An Overview of Countertransference With Borderline Patients

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Successful management of countertransference is critical to the psychotherapy of borderline patients. The author discusses the most common countertransference reactions encountered in such treatments. A theoretical framework is also proposed that conceptualizes countertransference as a joint creation between therapist and patient. It follows from this conceptual framework that therapists must constantly monitor their own contributions from past relationships as well as the aspects of countertransference evoked by the patient's behavior. Countertransference in the psychotherapy of borderline patients must be viewed as a source of valuable diagnostic and therapeutic information and not simply as interference with the therapeutic process.

> I feel used, manipulated, abused, and at the same time I feel responsible for her feelings of rejection and threats of suicide, or feel made to feel responsible for them because I don't have time for her and don't choose to be/cannot be always available as a good object, nor as a stand-by part object.
>
> She has hooked me into thinking love and friendship will heal her, as if there were nothing wrong with her but rather it was all of the people in her life who were the problem. Then I come up with fatherly friendship, and her control begins. She tells me, in different ways, that I am different from the others. And just when I'm basking in "good objectivity," she really begins to control me by telling me that I'm just like the rest, that I don't care: "I see you looking at your watch. I know you want to leave. I know you have a life out there. It will be a long night. You don't care. Nobody cares."

As this quotation from a borderline patient's therapist vividly conveys, patients suffering from borderline personality disorder tend to overwhelm the clinicians who treat them. A comprehensive treatment program for such patients often includes individual psychotherapy or psychoanalysis, adjunctive pharmacotherapy with any one of a number of agents, brief or extended hospi-

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talization, family or marital therapy, and group psychotherapy. Regardless of the specific form of treatment, however, countertransference can be a major impediment to successful therapeutic efforts.[1] The treater's emotional reactions to the patient sweep through the course of treatment like a tempest with the potential to create havoc for both patient and therapist. Although the skillful management of countertransference is only one aspect of an overall treatment approach to borderline personality disorder, it constitutes the foundation of the treatment on which all other efforts will rise or fall.

The primitive defenses of borderline patients, particularly splitting and projective identification, produce a kaleidoscopic array of complex and chaotic transferences in the therapeutic setting. As these varying configurations of self- and object-representations parade before the therapist, they are further complicated by accompanying affective states that are unusually intense and raw, often inducing in therapists a feeling that they are trapped in a life-and-death struggle.[2] Some clinicians have even suggested that countertransference reactions may be the most reliable guide to making the diagnosis of borderline personality disorder.[3] These patients make us "come alive" in a specific way that heightens our awareness much like the experience of driving over a mountain pass on a narrow two-lane road without a guard rail. Because they are so sensitive to the therapist's choice of words and nonverbal nuances, they are able to evoke a sense of walking on eggshells, as if our margin of error were very narrow indeed. Yet, in spite of this untoward impact, they somehow become "special" to their therapists[4] and inspire a surprising optimism despite a host of pessimistic prognostic signs.[3] Therapeutic zeal rises like a phoenix from the ashes of previous failures.

Borderline patients seem to have the peculiar ability to inflict a specific form of "sweet suffering" on their therapists. They themselves have suffered throughout their lives, and it is important to them to have their therapists suffer for them.[5] They seem to demand that the therapist abandon the professional therapeutic role: anyone who attempts to treat them must share in their misery. Searles[6] has cautioned that the traditional analytic posture of evenly suspended attention is neither viable nor appropriate in the psychotherapy of borderline patients. Therapists who attempt to assume a detached, "objective" role vis-à-vis the borderline patient are at risk of projectively disavowing their own conflicts and anxieties and using the patient as a container to receive them. The classical notion of the therapist as "blank screen" is simply not applicable to the psychotherapy of borderline patients.

SPECIFIC COUNTERTRANSFERENCE REACTIONS

Controversy over the diagnosis of borderline personality disorder persists despite the introduction of this category into DSM-III 12 years ago. The first systematic empirical study of the disorder by Grinker et al.[7] suggested that borderline personality disorder is a spectrum that ranges from the psychotic to the neurotic. Kernberg[8,9] argued that the borderline concept is really a personality organization rather than a specific nosological entity. A variety of different personality disorders, including paranoid, antisocial, schizoid, infantile, narcissistic, and cyclothymic, all could be subsumed under the overarching ego organization.

