Borderline Psychopathology and its Treatment

Misuses of Confrontation

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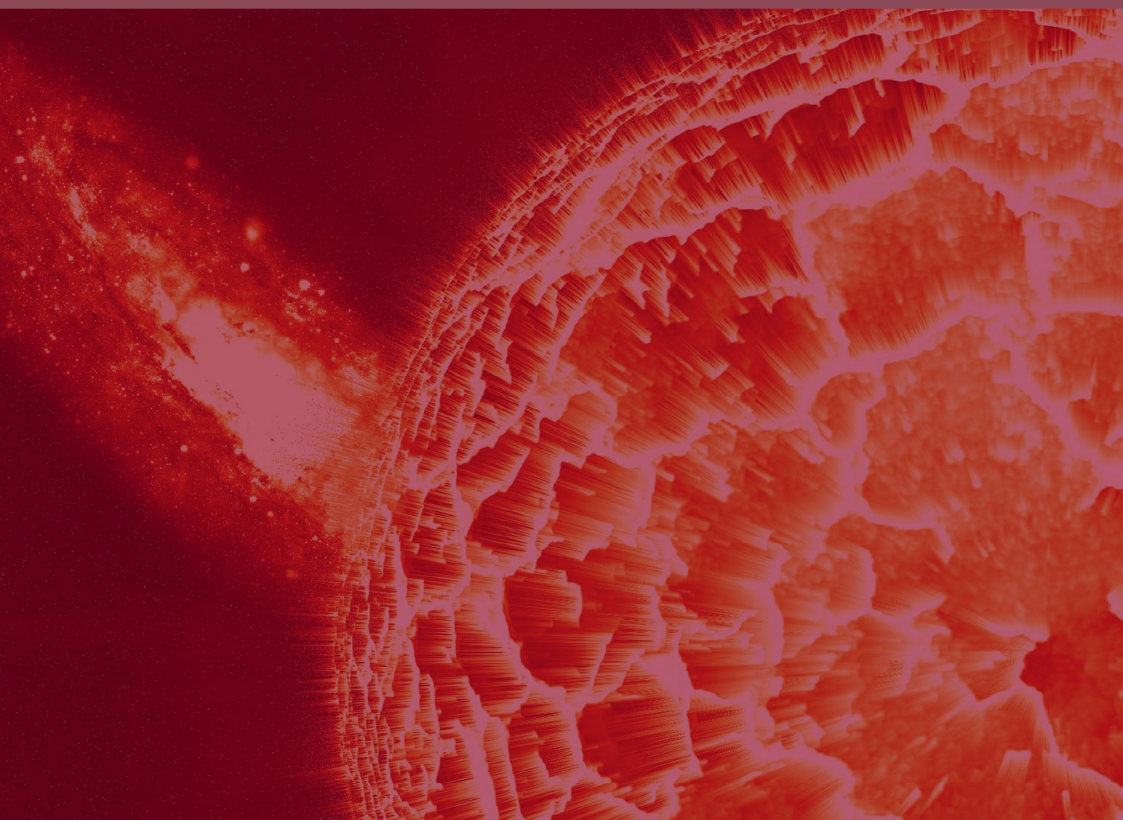

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Although convinced of the importance of confrontation in treating borderline patients, I have also been impressed with the vulnerability of such patients to the misuses of confrontation. Misuse of confrontation can arise from faulty clinical understanding as well as from the therapist's transference and countertransference problems. In this chapter I shall discuss the misuse of confrontation and in the process begin to shift the focus of my considerations away from the patient to the therapist and his countertransference difficulties in borderline psychotherapy.

The Borderline Patient's Vulnerability to Harm from Confrontation

Because of his intense impulses and inadequate defenses, the borderline patient's psychic equilibrium is tenuous. For him, confrontation is a powerful instrument that can be as harmful as it can be helpful. Confrontation is most useful in a setting that takes into account the tenuous working relationship with most borderline patients. A good working relationship requires that the patient be able to trust in the therapist's judgment and constructive purpose. I am referring here not only to basic trust, but also to a trust gained through experience that the therapist will not harm the patient by placing him under more stress than he can tolerate and use. Because the trust is tenuous for a long time with these patients, the therapist, in using confrontation, must observe certain restrictions and precautions in order not to undermine that trust. I shall list and discuss these restrictions and precautions, not as a set of rules, but as matters to take into account when deciding how, when, and about what to confront.

