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The Management of Affect Storms in the Psychoanalytic Psychotherapy of Borderline Patients

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Affect storms are a frequent complication in the psychoanalytic approach to borderline patients. The descriptive, psychodynamic, and structural characteristics of these storms are explored, and the verbal,

nonverbal, and countertransference manifestations that permit the formulation of interpretations under such conditions are described, as are the interventions required to maintain the treatment frame as a precondition for an analytic approach. The principal theoretical formulations regarding the affect pathology of borderline patients are reviewed and related to a proposed interpretive approach. An apparently opposite development, the utter absence of emotional developments in the sessions, is examined, and its defensive function of avoiding affect storms is explored. Clinical case material illustrates the proposed approach to these storms, and clinical evidence is given to support the approach, which centers on systematic analysis of the primitive internalized object relations of these patients in the transference, the use of counter-transferenceanalysis without countertransferencecommunication to the patient, and the repeated restoration of technical neutrality in the service of protecting the treatment frame.

The following discussion is based on experience treating borderline patients with the psychoanalytic psychotherapy referred to as transference-focused therapy, or TFP, that we have developed at the Personality Disorders Institute of the Cornell University Medical College (Clarkin, Yeomans, and Kernberg 1999). The management of affect storms in sessions of patients with borderline personality organization and severe regression in the transference presents us with two apparently opposite and yet complementary situations. The first situation is one in which an open, observable affect storm explodes in the psychotherapeutic setting, usually with an intensely aggressive and demanding quality, but also, at times, with what on the surface appears as a sexualized assault on the therapist, the invasiveness of which reveals the condensation of sexual and aggressive elements. The patient, under the influence of such an intense affective experience, is driven to action. Capacities for reflectiveness, cognitive understanding, and verbal communication of internal states in general are practically eliminated. Thus, the therapist must depend mostly on observation of nonverbal communication and countertransference to assess and diagnose the nature of the object relation whose activation is giving rise to the storm of affect.

The explosive behavior of some severely ill patients takes the form of repetitive, consistent enactment of affect outbursts. Here the patient's verbal communications, session after session, are punctuated by intense affects that momentarily dominate the picture, only to shift rapidly into a different kind of affective explosion. Under these circumstances, a chronically chaotic situation is enacted that may convey the impression that the patient experiences the therapist's every statement as traumatic; the patient's readiness to feel traumatized is consistently, monotonously enacted, session after session.

The second situation seems almost the opposite of such flagrant affect storms—namely, long periods during which the patient's rigid, repetitive behavior, along with a paucity of affective expression (in fact, a deadly monotony) permeates the session. The effect on the interaction between patient and therapist during such periods can be as powerful and threatening as that of overt storms. The therapist can feel bored to the point of despair, rage, or indifference, or can at least recognize that an impasse has been reached. Upon realizing that the significant information to be had here is coming from these countertransference reactions and the patient's nonverbal communication, the therapist can attempt to analyze and interpret the scenario being enacted via the patient's behavior. This regularly leads to the striking emergence of the violent affect that the rigid monotony had masked, a violent affect often felt first in the countertransference, and then rapidly emerging in the therapeutic interaction, once that countertransference is used in interpreting the transference.

Affect storms and extreme defenses against them are far from ubiquitous in the treatment of borderlinepersonality disorders. In the psychotherapy of most borderline patients, as in the psychoanalytic treatment of neurotic patients, we can generally rely on their verbal description of subjective states, their free associations being the most important channel of communication. Over time, carefully pursuing the ever changing nature of these patients' communications, we discover the affectively dominant themes in their discourse, as well as derivatives of unconscious conflicts in the interplay among defensive operations, impulse

derivatives, and compromise formations. Usually we are able to diagnose the gradual emergence and consolidation of dominant infantile object relationships in the transference.

Naturally, nonverbal communication and countertransference are important channels of communication in all cases, but in the treatment of severely regressed personality disorders they convey dramatically more meaning than does the content of verbal communication (Kernberg 1984, 1992). It is typical with borderline patients that long-term evaluation of the course of their free associations fails to yield a clear picture of the dominantunconsciousconflict in the transference. The communication of these patients is fragmented, and the dissociation or splitting, with fragmentation of their world of object relations, presents itself as rapid sequences of verbalized fantasies and action modes of relating themselves to the therapist that change from moment to moment. This kaleidoscopic behavior is based on the activation in the transference of shifting unconsciousobject relationships manifest as rapid “exchanges” between enactment of self- and object representations, while reciprocal representations of object or self are projected onto the therapist; alternatively, primitive dissociation or splitting manifests itself as a dissociation between verbal communication, nonverbal communication, and countertransference, determining a confusing experience for the therapist even when there seems to be a certain continuity of the verbal material of free association. Primitive dissociation, therefore, may take the form of dissociated or fragmented verbal communication, and/or dissociation among the various channels of communication in the transference.

We have learned through experience that the optimal way to explore the patient's material analytically is to attempt to diagnose the transference developments moment to moment(Clarkin, Yeomans, and Kernberg 1999). The therapist has to take a very active role in such rapid diagnosis and interpretive interventions, paying close attention simultaneously to all three channels of communication (verbal, nonverbal, and countertransference) and describing (to him- or herself) in a metaphorical way the dominantobject relation activated in the transference. This permits the therapist gradually to assess which pair of opposite internalized object relations is serving the function of defense and which represents the corresponding impulse configuration in the transference at any given moment. Analysis of the rapidly emerging and shifting transference dispositions gradually reveals a typically rather small repertoire of dominantobject relations in the transference. These can gradually be sorted out into object relations dyads that function defensively and other dyads, with impulsive functions. These functions may be rapidly interchanged, while yet the dominance of the same pair of object relations dyads remains stable.

For example, a patient may in rapid succession attack the therapist, complain bitterly about how she is being treated, furiously criticize the therapist's behavior, and cry silently, as if bitterly disappointed and depressed over being rejected and unfairly accused or mistreated. What appears at first to be chaotic shifts in the relationship turns out to be the systematic repetition of the relationship between a persecutory, scolding, and derogatory object, and a rejected, depressed, and impotent self, the roles being rapidly assigned and reassigned to the patient and the therapist. The role reversals repeat the same relationship again and again. Meanwhile another object relation may be enacted with the same pattern of role reversal, representing another aspect of the transference, completely dissociated from the first. For example, a sexualized form of transference may emerge, the therapist being accused of prurient interest as his only investment in the treatment, while at the next moment the patient may become unmistakably seductive. Here two sets of mutually split object relations dyads are dominant in the transference, and may become impulsive or defensive in relation to each other. The relation of these dyads to each other needs to be worked through gradually.