Gunderson,[10] on the other hand, sought to identify discriminating criteria that would distinguish borderline personality disorder from other related Axis II conditions. Abend et al.[11] raised serious questions about Kernberg's diagnostic understanding of borderline patients by documenting the successful psychoanalytic treatment of such patients with classic psychoanalytic technique based on traditional conflict theory. Adler[12] presented yet another point of view. He proposed that borderline patients could best be

understood as suffering from a deficit-based condition rather than intrapsychic conflict. Specifically, this condition involved the absence of a holding-soothing introject that could sustain them emotionally in the absence of their psychotherapists. Other clinicians influenced by self psychology[13,14] maintained that borderline symptomatology results from breakdowns in the empathic relatedness between therapist and patient and should therefore be reconceptualized as an entity that is definable only in the context of a relationship.

This controversy about diagnosis is mirrored in a corresponding controversy regarding the optimal treatment. Many (though not all) of the differences of opinion can be accommodated by embracing Meissner's[15] notion that the borderline diagnosis is essentially a spectrum of conditions that are psychodynamically related. At the high end of the spectrum are patients who have notable ego strengths and can undergo psychoanalytic treatment with little modification. At the low end of the spectrum are patients who are prone to psychotic disorganization because of prominent ego weaknesses and who require more supportive approaches.

From a clinical perspective, however, the spectrum must be regarded as a metaphorical construct. Borderline patients are known for wide fluctuations in their clinical presentation. One can see normal, neurotic, and psychotic transferences in the same patient in the course of one therapeutic hour.[16] A corollary of this observation is that therapists must assume a flexible approach to the psychotherapy, wherein their interventions shift to and fro along the expressive-supportive continuum according to the patient's needs at a particular moment. Meissner[15] shares this point of view and has offered the following observation:

> My own view is that, while the theoretical discrimination between supportive and expressive modalities has a certain utility from the point of view of articulating and describing aspects of the psychotherapeutic process, attempts to hold rigidly to a dichotomous view that prescribes a given form of therapeutic modality to specific diagnostic entities is neither theoretically sustainable nor clinically practical. . . . the therapist needs to maintain a position of flexibility and adaptability, allowing the selection of available techniques from the range of psychotherapeutic interventions to deal with the problems presented. (p. 121)

The concept of a spectrum is important because, in discussions of countertransference, one must keep in mind that the therapist's reactions may vary considerably depending upon where on this continuum a particular patient stands. Meissner[15] observes: "Countertransference in relation to borderline conditions is therefore not an univocal phenomenon but rather involves a spectrum of levels and intensities of transference/countertransference interactions that can vary considerably in both quality and quantity" (p. 211). With this caveat in mind, I will consider several common countertransference reactions to borderline patients.

Guilt Feelings

Borderline patients have an uncanny ability to tune in to the therapist's vulnerabilities and exploit them in a manner that induces feelings of guilt. A common development is that a patient will behave in such a way as to infuriate and exasperate the therapist. At the very moment when the therapist is wishing the patient would disappear, the patient may accuse the therapist of not caring and of disliking the patient. Such accusations may create feelings in therapists that they have been "found out." Under such conditions therapists may reproach themselves for their lack of professionalism and attempt to make amends to their patients by professing undying devotion. The patient's accusatory charges may strike to the very marrow of the therapist's professional identity

and create a form of "physiological countertransference"[4] that involves manifestations of sympathetic discharge, such as a pounding heart, a dry mouth, and trembling limbs.

Another common scenario is that the therapist begins to feel responsible for apparent clinical deterioration in the course of psychotherapy. Many borderline patients appear relatively intact at the beginning of treatment and seem to unravel as therapy progresses. Searles[6] has suggested that such guilt feelings by therapists may be related to unconscious empathy with the patient's child self-representation, who felt guilty about driving a parental figure to the point of madness. He has noted also that some therapists will feel guilty that the patient's more psychotic aspects provide greater fascination than the healthier or more neurotic areas of the ego.

