Borderline Psychopathology and its Treatment

Treatment of the Aggressive Acting-out Patient

Gerald Adler MD

Treatment of the Aggressive Acting-Out Patient

Gerald Adler, M.D.

e-Book 2016 International Psychotherapy Institute

Table of Contents

Treatment of the Aggressive Acting-Out Patient

As concern grows about problems of violence, crime, delinquency, and serious drug abuse in our society, questions about therapeutic approaches have recently received increasing attention. Group and family therapy, encounter groups, halfway houses, therapeutic communities, and operant conditioning methods have been described as exciting and promising treatment possibilities.

Understandably, individual psychotherapy has not been viewed as a method that has much to offer such a large patient population when limited human resources are already overburdened with seemingly insoluble treatment tasks. Still, the individual psychotherapeutic approach can be extremely useful (1) in defining the therapeutic issues that any treatment modality involving these patients has to face, (2) in studying the countertransference problems that most workers will experience with these patients, and (3) in improving individual psychotherapeutic techniques for the treatment of adolescent, psychotic, and borderline patients who manifest certain elements of the problem that patients with more severe aggressive, acting-out character disorders present in pure culture. In addition, individual treatment of selected patients in this group can be a rewarding experience for both participants. In this chapter I shall focus on some issues involved in treating aggressive acting-out patients, and stress transference and countertransference problems.

Although different in many ways, severely aggressive acting-out patients share certain characteristics: an inability to tolerate frustration and delay, major conflicts involving oral ambivalence, serious problems with trusting, a tendency to assume a paranoid position or at least to externalize responsibility, a poor capacity to form a working alliance with another person, and little capacity for self-observation. Their frightening anger can be hidden by such primitive defenses as denial, distortion, projection, reaction formation, and hypochondriasis, or, most frequently, by flight, literally or through drugs, from the situation causing their rage.

Engaging these patients in treatment can be a difficult task, because their usual flight mechanisms may keep them from returning for their next appointment. The therapist's ability to interest the patient in looking at himself, defining "problems" instead of allowing him to present himself as totally bad, and

early emphasis on the trust problem are important ingredients in the preliminary work with these patients. The personality, conflicts, and skills of the therapist will be a major factor in determining his success in working with these patients. I shall discuss these aspects of the therapist as they apply to several issues in the treatment of this group of patients.

Violence and Aggressiveness

The core conflict of most of these patients involves the persistence of, or regression to, the infantile devour-or-be-devoured position, although their higher-level defenses may mask this conflict. Wishes for closeness and nurturance either lead to the terror of engulfment and fusion, or to inevitable frustration of their feelings of entitlement to be nourished, followed by the primitive rage of the small child. What is frightening in this group is that the primitive fury is now present in a patient with an adult body capable of real destruction. And some of these patients are seen by us after they have put this destructive fury into action. Realistically, then, they can pose a threat to a person who wants to work with them.

Although there are situations in which work with such patients presents a genuine danger for the therapist or potential therapist, the threat is more often a feeling of inner terror in the therapist derived from his own conflicts. This feeling is often projected onto his patient, adding to the patient's fear of impending loss of control. The therapist in this situation does two things: (1) He may communicate his own difficulties with his own aggression to the patient, and (2) he may act in such a way that he places the patient in a bind that leads either to flight or to the possibility of some violent outburst toward the therapist.

The therapist's inability to convey the feeling of stability and confidence in which successful treatment can occur is compounded by his need to get rid of his own violent impulses stirred up by the patient by putting them onto the patient, who intuitively senses the therapist's difficulties. On some level the therapist may be aware that he is doing this, or he may only be aware that he wants to rescue the patient. He therefore may withdraw emotionally and lose his patient, or overcompensate by placing himself in a situation that is realistically dangerous—for example, forcing himself on a patient overwhelmed by wishes and fears of fusion or aggressively out of control.