Assess Reality Stress in the Patient's Current Life. When a patient is under serious stress in his life—for instance, when a loss is impending—we do not want to load him with even more stress in therapy. Clinical judgment regarding the amount of stress a patient is bearing is often difficult; it requires thoughtfulness, empathy, and an examination of mental status. This task is particularly difficult with patients who can employ avoidance devices as defenses. The patient can be near a breaking point and yet feel and show little evidence of it. Only with the additional aid of thoughtful appraisal of the patient's real-life situation and psychological makeup can the therapist reliably evaluate how much stress the

patient is experiencing and how much more he can stand. The therapist can then decide whether a confrontation should be made at that time and, if it should, how much support is needed along with it.

Avoid Breaking Down Needed Defenses. This precaution applies with all types of patients. With borderline personalities, however, these defenses, especially denial, are brittle. Although they may at times be massive and formidable, they are inclined to give way to confrontation all at once. The patient may be overwhelmed with impulses and fears as well as with a sense of worthlessness and badness. All sorts of confrontations can have this effect—not only those aiming at awareness of impulses but also those promoting acknowledgment of the therapist's caring for and valuing the patient.

Avoid Overstimulating the Patient's Wish for Closeness. In the feelings and beliefs of these patients, closeness always carries with it the threat of destroying and being destroyed. Showing strong feelings of any type can stimulate the wish for or feeling of closeness. So can being personal in any way—for instance, telling a personal anecdote. At certain times these patients can be overstimulated quite easily. Even the therapist's leaning forward in his chair for emphasis can be too much. Heightened oral-level urges, fear, and defensive rage can ensue, flight or some form of endangering action may result, and the tenuous working relationship may be lost in the course of the rage. In his anger the patient may feel that he has destroyed the therapist within himself or that he has evicted the therapist from the premises of his person. In this way his rage sets up a chain reaction. He is now alone within, and the intense borderline experience is precipitated: fear of abandonment and aloneness, raging destructive oral urges to get the therapist back inside again, panic over the destructiveness and expected retaliation, and efforts to protect himself by rejecting the therapist further, thus only increasing his aloneness.

Avoid Overstimulating the Patient's Rage. Confrontation may involve deprivation and frustration for the patient. It may also involve a show of anger by the therapist. In either case, these patients, who much of the time labor under considerable pressure of denied and suppressed anger, are easily stimulated to overburdening levels of rage. Usually the patient's rage also brings fear, panic, and ultimately a sense of annihilation. The ensuing dangers are the same as those evoked by overstimulation with closeness.

Avoid Confrontation of Narcissistic Entitlement. As long as a patient is in a borderline state, he feels and believes that his subjective being is threatened—his entitlement to survive, as it were. I have already

suggested the ways in which this entitlement to survive can be distinguished from narcissistic entitlement, and yet one can easily be mistaken for the other. Some therapists believe they must help borderline patients to modify their narcissistic entitlement. It is important that these therapists not misdiagnose entitlement to survive as narcissistic entitlement. If they make this mistake, they will believe they are confronting therapeutically a wish to which the patient feels entitled, when actually they are threatening him with harm by attacking a fundamental need: his entitlement to survive.

In my opinion, direct work with narcissistic entitlement should not be undertaken at all until adequately functioning holding introjects are firmly enough established to prevent regression into aloneness and significant loss of self-cohesiveness. My experience indicates that as long as entitlement to survive is insecure, narcissistic entitlement is needed as a source of some feeling of self-worth, power, and security, even though it is at the level of infantile omnipotence and liable to give way transiently to its obverse. Indeed, the patient's narcissistic entitlement may be a significant force in keeping him alive. The confrontation of narcissistic entitlement can demolish self-esteem and security and leave the patient feeling worthless, helpless, and evil for having made inappropriate demands. He is then more vulnerable to threats to his entitlement to survive, such as aloneness and helplessness against annihilatory dangers. The patient will react with rage to this exposure to danger. If he is strong enough, his rage can lead to redoubled insistence on his narcissistic entitlement, along with some degree of protective withdrawal. If he does not have the strength to reassert his narcissistic entitlement, he will probably in his rage have to reject and in fantasy destroy the therapist, or become seriously suicidal. Desperate aloneness must be the result; with it comes the panic of being overwhelmed, and the rest of the borderline conflict follows.

