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

The Uses of CONFRONTATION in the PSYCHOTHERAPY of BORDERLINE PATIENTS

Confrontation in Psychotherapy

The Uses of Confrontation in the Psychotherapy of Borderline Patients

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

e-Book 2015 International Psychotherapy Institute

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

The Uses of Confrontation in the Psychotherapy of Borderline Patients

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

Experience convinces us that confrontation is useful in treating all borderline patients. For certain ones, it is essential to their progress. But borderline patients are more vulnerable than neurotic patients to misuse of confrontation. Misuse can arise from faulty clinical understanding as well as the therapist's transference and countertransference problems.

Definition of Confrontation

No single definition is widely accepted, and some disagreements on the subject are the result of covert differences in the way it is technically defined. Some problems also arise out of confusing the technical meaning of confrontation with some of the meanings given in standard dictionaries. "To stand facing... in challenge, defiance, opposition" is one such meaning (Webster's New World Dictionary, 1960). This confusion, also covert, leads to implications that by confronting, the therapist necessarily endangers his constructive working alliance with his patient. Another source of confusion arises from teaching and writing about confrontation through the use of clinical examples. These examples are complex. The specific confrontation is

usually artfully integrated with other maneuvers, such as clarification or interpretation; the affects and personal style of the therapist are also expressed. Separating out that which constitutes the confrontation can be quite difficult, and discussions about it can imperceptibly shade and shift into the pros and cons of the other elements, any of which may come to be mistaken for facets of confrontation.

In response to these problems we have attempted to work out a definition. We approach it through the teachings and writings of Semrad (1954, 1968, 1969),[1] Murray (1964, Chapter Three), and E. Bibring (1954). Semrad's work concerns psychotic and borderline patients. He emphasizes their reliance on certain defenses—denial, projection, and distortion—that he terms "the avoidance devices." These defenses operate to keep conscious and preconscious experience out of awareness. As such, they are to be differentiated from other defenses, such as repression, which serve to keep experiences not only out of awareness but also unconscious. To help patients become aware of avoided painful feelings, impulses, and experiences, Semrad uses a combination of support and pressure. The support makes distress more bearable, thus lessening the need for avoidance. The pressure against avoidance is then applied directly and actively, usually by a series of questions along with various countermoves in response to the patient's evasions.

Murray writes about work with borderline and neurotic patients who exhibit considerable regression to the pregenital level. An infantile, narcissistic entitlement to life on their terms is often a major force behind resistance of these patients to clarifications, interpretations, and acceptance of the real world. Even after clarifications and interpretations have been thoroughly established, this kind of patient tries to maintain his pleasurable pregenital world by avoiding acknowledgment of what he now consciously knows. In the setting of support, Murray, like Semrad, applies pressure in various forms (surprise, humor, forceful manner, etc.) against these avoidances. Murray refers to this technique as confrontation. It seems to us appropriate to apply the same term to Semrad's technique.

In his classical paper, Bibring listed five groups of basic techniques used in all psychotherapies. His categorization continues to be very useful, but it was derived primarily from work with neurotic patients. As such, he described a technique, interpretation, for working with those defenses that keep material unconscious. But no method was included for working with defenses that simply prevent awareness of material that is already available in consciousness; *i.e.*, is preconscious or conscious.[2] Because avoidance devices are used so prominently by psychotic, borderline, and pregenitally regressed neurotic patients and because confrontation, as employed by Semrad and Murray, is specifically designed to deal with these defenses, we believe that confrontation should be added to Bibring's categories of

techniques.

Accordingly, we would define confrontation as follows: a technique designed to gain a patient's attention to inner experiences or perceptions of outer reality of which he is conscious or is about to be made conscious. Its specific purpose is to counter resistances to recognizing what is in fact available to awareness or about to be made available through clarification or interpretation. The purpose is not to induce or force change in the patient's attitudes, decisions, or conduct.[3]

Confrontation can be used in combination with other of the basic techniques. For example, when a patient can be expected to mobilize denial against a clarification that he otherwise is able to grasp, the therapist may combine the clarification with a confrontation. Instead of delivering the clarification as a simple statement, the therapist will try to capture the patient's attention at the same time, perhaps by using a loud voice, an explicative, or an unusual phrase.