There is a fine line between appropriately firm, confident intervention with a frightened patient and a smothering imposition by the therapist that can lead to serious consequences. However, one can usually count on the flight mechanisms of this group of patients to minimize the risks to the therapist when he makes a mistake. In my experience as therapist and supervisor with this group of patients inside and outside of prisons, only several potentially serious incidents have occurred, all related to some variety of the inappropriate type of intervention described.

Most members of this group of patients have serious difficulty in distinguishing their murderous fantasies from reality. And because their ego boundaries are often ill defined, they are not clear as to whether they have really hurt someone, or whether someone is about to hurt them. In addition, these patients often actually live in a dangerous, distrustful environment; it may be impossible for the therapist to separate in his own mind the intrapsychic conflict of the patient from the dangers in the patient's real world. In some extreme circumstances several patients became treatable in prison only when they were in maximum security isolation, so that the external environment became safe for the moment.

One of the therapeutic tasks with these patients is the repeated differentiation of fantasy from reality, and inner from outer. The therapist who has a major tendency to regress in similar but less marked ways when confronted with his or the patient's anger under stress will have obvious difficulty. Rather than maintaining an empathic capacity to grasp the patient's distress and be in touch with his inner terror as well as real present and past deprivation, the therapist may respond to the patient's life-and-death feelings as if they were too real. The result may be a loss of empathy, including withdrawal, attack, or the described overbearing rescue, which may cause the patient to resort to his usual flight mechanisms.

The effective therapist is comfortable with his own anger. He is aware of it, can tolerate it without projecting it, can test how much really belongs to the patient, and does not lose this ability when faced with a frightened and frightening patient who never had that capacity or who has lost it. No therapist exists who has this ability all the time. We depend on the therapist's strength most of the time to be able to test the reality of the fantasies aroused in him by these patients and distinguish his feelings from theirs, and to endure in the face of his own and the patient's anxieties. Included is his ability to distinguish fantasies from real dangers to himself or the patient as he works with him. When the therapist decides

that real dangers exist for himself, he must define the limits in which he can work with the patient.

Limit Setting

I want to discuss three aspects of limit setting: its meanings to the patient, the limits necessary that may make therapy possible, and the definition of who the therapist is and what he can tolerate as a human being.

Many of these patients have had backgrounds of deprivation and neglect. Their feelings of abandonment are often based on real experiences of parents or parent surrogates not caring for or abandoning them. Their childhoods have included experiences of not being able to depend on their parents to protect them or comfort them. Translating such experiences into the issues that arise in therapy with these patients, nonintervention when the patient is out of control or realistically perceives that he is losing control can easily be interpreted by such a patient as evidence that the therapist does not care. At the same time, however, intervention, for instance, prohibiting a specific piece of behavior, is often viewed by therapists as an interference with the autonomy of the patient and as the elimination of choices the patient has.

Any limit setting intervention does ultimately extract a price the therapist has to pay later—for example, arousing omnipotent fantasies about the therapist that have to be resolved in future treatment. But without the intervention, therapy may be impossible, for the patient frequently does not have the choices ascribed to him. Instead, he often can only repeat earlier patterns: to flee instead of acting impulsively, or to put an aggressive, destructive fantasy into action. If the therapist chooses not to intervene, he risks losing the patient, who may have no choice but to view the therapist as the same as his noncaring, nonprotective parents.

The therapist's judgment is crucial if the intervention is to be successful. If the therapist's assessment that the patient is out of control is correct, his limit setting action can be a new experience for the patient with a person who appropriately cares and protects, as we have already seen. In contrast, if the therapist has intervened because of his own conflicts and need to project anxiety and anger onto the patient, he can lose his patient by compromising the patient's tenuous capacity to function autonomously.

The patient may then leave treatment feeling controlled and smothered.

Limit setting at times may include involving a probation or parole officer or the police when the therapist feels the dangers of the situation for the patient warrant it. The judgment of the therapist here is particularly crucial for the future of any treatment. The result can be a grateful patient with an increasing capacity to maintain a working relationship, or a furious former patient who justifiably feels betrayed. The task can be easier when the patient is willing to be involved in weighing the evidence for the intervention. But when a patient is out of control, such ego strength may not be evident.

