Establishment of Optimal Distance

Throughout the course of psychotherapy with borderline patients, therapists may feel that they are engaged in an ongoing struggle to maintain their professional role and identity. Many patients with borderline personality disorder convey either explicitly or subtly that something other than a psychotherapeutic relationship is what they really need. Therapists may feel they are under powerful pressure to cross boundaries by extending sessions, not charging a fee, disclosing aspects of their personal lives, or engaging in physical contact. Alternatively, because of these pressures, they may become overly rigid and distant toward the patient to ensure that no ethical transgressions will occur. Establishing and maintaining optimal distance in the therapeutic relationship, therefore, is one of the primary challenges facing the therapist.

Especially during the opening phase of the treatment, therapists may feel that the boundaries of the relationship are tested repeatedly. A sense of floundering is a common experience while searching for an appropriately therapeutic atmosphere. Therapists may feel overwhelmed with the patient’s wish to establish a relationship that in no way resembles psychotherapy. Often the boundary testing comes in a remarkably concrete form, as illustrated by the following:

In the first session of psychotherapy, Ms. Z entered Dr. A’s office, and Dr. A offered her a chair at the side of his desk. Ms. Z proceeded to sit down and scoot the chair across the floor until it was
next to Dr. A's desk chair. Ms. Z had relocated the chair in such a way that when she sat, her knee was actually touching Dr. A's knee. The therapist immediately felt intruded upon, anxious, and a bit off balance by this unexpected development. Ms. Z immediately began to launch into an account of her problems without any apparent recognition of Dr. A's discomfort.

Dr. A did nothing for a few moments as he contemplated his options. Should he simply tolerate this encroachment to indicate his flexibility and empathy with the patient's needs? Should he slide his chair back away from the patient? Would such a decision result in devastating consequences for Ms. Z's self-esteem? Should he ask her to return her chair to its original location?

After considering the various options, Dr. A recognized that he was too uncomfortable to achieve the optimal state of mind necessary for conducting psychotherapy. He said to Ms. Z: "I don't want to hurt your feelings, but I would feel much more comfortable if you returned your chair to its usual place." The patient acceded to his request without protest and continued talking. Later exploration in psychotherapy revealed that Ms. Z had been an incest victim and had never really established generational boundaries in her own family. An attempt to reestablish a boundaryless situation in psychotherapy was thus natural for her.

In this vignette the establishment of optimal distance involved a literal, spatial distance. Dr. A used his countertransference anxiety to recognize that his inability to enter into a psychotherapeutic space was directly related to the lack of physical space between the patient and him. Processing his feelings and requesting to restore physical distance in the relationship helped Dr. A regain psychological distance and a sense of control and mastery over the situation. More often, however, the issue of distance is a symbolic, psychological one rather than a concrete, physical one, as in the following case example:

Ms. Y entered Dr. B's office for her first session and stared for a moment or two at her therapist. She looked disappointed and even irritated.

Dr. B: I take it that I don't look like what you expected.

Ms. Y: No! I wanted someone older. Someone to mother me. Someone like Ellen, my last therapist. [Ms. Y begins to cry.] You look younger than I am. I know you are!

Dr. B was uncomfortably aware that she was actually a few years younger than the patient. Despite her attempt to be objective about this nagging awareness, the therapist had a vague feeling that she should apologize to the patient. As she speculated about why she might be feeling that way, she invited further elaboration from Ms. Y about her wish for "mothering" and her feelings about her last therapist.

Ms. Y: Ellen gave me this necklace I'm wearing. [She stroked the beads.] It used to be hers.

Dr. B: So you feel like she's with you.

Ms. Y: She was like a mother to me for 2 years. Now I'm not with her because my husband had to change jobs and move here. [Ms. Y cries profusely.]

Dr. B felt as if Ms. Y had been wrenched unjustly from the only person in the world who could possibly help her. She began to doubt if she would ever measure up to this idealized figure.

