

Treatment Planning, Pacing, and Countertransference: Perspectives on the Psychotherapy of Early Affect-Confusion

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Abstract:

This article is a rejoinder and elaboration on the article “Early Affect-Confusion: The ‘Borderline’ Between Despair and Rage: Part 1 of a Case Study Trilogy” and addresses the distinction between personality style, pattern, and disorder. It describes the pacing of a time-limited psychotherapy, the use of phenomenological inquiry in resolving transference enactments, and the psychological function of idealization.

Key Words: psychological functions, personality style, personality pattern, personality disorder, phenomenological inquiry, pacing, time-limited therapy, transference, countertransference

It is a privilege to join each of my four esteemed colleagues -- James Allen, Grover E. Criswell, Ray Little, and Maša Žvelc -- in this lively dialogue aimed at expanding our collective knowledge about psychotherapy. Such a professional discussion provides an opportunity to engage in a meaningful discourse about therapeutic process, exchange theoretical concepts, and arrive at new understandings of clinical involvement.

It is always possible to criticize any approach or method used by a therapist if the colleague merely addresses the clinical work from a different theoretical orientation or personal perspective than that used by the therapist or writer. However, each of our four colleagues were asked by the editors, Gregor Žvelc and Marye O'Reilly-Knapp, to write their personal reactions to the trilogy on “Early Affect-Confusion”, to address the clinical work from other theoretical perspectives, and to focus on what they would have done differently. The result

is this lively discussion. Now, I have an additional privilege to write this rejoinder and invite you to engage in this dialogue with us.

Rejoinder to Grover Criswell

Grover Criswell begins his discussion with three self-reflective questions. In my first session with Theresa I had a version of his first question in mind: "Inside of the explosive feelings is there any solidity in her personality structure?" Midway through my first session I had two answers to this question: "Yes" and "No". Theresa performed well in a difficult yet well-structured job. However, she seemed to lack internal solidity and personal resources when it came to interpersonal relationships. I decided that she did not have the internal solidity to handle varying points-of-view, potential confrontations, and the interpersonal intimacy that existed in my on-going therapy groups. Because of this lack of internal solidity I decided to have three evaluation sessions before proceeding with a time-limited individual psychotherapy.

Grover, you were interested in knowing where in the course of treatment I decided to use the term "borderline". Although Theresa met the categorical requirements for personality disorder in the DSM IV, I have not used the diagnostic term "Borderline Personality Disorder" to describe her. A previous psychologist diagnosed her as "borderline psychotic" and a psychiatrist had told her that she had a "bi-polar disorder" that required medication. In this article I used the word "borderline" in two intentional ways: as a metaphor and as an analogy.

"Borderline" was used as a metaphor to symbolize Theresa's early affect-confusion and delicate balance between despair and rage. "Borderline" was also used as an analogy to infer the intricate and adroit task I faced in fostering attitudinal and behavioral change, while keeping the transference just active enough so Theresa's unconscious story could unfold within the healing responsiveness of our therapeutic relationship. And, at the same time, protect her from my potential reactive countertransference – a countertransference that would reinforce her original self-regulating script beliefs and archaic ways of coping.

I prefer to think of personality on a continuum - from style, to pattern, to disorder. "Style" refers to a general way in which the diagnostic characteristics may affect the client's way of being in the world. A "style" may not be particularly problematic to an individual or to others except when the individual is under extreme stress and may revert to archaic patterns of self-stabilization. Clients will reveal a personality style often later in the course of psychotherapy when they describe how they manage a crisis or a family reunion, through dreams or an envisioned future, and through subtle transferential enactments.

A personality “pattern” refers to a more problematic level of functioning on a day-by-day basis in relationship with others. An individual’s repetitive personality pattern is often more uncomfortable to family members and close associates than to the individual who often sees his or her own behavior as natural and ordinary. As disappointment, tiredness, or stress increases, they are likely to revert to archaic patterns of clinging, avoidance, disorganization, or isolation. Personality “patterns” become evident early in psychotherapy through the client’s encoded stories, overt transferences enacted in both therapy and in daily life, and the physiological and affective response engendered in the psychotherapist.