Rescue Fantasies

Intimately related to guilt feelings are the evocation of rescue fantasies in the therapist. This aspect of the countertransference involves more than simply therapeutic zeal. It also reflects a perception that the patient is essentially helpless. Therapists often feel that they must do things for the patient. Borderline patients often present themselves as Dickensian orphaned waifs[4] who need the therapist to serve as a "good" mother or father to make up for the "bad" or absent parent responsible for victimizing the child.

Transgressions of Professional Boundaries

The third form of specific countertransference reaction follows naturally from the first two. Borderline patients are notorious for evoking deviations from the therapeutic frame that lead to ill-advised boundary crossing.[17-19] These patients may feel a specific form of entitlement resulting in demands to be treated as exceptions to the usual procedures. They are known to have a "short fuse" that leads to frequent expressions of rage. The origins of this proneness to primitive expressions of aggression may be constitutional[9] or secondary to trauma,[20] but the end result is that therapists often feel threatened or intimidated by the patient's volatility and potential to explode.

To ward off the patient's anger, the therapist may extend the session, engage in self-disclosure, defer payment or not charge any fee whatsoever, or engage in physical or sexual behavior with the patient. In some cases, this violation of professional boundaries is rationalized because of the perception of the patient as a victim who is entitled to compensation in the form of extraordinary measures because of the suffering he or she has endured. Suicide threats may also lead therapists to justify various boundary transgressions, often with the claim that if they had not deviated from their usual practices, the patient would have committed suicide.[17]

Still another source of boundary transgressions relates to the issue of abandonment. Many borderline patients feel that they are always on the verge of being abandoned by significant sources of nurturance and support, typically their parents, lovers, or therapists.[21-22] Some patients interpret any communication from the therapist—except unconditional love—as having an implicit threat of rejection.[12] These patients' demands for reassurance that one really cares and is not simply a prostitute who receives a fee in return for time and attention may lead therapists to go to extraordinary lengths to demonstrate their sincere concern. Because these demands may escalate to late-night phone calls, a rendezvous outside the therapy, and sexual liaisons, therapists who treat borderline patients have an ethical as well as a clinical need to understand countertransference pitfalls thoroughly.[23]

Rage and Hatred

A common phenomenon in the psychotherapy of borderline patients is their allevi-

ating tension by evacuating or "dumping" feelings into the therapist[1]: what Rosenfeld[24] has termed a "lavoratoric transference." Whereas neurotic patients tend to project superego constellations into the therapist, borderline patients project the "sick" or "bad" self in a primitive split-off form.[9,25,26] Volkan[26] has described the feeling of being "choked" by the externalization of such primitive and negatively charged affects and introjects. One can hardly avoid feeling rage, hatred, and resentment when being used in this way by the patient. Being held hostage to suicide threats or driven to distraction by late-night phone calls and unceasing demands for extraordinary treatment can also lead to profound feelings of seething resentment.

Helplessness and Worthlessness

Borderline patients tend to devalue their therapists' efforts.[12] Also, when their demands are frustrated rather than gratified, these patients can shift from idealizing to contemptuous transferences in the twinkling of an eye. They tend to indulge in *pars pro toto* thinking in which one becomes "all bad" for even a minor transgression. The result is that therapists often feel unskilled, incompetent, and helpless to do anything about it. This form of countertransference is further enhanced by the expertise of borderline patients at identifying vulnerable areas and exploiting that awareness by constantly pointing out weaknesses to the therapist. Defensiveness and withdrawal are often overt postures of the therapist in the throes of such devaluing attacks, but underneath the surface the feelings of helplessness and incompetence are prominent.

