BORDERLINE PSYCHOPATHOLOGY AND ITS TREATMENT

# DEVALUATION AND COUNTERTRANSFERENCE

GERALD ADLER MD

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**Gerald Adler, M.D.**

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# Devaluation and Countertransference

In this chapter I shall discuss the countertransference responses of the therapist to the devaluing borderline patient. To the extent that devaluation contributes, from the patient's side, to the characteristic feelings of helplessness and hopelessness of the therapist in borderline psychotherapy, it represents, in microcosm, the constellation of issues that therapists must confront in their work with such patients.

## Devaluation

Devaluation of the therapist is a frequent manifestation of many of the pathological defenses and character styles of borderline patients. It can take the form of belittling the therapist verbally about his manner, appearance, understanding, skill, or intelligence. He can be contrasted negatively with previous therapists or consultants. Nonverbally, devaluation may be manifested in treating the therapist as inanimate or not present in the room (Searles 1963). Such patients may never greet the therapist or allow any conversation that acknowledges him as a human being. They may respond to the therapist's clarifications and interpretations as if they were never spoken, continuing with what they were saying before they were interrupted. Some patients use action to demonstrate their devaluation. They may miss appointments, come late, leave treatment, or commit some antisocial act that takes them away from the therapist. The verbal and nonverbal behavior by the patient communicates many things; among them is the message "You are worth nothing to me and have nothing to offer me. You may think that you have some way to help me, but I am showing that you are valueless and do not."

There are many motivations that lead to this devaluation of the therapist as an end result. I shall enumerate some, with the understanding that I am separating processes that intertwine and overlap.

### AN EXPRESSION OF RAGE

We have already seen that the borderline patient anticipates rejection and tends to interpret anything except unconditional giving as an abandonment. The expression of rage, therefore, appears in therapy after experiences of fantasied rejection, or after the therapist is unable to gratify the patient's

unrealistic expectations. The patient often uses devaluation to express his rage that the therapist is not the warm source of nurturance he had wished for.

A 30-year-old accountant came into treatment because of his loneliness and inability to have satisfactory prolonged relationships. He quickly revealed his difficulties in therapy by maintaining an aloof, supercilious air, rarely looking at the therapist and belittling any clarifications. The therapist began to focus on this patient's aloofness as a protection against underlying anger when he did not get the comforting he wanted from the therapist. Gradually the patient became increasingly angry, verbally attacking the therapist for his incompetence and weakness, and then had the frightening experience of feeling himself and the therapist turning into apes who would destroy each other.

### PROTECTION AGAINST WISHES FOR NURTURANCE

The longings and wishes for closeness, love, and nurturance that these patients experience are terrifying to them. Such feelings bring up concerns about being disappointed, helpless, and abandoned. In some patients these wishes may threaten regression, with the felt threat of annihilation. If the therapist has little worth to the patient and the therapeutic situation little to offer him, the patient can deny his intense longings. As the patient in this situation begins to be aware of his increasing involvement, devaluation of the therapist protects him against the feared disappointment or regression. At the same time, devaluation symbolically represents a defensive refusal to take in what is so intensely longed for.

The patient just described gradually became aware, mainly through dreams, of his wishes to be held and nursed by the therapist. After a period of increasing attacks, consisting of complaints that the therapist was weak, feminine, and stupid and lacked an understanding of the problems involved, the patient had a fantasy that he was like a sea lamprey, wanting to hang onto the therapist, never let go, and suck forever. From that moment he could see spontaneously that he would have to attack and belittle the therapist to keep such fantasies from consciousness.

### PROTECTION AGAINST ENVY

Akin to affectionate longings for the therapist is an intense envy of him and a wish to swallow him

whole and be like him. Such envy may arouse so much discomfort in the patient that devaluing the therapist feels like his only means of protection; there is nothing to envy and engulf if the therapist is valueless.