This definition of confrontation involves differentiating it especially from two of the techniques listed by Bibring, suggestion and manipulation. Some clinical vignettes offered as examples of confrontation are in fact accurately described by Bibring's accounts of these two techniques. They amount to forcefully executed suggestion or manipulations. Limit-setting is

one such maneuver. Often it is presented as a confrontation when it is well subsumed under the category of manipulation.

Description of Confrontation

There are, of course, very many methods used by patients for avoiding awareness of that which is consciously available. Suppression, denial, projection, and distortion are the ones classically described. Diversion through activity, superficial acknowledgment followed by changing the subject, rationalizing, and intellectualizing are a few more of the ways to avoid. Any complete discussion of the topic of avoidance would carry us beyond the scope of this paper. Anna Freud (1936), Jacobson (1957), G. Bibring et. al, (1961), Lewin (1950), Vaillant (1971), and Semrad (1968, 1969) are among the authors contributing to our understanding.

We should, however, make a few more comments describing the technique of confrontation. Occasionally the verbal content of a confrontation is itself sufficient to claim the patient's attention. More frequently the manner of delivery is the effective agent. Surprise, humor, and unusual choice of words, or an emphatic delivery might capture the patient's awareness. Or the therapist might choose to use a show of personal feelings, such as obvious person-to-person caring, sadness, frustration, or anger. Essentially, any departure from the usual tone or format can be used in the service of

confrontation.

A caveat for the therapist has been issued by Murray (Chapter Three) and Myerson (Chapter One). It is specific for confrontations that involve the therapist's showing his feelings: his feelings must always in fact be experienced by the therapist as being in the patient's behalf. This is especially true of anger. Otherwise the therapist violates his part of the working alliance. Such violation constitutes a narcissistically based power play in the form of antitherapeutic suggestion or manipulation.

Qualities of Borderline Patients

In order to describe the use of confrontation with borderline patients, we should specify more exactly the characteristics of these patients. Chase (1966), Little (1960), Kernberg (1966, 1967, 1968), Grinker, *et al.* (1968), Zetzel (1971), and Balint (1968) are among the authors and teachers who have clarified the qualities that make up the borderline aspect of a patient's personality. Briefly, these qualities are fear of abandonment, belief that closeness means destroying and being destroyed, self-esteem precariously oscillating between omnipotence and worthlessness, a concrete and severe superego, inadequate reality testing, and defenses that are brittle and deficient, as well as higher level neurotic structures that can crumble under stress. Although borderline patients have received much attention in the

literature, we would like to comment in some detail on certain of their attributes in preparation for our discussion of confrontation.

The borderline patient's psychopathology is founded on one fundamental belief: that he is, or will be, abandoned. He believes it because internalization of basic mother-infant caring is incomplete. His fundamental feeling is terror of utter aloneness, a condition that feels like annihilation. Concomitant and derivative experiences are emptiness, hunger, and being cold, within and without.

Abandonment by the person needed to sustain life—mother or her surrogate—is not simply terrifying; it is enraging. His rage may be simply destructive, but more often it is experienced together with desperate efforts to obtain the needed person permanently. All this occurs in the mode of the infant at the oral level. He urgently, savagely, wants to kill that person, eat him, be eaten by him, or gain skin to skin contact to the extreme of merging through bodily absorption or through being absorbed. This oral raging acquisitiveness, mobilized in response to abandonment, brings in its wake further difficulties. Destroying his needed object mobilizes primitive guilt; it also threatens him again with helpless aloneness. He may attempt to save the object from his destructive urges by withdrawal. But that, too, threatens intolerable aloneness. Projection can be called upon to deal with his rage. But projecting it onto his object now makes the object a dreaded source of

danger; selfprotection is once again sought by distancing, and by withdrawal —again the state of aloneness is faced.

The borderline patient is self-centered and appears to feel entitled to life on his terms, whatever they may be. This orientation can be manifest to an extreme. Murray (1964, Chapter Three) has described narcissistic entitlement in excellent detail. It represents essentially an arrest in development with little modification of the infant's or child's feeling that he is entitled to have his way. Murray ascribes this arrest to two influences: one is overgratification, such that the child believes he has been promised that he will always be granted his wishes by the world; the other is deprivation, on the basis of which he insists the world owes him reparations in the form of granting indulgence of all his wishes. Narcissistic entitlement forms part of the borderline's self-image. He is a special person with special rights to have his way. Like the normal infant, severe frustration of his narcissistic entitlement shatters his self-esteem, and he feels himself to be powerless and unloved.

