A Little Cream and Sugar: Psychotherapy With a Borderline Patient

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This case report describes selected parts of a psychotherapy with a patient diagnosed with borderline personality disorder. Although this report features aspects of psychodynamic psychotherapy, readers should recognize that this modality usually needs to be used selectively as part of a treatment program involving family, cognitive/behavioral, and psychopharmacological modalities (1). Process material has been chosen from the first year of a twice-weekly psychotherapy to highlight issues that are commonplace during the course of such therapies: establishing an alliance, managing boundaries, setting limits, and responding to rage and suicide threats. The clinical material examines how countertransference feelings arise and become enacted. Insofar as this case report documents the common, recurrent, and oft-feared problems in psychotherapy with borderline patients, the discussion is intended to offer a primer for how these problems can be effectively managed. Indeed, the testing, the combativeness, and the dangers characteristic of the borderline patient presented here provide a backdrop against which we hope to convey a larger thesis. While the depth and intensity of dependent and rageful feelings, technical challenges, and commitment inherent in such work are often seen as a reason to avoid such patients, the work can be, and with experience will be, an enriching and satisfying professional activity.

CASE PRESENTATION

I, Dr. Wheelis, was a second-year resident on call when I first met Ms. A. At the time she was a psychiatric inpatient who had been admitted a week before for suicidality and increased alcohol abuse. I had been asked to meet with Ms. A and potentially take over her treatment, since she had recently terminated with her therapist. The inpatient psychiatrist in charge of the care of Ms. A, as well as an outpatient consultant, had recommended a confrontational dynamic psychotherapy. I had arranged a first appointment for the following morning, but as the doctor on call the evening before, I was asked to see her for medical attention. In a rage at having been put in a quiet room, Ms. A had hit her elbow on the wall and was complaining of great pain. I felt uneasy that my first contact should be under such circumstances and wondered if she knew I was the doctor on call that night. When I arrived to see her, I was met by a short, medium-built woman wearing jeans, sitting cross-legged on the floor, looking angrily at me. Before I'd had a chance to introduce myself, she snapped:

Ms. A: You could be dying before you got any help around here! My arm is killing me! This place is crazy!
Therapist: Ms. A, I would like to introduce myself. I am Dr. Wheelis.
Ms. A: Oh, no kidding! I didn't expect you. You're a resident? Interesting. You must be either very good or very crazy to have taken me on.
Therapist: I can't tell if that's an invitation, a warning, or both [she smiled at my comment], but we have an appointment tomorrow. Why don't we discuss it then. For now, perhaps I should take a look at your arm.
Ms. A: No, it's okay, just a little bang.
Therapist: Are you sure? You suggested that it was giving you considerable pain.
Ms. A: No, it's fine, really. I'll see you tomorrow. By the way, I hate being called Ms. A.
Therapist: How would you like to be called?
Ms. A: Lotta. That's what everyone calls me.
Therapist: Very well, as you wish.

Already in this initial interaction with her therapist-to-be, harbingers of the therapeutic challenges are evident. Ms. A demonstrates a manipulative style that predates the first interaction by seeking help through the exaggeration of a minor physical complaint. There is also the hint that Ms. A may be taking pleasure in suggesting to the therapist-to-be that working with her will be more than a small challenge. Her final request, to be called Lotta, betrays her desire to bypass professional formality by requesting an immediate familiarity.

Ms. A was a 35-year-old, single, white librarian when I met her as an inpatient. The hospitalization was her 10th psychiatric admission. Her past history was replete with self-destructive behavior including wrist slashing as a teenager, alcohol and benzodiazepine abuse, chronic dysthymia, and suicidality. She was diagnosed with borderline personality disorder following her first hospitalization at age 18, having met seven of the nine diagnostic criteria of DSM-IV. At other times she had been given additional axis I diagnoses including bipolar disorder. She had had several medication trials without benefit. Her dominant symptoms were emptiness and aloneness; although she was impulsive and labile as well, these symptoms were connected to interpersonal stressors and did not fit criteria for bipolar disorder. Her current admission was precipitated by increasing depression and suicidality, but without a suicide attempt, following the loss of her boyfriend of 8 years. Her psychiatrist of 10 years had terminated treatment because of a geographic relocation. She felt increasingly withdrawn from her family, especially her mother, with whom she had been particularly close. Ms. A was quite specific as to the goals of her current hospitalization. She wanted to find a new therapist and to become involved in Alcoholics Anonymous in order to stop drinking.

After the initial meeting in the quiet room, I met with Ms. A for her first scheduled appointment the following day. She was waiting for me when I arrived on the inpatient unit.

Ms. A: Could we go where I could smoke? You'll have to get the matches from the nurse. I'm on supervised flames.

I proceeded to get the matches and found a room where smoking was permitted. I handed her the matches.