A 31-year-old engineer, early in analysis, saw the analyst as a helpful person but had intermittent paranoid fears that the analyst would exploit him, take his money, and change him. After one year of treatment the patient reported a series of dreams: The first was about a group of nurses having a lunch of round doughy things topped with whipped cream and a red cherry. The succeeding dreams became explicit seductions of compliant women in which the patient would fondle or suck their breasts. Concomitant with these dreams, whose oral transference implications were spelled out to the patient, were days of increasing attacks on the analyst for not understanding him and having nothing good to offer, as well as feelings that analysis was useless and not the solution to his problems. After several sessions of analyzing this material, the patient discussed the devaluation as a protection against his wishes to suck. In addition, he then spoke of his envy of how much the analyst had and could give to him and other patients.

**PROTECTION AGAINST PROJECTED ANGER**

A therapist who is valued is often felt by borderline patients to be dangerous and retaliatory, because their anger may be projected onto him. The therapist seen as weak, helpless, and worthless cannot destroy the patient.

A 21-year-old waitress, described by a colleague as “The Black Death” to capture the feeling of her intense, chronic rage and depression, repeatedly minimized the importance of the therapist, the value of his comments, and his ability to care about and help her. Early in therapy there occurred several episodes of increasing anger, immediately followed by intensely fearful outbursts that the therapist hated her and would throw her out or physically injure her. She then returned to belittling the therapist and the therapeutic relationship to protect herself against her fury and her need to project it onto the therapist.

## PROJECTION OF LOW SELF-ESTEEM

Borderline patients invariably have extremely low selfesteem. Its components often are related to the patients' feelings about their inability to control their fury or the unacceptability of their infantile longings. They may attempt to rid themselves of such feelings by placing them in the therapist. This displacement can be expressed in the devaluation of the therapist, sometimes resulting in the patient's feeling more worthwhile.

A 45-year-old single bookkeeper suffered from years of chronic depression and isolation; she began working again in order to pay for her therapy after several years of serious withdrawal. In therapy, after weeks of crying and virtual silence, she spoke of her worthlessness, emptiness, inability to give anything to anyone, and hopelessness. Her discussion of these feelings was characterized by little affect except for that associated with her repeated attacks on the therapist. He was described as a worthless, useless person who could not give her anything, not even pills. At times she would storm out of the office angrily, but on other occasions she appeared more relaxed and friendly after these repetitive barrages.

## A TRANSFERENCE MANIFESTATION

Borderline patients may be reliving real or fantasied devaluation by a parent in the transference. By identification with the devaluing parent, they become that parent and treat the therapist as they themselves felt treated in childhood.

The 21-year-old waitress described earlier had seriously disturbed parents who reacted to her as an inferior version of a brother who died shortly after she was born. In the analysis of the transference, it became clear that she expected her therapist to see her as his most inferior patient. She also recognized that she belittled the therapist in the way her parents belittled her.

The personality and skills of the therapist are particularly crucial in working with this group of patients. The capacity to develop trusting and loving relationships with people, so lacking initially in these patients, is related to the process of internalization of the good therapist who himself demonstrates these capacities in his work with the patient. As already suggested, the chief experiences that permit this process to occur are repeated encounters with the patient's anger in therapy. The therapist's consistent,

tactful, non-retaliatory handling of the patient's rage allows pathological defenses to be given up slowly and permits the patient to experience the therapist as the truly good object who can safely be introjected. The therapist's appropriate response to the patient's anger gradually provides the patient with the knowledge that he can feel intimate and helpless with the therapist without being swallowed, even though he and even the therapist may wish for it.

The verbal expression of anger in psychotherapy provides the patient with the possibility of a new kind of experience. He can experience and ultimately learn that he can verbalize anger, not act on it, not destroy the therapist, not have the therapist retaliate, and not be rejected or abandoned by the therapist. This repeated encounter thus provides a model for identification that helps the patient develop new ego capacities. Once it is safe to verbalize anger, the patient and therapist can investigate more readily the meaning of its presence at a particular moment and its origins, all of which are important in the resolution of the patient's rage.

