**Psychopathology II: Borderline States**
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March 20th 2020 – May 29th 2020

Hello, and welcome to Psychopathology II: Borderline States.

Early analysts emphasized the fixed character structure of such "primitive" patients. It is my opinion that this fixed view is reductionistic and less clinically useful than a more flexible model whereby structures and defenses and emergent clinical phenomena are thought to be greatly influenced by the framing, containing, and holding capacities of the analytic situation and person of the analyst.

We will approach the affect-laden enveloping quality of the work with a focus on the developmental conditions and clinical manifestations of this psychopathology spectrum. This is rich, intricate, challenging, and at times uncomfortable work. Unbearable discomfort can lead to empathic failure and collapses of the space for thought on both sides of the relationship. We will emphasize how the analyst is affected by such patients, the various means by which disturbing experience is transmitted, and how these processes are a ubiquitous, inevitable, and potentially useful/reparative part of the analytic process.

Immersing oneself in the literature relevant to this psychopathology spectrum can lead to similar disorganizing affective states in the reader, accompanied by a reactive wish for a clearer more durable way of conceptualizing and organizing the material; a wish for more clarity where entropic disorganization often reigns. It is my hope that as a group we can cultivate the space to together metabolize the fragments and integrate the experience into a good-enough whole.

As you read through the articles for this class recall from psychopathology I Sugarman's model for a neurotically organized mind consisting not of particular mental content but rather certain mental capacities (i.e. self-reflective capacity, capacity for affect regulation, capacity for narcissistic regulation, and internal conflict). We will make use of this to understand the struggles that characterize the phenomena that present in borderline states and states of narcissistic fragmentation / breakdown.

Learning Objectives:

1. The clinical associate, as a result of gaining greater knowledge of the hypothesized etiologies of borderline-level character disorder, will have a greater capacity to understand, empathize, and connect interpersonally with this clinical population, and thereby improve the odds of the treatment retention necessary for a positive clinical outcome.

2. The clinical associate, as a result of gaining a greater understanding of and capacity to work with the intense transference-countertransference phenomena that develop when working with this population, will have an increased ability to assist their patient in reflecting on these phenomena, and thereby improve the odds of a positive clinical outcome.

3. The clinical associate, as a result of gaining a greater capacity to work with collapses in reflective functioning under the weight of unbearable affect, will become more capable of assisting this population in such a way that they are better able to tolerate, regulate, and reflect on their affect states and associated triggers, thereby improving their defensive structures, self-understanding, interpersonal relationships, and overall life functioning.

**March 23th 2020: Etiology - 37 pages**

We will begin with Fonagy, Mancia, and Winnicott to highlight the relational - etiological factors contributing to the emergence of these character / self-disorders.

In *Attachment and Borderline Personality*, Peter Fonagy outlines how the caregivers' reflective capacity impacts their child's capacity for mentalization and the development of a secure attachment. He links these concepts with the idea that early *trauma* may result in a child's inhibition of mentalization in an effort to avoid the pain of reflecting on their lived experience, thereby resulting in impaired reflective abilities and an impaired sense of self. Per Fonagy, these impairments may explain the link between childhood maltreatment and character pathology.

In *Implicit Memory and Early Unrepressed Unconscious*…, Mauro Mancia proposes that that the affective pre-symbolic and pre-verbal experiences of the primary caregiver – infant relationship are stored in the implicit memory system and hence can be considered part of the unrepressed unconscious. He outlines how access to this material is present in the *musical dimension* of the transference and in dreams and that it is the analyst's task to engage in a *reconstruction* of that which has been recorded but has yet to be thought / remembered.