The interpretive spelling out of the unconscious meanings in the here and now of each internal object relationship activated in the transference, with the gradual sorting out of self- from object representations and the dominantaffectlinking them, permits the therapist to achieve the strategic goal of eventually integrating

mutually split-off, idealized, and persecutory internalized object relations. This cannot be done during severe affect storms.

Theoretical Formulations

Several authors have dealt with the theoretical implications of these clinical phenomena. The approach developed at our Personality Disorders Institute, already implicit in what has been said so far, assumes that, in the transference, primitive dissociated internalized object relations have been activated, split along the lines of idealized and persecutory relations that in our view need to be clarified, confronted, and interpreted in terms of their self-representation, objectrepresentation, and affective dominance. This approach consists of first sorting out the dominantobject relation in the transference; then diagnosing the self- and object representations and their reciprocal enactment or projection in the transference in both the idealized and persecutory segments; and, finally, achieving integration of these mutually dissociated transferences through interpretation. The successful carrying out of these three major strategic steps leads eventually to integration of the patient's self (and internal world of object representations) and, consequently, to resolution of the syndrome of identity diffusion and the establishment of a normal ego identity. This development also brings about a toning down and maturation of the patient's affects, with a concomitant increase of cognitive control, self-reflectiveness, impulse control, and anxiety tolerance, and the development of sublimatory potential.

The consistent attention to transference and countertransference developments, the implicit split of the therapist into one part that is included in the transference-countertransference bind, while another part remains as the “excluded other” carrying out the analytic task symbolically and thus consolidating the triangular oedipal relationship over regressive dyadic enactments, complements this technical approach. The approach is essentially analytic, in that the transference is managed by interpretation alone; technical neutrality is maintained or analytically reestablished as needed, and a maximal focus is placed on analysis of the transference rather than on its supportive management.

This approach, I believe, is commensurate with the main currents of object relations theories, and reflects an integration of aspects of Kleinian, British Independent, and ego psychology approaches (Kernberg 2001). Several other theoretical formulations, potentially alternative but in my view complementary, appear to me commensurate with the overall approach outlined above.

Matte-Blanco's Theory of Bi-logical Functioning

Ignacio Matte-Blanco (1975, 1988) has proposed that the unconscious treats the converse of any relation as identical with the relation. In other words, it treats asymmetrical relations as if they were symmetrical. For example, given the relation “John is the father of Paul,” it treats the converse relation, “Paul is the son of John,” as if “Paul is the father of John”—that is, as symmetrical. This principle of symmetry is complemented by the principle of generalization. In simple terms, the dynamicunconscious, Matte-Blanco suggests, treats a part or segment or individual member of a larger set as equivalent to the whole, which is in turn regarded as equivalent to whatever still larger set it may belong to. The equivalences that flow from this principle of generalization allow subsets of the general set that are in fact markedly disparate to be treated as the same. For example, if a dark room represents the absence of the needed mother, an infant's primitive fantasy transforms darkness into a bad mother, a general principle of which any black object may be regarded as a specific instance. Thus, the black pupils of a stranger's eyes, or a black dog, may induce terror in the infant by signifying a bad, frustrating mother.

The fusional experience that accompanies both primitive rage and sexual excitement, the experience of the entire world as a hostile, invasive, destructive force under the dominance of primitive hatred, or the sense of transcendence or oneness with the world experienced by the individual in love illustrates this symmetrization that under certain circumstances, we might say, disrupts ordinary secondary processthinking. Usually, however, secondary processthinking respects asymmetry and rejects the generalization of subsets.

The mental apparatus, in Matte-Blanco's view, thus functions as a “bi-logical” system, alternating between symmetric and asymmetric thinking. The earliest affective experiences between mother and infant, particularly those peak affect states that express primitive rage and euphoria, operate under the principles of symmetry and generalization, and may be considered, precisely, as the point of origin of the psychic manifestations of drives. Peak affective experiences alternate with other interactional experiences under low-level affect conditions from birth on, in which a surprisingly high degree of inborn capacity for differentiation—that is, for asymmetrical thinking—takes place. From this viewpoint, one might consider that symmetrical and asymmetrical thinking operate alternately from birth on—hence the various combinations of symmetrical and asymmetrical thinking under varying developmental levels, affect activation, and regression.

The implication of this theory is that what on the surface appears as a simple loss of the capacity for symbolicthinking and cognitive control during affect storms represents the activation of symmetrical thinking reflecting the deepest unconscious layers of the mind. Hence, during intense affect storms, a focus on the kind of logic implied in the patient's thinking may be helpful in analyzing both the primitive object relation activated at such times and the emerging unconscious fantasies apparently blurred by the very intensity of the affective situation. The understanding and interpretive explanation of the patient's experience may be significantly facilitated by the therapist's tolerance and use of partial symmetrization of his or her affective experience in the countertransference and in communicating interpretations.

Kleinian and Generally British Contributions

Another theoretical view commensurate with our approach is the Kleinian analysis of the dominance of primitive defensive operations, particularly projective identification, during transference regressions. The result of projective identification is to induce in the therapist the affective experience the patient cannot contain while in the grip of powerful affects (Klein 1946, 1957). The therapist's function of transforming the patient's projected “beta elements” into “alpha elements” is carried out by providing for the patient, by means of interpretation, an “apparatus for thinking” (Bion 1967, 1970). Thus, the therapist facilitates the patient's reintrojection of the previously untol-erated and projected psychic experience.

The contemporary Kleinian focus on the “total transference situation” (Spillius 1988) is compatible with our focus on interpretation of verbal content, nonverbal behavior, and countertransference in an integrative formulation guided by analysis of the dominant primitive internalized object relations of the patient that are activated in the transference(Clarkin, Yeomans, and Kernberg 1999). Our focus on the unconscious in the here and now, before any attempt at genetic reconstruction, is commensurate with a contemporary Kleinian approach, and also with Joseph and Anne-Marie Sandler's stress (1998) on the analysis of the “present unconscious” as a precondition for the analytic elaboration of the unconscious template reflecting the “past unconscious.”

