Response to the Richard Erskine's article Early Affect Confusion: The "Borderline" Between Despair and Rage - Part 1 of a Case Study Trilogy

Grover E. Criswell, Maša Žvelc, Ray Little, & James Allen

Abstract:

This article provides four responses from senior psychotherapists and supervisors to Erskine's article Early Affect-Confusion: The "Borderline" Between Despair and Rage. The authors approach the first part of case study trilogy from their particular perspective and provide both challenge and respect for the author's work.

Key Words: borderline personality disorder, integrative psychotherapy, case study, supervision

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Response from Grover E. Criswell

Here in the beginning we have to acknowledge the difficulty of the task we are attempting. No matter how carefully we read this clinical narrative or reflect upon the flow of the work in the evolution of their therapeutic relationship, we will miss some of the points crucial to a full understanding of what took place. What we have are various images shared by this client out of which we try to construct a mosaic of who she is and the difficulties she has brought with her into therapy. We need to remember that what we know is fragmentary. As we give ourselves to this process of discovery, we will also reflect together on the salient therapeutic issues. Our handicap is that we were not active participants and our comments will always be educated guesses.

Fortunately, we have a skilled witness who was there in the relationship who can guide us in our exploration. He was present not only as the observer but as an active participant in the therapeutic alliance. We learn not only about the client but also about the process that was going on in the therapist and how the

two of them engage in this therapeutic dance. By sharing in significant detail his own thinking and subjective experience, he models for us his own evolution of insights as the therapy progressed. We can know why he gives certain issues priority and sets others aside for later. We can see how his psychodynamic theory plays out in this actual clinical situation. He invites us into the room to learn what he might teach, but also to learn from us from our agreements, our questions and how we fantasize what we might have done differently.

So the therapy begins with a rush of turbulence and anger with the call for an appointment. She has enormous control needs related to these feelings and it is quickly clear she will be a difficult client. If I had been in the therapist's spot, I might be asking several questions: Inside of the explosive feelings is there any solidity in her personality structure? What is the level of disturbance? Does she take any ownership for what has happened in her relational history? I find that when I get calls from potential clients who are this upset, it is difficult to get more than hints concerning answers to these questions. Mostly, like the therapist in this situation, I am working to make contact and set an appointment. This is a prime reason that I always have at least one appointment with a client before putting them in a group. The therapist quickly decides that placement in a group, which is her request, would not be appropriate.

The focus of the therapy during this first phase is clearly with her many troubled relationships, going from her current boyfriend back to the relationship with her father. The therapist maintaining a consistent relationship and presence with her seems essential. It is not clear to me the balance between her assets and liabilities. Using the term "borderline" to describe the case is confusing. This term is most often used to describe a Borderline Personality Disorder which typically has some of the features of this client: unstable relationships, poor self image, fears of abandonment, and the pushing of people away so they won't feel rejected. This client does have the clinging dependence and significant impulsivity that is often present with this disorder. She does have "borderline" features but the use of the term suggests a level of pathology that may or may not be present. It would be interesting to know where in the course of the treatment the therapist decided to use this term.

What has me conclude that the therapist does not see her as a Personality Disorder are the levels of interaction and the pace of the work that seems to cover a considerable amount in a relatively short period of time. The development of a therapeutic alliance with someone deeply disturbed often takes a considerable period of time with many points of testing. She does seem capable of using the various explanations he provides. The other factor that weighs on the side of client strengths is setting a contract with a significant time limit of seven months, especially when the pivotal issue is her feeling betrayed in relationships. The therapist must have concluded that she could handle it and they could work through whatever upset might surface. This is where the therapist is probably more tuned to her strengths than we who are simply reading about it.

The other place in this early segment of the therapy that is confusing is at the end of the contract period. The therapist is making a case for why she should return after the five month break. He underlines her emotional turmoil and how she needs to continue in therapy "to find new ways for affect-regulation and psychological stabilization." What is lacking is any dealing with the reality of the interruption of the therapy and how that is being experienced by the client. I am left wondering. When she voices a fear of being too dependent on the therapist and reluctant about continuing in therapy, I am curious if this is a cloaked expression of anger and a view of the therapist as not being dependable? The discussion seems far too rational and could be skating around her potential feelings of neglect or abandonment adding to her affect confusion. I would have anticipated some arguing with the proposed absence.

Response from Maša Žvelc

The author shows very good understanding of empathy and of the inner world of the human being: how it is to be in the world feeling despised and alone and to need someone on one hand and push him away on the other hand. Erskine clearly explains the development of defensive relational and behavioral patterns. Simultaneously he knows and senses the unmet underlying relational need for other and the pain of the need unmet. He shows and explains the use of the basic integrative psychotherapy methods: inquiry, attunement and involvement.

