Borderline Psychopathology and its Treatment

Regression in Psychotherapy
Disruptive or Therapeutic?

Gerald Adler MD

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Gerald Adler, M.D.

e-Book 2016 International Psychotherapy Institute

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Discussions about the usefulness of regressions in psychotherapy often arouse feelings that can polarize the participants. Interpretation of the transference in psychotherapy is viewed by some as inducing regression and therefore dangerous, and by others as a helpful tool that may limit regression, especially as the negative transference emerges.

How can we explain the contradictions, heat, and confusion in an aspect of psychotherapy that is manifest so frequently in therapists' work with patients? I believe that among the factors involved is a lack of clarity with regard to certain crucial questions: (1) What do we mean by a regression in psychotherapy? Is it a return to early unresolved or safe modes of functioning that is part of an experience within the psychotherapeutic situation that both patient and therapist can observe? Or is it a disintegrative experience that disrupts therapy and the patient's and sometimes the therapist's life? Or is it sometimes a combination or alternation of both? (2) When a regression occurs in psychotherapy, does the therapist believe that a specific regression, or regressions in general, are destructive to the psychotherapeutic goals and should therefore be discouraged or viewed with concern? Or does the therapist feel that a regression can sometimes offer "a new beginning" (Balint 1968) or an opportunity to resolve earlier conflicts? And how can he decide whether one regression is destructive while another is therapeutic? (3) Does the personality of the therapist permit comfort with the specific area of the patient's regression, or does he use defenses that change the character of the regression and its utility to the patient? (4) Is the patient's diagnosis important in determining the usefulness of a regression? Is a regression in a neurotic patient more desirable than a regression in a borderline patient, and under what circumstances?

Implicit in the regression than can occur in the psychoanalysis of a neurotic patient is a feeling, usually shared by both patient and analyst, of a sense of basic safety. The regression has a slow evolution and unfolding and usually is preceded by the establishment of the positive transference aspects of a therapeutic alliance. Within it the patient maintains a capacity to observe himself, has the ability to delay

acting on any impulses and wishes that may emerge, reserving them for an affective reliving within the analytic hour, and can make use of the analyst's clarifications and interpretations in integrating the regressive experience. At its best, a transference neurosis develops, that is, the analytic situation and the analyst become a major concern of the patient; within the analysis the patient relives a previously unresolved conflictual area, with the analyst representing the early important objects, previously internalized but now projected onto the analyst. At the same time, the patient can make the distinction between the analyst as a real person and the wishes, feelings, and conflicts he places on the analyst that belong to the past. Although many of his thoughts and fantasies are involved in his analysis, the rest of the patient's life does not become enmeshed with the analytic regression; as a result, the emerging conflicts do not get acted out in the patient's daily life. This ideal, though rarely attained, picture of a therapeutic alliance and transference neurosis partially explains the basic comfort of the patient and the analyst; in spite of fantasies to the contrary, there is often little that is significantly disruptive or uncontrolled. And the acting out that is most invariably present is usually nondestructive, although it may impede the analytic process. The regression is clearly "in the service of the ego" (Kris 1952); the reliving of old, unresolved childhood conflicts offers the adult in the analytic situation the opportunity to find new and more adaptive solutions.

In contrast, patients with borderline personality organization can present a very different picture of regression in a psychotherapeutic or psychoanalytic situation. Because the life-and-death, devour-or-be-devoured issues are not settled in these patients, and their ego structure lacks the flexibility and synthetic capacity to allow gradual regressive movement and to modulate the intensity of affects, the regression can be a disruptive, all-or-nothing, frightening experience, either transiently or over a long period. In addition, these patients, especially during a regression, have difficulty separating inner from outer, and use primitive defenses such as splitting, projection, projective identification, and primitive idealization (Kernberg 1967) or go through long periods of fusion with the therapist (Little 1960). Understandably, such events do not allow a clear distinction between patient and therapist, and leave blurred what belongs to the patient's past and present, and what is projected onto the therapist or is really the therapist. In such a world, where relationships are experienced as full of danger to the patient, trust and a capacity to observe, listen, and integrate can be absent or only transiently present. The dyadic psychotherapeutic relationship can be the stressful stimulus that triggers unresolved feelings of