Ms. Y: I sold my collection of rare stamps so I could be in therapy with Ellen. Those stamps were the most valuable things we owned. But I sold them because Ellen was my life. I had no money left, so I arranged to work at a convenience store so I could be in the neighborhood where Ellen lives. But the people I worked for didn't appreciate my sensitivity to allergens. When I started to be unable to go to work, they put a lot of pressure on me. I was in and out of hospitals for a while, and most of the doctors wouldn't okay passes for me to go to Ellen's office for therapy. They thought I would kill myself. But not as long as I was with Ellen! I would never do that as long as I was with her. One doctor during one of my hospitalizations let me go to Ellen's office. Once I was there, I couldn't leave. I wouldn't leave. It became a bit of a problem.

Dr. B knew that the patient had refused to leave her previous therapist's office on many occasions. For some reason this detail made an extraordinarily strong impression on Dr. B. In fact, she had noted that, even prior to this first session, she had already been
aware of anxiety connected with the fantasy that she would have to pry the patient from her office at the end of the hour. As Ms. Y spoke, the therapist took note of how the patient minimized her own contributions to her presenting problems.

Ms. Y: Did you know that I have severe TMJ? It’s horrible. I suffer constantly. My head feels strange, and I can’t function. I didn’t know that I had it until Ellen diagnosed it. Since she helped me discover it, I’ve been to many holistic health doctors. I’ve tried herbs and altered my diet. Now I’m taking medication. It’s the only way that I can survive.

The patient became increasingly tearful and was soon gasping for air because she was crying so hard. Dr. B, without the benefit of a shared history with the patient, wondered what would come next. With growing anxiety, she waited to see what the patient would do.

Ms. Y [still gasping for air between sobs]: Ellen knows me so well! We are like mother and child. She rearranged the furniture in her office so I would be comfortable. She knows me so well. She used to say she’s keeping all of the parts of me, and then one day we’ll put it all back together. Now I’m here, and she has all of me back there!

Dr. B felt it was necessary to begin to establish herself as the patient’s therapist. She began to grow weary of all the focus on Ellen and wanted to reorient the patient’s attention to the difficulties she was having entering a relationship with her.

Dr. B: You are here, and yet you’re not here.

Ms. Y: Ellen is so wonderful. There’s no way for me to tell you all that she knows. I could never tell you what I’ve told her. She knows about my mother, my husband, and my fear of people. Ellen said she’d be there for me always. If I could be with her, everything would be okay.

Dr. B: Have you written to her?

Ms. Y: No! I’m angry with her for referring me to you! She said she couldn’t help me any more. She said she’d always be there, and she left me! If she left me, that means other people can do it too!

Dr. B [empathizing with how the patient’s anger had turned to anguish]: So what you are feeling is that much worse!

Ms. Y: Yes. That kind of match will never happen again.

Dr. B: I don’t know about that. I think with new people there are always uncertainty and worries and fears. But uncertainty is not the same as “no possible match.”

Ms. Y: I saw Ellen three or four times a week for 2 years. We did good work together. I ended up in the hospital and couldn’t see her. All I wanted was to get back to her. I talked to Ellen on the phone every day. Ellen told me that she couldn’t help me on the phone. So I did everything I could do to get well enough to go back to Ellen. I sold everything. I ran out of money. But I finally got back to Ellen. Finally, all I had to do was take the bus to Ellen’s office, but I couldn’t leave her. I wouldn’t leave at the end of the session. Then something happened to change me about 4 months ago. I haven’t been able to do anything since. I’m afraid to go out. I can’t work. I’ve been disconnected with people—even Ellen—since then. Ellen noticed a change in me, and she called it borderline [spitting out “borderline” as if it were an unthinkable insult].

Dr. B: Disconnected? Meaning withdrawn? Or feeling disconnected inside?

Ms. Y: Inside.

Dr. B observed that the patient described this inner “disconnectedness” as if it were equivalent to the social isolation about which she also complained. Dr. B’s anxiety skyrocketed as she soberly noted to herself that Ms. Y seemed to assume that it was the therapist’s job to resolve both types of difficulties for her. Clearly, the patient expected Dr. B to resolve all of her difficulties. The therapist felt that she was being inordinately pressured to make a deal. She also had a sinking feeling that she could not possibly be adequate to the task. Moreover, the therapist knew that if she promised anything to the patient, the result would be disastrous because the patient would inevitably be disappointed. Dr. B began to realize that the intense pressured experience could be understood as something that was being “dumped” from the patient into her through the process of projective identification. She was then able to intervene from an empathic perspective.