A personality “disorder” refers to the continual reliance on archaic methods of problem solving and being in relationship. An individual’s archaic form of self-reparation, self-stabilization, and coping is pervasive in nearly every relationship with people and in nearly every aspect of his or her life. Clients with a personality disorder will often dramatically enact some element of their life script in their first and subsequent sessions. Evidence of the severity of the script may be embedded in the client’s presenting problem, embodied in their physical gestures, and engendered in a strong physical and emotional reaction from the psychotherapist.

Theresa revealed her intense distress and confusion on the phone, in the first session, and certainly in subsequent sessions. Rather than referring to such clients in the diagnostic terms of “borderline” or “borderline personality disorder”, I prefer to use the developmentally descriptive and caringly humanistic term *early affect-confusion* that describes the relational conflicts and overwhelming affect experienced early in life.

Theresa seemed to function well when I postponed her discussion of certain issues and limited her expression of emotions. I assumed that she had sufficient internal strength to understand her motivations and to make significant attitudinal and behavioral changes. Therefore, I made the decision to see Theresa in psychotherapy for only 7 months, from the beginning of October through May. It was precisely because of Theresa’s degree of affect-confusion, the potential of perceiving me as either “cold” or rejecting, and her anticipation of not being understood that it seemed necessary to provide Theresa with a sense of control by limiting the time of the psychotherapy. By setting a contract for only seven months we had an explicit agreement. She had my commitment for seven months – a counterbalance to the abrupt termination in previous psychotherapies. In addition, I knew that I would be out of the office for twelve weeks beginning in June and did not want to create a situation wherein she would feel abandoned by me.

Such time-limited psychotherapy can be particularly effective in focusing on a specific problem, facilitating behavioral change, and in managing incidences of “acting out” what has not yet been resolved in the psychotherapy. Time-limited psychotherapy contractually circumvents the client’s predictions of abandonment, provides time for a real therapeutic alliance to develop (if it is going to develop at all), and keeps the therapy focused on specific issues. Once the therapeutic alliance is well established and there has been some success, the time frame of the psychotherapy can be extended. With an on-going psychotherapy the focus will primarily be on the transference-countertransference matrix to resolve the primal dramas of early childhood that are being lived out in the client’s interactions with the therapist and /or other people.

At the end of May, as we were crystallizing what we had accomplished together, Theresa seemed to accept that our therapy contract was at an end. She was pleased with what she had accomplished and was surprised when I offered her the opportunity to continue in September. When Theresa voiced her fear of being too dependent on me I had no sense of her being angry. I think she was genuinely afraid of becoming dependent on me, and the potential of being humiliated and abandoned once again by someone on whom she had tried to rely for support, guidance, and protection. I think that it was because she experienced me as reliable and dependable that she was afraid – a juxtaposition reaction (Erskine, 1993/1997).

Rejoinder to Maša Žvelc

Maša, thank you for your compliments about my gentle engagement, empathy, and respect for Theresa’s needs, feelings, and modes of self-restoration and self-stabilization. You wanted to know more about my feelings. An element of her was very enduring and evoked in me a sense of caring and protection – a *responsive* countertransference.

Alongside that sense of care and protection, I disliked her treatment of others, her aggressive attitude – a *reactive* countertransference. Frequently I found myself in the position of wanting to make humiliating comments; I refrained. Yes, on several occasions I experienced her as a “pain in the ass”. I did not feel a desire for revenge but on occasions I did want to push her away. After the sessions I was often glad that she was gone for another week. I kept what you refer to as “forbidden” experiences to myself. I either converted my reactions into a series of inquiries or used them to infer and understand the intrapsychic dynamics between the attitudes that she may have introjected and the needs of a neglected/abused child.