Countertransference Issues that Lead to the Misuse of Confrontation

Within the intense dyadic relationship that these patients form with the therapist, they can experience with great urgency the issues of annihilation and aloneness already discussed. The patient yearns to be held, fed, and touched and often becomes angry and despairing when his infantile demands are not gratified. The therapist, in response, may feel that the patient literally has to be rescued and may therefore tend to give the patient more and more time, support, and reassurance. This dangerous kind of giving by the therapist may satisfy some patients and alleviate the emptiness and despair for short, or

even longer, periods of time. At best it offers a corrective emotional experience for the deprivations of the patient's earlier life. But more often than not, this giving with the feeling of having to rescue the patient opens the door to further regressive wishes and angry demands. For this type of patient, nothing is enough, and the therapist's nurturant response may lead to further regression. Balint (1968) describes this phenomenon in therapy as a "malignant regression." The therapist, facing persistent demands in spite of the great deal he has already given, may feel helpless and depleted and may become increasingly angry that this giving does so little good— indeed, it seems to make the patient emptier and more desperate. The therapist may also feel envious of the patient's demandingness itself and his apparent success in arousing intense rescuing responses in other persons. At such a point a therapist may use confrontation as a vehicle for expressing his fury and envy. Rather than a confrontation with which the therapist attempts empathically to put the patient in touch with something he is avoiding, it may be an assault on the patient's narcissistic entitlement—in reality a hostile manipulation. For example, the therapist may angrily state that the patient has to give up these outrageous, infantile demands. As described earlier, asking the patient to give up narcissistic demands at a time when he is struggling with an entitlement to survive can be disastrous for the patient, whether or not the regression to the life-and-death position was provoked by the therapist's initial rescuing response. In addition, because these patients have a primitive, severely punitive superego that they easily project onto others and reintroject, the therapist's anger as he attacks is readily confused by the patient with his own and may strengthen the destructive self-punishing position that the patient has already established.

Even when the therapist does not respond to the patient by acting on wishes to rescue him, the patient will often feel increasing anger during treatment. He expects nurturance from the therapist and envies all that the therapist possesses. At times this anger is provoked by something that makes the therapist less accessible—an illness or preoccupation with a personal issue—and may take the form of a devaluing, sadistic assault on the therapist. The patient may minimize the importance of the therapist in his life, destroy anything the therapist attempts to give, or devalue whatever the therapist says as incorrect, inadequate, or inconsequential (for further comments on devaluation, see Chapter 10). For the therapist this attack can be a painful, dehumanizing experience in which he feels isolated, helpless, and totally unimportant to another human being, especially if he has had little experience with these patients and does not recognize the attack as part of the transference. Because all therapists wish to be

helpful and competent, such behavior by the patient can be particularly distressing. In this setting a supposed confrontation by the therapist may, in fact, serve as an attack in defense against his feelings of intense isolation and abandonment by his patient. It may also be retaliatory. What the therapist overlooks in his distress is that what he is experiencing so intensely at the hands of his patient is what the patient feels at the roots of psychopathology and has usually experienced repeatedly and severely early in his life. Such oversight by the therapist means loss of potential therapeutic work.