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Ms. A: You're going to trust me with these?
Therapist: I'm going to see if I can.
Ms. A: What if I try to set something on fire? [She said this sarcastically.]
Therapist: Then I won't be able to trust you, and I'll ask for them back.
Ms. A: Hm! You ask a simple question, you get a simple answer. Doesn't happen so commonly around here. Do you smoke?
Therapist: On occasion.
Ms. A: Two for two! Most shrinks don't answer my questions.
Therapist: Let's not try to set a record.
Ms. A: I feel much better now that I have a therapist.
Therapist: I want to interrupt you; I've only a half an hour today and I wanted to speak with you about a few things. What I had in mind was to meet with you several times between now and when you're discharged and give ourselves the opportunity to see if you want to work with me and for me to see if I think I can be of help to you. If we decide we can work together, then we'll continue on an outpatient basis two or three times a week, which we can decide together. [Ms. A starts to shake her head.]
Ms. A: Let me interrupt you a minute! I'm not a nine-to-fiver. Now, I know I have trouble with limit setting and you can tell me this is out of the question, but I have in mind five times a week, and I need to know I can call you, you know?
Therapist: No, I don't know.
Ms. A: Well, like if I get into trouble, I want to know that I can contact you.
Therapist: If you feel in trouble and unable to wait until our next appointment, I would be available, but if this were to occur frequently it would not be all right. I would question the utility of the therapy and would want to reassess it.
Ms. A: Well, I never called my last therapist, but it mattered that I knew I could. You know, I always imagined I'd be in treatment forever.
Therapist: Is that a wish?
Ms. A: I'd just assumed since I'd been in therapy this long already, I will continue to be in therapy forever.
Therapist: Do you want to change?
Ms. A: Well, of course.
Therapist: Then I think it's a mistake to make that assumption without question.
Ms. A: Well, are you saying I won't need therapy forever?
Therapist: I cannot say that.
Ms. A: Well, then, are you saying I'll need therapy for the rest of my life?
Therapist: I can't say that, either. I don't know, but I am suggesting that if you leave the question open, your therapy might be more effective.
Ms. A: You're also telling me that you're not sure you're going to be my therapist.
Therapist: That's true.
Ms. A: What does it depend on?
Therapist: If I feel I can be of help to you.
Ms. A: What? Do I have to prove myself a good patient?
Therapist: I would think it more worthwhile for you to be thinking if you want to work with me.
Ms. A: I never really thought about that kind of thing.
Therapist: Well, time to start.
Ms. A: You're something else.
Therapist: How so?
Ms. A: Well, nobody really talks to me the way you do.
Therapist: How's that?
Ms. A: I don't know. Like you treat me like an adult, no kid gloves.
Therapist: Should I?
Ms. A: No. I don't know.
Therapist: You're not quite sure?
Ms. A: Well, most people treat me with kid gloves, you know, Lotta the sick one, the one who can't deal with anything. It makes me mad, makes me feel like a cripple. But then I think, they're probably right, and I can't handle anything anyway.

I was aware of the way in which Ms. A's style of engaging me was static and rigid. She wanted me to conform with what she deemed the appropriate treatment plan—my being actively available to nurture her without question. My efforts to encourage her capacity for critical thinking were met with resistance but not rejection. I felt that this session significantly shaped my initial treatment plan. The primary task was to encourage her as an active participant in her treatment rather than as a passive recipient of her treatment. We clarified other goals of her treatment to include improving her relationship with her mother, friends, and lovers through the examination of her conflicted feelings of neediness and anger. I told her that much of the work that we could do together would depend upon her ability to examine such problems in the context of our relationship as we had in this first session. Although reluctant, Ms. A was intrigued.

This initial session is illustrative of a couple of important issues regarding alliance building. The interactions are characterized by the therapist's repeated attempts to question Ms. A's unrelenting efforts to force an unquestioned relationship based on her needs alone. The therapist wisely sets a preliminary agenda of considering the viability of a treatment relationship. She sets the stage by underscoring that therapy is to be tied to forward progression and not to continuation of old ways. The implicit differentiation between therapist and patient suggested in this process material covertly indicates that ultimately, separation is the goal of treatment. Later in the session, specific goals of therapy were discussed. Together they agreed that their work would focus on managing her anger and impulsivity and improving her relationship with her mother.

I met with Ms. A as we had planned for a total of six sessions while she was hospitalized. I obtained the following history from her and her old records.

Ms. A was born in the Midwest and was the older of two children; she had one sister 3 years younger. Her parents both worked in the auto parts industry. She had little to say about either parent: she described her father as difficult, her mother as rigid, like herself, but her "best friend." She had always hated her sister. Her mother reported that Ms. A was the product of an unremarkable pregnancy and that her early development was normal. She also commented during one of Ms. A's hospitalizations that she had found the task of mothering to be difficult, finding it frustrating to be tied to the house and to be caring for a child.

Ms. A's earliest memory, at age 3, was of offering her mother a picture she had carefully and painstakingly drawn for her upon her arrival home from the hospital with her new little sister. She remembers shredding the picture into little pieces as her mother reached to accept it. When Ms. A was 13, her father suffered a fall at work and was paralyzed from the waist down. Whereas before she had been an active, helpful, and good-humored child who was open and talkative, she became withdrawn, solemn, and uncommunicative. Around the same time she began a friendship with a friend, Susan. She described the relationship as intense and said that its breakup after 4 years was instigated by Susan, who found the closeness suffocating. Susan apparently felt so controlled by Ms. A that Susan's mother became concerned that this was interfering in her daughter's development and so urged her to end the relationship. After the breakup of the friendship, Ms. A, then age 16, became depressed and cut her wrists for the first time, telling no one. Subsequently her schoolwork in a local public high school deteriorated, and she went from being an A student to a D student.

This history frames important issues for the subsequent treatment. Her earliest memory introduces the issue of exclusivity, rivalry, and spitefulness. Until this point, Ms. A had been the sole proprietor of the parental attention; the disillusionment occurred when she saw her mother giving attention to her sister. Ms. A's intense relationship with her friend Susan was so exclusive and controlling that Susan's mother became concerned and intervened. The immediate effect of this was that Ms. A cut her wrists for the first time. It is notable that like many people who subsequently become identified as borderline, Ms. A made the initial self-destructive gestures in private. Only later did the secondary gain (the attention drawn from family and therapists by such actions as wrist cutting) become conscious and manipulatively—even spitefully—exploited. Perhaps more telling than the cut wrists is the fact

that Ms. A's schoolwork deteriorated. This might have been a signal to caretakers that she was in trouble and calling for help, but, in any event, it reflects the serious and sustained injury that the breakup of this friendship involved for Ms. A.

The loss of an exclusive relationship, as these vignettes suggest, reveals a core vulnerability in borderline patients (2). The therapist can anticipate that the patient is likely to want to recreate an exclusive relationship and can expect that the inevitable disillusionment of such claims will be greeted with similarly spiteful actions.

Ms. A skipped many classes and began taking street drugs including marijuana and barbiturates. During her junior year of high school she began shoplifting and missing school altogether. There was increased friction at home with her parents. Despite their attempt to set limits through insisting on a curfew and other rules of conduct, they were ineffectual at controlling their daughter's behavior. The same year, at age 17, Ms. A was hospitalized for the first time after cutting her wrists and, this time, showing them to her parents. She continued to cut her wrists superficially while in a general hospital; unable to abide by the limits set on this, she was transferred to a state hospital briefly. After returning to the general hospital, she continued to violate the rules and regulations, even once setting her hair on fire in anger at a staff member. This and other breaches of agreements that she not harm herself necessitated her return to a state hospital, where she stayed for 6 months.