Dr. B: You must feel a great deal of pressure right now.

Ms. Y [nodding affirmatively, pausing thoughtfully for a few moments]: Things didn’t work out too well with Ellen. I might as
well die if I'm going to suffer like this. I can't live without Ellen. I have to get better to get back to her. I keep looking for Ellen here. I know I get delusional at times. Ellen told me that I do. I know she's not here. But I look for her, and I hope I'll see someone like her here who will be my therapist.

Dr. B: You're right of course. Ellen is not here. But she seems to be with you in the necklace you're wearing.

Ms. Y: Yes. But I'm not real good at keeping people with me inside. Something in there eats them up.

Dr. B: It's fortunate that you understand how that works in you. Some people only suffer and never know why. You seem to have some understanding of your suffering.

Ms. Y: Yes, I do. I don't even know your name. I can't remember. I know your first name. Can I call you that?

For a moment, Dr. B wanted to say yes. She wanted to be as good as Ellen had been and inspire the confidence in Ms. Y that her previous therapist had. However, she caught herself in the midst of this wish to gratify and decided to stick to her typical professional boundaries.

Dr. B: I prefer to be called "Dr. B."

Ms. Y: When I was with Ellen, there were times when I just wanted to suck on her breast. We would talk about that. Ellen explained to me that that is how things go wrong between a little baby and her mother. I thought it was weird when she first said those things—about sucking on breasts and all. But she explained to me how it worked. Ellen said that I had trouble with dependency.

Dr. B: There are about 10 minutes left. I wasn't sure if you wanted to comment on our talk so far or talk about what comes next.

Dr. B recognized that she was anxious to address the end of the hour because she felt overwhelmed by the dependency longings in the patient concretized in the form of a wish to suck her previous therapist's breast. She was continuing to harbor the fantasy that the patient might refuse to leave her office. She was concerned that the patient's sobbing would complicate the end of the hour, and she wanted to bring the session to a gradual completion.

Ms. Y: You seem awfully young. Younger than me. I equate youth with inexperience. Ellen was more experienced than you. She taught at the medical school.

Dr. B: What you know of me is what you see, and you're uncertain what I have inside of me.

Ms. Y: Yes—you are young. I knew it.

Dr. B [slightly ruffled and a bit annoyed]: You have yet to become familiar with who I am on the inside.

Ms. Y: We haven't decided how often we'll meet. I brought this letter from Ellen for you. May I read it? This is her handwriting. Isn't it lovely?

The therapist listened as the patient read the entire seven-page letter. Ellen expressed feelings of affection and compassion toward Ms. Y. She offered reassuring statements that the patient would always be important to her. Ellen suggested to Ms. Y that she needed four psychotherapy sessions a week plus the opportunity to make up to 10 phone calls a week if she were in crisis.

Dr. B heard the letter as a cautionary tale about the difficulties of future work with Ms. Y. The prospect of being available to the patient through numerous sessions and phone calls each week felt overwhelming. In addition to her reluctance to attempt to offer the patient more than she knew that she could deliver, Dr. B felt hesitant to compete with such a highly idealized object. Based on a diagnostic understanding of the patient's need to develop further the ego strength necessary to sustain her between sessions, as well as the patient's need to mourn the loss of this idealized figure who functioned as an external prop to her internal world, Dr. B decided to offer the patient two sessions per week.

Ms. Y: That's what she wrote. I know the time is up now.

Dr. B: Yes, it is. Thank you for sharing the letter. I suggest that we meet twice a week.

Ms. Y: That would be fine. Is there any possibility we could meet three times a week?

Dr. B: Let's get started first. Later, we can talk about that possibility. It's time to stop for today. [The patient leaves very slowly.]

This excerpt from the beginning of a psychotherapy process can be used to illustrate a number of the issues involved in establishing optimal distance during the opening phase of therapy.
Confusion and Uncertainty

Within moments of meeting Ms. Y, Dr. B was plunged into a state of chaos, ambiguity, and confusion. Her anxiety escalated as Ms. Y informed her that she was too young. The patient began to sob as an expression of her disappointment. The previous therapist, Ellen, was held up as an impossible standard—one that Dr. B could never hope to match. Additionally, Ms. Y presented the relationship as a mother-child situation rather than a psychotherapeutic encounter. Dr. B felt overwhelmed by the sense of desperation Ms. Y conveyed when she described her previous therapeutic relationship. The immersion in this intense affective experience is an essential and unavoidable aspect of the psychotherapy with borderline patients. Bollas (1987) described it well: “The [analyst’s] most ordinary countertransference state is a not-knowing-yet-experiencing one” (p. 203).