Fonagy, P. (2000) "Attachment and Borderline Personality Disorder" *JAPA* 48/4: 1129-1146

Mancia, M. (2006) "Implicit Memory and Early Unrepressed Unconscious: Their role in the Therapeutic Process (How Neuroscience Can Contribute to Psychoanalysis)" *IJP* 87: 83-103

**March 30th 2020: Etiology (continued) - 23 pages**

*Fear of Breakdown* is a classic. In it Winnicott precociously captures what Mancia represents in neurobiological terms; that there is a storing in the implicit memory systems an awareness of lived events of past emotional overwhelm (primitive agonies) that have not been fully psychologically experienced and hence have not been thought about and hence haunt the person and at times present in treatment as a fear of breakdown. This paper and its concepts offer a foundational link to many papers that follow in this course. Thomas Ogden walks us through Winnicott's paper and Claire Winnicott offers an (optional) illustrative case. Please bring in clinical material of your own.

Winnicott, D.W. (1974) "Fear of Breakdown" *International Review of PSA*, 1: 103-107

Ogden, T.H. (2014) "Fear of Breakdown and the Unlived Life" *IJP* 95:205-223

Optional

Winnicott, C. (1980). Fear of Breakdown: A Clinical Example. Int. J. Psycho-Anal., 61:351-357

**April 3rd 2020: Conceptualization / Treatment Implications – 44 pages**

Socarides and Stolorow in *Affects and Selfobjects,* bring to our discussion of borderline and narcissistic fragmentation experiences the language of self-psychology and highlight the experience of affect modulation / tolerance. They propose that selfobject functions pertain fundamentally to the affective dimension of self-experience, and that the need for selfobjects pertains to the need for specific responses to varying affect states throughout development;

responses that that allow for the differentiating, synthesizing, modulating, and cognitively articulating emergent emotional states and thereby to the overall experience of the "self".

In *The Mental Organization of Primitive Personalities and its Treatment Implications,* Michael Robbins encourages us to think of more primitive personalities as differing in *qualitative* rather than *quantitative* ways and that assumptive errors along these lines lead to technical approaches that may be regressive or promote what Winnicott described as an analysis with the false self.

Both articles propose analytic technique(s) stemming from their unique conceptualizations of mental organization / self-experience. How do these resonate with your experience? Please bring clinical material.

Socarides, DD. Stolorow, R.D. (1984) "Affects and Selfobjects" *Ann. Psychoanal.*, 12:105-119

Robbins, Michael (1996) "The Mental Organization of Primitive Personalities and its Treatment Implications" *JAPA* 44/3: 755-784

**April 10h 2020: Trauma – 56 pages**

Joyce McDougall provides us with ample clinical material to show the impact of traumatic experiences that occur in the preverbal period of development and to highlight how these early experiences present via route of the non-verbal expressions (think of Manica's procedural memory system of unrepressed unconscious) affecting that analyst's countertransference. She calls these *primitive communications*. Her paper speaks of the analytic process as helping to transform action-communications / action-symptoms into that which can be verbally represented in language, allowing containment of the experience.

Richard Tuch adds to our discussion an emphasis on separation anxiety and the links of this to difficulties in reflective thought and an intolerance of being thought about by the (other) analyst. Although not referenced in this paper I encourage you to think back to the paper by Britton (*Subjectivity, Objectivity, and Triangular Space*), as it set the foundation for understanding the developmental experiences leading to the clinical struggles highlighted by Tuch's article.

McDougall, J. (1978) "Primitive Communication and the Use of Countertransference-Reflections on Early Psychic Trauma and its Transference Effects" *Contemp. Psychoanal.*, 14;173-209

Tuch, R.H. (2007) "Thinking with, and About, Patients too Scared to Think" *IJP.*, 88:91-111.

**April 17th 2020: Trauma (continued) - 36 pages**

This week we continue our focus on the deep and lasting impact of trauma. Phillip Bromberg in *One need not be a house to be haunted: a case study*, highlights how psychic trauma exceeds the capacity for cognitive processing, thereby leading to unintegratable affect that at times disorganizes the internal template on which self-coherence, self-cohesiveness, and self-continuity depend. He beautifully depicts how having affective memory without autobiographical memory leads to dissociated *not me* experiences that haunt the self (think back to *Fear of Breakdown*).