Anxiety and Terror

Regardless of what else is going on in the treatment, borderline patients almost always make the therapist anxious. The sources of this anxiety are many and varied. At the most primitive level, the borderline patient's confusion about boundaries may lead therapists to feel a primal terror related to the concern that they will be swallowed up by their patient and annihilated. In psychotic transferences, patients may misidentify feelings belonging to them as residing in the therapist instead. A feeling of merger or fusion may be extremely unsettling to the therapist in such situations. A common response is to distance oneself from the patient and become aloof.[27] The anxiety that the patient will commit suicide is ever present in many treatment processes, and the sense of guilt and responsibility induced by the borderline patient amplifies such worries. The previously mentioned concern that one will say the wrong thing and cause the patient to explode, fragment, or abruptly walk out of the office also creates countertransference anxiety. Finally, an overriding anxiety that runs throughout the treatment arises from the feeling that therapists often have that they are simply not up to the clinical task or are failing in their efforts.

THE NATURE OF COUNTERTRANSFERENCES

As the concept of countertransference has moved to center stage in contemporary psychoanalytic discourse, it has undergone a transformation in meaning. Countertransference as a disruptive obstacle has been replaced by a view of countertransference as a valuable, if not essential, source of understanding. Accompanying this shift is heightened interest in how the patient-therapist relationship serves as a forum for reenactments of past experiences. The archaeological search for the buried past has been replaced by careful attention to the moment-by-moment reverberations between therapist and patient.[28]

Freud's[29] original definition of countertransference was narrowly focused on the analyst's transference to the patient. In other words, countertransference involved feelings

that belonged to the analyst's past but were displaced onto the patient in the same way that the patient displaced feelings from the past onto the analyst. This view conceptualized countertransference as an interference or obstacle that needed to be removed by rigorous analysis of the analyst.

Paula Heimann[30] altered the landscape of psychoanalytic thinking. In her view, countertransference needed to be construed in a much broader form as all the feelings that the analyst experiences toward the patient. Implicit in Heimann's understanding of countertransference was the notion that some of the feelings the analyst experiences are induced by the patient's behavior.

Racker[31] divided such patient-induced reactions into concordant and complementary countertransferences. Concordant countertransferences are those involving an empathic link between therapist and patient (i.e., the therapist identifies with the patient's subjective affective state or self-representations). Complementary countertransferences involve identifications with an internal object-representation of the patient that has been projectively disavowed and attributed to the therapist. Racker viewed this complementary reaction as an instance in which the analyst's own conflicts were activated by the patient's projections. Grinberg[32] took this notion one step further with the concept of projective counteridentification, in which the analyst introjects a reaction, feeling, or object-representation that comes entirely from the patient.

Winnicott,[33] in his classic paper on countertransference hate, spoke of an "objective" form of countertransference in which the analyst reacted to the patient in a specific manner evoked by the patient that was consistent across all people who interacted with the patient. According to this schema, certain patients might consistently induce feelings of hate in other people that reflect more about the patient than about the analyst's or other person's past.

This shift in thinking led to an outpouring of interest in the Kleinian concept of projective identification.[1,6,9,25,34–43] Although the original concept as used by Klein[44] involved an intrapsychic fantasy rather than an interpersonal coercion, the modern usage has focused to a great extent on changes in the recipient of the patient's projective identification. Whereas the concept remains highly controversial, there is a general consensus that the split-off self-representation, object-representation, or affect that the patient projects into the therapist produces changes in the therapist to conform to the nature of that projection. These changes are effected largely through powerfully coercive interpersonal pressure exerted by the patient. Projective identification, as one of the central defense mechanisms used by borderline patients, takes on crucial importance for this discussion, and I will elaborate on it below.

One implication of this shift in thinking about countertransference is that the analyst's response to the patient provides a great deal of information about the patient's internal object world. Moreover, countertransference entails first serving as a container to receive projected aspects of the patient and then studying the contents of those projections. Sandler[45] suggested that the analyst's free-floating attention must be supplemented by a free-floating responsiveness involving a form of introspection that determines what complementary role is being coerced by the patient's words and behavior.