The therapist needs to tolerate this experience without feeling the need to organize all the material immediately into a coherent conceptual framework. Moreover, prematurely interpreting the primitive transference that is being observed can be a technical error. At the outset of therapy the transference is a more general one to the unknown qualities of the therapist (Casement 1990). Often such early interventions may grow out of a countertransference need to gain immediate ideational mastery over the intense affect and may be viewed by the patient as too general or even hostile.

As one tolerates the transference-countertransference chaos of the process, a pattern usually emerges that sheds considerable light on the difficulty establishing optimal distance. Borderline patients tend to oscillate between twin dangers (Lewin and Schulz 1992). On the one hand, attachment brings with it the fear of merger, with the accompanying loss of self. On the other hand, borderline patients fear that if they allow too much distance, they will then lose the therapist. These dual dangers place borderline patients on the horns of a dilemma—if they defend against the anxiety about fusing with the object, they are then thrust into the opposite danger of being isolated from the object they so desperately need. The result is an oscillating pattern of clinging followed by retreat. The therapist’s countertransference responses mirror these shifts between oscillating poles. As Lewin and Schulz (1992) noted, “either there is overidentification with the patient or there is complete empathic rejection. The first aggravates the fusion danger for the patient. The second accentuates the loss danger” (p. 79). Both members of the therapeutic dyad struggle to find some sense of middle ground in the context of what seems like an obligatory all-or-none situation.

One way to view the therapist’s intense affective state and the sense of floundering accompanying that state is that the patient has created an “illness” in the therapist. Dr. B’s mounting anxiety about whether Ms. Y would leave the office, whether she would fall apart, and whether she would be able to engage in a psychotherapeutic process made her feel pressured to act in some manner to relieve the anxiety. Much of her efforts were directed more at management of her own anxiety than at the patient’s presenting concerns. Bollas (1987) acknowledged this aspect of therapy by commenting that therapists must often treat their own situational illnesses before being able to treat those of the patient. By extension, the therapist is also treating the patient’s illness as it manifests itself in the induction of certain states in the therapist.

Time Urgency

Throughout the course of psychotherapy, but particularly in the early phases, many borderline patients will present their problems as though they require emergency attention involving some form of drastic action by the therapist. This presentation creates a sense of countertransference urgency that makes the therapist feel as though the patient cannot possibly wait until understanding of the situation can be achieved through psychological exploration. The heaving sobs of Ms. Y made Dr. B feel as though a catastrophe was occurring that would not be amenable to ordinary psychotherapeutic interventions.

Many borderline patients spend a great deal of time functioning in a paranoid-schizoid mode of thinking. In this psychological con-
stellation, there is no subjective "I," no sense of self that involves personal agency that extends over time (Ogden 1986). Patients operating in this mode live in "the now," with no recall of times in the past when they were able to survive experiences of intense affective pain or emptiness. The notion of delaying gratification of their needs is also dismissed as unthinkable because the future seems irrelevant and unconnected to the immediate sense of urgency. One central feature of splitting as a defense mechanism is that self-experiences are kept in a kind of psychic limbo where they remain unconnected with other self-experiences. There is no continuous thread woven between the needy, desperate self and the quiet, contented self so that the two experiences of being can be integrated into a complex, continuous self-experience.

The kind of overwhelming despair that patients like Ms. Y bring to a psychotherapy hour is powerfully compelling. A psychological emergency is apparently taking place and requires immediate attention. This affectively powerful self-presentation may coerce a complementary object response in the therapist through the process of projective identification. The object response that "possesses" the therapist is that an action outside the conventional therapeutic role is needed to address the emergency. The patient may need to be physically held. The next hour may need to be canceled so the therapist can remain with the patient. The patient may seem to require medication to regain control. A third party (a boss or spouse, for example) may need to be called so the therapist can intervene on the patient's behalf.

