Gerald Adler, M.D.
Dan H. Buie, Jr., M.D.

The Misuses of Confrontation in the Psychotherapy of Borderline Cases

Confrontation in Psychotherapy

The Misuses of Confrontation in the Psychotherapy of Borderline Cases

GERALD ADLER, M.D., & DAN H. BUIE, JR., M.D

e-Book 2015 International Psychotherapy Institute

From *Confrontation in Psychotherapy* edited by Gerald Adler and Paul G. Myerson

The Misuses of Confrontation in the Psychotherapy of Borderline Cases

GERALD ADLER, M.D., & DAN H. BUIE, JR., M.D

Although we are convinced of the importance of confrontation in treating borderline patients, we are also impressed with the vulnerability of these patients to the misuse of confrontation. Misuse can arise from faulty clinical understanding as well as from the therapist's transference and countertransference problems. In this chapter we shall convey some of our thinking about these matters.

In the preceding chapter we discussed some crucial characteristics of borderline patients relevant to the issue of confrontation. We stressed their vulnerability to feeling abandoned, their life and death destroy or be destroyed position, and the serious threats to self-esteem that their fury and infantile wishes pose for them. We also described their brittle defensive structure and the particular importance in understanding their use of avoidance defenses. We then presented the thesis that confrontation was needed in the therapy of borderline patients in everyday treatment as well as in crisis situations because of the specific characteristics we described in these patients.

Borderline patients, by definition, have areas of strengths as well as areas of great vulnerability. In part because their vulnerabilities can be masked by their higher level defenses (Kernberg, 1967), and in part because of what they can provoke in the therapist (Adler, 1970; Adler, 1972), they are particularly prone to the misuse of confrontation. We shall approach the subject of misuse of confrontation from two vantage points: (1) the borderline patient's vulnerability to harm from confrontation and (2) the countertransference issues that lead therapists to confront in destructive ways.

The Borderline Patient's Vulnerability To Harm From Confrontation

The borderline patient's psychic equilibrium is tenuous because of his intense impulses and inadequate defenses. 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 alliance present with most borderline patients. A good working alliance requires that the patient be able to trust in the therapist's judgment and constructive purpose. We are referring 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. Since the trust is tenuous for a long time with these patients, the therapist must observe certain restrictions and precautions in using confrontation in order not to

undermine that trust. We shall list and discuss these restrictions and precautions about the use of confrontation with these patients, not as a set of rules, but as matters to take into account in order to decide how, when, and about what to confront:

(1) *Assess reality stress in the patient's current life*. When a patient is under more serious stress in his life—*e.g.*, when a loss is impending—we do not want to load him with even more stress in therapy. Clinical judgment of the amount of stress a patient is bearing is often difficult and requires thoughtfulness as well as a mental status examination and empathy. This task is particularly difficult in this group of 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 his life situation and psychological makeup can the therapist reliably evaluate how much stress his patient experiences as a result of various real life traumata and how much more he can stand. He can then decide whether or not a confrontation should be made at that time and, if it should, how much support is needed along with it.

(2) *Avoid breaking down needed defenses*. This precaution applies to all types of patients. However, when working with borderlines, these defenses, especially denial, are brittle. While 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 ones aimed at awareness of impulses, but also those promoting acknowledgment of the therapist's caring and valuing the patient.

(3) *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; *e.g.*, 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. The outcome may be that the tenuous working alliance will be lost in the course of the rage. In his anger the patient can feel he has destroyed the therapist within himself, or he can feel he has evicted the therapist from the premises of his person (Frosch, 1967; Adler, 1972). 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.

(4) *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.

(5) *Avoid confrontation of narcissistic entitlement*. As long as a patient is borderline, he feels and believes his entitlement to survive is threatened. We have already described the similar ways in which narcissistic entitlement and entitlement to survive are manifested (Buie and Adler, Chapter Six). One can easily be mistaken for the other. Some therapists believe they must help borderline patients modify their narcissistic entitlement. For these therapists it is important that they not fall into the error of misdiagnosing 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.

It is, however, our opinion that direct work with narcissistic entitlement should not be undertaken at all until the patient has emerged out of his borderline state into a character neurosis. Our experience indicates that as

long as entitlement to survive is not secure, narcissistic entitlement is needed as a source of feeling some self-worth, power, and security, even though it is at the level of infantile omnipotence and liable to give way transiently to its obverse. We are emphasizing that the patient's narcissistic entitlement may be a significant force that is keeping the patient alive. The confrontation of narcissistic entitlement can demolish self-esteem and security, leaving the patient feeling worthless, helpless, and evil for having made inappropriate demands. He is thereby made more vulnerable to threats to his entitlement to survive; *i.e.*, to aloneness and helplessness against annihilatory dangers. The patient cannot be exposed to danger this way without reacting with rage. If the patient is strong enough, this 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 have to reject his therapist in his rage and in fantasy destroy him or become seriously suicidal. Desperate aloneness must be the result; with it comes the panic of being overwhelmed, with the rest of the borderline conflict following.