This influence from the British school of object relations theory has traveled across the Atlantic and has had a significant impact on the classical or ego-psychological school, creating considerable interest in concepts such as interaction and enactment.[46–50] In a recent overview of countertransference and technique, Abend[51] acknowledged that the notion originating with Klein that the analyst's countertransference can be a crucial source of understanding the patient's inner world has now become universally accepted. As part

of this acceptance, the self-analytic activities of the analyst have come to be regarded as a systematic effort at collecting data about one's analysand. The analyst must be particularly attuned to subtle or not-so-subtle forms of "acting in," whereby the patient's internal object relationships are enacted in the clinical setting between patient and analyst. In speaking of enactments, Chused[46] notes:

> An analyst reacts to his patient—but catches himself in the act, so to speak, regains his analytic stance, and in observing himself and the patient, increases his understanding of the unconscious fantasies and conflicts in the patient and himself which have prompted him to action. (p. 616)

Borderline patients, in particular, evoke enactments through the sheer power of the affect and the primitive self- and object-representations that are projected into the therapist. However, it would be erroneous to assume that all of a therapist's countertransference reactions are simply aspects of the patient. In my view, countertransference must be thought of as a joint creation, in which both the therapist's past conflicts and the patient's projected aspects create specific patterns of interaction within the therapeutic process. Indeed, a central feature of the therapist's role with such patients is to engage in an introspective process that attempts to differentiate one's own contributions from those of the patient.[2,34] Bollas[52] notes: "In order to find the patient we must look for him within ourselves. This process inevitably points to the fact that there are 'two patients' within the session and therefore two complementary sources of free association" (p. 202). The therapist, then, must maintain both an intrapsychic focus and an interpersonal focus in an effort to sort out what is going on within the patient and bear it within himself.[47]

If one accepts the premise that countertransference is a joint creation, it also follows that the relative contributions of therapist and patient vary according to the severity of the psychopathology. In general, projective identification or "objective" countertransferences occur with sicker patients, such as those suffering from borderline personality disorder, whereas the narrow or "subjective" countertransferences are more prominent with healthier or neurotic patients. Although many countertransference reactions with borderline patients are overwhelming in intensity, we must not neglect more elusive forms of enactment that also occur throughout the spectrum of psychopathology. Jacobs[49] has pointed out that even aspects of the standard analytic or therapeutic posture, such as neutrality or silence, can become involved in subtle enactments that are unconsciously determined by issues in both patient and therapist.

This modernization of the concept of countertransference has led some to believe that the term has been so greatly expanded as to lose its specificity. Natterson,[53] for example, makes a differentiation between countertransference and the therapist's own subjectivity. He prefers the language of intersubjectivity because the therapist initiates as well as reacts. It is my view, however, that in actual practice the interactions between therapist and patient are so inextricably bound up with one another that what is initiative and what is reactive may be next to impossible to dissect.

Meissner[15] has also argued for a narrower or more limited definition of countertransference. In his view, not all reactions that the therapist experiences toward the patient should be construed as countertransference. He proposed that only the analyst's transference to the patient and the analyst's reaction to the role assigned by the patient should be regarded as countertransference. In this conceptualization, reactions that involve the therapeutic alliance and the "real" relationship (outside of technique) between therapist and patient are not necessarily countertransferential. Again, this distinction may be extremely difficult to tease out in the

heat of the affective storms generated by borderline patients in psychotherapy.

The conceptualization of countertransference that I have been advocating here places great responsibility on therapists to see themselves as both clinicians and "patients" whose own issues enter into the therapeutic arena.[6,25,52,53] Self-analysis, then, is of paramount importance in effectively managing countertransference. Indeed, Bollas[54] observed, "My view...is that contemplation of the countertransference is a systematic reintegration into the psychoanalytical movement of an exiled function: that of self-analysis" (p. 339).

The Role of Projective Identification

In light of the central importance of projective identification in the psychotherapy of borderline patients and in the conceptualization of countertransference as I have defined it, a more careful consideration may be helpful in clarifying my use of this term. Despite the controversy over confusing usages of the term, I view the concept of projective identification as essential for understanding the transference-countertransference developments in the psychotherapy of patients with borderline personality disorder.