## Countertransference and Self-Psychology

Among the many contributions of self-psychology is its recognition that selfobject needs exist in all people to varying degrees throughout their lives. Relatively mature therapists and analysts require some validation from their patients that they are competent, effective clinicians. They receive this validation from experiences of understanding their patients and being useful to them, from the realization that the functions they perform for their patients ultimately lead to their patients' growth. As long as the patient uses his therapist and responds to him sufficiently to confirm his competence, the therapist will maintain a solid, comfortable feeling about himself as someone of worth and value. But when the therapist has one or more borderline patients who devalue, reject, or deny his attempts to help, consistent with the nature of their emerging transference, the therapist may then find himself feeling very much as the patient does.

The therapist's despair and anger can be viewed as a response to his own experience of feeling that he has failed as a selfobject; that is, he does not appear to be performing the selfobject functions that the patient says he wants from him. Usually unrecognized by both patient and therapist are the silent (and therefore often preconscious or unconscious) holding selfobject transferences that provide the stability necessary to permit unresolved issues of the past to emerge. Disappointment, despair, and anger from

the past are thus reactivated and relived in the transference. They elicit countertransference responses in the therapist to the extent that they involve him as the failing selfobject recreated from the patient's past failing selfobjects. Because neither the patient nor therapist is in touch with the positive selfobject bond that allows these feelings to emerge, both experience pain in the transference-countertransference. The patient feels helpless and hopeless in the transference; the therapist, because he cannot soothe, satisfy, adequately understand, or help the patient (from both his and the patient's perspective), experiences the situation as his own failure. When chronically repeated, this experience ultimately relates to the therapist's failure to receive the validation of his professional competence that he requires. A paradox of this transference-countertransference situation is that, in the *successful* transference reliving, the therapist experiences his failure as a selfobject only after he has first succeeded as a holding selfobject; the patient in turn, in experiencing the therapist as the failing selfobject, fails the therapist by not performing the selfobject validating function that the therapist intermittently needs. (This should not be taken to mean that it is the patient's *task* to perform this validating function, only that when at such times the patient does not validate the therapist's sense of competence sufficiently, the described countertransference experiences are usually inevitable.)

When the therapist can view his countertransference experience as his empathic response to the feelings of his patient, he has a clue to the nature of the patient's current and past experiences. But it is not easy to maintain a balance between immersion in the patient's feelings and the requisite distance from them necessary to function most effectively as therapist and selfobject. The task is particularly difficult to the extent that the therapist's intense countertransference experiences include a transient or more prolonged conviction that he indeed does not understand, or that he lacks an adequate empathic capacity with, this specific patient. He may, as described, question what he previously felt were solidly established aspects of his own self and his therapeutic skills. Are the patient's feelings of hopelessness, rage, and rejection of the therapist the reliving in the transference of early selfobject failures? Are they being experienced in response to the expectable failures of a good to excellent selfobject therapist? Or has the therapist indeed failed the patient because of his significant empathic limitations or countertransference difficulties with the specific patient? The therapist's ability to raise these questions puts him in a good position to examine the various possibilities as he continues his work with the patient. Sometimes consultations with a trusted and respected colleague are necessary to sort out these complex

issues and gain some perspective.

## Countertransference Responses to Devaluing Patients

What does it feel like to sit with the patient who repeatedly devalues us? The experience can be devastating, especially for the young therapist. It may arouse feelings of intense worthlessness and depression, fear, rage, guilt, shame, and envy. The therapist may turn his rage against himself if he feels guilty about it, intensifying his depression. He may feel guilt and shame that he cannot rescue the patient and live up to the patient's expectations that he be the omnipotent parent. He is particularly vulnerable to feeling shame when he is confronted with his all-too-human response of envy to the patient's demands for unconditional care and nurturance.

The young therapist especially may respond to persistent devaluation by these patients with a temporary, sometimes prolonged regression that exposes his doubts, not only about his abilities, but as to whether working with a patient in a theoretical model that values verbal interchange is at all helpful. He is particularly vulnerable to the patient who tells him that his professional and personal doubts are correct. These patients are expert in perceiving aspects of the therapist's personality that are problem areas for the therapist. Primitive patients probably develop this skill from their style of existence, in which every encounter with any person is so threatening that they must perceive his weaknesses in order to be prepared for the final battle for survival.