Lawrence Brown, in *Julie's Museum: The Evolution of Thinking, Dreaming, and Historicization In the Treatment of Traumatized Patients*, complements and extends Bromberg's paper by linking trauma's destruction of one's internal thinking-containing capacity with the concretization of thought. His clinical example highlights the importance in these cases of the analyst's imaginative

capacity being crucial for helping their patients begin to think and dream, and to free themselves from the mental captivity of concrete thought. How do you share your imaginative capacity with your patients?

Bromberg, P (2003) "One need not be a house to be haunted: a case study" *Psychol. Dial.* 13: 689-709.

Brown, L (2006) "Julie's Museum: The evolution of thinking, dreaming and historicization in the treatment of traumatized patients" *IJP*., 87, 1569-1585.

**<u>April 24th 2020: Reflective Collapse and Relationship to Violence and Suicide</u> – 28 pages**

Peter Fonagy, in *Understanding the Violent Patient: The Use of the Body and the Role of the Father*, presents the case of Mr. T to highlight the role of violence as an attempt to obliterate intolerable psychic experience (impaired mentalizing capacity) and to make, albeit pathological, an attempt at finding a containing self-organization. He makes important connections of violence to the experience of a fragile self, the role of the body as a representation of the hated *other*, the importance developmentally of the father in facilitating separation and offering a new connection, and lastly provides his advice with respect to technique in treating this population.

John Maltsberger, in *The Decent Into Suicide,* discusses the factors leading to suicidal collapse (affective flooding, desperate maneuvers to counter the emerging mental emergency, loss of control as the self begins to disintegrate, and grandiose mental scheming for mental survival) and connects these with the difficulties in the realm of affect regulation, ego helplessness, narcissistic surrender, breakdown of the representational world, and loss of reality testing.

Fonagy, P and Target, M. (1995) "Understanding the Violent Patient: The Use of The Body and The Role of The Father" *IJP*. 76:487-501.

Maltsberger (2004) "The Decent into Suicide" *IJP*, 85:653-667

**<u>May 1st 2020: Hatred and Destruction and a Movement towards the New</u> – 26 pages**

Donald Winnicott's paper *The Use of an Object* deserves to be read many times over. In it he introduces his distinction between object relating and object usage. He walks the reader through the transition from object relating to object usage (the capacity of which is determined by an adequate facilitating environment). The transition requires the placing of the object outside of the subject's omnipotent control. Failure to make this transition can explain many areas of difficulty in this population (separation-individuation, narcissistic rage, capacities to empathize / love, stability of interpersonal relationships, acceptance of external reality).

Kathleen White in *Surviving Hatred and Being Hated: Some Personal Thoughts About Racism from a Psychoanalytic Perspective,* brings a discussion of the experience of being the object (as a result of one's race) of toxic attributions and projections. She highlights the subsequent response(s): the self-hatred stemming from the internalization and identification with such projections; and the emergence of the hatred of the other. She stresses that hatred is learned and that the analytic endeavor must include helping patients recover the learning process in hateful experiences so that unlearning and relearning is possible. Please bring in accounts of any experiences (personal or professional) this paper stimulates in you.

Winnicott, D.W. (1969) "The Use of an Object" *IJP*., 50:711-716.

White (2002) Surviving Hatred and Being Hated: Some Personal Thoughts About Racism from a Psychoanalytic Perspective" *Contemp Psychoanalysis*, 38(3): 401-422

**May 8th 2020: Narcissistic Vulnerability and Treatment Implications - 28 pages**

The following two papers contain key frameworks for understanding the enactments that arise in working with narcissistically-sensitive, highly defended individuals.

Alex Bateman, in *Thick-Skinned Organizations and Enactment in Borderline and Narcissistic Disorders,* proposes that narcissistic and borderline individuals move between thick and thin-skinned positions, lending an instability to the clinical picture which is both a danger and an opportunity for the treatment. He helpfully uses clinical material to outline his impression of the three countertransference experiences contributing to enactment (complementary, concordant, and defensive) and to highlight three levels of enactment (collusive, defensive, and the un-named *role of father, corrective).* The last he feels serves as a new helpful developmental experience that moves the treatment forward.