A consideration of the sense of time urgency engendered by borderline patients leads naturally into a discussion of pharmacotherapy. One survey of psychiatrists in private practice who were experienced in the psychodynamic psychotherapy of borderline patients (Waldinger and Frank 1989) revealed that 90% of them prescribed medication at some point in the treatment of borderline patients. A recurrent issue for such psychotherapists, however, is to monitor whether the decision to prescribe grows out of countertransference exasperation or solid clinical judgment.

A rational and systematic approach to prescribing for borderline patients is essential to avoid ill-advised pharmacotherapy out of a sense of despair or a need to "do something." For thorough discussions of the pharmacotherapy of borderline personality disorder, see Soloff (1993) and Cowdry and Gardner (1988).

Feelings of Inadequacy

From the first moments of Ms. Y's encounter with Dr. B, she induced feelings of inadequacy in her therapist. She was dismayed at the relative youth of Dr. B. She was reduced to tears when she compared Dr. B with her previous therapist. Dr. B's reaction to her own awareness of the age comparison was to feel guilty and to contemplate making an apology to the patient. This reaction, which the therapist noted as irrational, is a typical development in the psychotherapy of borderline patients. They are masters at inducing feelings of guilt about things for which the therapist should feel no compunction whatsoever.

Having had a string of therapists is common for patients with borderline personality disorder because they move from one clinician to another, always hoping that their needs will finally be gratified in a magical manner by a particularly special therapist. Hence, previous therapists are frequently invoked in either idealized or devalued terms by these patients. In the case of Ms. Y, her previous therapist, Ellen, was regarded as nothing short of a savior. As the number of superlatives applied to the previous therapist mounted, Dr. B felt increasingly futile about ever being able to live up to this paragon of therapeutic virtuosity. A key element in this aspect of the countertransference was Ms. Y's portrayal of her clinical improvement as totally outside her own control. Only what the therapist does matters. Dr. B felt that she could not possibly measure up to Ellen, so her ability to help the patient was severely limited. These feelings of being inadequate and "deskilled" dislodged the therapist from her professional role and made her feel helpless to influence the course of the session.

For therapists to react defensively in such situations in an effort to assert their own competence vis-à-vis the previous therapist is understandable. Another common countertransference response is to
compete with the previous therapist by becoming more active, more interpretive, or more gratifying than therapists ordinarily would be in a first session. Some may also respond with contempt or disdain for the actions of the previous therapist. Borderline patients often tell stories about the extraordinarily special relationship they had with their therapists. Although some of these accounts may well be accurate, caution should be used in accepting such reports at face value. In many instances, including Ms. Y’s account of Ellen, the previous therapist will insist that the accounts are heavily contaminated by transference wishes.

The Wish for Parenting

Another characteristic of the paranoid-schizoid mode of functioning is a collapse of “analytic space,” which Ogden (1986) defined as “the space between patient and analyst in which analytic experience (including transference illusion) is generated and in which personal meanings can be created and played with” (p. 238). One result of this phenomenon is that borderline patients will often view the psychotherapist literally as though he or she were a parent. The “as if” nature of the psychotherapeutic relationship is lost and requires an opening of analytic space so that the therapist can be viewed as like a parent but still different. Ogden (1986) noted, “the therapist working with borderline patients is forever attempting to ‘pry open’ the space between symbol and symbolized, thus creating a field in which meanings exist, where one thing stands for another in a way that can be thought about and understood” (p. 241). The wish for parenting can then be reflected on and examined as an idea worth understanding.

In the absence of this capacity, the patient may relate to the therapist in the same manner described in the first session with Ms. Y. She did not enter into the therapeutic relationship with the expectation of working through problems with her actual mother by reexperiencing those issues with a new object. Instead, she literally expected the therapist to be a mother to her. She was devastated that Dr. B was so young because she was afraid she would not be mothered by her therapist. She then went on to give an account of her previous therapist that made it appear as though Ellen actually served as a mother in her life. The most dramatic example of this concretization of the transference wish was her comment that she wanted to suck Ellen’s breast.

