

Krista: thirty plus years of treatment in a borderline group

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Abstract

This article describes as a patient, Krista, after twenty-five years of group therapy begins to resolve her capacity to mourn. She has resolved her aloneness issues and has developed the capacity for sadness. She has taken in the solid introject of Dr. Shaskan and has been able to remain “affectively connected to the therapist...in the face of current ambivalence, that is, libidinal object constancy must have been achieved”. Krista has moved from a state of aloneness to one of loneliness in which she can miss Dr. Shaskan and long for him, all manifestations of libidinal object constancy. At the same time, her primitive guilt is modified so that she can experience his loss with anger with minimal destructive self-punishment: she develops a psycho-somatic illness shortly after his death.

In conclusion, what happens for Krista is that in her capacity to mourn Dr. Shaskan, she develops the capacity to mourn for her own life and her own tragedies. In so doing, she begins to explore the issues that are illustrated in Dr. Adler’s phase three; namely, the reliving of old experiences. She begins to confront the sexual abuse she has received from her father and uncle and to begin a life long task of repair from this horror. Krista is able to sustain a long-term relationship with a male figure and begins to confront and resolve conflicts in her life.

Key words: borderline patient, group psychotherapy, conflict, abuse, primitive guilt

Historical Background

Patient background

Krista is a 62 year-old female, born and raised in Texas. She is the oldest daughter of a wealthy self-made, oilman and a passive, housewife mother. She currently has two younger brothers, one two years younger and the second five years younger; and two much younger sisters, one thirteen years younger and the other fifteen years younger. Her older brother by two years died in 1976 of a tragic small plane accident in which he was the pilot.

Krista’s initial presentation revolves around two issues: the violent rages that her mother had gone into that included physical abuse of Krista; and, her witnessing of the primal scene and subsequently, her problems with sexuality with males. She enters treatment after the death of her mother and her fleeing from this event and the breakup of her several year marriage. Initially, she flees to Europe where she has several affairs with married men. Impulsively, she leaves Europe, returns to the United States and moves to San Francisco where she has stayed.

In 1972, Krista had recently rejoined group treatment after a hiatus of several years. She started treatment with Dr. Shaskan in 1968, dropped out and then returned in 1972 after the death of her father.

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Co-Therapist's Backgrounds

In 1972 I returned to the United States after obtaining my social work professional degree in England. I began a twenty-three year internship as a co-therapist with my father, Dr. Donald Shaskan. Dr. Shaskan had co-founded group psychotherapy in 1946 on the West Coast of the United States. He had been trained in group psychoanalysis by Dr. Paul Schilder in 1937 in New York prior to Dr. Schilder's untimely death. In 1985, he co-authored a book about Dr. Schilder.

Dr. Shaskan had three separate psychotherapy groups each week and Krista was a member in each one. Although this was unusual, another patient was a member in two groups and, if for example, a holiday fell on one of the group days, patients were allowed to attend another group if they so chose.

I was a co-therapist in two of the groups as time and other circumstances did not allow me to be the co-therapist in the third group. An important aspect of the groups was that Dr. Shaskan and I would take different vacations, so, essentially the groups were in session 52 weeks of the year. This practice continued until 1986 when I started attending the American Group Psychotherapy Association annual conferences. Dr. Shaskan had been past president of this organization and was actively involved until his death.

In 1995 Dr. Shaskan died, one week after the last group session he co-led. After another week of my absence, I started leading the two groups I had co-led and convinced the other person from the third group Dr. Shaskan led (that Krista was a member) to come into group one. This same merged group has continued until today with three members. Attempts to bring in new members to this group have been a failure, as the new members are overwhelmed by the historical aspects/the Genius loci of the group. (This is a term used by Dr. Neri to denote "the rigidity of the group's boundary and the identity of the group especially the emotive, affective identity." (pgs. 52,53.)

Theoretical Background

Group Characteristics

The offing was barred by a black bank of clouds, and the tranquil waterway leading to the uttermost ends of the earth flowed somber under an overcast sky – seemed to lead into the heart of an immense darkness. (Conrad, 1902, final paragraph)

A group can be destructive or creative. Conrad's above description and Freud's concept of the primal horde as illustrated in his Totem and Taboo are examples of the destructive aspects. On the other hand, "groups which are conducted in a more nurturing and less anxiety provoking manner have repeatedly proved to be able to transcend the destructive forces within them and produce good outcomes for most committed and well motivated patients." (Roberts, 1994, pg. 129). Groups can be containers, casings, fields in which individual members can make deposits. (For a fuller discussion of these concepts, please refer to Dr Neri's book, Group, on pages 50,51 & 60-64. I am particularly interested in Dr. Neri's summation of Bion's theory

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on page 64: “these patients, in fact, depend on being thought of by the analyst in order to maintain a certain coherence in themselves.”

In groups there is the experience of belonging, of which the sense of continuity gives a completeness; a sense of protection from outside events, an affective and emotive environment that is safe. (I refer the reader back to Historical Background in which Krista’s groups have this sense of continuity and omnipresence.)

