It Takes Two To Split

YEARS AGO, WHEN PROJECTIVE IDENTIFICATION AND "SPLITTING" WERE NEWISH CONCEPTS SOMEHOW CONNECTED WITH "BORDERLINES," MY LONG-TIME FRIEND AND COLLEAGUE, FRANK KLINE, DRAFTED A PROVOCATIVE PAPER ON THE SUBJECT. OTHERS WERE WRITING AND TALKING ABOUT WHAT THE PATIENT DID. THE FOCUS WAS ON HOW, AS IN MELANIE KLEIN'S TERMS, THE PATIENT SPLIT OFF FRIGHTENING, BAD, OBJECTIONABLE PARTS OF HIMSELF AND PROJECTED THESE ONTO AN EXTERNAL OBJECT (PERSON/THERAPIST) WHO WAS THEN FORCED TO ACCEPT THE UNACCEPTABLE CHARACTERISTICS AND BE CONTROLLED BY THEM.1 BUT FRANK SAID, "HEY, TWO PEOPLE ARE INVOLVED IN THIS PROCESS; A PATIENT CAN'T BE A PROJECTOR UNLESS THERE IS A READINESS ON THE PART OF THE OTHER TO BE RECEPTIVE." AT THAT TIME I WASN'T CLEAR IF FRANK WAS ENGAGING IN A CREATIVE DEBATE OR RELISHING HIS ROLE AS PROVOCATEUR. THAT WAS PROBABLY WHY I INITIALLY RESISTED HIS IDEA. I SENSED MY OWN VULNERABILITIES IF WHAT HE SAID WAS TRUE, AND I DIDN'T LIKE IT.

In spite of all the papers on countertransference, there is still a reflexive tendency to think and react in terms of what the patient does to us and not so much in terms of why we absorb the projections. The diagnosis of borderline personality disorder traveled a long, muddied, and bumpy road to arrive where it is today. Perhaps the blurred definition that existed over the years contributed to the confusion about who was doing what to whom. Michael Stone's book, *Essential Papers on Borderline Disorders: One Hundred Years at the Border,* provides an excellent chronicle of this search for definition. In his editorial comments, he writes about papers written as early as 1885 and proceeds forward through Deutsch's "As-If Personality," Hoch and Polatin's "Pseudonuerosic Schizophrenia," Michael Balint's "Basic Fault," and many other important contributions. Taken in this historical context, we see that, by 1980, the diagnosis had taken sufficient shape to be included in DSM-III with specific inclusion and exclusion criteria.

Stone writes about how Michael Balint touched on the essence of the problem of our reactions to these patients when he talked about "the uncomfortable emotions engendered in us by the borderline patient, who makes us feel we have not understood him properly, that his words fail to convey his distress whilst our efforts fail to convey reassurance" (p. 156).2

Balint's words took on an immediacy for me as I was writing this paper. On a quiet Sunday afternoon, my answering machine forwarded a message to me from the patient of a colleague whose practice I was covering while he was out of town. The patient said she was in the midst of an emergency and needed to talk to me right away. I immediately returned the call and discovered she had left the wrong number. Replaying her message four or five times did not improve the situation, nor did trying to rearrange the numbers in various ways. My colleague was miles away, sailing on the Pacific Ocean, and I was a failure in my efforts to respond. I assumed that, in her agitation, the

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patient had confused the numbers. I pictured her at one end of the line, agitated and waiting for help to arrive. I was at the other end, completely cut off from the possibility of helping. (It turned out that, when she didn't hear from me, the patient called a friend who came over and stayed with her for a while. She was fine.) What was strange, and in certain respects ludicrous, was that I felt somehow responsible for the miscommunication. There was something in her voice, the anxiety and distress, similar to the infant's cry, that made me instinctively respond. Could it be that this response is in fact instinctual? Would the evolutionary psychologists conceptualize this automatic response to the borderline's cry as evolutionarily important, a survival mechanism that rouses the mother from her deepest sleep to save her infant who is crying out, hungry, helpless, and in danger? It is perhaps not too great a stretch to think of psychotherapists being flooded with the distress of too many cries for help; cries they instinctively respond to; cries from patients whom they initially believe they can soothe, but who turn out to be inconsolable. If the situation is considered in this way, are therapists then fending off their own despair by angry attacks in which they talk about how the patients "do this to us" when in truth it is our instincts, our empathy, our compassion, our wish to heal that "does it to us"?

What is a good psychotherapist to do?

First, we have to put aside the idea that all this is under the patient's conscious control. There is increasing evidence that patients with borderline personality disorder suffer from a limited capacity to internally self-regulate, in much the same way that patients with bipolar disorder have a limited ability to regulate affective states. Kernberg\cite{Kernberg} describes the borderline patient's raw, vulnerable, intense anxiety, Gunderson\cite{Gunderson} the fears of aloneness, and Klein\cite{Klein} rejection sensitivity. These are all examples of dysregulation. This is not to say that patients with borderline personality disorder are like a colicky baby, the instinctive mother present in every therapist responds and is pained by the screams of the infant and the inability to soothe and ease the internal pain. Similarly the frightened patient, driven by internal forces, is terrified of being alone, and looks to an idealized therapist as the longed for savior. The patient, unable to believe that anything less than an omnipotent nurturer will suffice, idealizes, clings to, and cherishes the therapist or a member of the staff or group. The good mother instinct in us leads us to respond to these needs and to try and fend off the evil forces. When we fail, and the patient turns on us or whomever they have idealized in panic, anger, or despair, it is all too easy to ascribe it to splitting.

We each have our own personal history and for some this means special vulnerability to this process. It is important, however, that we not be so uncomfortable with our very human wish to be the omnipotent caretaker that we lose sight of the true nature of the transaction.

References


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