THE INSTITUTE FOR CLINICAL SOCIAL WORK

FUNCTIONS OF COUNTERTRANSFERENCE IN PSYCHOTHERAPY OF BORDERLINE DISORDER: THE CLINICIAN'S EXPERIENCE

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TABLE OF CONTENTS

Page

ACKNOWLEDGMENTS ii

Chapter

I. INTRODUCTION 1

II. LITERATURE REVIEW 5

Countertransference and the Borderline Patient
Countertransference: Early Theorist and the Borderline Patient
Countertransference: Projective Identification and Empathy
Countertransference and Narcissism
Countertransference and the Holding Environment
Countertransference: Narration and Self-Cohesion

III. METHODOLOGY 44

Research Strategy
Sample Selection
Data Collection Method and Instrumentation
Analysis of the Data
Limitation and Generalizability

IV. RESULTS: STRUGGLE TO SURVIVE 55

Out of Control
Suicide
Helplessness
Invasion
Responsibility
Summary

TABLE OF CONTENTS.--Continued

Chapter | Page

V. RESULTS: STRUGGLE TO CONNECT 70

The Special Connection
The Tenuous Connection
Summary

VI. NOT ALONE 80

Consultation
The Therapist's Therapy
Other People
Being a Subject
Summary

VII. RESULTS: FACILITATING HOPE 89

Faith in the Patient
Faith in the Relationship
Faith in Myself
Summary

VIII. DISCUSSION 99

Introduction
Central Themes
Thematic Narratives
Winnicott's Developmental Theory and Implications for Present Study

IX. IMPLICATIONS FOR THEORY, RESEARCH, AND PRACTICE 141

Objective and Subjective Functions of Theory
Hope in Therapy
Secondary Traumatization of the Therapist
The Therapeutic System
Narrative Process
Social Work
Conclusion

APPENDIX 151

REFERENCES 153

CHAPTER I

INTRODUCTION

Treating the borderline patient is an arduous and formidable endeavor (Plakun, 1991; Waldinger & Gunderson, 1987). It is intense and unsettling (Searles, 1986). It challenges the therapist to submit to extraordinarily uncomfortable experiences which one would otherwise wish to avoid. These experiences often include dangerous, impulsive, and self-destructive acts on the part of the patient. Such behaviors constellate strong, visceral countertransference reactions in the therapist. Therapists often feel overwhelmed and exhausted by these patients' "suicidal threats, unreasonable demands, and a wide variety of other coercive behaviors to draw the therapist out of a position of psychotherapeutic neutrality and into the roles of caretaker, parent, persecutor, and adversary" (Waldinger & Gunderson, 1987, p. 6). This represents one of the major difficulties in the treatment of the borderline patient.

Although theorists differ greatly in their understanding of the origins and meanings of these dangerous, impulsive, self-destructive behaviors, they

generally agree that these behaviors are used primarily in connection with uncomfortable affective states (Gunderson, 1984; Kernberg, 1975; Masterson, 1976; Shapiro, 1982; Stolorow & Lachman, 1980). Patients are often unable to make a connection between these behaviors and their affective experiences. The borderline patient experiences a "sense of internal disruption that interferes with his capacity for self-regulation" (Palombo, 1983, p. 16). This disruption results in an overwhelming sense of inadequacy in their efforts to negotiate the world. Events, feelings, and actions remain separate. Their world often feels incomprehensible and uncontrollable. This inability to understand and to see the connections in the world leads to a devastating sense of isolation, aloneness and depletion (Palombo, 1983). It is in this sense of isolation and deadness that these "impulsive, self-destructive, acting out behaviors" occur.

Because of the borderline patient's chronic experience of overwhelming chaos and fragmentation, one of the initial tasks of the therapist is to create a holding environment for the patient. In classical psychoanalysis this is facilitated through interpretation but for the borderline patient the holding environment contains a more essential component. The therapist must be a stable, consistent, nonpunitive, caring person who survives the patient's rageful and destructive impulses and continues to

perform the holding and soothing functions that the patient cannot perform for himself (Buie & Adler, 1982; Palombo, 1983; Waldinger & Gunderson, 1987). When these impulsive and destructive behaviors occur, they evoke feelings in the therapist, which the therapist, like the patient, would rather avoid. There is a tremendous pull on the therapist to avoid these uncomfortable feelings by responding with countertransference reactions of retaliation or withdrawal. These feelings, however, must not be avoided. They must be experienced, contained, understood, and processed, thereby sustaining the therapist's self-cohesion. It is the therapist's own cohesive sense of self that makes it possible to hold the fragmented patient.

In this context both patient and therapist are faced with an intensely disturbing but parallel process. They must both stay in and actively address a dangerous and frightening world which neither can fully understand nor control. It is a world that repeatedly threatens and challenges the continuity and integrity of the self for both.

One way to explore these problems is in relationship to the construction and function of a narrative. To make a connection between ones feelings and ones behaviors is essential in order to both organize and preserve a sense of self. This is as true for the therapist as it is for the patient. It represents a level of experiencing the self,

even if only in the moment, as an integrated whole. An affect is an experience of a self which when linked with an action or behavior becomes a story about a self, a narrative. The therapist participates in helping the patient to make sense by making connections between feelings and actions, to experience the self in a meaningful way. This construction of meaning validates and assures the continuity of the self. This function must go on for the patient but it must also proceed for the therapist in order to maintain the therapist's own sense of cohesion so that the therapist can provide the holding function for the patient.

What are the feelings, thoughts, and behaviors that borderline patients evoke in therapists and how do therapists maintain a sense of self-cohesion in spite of the threatening onslaught that the patient's dangerous and threatening behaviors represent? What are the narratives that therapists create about these experiences and what functions do they provide in creating the holding environment for both patients and therapists? These are the problems that have been addressed in this study.