Sometimes the therapist sets limits in part because the patient is in distress, but also because the patient's behavior goes beyond the limits that the therapist can tolerate personally. For example, a patient who has made repeated homicidal threats can cause the therapist so much distress that he forbids the patient to possess any dangerous weapons as a condition for continued treatment. Obviously, such a position by the therapist protects the patient from making a fatal mistake, but the primary motivation at the time the therapist makes such a decision may be his own incapacity to tolerate such anxiety-arousing and potentially selfdestructive behavior on the part of the patient. In addition, such an intervention has implications in whether the patient perceives it also as a caring gesture or as an incapacity of the therapist to tolerate what is necessary in working with him. Some of these theoretical and clinical issues are illustrated in the following vignette.

Clinical Illustration

The patient was a 24-year-old single man who began treatment in prison six weeks before his scheduled parole hearing. He had been in the prison for several years for assault and battery during an armed robbery; four years before his present offense, he had been found guilty of manslaughter in a car accident in which three friends had died. The evaluation staff was unclear why he had applied for treatment, but observed that he was frightened and belligerent. They wondered if he sensed his anxiety about his parole hearing and hoped that the treatment unit would intervene.

His history revealed that he came from a middle-class family with a veneer of stability. His parents had almost divorced several times, however, and although they lived together, they had not talked to

each other for years. His mother drank excessively at times and was known to have had extramarital affairs. The patient described his father as strict and punitive, moody and sulky, spending as much time away from home as he could.

The patient had an older brother and sister; he was particularly close to his sister, whom he described as very much like himself. She had to be transferred from a mental hospital because of her unmanageable behavior. He and his sister each had made several suicide attempts, the patient's last occurring in his jail cell, after the car accident, when he attempted to hang himself.

Few data are available about the patient's early years, except that he was born with a harelip that was repaired in infancy. In school he made the honor roll until the ninth grade, when his behavior began to deteriorate. From the age of 16 to his present sentence, he was arrested 13 times and was convicted of auto violations, drunkenness, disturbing the peace, breaking and entering, larceny, and the described manslaughter and assault. He had served four previous brief prison sentences.

In the first few sessions with his therapist, the patient spelled out his impulsivity and fears of going crazy or out of control. He stated that he had fears of running wild in the prison, screaming, or smashing things; he controlled these feelings by going to his cell and staying by himself. He described his history of difficulties with the law and outlined that his seven months out of prison after the manslaughter conviction were successful until he met the mother of one of the friends killed in the auto accident:

> She looked at me and I fell apart and drank, and in three hours was picked up. ...How did I feel? I killed her son. I was panicky and had to get away. I can't go home because I can't stand people who remind me of this. ... When people become emotionally involved with me I hurt them, and when people try to help me I fail them. ... I hate authority. I got this from my father. I used to hate him; now I feel I have no relationship with him. I'm worried whether I'm a stable person.

One of the issues the therapist discussed with the patient was the treatment unit's policy of writing a letter to the parole board stating the therapist's thoughts about the patient and any information that might be useful to the board in its deliberations. Clearly such a letter brought issues of trust and confidentiality to the surface; at its best the parole letter could be used as a collaborative effort between patient and therapist. In preparing to discuss the writing of this letter with the patient, the therapist became aware of his own fantasies that any limit setting recommendation would arouse the patient's fury and lead to the patient's leaving treatment or even physically assaulting the therapist. In spite of these

fantasies and fears, the therapist felt he had sufficient evidence to suggest in his letter that the patient was not ready for parole. Because he could not get the patient's collaboration in writing the letter, he presented a draft to the patient. One portion read: "This inmate in the past has been subject to impulsive destructive acts, and although he has recently been making some attempts at socialization and control of this tendency, it is my opinion that the gains have not been sufficient to enable him to modify his behavior, should he be faced with stresses similar to those he has been subjected to in the past." Instead of the indignation and fury the therapist expected, the patient's only comment was that the "destructive acts" be changed to "destructive acts against himself'; the therapist agreed to this.