Another theoretical approach, again compatible with our approach to the treatment of affect storms in borderline patients, is found in both Kleinian and British Independent authors who have described the imprisonment of a traumatized self within a sadistic object (Kohon 1986; Rosenfeld 1987; Spillius 1988). This formulation proposes the equally threatening alternative, in the patient's unconsciousfantasy, of a complete defensive isolation of the self, with total unavailability of any object contact. Under either condition the patient lacks a protective “skin” that would separate self from non-self and at the same time permit contact with a human environment.

André Green's Formulations

The threat of either catastrophic isolation or boundary-blurring invasion overlaps at least in part, it seems to me, with André Green's conceptualization of the patient's identification of the patient with a “dead mother” (Green 1993a). This is an identification in which contact with a lost object, ambivalently loved and hated, can be maintained only by elimination of the self's mental functioning in a paralyzing emptiness. In Green's

formulation, the capacity for affective representation is destroyed in this process and replaced by violent acting out and/or somatization. This represents, at a metapsychological level, the overwhelming dominance of the death drive in terms of a destructive and total “deobjectalization” (Green 1993b).

A related approach to affect storms, more recently developed by Green (2000), involves the “central phobic position” of borderline patients. He proposes that there exists in these patients a central fear that a traumatic situation will be activated, a fear that forces them either to withdraw regressively from a particular mental content or to anticipate its consequences defensively, leaving the patient in a constant attitude of needing to escape from any traumatic recognition of his or her psychic experience. Under these circumstances, any effort by the therapist to help the patient become aware of that psychic experience becomes itself a traumatic event. Here the struggle against mental representation reflects not only the effort to avoid a specific internalized object relation, but a general effort to eliminate the representation of mental conflict. Thus, a patient's active efforts to destroy the representational expression of the conflict may reflect both a general defense against the activation of a traumatic situation and a specific unconsciousidentification with a dead or destructive object.

I believe that these formulations parallel our efforts to clarify the nature of the most regressive transferences of patients whose mental life is dominated by hatred—that is, by the aggressively determined object relations typical of the syndrome of malignant narcissism, where only mutual destructiveness seems to provide meaning and closeness and only a very reduced remnant of a libidinal investment is available (Kernberg 1992).

An Ego Psychological Approach

Still another formulation of the nature of severe transference regressions in borderline patients has been suggested, from an ego psychological perspective, by Peter Fonagy's hypothesis of “mentalization” and “self-reflectiveness” (2000; Fonagy and Target 2000). In essence, he proposes that in the infant-mother relationship the normal function of mothering includes both her empathic internalization of the infant's experience and her capacity to formulate that experience and convey it to the infant even while indicating her differentiated relationship to the experience. Thus, the mother's communication includes clarification of what is going on in the infant's mind, her empathy with it, and her different reaction to the infant's experience.

The mother of the future borderline patient is postulated to be incapable of accepting empathically the infant's communication and unable to elaborate it, thus leaving the infant alone with what becomes an unbearable, overwhelming psychic experience that cannot be mentalized adequately; alternatively, the mother identifies herself with the infant without being able to establish an internal distance from the child's experience. Reflecting to the infant such a total identification with an intolerable affect state results in that state's becoming even more overwhelming, with a momentary loss of ego boundaries.

If the mother can appropriately reflect and communicate the infant's experience, this permits the infant to internalize not only the understanding of that experience but also the mother's reflection about it, thus fostering in the infant a normal awareness of and interest in one's own mental functioning and that of others (“mentalization”). These processes foster the development of a self-reflective integrative ego function that strengthens capacities for symbolization and for the containment of emotional experience. This formulation, which stresses the cognitive aspects of the structualization of primitive internalized object relations, seems to me eminently compatible with the object relations perspective underlying our approach.

Transference-Focused Managementof Affect Storms

In initial interviews borderline patients usually show far better control of affect than they are able to maintain during effective treatment. The likelihood of periods of inordinate violence of the patient's affect, and its expression in action and/or countertransference, requires, however, that patient and therapist agree in advance on the conditions of the treatment that will make management of such episodes possible. These conditions must include the maintenance of a clear and stable boundary for the therapeutic setting. This boundary

involves not only a fixed time and place for the psychotherapeutic relationship, but also the extent to which the patient may yell or not, prohibition of any destructive action against the therapist or the surroundings in which the treatment takes place, and the need to protect the patient from any dangerously destructive action against the self. The patient must understand that physical contact between patient and therapist is prohibited as a condition of treatment.

With these boundaries in place, it is possible to carry out the diagnosis and interpretation of the dominantobject relation and of the corresponding primitive defensive operation (particularly projective identification) as these become activated in the sessions. When affect storms occur, however, the patient may not be able to accept any interpretation, particularly of projective identification, perceiving the interpretation as a traumatizing assault. Here the recommendation of Steiner (1993), to interpret the nature of what is projected as “object centered,” spelling out the patient's perception of the therapist in great detail, neither accepting nor rejecting that perception, gradually facilitates the patient's tolerance of what is being projected and can clarify its nature and the reasons for it, before interpretation of the projection proper “back into the patient.”

Affect storms place a special strain on the therapist's tolerance of the countertransference; it is necessary both to keep one's mind open to exploring (mentally) the implications of the strong feelings aroused by the patient's behavior, and to protect oneself against acting them out. The therapist must attempt to stay in role, even when responding with corresponding intensity to the intensity of the patient's affect.

We have observed in our borderlinepsychotherapy research project that some therapists, whose interpretive interventions seem relevant, clear, sufficiently deep, and appropriately timed in moment-to-moment contact with the patient, nevertheless have difficulty in their treatment because of a pronounced discrepancy between the intense affective activation in the patient and the outward serenity of the therapist. Nothing is more certain to further inflame an affect storm than a wooden, unresponsive, or soft-spoken therapist whose behavior suggests that he or she doesn't “get it,” is contemptuous of the patient's loss of control, or is terrified and paralyzed by the intensity of the patient's feelings. The therapist must be willing and able to engage the patient at an affective level of appropriate intensity that recognizes and yet “contains” the affect of the patient.