I highly respect the author's deep and gentle engagement, empathy and respect towards underlying needs, feelings and defenses. In my opinion this is one of the biggest strengths of integrative psychotherapy. Deep respectful attunement, respect and validation of the relational needs, underlying vulnerability and defenses are foundations of the therapeutic work. Respect of "who you are" and "what is" is in my opinion the best remedy for the hurt psyche. With this kind of attunement and involvement a safe and trusting therapeutic relationship can develop. All other interventions are effective only in the interaction with proper attunement and involvement- and within it- good therapeutic alliance.

I would also like to stress the importance of the interventions, as when the therapist was helping the client to distinguish the past from the present. This is the important goal in working with trauma and the regulation of affect.

I will present some concrete examples from the text which I especially found skillful and useful:

- On the first conversation on the phone the client told the therapist that she left ex therapists because they were cold or criticizing. The therapist was cognitively attuned and skillfully read the underlying message of the client. He knew that Theresa was communicating to him relational qualities she needed. In other words, she was begging him: be respectful and involved.

- A thoughtful decision was made to take Theresa in individual psychotherapy (not in the group) - *"…she needs more careful attention to her needs than I could provide in the group."*
- Therapist addressed his internal questions before starting the therapy with Theresa (for example: "*Could I build a therapeutic relationship with this yet unseen woman that may have a positive effect in resolving her relational difficulties?)* This excerpt shows the importance and usefulness of the internal supervisor, which the therapist should develop through the practice and relationship with his/her supervisor.
- Meaning was given to the client's experiences and story. For example: "*I described my impression of her rocking and repetitive "I'm unlovable" as a way to manage the loneliness and to make some sense of what was missing in relationship with her parents"*. *"…as we talked about it several times, she realized that the rocking and the mantra-like repetition of "I'm unlovable" was a desperate attempt to avoid the intensity of the loneliness by soothing herself with repetitive words*".
- Therapist encouraged her to reflect her behavior and helped her to realize the responsibility for the interpersonal conflicts.

A lot of thoughts and questions were raised in my mind connected to the therapist's countertransference and method of working with it. While reading the text my frequent question for the therapist was: "What are you experiencing?" I was missing the other half of the therapist - who isn't just good, tolerating and validating. I was waiting for therapist to share "forbidden" experiences… I thought: "Theresa with her aggressive attitude and coquettish behavior may provoke many things in people - I expect in therapy, too. What does it provoke in this therapist?"

Towards the end of the first part Erskine indeed shares with us: "These were the sessions when I experienced her as a pain in the ass. I wanted to tell her that she deserved her miserable life. Other times I was feeling provoked to justify my behavior. Prudently, I kept these reactions to myself. "

I was glad the author shared his responses with us. From these words I understood he felt anger and drive for revenge. I sensed from his words also impulses to humiliate and to destroy her. I would like to hear even more about what was happening inside of him: during the sessions, before, after the sessions… Did he think of Theresa in his private life? What kind of thoughts, fantasies, memories, emotions, body reactions resonated in him? Did he fear her? How did he resonate to the sexual energy which was in the field? It is interesting that shame isn't mentioned- neither connected to Theresa… nor to the therapist. Did an enactment take place (I would anticipate that, because therapist was working with client with borderline features) and what kind of enactment?

And then, the therapist partly answers me: "*Prudently, I kept these reactions to myself."* and somewhere else: "*It was important that I too walk on a tightrope, the "borderline", between my keeping the transference just active enough so her unconscious story could unfold within the healing responsiveness of our therapeutic relationship and, at the same time, take the responsibility to protect her from my becoming defensive or self-explanatory, a reactive countertransference, that would reinforce her original self-regulating script beliefs and archaic ways of coping."*

I found useful concrete questions of the therapist for the client when she had outbursts as: *"How do you expect me to respond when you shout at me?"; "What were you feeling just before you shouted at me?"; "How do you need me to respond to you?"*
In some occasions I would say and ask: "I see I hurt you…. With what did I hurt you?" I would show my contribution, meta-communicate of the relationship and explore the meaning of the client's reaction.

I would like to share my thoughts about therapist's contributions. For instance, my opinion is that clients unconsciously feel thoughts and feelings of the therapist towards the client. The client doesn't get upset only because of her wounds and in the way she learned to adapt. There is something in the therapist that she is also reacting to. I think it's important to validate this too; otherwise the client can feel missed even more.
"On several occasions I explained that her feelings and reactions were valid but valid only in another time and context.", explains the therapist. I partly agree with it. The intervention can be very helpful to the client, that she starts to distinguish the present from the past, starts to see how she is reliving the past in the present. I would add - the sense of the client of some kind of rupture in relationship is valid. Theresa felt the therapist energy corresponding with his words:"…I experienced her as a pain in the ass. I wanted to tell her that she deserved her miserable life" …. and she communicates to the therapist that he is critical. And despite her script which intensifies her experiences and reactions- she is right! The therapist is not just a good object.