The borderline patient, then, fluctuates in his self-image and self-esteem between extremes of overvaluation and devaluation. We must add that his fall in self-esteem is accompanied by other reactions. The frustration that precipitates it is also experienced as an outrageous all-or-none deprivation. He may react by trying to force whatever he wants from his object. Or he may

reject his object and, in doing so, threaten himself with aloneness and becoming all the more frightened.

We have listed these reactions to frustration of narcissistic entitlement because we would like to differentiate narcissistic entitlement from another phenomenon that on the surface appears to be identical but that actually arises from a different source and involves different stakes. We would call this other phenomenon *entitlement to survive*. When an infant's mother is not in touch with him, is emotionally unresponsive, or is destructive, his feeling state is one of aloneness. His inner world is empty. This state is experienced as a threat to his survival, and survival (for all but the most seriously damaged infants), is felt to be his entitlement. Threats to this entitlement are terrifying and vastly enraging. We have already, without using the term entitlement, described this experience as central to the borderline patient's illness. We have outlined his reaction of devouring rage as he attempts to regain his object, and we have enumerated the reasons he must take flight from the object.

Now we can compare the patient's response to challenges to narcissistic entitlement with his response to challenges to entitlement to survive. On the surface they appear similar or identical—both involve rage, grasping what they feel they deserve, rejecting the object, followed by aloneness and fear. Psychodynamically, they are very different. One is related to wish-fulfillment,

the other to the supplying of a relationship necessary for survival. More succinctly, one is a wish, the other a need. One involves rejecting the object out of anger; the other involves rejecting in order to preserve life; *i.e.*, to avoid destroying and being destroyed. One involves fear of being powerless but still somebody, the other presents threat of extinction.

Threats to entitlement to survive exert a particular influence on self-image and self-esteem. The original pathogenic threats involved the patient's having been treated as if he were without meaningful existence and worthless or nothing. He experienced this with his primary objects, chiefly his mother. In part because of defensive efforts that reinvolved him in the same experiences, subsequent adult life reinforced this self-image. As a result, the self-esteem of a borderline patient is precarious. From whatever higher levels of development he has achieved, he has attained some degree of self-esteem; however, insofar as he is borderline, he has none.

For neurotic patients with pregenital fixations, the problem with self-esteem primarily relates to narcissistic entitlement. For borderline patients, narcissistic entitlement is the healthier level of their self-image and self-esteem. It may at least provide them with an overlay of megalomania. Without it, they face a highly painful belief that they are devoid of significance. Under these circumstances they find comparing themselves with others, especially a valued therapist, to be a devastating humiliation.

We have already described two of the borderline's methods of defense. One is projection of his oral destructiveness. By projecting, he achieves only the partial relief offered by externalizing; he still feels in danger, but now from without rather than from within. Related is projective identification that includes projection plus the need to control the object in order to avoid the projected danger (Kernberg, 1967). The other defense is mobilization of rage in the service of defending against expected abandonment or oral attack. This defense is very primitive, derived more from the id than from the ego. As such it constitutes an impulse that is nearly as frightening to the patient as the threats against which it defends.

Kernberg (1967) has elucidated the borderline patient's use of splitting his internal objects in an effort to deal with intense ambivalence. These patients also employ displacement and turning against the self. Repression and a variety of other defenses are likewise available to them. In our opinion, however, Semrad (1968) is correct in emphasizing the avoidance devices as their main line of defense. Specific methods of avoidance, as he lists them, are denial, distortion, and projection—they are put in operation against conscious content in an effort to keep it out of awareness. We would add yet another mode: avoidance by taking action.