I would like to illustrate these points with reference to the treatment of a borderline patient, Ms. E., "confronted" about her narcissism at a time when she was concerned with her ability to survive. Ms. E. was a 23-year-old, single secretary who had been hospitalized following the termination of four years of psychotherapy. She had felt her therapist to be aloof, ungiving, and uninterested personally in her. Although the therapy ended by mutual agreement, the patient began to feel increasingly abandoned, empty, desperate, and suicidal. During her hospitalization the tenuous life-and-death quality of her life was spelled out; it included a long history of abandonment by important people and her inability to tolerate her fury and disappointment when this abandonment occurred. While in the hospital she began therapy with a new psychiatrist whom she felt was empathically in tune with her. Although there were many tense moments for the patient, therapist, and hospital staff, she gradually became more comfortable and was able to leave the hospital to return to her job. Shortly after her release, her therapist had an accident in which he sustained a serious comminuted fracture of his leg. Not only did he suddenly miss several sessions with the patient but he felt less emotionally available, more preoccupied with himself, and unable to talk about the accident with his patient. He also experienced a sense of personal vulnerability. The patient began to complain angrily about his not caring enough and about his lack of understanding her feelings. The obvious vulnerability of her therapist to these devaluing attacks led the patient to talk increasingly about her love and admiration for him, while she covertly nursed her fury and concern for his vulnerability. The therapist later acknowledged that he found the patient's love gratifying and relieving.

Gradually, however, the patient became increasingly suicidal and required readmission to the hospital. During her sessions with the therapist in the hospital, her angry complaints reappeared with increasing demands that he be more available, give her more, and stop using her treatment for personal gratification for himself. She also acknowledged how concerned she was for her therapist's physical

condition and how important he was to her. The therapist's continued inability to respond adequately to this acknowledgment led to further complaints. His own fury grew. After several more sessions of these complaints, he responded angrily, asking the patient why she considered herself so special, why she felt entitled to so much—more than he gave any other patient. The patient then became more frightened and increasingly suicidal.

Following this session the therapist obtained a consultation in which he spelled out his feelings of vulnerability since his accident, his discomfort about it when the patient brought it up, his relative emotional unavailability, and his discomfort with the patient's demands and attacks. He felt that his preoccupation with his injury had made him feel helpless, passive, and less resilient in the face of the patient's concerns and angry attacks. Now he saw his angry statement as a retaliatory gesture to counter his helpless rage during the patient's assaults. He was able to go back to the patient and help her to explore her feelings about his accident; he could also tell her some of the details about it. Both the patient and therapist felt relief, and the patient could speak angrily about her disappointment in her therapist for not being omnipotent, her concern that he was vulnerable, her belief that she had magically harmed him, and her fear of expressing her fury toward him once she felt he could not take it. After these sessions the patient was able to return to her previous and more integrated level of functioning.

I want to stress here the sense of helplessness experienced by the therapist in the face of a patient who seems unresponsive to his efforts. The patient's unyielding passivity may arouse a defensive activity in the therapist, who tries increasingly to clarify or interpret away the patient's regressive position. Balint (1968) and Little (1960, 1966) emphasize the importance of the reliving and working through of this position in the treatment of such patients and describe the difficulties that arise when the therapist feels that he has to make the regression disappear. In order to help the patient work through the regression, the therapist must come face to face with prolonged, unbearable feelings of depression, emptiness, despair, loneliness, fury, and a sense of annihilation, both in the patient and in himself. For long stretches empathic listening with clarifying questions may be the only activity required of the therapist. But as time passes, the burden the therapist has to shoulder may become overwhelming. He may then choose the angry, attacking, pseudoconfrontation as a means of seeking relief: He expresses a demand to the patient to give up such behavior.

There are basically three types of countertransference difficulties that may occur in the treatment of the borderline patient and that are relevant to the issue of confrontation: (1) the therapist's wish to maintain the gratifying position of nurturant mother, (2) the therapist's response to the biting attacks of the patient, and (3) the therapist's wish to have a well-behaved patient.