This situation, in which patient and therapist express themselves at the same affective level, is not infrequent in the treatment of severely disturbed patients. It may reflect Matte-Blanco's concept of a primitive level of symmetric logical functioning, where the self's very intensity of affect determines the combination of generalization and symmetric thinking, with the result that only a related, somewhat corresponding intensity of affect on the part of the object enables communication to be maintained.

It may seem obvious to state that the therapist's affective response must be sensitive to that of the patient, particularly when the dominantaffects are so extremely aggressive or invasive. The fact remains that at certain points technical neutrality, in the sense of not taking sides regarding the issues in conflict in the patient, may be perfectly commensurate with an intensity of affect expression that signals the therapist's availability, responsiveness, and survival, without contamination by the patient's hatred. The enactment in the transference-counter-transference bind that intense types of projective identification provoke may be functional in the sense of permitting the diagnosis of the primitive object relationship being enacted.

The effective management of affect storms eventually makes it possible to interpret the dominant set of object relations from surface to depth—that is, from the defensive to the impulsive side, starting from the patient's conscious, ego-syntonic experience and proceeding to the unconscious, dissociated, repressed, or projected aspects of the patient's experience and the motivations for the defenses against it. This process permits the transformation of the affect storm, with its components of action and bodily responses, into a representational experience, a linkage of affect and cognition in terms of the clarification of the relationship between self- and objectrepresentation within the frame of a dominantaffect(Clarkin, Yeomans, and Kernberg 1999).

The psychoanalyst whose patients can tolerate a standard psychoanalytic technique may never have to address the occasional affect storm in the manner just described. But it may be an essential application of psychoanalytic technique to those cases in which most psychoanalysts would see standard psychoanalysis as contraindicated and where a transference-focused psychoanalytic psychotherapy may be the treatment of choice (Kernberg 1999).

The deadening calmness with which some patients defend against affect is a chronic behavioral enactment that is split off from the content of verbal communication. Seemingly just the opposite of an affect storm, it nevertheless evokes an intense countertransference reaction that may be understood in relation to the patient's nonverbal behavior but is much more difficult to relate to what is communicated verbally, because the therapist tends to get lulled over time into accepting the patient's monotonous behavior. Here the therapist's problem is not the containment of an intolerably intense countertransference reaction but rather the sense of internal paralysis or guilt over increasing loss of interest in a patient who, at the surface, seems “so uncommunicative.”

For example, one of our patients spoke in an aggressive and derogatory tone of voice, almost never looking at the therapist, while talking about various subjects apparently unrelated to this chronic aggressive demeanor. Another patient used to slouch on a sofa, sipping from a water bottle, almost conveying the impression of a sleepy baby expecting to be soothed and comforted into total sleep, while filling the hours with trivial contents. The first patient reported chronic experiences of hostile reactions by other people toward her, which she interpreted as directed against everyone having her racial characteristics. The second patient would exasperate health personnel because of her effective way of extracting supplies and support for her totally passive, indolent, and parasitic lifestyle. The task in both cases, obviously, was how to bring into consciousness an aspect of the therapeutic interaction that was totally dissociated from the verbal communication, and yet central both in the transference and in the patient's life experience outside the sessions.

The indication is for a clear, noncritical focus on what is going on in the session, raising patients' interest in their nonverbal behavior and gradually facilitating the explanation of its transferential function. Such an approach tends to evoke strong denial, or else the patient may simply ignore the therapist's comments, smile indulgently, and maintain the behavior that has been highlighted. The patient may be accustomed to similar confrontations from others less friendly, and so be prepared to neutralize them. It may be helpful to analyze the patient's view of the motivation of those others: this information gives a preview of how the patient is going to experience the therapist's confrontations. The therapist's persistence in analyzing what is going on in the session eventually transforms the monotony of behavior into a storm of affect: this represents a moment of truth, in which the violent reaction reflects the object relation against which the monotonous behavior had been defending. At such points, the therapist may interpret that underlying object relation in Steiner's “object centered” way (1993). Object-centered interventions facilitate an immediate analysis of the total object relationship, as in the statement, “Because you perceive me as having such hostile and derogatory ways of treating you, it is natural that your own reaction to me at this point should be like that of an enraged child scolded by a cold and cruel father.”

In these situations, Winnicott's concept of “holding” (1958) or Bion's concept of “containing” (1970) are useful ways to conceptualize the therapist's capacity to integrate, in interpretive interventions, an understanding both of the patient's behavior and of the counter-transference, without enacting the latter. That said, it needs to be added that partial enactment of countertransference responses are almost unavoidable under the trying circumstances created by repeated affect storms or the deadening defensive patterns against them. Such partial enactments or even acting out of the countertransference do not, in my view, represent a serious danger to the treatment, or a significant distortion of technical neutrality.

To the contrary, if the therapist feels comfortable with his or her overall approach to the patient, and can honestly acknowledge, without excessive guilt or defensiveness, having lost control over affect expression at a certain point, this may convey to the patient that affect storms are not that dangerous, that some mild loss of control is only human and does not preclude a return to an objective and concerned treatment relationship. At times, the therapist's expression of outrage at something outrageous communicated with a provocative calmness by the patient may be an appropriate way of maintaining contact. These patients may require, as part of the analysis of the underlying dynamics, an affectively intense investment on the part of the therapist in pointing, moment by moment, to the hidden violence behind the deadening monotony. Observed from the outside, it might appear as if a totally phlegmatic and controlled patient were in treatment with an hysterical or even violent therapist. Indeed, the therapist may feel uneasy in this role, which may be experienced as "supportive" (because of the intense activity required) or even controlling or manipulative. However, the therapist may have good reason to think, reassuringly, that this intensity is not in the service of controlling the patient's actions or of "moving" the patient in any particular direction, but rather is designed to clarify what is going on through accentuating the emotional exploration of a development in the session at that moment. The therapist works, to use Bion's phrase, "without memory or desire" in exploring in depth the hidden violence in the present interaction (manifest in the therapist's reading of the patient's behavior and the counter-transference). The therapist's manifest affective investment may be an important way in which to assert that he or she is standing on the side of life and of investment in object relations, as opposed to deadly "deobjectalization." Insofar as the therapist is not "pushing" or "encouraging" or "demanding" in his response to the patient, but is simply verbalizing a perception of the present interaction, this is still an "exploratory" rather than "supportive" approach.