Having already described the borderline's use of projection, we can turn to denial, distortion, and avoidance by taking action. Denial, as defined by

Jacobson (1957) and G. L. Bibring, *et al.* (1961) may be employed lightly by the borderline; or it may be used massively, to the point where he is unaware of any feeling or impulse life. Much the same can be said of distortion, whereby the patient not only denies inner or outer reality but also substitutes a fantasy version to suit his defensive purposes. Denial and distortion carry two serious defects. One is that they are brittle. When threatened with facing what he avoids, the patient can intensify his denial or distortion. But he is likely to become desperate in doing so. And when the defense is cracked, it too readily can give way altogether. The other defect is that these defenses heavily obfuscate reality.

Avoidance can also be achieved by discharging impulses and feelings through the medium of action. The action may be a more or less neutral form of outlet, or it may express, at least in part, the nature of the feelings or impulses that the patient does not want to acknowledge. Since it always involves taking action more or less blindly, without understanding, this method of avoidance is hazardous. Through it, the patient allows himself action that is directly destructive or places him in danger. Avoidance through action is commonly used along with massive denial of feelings, so that the patient may be in the especially dangerous situation of discharging impulses like an automaton, feeling nothing at all, and even utterly devoid of awareness of the nature and consequences of his acts. This problem will be discussed further in a later section.

On the basis of this description, we can make three general statements about the borderline's defenses: (1) they are maintained at a sacrifice of being in touch with reality that is far greater than that involved with higher level defenses; (2) they tend to be inadequate to maintain equilibrium, to be brittle, and to be a source of distress themselves; and (3) they can place the patient in danger.

The Need For Confrontation In Treating Borderline Patients

Intensity and chaos characterize life insofar as it is experienced at the borderline level. Most borderlines occasionally experience their lives almost solely at that level, unmodified by more mature attainments. But usually their borderline problems are simply interwoven into the music of everyday life, sometimes in counterpoint and sometimes in blending with healthier themes and rhythms. At times they swell to dominate the composition; at other times they are heard only softly in the background.

Most therapy hours are, then, characterized by steady, undramatic work by therapist and patient. Is confrontation needed, or useful, during these hours? In our opinion, it is. The reason lies in the borderline's extensive use of avoidance defenses. An example follows.

The patient was a young social scientist who was progressing well professionally. His specialty allowed him to remain relatively distant from

people. But his inability to form stable relationships and his sense of aloneness and hopelessness had brought him to the brink of suicide. He entered psychotherapy and very quickly was deeply involved in borderline issues. The belief that he would be, and indeed felt he was, abandoned by his therapist dominated the work of the first year. At the same time he gradually and intermittently became aware of intense longing for the therapist. As treatment proceeded, he recognized vague sexual feelings towards him that resembled those he felt as a child when he stood close to his mother, pressing his head into her abdomen. He also became aware of urges to rush or fall into his therapist's chest and was afraid because it felt to him that he might in fact destroy his therapist in this way, or perhaps be destroyed himself.

With these transference developments, he resumed an old practice of promiscuous, casual homosexual activities. He reported seeking to perform fellatio when under pressure of severe yearning to be with the therapist. In one treatment hour he described these feelings and activities as he had experienced them the night before. And he added a new self-observation. Looking away to one side, he quietly, almost under his breath, said he had found himself "sucking like a baby." Generalized obfuscation followed this admission. Everything he said was vague, rambling, and indefinite. The therapist hoped this new information could be kept conscious and available to awareness. It would be important for later interpreting the infant-to-mother transference; *i.e.*, that the patient was experiencing urgent need for

sustenance from the therapist as he had continued to experience with his mother since infancy—a need to suck milk from the breast-penis.

Later in the hour he returned to his experience the night before. Once again his narration became clear as he described his longing for the therapist and seeking homosexual contact. But he omitted any mention of his infantile feelings and sucking activity. The therapist suspected that the patient had mobilized some method of avoiding, perhaps denial, perhaps simply withholding. In an attempt to counter this defense, the therapist made a confrontation. When the patient seemed to have finished retelling the story, the therapist directly, with emphasis and with minimal inflection, said, "And you found yourself sucking like a baby." The patient winced, turned his face away, and was briefly silent. Then he said, "Yes, I know." In another short silence he turned his head back towards the therapist; then he continued his association. He did not directly pursue the matter that had been forced to his attention, but it was clear that he had fully acknowledged it and was also aware that his therapist knew about it too. Because of the patient's fear of feeling close to the therapist, the therapist chose not to confront any further. He felt that any further attempt to hold the patient to the subject in that session would now be more threatening than constructive.