Countertransference Issues That Lead To The Misuse Of Confrontation

We have stressed the intense dyadic relationship that these patients crave and that they often begin to feel rapidly with their therapists. And with this relationship the issues of living or dying can be experienced by these

patients with great urgency. These feelings in borderline patients inevitably arouse a response in their therapists. The patient yearns for holding, touching, and feeding; and he often becomes increasingly angry, helpless, and despairing when these infantile demands are not gratified. The therapist, in response, may feel that his patient literally has to be rescued; and, therefore, tends to give the patient more and more; *e.g.*, time, support, reassurance, and touching. For some patients, this giving by their therapist may fill them up and remove the emptiness and despair temporarily or even for long periods of time. At its best, it may offer a corrective emotional experience in contrast to 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 for increasing regressive wishes and angry demands by the patient. For this group of patients, 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 these persistent demands in spite of how much he has already given, may feel helpless and depleted, as well as increasingly furious that his giving does so little good—indeed it seems to make the patient emptier and angrier. The therapist at this time may also feel envious of a patient who seems to feel free to demand so much and apparently is successful in arousing an intense rescuing response in another.

At such a point, a confrontation may be used by a therapist as a vehicle

for expressing his fury and envy. Rather than being a confrontation that attempts empathically to put the patient in touch with something he is avoiding, it may be an angry assault on the patient's narcissistic entitlement. As we shall discuss, the therapist is in reality using 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 the time 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 may have been provoked by the therapist's initial rescuing response to his patient. In addition, 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 redouble the destructive self-punishing position the patient already is in.

Even when the therapist does not respond to his patient by acting on wishes to rescue him, the patient will often feel increasing anger during treatment as he expects nurturance from the therapist and envies all that the therapist possesses. At times these angry attacks can be provoked by something in the therapist that makes him less accessible; *e.g.*, an illness or preoccupation with a personal issue. The patient's anger at such times may take the form of a devaluing, sadistic assault on the therapist. As part of this attack, the patient may minimize the importance of the therapist in his life or

in his anger may destroy anything the therapist attempts to give. This destruction can be manifest by the patient's devaluing anything the therapist says as incorrect, inadequate, or inconsequential (Adler, 1970). For the therapist this can be a painful, dehumanizing experience in which he may feel isolated, helpless, and totally unimportant to another human being especially when he has had little experience with these patients and does not recognize it as part of the transference. Since wishes to be helpful and competent are important strivings in all therapists, such behavior by the patient can be particularly distressing. A "confrontation" by the therapist in this setting may in fact serve as an attack in order to cut through his intense isolation and sense of 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 his psychopathology and has usually experienced repeatedly and severely early in his life. Such oversight by the therapist also means loss of potential therapeutic work.

We want to illustrate the treatment of a borderline patient "confronted" about her narcissism at the time that her concerns were about her ability to survive. The patient 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 in her personally. Though 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, including a long history of abandonment by important people and her inability to tolerate her fury and disappointment when this occurred. While in the hospital she began therapy with a new psychiatrist whom she felt was empathically in tune with her. Though there were many tense moments for the patient, therapist, and hospital staff, the patient gradually became more comfortable and was able to leave the hospital to return to her job. Shortly after this, 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, preoccupied with himself, unable to talk about the accident with his patient, and experienced a sense of personal vulnerability. The patient began to complain angrily about his not caring enough and his lack of understanding of her feelings. The relative 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 he found the patient's love gratifying and relieving. Gradually, however, the patient became increasingly suicidal, requiring 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 so

much personal gratification for himself. She also acknowledged her concern for her therapist's physical condition and how important he was to her. The therapist was still unable to respond adequately to this, which led again to the repeated complaints. Without his awareness his anger grew. After several more sessions of these complaints, he responded most angrily, asking the patient why she considered herself so special that she felt entitled to so much —even more than he gave any other patient. The patient then became more frightened and became increasingly suicidal.

Following that session, the therapist obtained a consultation in which he could readily spell out his feelings of vulnerability since his accident, his discomfort about it when the patient brought it up, and his relative emotional unavailability and 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 then 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 then 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 could

return to her previous more integrated level of functioning.

We also want to stress the sense of helplessness and hopelessness in a therapist who struggles to work with a patient, but who finds the patient seemingly unresponsive in spite of his every effort (Adler, 1972). The patient's unyielding passivity may arouse a defensive activity in the therapist who tries to clarify or interpret away the patient's regressive position with increasing effort. Balint (1968) and Little (1960, 1966) have stressed the reliving and working through of this position as important in the treatment of such patients and the difficulties arising when therapists feel they have to make it disappear. If the therapist is to help the patient resolve this regression, he 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 the burden the therapist has to shoulder may be overwhelming as time passes. And the angry attacking pseudo-confrontation is often the means chosen by the therapist as a way of seeking relief and as a demand to the patient to give up such behavior as he becomes increasingly overwhelmed by what his patient is experiencing, especially as he senses that often his words mean so little to the patient.

We now want to summarize three types of countertransference

difficulties that may occur in the treatment of the borderline patient that are relevant to the issue of confrontation: (1) the therapist's wish to maintain the gratified 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.