As expected, Ms. A learned the power that is associated with self-destructive acts. Her first hospitalization was precipitated by showing her cut wrists to her parents. Her parents, however, were in no position to assess the seriousness of such actions. Even for clinicians, judging potential lethality and the appropriate response is difficult. When inexperienced clinicians first encounter young adult patients who have slashed their wrists or otherwise have behaved in a self-destructive way, such as minor overdosing, they often respond instinctively by assuming suicidal intention, then take on responsibility for preventing any recurrence. This often takes the form of psychiatric hospitalization; motivations may include anxiety about distinguishing between true suicidal ideation and self-harming behavior without lethal intent or fear of the legal, administrative, and psychological consequences should a suicide occur. Often conscious and unconscious enthusiasm for taking such a role stems in part from the opportunity it represents to fulfill what is the most dramatic and perhaps the most alluring promise of becoming a caretaker, i.e., to save a life.

Repeated self-destructive acts by any patient should alert clinicians to the fact that the acts may not be suicidally intended. Such self-destructive acts are usually done for self-punitive purposes (3) and are sometimes associated with an experience of relief from painful ("intolerable") affective states (4), but they are also done with progressively more awareness of the controlling effects that such acts have on significant others. Follow-up studies show that in fact, about 8%–9% of borderline patients commit suicide (5) and that the suicide rate is particularly high among those, like Ms. A, who have comorbid substance abuse (6). This rate is about 400 times the rate (about 0.01%) in the general population and more than 800 times the rate (0.005%) found in young female subjects (ages 15–34) (7). By itself, this vindicates those clinicians who attempt to preclude the opportunity for borderline patients to perform suicidal acts. This can mean involuntary hospitalizations but more often entails decisions such as giving prescriptions for only small quantities of medications, enlisting family members to help monitor the patients' suicidality, and encouraging patients to know of one's availability in crises. Despite the high frequency with which borderline patients perform multiple self-destructive acts, the comparative frequency of those which result in actual suicide is low (4, 6). From this perspective, the data vindicate those clinicians who are primarily concerned about the secondary gain and manipulative intentions related to borderline patients' self-destructive acts. Their interventions are typically directed toward diminishing the secondary gains from self-destructive acts by, for example, staying uninvolved with hospitalizations or being unavailable between sessions.

On balance, these facts offer little comfort for clinicians. The painful truth is that borderline patients do commit suicide, often under circumstances that may have begun as a gesture but in which they have miscalculated the response of those from whom a "saving response" was expected. Thoughtful judgment must be employed that takes into consideration the complexity of the patients' motives, the expected lethality, the self-destructive mode, the nature of the patients' relationship to significant others, including oneself, and the past responses from those others, including oneself.

Following her discharge Ms. A completed high school studies. As a graduation present she was given a trip to Cuba to work with other college-bound students on a sugar cane plantation. Although she had been looking forward to this trip, shortly after her arrival she found herself feeling increasingly isolated and suspicious that other people around her did not like her. After only 2 weeks there, she decided to come home and called her parents. Following her mother's reluctant agreement with her adamant wish to come home, she wrote her parents a letter in which she stated that she felt like a failure and proceeded to overdose on her antidepressant medication. Her family flew to Cuba to bring her home, and she was then hospitalized psychiatrically for 6 months. Subsequently, Ms. A, then 19, took a job and began at a local college. She saw a therapist intermittently, and her next psychiatric admission occurred 3 years later. The context of that hospitalization was related to her inability to make a contract for safety with her therapist before the latter's vacation. Found not to be actively suicidal, however, Ms. A was discharged after only 5 days.

The phenomenology of borderline psychopathology needs to be evaluated in terms of the patient's relationships to primary caregivers. When a borderline patient feels in the presence of one who is supportive or holding, the depressive features become paramount. Borderline patients can work collaboratively within a therapy, and their complaints are usually of boredom, loneliness, or emptiness. When a borderline patient feels endangered regarding the potential loss of the supportive, holding relationship involving a person or institution, then manipulative, self-destructive acts are common. These acts, then, have angry motivations as well as conscious manipulative intentions of preventing the separation from occurring by enjoining the therapist (or any other needed person who might be leaving) to respond in ways that will provide ongoing holding and support to the borderline patient. In contrast to such secondary gain associated with self-destructive acts, primary gain is evident under circumstances in which borderline patients find themselves without a holding or caring object relationship. In such cases the intention of self-mutilation is not manipulative; rather, it serves to diminish the anxieties associated with deficient self-object differentiation, boundary delineation, and dissociative experiences. On an unconscious level it may serve the purpose of exculpating themselves from the sense

of profound badness. Under these circumstances, paranoid ideas of reference such as Ms. A experienced in Cuba can occur. They serve to diminish the sense of aloneness. Potentially dangerous impulsive actions can also occur that are neither intentionally manipulative nor self-destructive, e.g., promiscuity or getting into fights, often in the context of substance abuse.

At the age of 22 Ms. A began her one long-term psychotherapeutic treatment. She described this 10-year therapy as "friendly," commenting that the "boundaries were loose." She was often not billed if she was having financial difficulties, and she and her therapist occasionally met over a meal. She felt fondly toward him. She had several hospitalizations shortly into this treatment because of suicidal ideation, but for the 4 years before the index hospitalization, Ms. A was relatively stable. She was in a long-term romantic relationship and had a stable job in a small library.

Ms. A's diminished self-destructiveness and ability to sustain employment during this earlier period are probably attributable to the stabilizing effect of this therapist's supportive availability, as well as that of her romantic relationship. As noted earlier, when borderline patients find themselves within supportive or holding relationships, their ability to work collaboratively emerges, and there is an absence of the self-destructive and impulsive behaviors that otherwise would characterize them. If these supportive relationships are sufficiently stabilizing, they allow borderline patients to find alternative stabilizing sources of support in their lives outside of their therapy. Such supportive therapy can consolidate some developmental gains, which later permits more exploratory, expressive, focused treatment around character structure and organization. The reemergence of Ms. A's full repertoire of borderline behaviors and feelings at the time of the index hospitalization for this report is a testimonial to the persistence of her basic character problems. Although it is likely that her prior therapy had an overall positive effect, the lax professional structures within the relationship may have had the unfortunate effect of making her less willing to conform and accept the boundaries of a usual therapy. They may also have robbed her of the potential benefits that more ambitious exploratory or expressive psychotherapies can sometimes offer in terms of bringing about character change (8, 9).