John Steiner's, *Patient-Centered and Analyst-Centered Interpretations*, offers a new way of thinking about the subject of interpretation to shift from patient to analyst and allow for important communication between the analyst and their patient without provoking a defensive withdrawal or rejection. Does *Steiner's* approach make sense to you? If so, have you made an effort to approach interpretive communication this way and with what affect?

Bateman, A. (1998) "Thick-Skinned Organizations and Enactment in Borderline and Narcissistic Disorders" *IJP* 79:13-25.

Steiner, J. (1994) "Patient-Centered and Analyst-Centered Interpretations: Some Implications of Containment and Countertransference" *Psychoanal. Inq*., 14:406-422.

**May 15th 2020: Hysteria / Psychosomatic States - 28 pages**

This course would be incomplete without making connections between early life trauma, deficits in the capacity to mentalize / symbolically represent and reflect on internal psychic experience, and the expression of psychic phenomena through bodily experience and / or illness.

Anita Weinreb in, *Healing the Split Between Body and Mind: Structural and Developmental Aspects of Psychosomatic Illness,* follows the analytic journey of two women with multiple somatic problems. They discover and examine how their bodies became the vehicle into which unprocessed feelings had been emptied and how with treatment helped them to develop the ability to verbally represent their experience, contain it, and reflect upon it, thereby revealing the underlying conflicts and functions embedded in their previous somatic expression.

Eileen Kohutis in, *Concreteness, Metaphor, and Psychosomatic Disorders: Bridging the Gap*, highlights the frustration that can arise in working with the concreteness that often accompanies somatic expressions of psychic phenomena. Please bring in your experiences of working with psychosomatic expressions of psychic experience.

Weinreb A (2010) "Healing the Split Between Body and Mind: Structural and Developmental Aspects of Psychosomatic Illness" *PsychoA. Inquiry*. 30(5):430-444

Kohutis EA (2010) “Concreteness, Metaphor, and Psychosomatic Disorders: Bridging the Gap” *Psychoanalytic Inquiry*, 30(5)416-429

**May 22nd 2020: Perverse Mechanisms – 62 pages**

The last two weeks of this course are dedicated to the exploration of perverse mechanisms, within which sadomasochism resides. While somewhat heavy on the reading, my hope is that given the difficulty engaging, surviving, and proving helpful to this character type the time spent is worthwhile.

Sheldon Bach’s chapter, *Sadomasochistic Object Relations,* I think is invaluable in terms of working with sado-masochistically organized individuals. The chapter draws on many of the themes described in articles earlier in the course (difficulties in the realms of separation-individuation, developmental trauma, role of aggression, inability to mourn, narcissistic omnipotence, failures of seeing the other as separate, concrete mental processes) to explain the developmental line of perverse relating and guide the treatment approach.

Jessica Benjamin, in *Beyond Doer and Done To*, is a must read and speaks directly to the developmental contributors and interpersonal struggles that present when an individual has been unable to recognize the other as a subjective other (think back to Winnicott). The result is a failure of what she calls a *shared third* that results in an endless power struggle with a drastically impaired capacity for collaboration and sharing (true togetherness); a world where everything is *mine or yours*, including the perception of reality. This struggle inevitably becomes a centerpiece of the transference-countertransference experience. Please bring examples from your work.

Bach, Sheldon. (1994) “The Language of Perversion and The Language of Love” London: Aronson. Chapter 1 “Sadomasochistic Object Relations: 3-25. (To be provided.)

Benjamin, J. (2004). Beyond Doer and Done To. Psychoanal. Q., 73:5-46

**May 29th 2020: Perverse Mechanisms (continued) – 42 pages**

Richard Tuch, in *Murder on the Mind: Tyrannical Power and other Points Along the Perverse Spectrum*, gives comprehensive overview of the history of thinking about perversion and perverse relatedness.