This striking loss of psychological distance creates profound countertransference reactions that are likely to disarm a therapist during the opening phase. Dr. B felt overwhelmed by the intense dependent longings expressed by Ms. Y. She felt as though she were being swallowed up by her patient’s voracious need for succor. She also felt deskillled, as though her technical expertise and training were of no use to the patient. The patient’s crushing disappointment made Dr. B feel as though she would need to be an idealized “good mother” to be of any help whatsoever to the patient.

Although Ms. Y’s demands for parenting were “up front” in the beginning of the process, other borderline patients may not explicitly ask for a parental relationship but unconsciously expect unconditional loving responses from the therapist and react with rage when they do not receive it. An advantage of Ms. Y’s presentation was that the transference wish was out on the table so that it could be dealt with at the outset as an issue in the psychotherapy.

The Therapeutic Frame

The wish for mothering or fathering is one example of a broader issue that makes optimal distance difficult to establish in the beginning of a psychotherapy process with borderline patients. Almost all the usual boundaries of treatment—which constitute the therapeutic frame—are challenged or tested by the patient. In the vignette featuring Ms. Y, the patient wished to establish the therapeutic frame on her own terms instead of the therapist’s terms. Matters such as frequency and duration of sessions, phone calls between hours, length of sessions, and professional forms of address are usually established by the therapist according to guidelines of professional conduct. However, Ms. Y suggested that she would require four sessions a week (as opposed to the two suggested by Dr. B); she
suggested that she should be allowed up to 10 phone calls per week to deal with crises; she asked if she could address her therapist by her first name; and she made it quite clear that she would have difficulty leaving after the 50-minute session.

Other patients may request special fee arrangements, including no payment at all, extratherapeutic contacts, and physical touch as part of the process. The therapeutic frame is like an envelope or membrane around the therapeutic role that defines the characteristics of the therapeutic relationship (Langs 1976; Spruill 1983). The elements of the frame are constructed out of the various parameters of treatment, including frequency and duration of appointments, absence of physical contact, specific forms of appropriate social behavior, language, mode of dress, fee arrangements, and the office setting itself (Gutheil and Gabbard 1993). These boundaries function as limits that maintain the optimal psychotherapeutic distance in the relationship so that both parties can enter a symbolic realm where ideas can be examined in a collaborative way by patient and therapist.

One of the most useful ways to manage countertransference reactions and establish optimal distance is to clarify the treatment boundaries at the beginning of a psychotherapeutic process. In the case of Ms. Y, for example, the therapist clearly will need to spend some time helping the patient understand what are realistic expectations of a therapeutic relationship and what are unrealistic false hopes that will lead to disillusionment. Among the common countertransference problems in the psychotherapy of borderline patients is that therapists begin to believe they actually may be better parents than the real parents. They may feel coerced into a parental role as though no other interaction will be of any use whatsoever. The decision to attempt to “out-mother” the patient’s actual mother is doomed to failure from the outset because a therapeutic relationship can never provide what a parental relationship provides in reality. As Spruill (1983) noted, “it is as disastrous for analysts to actually treat their patients like children as it is for analysts to treat their own children as patients” (p. 12).

Kernberg and colleagues (1989) wrote eloquently on the establishment of an initial contractual understanding with the patient that serves the purpose of educating the patient about realistic expectations for the therapeutic process while at the same time informing the patient implicitly that therapists have rights and will not submit themselves to abuse. Before therapists agree to start a psychotherapy process, they must have an agreement from the patient that the treatment structure will be followed. For example, matters such as the fee payment, the length of sessions, the handling of vacations, the frequency of sessions, the need for psychiatric hospitalization, the management of suicidal crises, and a general understanding about phone calls between sessions can all be laid out as part of the initial contract. Establishing these boundaries or parameters of the treatment also serves as a valuable adjunct in managing countertransference. Any deviation from the standard therapeutic frame can alert the therapist to the emergence of countertransference reactions.

Some borderline patients will present a good deal of reluctance when asked to agree to the structure of the treatment. Therapists must be prepared to come to the conclusion that no psychotherapeutic work will be possible if the patient is unable to agree to the treatment conditions (Kernberg et al. 1989). Therapists of borderline patients must always remind themselves that there are much worse fates than termination of the treatment. It is better not to begin at all than to begin under grossly misguided circumstances.