I shall now discuss the various ways that the therapist may respond to these devaluing, angry attacks.

### WITHDRAWAL

I have already outlined how these verbal attacks may leave the therapist feeling personally hurt, angry, or hopeless. His behavioral response to these feelings may be withdrawal. He may stop listening to the patient, daydream about something else, or feel bored or angry. He may have conscious wishes that the patient leave treatment. This withdrawal may be manifested in his nonintervention when a clarification or interpretation would be useful. These sensitive patients will intuitively feel the therapist's withdrawal and often respond with increasing concerns about rejection and abandonment.

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They may either become angrier or passively compliant in order not to lose their therapist completely.

When the patient complains that his therapist is less available as a caring, interested person, the therapist may have a ready explanation to support his withdrawal. Especially manifest in the beginning therapist is his use of the defense that he is being a good, nondirective psychotherapist. Therapists often start their training attempting to fulfill a fantasy of what the psychoanalytic model of treatment is, including the fantasy of the mirrorlike image of the analyst. The therapist's retreat into this fantasied identification often masks his fear, anger, depression, or hopelessness when confronted with a difficult and threatening patient. An example of such behavior was a therapist working in a prison with an angry, devaluing, frightening inmate. This patient wanted to shake hands with him at the end of the meetings. The therapist refused, feeling that he was gratifying the patient too much rather than analyzing what the patient's wish meant.

The therapist's withdrawal may be manifested in the ways he allows the patient to devalue their work within the therapeutic sessions by not pursuing actively the meaning of lateness, missed appointments, or nonpayment of bills.

Withdrawal can lead to very serious consequences when it involves the therapist's reluctance to intervene in destructive or self-destructive activities of the patient outside the therapeutic setting. The patient may be communicating that he is out of control, or may be testing to see whether the therapist cares enough for him to prevent him from doing anything destructive to himself or the important people in his life. The nonintervention by the therapist at this point is often felt by the patient as confirmation of his fears that the therapist does not care about him.

### DEFENDING HIMSELF

The therapist may respond to repeated attacks by defending himself, telling the patient that he knows what he is doing and has worth and something to offer. As part of this response he may point out to the patient the progress they have made and how much better the patient is in certain ways. The defensive nature of this position is evident to the patient, who may respond with increasing anger and anxiety, or with compliance and suppression of anger.

#### PROVING HIS OMNIPOTENCE AND LOVE

The therapist can respond to the patient's provocations by active demonstrations that he loves the patient, has the magical supplies the patient demands, and is the omnipotent, giving, rescuing parent. He may tell the patient he cares about him, terrifying him by the threat this presents to his tenuous autonomy. He may give and smother symbolically or actually, sometimes making the patient feel content momentarily but often frightening the patient, who has a part of him that knows that such gratification of his primitive demands is no solution and will only make him feel more helpless and worthless.

#### RETALIATING

A common outcome of attacks by these patients is retaliation by the therapist. Its manifestations may be mild, as in teasing or subtle criticism, or overtly angry and rejecting. It may take the form of interpreting the patient's feelings of entitlement, not as part of the therapist's commitment to the selfobject transference, but as an angry counterattack involving envy of the patient's feelings. This is not to say that the anger of the therapist is not a useful tool, but when it is used to reject the patient, it is extremely destructive. It intensifies the distrust already present and ruptures the tenuous working relationship.

#### INTERPRETING THE ANGER AS MASKING LOVE

The therapist may be so uncomfortable with the repeated angry attacks that he unconsciously defends himself by deciding that they are masking feelings of love and closeness that the patient cannot accept. Sometimes, of course, this is true. But if the issue for the patient is really his murderous rage, the therapist's incorrect interpretation will tell him that the therapist cannot tolerate it.