abandonment and neglect, and the emergence of early childhood needs followed by rage, since these needs cannot be fulfilled in any adult relationship. The ensuing regression can be a furious, destructive clinging in which the desperation of the patient increases as he destroys the memories of good sustaining introjects, including those of his therapist. He also develops the feeling that he no longer has any relationship or contact with the real therapist. With the sense of loss of a sustaining relationship with the therapist, the regressive feelings and behavior can easily extend outside the therapy hours with the possibility of serious acting out, including suicide. Another aspect of the regression can be the emergence of a desperate, helpless withdrawal and isolation, which Guntrip (1971) feels is at the core of the difficulty in this group of patients, and which can be very difficult for patient and therapist to bear.

Because regressions in psychotherapy of other than "ideal, analyzable patients" may have a disruptive and even life-endangering potential, may bring frightening material into the therapy, and may possibly seriously affect the patient's daily functioning, why not do everything possible to prevent regressions in those patients whose regression does not seem to have clear features of a controlled, analyzable transference, or transference neurosis? Alternately, can we at least define as clearly as possible when this painful and potentially dangerous regression is useful, or especially important? Studies by workers who have had significant experience with patients who have a serious regressive potential, such as Balint (1968), Guntrip (1971), Little (1960, 1966), Rosenfeld (1965), and Winnicott (1965), suggest that regression in borderline, schizoid, or schizophrenic patients offers the possibility for a "new beginning" or a "rebirth." These workers firmly believe that regression in psychotherapy has the possibility of exposing the basic vulnerability that resulted from very early and usually repeated experiences involving an environment that did not respond adequately to the needs of the infant and very small child. The regression permits a reliving that can lead to a partial repair of an old wound. Little (1960), in particular, writes about "basic unity," a return to the undifferentiated state of earliest infancy as a painful but sometimes necessary regression that ultimately permits a new differentiation and integration.

My own experiences, although of much shorter duration than these workers', convince me of the validity of their position. I am referring to the usefulness of therapeutic regression in a group of patients in the borderline spectrum who might function adequately in certain areas and who can even make gains in the kind of psychotherapy that discourages regression but whose lives have a quality of

conformity and a sense of unreality described in the literature as a "false self" (Winnicott 1960). The "false selves" of these patients—the price they pay in order to function adequately—may not permit satisfying mutual relationships to the extent that they protect patients from their underlying wishes and fears. It is much easier to modify symptoms than to affect profoundly a person's way of feeling and caring about himself and others.

It is also important to keep separate from the patients I am discussing the majority of patients who come to a therapist for help: people who have an essentially solid sense of themselves and who can benefit from brief or longer therapy that does not have to include any significant regressive component. And, as I have stated, patients in the borderline group can benefit significantly from therapy that carefully steers clear of regression, especially when therapeutic goals can be reached without it and without the potential dangers that accompany it.

I think that most therapists, even if they believe in the possible usefulness of regression in this group of patients, do not begin psychotherapy with a new patient with the idea that they will encourage a regression. Most of them are all too aware of the possible turmoil and potential self-destructiveness that could be unleashed. They would probably agree that a careful diagnostic assessment, possibly requiring many sessions, is crucial. The task includes acquiring some understanding of the patient's problems, conflicts, strengths, and weaknesses, a feeling for how solid a sense of self he has, and the formulation of a treatment plan. Important in the assessment is the use the patient makes of the therapist, assuming a "good-enough" therapist. Among the questions are: Does the patient develop a relationship with the therapist over time that demonstrates increasing trust and a sense that he and the therapist are whole people? Can the patient make use of the therapist and the therapist's comments as a sustaining force as well as a person who helps him to "acknowledge, bear, and put in perspective"(Semrad 1969) significant aspects of his life, or does he have to reject and devalue the therapist from the beginning? Can the patient make use of a careful, supportive look at recent stressful events that may have precipitated his current difficulties? Can he work with the therapist to recognize difficulties in his relationships with important people and make use of his understanding within these relationships? Can he see the role guilt has played in his life story and relate it to difficulties with present relationships? Does the patient make use of the sessions to confirm his own sense of badness, or to find constructive understanding and alternatives? The answers to these and other diagnostic questions determine the level on which therapy