Work with borderline patients can be quite different from that just described. By contrast, some hours are characterized by intense involvement

in one, several, or all aspects of life at the borderline level. Help may be urgently needed at these times to deal with two multiply determined problems: (1) the patient's becoming overwhelmed with the belief and feeling that he is in danger and (2) his unwitting action through which he puts himself in real danger. At these times he needs help to recognize (1) the actual safety afforded by reality, especially the reality of his relationship with the therapist, and (2) the actual danger involved in using certain pathological relationships, in taking action on instinctual pressures and fear, and in failure to acknowledge that what he fears arises only from within himself. Ordinarily one would expect a patient to accept reassuring reality-oriented help of this kind. Paradoxically, the borderline patient may resist it, even fight it, mobilizing avoidance for that purpose. Then confrontation is required. We shall now consider this situation in detail.

The borderline patient's feeling of being in serious danger no matter which way he turns is of utmost importance. A brief resume of leading determinants of this fear would begin with his belief he will be or is abandoned. It would then include his impulses, which he feels threaten destruction of the objects he depends upon. This in turn means to him aloneness or being destroyed. Self-esteem at these times is demolished; his primitive superego threatens corporal or capital punishment. Simultaneously, reality gains little recognition and holds little sway.

When overwhelmed or about to be overwhelmed with this complex experience, the patient needs the support of reality. Most of all he needs the real reassurance that he will not be abandoned and that no one will be destroyed.[4] If the therapist tries to respond to this need with simple clarification or reality testing, he often meets resistance. The patient avoids acknowledging the safety provided by reality, especially the reality of his relationship with his therapist. Confrontation is needed to meet this avoidance.

Why does the patient sometimes avoid acknowledging the safety afforded by reality; *e.g.*, that his relationship with this therapist is secure? There are three reasons. (1) The fear of being abandoned (and destroyed) arose, for most borderlines, out of real experiences over prolonged periods of time with primary objects. Through certain complex mechanisms this experience was perpetuated throughout their lives in subsequent relationships that they formed in the quest for sustenance. A large part of their experience, then, speaks against the therapist's version of reality. The patient fears to risk accepting the therapist's offer as if the therapist were leading him to destruction. (2) The force of the patient's raging hunger and his partial fixation at the level of magical thinking convince him that he really is a danger to people he cares about and needs. Even though he may acknowledge them to be of no danger to him, he fears using relationships when he so vividly believes that he will destroy his objects. (3) These patients

use projection to avoid the recognition that the supposedly dangerous, raging hunger arises within themselves. The patient's acknowledgment that his object is safe rather than dangerous threatens the breakdown of this defense. These three fears may be experienced unconsciously, or they may be preconscious, conscious but denied, or even conscious and acknowledged.

Now we will turn to the problem of the borderline patient's putting himself in actual danger. Of course, danger in his life can spring from many sources. But the one germane to discussing confrontation is his use of avoidance mechanisms so that he remains insufficiently aware of the dangers as he acts. Specifically he employs avoidances against recognizing (1) the real danger in certain relationships, (2) the real danger in action used as a defense mechanism, and (3) the real danger in action used for discharge of impulses and feelings.

(1) The potentially dangerous relationships are those he forms with other borderline or psychotic persons; *i.e.*, persons who seek primarily exclusive possession and succorance. These people are also ridden with fears and destructive urges upon which they tend to act. The patient may throw himself into togetherness with some one like this, believing he has found a wonderful mutual closeness, perhaps feeling saved and exhilarated. In fact, the reality basis for the relationship is tenuous, if present at all. It simply provides the illusion, partially gained vicariously, of gratifying each other's

needs for supplies of infantile closeness. Belief in the goodness and security of the partner may be maintained through the mechanism of splitting. Along with it, denial and distortion may serve to obfuscate his real ambivalence, instability, and untrustworthiness. Inevitably the partner will act destructively, independently, or in concert with the patient's own destructiveness. The least noxious outcome is desertion by one or the other. In all events, with their high hopes they ride for a fall, one that precipitates the full borderline conflict, often in crisis proportions. The therapist must realize the risk in these relationships and try to show it to the patient. Failing that, he must set limits. Often the patient will not acknowledge the reality his therapist tries to bring to his attention and will not heed the limits set down. The lure of infant-mother closeness is too great. Furthermore, acting upon it with the "friend" may relieve by displacement his similar urges towards his therapist. But most importantly, acknowledging the real danger in such a relationship would mean giving it up. That would feel like an abandonment following close on the heels of wonderful hope. So the patient avoids the reality, and the therapist must turn to confrontation.