## Clinical Illustration

Some of these points can be illustrated with reference to the 30-year-old accountant described briefly at the beginning of this chapter. Because I am concerned here so largely with countertransference issues, and wish to emphasize the personal quality of the therapist's responses, I shall use the first-person throughout this account.

Mr. F. was of average height, thin, awkward, and adolescent in his gestures and voice. His sitting position from the start was characteristic of the way in which he related to me for years: He would slouch and practically lie on the chair, talking to the overhead lighting fixture, the picture to the left of my head, or the window to the right. He spoke with a soft southern drawl in an aloof way, yet at the same time he could summon up articulate and bitingly humorous descriptions of his work, his past, and the few people in his current world. He could readily define the major disappointments in his life that had determined his responses to people ever since: His mother, who had held, hugged, and hovered over him for the first five years of his life, had abandoned him for his newborn sister. To him it had felt like being an infant suddenly thrown off his mother's lap. He had tried to woo her back by adopting her loving, smiling fundamentalist religious position, which included a denial of jealousy or anger. He had also tried turning to his brusque, busy father, who scorned him for his awkwardness and weakness. He struggled to love but at the same time found himself vomiting up the lunches his mother had packed for him to eat in school. Gradually he began to vomit the food he ate at home. His friendships at school were jeopardized by his need to report to his mother the nasty things the other children said and did; he agreed with her that he would never think such naughty thoughts himself. During his adolescence he became increasingly preoccupied with thoughts of inadvertently hurting people, which culminated in marked anxiety in his early twenties when he became afraid that he would stab pregnant women in the abdomen. This anxiety led him to his college health service and his first experience with psychotherapy.

In spite of these difficulties, he did well academically in high school, spent two years in the navy, where he felt liberated, and was able to complete college successfully. His relationships with women consisted of looking at them from afar, actively fantasying closeness and hugging; actual contacts were awkward and brief. He could form more sustained but still distant relationships with men. He was transiently concerned that he might be a homosexual at the time he was discharged from the navy.

His first psychotherapy occurred during his last year at college. He had felt frightened and desperate and had quickly come to see his therapist as the man who had rescued him. His therapist was a psychiatric resident whom the patient described as large, athletic "like a football player," a smoker of big cigars who actively gave advice and was very real and direct with him. In looking back at this therapy, my patient felt that it had helped to diminish his preoccupations and anxieties but had left him still unable to form lasting, satisfying relationships with people. It had ended before he felt ready, because his

therapist, after one year of work with the patient, had finished his training and left the area. When I first saw the patient six years later, he defined his problem as a chronic one that he felt he could not solve alone. Yet he felt pessimistic that anything could be done to change things.

This patient was one of my first private patients and really puzzled me. I was impressed by his wish to work, on the one hand, and by his loneliness and isolation, and the frightening quality of his anger, on the other. I was concerned about his aloofness and distance from me; I did not feel that he and I were making contact with each other, but I did not know what to do about it either. At that point in my experience, I could not even formulate the question of how much I liked him and whether that was important. I did recognize that he had a choice of whether he wished to see me regularly, and I offered him that opportunity at the end of our first meeting. He replied that he was willing to see me and felt that one hour a week was what he had in mind.

From my perception of the first few months of our meetings, nothing much happened. He gave me more history to fill out the outline of his life and told me more about the emptiness of his current existence, but all in a manner that shut me out and maintained an amused distance. He became a patient about whom I would sigh wearily before inviting him in. Because of my distress and increasing boredom, I began to point out as tactfully as I could the way he was avoiding contact with me and keeping me out of his world. His response over a number of months, with an insistent sameness, was a quick glance followed by the sad admission that he had made a mistake. He did not know how to tell me, but I was not the right therapist for him. In addition to my soft voice and mild manner, I probably had never been in a bar in my life, had never been in a fist fight, and did not smoke cigars. He would then speak with affection about his previous therapist and again spell out the vast differences between us.

