negative self-object, not as his ally, and that he needs me to contain and process the internal disturbances he induces.

The subject of strategies and interventions for treating the borderline patient is a large one and beyond the scope of this paper. I will confine myself to the following remarks.

In the initial negative narcissistic phase of the transference prior to the establishment of an authentic working alliance, the patient's resistances are usually heightened rather than lowered by the analyst's efforts to interpret them. In this phase of treatment the patient needs the analyst to perform two essential tasks: (1), to accept, contain and investigate the patient's verbally expressed projections of unwanted self and object parts until they become

sufficiently detoxified to be taken back and owned by the gradually strengthened self and, (2), to optimally frustrate the patient's more aggressive covert and overt thrusts at penetrating the analyst's boundaries and obliterating his separate reality. This is necessary to prevent the development of a psychotic process that begins with the omnipotent destruction of the Other and ends with the self weakened and made vulnerable by the ravages of paranoid anxiety and a heightened sense of its own badness.

In the performance of such tasks, the analyst functions as a maturational agent, facilitating the working through of the patient's internalized hate-ridden and persecutory self-and-object relations, and gradually enabling the patient to tolerate both his own reality and the separate reality of the Other. With the diminution of his sense of badness and the progressive internalization of an enduring sense of goodness, primitive splitting and projective processes are less frequently activated and gradually becomeobsolescent.

The patient's need for a negative self-object transference yields to a need for a positive self-object transference. He becomes aware of the analyst as someone he loves and admires, as well as hates and envies. He joins the working alliance and becomes emotionally committed to the therapy and the therapist. With the dissolution of his lifelong cynicism and his primitive defense-resistances, he becomes increasingly vulnerable to slights and disappointments and abandonment anxieties. His negative therapeutic reactions, like those of the narcissistic patient, are more often activated by the analyst's empathic failures than they are by his own projective processes, and they are usually reversed by sympathetic-empathic interventions.

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