Borderline Personality Disorder: Splitting Countertransference

August 25, 2006
By Marcia Kraft Goin, MD

Splitting, archetypally imbedded in a patient's psychic structure, acts as a powerful unconscious force to protect against the ego's perception of dangerous anxiety and intense affects. Rather than providing real protection, splitting leads to destructive behavior and turmoil in patients' lives.

A popular slang definition of the verb *to split* is "to depart" or "to leave." In this context, *to split* describes the occasional wish of a psychiatrist who may be mired in the chaos created by the behavior of a patient diagnosed with borderline personality disorder. The primary definition of *to split* is "to divide sharply or cleanly." The ego mechanism of *splitting* is derived from the latter definition.

In this context, splitting refers to a primitive mechanism of defense characterized by a polarization of good feelings and bad feelings, of love and hate, of attachment and rejection. Splitting, archetypally imbedded in a patient's psychic structure, acts as a powerful unconscious force to protect against the ego's perception of dangerous anxiety and intense affects. Rather than providing real protection, splitting leads to destructive behavior and turmoil in patients' lives, and the often confused reactions manifested by those who try to help.

Some degree of splitting is an expectable part of early psychic development. We see it in young children who, early on, press us to tell them "Is it good?" or "Is it bad?" We hear their frustration when we answer, "Situations are not black or white; life is more complicated!" "Yes, I know all that," they say, "now tell me, is it good or is it bad?"

Subsequent developmental advances foster the ego's ability to accept paradoxical affects, and to synthesize and integrate good and bad, love and hate along with the associated affects. The need for a definite "yes" or "no" decreases, and multiple possibilities and variations on a theme become tolerable.

The expression *splitting* has become a part of the vernacular of everyday life. Despite its psychoanalytic origins, even those who are psychodynamic nihilists find it natural to describe those patients who are creating chaos on the ward or in life by the terms: "he splits," "she splits," or "they split." In this context, they are referring to a split in the hospital community provoked by the patients' behavior.

A familiar scenario follows: A patient, struggling with inner turmoil, finds someone on the ward who seems responsive to his or her needs, idealizes that staff member and invests this person with strength, love and power. The staff member, standing beneath this shining light, finds it hard to resist the temptation to accept as reality the wondrous feelings of idealized specialness. Whatever tensions might exist on the ward are magnified by a subtle intensification or manipulation of those who are experienced as good and those who are determined to be bad.

Inevitably, the staff member betrays the patient's idealization by some evidence of human frailty. The patient, overcome by the intense affects and anxiety this evokes, turns on the person as he would a deadly enemy and attacks. The patient then goes off in search of someone else to idealize and use as protection. The staff member feels demeaned, humiliated and attacked.

This is a simplistic but commonplace explanation of what happens both in the hospital community and in psychotherapy. Both transference and countertransference can be powerful forces in our work with patients who utilize splitting as a primary mechanism of defense.

**What Do These Patients Need?**

Splitting patients need a psychiatrist who is a constant, continuing, empathic force in their lives; someone who can listen and handle being the target of intense rage and idealization while concurrently defining limits and boundaries with firmness and candor. These patients need someone who can provide them with the necessary experience of being understood and accepted, and who will not be overwhelmed by their needs, fears and anxieties.
On the surface, meeting these needs does not seem difficult, were it not for the existence of that powerful force known as countertransference. Countertransference is used here to mean both the therapist's transference reactions to the patient's transference, e.g., products of one's own personal history and unresolved conflicts, and also those reactions that are natural human responses to both idealization and anger.

We all enjoy being admired and respected and are tempted to believe in this veneration. Similarly, the cry of a screaming child touches the heart of a feeling person, and hatred directed with fierce intensity sears the soul of the most hardy. But the intensity of countertransference reactions that surface during therapeutic work with a patient whose primary mechanism of defense is splitting can be surprising and frightening to even the most experienced therapists. Psychiatrists in training frequently ask: How can I deal with these countertransference reactions? with the expressed hope that in some way they can be analyzed or swept away. However, the therapeutic situation requires that we move forward with our work re-gardless of our countertransference feelings. Otherwise, while waiting for our reactions to abate, the patient may make a suicide attempt, elope from the hospital or engage in some other dangerous and impulsive behavior.

Understanding and analyzing our own developmental history helps to mute, utilize and control our affects and responses. However, appreciating our own past histories will not eliminate our emotional responses, nor would we want it to.

Since we cannot escape the impulse to recoil or be overly protective, how do we proceed? This process of going forward therapeutically conjures up images for me of watching my first autopsy. As an eager pre-med student I very much wanted to see an autopsy. A medical student working in pathology made it possible, but as I stood outside the door of the lab I was suddenly drained of all my energy and medical curiosity. About to consider slipping away, the firm pressure of my friend's hand pushed me through the swinging doors. There I was, feeling swamped with the realities of illness, disease, and death, and asking myself, Was this truly where I wanted to spend the rest of my professional life?