I seldom thought of her during my private time. Theresa was unlike the clients who are more self-centered and self-righteous whom I often find myself thinking

about between sessions – they appropriate my attention even when I do not want to think about them. I did make it a point to re-read my case notes before each session with Theresa so that I would have a clear perspective on what was unfolding in the psychotherapy. I did not have fantasies or fears about her. I had a responsible position that I took seriously.

Theresa was coquettish, but in what I experienced as a very child-like way, not in a sexualized form. I have had clients who eroticized the therapeutic relationship in order to avoid the heart-to-heart intimacy that was possible. This was not what happened in Theresa's psychotherapy. As I provided attention and responsiveness to her current relational-needs her seductiveness waned.

I did not focus on shame; attending to shame during this time-limited psychotherapy would have taken us away from Theresa's cognitive understanding of her behavior. If I had focused on Theresa's shame prior to developing a strong therapeutic alliance, we may have become immersed in her lifelong sense of worthlessness, an immense sadness, and her profound fear of abandonment because of *who she is* (Erskine, 1994/1997). Work with her sense of shame would have to wait until she had a secure and dependable relationship with me. My focus was on the original contract of helping her find constructive ways of being in relationships and countering her experience of "no one is there for me" and "no one understands me".

Maša, thank you for pointing out an important series of therapeutic transactions that are often very effective in uncovering the internal dynamics in an aggressive transference. I have found it extremely useful to engage in a series of phenomenological and relational inquiries such 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?*" These inquiries invite the client to explore internally, to feel, to remember, and to become aware of what they needed in important interpersonal encounters. I often use these inquiries about the present relational moments in psychotherapy; they inevitably simulate affectively-laden memories of earlier relational disruptions.

Maša, you also point out that I explained to Theresa that her feelings and reactions were valid but valid only in another time and context. Such explanations are extremely helpful to the client in distinguishing the present from the past, to separate emotional memory from current feelings, and to facilitate her understanding of how the past can be relived in the present. This type of explanation is a momentary step outside the transference-countertransference matrix that typically distinguishes relational psychotherapy. Yet, such an explanation is also relational; it provides the client with a cognitive understanding of archaic emotional experience and has the potential of providing a great deal of psychological relief.

Our therapeutic relationship required that I help her build a safety net as she walked that emotional “borderline” between acknowledging her unmet needs and angrily attacking people. This required a multipart treatment approach: first, helping her cognitively understand her own emotions and behavior; second, teaching her how to engage in a relationally contactful anger; and, third, validation and normalization of her relational-needs.

Rejoinder to Ray Little

Ray, I liked the way you began your reaction paper by emphasizing that any case presentation is from the “therapist’s particular clinical perspective”. I would like to add that both the case presentation and how we respond to each other is also formed out of the each person’s autobiography – the theories, concepts, methods, individual proclivities, and ways of being-in-relationship that we each value. Therefore, no two psychotherapists will ever do the exact same type of therapy. I am excited by your answers to the question: “How do you see this case differently than me and what would you have emphasized?”

It was predictable that Theresa would eventually perceive me as cold and critical of her, rejecting and demanding, like she experienced significant others in many previous relationships. I wanted to minimize that possibility during this time-limited psychotherapy and reserve the working through of the unconscious story being enacted in her aggressive transference until we had established a secure working alliance. In the first few months I was not certain that I wanted to continue with her after the seven-month period of contracted time. Was this engendered reaction a resonance with her pre-symbolic and implicit memories or an attunement with introjected emotions of a significant other in her life? Or both? Your writings on psychotherapy theory would imply both of the above (Little, 2006, 2011).

In addition to the above-mentioned countertransference, I suspected that she might terminate the therapy at any time. Therefore, I focused on what she needed in our immediate relationship. Parallel to these two thoughts was the realization that a psychotherapist mindful of the intense emotionality and relational degradation that is part of early affect-confusion would not address the deep-seated affects of terror and pain entrenched in the aggressive transference until there is a well-established secure working alliance.