In the following session the patient talked about his problem with distrust of the therapist and expressed surprise that he had accepted the therapist's letter with only mild anger. He missed the next appointment because of his parole board hearing. He returned the following week, quiet and angry. "I'm in a bitchy mood. I feel lousy. I got my parole." The therapist asked how he felt about it. He could hardly reply, getting up from his chair and checking the closet to see if a tape recorder was hidden. "The administration is fooling you too and has it there without your knowledge." Later he said, "It was a terrible hearing. I only spoke for 30 seconds. At least I didn't have a chance to talk myself out of the parole."

What there was of a working relationship continued to deteriorate after this meeting. Distrust markedly increased, the patient having increasing difficulty saying anything to the therapist. He spoke of his brother, who would lead him into things and then skip out. He wondered how many years of training the therapist had had and whether he was still a student. The patient came for several more interviews but, in spite of considerable efforts by his therapist, broke off treatment several weeks before being paroled.

This vignette illustrates the struggles of a therapist who seems to have made a correct assessment of the patient's tenuous capacity to control his impulses in spite of the therapist's conscious countertransference fantasies about the dangers of setting limits. It also spells out the meaning to the patient of the parole board's decision to release him. He viewed this action as a confirmation that the therapist was uncaring and helpless; in that setting he became extremely distrustful, used increasing projection, and felt that the therapist had abandoned him. The therapist could find no way to reestablish

any working relationship, and, as is characteristic of such patients, this one quickly gave up treatment.

The Therapist as a Real Person

Limit setting is part of the process of a therapist's defining who he is, what he can tolerate, how he himself responds to stress, and whether he really cares about his patient. This definition of the therapist as a real person is often a crucial ingredient in successful therapy with these patients.

There are specific reasons why this group of patients requires much more than a mirrorlike therapist. Because these patients usually have significant ego defects, major changes that may occur through psychotherapy include identifications with certain aspects of the therapist, which must be clearly visible. Before a relationship can be established that can lead to a process of identification, the patient has to see the therapist as he really is, not as a confirmation of all his negative cultural expectations as well as his projections and distortions. A nondirective therapist permits these problems to occur in a group of patients all too prone to lose the capacity for testing reality.

The problems arising when therapists from one cultural background attempt to work with patients from a very different life experience are enormous. The honesty and integrity of the therapist and his willingness to reveal his position, knowledge, or lack of it can cut through the cultural differences, provided the therapist is genuine in his stance. Particularly for adolescent patients, a real therapist willing to stand for real values and not attack, provoke, or run away himself is a new kind of experience.

The therapist who wants to help such patients with their murderous rage, and yet who recognizes their need for an experience with a real person, faces a genuine dilemma. In order to tolerate their anger and not be destroyed by it, he must seemingly adopt an omnipotent position very different from that of a "real" person vulnerable to feeling hurt by such fury and hate. Yet it is also crucial that the therapist be a real person with human qualities, so that the patient can have a clearer picture of him as a model for identification. This real aspect of the therapist also helps the patient evaluate the reality of his fantasies about his therapist. The capable therapist with these patients is one who can assume both positions flexibly, and in rapid succession when necessary. Both positions involve new experiences, one concerning whether angry fantasies destroy and drive important people away, the other concerning a

real person who cares what the patient believes and who is willing to let the patient know what he stands for.

Containment

Winnicott's (1965) concepts of the "holding environment" and "good-enough mothering," although coming from mother-child observation and utilizing a different theoretical framework, are closely related to Kohut's concept of the "selfobject." Like Kohut, he defines a dyadic relationship in which an environment of safety, security, and trust is created that allows the child (or patient) to feel "held" and complete. In such an environment, deficiencies can momentarily be complemented by the other person in the dyad. Growth potential can be reactivated, and unresolved issues can be settled.