(2) Borderline patients are inclined to endanger themselves by resorting to action as a defensive measure. For example, if psychological avoidances become insufficient, they may take refuge in literal flight, perhaps running out of the therapist's office, failing to keep appointments, or traveling to some distant place. If in the process they deprive themselves of needed

support from the therapist, they may be unable to check their frightening fantasies and impulses. Decompensation or other forms of harm may result. Another means of defensive flight is offered in drugs and alcohol—the dangers are obvious to the therapist. Some patients use displacement in order to allow their destructive impulses towards the therapist to be expressed in action. While avoiding acknowledgment of rage at the therapist, the patient can be unleashing it on the outside world. He might break windows, verbally attack policemen, incite brawls, etc., mobilizing various rationalizations to justify his behavior. All the while he keeps out of awareness his bristling hostility towards his therapist.

(3) Endangering action may also be used simply as a means of discharging a variety of highly pressing impulses. All of the borderline's various sources of destructive urges can be expressed through harmful activities, including self-destruction. Wishes to incorporate and merge can likewise be expressed in ways that endanger. Drugs, alcohol, promiscuity, suicide to gain Nirvana, pregnancy, and obesity form a partial list. The patient resists giving up both the destructive and the incorporative activities. To do so would mean bearing the pressure of unrelieved impulses.

In all these instances of using action in the service of defense or impulse discharge, the patient to some degree avoids recognizing that his actions are in fact dangerous to himself. If he knows it intellectually, he is likely to say

that he has no feeling about it, that it does not seem real, or it does not matter. This avoidance allows him to pursue the endangering activity unchecked. Mere reality testing and limit-setting will not induce him to recognize that he endangers himself and must work to give the activity up. However, by combining confrontation with reality testing and limit-setting, one can often break through the denial and accomplish this aim.

There remains one more danger in the use of avoidance mechanisms, one that was mentioned in an earlier section. It involves massive denial of intense feelings and impulses. It is true that much of the time there is no need to force a patient to face denied feelings and impulses. But there are occasions when it is urgently necessary to do so. For example, the patient may be under the extreme pressure of wanting to kill his therapist and, as a defensive alternative, be on the verge of actually killing himself. In order not to be aware of such unbearable emotional and impulse pressure, these patients are capable of employing denial and other avoidance devices massively. They may avoid to the point of literally eclipsing all feelings from their subjective view. Distressing as it is for them to face what they avoid, nonhospitalized patients cannot be allowed this much denial. It is too dangerous. It is dangerous because totally denied intense impulses and feelings are especially subject to expression in uncontrollable, destructive action. This action may take place with a sudden burst of feelings, or it may occur in a robot-like state of non-feeling. Clarifications and reality testing are to no avail against massive

denial. Confrontation is required. In doing so the therapist's aims are (1) to help the patient become aware of his impulses so that he need not be subject to action without warning, (2) to help him gain temporary relief through abreaction, and (3) to help him gain a rational position from which he can exert self-control or seek help in maintaining control.[5]

All facets of the urgent need for confrontation cannot be illustrated in a single clinical example—two are involved in the vignette which follows. One involves the patient who is overwhelmed with the belief that he is in danger of abandonment. The other is the patient who puts himself in danger by discharging feelings through action. The patient to be described is the one we referred to once already. This episode took place a few weeks after the one previously discussed.