Ray, you picked up on the various forms of idealization that were evident in Theresa’s story. I think of idealization, as in Theresa’s situation, as an unconscious desperate call for acceptance by a stable, dependable, and protective other person. It reflects a normal developmental need to look up to and rely on parents, elders, teachers, and mentors. The relational-need for acceptance by a consistent, reliable, dependable other person is the normal

search for protection and guidance that is often manifested as an idealization of either the psychotherapist or another significant person. Idealization frequently reveals a search for protection from one's own escalation of affect or exaggeration of fantasies. In psychotherapy such idealization most often represents the search for protection from a controlling, humiliating Parent ego state's influence on the vulnerability of Child ego states.

I think these two concepts are what you mean by "an idealized needed relationship" and a "protective self-other relational unit". In your article, "Ego State Units and Resistance to Change" (Little, 2006), you clearly describe how various Child and Parent ego states are linked by affect into relational units – physiologically/affectively infused implicit memories of intolerable, traumatic experiences that become fixated as a Child ego state with a corresponding introjection of a significant other.

I agree with your statement, Ray: "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." This is the position I usually take with most clients and recommend to my trainees and supervisees. Yet if cognitive mastery and behavioral control are necessary to establish a working relationship, as was the case with Theresa and other clients who suffer from early affect-confusion, then it seems absolutely necessary that the client be able to distinguish the past from the present. Please see my comments about this in my notes to Maša.

Theresa did scoff at my attempts at empathy. I have found that such *juxtaposition reactions* are usually an indication of three factors: the existence of an avoidant or disorganized attachment pattern; an indication that the psychotherapy is proceeding too rapidly; an indication that the level of interpersonal contact is too rich - or some combination of the three. The client is not able to tolerate the quality of contact and therefore acts as though she/he is pushing the psychotherapist away. In actuality the client may be pushing affect-laden implicit memories away.

A client's juxtaposition reaction can create a reactive-countertransferential trap if the psychotherapist is invested in creating intimacy and then has his or her attempts rejected. Understanding the significance of juxtaposition reactions is an important aid in working with clients who suffer with early affect-confusion. With Theresa I took her scoffing at my empathy as an indication that I was providing a therapy that was too intimate too quickly. It was my responsibility to slow the pace of the psychotherapy and/or dilute the affect intensity of our interpersonal contact. I did not put any emphasis on "her self-reliant defenses" but rather took the responsibility to pace the therapy at her rhythm of integration. The locus of

responsibility is with me, the psychotherapist, and not on defining the client as acting defensively: I think that this respectful position is the essence of a relational psychotherapy.

Ray, I did state that it was important that Theresa “eliminate her aggression and fighting with people” as a *preparatory stage* in the psychotherapy. Her conflicts with people constitute the *transferences of everyday life*. Every conflict is an enactment of both her anger at and rejection from her mother. But, as long as she was involved in such current conflicts with coworkers and her boyfriend, all the therapy time would be absorbed by current extraneous events and we could not do the in-depth psychotherapy that was sorely needed. I certainly noted for further attention that Theresa’s reporting of each of her current relational conflicts most likely represented an encoded story about her early life.

Ray, you end your commentary by saying “My approach would be to stay in the present moment, working with the past in the present and drawing the critical aspect to me.” This is certainly an important and necessary way in working with many clients. With Theresa such interpersonal-contact was essential in the next stage of therapy once a secure therapeutic alliance was firmly established. As you read the ongoing case, there will be many instances of working within a relational context – in the present moment, with full interpersonal-contact.

Rejoinder to James Allen

Jim, I was touched by your opening comment regarding the need of many people around the world to experience a healing therapeutic relationship. As a profession we need to develop a short-term psychotherapy that provides clients with many of the components of a healing relationship. Perhaps a part of the solution lies in the moment-by-moment interpersonal-contact, respect, attunement, and validation that an involved psychotherapist can provide.

As I began this therapy with Theresa I expected that it would last only a few months and that I had to do my best to make our time together as productive as possible. That meant creating a respectful, caring, and involved relationship while helping her think about her feelings and behavior in order make a distinction between archaic experience and the current situation.