While Ms. A was hospitalized, recommendations were made that she be transferred to an alcohol and drug treatment center. She was adamantly opposed to this and proceeded to make plans to leave the hospital without this transfer occurring. She insisted that she could not take any more time off from her job. I reminded her of her self-assigned task for this hospitalization and urged her to participate in the alcohol-related programs and to consider strongly the recommendation for a transfer. She refused, claiming that her drinking was "not a big deal anymore" and that her job was more important.

If a borderline patient has a significant problem with substance abuse, his or her involvement in treatment for that condition should usually be insisted upon before individual psychotherapy begins. If an individual therapist does not insist upon such involvement at the beginning of therapy, it becomes extremely unlikely that the patient will enlist in it voluntarily. Self-help groups, such as Alcoholics Anonymous, like employment, are the best "co-therapies" one could have; they both structure the patient's time and offer support while providing added resources for the patient to deal with the issues raised within individual therapy.

In a session shortly before the decision would be finalized regarding our working together, Ms. A spoke of her anxiety regarding that issue.

Ms. A: I like you. If you tell me on Thursday that you will not be my therapist, I am going to be very, very upset!
Therapist: That sounds like a threat.
Ms. A: No, I am just telling you.
Therapist: Have you been thinking about your needs?
Ms. A: I really like what you said about maybe not being in therapy for the rest of my life. I've been afraid to ask you how much you charge. I won't be able to afford it when I leave.
Therapist: If we continue, you would be transferred to the outpatient clinic. The fee there is $28.
Ms. A: What? [She sounds disappointed.] I thought it was going to be about $100.

Ms. A's positive attitudes toward the desired therapist-to-be should be noted. In saying that she really likes the notion that she does not have to be in therapy for the rest of her life, does she really mean this? If she does, is it because it is a relief from the fear of being trapped and controlled by her therapist? One would hope that it means that she is truly interested in changing and making that therapy obsolete in time, but that would involve a loss which we can predict already that she is likely to dread. It is thus prudent to listen to such complimentary remarks with some skepticism. As Ms. A goes on to suggest that she thought the fee would be $100 and that she would not have been able to afford this, she may be hinting at her ambivalence even as she flatters the therapist-to-be. She would like her therapist to begin feeling very much needed and special.

The final meeting while Ms. A was an inpatient occurred a couple of days later.

Ms. A: So today's the day. You know, I never thought that you would need to make a decision, too. I thought that if I wanted to see you and could agree to the terms, it would be all right.

Are we hearing echoes from Ms. A's childhood? Is this a small child speaking to her mother before her sibling arrived? Did she believe that if she wanted to be with her mother, that would be sufficient to ensure its actualization? Ms. A did not and probably still does not accept the idea that her relationships can be worthwhile if they are not exclusive.

Therapist: Did you think I might not have some impression, too?
Ms. A: [nervous] I never thought about those things before.
Therapist: You seem nervous.
Ms. A: I am because I want to know what your decision is.
Therapist: You're worried that I might say no.
Ms. A: I'd be very upset.
Therapist: What are your thoughts?
Ms. A: I don't want to talk about it. But I'd be very upset! I feel like the only thing I might get out of this hospitalization is finding a therapist, and since I am leaving in a couple of days, if you don't see me, I'll be very unhappy!
Therapist: You sound like you're hoping I'll feel guilty.
Ms. A: No, I'm not. I've nothing more to say.
Therapist: You say you don't want to talk about your thoughts and feelings that upset you. That is one of the many things I was talking about the other day, when we spoke of making a contract for therapy. You're going to have to try to explore those different feelings and thoughts if I'm going to be of any help to you.
Ms. A: Listen, I'll *do* the work. You haven't even told me yet if you're going to work with me. Christ almighty, this is like torture!
Therapist: I am curious to know why you find yourself so confident that you can work with me when it sounds like your previous therapist had such a different style.
Ms. A: Well, just because I stay with something doesn't mean it's a good thing.

Therapist: So what kept you in that treatment for so long if you felt it wasn't a good thing?
Ms. A: I liked him. He was a friend and he cared about me, but I also knew I didn't do any work, certainly later on. I like you; I want to work. I'll tell you now, I'll get angry and fuss when you ask me to work, but I'll do it. I really was intrigued with the idea you put in my head that maybe I don't have to be in therapy for the rest of my life.
Therapist: Well, I have decided to work with you. These are my conditions: that we begin with meeting twice a week, that I am available in between appointments only in emergencies, and that you work, meaning paying attention to your feelings and that you pay your bill in a timely fashion.
Ms. A: I won't miss work to come to my appointments. I need a 7:00 a.m. or 7:00 p.m. appointment.
Therapist: I could see you at 7:30 a.m. or 6:30 p.m.
Ms. A: [She shakes her head.] I can't do it.

Notice the dramatic shift that takes place in Ms. A. She has started the session in a kind of plaintive, pleading way reflecting an idealized transference toward the therapist-to-be and a hungry wish to please. She then shifts into a demanding and controlling attitude reflecting a view of a therapist as someone who should be willing to sacrifice in order to see her. This is an example of what is referred to as pathological splitting. Ms. A begins the hour aware of what she wants; being needy and solicitous, she hopes to gain the therapist's commitment and to assure caretaker proximity. Once she feels that she has that, Ms. A treats the therapist with devalued contempt—insistently attempts to control her. Another way to put this is that she longs for an idealized relationship, i.e., exclusive, nurturant, always accessible. When the therapist, however, sets forth conditions, Ms. A is easily disillusioned. Those conditions are inconsistent with her idealized hope and set in motion angry efforts to impose controls on the therapist.