has to proceed as the therapist formulates his understanding of the patient's difficulties and capacities in order to develop and maintain a working relationship and foster a capacity to observe. And part of this formulation involves the therapist's current understanding about the kind of therapy his patient requires, that is, whether short-term or long-term therapy that discourages regression is most useful, or whether he has a patient who might make only minimal gains without the possibility of a regression in the psychotherapy.

For those who agree that regression in a patient in the borderline spectrum can be useful, how is the therapist to decide when a specific regression has the potential of helping—or when it can be destructive? Obviously, the distinction is very difficult to make, especially in a group of patients so expert in arousing feelings of hatred, worthlessness, helplessness, and hopelessness in the therapist. In arriving at an assessment, the therapist is always in the position of trying to observe his countertransference responses to the patient as a way of understanding the transference and to separate pathological ways that he could respond to the patient because of his countertransference. He must also evaluate the impact of the patient's regressive feelings on the latter's daily life, including frequent assessment of the patient's potential and actual self-destructiveness. Because there is probably no patient who does not spill some of the therapeutic issues into his daily life, it is hard to draw a line and say that something beyond a certain point makes the regression too self-destructive. Many therapists have had experiences with relatively healthy patients who became significantly depressed in therapy or analysis, with resultant behavior that affected their relationships and work. Yet many of these patients have ultimately benefited significantly from their treatment, leaving the therapist with the feeling that the behavioral regression was probably inevitable and necessary. At what point does the therapist say that it has gone too far? And if he chooses the "wrong" point, is he telling the patient to push away an important aspect of his life that is being analyzed and relived in the treatment?

In my experience, intense regressive feelings that appear very early in treatment have a greater potential to produce self-destructive behavioral regression. Although some workers disagree (for example, Boris 1973), a relationship with the therapist that allows the opportunity at least to define the work seems to be an important prerequisite for the emergence of therapeutically useful regressive feelings. But there are patients who bring very intense feelings immediately into the first session as their means of negotiating with the therapist. Part of the therapist's response must be based on his rapid

formulation of the meaning of this patient's statements and affect, the quality of the relationship formed immediately between them, the way the patient responds to the therapist's attempts to tune in and understand, and the therapist's own comfort with the issues. Does the understanding he communicates establish a safer climate, or is the patient's life in such disorder or jeopardy that he cannot wait until the next appointment with the therapist, even if it is the next day? Implicit in this assessment is an estimate of the patient's capacity to make use of the relationship with the new therapist by means of internalization of the therapist and the therapist's relationship with the patient as a sustaining force, even though the internalization may be highly transient at first.

The therapist's assessment as to whether the regression is a defensive avoidance is another aspect related to his response to it. At times when a patient can tolerate a conflict or painful affect with support, he may nevertheless retreat into regressive behavior. The distinction is difficult but crucial; if the therapist is correct in supportively confronting his patient with the thought that the regression is an avoidance of a painful but bearable issue, his confrontation can open the way for an important piece of work. If incorrect, the confrontation tends to confirm the patient's fantasies of being misunderstood and abandoned by his therapist.

Limit setting can be used early in treatment as a way of attempting to contain a rapid regression. For example, the therapist can simply say that he is not interested in hearing about a specific area of the patient's life or feelings at present, although acknowledging its ultimate importance. Again, the correct assessment, including the therapist's comfort with certain material, often determines the success of the limit setting.