To begin with, projective identification should be regarded as more than simply a defense mechanism of borderline patients. Ogden[38] has defined it as a three-step procedure in which the following events occur:

1. An aspect of the self is projectively disavowed by unconsciously placing it in someone else.
2. The projector exerts interpersonal pressure that coerces the other person to experience or unconsciously identify with what has been projected.
3. The recipient of the projection (in the therapeutic situation) processes and contains the projected contents leading to a reintrojection of them by the patient in modified form.

Ogden also stressed that the projector feels a sense of oneness or union with the recipient of the projection.

This model transcends the simple purpose of defense. As Scharff[42] has eloquently summarized, four distinct purposes can be delineated for projective identification:

> 1) Defense: to distance oneself from the unwanted part or to keep it alive in someone else, 2) Communication: to make oneself understood by pressing the recipient to experience a set of feelings like one's own, 3) Object-relatedness: to interact with a recipient separate enough to receive the projection yet undifferentiated enough to allow some misperception to occur to foster the sense of oneness, and 4) Pathway for psychological change: to be transformed by reintrojecting the projection after its modification by the recipient, as occurs in the mother-infant relationship, in marriage, or the patient-therapist relationship. (p. 29)

This model of projective identification carries with it a spirit of therapeutic optimism. If therapists can bear the projections of their patients, they offer the hope of helping patients transform their internal world through containment and modification of those projections and affects in the crucible of the therapist's countertransference.

Some critics of this model[37,41] have objected, arguing that Ogden[38] has broadened the definition beyond Klein's original intent by including the third step involving reintrojection. Kernberg[8] preferred to regard projective identification as a primitive defense mechanism involving projecting intolerable aspects of the self, maintaining empathy with the projected contents, attempting to control the object, and unconsciously inducing the object to play the role of what is projected in the actual interaction

between the projector and the recipient.

Sandler[41] also objected to extending the projective identification concept to include the therapeutic actions of containment, detoxification, and modification as described by Ogden.[38] However, Sandler's[45] notion of role responsiveness is very much in keeping with the first two steps of Ogden's concept and with my view of countertransference as joint creation of patient and therapist. He said:

> Very often the irrational response of the analyst, which his professional conscience leads him to see entirely as a blind spot of his own, may sometimes be usefully regarded as a compromise formation between his own tendencies and his reflexive acceptance of the role which the patient is forcing on him. (p. 46)

Of those who write about projective identification, most agree that control is a central feature of the process. Patients may experience the depositing of aspects of themselves in the therapist as forging a powerful link between the two members of the dyad, giving them the illusion of influence over the therapist. Often the power of this control is recognized only after the therapist has responded in the specific manner that has been unconsciously programmed by the patient's projective identification. Therapists of borderline patients must accept that countertransference enactments are inevitable. By rigorously monitoring internal responses, therapists can at least regroup and process what has happened with the patient following such enactments.

Boyer[55] has also construed projective identification broadly in the manner of Ogden.[38] In fact, he has written that the patient's reintrojection of what has been projected into the therapist is a neglected aspect of the process. For example, when they project hostility into their therapists, these patients may benefit from the "detoxification" of the affect and associated self- or object-representation through the therapist's containment process. Boyer believed that an important therapeutic element of projective identification is the patient's observation that neither therapist nor patient is destroyed by the projection and reintrojection of negative affects.

Although Scharff[42] shares the broadened view of projective identification that I am endorsing, she stresses that the patient and therapist engage in a mutual process. Moreover, she places greater emphasis on the introjective identification component of the therapist who receives aspects of the patient. The therapist may respond in a concordant or complementary manner, according to Racker's[31] distinction, but Scharff also notes that introjective identification is determined in part by the therapist's own propensity to respond in an identificatory manner with what is projected by the patient. In other words, some projections may represent a "good fit," whereas others may be experienced as alien and discarded. Finally, Scharff observes that the reintrojective process by the patient/projector may promote change if the containment by the therapist/recipient has made slight modifications that can be accepted within the limits of the patient's capacity to change.