Therapist: Well, if it matters to you to come to therapy, I'm sure you will find a way.
Ms. A: All right. Can't I wait a while to pay the bill?
Therapist: Why do you ask?
Ms. A: Too many things to pay for now.
Therapist: You have a job. Seems like a matter of priorities again.
Ms. A: All right, all right, I'll pay for it.
Therapist: You seem troubled by this.
Ms. A: I hate talking about money.
Therapist: How come?
Ms. A: Because I do.
Therapist: That's not really an answer.
Ms. A: You'll get paid on time. It won't be an issue, all right?
Therapist: I'm much more interested in understanding what troubles you so much about discussing money.
Ms. A: Because it makes it seem so business-like.
Therapist: What does that mean to you?
Ms. A: That you don't care about me if I have to pay.
Therapist: Not charging is no guarantee of caring. For me, not to charge would not be doing my job. I'm not a friend or a parent. I am your therapist. I charge you for the service I give you. That doesn't mean I don't care. You will need to find that out for yourself. You can't exact it from someone. You'd only feel like you twisted my arm.

And so I began a twice-weekly therapy with Ms. A. I liked her and felt challenged by the work. I also felt anxious that I had agreed to see her at 7:30 a.m. and 6:30 p.m. Although I had offered these hours to her, I would have preferred more traditional hours but felt that I might lose her if I had insisted otherwise.

A subtle transformation has taken place here in which the therapist's growing concern about losing this patient has eroded and displaced the patient's abandonment concerns, i.e., that she, the patient, would become attached to someone, the therapist, whom she would then lose. By bending over backward to accommodate the patient, the therapist is enacting a reassurance about the patient's specialness and about the patient's ability to control the therapy. Such countertransference developments, a result of projective identification, are not uncommon in the treatment of borderline patients. In the material presented earlier, projective identification is evident as Ms. A attempts to distance herself from feelings of inadequacy and unlovability by accusing her therapist of "not caring." Here projective identification entails the disavowal of core identifications (low self-esteem) through the splitting off of the feared and unacceptable ("I'm not good enough to be truly cherished and valued by another") and projecting it into another ("You don't care about me") (10). There is a clear and close relationship between splitting and projective identification. The therapist's ability to recognize, acknowledge, and separate from the patient's projections allows for the possibility of their modification.

Such countertransference issues arose with every hour. Ms. A flitted from one subject to the next with an endless running commentary on my appearance, car, office, and a multitude of questions about my age, background, and education. With the exception of the last subject, I answered few of her questions and tried to help her focus her thoughts on herself.

After her discharge from the hospital, our first few hours centered on her drinking. I had not insisted upon a transfer to the alcohol and drug rehabilitation program, nor made our therapy contingent upon her abstinence. I continued to remind her of her own motivation. She told me she wished I had insisted that she be transferred to the alcohol and drug inpatient unit and wondered why she had not been pushed. I suggested that perhaps her oppositional vehemence had bullied me and the rest of her treatment team to back off. I repeatedly pointed out her dilemma of wanting both to be taken care of as a helpless child and to be respected as an adult. The issue was less about her drinking, which was greatly reduced, and more about her ambivalent feelings in having affected me so significantly.

In the discussion with Ms. A about substance abuse treatment, the therapist admits her countertransference. By acknowledging that perhaps a wrong decision had been made because Ms. A may have bullied her and the treatment team, she puts the issue into an interactional frame. It draws the patient's attention to something that, if interpreted in terms of the patient's psychopathology without the therapist owning her own participation, might precipitate an angry response, perhaps even drive the patient off. In this case there is no offense intended and none taken. The point, however, is made. It is an important technique that many therapists are often reluctant to use. If they feel they have done something out of their own needs or out of countertransference feelings, they are often reluctant to own up to it as part of the process. This reluctance greatly adds to the burden of treating such patients. The issue here is that having noted and acknowledged the countertransference enactment, the therapist could still now insist on the patient's participation in the substance abuse program should it have been indicated.

Ms. A did stop drinking and came promptly to all of her appointments; she went, however, to great lengths to avoid talking about her feelings. She asked questions about me and how therapy worked. I answered some of her questions but continued to pursue her own emotional life, hoping that she would run out of questions. I began to have fantasies of keeping the patient I saw before her overtime or of coming late myself to artificially create an entry into her emotional life. I did neither. But a couple of months into treatment something did come up in my own life, and I had to cancel an appointment

with her for that evening. On the phone she revealed being upset.

Ms. A: You could have called me yesterday. It's like being promised a treat and then suddenly not getting it.

I tried to reschedule, but she told me that she could not make any of the many alternative times I offered her.

Ms. A: Just forget the whole thing.
Therapist: Is that what you want to do?
Ms. A: No.

I offered her an 8:00 p.m. appointment for the following evening and she agreed.

Ms. A: Are you on call tonight?
Therapist: Why do you ask?
Ms. A: How come you are seeing me so late? You said you wouldn't see me any later than 6:30 p.m.
Therapist: Perhaps you have some thoughts about it.
Ms. A: You must be feeling guilty. Are you?
Therapist: What makes you think I'd be feeling guilty?
Ms. A: Because you canceled and I got upset. You could have seen me. You said you had an emergency. But unless it was a funeral you could have seen me.
Therapist: Maybe you could explore your feelings about what I was doing?
Ms. A: I don't know but clearly something more important than seeing me.
Therapist: It sounds like you feel as though my canceling had directly to do with not caring enough.
Ms. A: Yeah. How can you care when you ask for money? It's just a job for you.
Therapist: You seem to have very specific ideas about what caring means.
Ms. A: You're guilty [smiles], aren't you?
Therapist: You seem to take some pleasure in that thought.

If the appointment had been made at 8:00 p.m. out of guilt, the therapist could productively say "yes" to the patient's interpretation. She might even have gone on to say: "It was a mistake on my part based on my own feelings and I probably shouldn't be meeting with you at this time." The point is that it is valuable to allow countertransference enactments to become part of the process. It assures patients of their significance to you and sets the stage for not repeating the same enactment.

As the months of treatment proceeded, Ms. A began to speak of overwhelming physical sensations that were difficult to describe. She demanded medication and made it clear that if I did not give her anything, she would go ahead and find something to take. She began to talk more and more about suicide in a threatening way.