During intense affect storms, whether spontaneous or following the confrontation of deadening dissociative behavior patterns in the hours, the patient may not be able to listen at all to the therapist. It is as if these patients' intolerance for developing representational expression of their own affective experiences now includes efforts to destroy their representational expression by the therapist. In other words, the patient's destructive impulses may take the path of efforts to destroy the therapist's capacity for cognitive functioning.

The therapist has to differentiate incapacity to listen, at the height of affect storms, from the chronic dismissing of everything the therapist says as an expression of the "syndrome of arrogance" described by Bion (1970). As part of this syndrome, a combination of pseudo-stupidity, curiosity (regarding the therapist), and arrogance reflects the dominance of primitive hatred in the transference, together with the patient's incapacity to tolerate the awareness of this hatred. Here acting out replaces entirely the ordinary subjective awareness of affective experience. There are still other patients whose chronic dismissal of what comes from the therapist is part of narcissistic resistances in the transference that need to be resolved with the usual interpretive approaches to the intolerance of a dependent relationship to the therapist (Kernberg 1984).

Returning to the problem of affect storms, there are times when the therapist has to wait for the intensity of the affect storm to subside before an interpretive comment can be made; at other times, it might be helpful simply to ask directly whether the patient could tolerate a comment from the therapist at that point. I sometimes find it helpful to tell the patient that I have thoughts on my mind that I am hesitant to spell out, because I do not know whether the patient might react to them with such vehement anger as to obscure an understanding what I am trying to say. If the patient then tells me, ragefuly, not to say anything, I may remain silent for the moment, and interpret only later what the reasons might be for the patient's intolerance of any communication from me.

Under such circumstances, the therapist should ascertain, before speaking, whether the intended intervention elaborates the counter-transference disposition as part of the material included in the intervention. If the therapist feels controlled by the countertransference, this is an indication for waiting and for internal elaboration before intervening. It is also extremely important that the therapist feel safe in making the intervention, because

to be afraid of the patient is a powerful message that cannot but increase fear in the patient; at such times, the patient's rage is a defense against fear of his or her own aggression. The therapist's physical, psychological, professional, and legal safety are indispensable preconditions for work with very regressed patients, and the therapist must take whatever measures are necessary to assure that safety: this is a precondition for effective concern over the safety of the patient.

An important complication in the psychodynamic psychotherapy of borderline patients is the danger of “spilling over” of severe affect storms from the sessions into the patient's life outside the sessions. For example, one patient developed an intensely erotic attachment to the therapist, feeling that if the therapist were not to leave his wife and all other emotional commitments and dedicate himself solely to the patient, her life would no longer be worth living. This intense erotic transferencecontained, as may seem obvious, significantly pre-oedipal elements, the desperate claim of a baby to have the exclusive attention of its mother. On the surface, however, it took the form of a “falling in love” that became so disturbing to the patient that she expressed to her husband her despair over the therapist's failure to respond to her love. This of course threatened her marriage as well as the treatment.

Under such circumstances, it may become important to set limits to the patient's behavior outside the hours or even to intervene directly in the patient's life, with a clear understanding that this means a significant move away from technical neutrality, requiring its interpretive reinstatement later on (Clarkin, Yeomans, and Kernberg 1999). These, fortunately, are complications that rarely occur when general concern is taken to maintain clear treatment boundaries. If, however, the therapist ignores or does not systematically interpret acting out of the transference, major “spilling over” into the patient's external life becomes much more likely. For example, one patient lingered on in the therapist's waiting room, often for several hours. As this transferenceacting out was not addressed in the sessions, the patient ended up practically sleeping in the waiting room all day long, creating serious complications both for the patient and for the therapist's practice.

Particular Complications of Severe Affect Storms

Some patients learn to use affect storms to frighten family members and the therapist, eventually controlling the latter by instilling fearful avoidance of dealing with particular issues. Some inexperienced therapists may remain paralyzed by fear of losing both the patient and the supervisor's favorable opinion if they confront the patient with the intimidating behavior. Therapists of difficult borderline patients need the support of their supervisors and their peers so as not to be judged negatively if the patient disrupts the treatment, and to be helped to face this situation by evaluating the paranoid fantasies these patients may induce in the therapist's mind.

Patients “spoiled” by a lifetime of success in intimidating others may threaten to injure the therapist or objects in the therapist's office, may declare vehemently the intention to end the treatment because of rage at the therapist, or may threaten lawsuits. The therapist must maintain the boundaries of the treatment and so structure the situation as to be able to maintain control without being provoked into a “counter-provocative” mode, “threatening” the patient with certain action unless the patient “behaves.” The situation is best handled by means of a calm statement that reclarif ies the conditions under which the treatment can be maintained, perhaps a comment indicating that the therapist would be sad if the treatment had to be interrupted because the patient was not willing or able to maintain these conditions, followed by interpretation of the unconscious functions of the patient's behavior.

A therapist may be taken aback by the extent to which certain outrageous behavior patterns are “second nature” to the patient. If the therapist feels that the therapeutic relationship has not developed sufficiently for an effective exploration of this behavior and postpones addressing it for too long, the therapist may cease to expect the patient to behave differently. Chronically self-destructive behavior patterns that express severe regression, such as staying away from work, avoiding interaction with significant others, or rationalizing an isolated, vegetative, or parasitic lifestyle, may remain so ego-syntonic that, when the therapist finally raises

questions about them, the patient may react with intense indignation. The implicit threat of violence or of abandoning treatment when the patient's lifestyle is being questioned, or a consistently dismissive reaction to the therapist's efforts to examine this issue, may induce in the therapist an internal state of passively giving up.

There probably are thousands of borderline patients who have managed to lead empty lifestyles, obtaining medical disability, becoming dependent on more fortunate family members or on endless welfare support, and ending up with a life restricted to obtaining pleasure from food or drugs or alcohol, or simply from sleeping and watching television. Often these patients turn out to be highly intelligent, well-educated people whose early traumatic experiences and severe pathology of object relations in adolescence is followed by a gradual extinction of all investments in intimate encounters, sexual life, work, and other interests. When eating remains as almost their only pleasure in life, such patients reach middle age morbidly obese, physically neglected, welfare “contained.” They enter psychoanalytic psychotherapy with the typical “deadening” transference that replicates their destruction of object relations in ordinary life. The therapist is faced with the dissociation between verbal content and nonverbal manifestations in the hours, as well as the corresponding countertransference activation mentioned earlier. Psychodynamically, the unconsciousidentification with a sadistic object whose love is ensured only by the patient's self-destructive submission to it may now become manifest in attacks on the therapist and the treatment, the patient projecting an unrealistically demanding self onto the therapist. The identification with a “dead mother” described by Green may be a specialized instance of this development.