This can also be pathological, however, if the projection is returned in a completely distorted form that does not modify the patient's anxiety or lead to psychological change. Certainly in nontherapeutic settings the aspects that are projected are routinely "crammed back down the patient's throat" rather than contained or modified, often with considerably intensified affect. The expanded model of projective identification assumes a therapeutic context in which containment and modification are goals. (It should be noted that close friends, parents, lovers, spouses, and the like may also be "therapeutic" in the way they contain what has been projected into them even though a formal psychotherapy process is not involved.)

The joint-creation model of countertransference that I believe is most apposite

for the psychotherapy of borderline patients depends heavily on the expanded model of projective identification as described by Ogden,[38] Boyer,[1] Scharff,[42] and others. It is of crucial importance, however, that therapists keep in mind the metaphorical nature of the exchange of mental contents. There is nothing mystical about projective identification. When patients coerce us into specific behaviors or feelings that correspond with what they have projected into us, they have simply stimulated repressed or split-off aspects of ourselves just as troops far from the front may be called into service when specific forms of battle need to be fought. We all possess myriad self-representations that are integrated into a more or less continuously experienced sense of self. We all have sadists and murderers lurking in our depths as well as saints and heroes. Considerable insight is gained in conceptualizing the psychotherapeutic process as involving two patients rather than one, understanding that the most bizarre aspect of the patient has some parallel counterpart in ourselves.[6]

THE ROLE OF THEORY

Francis Bacon once said that even wrong theories are better than chaos. My attention here to theory emphasizes that theoretical models are perhaps most useful when one is struggling with intense countertransference feelings. They bring order to the chaos of overwhelming affect and intense transference distortions. Friedman[56] has noted that the practice of psychotherapy involves considerable discomfort for the psychotherapist a good deal of the time. One dimension of the application of theory to the clinical situation is that it also is applying balm to soothe the therapist's anxiety.

Nevertheless, one must never regard theory as absolute or allow it to become reified. Theories are only as valuable as their clinical utility. Although I have borrowed from object relations theory in my conceptualization of countertransference, and specifically of projective identification, other theoretical models have been used to explain the same clinical phenomena. Porder[40] shares Ogden's[38] view that projective identification is not simply a defense mechanism. However, he explains it from a traditional ego-psychological perspective. Projective identification, in Porder's view, is an identification with the aggressor that is a chronic repetition of an entrenched pattern of relatedness between child and parent. The patient achieves active mastery over a passively experienced trauma by unconsciously casting the analyst in the role of the child while the patient assumes the parental role. In Porder's model the affect is not projected into the analyst; it is simply induced by the patient.

Adler and Rhine[57] approached projective identification from a self psychological perspective. Kohut[58–60] stressed the need for the therapist to serve as a selfobject to the patient. In other words, therapists must allow themselves to be used by the patient for psychological growth. The therapist's selfobject functions include allowing mirroring, idealization, and twinship in the patient's transferences. Adler and Rhine described a case of a patient who insisted that her therapist function as a selfobject by accepting her provocations and projections. They pointed out that the containing and modifying aspect of projective identification converges with selfobject functioning in situations where the therapist understands and tolerates the need to be used by the patient and helps the patient verbalize feelings rather than acting on them. Different theories, the authors suggested, are essentially struggling with the same clinical issues.

Most therapists use multiple models.[34,61,62] Rigid adherence to only one theoretical frame when the clinical data do not fit the theory is an unfortunate phenomenon in contemporary practice that privileges theory over clinical observation. Theory can also be misused to rationalize countertransference acting out.[23] One can use self psychology to rationalize enjoyment of idealization by a pa-

tient. Similarly, one can misuse Kernberg's[9] encouragement to confront and interpret the negative transference early on in the therapy to justify expressions of anger at the patient. Bollas[63] has stressed that modern analysts must understand a variety of analytic schools: "The psychoanalyst is an object performing multiple functions, each analyst-object being significantly more present than another analyst-object according to the clinical requirements of the analysand" (p. 100).

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