With her increasing reluctance to speak of her feelings alongside the increasing threats to hurt herself, I suggested that she think about the hospital. Although able to acknowledge that the feeling would likely go away if she came into the hospital, she also knew it would likewise return upon discharge. Ms. A insisted that I take responsibility for making the decision. I told her that without understanding how she felt, my making such a decision for her would be unwise. I found her behavior to be manipulative and was not sure how far she would go to force me to take action.

Demands that a therapist do something to take care of subjective states that feel intolerably bad often cause therapists to take ill-advised actions. If something is done, whether it be a medication or a hospitalization, it is important that the enactment be accompanied by a statement that while both you and the patient might do many things to diminish the patient's bad feelings, there is reason to fear that this will be harmful. Unwanted feelings are important experiences where the occasion to think about one's feelings (e.g., defining the type and the relationship to life events), to talk about them, and to improve tolerance is often more meaningful in helping such patients than are efforts to get rid of them. The therapist can say, "Insofar as you feel you need to get rid of these feelings, you'll just get angry if I don't do something to help. Rather than risk your acting out on that anger, I'm willing to do what you want. But as I also think doing what you ask may actually be bad for you, do you still want me to proceed?" The message here is that while you are willing to submit to such demands, it is associated with possible harm to the patient and with acknowledgment of the therapist's personal limitations. This robs the submission of its unconscious significance, i.e., that you agree that a painless life is possible, or that unwanted feelings can be exorcised, or that your efforts demonstrate what a good person/therapist you are. It is useful to interpret how such feelings usually relate to whether the patient feels there is adequate care and attention.

It made me uneasy and I reminded her that if she felt unsafe, she should page me. She, in fact, did page me and told me over the phone that she felt overwhelmed inside and unable to describe what she was experiencing. She tried to engage me in deciding whether she should stay with a friend or not. With my noncommittal response that she must make such a decision herself on the basis of how she understood her current state of distress, she hung up on me. I was anxious about her safety.

Again the issue of false submission is present. When Ms. A invites her therapist to decide whether she should move in with a friend or not, the therapist might respond as follows: "You think and I think that it would be good for you to make decisions for yourself and trust your own experience, and you know that you'll feel lousy if you do it at someone else's behest. But if you push me I'll do it. Is that really what you want of me?" The significance of this exchange can be deepened by reference to early development. One might remind Ms. A, for example, that she had begged her mother to let her come back from Cuba. As soon as her mother had agreed, however, Ms. A experienced it as shameful and she became self-destructive. One can focus the patient's attention on the repetition of such dynamics in the transference.

Following her paging me over the weekend, Ms. A returned in seemingly better spirits with a paper bag in her hand. She proceeded to unpack two cups of coffee.

Ms. A: I don't know how you like your coffee, so I brought sugar and cream in separate containers. [pause] Well, how do you like it? Well, since you are not going to answer, you do it yourself. But if I ever do this again, it would be nice to know how you like it so I don't have to ask for separate containers of cream and sugar. [She extended the coffee. I did not reach for it and noted that my hands were sweaty.]
Therapist: What made you decide to bring me coffee?
Ms. A: Jesus, are you going to question this, too?! I just thought I'd be nice. Can't anything be simple? I was just being courteous. It is early in the morning. I wanted coffee. It seemed rude to drink by myself. I imagine you would probably like a cup yourself. And I haven't noticed a coffee machine around here. I suggest you get one, especially if you are working so early in the morning. As a matter of fact, if you buy the coffee machine, I'll supply the coffee.

Her pleasant demeanor was fading fast. I felt an odd twisting of emotions within. I thought perhaps Ms. A was grateful for how I had handled the past weekend and really meant the coffee to be an appreciative gift. If that were the case, it would be rude not to accept. But acceptance might make me feel in her debt, and she might refer to this gift repeatedly in an attempt to extract something from me. I felt the truth lay somewhere in between, and I decided to err on the side of gracious acceptance and take a chance on the consequences.

Therapist: [I reached for the coffee.] Thank you.
Ms. A: Jesus Christ, what a big deal you make

everything into. So how *do* you like your coffee?

I felt uncomfortable; to reveal how I liked my coffee at that very moment seemed like sharing the most intimate details of my personal life.

Therapist: A little cream and sugar.
Ms. A: There . . . was that so bad?
Therapist: We are here to talk about things, feelings, relationships. I think it important to take a look at how you decided to bring me coffee today.
Ms. A: I already answered.
Therapist: It seems a lot has been going on lately.
Ms. A: What do you mean?
Therapist: Do you really not know what I'm referring to?
Ms. A: Not really.
Therapist: You seemed to be feeling pretty badly over the weekend, so much so that you called me.
Ms. A: I'm feeling better. I just don't want to talk about it. It might jinx my mood. Just drink your coffee.
Therapist: I think it's important to talk about these issues. Especially since one issue for you has been about people taking you seriously.
Ms. A: Yeah, who is paying who around here? I'm paying you so that I can choose to talk about what I want.
Therapist: Well, that's true, but that doesn't mean I don't have opinions about this therapy.

I noted after Ms. A left that I hadn't taken a sip.

The therapist, feeling somewhat battered and not particularly self-confident, goes ahead and concedes something that really isn't true—she concurs with the patient that because she is paying, she can choose what to talk about. The therapist always retains the prerogative to judge whether the patient is spending their time in therapy usefully. The patient pays for the opportunity of coming and talking in ways that can help her learn about herself. If the patient wants to talk about the price of coffee, that's her prerogative, but it's the therapist's responsibility to insist that the patient's reasons for wanting to discuss this become the topic. It is not an issue of whether the therapist should or should not drink Ms. A's coffee. But that the patient would follow a desperate "emergency" phone call, concluded with a hang-up, by bringing it gives the meaning of this "gift" overriding importance. If one drinks the cup of coffee without exploring its meaning, it encourages the patient to believe the therapy task is not primary or that she has intimidated the therapist. During the early phase of therapy such testing of boundaries is inevitable. The therapist's responses shape the relationship and determine whether a task orientation will prevail.