What helped me to get past those feelings? It was the same thing that gets us past all of the very real tragedies that we see and feel in our work. I pushed the feelings aside and began to immerse myself in understanding the puzzles that the autopsy presented. What was the disease process? Where did it begin? What pathology did it produce? How could it have been prevented?

When the patient with a borderline personality disorder emits a plaintive cry of despair or strikes out at us with a verbal slap in the face, we constrain the impulse to be overly protective or to recoil. Then we begin the search for understanding. Why did it happen? What in the patient's developmental history predicted the eruption? What internal conflicts, affects and anxieties engendered the patient's attack? Consciously focusing on the clinical reality of the moment increases our ability to be understanding, empathic and accepting. Although an interpretation of our discovery only occasionally helps the patient, puzzling it out in our own mind focuses our response in the right direction. Beginning the Work

Usually during the beginning phase of treatment we are involved in keeping patients alive, helping to identify the painful and intolerable affects that lead to destructive behaviors while simultaneously providing a holding environment, as described by Winnicott (1965). This is neither an easy nor a quickly completed task.

This beginning phase of identifying and containing affects is one that can seem endless but is a core factor in successful treatment. Typically, the patients' explosions do not occur at a gentle pace after you have comfortably established a good working relationship. Characteristically, they erupt in the middle of the night when you have barely had a chance to say hello. There is a frantic telephone call and the intensity of despair elicits the psychiatrist's reflex reaction to soothe and reassure. The next day, relieved that the patient is still alive, the psychiatrist may be reluctant to rock the boat with probing questions about what precipitated the call, much less what transpired to enable them to feel better.

It is not uncommon for less experienced psychiatrists to hope that the fires of separation anxiety will be extinguished by constant availability and soothing empathic responses, as found in Kohut (1971). Besides the fact that these fires rarely burn out before the therapist begins to be depleted, there are at least two other reasons that this approach does not work. One is described well by Gunderson:

Such contacts can increase the detached borderline patient's awareness of repressed neediness, which is then accompanied by intense shame and the emergence of suicidality [1996]. It is analogous to the hunger that is triggered when we pass a bakery, and the smell of baking bread stimulates the flow of gastric juices and fires a craving we didn't even know was there.
Secondly, with disorders that are as developmentally deep and wounding as those present in borderline patients, our availability for a 15-minute telephone call cannot begin to plumb the depths of their anxiety and neediness. Brief contact may provide temporary relief, but we need to provide much more if the patient is to alter the underlying problems.

Of course, the patient will be angry if the therapist, in addressing the previous night's telephone call, gives nothing more than an interpretation such as: I guess you were feeling frightened about being alone and wanted me to wave a magic wand to drive away the nighttime fears. While probably accurate, hearing the behavior described in the light of day can make the patient feel isolated and ashamed unless the underlying affects and needs are addressed.

Instead, the therapist must demonstrate interest in listening to and understanding the intensity of the fears that precipitated the telephone call, and then, without implying criticism, explore what it was about the telephone call that seemed to make things better. Engaging the patient in this manner puts you both on the road to a working relationship that can slowly tease out those primitive fears that generate such anxiety.

When you are comfortable with the reality that you cannot (even if you wanted to) be an idealized parent, it is possible to work toward achieving a therapeutic alliance, seeking alternatives, substitutes and eventually more mature means to deal with the internal affects, conflicts and anxiety.

Once this juncture in the therapeutic relationship has been reached, one may successfully introduce such comments as: When I hear the fear in your voice, I wish I could wave a wand and make it all disappear. You must feel that way, too. But I don't have that power. Let's look to see what alternatives we can find.

The statements are all very real and candid. Don't we all wish we could find just the right word, phrase or insight to provide instant relief! That's one reason many of us decided to become physicians. As psychiatrists we have much to offer, but without an acceptance of our limitations we are exceedingly vulnerable to attack.

In Conclusion

Working with patients suffering from borderline personality disorders begins with an acceptance that they live in an immature psychological world, fueled by certain constitutional vulnerabilities, where they attempt to shield themselves from conflict and anxiety by splitting the world into all good and all bad. Although this produces an illusory sense of psychological safety, in fact, it renders relationships fragile and chaotic and drives away the very people who are so badly needed to stabilize the patient.

The challenge to therapists is not to be driven away physically or emotionally, but rather to engage with the patient in a consistent and constructive exploration of their affects and behavior, no matter how intense the explosion of feeling or how lacerating their attack on our self-esteem and professionalism. Only when patients are able to recognize what they are feeling, and how this relates to what they are doing, will they begin to develop more mature psychological structures. Exploration and insight into the developmental and genetic roots can often facilitate this process, leading to a world less split in dichotomous good and bad.

Dr. Kraft Goin is clinical professor of psychiatry at the University of Southern California School of Medicine.

References:

References


Source URL:
http://www.diagnosticimaging.com/articles/borderline-personality-disorder-splitting-countertransference