In these cases, the activation of primitive affect storms in the hours may be the first sign of psychological life for many years. These are extremely difficult cases; the prognostic indicators for change include, in addition to at least normal intelligence, the absence of antisocial behavior and the possibility of reducing secondarygain via an active work situation that can eventually provide more gratification than that obtained from a parasitic social support system. If the patient has been able to maintain some semblance of object relations, and a stable work situation or professional engagement, the prognosis is much better.

Some patients test the therapist's limits of tolerance in ways that are difficult to control without the therapist's feeling inappropriately punitive. Examples include patients who neglect themselves physically, smell bad, and make the therapist's waiting area and office space unpleasant for others; patients whose erotic seductiveness takes primitive forms, like arriving without underwear and exposing themselves in the hours in ways subtle enough that the therapist is concerned whether confronting the behavior may be experienced by the patient as an erotic seduction or an attack; patients whose aggressive behavior takes the form of chronically insulting not only the therapist but the office staff, with potentially damaging door slamming and the throwing of objects in the therapist's office. Obviously, these are not behaviors that are expected from patients in standard psychoanalytic treatment. Senior therapists often refuse to treat such patients. Junior therapists, in turn, may lack the experience to deal effectively with such extreme yet at times subtly disguised behaviors.

Unless the therapist explicitly informs the patient of what will and will not be tolerated, it may be impossible to analyze the patient's motivation for behavior that makes the therapist uncomfortable. When the patient's behavior exceeds limits that have not been clearly spelled out, it is helpful for the therapist to be direct and matter-of-fact in specifying the unacceptable behavior, without any interpretive effort at that point. It may be neither possible nor necessary to justify, on the basis of therapeutic principles, why exactly some behaviors need to be limited. For example, a patient may start taking books down from the therapist's shelves and examining them without having asked permission. Such mild yet maddening presumptions of intimacy and entitlement cannot be addressed as long as doing so will restrict the therapist's technical neutrality. If the therapist returns to such behaviors at a later point, when their transference implications have become available for interpretive work, and technical neutrality is thus restored, these situations can be resolved very

satisfactorily. What is important is that the therapist feel comfortable within the treatment structure, and able to maintain it in the long run without feeling unduly restricted.

There are patients who express an unconscious tendency to burn all the bridges behind them—and before them—through a subtle, unobtrusively alienating behavior in the hours. It can take the form of repetitive dismissal of whatever comes from the therapist, or a chronic lack of concern for themselves expressed through consistently missing sessions, coming late, or declaring the wish to end the treatment as part of minor tantrums. In the long run the therapist may be tempted to agree with the patient that the treatment is useless, and to be relieved at the prospect of ending the attempt. This, on the surface, is not an affect storm in the ordinary sense; rather, it is a gradual erosion of the therapist's emotional involvement and commitment to the patient that eventually requires only a relatively minor acting out on the patient's part to provoke the therapist into colluding with ending the treatment. The diagnosis of such a situation in the course of its development is equivalent to diagnosing the chronic countertransference distortions that may occur also with much less severely ill patients, and without the serious consequences they have here. It is important to transform such a slippery road into an active exploration. Insofar as it is the destructiveness of the patient that is insidiously producing deterioration of the therapeutic relationship, an active clarification and confrontation of that situation unmasks the violence of the destructive impulses unconsciously expressed by the patient. This “unmasking” may initially strike the therapist as violent behavior, perhaps eliciting guilt, a countertransference reaction that requires analysis.

Some of these patients may evoke in the therapist the emotional conviction that they are less than real, or less than human, or that ordinary responses of concern for themselves and their lives cannot be expected of them. Eventually the therapist may realize that any hopeful expectations for the treatment have begun to erode. I am talking about hopefulness in the sense of a conviction that, were the patient to make a real effort, he or she could achieve a life situation far more satisfactory than the current one of near paralysis. The loss of this hope is a serious countertransference problem, complicating and threatening the psychotherapy in a basic way.

There are patients who appear to use the passage of time to destroy themselves and the treatment in unobtrusive ways. By wasting time in the sessions they implicitly deny the value and the transitory nature of life itself. A general attitude that may be helpful to the therapist is to combine a long-range “patience” in working through the same issues again and again, with a clear sense of “impatience” in each session, interpreting over and over the patient's efforts to eliminate the signifi-cance of each concrete encounter with the therapist. Yielding to the temptation of the opposite behavior—that is, endless “patience” (actually, mere passivity) in each session, while a chronic impatience accumulates and disposes the therapist to a sudden, impatient rejection of the patient, determined by an outburst of negative countertrans-ference—is a major danger in such cases.

A tendency of some patients toward a masochistic exploitation of the therapeutic situation may be uncannily linked to the development of perversity in the transference. I refer here to patients who use the fact that they are in a psychotherapeutic treatment as a defense against the anxiety caused by their deteriorating life situation. It is as if, as long as they are in therapy and can harbor the unconsciousfantasy that now the therapist carries the responsibility for their lives, they may abandon realistic anxiety or depression over the destructiveness of their life situation. Other patients implicitly challenge the therapist to change their life situation, with an unconscious, and sometimes conscious, sense of triumph over the therapist's inability to effect change in their circumstances. Unconscious envy of the therapist, particularly prominent in severe narcissistic pathology, may express itself in this way; such patients may unconsciously arrange for the treatment to harm them by choosing a therapist whose location requires inordinate travel time, or who costs too much, or who cannot schedule sessions that do not interfere with vital aspects of personal life or work. The linkage of this complication with the syndrome of perversity consists in the implicit recruitment of love, concern,

and dedication implied in the therapist's work at the service of self-directed and other-directed aggression(Kernberg 1992).