Ms. A began to talk more and more about her increasing fondness for me and attempted repeatedly and unsuccessfully to elicit some acknowledgment of my caring for her. Four months into her treatment with me, she came in complaining that she felt desperate inside and felt a need for something and requested a pill. I suggested that an upcoming 4-day weekend might be difficult for her. With her voice raised she demanded new medication to make her feel better. When I reiterated that I needed to understand how she felt in order to be helpful, she began swearing at me. I tried unsuccessfully to halt her tirade with the suggestion that she explore her feelings and that I would have to terminate the hour if she did not stop speaking to me in that fashion. Finally, I stood up from my chair.

Therapist: I need to terminate the hour now. I cannot work when I'm being treated in this manner.
Ms. A: You better only bill me for a half an hour.

With that she stormed out of my office. An hour later, she called and again demanded medication. I told her that since I did not understand what was troubling her, I felt it inappropriate to treat it with medication. To this she replied:

Ms. A: Well, you're full of shit and you don't understand and you're not helping, I'm not coming Wednesday or ever again.

I urged her to keep her next appointment, so we could try together to understand her experience. She told me there was nothing further to discuss and hung up.

Being able to accept experiences of anger without retaliation or abandonment is an important component of dynamic psychotherapies with borderline patients, but therapists should not confuse this with accepting rude, abusive, or dangerously uncontrolled expressions of anger. Insofar as this session was unproductive and the therapist felt the patient was disregarding her efforts to attend to their task, the session was appropriately terminated. The hope is that Ms. A will subsequently return to the therapeutic task in this session, i.e., talk with her therapist about why she became so angry and demanding.

From another perspective, the patient's rage can be seen as evidence that the frustrations within the therapy or the absence of supports outside the therapy are overwhelming her. This, then, would be reason for the therapist to become more supportive, even, as suggested earlier, indicating a willingness to do things that the therapist does not believe will help, like a circumscribed trial of a new medication. Always, however, such concessions are accompanied by interpreting the anger and demands as originating from her unrealistic expectations and her need for control and noting how such demands have proven maladaptive in her past (e.g., losing Susan as an adolescent and losing her recent boyfriend). Although the literature has sometimes discredited interpretations early in psychotherapy with borderline patients (11), and it is true that a stable working alliance takes time to develop (12), sufficient fluctuations exist in the quality of an alliance within sessions (13) that well-timed interpretations can be useful and may be necessary in a treatment.

She did return and, in a characteristic way, behaved as if nothing out of the ordinary had occurred. I persisted in pointing out the need to explore her feelings and behavior. She persisted in complaining of her inability to sleep and the unbearable feelings in her stomach. Several weeks later, Ms. A paged me several times over a weekend, complaining of suicidality. With unfortunate coincidence, that same weekend I was attending the funeral of a friend's mother who had committed suicide. I was vulnerable and found myself less certain that Ms. A would not try to hurt herself. Again she complained of an ill-defined feeling that made her want to end her life. I was sympathetic, perhaps more so than I had been, spoke with her 15 minutes at a time, and tried to help clarify her feelings, although unsuccessfully. At the end of each conversation with her, I found myself saying, "I'll see you Monday," to which she would reply, "maybe."

She was late to her next appointment but arrived in good spirits. Mine, on the other hand, were frayed, and her being late filled me with fantasies that she had, in fact, killed herself. Seeing her walk in the door heralded relief and fury on my part.

Ms. A: I did something today which I have never done before. I turned off my alarm. Usually my cat, remember her name?
Therapist: Samantha.
Ms. A: Good; I'm impressed. Anyway, usually Samantha wakes me, but today she didn't.
Therapist: Maybe you didn't want to come.
Ms. A: I knew you were going to say that.
Therapist: Since you knew I was going to say that, perhaps you could address the issue.
Ms. A: Because you're a shrink. All questions, no answers, reasons behind everything.
Therapist: That's too general.
Ms. A: Hey, how did you remember my cat's name?

I knew I was angry with her. I was angry because of her sarcastic indifference to my

welfare over a weekend in which my fears had made me distinctly uncomfortable. I felt devalued and ridiculed.

Therapist: I feel there is another script for us today.

Ms. A: Oh, really! Maybe you'd like to write it.

Therapist: I think I will. You paged me several times this weekend, telling me you wanted to kill yourself. I listened seriously to what you said. I believed you were in serious discomfort. That I did not hospitalize you, nor give you a pill reflected that I did not feel an emergency hospitalization or medication was warranted. I know in the past you have been hospitalized for feeling this way and that you leave after a few days, realizing you are not suicidal but feeling something unpleasant inside which you felt you could not describe. I told you to call when you do not feel safe, but when I asked you if this was the case, you would not answer. You wanted me to make the decision. My decision was to ask that you take some responsibility for yourself and to not treat you like a cripple. My assessment was that you could bear sitting with your feelings until today. Today you came in late after being noncommittal on the phone whether you would be alive, and you are acting as if nothing happened. How should I take you seriously? [Silence. I felt better.]

Ms. A: Were you worried?

Therapist: Yes.

Ms. A: Why?

Therapist: Because I do not have a crystal ball and cannot know for sure if I am right. Were you worried?

Ms. A: I don't know. I don't want to answer that now.

This self-disclosure to Ms. A indicating how I was being affected by her, as I had been previously at the time of the considered transfer for alcohol treatment, seemed useful here. Increasingly, I pushed for more examination of Ms. A's aggressive and hostile feelings. There were other times when I was aware of backing off from such confrontation, fearful that she might leave treatment.

Getting the right mixture of support and confrontation to make therapy an ongoing, active, learning experience without being too frustrating is very difficult. If you frustrate too much, the patient might leave; indeed, many do (14–16). If, however, you give too much, no learning will happen in the treatment. The therapist's expression of fearfulness about the patient's safety here is supportive. It assures the patient of her significance to the therapist and of the therapist's concern. It should help diminish the patient's testing behaviors, insofar as those are propelled by questions about these issues. The therapist generally should feel free to convey these concerns from the start.