Most therapists acknowledge the importance of the therapist's personality in determining the success of the therapy. The ability of some consultants to make successful matches of patient and therapist is based on their ability to assess the personality qualities of the therapist and their "fit" with the patient's conflicts, personality, and diagnosis. Shapiro (1973) spelled out the differences between two therapists in their treatment of the same woman. The first therapist's open, warm personality, his difficulties in separating his professional from his personal life, his discomfort with his patient's anality, and his view that his patient was someone who had to be totally accepted led to a regression that appeared as a stalemate in the treatment. Her second therapist expected more of her, more clearly defined his limits,

and encouraged her experimentation with her anality. His position led to significant changes in the patient's behavior coincident with his incorporation as an increasingly active person in her anal fantasies. Shapiro believes that such personality characteristics of therapists are only minimally changeable in training, and yet are a major determinant of the success of treatment with many patients.

The personality of the therapist obviously plays an important role in the nature of his countertransference fantasies, as well as in his behavioral response to them in treatment, and ultimately is related to the outcome of the regression of a specific patient. The therapist's personality is especially crucial in the treatment of the borderline group of patients, who so often establish a primitive transference involving fusion with the therapist or his idealization or devaluation. Because the core issue for many of these patients relates to the very early life-and-death, devour-or-be-devoured struggle with a maternal figure, the therapist's comfort with an intense transference of such material is crucial. It includes not only the capacity to accept the transference of the role of nurturing mother—and to give it up later—but also the ability to feel relatively secure with the ego boundary fluctuations of early periods. Projections, projective identification, and fusion phenomena of the patient can be experiences for the therapist that lead to anxiety and a tendency to withdraw, counterattack, or somatize. The therapist's capacity to accept the idealization of the patient without clarifying his human fallibility has been defined by Kohut (1968) as one of the crucial aspects in the treatment of narcissistic characters. Kohut also describes the importance of the therapist's ability to listen to a patient who is using him as a mirror for early narcissistic, grandiose fantasies without having to interpret or respond nontherapeutically to the boredom that he may experience in allowing such material to unfold. Kohut emphasizes that the therapist's comfort with the primitive grandiose part of himself makes the work with these patients possible.

One of the most difficult ingredients of a therapist's personality to define is that of flexibility, that is, a capacity to determine the changing needs, affects, and conflicts of the patient and to respond to them appropriately. An acceptance of a patient's idealization of the therapist can be crucial early in the therapy of some of these patients. But the persistence later in treatment of the therapist's view of the patient as needing to idealize him may belie the therapist's wishes for precisely this type of narcissistic gratification, and retard the patient's capacity to grow. The nurturant mother transference, so important at one point, may be something that the therapist demands later to protect himself from the patient's fury

or the patient's increasing capacity to separate himself from the therapist. Balint (1968) discusses the countertransference omnipotence of the therapist as a determinant of whether regression is "benign" or "malignant." This omnipotence can be manifest when the therapist rationalizes his active giving to or rescuing of the patient because of his own needs rather than the patient's. The therapist's flexibility, then, has two aspects: a basic personality attribute that he brings to his work, coupled with a capacity to be aware of and to tolerate his own countertransference responses before they become actions that impede the therapeutic process. Often it means being able to acknowledge murderous hate, envy, or intense infantile longings in himself and to be comfortable with this primitive material. It requires a capacity to maintain a stance that is empathic, permitting the transference to unfold, whether murderous, idealizing, fusing, or other.