When I could recover from what occasionally felt like a devastating personal attack, I would try to help him look at the meaning of what he was saying. I would relate it to his relationship with his mother, his fury at her abandoning him and his wish to turn to the other parent, who also let him down; often I could point to specific parallels. Usually he rejected these interpretations as incorrect, irrelevant, and worthless. He would also deny that he felt any anger at me when I would point out the obvious attacking quality of many of his statements. How could he be angry when he wasn't even involved and didn't care, he would reply.

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Over a nine-month period I went through stages of boredom, withdrawal, fury, depression, and helplessness. I gradually began to feel like a broken record. I had run out of new ideas, and I found myself increasingly willing to acknowledge that maybe he was right: I probably was not the therapist for him. With relief I suggested that he see a consultant, who would help us make that determination. I also had to acknowledge to myself that my narcissism was on the line. To fail with one of my first private patients, and because of so many alleged personal inadequacies, was more than I wished to face at that time. Also, I had chosen a consultant I greatly respected, adding to my concerns about revealing my inadequacies as a therapist.

The consultant felt that therapy had certainly been stalemated, but largely because of the infrequency of the visits and the lack of confidence I had in the worth of my work with the patient. He minimized my insistence that the patient did not feel I was the right therapist. He stated that in his interview with the patient, the patient had talked about what he did not like but also conveyed a respect for our work and some willingness to continue with me. After the consultation I ambivalently negotiated with this patient for psychoanalytic treatment involving the use of the couch and five meetings a week. With the reassurance that at least my consultant loved me, I arranged to have the consultant continue as my supervisor.

Psychoanalysis with this patient lasted four years. The position he took in our earlier therapy was maintained but this time amplified and understood by means of dreams and memories that verified previous hypotheses. Clarifications about his murderous rage that appeared in dreams made it somewhat safer to talk about his fury with me. Gradually he could speak intellectually about the possibility of an involvement with me, but it was something he never really felt. Only on two occasions did he actually express anger toward me, both leading to near disruption of the analysis. One followed my inflexibility when he wanted to change an appointment, and led to his calling the consultant in order to request a change of analysts. The other occurred toward the end of analysis, when I pointed out his need to maintain a paranoid position in relation to people. It resulted in his storming out of the hour and phoning that he was never returning. He came back after one missed session. Gradually, I became personally more comfortable with this patient, although seeing him was always hard work. I felt much less helpless and hopeless as I came to see his attacks, isolation, and distance in the context of a theoretical framework and as part of the transference and defense against it. My supervisor’s support

and clarifications helped me to maintain this distance. But my helplessness was still present when my interpretations were rejected for long periods of time and I was treated as some nonhuman appendage to my chair. I often felt hopeless that we would ever achieve the goals we had set. I say “we,” but usually it felt like “I” and “him,” with little sense of our working together. I frequently had to ask myself whether I liked him enough to suffer with him all those years, but I had to acknowledge grudgingly that in spite of everything, I did. Somehow the process of long-term work with him had made me feel like a parent with a difficult child, a parent who could finally come to accept any change at all in that child with happiness. The changes that occurred were presented to me casually. They consisted of passing comments about his increasing ability to date women, and led ultimately to his marrying a woman with whom he could share mutual tenderness.

I believe that certain aspects of this patient’s defensive structure and the transference that emerged in analysis made working with him particularly difficult for me. He was reliving a relationship of helplessness and hopelessness with his mother. Not only did he feel abandoned by her when his sister was born, but he was allowed no direct way to express the anger and jealousy he experienced. He chose to comply on the surface but maintained an aloof, disparaging distance from her that protected him against his fury, helplessness, and despair. Because he did this with his mother to stay alive, he understandably repeated the same pattern with me, complying on the surface but vomiting up and rejecting what I attempted to give. In a sense he never left that position with me; he was able to change the quality of relationships outside of analysis but maintained his aloofness with me to the end. He would say that to show real change with me was to acknowledge that he had taken something from me and kept it as part of himself; he just did not want to do that openly, for he would have to admit the importance of our relationship and how grateful he was. His compromise was to remain very much the same with me, to change significantly outside, and then to ascribe the changes to things he could take from the new important people in his life.

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