Although the wishes of these patients to be one with their therapist can frighten both patient and therapist, there are also gratifying aspects to such longings. The omnipotence that the patient ascribes to the therapist as he (the patient) recreates the mother-infant dyadic tie can give the therapist much pleasure. In fact, the therapist may wish this tie to remain forever, in spite of his commitment to help the patient grow up. As the patient works through the infantile regression and as more mature choices become open to him, he may begin to take steps away from the therapist-mother. At this point a bereft therapist may repeatedly "confront" the patient with the lack of wisdom of the choice or with the therapist's feeling that they have not sufficiently explored the step the patient wants to take. At the same time, the therapist ignores the patient's healthy side and its growth in therapy. Consciously, the therapist sees himself as being helpful and cautious, but in effect he is manipulating to maintain the gratification of the infantile tie with the patient. The result is a patient stuck in this dyadic tie to his therapist because of countertransference wishes of the therapist. The therapist has used pseudoconfrontation, manipulation, or suggestion to keep the patient from growing up.

Because these patients' wishes for nurturance cannot be totally gratified by the therapist, the patient ultimately has to shift from warm sucking to angry biting in his relationship to the therapist. The patient's rage may destroy the sense of gratification the therapist was receiving from the previous, positive relationship with the patient. Rather than accept the rage as a crucial part of the treatment (Winnicott 1969), the therapist may repeatedly "confront" the patient with accusations that he is running from his positive feelings for the therapist. In the specific situation I am describing such confrontation is not useful. Again, it is instead a manipulation or pseudoconfrontation that serves primarily as a defense for the therapist against his discomfort with the patient's fury, and as a means to maintain the gratification of the positive dyadic tie with the patient. These manipulations also make a demand upon the patient. When they are about the patient's entitlement, they tell the patient that, if he chooses to retain a piece of behavior, he is bad and out of the therapist's favor.

The issue of the patient's "badness" is important in the treatment of borderline patients. Many of these patients present with their neurotic defenses and adaptive capacities more in evidence. The stress of some outside traumatic event or the intensity of the psychotherapeutic situation itself, however, is usually sufficient to lead to regressive use of borderline defenses and the emergence of primitive wishes, demands, and fears. The therapist may feel that there is a deliberate, manipulative quality to this regression and thus view the patient as bad. This response occurs most intensely in therapists who are inexperienced in working with borderline patients or in those who are frightened by their patient's regressive manifestations (Frosch 1967). As a countertransference response, the therapist may use an angry pseudoconfrontation to punish the "bad" patient and to get him to give up his bad behavior or face losing the therapist's love and approval. Needless to say, this position is extremely threatening to the borderline patient, who has blurred ego and superego boundaries, a primitive superego, and fears of abandonment, engulfment, and annihilation. It intensifies feelings that his own sense of worthlessness and badness is indeed correct.

Even the experienced therapist usually feels some anger in working with regressed borderline patients. Is it possible for him, when necessary, to use his anger in constructive, forceful, appropriate confrontations? I think it is, so long as he has no wish to destroy the patient—not even his sick side. I recognize that this attitude is an ideal; in practice the therapist inevitably has some destructive wishes and must be consciously in touch with them if he is to avoid putting them into action. If no harm is to come from angry confrontation, these destructive wishes need to be balanced by the therapist's desire to be helpful to his patient and by his struggle to master his own destructiveness. The therapist's capacity to stay in empathic touch with his patient enables him to monitor the amount of force he can use without having the patient subjectively experience the force as an attack. Thus the therapist's awareness both of the character structure of the patient, with its vulnerabilities, and of his own sadistic, destructive urges places him in a position to use confrontation constructively, even when angry.

Many borderline patients do not easily learn that the therapist can be trusted and relied on. For them, the frightening experiences of their rage and the projection of it onto the world may result in perpetual distrust and isolation, no matter how trustworthy the therapist is, behaves, or states he is to the patient. I feel that the experiencing of murderous rage in the transference and nonretaliation by the therapist are crucial for many of these patients. Only then can the transference experience occur that

ultimately removes the terror or aggression and the frightening primitive ways of getting rid of it. When the patient observes his therapist struggling successfully with his own countertransference fury, he has the opportunity to learn how another person can master murderous rage and to internalize important new ways of tolerating fury and using its derivatives constructively. If the therapist fails in his struggle, the patient may then comply helplessly as the victim of an attack and thus reconfirm his view of the world as untrustworthy. Through his observations of the therapist's struggle, the patient can learn most effectively that neither he nor the therapist, in spite of mutually destructive urges, need destroy the other.