One of the most effective ways to maintain the appropriate professional distance in the early going is to make the therapeutic frame the main focus of the sessions. It is helpful to remind the patient continually that psychotherapy has not yet begun. Until the negotiations are successfully completed regarding the treatment structure, the process is basically a consultation or evaluation. Therapists can also use this opportunity to delineate the patient’s responsibility for collaborating in a psychological, exploratory process. Fantasies of being passively healed by a perfect parent can be brought up from the beginning and addressed as unrealistic. A successfully negotiated initial contract may be one of the best prophylactic measures involved in the successful management of countertransference later in the treatment.
Another reason for the special attention to establishing a contract during the initial period is that the therapeutic frame contributes to the formation of the therapeutic alliance. Best defined as a mutual collaboration between patient and therapist in pursuit of common therapeutic goals, the therapeutic alliance is a critical ingredient in the success of psychotherapy with borderline patients (Gabbard et al. 1988; Meissner 1988). Patients who make a sincere commitment to the contractual understanding are implicitly agreeing to a perspective that involves forming a collaborative working relationship.

**Countertransference Rigidity Rationalized as Textbook Technique**

One of the paradoxes in psychotherapy of borderline patients is that the practice of setting the structure for the treatment may itself become a fertile field for countertransference enactment. Many beginning therapists (and even more seasoned ones) respond to their anxiety about the patient’s near-magnetic pull to transgress the therapeutic frame by becoming excessively rigid. The term *borderline* is often used pejoratively as a synonym for “manipulator,” “splitter,” or “pain in the neck.” The patient’s transference wishes to be mothered may be regarded as a malevolent assault on the therapist’s professional competence and integrity. This countertransference perception may be handled by assuming a steely, withholding posture so as not to be “taken in” by the patient. Such strategies may then be rationalized as textbook technique—an example of “setting firm limits.”

Another way to understand the therapist’s withdrawal and attitude of nonresponsiveness is that they are directly proportional to the perceived object hunger and affective intensity of the patient. Therapists may feel that they are being drawn into a maelstrom of affect where they, too, will undergo a merger that involves a loss of self. As Lewin and Schulz (1992) observed, “the therapist presents the patient with a threat of loss in order to protect against what he sees as a dangerous invitation to fusion” (p. 80). In this counter-

transference distancing maneuver, the therapist is behaving as though the patient’s all-or-none point of view is an unalterable reality that must be contended with. The therapist is inadvertently “buying in” to the notion that no middle ground exists. Throughout the psychotherapy process with borderline patients, therapists must repeatedly strive to find a reasonable middle ground in the context of the patient’s coercion to view the situation as an either/or choice between catastrophic polarities.

Virtually every session of psychotherapy with a borderline patient involves a countertransference dilemma regarding the extent to which partial gratification of transference wishes is indicated. The therapist must decide which is the greater technical error: complete deprivation or partial gratification? A judgment call must be made in such circumstances based on the therapist’s best assessment at the time. One helpful guideline is the distinction drawn by Casement (1985) between “libidinal demands” and “growth needs.” The former cannot be gratified without gravely jeopardizing the treatment and committing serious ethical compromises. The latter cannot be frustrated without preventing growth. Casement’s notion of growth needs can be understood as what has traditionally been termed the provision of a holding environment.

Consistency is, to be sure, an essential aspect of the holding environment. But as Casement (1990) noted, “paradoxically, a part of the consistency that a patient needs from the analyst is that of empathic responsiveness to changing needs, which means the analyst sometimes adapting to the patient rather than remaining rigidly the same” (p. 333). A patient, for example, may need the therapist to take a more active stance regarding verbal interventions because of experiencing silence as a retraumatization that parallels childhood experiences with a cold, withholding mother. Another patient may need to make a brief phone call to the therapist over a long weekend because of a severe lack of object constancy. A few words from the therapist may immediately restore the therapist as an alive and vital presence for the patient and put to rest the catastrophic anxiety that had arisen during the separation.