Another aspect of groups is the way certain groups are defined by their culture. I am reminded of the difficulty in bringing members into the long established groups I run. Relating the concept of culture to Krista, I am reminded how she, the quiet submissive one, is enamored by a large, aggressive older male. She connects to the story of how he testifies in court during his parent’s divorce and his lasting memory of his father throwing his favorite teddy bear out the window after the hearing. Krista repeats this story long after the older male has died. Later, we learn that she, too, has had to testify against her mother in court that ultimately, for Krista, has very destructive consequences. Another example, re: culture, is from Dr. Shaskan’s third group. The air is permeated with death as another patient is relating her being accused of murdering her younger sister. Krista, initially, identifies with the other patient as the younger sister; and, she struggles with aspects of deadness. Again, later we learn of the many abortions and miscarriages that Krista has had when she was younger and prior to group treatment.

Dr. Neri (1998) states:

One of the primary aspects of the therapeutic function of group thought is its capacity to metabolize anxiety and anguish, which the individual may not be able to work through on his own. In other words, the group has the capacity to free the individual’s mind from excessive tensions which may have accumulated. (pg. 93)

He goes on to describe how Searles (on page 94) has theorized that in the treatment of severe patients that sometimes the patient with the fragmented ego has to depend on the external environment to hold and then re-integrate the different fragments of his ego. Krista has certainly used the three groups that she has attended weekly to hold her/to contain her as evidenced by her referring back and forth across the groups to what she deems to be important to keeping her going. Especially, she is constantly repeating the comments of the co-therapists.

In addition, in Dr. Neri’s Chapter 16, The Group as Self-object, he states:

When there is an adequate development in the analysis, the group gives the participants an experience of belonging, something which is very important for the construction (or reconstruction) of the sense of Self as a person who has the right to exist and occupy an affective space. (pg.121)

Dr Neri then relates his theories to those of Kohut in which the individual in the group relates to the group as a partially differentiated subject. For example, in Kohut’s twin or alter Self-object, Krista begins to accept her identity as a human not as a monster for what she has done in the past. As related to the ideal Self-object, Krista gains from the group the strength to continue her existence. She asks, “How

did I survive the horrors of my childhood?” And with the mirror Self-object, the group “reflects not an exact image, but a beautified one” (pg. 125). Neri continues:

When the group has a friendly atmosphere it participates in the victories of each member. Each participant realizes that if any of the others takes a step forward, they all move forward. In turn, this leads to an enhancement of positive aspects and shared successes. (pg. 125)

Is not this what J. Robert’s said at the beginning of this section?

Thus, theories are relevant to group leaders. In her article in 1994, Lonergan points out that theories are relevant in three ways:

(1) they help organize data that otherwise would be overwhelming, (2) they generate new ideas for group interventions, (3) having a theory increases confidence that therapists know what they are doing; patients pick up on this and increase their engagement in the therapeutic process. (pg. 189)

She follows this with a comment from another group investigator who finds that leaders who have a strong conviction about leadership and theoretical background, no matter what the theory, obtain better results.

In the group a certain amount of cohesion sets in. Group members learn about empathy. Pines has written in *Funzione/Gamma* that empathy is a development for therapists to be attuned to and to be fostered. On page four he quotes Bion:

Finally, concern for life means that a person must have respect for himself in his qualities as a living object. Lack of concern means lack of respect for himself and, a fortiori, of others, which is a fundamental and of proportionately grave import for analysis. (2000)

He goes on to quote from the Norwegian philosopher Vetlessen: “In empathy there is always a thou, never only a me.” And on the next page, Pines quotes James Grotstein talking about his analyst Bion recognizing that external reality is unempathic and non-containing:

I shall never forget an interpretation he (Bion) gave me once in my own analysis which began somewhat as follows, ‘You are the most important person you are ever likely to meet; therefore it is of no small importance that you get on well with this important person.’ (pg.5)

It is through total group interactions as espoused by Foulkes that the patient learns about concern and empathy through, for example, mirroring and resonance:

It is through such processes that persons come more deeply to recognize the truth about themselves through their work with others, through being seen, and seeing denied, split off unwanted parts of the self in others; accepting the vision of others about hidden aspects of the self which come to the fore in the interactions within the group situation. (pg. 8)

In the preceding review of group processes, I have focused on the processes that I have felt to be most important in groups and in the treatment of Krista in particular. With the information presented in mind, I, now, will focus on Krista’s diagnosis and individual characteristics and in my own theoretical construct of how Krista’s diagnosis and thus, her personality changes, grows.