(1) Though 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 these patients ascribe to the therapist as they recreate the mother-infant dyadic tie can give the therapist much pleasure. In fact, the therapist may wish it to remain forever, in spite of his commitment to help the patient to grow up. As the patient works through the infantile regression, he may begin to take steps away from the therapist-mother as more mature choices become open to him. At this point, a bereft therapist can 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 he 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 infantile tie with his patient. The result is a patient stuck in this dyadic tie to his therapist because of countertransference wishes of the therapist—and under the guise of "confrontation," manipulation or suggestion is used to keep the patient from growing up.

(2) Since 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 had been receiving from the previous positive relationship with his patient. Rather than accept the rage as a crucial part of the treatment (Winnicott, 1969), the therapist may "confront" the patient repeatedly that he is running from his positive feelings for the therapist. When correct, such confrontation is useful but in the situation we are describing, it is not true. Again, it is instead a manipulation and part of the therapist's attempt to return to the positive dyadic tie. This manipulation, or pseudo-confrontation, serves primarily as a defense for the therapist, this time because of his discomfort with the patient's fury. It also works in the service of his wish to maintain the gratification of the positive dyadic tie with his patient. The therapist's manipulations we have just been describing 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 not in the therapist's favor.

(3) The issue of the patient's "badness" is important in the treatment of borderline patients. Many of these patients present it initially with their neurotic defenses and adaptive capacities more in evidence. However, the stress of some outside traumatic events, or the intensity arising through the psychotherapeutic situation can be sufficient to lead to a regressive unfolding

of the borderline defenses and the primitive wishes, demands, and fears we have described. The therapist may feel that there is a deliberate, manipulative quality to this regression and view the patient as bad. This response occurs most intensely in therapists who are inexperienced in working with borderlines or in those who are frightened by their patient's regressive manifestations (Frosch, 1967). An angry pseudo-confrontation by the therapist may be his countertransference response 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 therapist's 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 in the experienced therapist some anger is almost inevitably provoked in his work with regressed borderline patients. Is it possible for him to use it constructively, when necessary, in forceful, appropriate confrontations? We think it is. However, it is our feeling that a therapist can best make a useful confrontation, even though angry, when he has no wish to destroy the patient, not even his sick side. We recognize this as an ideal. In practice the therapist inevitably has some destructive wishes, and he must be consciously in touch with them if he is to avoid putting them into action. These wishes, if no harm is to come from angry confrontation, need to be

balanced by the therapist's desire to be helpful to his patient as well as by his struggle to master his own destructiveness. The therapist's capacity to maintain his empathic touch with his patient enables him to monitor how forceful he can be without actually venting destruction on his patient or having the patient subjectively experience the force as an attack. That is, he is aware of the character structure of the patient, with its vulnerabilities, and of his own sadistic, destructive urges; this awareness places him in a position to use confrontation constructively, even when angry.

Throughout his work with his patient, the therapist can demonstrate his reliability and caring by using appropriate clarifications and confrontations of the potential self- destructiveness of the patient. The therapist's reliability and caring are also communicated through his attempts to demonstrate the concept of two people working collaboratively over time—that the patient can count on the ongoing relationship with his therapist and will not be abandoned by him. In spite of our statements about presenting a dependable relationship to these patients, many borderline patients do not easily learn that we can be trusted and relied upon. For them, as we have discussed earlier, 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. We feel that the experiencing of the murderous rage in the transference (Frosch, 1967; Winnicott, 1969) and the non-retaliation by the therapist are crucial for

many of these patients. Only then can the corrective emotional experience occur that ultimately removes the terror of aggression and the primitive ways of getting rid of it that are so frightening to these patients. When it happens that the patient observes his therapist struggling with his own countertransference fury, he has the opportunity to learn how another person can master murderous rage. The therapist's successful struggles provide the patient with an opportunity 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 a victim of an attack; and his view of the world as untrustworthy is further confirmed. Through this mutual observation and struggle the patient can learn most effectively that neither he nor the therapist need destroy each other in spite of mutually destructive urges. Hopefully, the therapist also gains something from the successful encounter with his own fury—moving toward a direction of never wanting to destroy, but only to catalyze growth.

Bibliography

Adler, G. (1970), Valuing and devaluing in the psychotherapeutic process. *Arch. Gen. Psych*iat., 22:454-462.

____(1972), Helplessness in the helpers. *Br. J. Med. Psychol*.

Balint, M. (1968), *The Basic Fault. Therapeutic Aspects of Regression*. London: Tavistock Publ.

Buie, D. H., Jr. and Adler, G. (This Volume), *Confrontation in the psychotherapy of borderline*

patients, I: the use of confrontation.

Frosch, J. (1967), Severe regressive states during analysis: summary. *J. Amer. Psychoanal. Assn*., 15:606-625.

Kernberg, O. (1967), Borderline personality organization. *J. Amer. Psychoanal. Assn*., 15:641-685.

Little, M. (1960), On basic unit. *Int. J. Psychoanal*., 41:377-384, 637.

____(1966), Transference in borderline states. *Int. J. Psychoanal*., 47:476-485.

Winnicott, D. W. (1969), The use of an object. *Int. J. Psychoanal*., 50: 711-716.