Clinical Illustration

These issues, difficulties, and dilemmas can be illustrated by returning to the case of Ms. D., described briefly in Chapter 5. When Ms. D. underwent a profound regression in therapy, her therapist was put in the position of having to decide where he stood on regressions in general, and with this patient in particular, as well as what role his countertransference responses played in the treatment. The patient sought help for her difficulties in forming relationships with people and completing her graduate studies. During the first few months of treatment, she was able to use her therapy as a supportive structure. She had no difficulty with the therapist's summer vacation, which occurred after a month of treatment. Over the next six months, however, she gradually began to feel desperate and empty in the treatment situation, and longed to be held constantly. What emerged was her acknowledgment that she felt furious at her therapist for not offering the amount of symbolic holding and support she believed she required. As her anger increased during a specific session, she might scream in rage and then hit her head against the wall or pound her fists against her head or thighs. Although this behavior at times terrified the therapist, he slowly became comfortable with all but the most severe outbursts. His increasing activity seemed important, especially his offers to her that she could phone him or come for extra sessions if necessary. She occasionally made use of these offers, phoning in panic but usually becoming comfortable after a five- or ten-minute conversation, with the realization that the therapist still existed and was not about to retaliate or abandon her. During one of his vacations she became seriously

suicidal, requiring hospitalization until his return. All the same, most of the time she was able to continue her graduate studies with distinction.

Although outbursts of fury followed by self-punishment continued throughout the therapy, the patient gradually became able to define some of the fantasies and feelings that led to the terrifying quality of her fury. In her rage she felt that she destroyed any image of the therapist or anyone else inside of her. She also felt at those times that the therapist either hated her or ridiculed and laughed at her. No clarification of reality seemed to make any difference in the middle of these outbursts, although she could describe the details of the feelings later in the session with some realistic appreciation.

The therapist was able to relate these episodes to the repeated loss of her parents early in life, especially a long separation when she was 2 years old. He explained her feelings to her as a reexperiencing of what had been unacceptable and impossible for her to feel if she was to survive within her family. At first she thought the therapist was imposing an explanation on her that did not relieve her immediate panic, but gradually she could make use of it as something of her own.

Several areas of change became apparent over the four years of therapy. Within the sessions the patient gradually came to feel more comfortable with her anger at the therapist and could even leave the hour feeling angry at him without losing the sense that he existed. She could occasionally have angry fantasies about him when not in his office, which previously would have been intolerable and would have led to panic. There was also an increasing ability to relate to the therapist with warmth and a sense of being more of a whole person. In her daily life, relationships with men became more satisfying. Instead of reliving the drama with them that was played out in her sessions, she gradually learned to contain her intense feelings and bring them into therapy. To her surprise, she found it gratifying to behave in a more mature way and learned that her infantile needs were not so intense as to require constant gratification. She also experienced periods in which she felt that she had a "self" and did not have to be held all the time.

The treatment of such a patient can be a frightening experience to a patient and therapist, with many risks, including the possibility of suicide. As described earlier, a constant danger in the outpatient therapy with such patients is the possibility that regression during the therapy hour will spill over into

the patient's life. The therapist's understanding, personality, and technical skill can help keep the regression confined largely to the therapy sessions with most of these patients, and can serve to structure it in such a way as to allow the patient to experience therapy with a greater sense of safety.

Suggestion, for example, is often a helpful technique in confining regression to the therapy hour, as illustrated by the case of Ms. D. When the patient was able to contain her feelings in her relationships with men, she was often liable to intense outbursts of affect in therapy. The therapist would then remind her, in part as a way of reminding himself, that she had done as agreed in not disrupting outside relationships between appointments. This also helped the therapist tolerate Ms. D.'s fury by allowing him to see it in terms of a theoretical model that limited acting out and brought the conflicts and feelings into therapy.