I shared some of my thoughts and questions. I understand that presenting the case is big work and it cannot cover all the fields. The first part of the article was very interesting and useful. I am very interested to read what follows.

Response from Ray Little

I wish to thank the editorial board for offering me this opportunity to respond to this paper. Richard Erskine has written a stimulating and thought provoking case study, in which he has given us an opportunity to discuss some important psychotherapeutic themes and issues and to discuss clinical material

from different theoretical points of view. One of the things I think is important when considering a case study by another therapist is to hold in mind that the presentation of the client is from that therapist's particular clinical perspective. This case presentation of the client is through Erskine's particular lens and is as a consequence of the inquiries through which he leads Theresa.

This is a lengthy presentation of five years of therapy written in 3 sections. One thing this case highlights is the difference in methodology and the technical choice between working alongside the client and working opposite the client. In my view this case example exemplifies working alongside the client.
What evolves between Richard Erskine and his client Theresa will be unique to their particular therapeutic dyad. Another therapist would experience the client differently and would co-create a different therapeutic dyad. There would of course be certain similarities and there would also be some significant differences. I will describe what I would do differently in general terms, based upon my view of the methodology of therapy. My comments follow the presentation of the client in being laid out in three sections. I will follow the traditional academic style and refer to the therapist as Erskine.

In the initial meeting between Erskine and the client, Theresa complains of not having been understood in her previous four therapies. Previously she has been in the presence of what she describes as cold and critical therapists. I also wonder if this reflects her relational difficulties, and further wonder how this may eventually become part of our work together. As I listen to the client I imagine that sooner or later I will be seen as cold and critical. She goes onto talk of a 'good' therapist, but this relationship ended abruptly. I wonder if it is part of her experience to lose the 'good other' too soon. She is looking for someone to understand her, be kind to her and fix things. I would see this as a possible expression of an idealised needed relationship (Little, 2011), and begin to wonder about how the transference-countertransference matrix will unfold.
She speaks of her boss in adoring terms and describes him in an idealizing manner. This seems to be a protective self-other relational unit, similar to the glowing terms in which she spoke of her first therapist. At this point there is a suggestion of a split internal world between a critical and cold other, linked to feelings of disappointment and not being understood, and an idealized other, linked to feelings of someone being kind to her.
When Erskine meets the client for the first time, she is flirty and flattering and more charming than she appeared on the phone, whilst also deflecting his questions. Here I am wondering who this person is and what is the function of being charming, and I am interested in listening to my own countertransference response; for example, questioning if I feel manipulated and seduced by her charm.
She is beginning to describe what sound like two distinct types of relationship; one, cold and critical and the other, good and idealizing. I continue to wonder about her relational units and ego state relational units (Little, 2006), and to

consider if this woman lives and functions in a split internal world, and whether her relational units are dissociated from each other.

Theresa's description suggests that she does not seem to sustain relationships because of incompatibility --- the men don't understand or respect her. This may indicate a further aspect of an ego state relational unit or possibly the core pain (Little, 2006).

When Erskine summarizes the therapeutic themes as he sees them, I notice I feel anxious about what might be involved in working with Theresa. As I think about the therapeutic themes as Erskine has described them, I am aware of a hesitation in offering a therapy contract for 7 months, with the therapeutic goals of resolving her fear of abandonment. I am uncertain at this stage as to what the underlying issues might be, what she might be defending against, and therefore what the risks of destabilization might be.

In general at the beginning of therapy I do not make historical inquiries. I stay with current affect, and wait for mention of childhood experiences that are connected with the present experience with me. In this way I have an affective understanding of the present moment through the client's historical associations. My focus is on phenomenological inquiry.

I agree with Erskine that one of the initial goals is to establish an empathic therapeutic relationship. He goes on to report that Theresa scoffed at his attempts at empathy. This would lead me to wonder whether I have got too close, too soon, and perhaps if her self-reliant defense has been activated.

When Theresa describes how she is seductive with her boyfriends, I wonder if she is avoiding separateness with them, trying to establish a merged relationship, which she then attacks herself for. It is interesting that her crying did not move the therapist to compassion. Since the therapist is not moved I wonder if the behavior is a further defense.

When Theresa talks of Joan, as the 'only' loving person in her life, this sounds grandiose and idealizing and may represent another relational unit, in particular another loving relationship that finished 'too soon'. Joan abandons her because of her violence and this confirms that 'no one can be there for her'. It seems that her violence drives others away, or that no one can handle it.

Theresa talks about falling madly in love, and the men then become aggressive. I find myself wondering if the men were beginning to struggle with a merged state and wanted to separate. Falling in love with men followed by aggression is similar to her experience with Joan.