Jim, you say that the case study of Theresa provides “a complexity that recent research in early child development and underlying neurophysiological activations inform.” I would like to hear more of your ideas and how you think about this “nuanced complexity”.

You capture my experience in writing about this case when you say,
“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 words”.

As I re-read Theresa’s case study many months later I am struck by how much I did not say and could not describe in words. Theresa had a variety of gestures and distorting facial grimaces when describing her conflicts with her boyfriend and coworkers. These distorting body movements were uniquely different than when she was being coquettish or when we were problem-solving together. Many of Theresa’s gestures were pre-verbal, sub-symbolic, and implicit expressions of the distress of a little child. I am continually impressed in how the client’s unconscious early childhood story is embodied in the client’s current physiology.

In writing this case study I only attended to those details that were obvious and provided only the information that communicated the general style of the therapy. I realize that there is so much more to tell. One of my failings, and perhaps you experience it as well, is the inability to attend to all that is emerging in any session. There is always so much is happening all at once:

- the ostensible story the client is telling;
- the relational experiences being revealed through the style of the client’s narrative;
- the primal dramas that are being lived out through the client’s behavior and transactions;
- what the client is unconsciously revealing about his or her relational history through gestures and physiological reactions;
- what is being engendered in me, either reciprocally or reactively;

Jim, I use the term “early affect-confusion” to describe the internal distress of a toddler age child. When caretakers are experienced as the only source of needs satisfaction and simultaneously as a source of danger, the child is left with disturbing confusion. There is often no one who notices the child’s distress, who provides safety, who helps the child express what he or she is feeling, and who helps make sense out of an emotionally overwhelming experience. This is what we psychotherapists do many years later in a relationally focused psychotherapy:

- identify and take the distress seriously;
- create security-in-relationship;
- provide an attuned responsiveness to affect expression; and,
- co-create language and concepts that provide new meanings.

Jim, you were curious as to why I found it important to have Theresa look me in the eyes so that she could see that I was taking her anger seriously. To

some degree this was influenced by my attunement to her level of development, her affect, her sense of helplessness, and her core belief “No one is there for me”. She did not yet have the internal security and relational support to express her anger directly to a fantasized image of her father. I was concerned that she would become overwhelmed with helplessness and fear of rejection. She needed to express her anger in a way that provided her with a sense of making an impact on the other person. So instead of having her face an image of her father, I asked Theresa to look me in the eye and express to me the intensity of her anger.

A theoretical perspective was also in play: to make an impact on another person is an essential relational-need. It seemed important that Theresa see my eyes and face as she clearly expressed what she did not like and observe the impact she made on me. If we did this work in fantasy, with an empty chair, she may never have had the sense of making an impact. In the following sessions we talked about how she felt when she could see the reactions in my eyes, my accepting her anger seriously, her new experience with a contactful anger, and how it was different from her habit of helplessly raging at people but never making the quality of impact she needed.

Theresa made many changes in the first year. Her therapy shifted from blaming others to taking a small amount of responsibility for her behavior. She began to realize that her emotional states were child-like in origin and were an attempt to tell a desperate and very meaningful story. My feelings toward her were softer and more paternal. She was not acting out the relational conflicts that were so time-consuming and distracting from the in-depth psychotherapy. Theresa was ready to terminate our time-limited therapy; she had gained insight and changed her behavior.

Yet, I thought it was time to offer Theresa an on-going therapy to resolve the internalized relational disturbances that maintained her early affect-confusion. When making the offer that Theresa continue the psychotherapy, I did realize that we may be engaged in a serious psychotherapy for a number of years. Theresa was reluctant to engage in an in-depth psychotherapy because she was afraid to become dependent on me – a fear of repetition of the humiliation and rejection she had known throughout her childhood.

Thank you, Grover, Maša, Ray, and Jim, for your insights and thought-provoking questions. I look forward to our continuing dialogues as we discuss parts 2 and 3 of this trilogy on Early Affect-Confusion.

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