There are patients who develop chronic affect storms in the ses sions as a vicarious living out of conflicts that usually are under control in their everyday life. Here a particular use of the treatment as “secondarygain” is an expression of a more general tendency of some borderline patients to replace life with the treatment interaction. This development becomes obvious over a period of time, where, on the one hand, interpretations seem not to bring about any change in the material of the sessions and, on the other, the patient's withdrawal from all other life situations, the emptiness and immobility evinced outside the ses sions, expresses a sharp contrast with what is going on in the treatment. This secondarygain needs to be interpreted consistently, and its destructive effects on the patient's life, as well as on the treatment, must be gradually clarified and interpreted.

The destructive and self-destructive impulses of some patients are so powerful that the unconsciouspleasure in destroying the treatment overshadows any concern these patients may have for improving their life situation and psychological functioning. It is as if the triumph over the therapist's efforts to help were the only unconscious source of pleasure remaining in the patient's life. At times, setting a realistic time limit to a treatment where such a “recruitment of love at the service of aggression” has taken place may present the last opportunity for the patient within this treatment frame. This situation may be considered a particular case of the development of perversity within the transference, and usually presents in patients with severe narcissistic pathology, particularly the syndrome of malignant narcissism(Kernberg 1992).

I referred earlier to patients who, instead of either severe affect storms or monotonous deadening of the hours, present a chronic, agitated, traumatophilic, histrionic, or chaotic affect display both in the transference and outside the therapeutic setting. The diagnosis of the dominantobject relation throughout that apparent chaos is essential if one is to interpret and modify this pattern. In these cases, one must carefully evaluate whether such a chronic affective pattern masks an undiagnosed secondarygain, such as the destructive undermining of intimate relationships, or of potentially satisfactory work situations.

When antisocial behaviors complicate the situation further, such behaviors require early attention, because they signal most clearly the destructive attempts directed at the patient's object relations. Irresponsibility toward the management of money, or unconscious or even conscious eroding of the support system that permits the treatment to be carried out, is an alarm signal that the treatment is under attack. Because such behaviors are often intimately woven into the patient's chaotic life system they may initially be neglected.

The interpretation of behaviors that reduce active therapeutic time must take precedence over everything else. The patient may attempt to seduce the therapist with life crises that would seem to be extremely urgent, while simultaneously underutilizing the therapeutic space and thus denying the therapist sufficient time to examine the crisis. Irresponsible exploitation of relatives who support the patient's treatment is another manifestation of perversity, as is acting out the negative transference by undermining the therapist in their eyes; here the therapist's technical neutrality and respect for the patient are exploited in the service of expressing unbridled aggression and destroying the therapeutic relationship.

Quite frequently, a severe transferenceacting out and mention of an urgent life situation, apparently unrelated, occur simultaneously in the session. The therapist is faced with an apparently impossible dilemma: Focusing on the life crisis prompts the patient to insist triumphantly that the therapist's efforts to understand the crisis do not help at all. If the therapist focuses on what is going on in the transference, the patient indignantly complains that the therapist is “narcissistically” concentrating on the therapeutic relationship while neglecting the urgent life situation the patient is facing. Patients who use such “double-edged affect storms” with some frequency manage to create extremely chaotic treatment situations in which the therapist can often feel disoriented.

There are several approaches that may help under such conditions. First, one must decide, session by session, what seems most urgent. If the crisis in the patient's external life situation indeed has a dangerous quality of urgency, it should be explored fully while keeping in mind that the patient may well undermine any attempt at collaboration with the therapist. If such a “blockage” occurs, one should revert to analyzing the transference situation as an impediment to helping the patient understand what is going on outside the sessions. In some cases, particularly if it is a relatively early manifestation of this pattern and the therapist is as yet uncertain how to deal with it in an integrated way, it may be helpful to suggest a temporary increase in the frequency of sessions, to have more time to deal with both the emotional crisis in the patient's life and its transference implications. The risk, of course, is of inadvertently encouraging the patient to use affect storms to extract more time from the therapist. This eventually will have to be explored.

To begin with, however, the additional time may enable the therapist to become clearly aware of the defensive nature of the double-edged affect storms and to convey this awareness to the patient. Gradually an emphasis on analysis of the transference can be developed to prepare the patient to use in sessions what the treatment offers, and to understand why he or she is not yet able to use it in daily life. Given the standard frequency of two psychotherapeutic sessions a week in our research project, an increase to three sessions weekly over a limited period of time seems reasonable for such patients, and may be reduced once the situation is under control. A three-sessions-a-week schedule might seem helpful over an extended period, but careful analysis may reveal that coming to sessions is acquiring the secondarygain of escaping from the tasks of the patient's life situation. In our experience, a frequency of two sessions weekly is the very minimum in which transference-focused psychotherapy can be carried out. Three sessions a week may be optimal for many cases, but four sessions do not in our experience increase the progression of the treatment. Indeed, for these severely regressed patients, four or more sessions a week tend to increase the secondarygain of “treatment replacing life.”

Patients with unlimited financial means present a special problem in the sense that the absence of the usual necessity of weighing costs against benefits decreases the motivation of patient and therapist to examine the meaning of a gradual increase in the frequency of sessions. Patient and therapist alike experience the additional sessions as indispensable, because any discussion of restoring the original frequency generates intense anxiety in the patient. Yet a careful analysis of the material usually reveals an unconscious destruction of what the patient is receiving from the therapist as the driving force toward increasing the number of sessions. Analysis of this unconscious destruction may make it possible to revert to a more reasonable schedule, one that prevents the treatment from replacing life.

A Clinical Case Illustration

The patient was a twenty-eight-year-old woman with a borderline personality organization and a narcissistic personality, functioning on an overt borderline level. Her main difficulties were chronic suicidal behavior, inability to maintain a work situation despite having obtained two master's degrees in the biological sciences, and lack of gratifying stable sexual or love relationships. Her chaotic relations with men would evolve into severely sadomasochistic interactions, with eventual rupture of the relationship. She had drifted from one subordinate job to another and had experienced severe affect storms and chronic fights with her family members, leading to such isolation from them that at one point she became almost a “street person.”

Sessions with her had been marked by intense affect storms, the patient's rejecting practically everything I said and distorting my statements into attacks aimed at her. She had expressed endless complaints about my coldness, indifference, invasiveness, and cruelty, and given endless descriptions of the warm, friendly, understanding, and spiritually uplifting quality of previous therapies she had engaged in. It was she herself, of course, who let me know that most of these therapeutic encounters were of brief duration, except with one psychotherapist who practically adopted her and blurred the boundaries between therapy and personal

friendship. She had been in treatment with me going on two years, the longest she had remained in a treatment situation, and in the context of this treatment she had been able to take on and maintain a job commensurate with her knowledge and experience, for the first time in her life. The suicide attempts had stopped, her impulsive and chaotic relations with men had decreased, and the relationship with her family had become less stormy, though it is not an exaggeration to say that “all hell would break loose” in most sessions with me.