Borderline patients talk vividly about their longings to be held and contained, and their panic about being dropped, abandoned, and rejected. Some primitive people engage in criminal acts in order to provoke the correctional system into providing the containment they need but that is not within their capacities to find elsewhere. Correctional workers all know of examples of poorly executed antisocial activity that can best be explained as the acted-out wish and need to be caught and protected (and sometimes punished as well). The containment that the correctional system offers provides functions that are absent, either transiently or permanently, in offenders with borderline and narcissistic personality features. These containment or holding functions are similar to the selfobject functions a therapist provides in a treatment setting. Containment also provides the necessary controls for offenders who have ego defects related to impulse control. Rather than serving as a negative or punitive use of force, the containment function of the correctional system can provide the beginnings of an effective treatment program that can address the specific defects or deficiencies of people who become a part of it.

An effective holding treatment program for an individual with impulse control difficulties can provide a safe environment that will allow him to talk about the issues in his past and present. It is not unusual for the individual to blame the correctional system for his difficulties and resent his containment and the fact that he is required to be in a treatment program. Once he realizes, however, that he does not have to assume responsibility for the dependency longings that the containment or holding can arouse, and begins to feel comfortable with the security that the containment provides, he will begin to respond

in a variety of ways depending on his psychopathology, self-cohesiveness, and ego capacities. For some, the security of the new situation, which permits the formation of a relatively stable selfobject transference, enables them fairly quickly to experience and talk about the disappointments in their lives as well as in the treatment situation. With more primitive people, that is, those who are borderline or have a severe narcissistic personality disorder, the containment often begins with an initial period of anger, with use of projection as a major defense, during which the individual tests the security of the containment and the worker's capacity to bear his rage without rejection or punishment. Thus, the holding environment can provide a secure place for anger to be expressed in words by those people who need to experience that their anger will not destroy. The physical security available in correctional settings also helps to assure this safe expression of anger. In addition, such a setting sometimes makes it possible to sort out the individual's projections of anger from genuine dangers; that is, a maximum-security setting that precludes contact with other inmates not only can protect an individual from real dangers, but can also clarify that he may be using projection to avoid acknowledgment of his own anger. Finally, the holding environment protects against the wish to run away, which impulsive offenders are very likely to carry out, by providing the parental protective function that Mahler (1968) describes as necessary in the process of separation and individuation.

When the holding environment is established in non-correctional therapeutic settings, it can include individual and group therapy, but in the prison and parole environments, it becomes a much broader concept. The effective structuring of the environment for the impulsive person by the variety of personnel in the system—judge, administrator, mental health professional, probation or parole officer, correctional officer or shop foreman—not only provides containment, but also enables the formation of selfobject transferences with any number of these people. The fact that so many different personnel are available often gives the individual an opportunity to relate to someone of his choosing who can provide qualities he admires or who can respond to his need to be mirrored, understood, or validated. The appropriate responses from the prison staff are crucial in enabling growth to take place. Countertransference difficulties or failure to understand the needs of the specific person in the program can lead to a repetition of the experiences that led to his hopelessness, despair, and chronic feelings of betrayal.

In addition to feelings of overt sadism, caretakers can find themselves withdrawing and feeling

disdainful and uninterested in the people they should be trying to understand and help. Because selfobject transferences can flourish only by means of understanding the individual's pain and anger from his own perspective, the countertransference reactions of the staff are more likely to repeat negative experiences with important people in his life than to allow the opportunity for a new experience that permits the growth and resolution of previous developmental arrests.

In order to provide the holding environment required by the individuals they wish to help, the caretakers themselves must have their own holding environment. Ideally, such an environment is established by the superintendent of an institution or the chief of a court clinic, parole, or probation program. A caring, respected leader who can be firm when necessary, without being punitive or retaliatory, provides an opportunity for the staff to use him as a selfobject who can be idealized to whatever degree is needed. The staff can also use the various clinical and administrative meetings to obtain the required amounts of mirroring, validating, and understanding from him and people working with him on a supervisory level. Under such circumstances the work setting can be a gratifying, creative experience for the staff.