It had become clear that this patient used considerable repression and that he also depended heavily on avoidance devices, especially denial. But these were not enough to meet his needs for defense. He also consciously withheld thoughts and affects, was vague, and nearly all the time avoided looking at the therapist. Details of a traumatic childhood had emerged. For periods of up to a year he was abandoned by his mother and left to the care of a domineering but emotionally cold grandmother. His mother fluctuated widely in attitude towards him. At times she was intensely close in a bodily seductive way. At other times she was uncaring or coldly hostile. She and his

father made it a practice to sneak off for evenings after he had fallen asleep. To ensure that he would remain in the house, they removed the door knobs, taking them with them. Repeatedly he awoke, finding himself alone, trapped, and in prolonged panics.

To summarize the earlier description, the most prominent quality of his transference was the belief that his therapist did not think about him or care about him. Outside the treatment hours he frequently felt that the therapist did not exist. He suffered marked aloneness, yearning, and rage—increasingly centered on the person of the therapist. The therapist's work had primarily involved clarifications of the emerging transference and relating it to early experiences and life patterns. The therapist also repeatedly implied that in fact he, the therapist, was not like mother, not like the patient felt him to be; rather, he was solidly caring and trustworthy. The patient's feelings, however, intensified; and he began to seek relief by occasionally discharging them through action. It was at this time that he increased his homosexual activities, and the previously reported hour occurred. At the same time more rage was emerging. Many times his therapist interpreted that his impulses and rage were so intense because he believed he was really alone, absent from the therapist's thoughts, and uncared about. Each time, the reality of the relationship was also implied. But the patient seemed unable to accept it.

Before long, the patient put himself in serious danger. Rage with the

supposedly abandoning therapist dominated him. He got drunk and purposely drove recklessly across a bridge, smashing his car on the guardrail. He himself was manifestly little concerned for his safety. He was concerned about how the therapist would react. That is, would the therapist be uncaring, as he expected?

Clarification, interpretation, and showing him the reality of the relationship had not been effective before. They would be less effective now. Certainly mere pointing out of the danger of his action would make little impression. The therapist elected to include confrontation in his efforts. First, he repeated the interpretation: the patient's erroneous belief that the therapist did not exist was the source of his intense anger. Next, the patient was confronted with the actual danger he had put himself in by discharging his rage in action. With emphatic concern the therapist said, "You could have been hurt, even killed! It was very dangerous for you to do that, and it is important that it does not happen again." Now the patient tacitly acknowledged the danger. Confrontation had succeeded. It was followed by a second confrontation, a confrontation designed to gain the patient's acknowledgment of the therapist's really caring about him. The therapist said, "The way to avoid this danger is to work with your feeling belief that I do not care or do not exist. By all means, whenever you approach believing it, whenever you begin to feel the intense rage which naturally follows, call me up. Call me, talk with me, and that way find out I really do exist, I am not

gone." Superficially this maneuver would seem to have been a manipulation, but in fact it was a confrontation, presented very concretely. Its message was that the therapist was in reality a reliable, caring person whom it was safe to trust. The patient responded with what seemed to be half-hearted acknowledgment and agreement. But he did not again endanger himself in any similar way.

However, about three weeks later he was again experiencing the same very intense transference feelings and impulses. He drank heavily and made contact with a group of homosexuals who were strangers to him. He went with them to a loft in a slum section of the city and awoke there the next morning. He found himself alone, nude, and without memory of what had happened. He was frightened at the time but not when he told his therapist about it. The therapist responded by first showing his feelings of strong concern as he agreed that it was a dangerous experience. This amounted to a confrontation against rather weak denial of danger and fright. Then he clarified the psychodynamic pattern along the lines already described, showing the patient that he had put himself in danger by taking action to express his yearning for and rage with his frustrating supposedly uncaring therapist. Next came a combination of limit-setting and confrontation. "This is much too dangerous, and you must not allow yourself to take such risks again. You felt so intensely because you believed I did not care. Anytime you feel this way and are in danger of acting on it, contact me instead. It would be much

better, much safer, to talk with me on the phone. Please do so, whenever it is necessary, at any time of day or night. See that I exist and that this relationship is real."

The patient gave the impression of neither agreeing nor disagreeing. He never called. But there were not further recurrences of discharging intense feelings and impulses in any dangerous actions. Two months later he was overwhelmed with fears of closeness with his therapist, and he felt suicidal. But he took no action, instead requested brief hospitalization. He was discharged at his own request after five days.