These partial transference gratifications may serve to create an atmosphere that makes psychotherapy possible. Certain growth
needs must be met, or there may be no treatment at all. The degree to which these needs are met has a great deal to do with the location of the therapist’s technique on the expressive-supportive continuum. Therapists must base their decisions regarding technique on a careful assessment of patient characteristics (Gabbard 1994; Meissner 1988). Even the partial gratifications that occur in supportive therapy, however, are still ultimately disappointing because they fall short of the patient’s longings for unconditional “mother love.” Moreover, supportive interventions that may be gratifying to the patient must be geared specifically to the patients’ areas of weakened ego functioning. Rockland (1992), who developed a systematic approach to supportive psychotherapy for borderline patients, issued the following cautionary statement:

It is in the supportive psychotherapy of the [borderline personality disorder] patient that the therapist’s ability to utilize countertransference reactions without acting them out, that is, to use support, advice, praise, or limit setting only as required by the patient’s ego deficits, and not to gratify conscious or unconscious wishes of the therapist, receives its most challenging test. (p. 190)

Acknowledging the need for flexibility, however, should not minimize the necessity of boundaries. Some transference wishes—such as wanting to be physically held—should not be gratified under any circumstances. For one thing, from a risk-management perspective, therapists who hug their patients are skating on thin ice (Guthiel and Gabbard 1993). Moreover, from a strictly clinical perspective, literally holding the patient collapses the analytic space and blurs the distinction between the symbolic and the concrete (Casement 1990). Finally, such an act may provide the patient with false hope that the therapist really will become the parent so earnestly desired.

The therapist must ultimately fail the patient. Only through failing to meet the patient’s all-consuming needs will the necessary disillusionment and mourning process take hold in psychotherapy. Attempting to be the “all-good” mother is doomed to failure. The role is not only impossible to sustain but is inherently non-

therapeutic. Patients need to experience the therapist as the “old object” from childhood to work through the vicissitudes of the internal object relationships that emerge in the transference. This necessary therapeutic work is bypassed when therapists represent themselves as perfect objects, suggesting that saintly persons are available if the patient can only locate them.

The oscillation between the new object and the old object is instrumental to successful psychotherapy of borderline patients. In this regard, Greenberg’s (1986) contemporary definition of neutrality is germane. In his view, neutrality “embodies the goal of establishing an optimal tension between the patient’s tendency to see the analyst as an old object and his capacity to experience him as a new one” (p. 97). This reconceptualization of the time-honored psychoanalytic concept allows for much greater flexibility by therapists and is therefore a more suitable definition for their stance vis-à-vis the borderline patient. An absolutely nonjudgmental role that is equidistant from ego, id, and superego might be actively harmful in treating many borderline patients who have suffered from parental neglect, abuse, or indifference. Patients must be actively confronted if their behavior is self-destructive or threatens to destroy the therapist or the treatment itself (Waldinger 1987).

Greenberg’s definition also captures the ebb and flow of transference-countertransference enactments followed by a systematic processing of those enactments that characterize the day-in–day-out drama of psychotherapy with borderline patients. Through the process of projective identification, therapists find themselves in the obligatory role of “the heavy” one day, and “the saint” the next, before they finally return to some semblance of their familiar professional persona. One soon learns that neither the persecuting bad object nor the idealized all-good object is in itself therapeutic. Only the new “real” object of the therapist (as a consistent figure who reflects on the experiences within the dyad that lead to the coerced old object experiences) leads to significant change. A reasonable goal for a borderline patient’s therapist is to be a “not-bad” object. After all, most of us would be content if all our family members and friends could simply meet this compromise between ideals and reality.
**Summary**

From the first contact between therapist and patient, establishing optimal distance is a high priority. Borderline patients repeatedly test the professional boundaries of the relationship and often directly or indirectly express a wish for a parent rather than a therapist. Early in the psychotherapy process, the therapist often feels a sense of floundering and an inner urgency to act rather than reflect. Because of the potential for pharmacotherapy to be contaminated by countertransference responses, a rational and systematic approach to medication, based on target symptoms and trait vulnerabilities, must be part of the overall treatment plan. Establishing a therapeutic frame and a contractual understanding is a useful way to construct an analytic space with the patient in which psychotherapy can take place. Matters such as fee payment, the length of sessions, the handling of vacations, the frequency of sessions, the need for psychiatric hospitalization, the management of suicidal crises, and a policy on phone calls should be part of this contract. On the other hand, a good deal of countertransference enactment can hide behind the rigid adherence to an inflexible structure. The balance between flexibility and boundaries parallels the therapist’s oscillation between playing the role of a new object in the present and an old object from the past.

**References**


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