The therapist still does not take up Ms. A's sadism. Ms. A's sadism is present within her innocent good cheer toward the therapist under circumstances when she knows—and hopes—she has created much anxiety (e.g., both the coffee incident and in the cat inquiries) and in her mocking the therapist when she knows the therapist has "given in" to her demands or manipulations. Therapists need to make borderline patients aware of their sadistic or other hostile motivations. Still, interpretations of hostile motives may cause borderline patients to respond by feeling they are bad (with the potential for suicidality, flight, or paranoid reactions). Such reactions are not a reason to avoid interpretation but, rather, to link them to reassuring clarifications, as suggested by Kernberg et al. (17). One might approach this issue gently by wryly noting the perceived pleasure a patient may take in making the therapist uncomfortable. Such sadistic satisfactions will usually be denied in the immediate context, but the therapist's observation conveys a familiarity and comfort with such hostile motives. Such observations are then returned to with increasing conviction as the therapy, and the alliance, progress.

When the therapist notices that she is more worried about the continuation of the therapy than Ms. A, the process of projective identification described earlier has occurred. If unrecognized, this can also encourage the patient to sadistically act out, while the therapist worries. Here, however, when the therapist, without denying her own fears, asks Ms. A whether she was worried, she is placing the anxiety back where it originated. This is very helpful.

Over the next few months, the treatment with Ms. A settled down into a regular routine. There were still acting out behaviors, although fewer. Over one weekend, she paged me several times regarding neck pain and wanted medication or the name of a good doctor. I told her that this kind of conversation could wait until our next appointment. She threatened to quit therapy but returned, reporting that she had gone to an emergency room and had her neck attended to appropriately. She apologized for having called. With further questioning as to why she *had* called, she said:

Ms. A: I was treating you like my mother, and I wanted you to take care of it right away. I was behaving like a baby. I did call my mother, but she said she didn't know any good doctors since daddy had died, and she was too busy. She told me to just take care of it.

The stabilization of the treatment was supported by a change in Ms. A's relationship with her mother. Her mother, who had for many years felt blown around by the wishes, fears, and threats of her daughter, was now setting some limits. In this way the process of treatment involving myself was paralleled by Ms. A's evolving relationship with her mother. With this development, Ms. A's treatment became much more focused on the relationship with her mother. She became overwhelmed by feelings of pending annihilation should her mother continue insisting on claiming her own freedom and independence. Ms. A became paranoid and resistant to exploring her concerns about this. I recommended that we include her mother in our sessions for a while. There were four such meetings. In the presence of her mother, Ms. A was more able to examine her rage and dependent longings in their relationship. These meetings served to help consolidate the important changes that were occurring in that relationship.

Such conjoint meetings signal the patient's accepting the therapist as an ally. This may be particularly useful with borderline patients who experience the growing attachment to a therapist as betraying their parents. The guilt about this, combined with abandonment fears, will aggravate suicidal thinking and testing behaviors. While peripheral to this case, it is relevant to note that psychotherapists often avoid such meetings "to preserve the transference" or "protect the relationship" under circumstances in which urging such meetings can be constructive for transference control, as well as establishing a truly therapeutic relationship.

The work became more effectively focused on impaired interpersonal dynamics, both with her mother and in the transference. The work became much less taxing for me and more rewarding for us both.

My treatment of Ms. A lasted almost a year. It ended when her mother became ill with leukemia. This occurred in the context of Ms. A having only recently acquired the ability to separate from her mother. Tolerating both the associated anxiety and anger was intolerable to Ms. A in the face of a potential real loss of her mother. Ms. A experienced this possible loss as in direct conflict with her therapeutic task of exploring and tolerating her disappointments with her mother. She opted to end the treatment rather than risk damaging her ties with her now more needy mother. Ms. A felt the need to devote all of her available free time before and after work to be with her mother.

DISCUSSION

The problems of suicidality, substance abuse, missed appointments, silences, intersession contact, rage, and

self-destructive behavior that Ms. A presented are characteristic of the early phase of a psychotherapeutic treatment with a borderline patient. These problems transform psychotherapy into what Dawson and MacMillan aptly describe as skilled relationship management (18). The therapist helps the patient recognize how his or her moods and actions are reactive to whether he or she perceives relationships as holding or withholding. Helping a borderline patient move from actions outside the therapist's office to words inside the office enables exploration and analysis of the patient's internal life to begin. While this sounds straightforward, it is invariably a complicated process, as seen with Ms. A, requiring support, interpretation, limits, and directives in the right admixture. This report illustrates how, by recognizing and accepting countertransference feelings of hate, anxiety, and vulnerability, a therapist offers invaluable help for borderline patients to better control these feelings. While the transition from acting to speaking takes place, other psychotherapeutic processes related to attachment are occurring. By the end of the first year of treatment, borderline patients should have become aware of their dependence on the therapist and have the sense that this is acceptable (19). A joint recognition of how maladaptively the patient can respond to separations should result in diminished severity and frequency of acting out, particularly in the self-destructive behaviors. By the second year of treatment, one may expect sufficient stabilization such that a patient can resume some kind of role performance in terms of work- or school-related activity. Ms. A's occupation was the best "co-therapy" available, better even than the self-help groups. A vocation structures time and encourages the development of a sense of self independent of the role of patient.

This case report describes a brief and interrupted treatment. This is not an uncommon story for a borderline patient. Affective instability and countertransference dilemmas, as presented here in the treatment of Ms. A, often result in premature terminations. While the potential progression of longer treatments with borderline patients is important, the beneficial impact of a single episode of treatment needs to be underscored. In an era of managed care and the catch phrase "episodes of illness," there is something to be said for the value of episodes of treatment to lessen the regressive pull of borderline states.

The treatment described here occurred after several different treatments over nearly two decades. We introduced this report by noting that individual psychodynamic therapy usually needs to be offered within a context of multimodal treatment plans. While Ms. A's therapy illustrates many of the vexing problems of such therapy and is intended to help readers recognize and be helpfully responsive to them, it also illustrates that such therapies frequently end abruptly with limited levels of change. One of the lessons to be learned from the documented success of a cognitive behavior therapy (20) in diminishing dropouts and self-destructiveness is that an integrated bimodal (individual and group) approach can offer containment for splitting that diminishes acting out and flight. We would now more strongly insist that Ms. A's individual therapy and pharmacotherapy be accompanied by psychoeducational efforts for her mother (21) and a substance abuse, interpersonal, or cognitive behavior group therapy. Having noted that the patient did not end this episode of treatment as a "well" person, we believe that she did end it in better health. This report illustrates the recurring processes involved in psychotherapy that make such progress possible.

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