Summary

It has been useful to us to define confrontation as a specific technique for dealing with avoidance defenses. Because borderline patients rely heavily on these avoidance mechanisms, we have found confrontation to be necessary in their treatment. In routine work confrontation is helpful in order to bring into view and keep in view therapeutically useful material. At certain difficult times it is needed as part of the therapist's effort to help his patient regain an experience of security and avoid actual dangers towards which he is inclined.

Bibliography

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

Bibring, E. (1954), Psychoanalysis and the dynamic psychotherapies. *J. Amer. Psychoanal. Assn*., 2: 745-770.

Bibring, G. L., T. F. Dwyer, D. S. Huntington, and A. F. Valenstein (1961), A study of the psychological processes in pregnancy and of the earliest mother-child relationship. Some propositions and currents. *The Psychoanalytic Study of the Child*, 16:9-72. New York: International Universities Press.

Chase, L. S., and A. W. Hire (1966), Countertransference in the analysis of borderlines. Read before The Boston Psychoanalytic Society and Institute, Mar. 23, 1966.

Freud, A. (1936), *The Ego and the Mechanisms of Defense*. New York: International Universities Press, 1946.

Grinker, R. R., Sr., B. Werble, and R. C. Dry (1968), *The Borderline Syndrome*. New York: Basic Books, Inc.

Guntrip, H. (1968), *Schizoid Phenomena, Object Relations and the Self*. New York: International Universities Press.

Jacobson, E. (1957), Denial and repression. *J. Amer. Psychoanal. Assn*., 5: 81-92.

Kernberg, O. (1966), Structural derivatives of object relationships. *Int. J. Psycho-Anal*., 47:236-253.

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

_____(1968), The treatment of patients with borderline personality organization. *Int. J. Psycho-Anal*., 49:600-619.

Khantzian, E. J., J. S. Dalsimer, and E. V. Semrad (1969), The use of interpretation in the psychotherapy of schizophrenia. *Am. J. Psychother*., 23: 182-197.

Lewin, B. D. (1950), *The Psychoanalysis of Elation*. New York: W. W. Norton.

Little, M. (1960), On basic unity. *Int. J. Psycho-Anal*., 41:377-384.

Murray, J. M. (1964), Narcissism and the ego ideal. *J. Amer. Psychoanal. Assn*., 12:477-528.

____(1973), *The purpose of confrontation*. In Confrontation in Psychotherapy. eds. Gerald Adler & Paul G. Myerson. 1973, 2013.

Myerson, P. G. (1973), *The meanings of confrontation*. In Confrontation in Psychotherapy. eds. Gerald Adler & Paul G. Myerson. 1973, 2013.

Semrad, E. V. (1954), The treatment process. *Amer. J. Psychiat*., 110:426-427.

____(1968), Psychotherapy of the Borderline Patient. Conference held at Tufts University School of Medicine, April 4, 1968.

____(1969), *Teaching Psychotherapy of Psychotic Patients*. New York: Grune & Stratton.

Vaillant, G. E. (1971), Theoretical hierarchy of adaptive ego mechanisms. *Arch. Gen. Psych*., 24: 107-118.

Webster's New World Dictionary of the American Language (1960), New York: World Publishing Co.

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

Zetzel, E. R. (1971), A developmental approach to the borderline patient. *Amer. J. Psychiat*., 127:867-871.

Notes

1) Also cf. E. J. Khantzian, J. S. Dalsimer, and E. V. Semrad (1969).

2) One of Bibring's techniques, clarification, does deal with material that is preconscious or conscious. He described it as a method for bringing into awareness or sharpening awareness of behavior patterns. However, he specified that no resistance is encountered to

acknowledging that which is clarified. The patient accepts it readily.

3) This definition resembles Myerson's (Chapter One); i.e., confrontation involves the use of force. It is, in fact, built upon it. The difference lies in being more explicit about the purposes for which the force is and is not to be employed.

4) Of course, we are not advocating empty reassurance. If control is so tenuous that a threatening situation really exists, steps in management are required to provide safety. For example, hospitalization may be indicated.

5) We should include here the importance of providing the patient sufficient sustaining support to enable him to bear the otherwise unbearable. It may not be possible to support adequately with the relationship alone. Temporary hospitalization may be needed as an adjunct.