To summarize the outstanding dynamics of her case, her mother was a chronically alcohol-dependent person who eventually developed an organic brain syndrome secondary to her dependency. During the the patient's late childhood and adolescence, the mother remained in bed, semicomatose. The father, a respected college professor, tried to “discipline” the patient, his youngest daughter, who in contrast to her older siblings became a major source of concern because of her severe behavioral disturbance from early adolescence on. He tried to interfere with the patient's chaotic sexual life, and she experienced him as both intrusive and jealous of her relations with other men.

In the transference, from early on, she alternated between times of violent and complaining behavior, with a haughty grandiosity and “pseudostupidity” that seemed to reflect closely Bion's description of the syndrome of arrogance. At other times, a subdued, complaining, yet subtly erotically seductive behavior prevailed. In this phase she presented herself in minimal acceptable clothing and engaged in clearly exhibitionist behavior. Early interpretations had focused on her fear that only a caring father could protect her from the empty indifference of the relationship with her mother, but that such a concerned father would invariably become sexually seductive and exploit her. There was no history of sexual abuse reported by this patient, and it was not difficult to interpret her fear that any concern of mine for her would seem a sexual exploitiveness as a projection onto me of her own wishes to seduce her father, the only alternative to her mother's catastrophic unavailability.

In simple terms, I was perceived either as intrusive, invasive, and perhaps sexually seductive, or as cold, indifferent, and lethargic. In recent months, this behavior shifted into ever more powerful rage attacks. She accused me violently of not listening, of distorting what she said, of imprisoning her in this treatment. She seemed totally impervious to all my interpretations. She attempted to throw objects at me and managed to damage minor objects in the room. On a few occasions, I had to forcefully warn her that any further damage to any object in the room or any physical attack on me would mean the immediate end of the session. She learned exactly what her limits were, and often would stand in front of me, shaking her hands and yelling at me.

The present session started exactly with such a development of intense rage and yelling. I pointed out to her that she had left the last session talking with me calmly about a problem at work, and had given indications that my helping her to sort out her emotional reaction to a subordinate at work had helped her decide how to handle the situation. Because of that, I went on, I wondered whether she now had to create a “scene,” and was attempting to provoke me into a rage because of her own experience of hatred and violence as an expression of profound guilt over the implications of having moments of a good relationship with me. Upon this comment of mine, the patient got much worse; she accused me even further of total ignorance and distortion and lack of memory of what had happened in the last session, and of focusing only on her relationship with me, rather than on the terrible problems she had to face at work every day.

My next comment was that she was feeling much worse after I pointed out that she maintained a fighting situation because she could not stand the memory of good moments of her work with me. I wondered whether she now felt that I was trying to make her feel guilty for treating me this way after the good relation that had evolved in the last session. The patient interrupted me several times and, in purportedly repeating what I said, distorted my words completely.

At that point, I grew impatient. In a strong voice I told her that she was talking sheer nonsense, and that she knew it perfectly well. I illustrated, point by point, in what way she had just distorted everything that I had just

said, interrupting her as loudly as she would interrupt me while I was trying to say this. Retrospectively, this acting out of my countertransference was probably motivated only in part by her rage attacks, to which I had already become quite adjusted, and reflected in part an impatience and irritability of mine having to do with unrelated administrative problems that had emerged on that particular day. In any case, I thought, as soon as I had finished talking, that I had enacted the hateful, persecutory object that she had unconsciously projected into me. I had reacted as the victim of a sadistic, overwhelming, invasive, hateful object, becoming myself such an object in turn, attempting to reproject the victim role onto her.

While I was thinking along these lines, the patient, to my great surprise, responded in a totally natural voice, and in a thoughtful way, that I couldn't tolerate her affect storms: wasn't the treatment geared to permit her to express herself freely in the hours? After a little while, recovering from my shock, I said: “I am impressed by the fact that you can only talk to me in a normal way if I talk to you as loudly and harshly as you talked to me before. I wonder whether this is a confirmation that you can't tolerate it if I talk to you in a thoughtful, calm way as if talking to an adult, rational woman.” “Or maybe,” I went on, “only when I yell at you can you really believe that I care. When I calmly try to help you understand what is going on, you experience that as indifference or phoniness.”Now the patient remained silent, and after a few minutes, started to cry. She then said that I did not know how much she was suffering. I wondered whether perhaps the only way in which she felt able to let me know how much she was suffering was to attempt to provoke me with hateful behavior, so that I could experience the sense of impotence and paralysis that she had said she sometimes experienced at work. Shortly after this exchange, the hour ended.

One may interpret this situation as the effect of projective identification of a primitive, hate-dominated, persecutory object, and the partial acting out in the countertransference of this projected object by the process of projective counteridentification. In other words, the relationship between a sadistic object and its victim, possibly a very primitive layer of experience reflecting the deeply dissociated hatred of an unavailable mother, or the relationship with a “doped” mother who could be aroused only by violence, had been enacted now. But the reversal of this relationship, which might have been expected as the consequence of my countertransferenceacting out, did not occur; to the contrary, the patient was able to register, for the first time in this session, my communication to her. This clinical vignette illustrates the complexity, challenges, and risks involved in the diagnosis and management of affect storms.

At the end, in successful treatments, affects are translated into a relationship between self- and object representations. The result of integrative interpretation of primitive transferences is a resolution of identity diffusion and the integration of the internal world of objects. The overall objective of retransforming somatization and acting out into a full emotional experience will coincide with what in Kleinian terms is the depressive position, and in traditional ego psychological terms the consolidation of ego identity. In Fonagy's terms, patients achieve the capacity for mentalization and self-reflectiveness, and in Green's terms the capacity of preconscious functioning with fantasy, daydreams, and dreaming, and the full capacity for symbolic representation. In the process, we expect those cases who are able to benefit from this treatment to be able to resume a satisfactory love life, intimacy and friendship, creativity and effectiveness in work, and the finding of their own ways of satisfaction and creativity in other areas of their life.

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