In *Collusive Induction in Perverse Relating…* Jamie Nos speaks directly to the experience of working analytically with people with perverse character structure (i.e. an emergence in the work of a pressure to pervert the analytic process) as well as perverse character serving the function of defending against death anxiety (think of Winnicott’s primitive agonies and object relating vs object usage). He stresses the essential role of the analyst taking a *second look* at their inevitable collusive participation in disavowal.

Tuch, R. (2010) “Murder on the Mind: Tyrannical Power and other Points Along the Perverse Spectrum” *Int. J. Psycho-Anal.*, 91:141-162.

Nos, J.P. (2014) “Collusive Induction in Perverse Relating: Perverse Enactments and Bastions as a Camouflage for Death Anxiety” *Int. J. Psycho-Anal.*, 95:291-311.

**Considerations For Further Reading:**

Briggs et al (2012) “Suicide and Trauma: A Case Discussion” Psycho. Psychotherapy, 26:13-33

Kernberg, O. (2003) “The Management of Affect Storms in the Psychoanalytic Psychotherapy of Borderline Patients” JAPA 51/2: 517-545

Frosch, Allan (2012) “Absolute Truth and Unbearable Psychic Pain: Psychoanalytic Perspectives on Concrete Experience” London: Karnac. Introduction. Pages xix – xxiv.
Britton R (2004) “Subjectivity, Objectivity, and Triangular Space.” Psychoanalytic Quarterly. 2004 Jan; 73(1): 47-61.

Kernberg O (1985) “The Subjective Experience of Emptiness” *Borderline Conditions and Pathological Narcissism.* Jason Aronson (213-224). Not available on Pep-Web. To be provided.

Anderson, M.K. (1999) “The Pressure Toward Enactment and the Hatred of Reality” J. Amer. Psychoanal. Assn., 47:503-518.

Anderson, M. (2012) “Concreteness, reflective thought and the emissary function of the dream.” Absolute Truth and Unbearable Psychic Pain: Psychoanalytic Perspectives on Concrete Experience. A Frosch, ed. London: Karnac. Chapter 1, pp.1-16. (Not on PEP Web. Provided upon request).

Ghent, E. (1990) “Masochism, Submission, Surrender—Masochism as a perversion of surrender” Contemporary Psychoanalysis 26: 108-136

Coen, S.J. (2005) “How to Play with Patients Who Would Rather Remain Remote” J. Amer. Psychoanal. Assn., 53:811-834.

Stein, R (2005) “Why perversion? False love and the perverse pact” Int. J Psa, 775-799.

McDougall, J. (1980) “A Child is Being Eaten—I: Psychosomatic States, Anxiety Neurosis and Hysteria—a Theoretical Approach II: The Abysmal Mother and the Cork Child – A Clinical Illustration” Contemporary Psychoanalysis, 16: 417-459.

Gabbard, G.O. (1991) “Technical Approaches to Transference Hate in the Analysis of Borderline Patients” *IJP*., 72:625-636.

Eaton, JL (2005) “The Obstructive Object” *Psycho. Review*, 92(3): 355-372

Caligor, E., Diamond, D., Yeomans, F.E. and Kernberg, O.F. (2009). The Interpretive Process in the Psychoanalytic Psychotherapy of Borderline Personality Pathology. J. Amer. Psychoanal. Assn., 57(2):271-301

Blechner, MJ (2009) “Erotic and Antierotic Transference” Contemp. Psychoanal. 45(1):82-92

Geist, RA (2011) “The Forward Edge, Connectedness, and the Therapeutic Process” *IJP. Self Psychol*., 6(2):235-251

Akhtar S (1996) “Someday…” and “If Only…” Fantasies: Pathological Optimism and Inordinate Nostalgia as Related Forms of Idealization” *JAPA*., 44: 723-753

Davies, J.M. and Frawley, M.G. (1992). Dissociative Processes and Transference-Countertransference Paradigms in the Psychoanalytically Oriented Treatment of Adult Survivors of Childhood Sexual Abuse. Psychoanal. Dial., 2(1):5-36