Erskine goes on to describe her affect-confusion between terror and longing; the terror of re-traumatization on the one hand and the longing for contact and connection on the other. I would describe this process as an emerging impasse (Little, 2011).

It seems that Theresa wants affection and protection from her father and has an attacking mother who sees her as seductive. This indicates that her mother may be jealous of her relationship with father. She grieves for not having had a potent

father; this would lead me to look for the presence of the absent-father in the transference-countertransference relationship with me.
She looks for comfort in the other, (possibly the needed relationship) but expects an attack (the repeated relationship). The attacking other consists of a mother who despises her and is let down by a spineless father.
Erskine states that it is important to eliminate her aggression and fighting with people, however he doesn't explain why he sees this as important. Clearly there is an important process occurring which involves the stirring of her needs and an aggressive defense. A pattern is emerging with Theresa being vulnerable with the therapist, followed by an attack against him in some way. She may be attacking to push him away when she feels vulnerable, and her needs are being stirred in his presence.
Theresa also engenders in Erskine aggressive and rejecting responses. I agree that transference-countertransference process demonstrates her unconsciously needed and repeated relational transferences. My focus would be to address these processes in the here-and-now within the therapeutic dyad. I might inquire with her about what it is like to be with someone whom she experiences as rejecting, or talk with her about how she has just pushed me away with her aggression.
In the transference-countertransference matrix the therapist is anticipated as a critical; this is an aspect of the repeated relationship. My approach would be to stay in the present moment, working with the past in the present and drawing the critical aspect to me.

Response from James Allen

It is an honor to have been invited to comment on Erskine's description of treatment of this 38-year-old woman, to have the opportunity to share vicariously in their therapeutic relationship, and to watch the gradual elevation of her preverbal and implicit experiences to the level of verbalizable awareness and mentalizing.

In reading the transcript, I also felt a twinge of sadness. Because of deteriorating economic conditions for a large number of people, this type of treatment is likely to become less available in the future in many parts of the world. Consequently, it seems imperative to consider how it may be conserved, even if shortened or condensed. Therefore, such a clear presentation is particularly timely.

Once again, I am impressed by the usefulness of this framework in directing therapeutic interventions. At one level, it seems deceptively simple. As such, it is an excellent framework to teach beginning trainees. Under the apparently simple surface, however, there is nuanced complexity, a complexity that recent research in early child development and underlying neurophysiological activations inform. However, beginning trainees do not need to get lost in all of this. Later, they will find that much of it easily fits into what they

already do, and how they already are able to conceptualize relationships and therapy.

In the treatment of this woman, I probably would have behaved in a similar fashion to Erskine, but my internal processing would perhaps have been somewhat different.

Because I spend about one-quarter of my professional time working with infants, preschoolers, and their families, I tend to think first in terms of what permissions an infant/child needs, at first non-verbally, relationally, and contextually, and then, as they grow older, what permissions they need to learn to provide for themselves.

Second, in reading this section, I became deeply aware of my dependence on non-verbal communications and signals from the patient – shifts in the tone of voice, breathing, subtle distancing – and my own somatic resonance, and efforts to lift these from non-symbolic to verbalizable symbolic status. All this, of course, is very difficult to describe in words.

Erskine highlights Theresa's confusions. Yet, the labeling of discrete emotions is, I think, really the last stage of a process going from noticing and orienting, then through a more diffuse sense of safety or danger and the related internal physiological changes before we actually become aware of and can label discrete emotional states. What Erskine describes as Theresa's confusion in regard to emotions, I would probably conceptualize more in terms of a developing process.

I admire Erskine's summary at the end of this chapter. It is the outline of a treatment plan. As such, it would be a useful initial framework for many patients. However, at this early stage, I wonder if Erskine had any idea of how long it would take!

Throughout this and later sessions, Erskine clearly is using his attunement to pace and structure interventions. However, I am curious as to what led him to believe that it was important to have Theresa look him in the eyes so that she could see he was "taking her anger seriously." To what degree was this dictated by his attunement at the moment, and to what degree by a theoretical perspective that one of her thwarted relational needs was to make an impact (on a man)?

Helping Theresa engage in relationally contactful anger, and validating and normalizing her relational needs as she relinquished old self-regulating habits and learned new ways of being in a relationship strikes me as essential for the patient – and hard work for the therapist! I appreciate the careful way Erskine did this.

It is interesting that Erskine had to work to convince Theresa to return to treatment. Despite her presentation in the therapy room, I wonder how her life

outside treatment was actually being lived at the end of the first year. With our therapeutic concern for pathology, do we miss aspects of resilience and health? Surely, there were moments in her past and present which were non-pathological and could be a source of strength.

The major thing I think I might have done differently was to deal more explicitly with the possibility of suicide, and what had kept her from it. From her history, I would have expected this to be a major issue.

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