Theoretical Constructs

Individual Characteristics

Krista, at the beginning of treatment, carries the diagnosis of Borderline Personality Disorder. Dr. Otto Kernberg (1996) in *Understanding Therapeutic Action*, describes a person such as Krista as: “the quiet borderline patient who impresses the therapist as relatively affectless, indecisive, undefined, and pseudosubmissive” (pg. 52). In further descriptions of borderline personality disorder, Krista meets Dr. Kernberg’s description of identity diffusion in which the patient “shows a remarkable incapacity to convey a live picture of those who are closest to her and with whom conflicts, dependency, submission, and/or rebellion are most intense” (pg.53). Krista presents her family as practically non-existent and non-communicative. As to splitting, she is intensely jealous of other members of the group and divides time into sections, “this for you, this for me.” She states what a wonderful person Dr. Shaskan is (primitive idealization) and how she cannot exist without him. Within minutes she is making sexually explicit demands of him and about his penis, an instance of devaluation and primitive projection. At other times the co-therapists are feeling tired, sleepy, unconscious, as Krista attempts to split off her badness through projective identification. She, incidentally, relates to me as a sibling.

To recap the material, Krista in 1972 presents as a quiet submissive woman who is ordered by her brother to stay in her job (teacher) in order to collect a pension. Her body image is one of extreme elasticity in which she wraps herself around a chair in a sort of sitting fetal position. She is frightened of both external criticism and of merger and thus, is unable to establish ongoing relationships outside the groups with either males or females. Schilder says that in the group, “We exist in a group where others and other bodies have the same basic significance as ourselves. ‘I and you’ presuppose one another. ‘I’ and ‘you’ are persons and have a body and a body image” (Shaskan and Roller, 1985, pg. 229). Krista in the early treatment is not able to hold a consistent image of her body.

Dr. Kernberg states that the borderline has a lack of superego integration. In Krista’s case, the external/internal world is one of persecution. She tells of a fellow teacher who pours salt into her coffee instead of sugar and she is immobilized to protest. She describes herself as “slinking away like a cowered animal.” She lives a lonely life of work and then, home. Krista reports an increasing amount of anxiety at the end of the school year because she faces a two-week hiatus before she starts summer school!

Theory of Change

I, now, will present my theoretical construct of how Krista, in a special way becomes cured of her borderline personality disorder and begins to move along the diagnostic continuum to a neurotic disorder. She begins to work in the area of conflict resolution.

In conjunction with the previous presented theoretical concepts, I will be using another chapter from Understanding Therapeutic Action, that is written by Dr. Gerald Adler, a psychoanalyst in the United States. He states:

Borderline personality disorder patients can be defined psychodynamically as patients with three areas of difficulties: (1) aloneness, (2) the need-fear dilemma, and (3) primitive guilt. (pg. 74)

Aloneness relates to their inability to hold an evocative image of their important others when facing separation. This is the result of impairment in their childhood in which soothing and holding introjects were not provided. Thus, when the important other is actually, or perceived, to be leaving, the patient is overwhelmed with sadness and/or rage. This leads to a regression in which feelings of abandonment, aloneness, emptiness and even, on instances, annihilatory panic, flood their mind and body.

The need-fear dilemma relates to the borderline's need for intimacy. However, as they approach intimacy the question of boundaries and fear of merging appears in their mind/body. The borderline patient fears the loss of self and flees from the potential boundary-less situation. This dilemma may include transient psychotic states.

And thirdly, guilt is primitive because of its all or nothing quality and is easily projected. Either the patient is feeling horribly bad or they are thinking the therapist is viewing them in this manner. This all or nothing quality relates to their splitting capacity: from grandiosity to total badness as espoused by Kernberg.

Dr. Adler writes that in order to change, the borderline patient must work through a process. He gives four key phases that allow for emotional growth:

The tasks and requirements...are: (1) the establishment of safety, (2) the work of mourning, (3) the modification of the internal world of the patient through the complex interaction of the new experiences with the therapist and the reliving of old experiences, and (4) conflict resolution. (pg. 76)

Dr. Shaskan, among others, knew of this safety issue and began writing in 1958 of successful treatment of borderline patients. He also knew, as Adler states: "all successful psychodynamic psychotherapy includes significant aspects of mourning work" (pg. 76). However, the problem borderline patients face is that with their aspects of aloneness, need-fear dilemma, and primitive (and punitive) guilt issues, they have a limited capacity to mourn in any consistent manner, especially relatively early in treatment. Dr. Shaskan understood that the borderline patient is fragile and when confronted with sadness to any degree, the patient regresses from disappointment and anger into self-hatred.

In several private conversations I had with Dr. Shaskan, we discussed his ultimate death and how I would be there to carry on the work with these particular borderline patients. In one poignant conversation, I remember saying, "What about my personal grief over the loss of my father?" He countered with, "I don't have any worries about that, you will be able to manage it. But, what about the patients? You must be there to help them."

It is at Dr. Shaskan's death that Krista begins to resolve her capacity to mourn. Krista, after twenty-five years of group therapy has resolved her aloneness issues and has developed the capacity for sadness. She has taken in the solid introject of Dr. Shaskan and has been able to remain "affectively connected to the therapist...in the face of current ambivalence, that is, libidinal object constancy must have been achieved" (pg. 76). Krista has moved from a state of aloneness to one of loneliness in which she can miss Dr. Shaskan and long for him, all manifestations of libidinal object constancy. At the same time, her primitive guilt is modified so that she can experience his loss with anger with minimal destructive self-punishment: she develops a psycho-somatic illness shortly after his death.

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