Extremely important in limiting a patient's regression is the therapist's basic position about his own omnipotence: his need to rescue his patients and receive adulation and narcissistic gratification from them. I have already discussed some of the relevant countertransference and personality factors involved. The therapist's acceptance of his human limitations without shame or guilt can help him find appropriate ways to clarify the extent of his capacity to be available to his patient. In an example from Ms. D.'s treatment, she became frightened that she might call her therapist on the phone more and more in her insatiable hunger and greed until he finally became angry at her and ultimately rejected her. Although the therapist was aware of a part of himself that had a similar concern, he replied that up to that time she had not called so often as to infringe upon his personal life. If she did he would let her know and would view it as a signal from her that she needed more structure. He would then consider hospitalization. He reminded her that he had hospitalized her in the past and had continued to see her while she was there. If she required hospitalization, he would certainly be available for appointments and would work with her as an inpatient until she was sufficiently comfortable with her relationship with him and her capacity to control her feelings as an outpatient. She found these remarks reassuring; her fury and fear of abandonment and rejection temporarily became less intense following them.

These vignettes also illustrate the use of limit setting in psychotherapy. If a therapist accepts his human limitations, he also defines the limits he feels are tolerable and appropriate in the therapeutic situation. In the light of his personality and his theoretical model of what is useful in psychotherapy, he

constantly assesses these limits. When the therapist feels he has to take a firmer position, he must always consider the role his countertransference rage and wishes to retaliate may play, since the need for limit setting often occurs at a time when the patient is being provocatively furious. Sometimes his limits are based on counter-transference difficulties that may be rationalized as theoretical issues. The therapist in the case of Ms. D., for example, was tempted to state that his patient's outbursts were so disruptive and disorganizing for her that she would have to control them more within the sessions. In looking at the matter further, however, he concluded that it was his own anxiety during the outbursts that was the major factor in his wish that she limit them. Nor does limit setting always have to be a firm statement to the patient to stop some behavior; it can also be couched as an expression of the therapist's concern. For many patients this concern is evidence that the therapist cares, and stands in sharp contrast to earlier experiences of significant neglect.

Even though patients in the borderline spectrum have serious difficulties in establishing an observing ego and maintaining even a tenuous working relationship, an approach that emphasizes the therapist's attention to these defects can help contain a regression. Clearly the therapist has to believe that it is possible to help the patient develop these capacities. On some level the patient must maintain an awareness of the therapist's constant attempts to share with him the assessment of the current situation and to help him observe the meaning of certain feelings and behavior. It took many months for Ms. D. to be able to look at the meaning of her regressive behavior, but relatively rapidly she could share with her therapist an assessment of her suicidal potential between sessions in a way that emphasized the collaborative aspects of her treatment.

The clarification of reality is also crucial during regressive episodes. The therapist may need to state that he is angry with his patient if he senses that his anger is perceived by the patient and is interfering with the treatment. In addition to this clarification, the therapist can ultimately help the patient explore what there was about his behavior that could have provoked the therapist to anger. Reality clarification also includes helping the patient be aware of the distortions and projections in the transference and in relationships with others.

Finally, many of these patients require help in learning to relate to people that can best be categorized as education. This type of education can sometimes short circuit the disruptive aspects of an

infantile regressive transference. With Ms. D. the therapist spent many hours discussing her graduate studies, her ways of relating to classmates and the students she taught, in an approach that focused on how people spoke to one another, felt about one another, and related to one another. The danger exists, of course, that the therapist can assume an authoritarian role in such discussions that may support a regressive transference rather than limit it. In addition, he can continue such work as an avoidance of anxiety-laden issues that both he and the patient are reluctant to face.

It is easier to talk about models of treatment that define ideal therapists than to face realistically that such therapists exist only in the fantasies of patients and their therapists. Since there are obviously many therapists who work effectively with patients, we have to define the balance of qualities necessary to make good therapy possible. The "good-enough" therapist does make mistakes. But his errors are rarely the serious acting out of destructive countertransference fantasies. On balance, his caring, concern, devotion, and understanding outweigh his errors. Just as the child senses the basic caring and respect of the good-enough mother even when she fails, so does the patient accept and forgive honest mistakes and lapses when the balance resides on the side of an effort to understand and work with him effectively.