The Utilisation of the Abandoned and Annihilated Models in Encountering and Understanding Borderline Personality Disorder.

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The aim of this article is to compare the efficacy of two different conceptual models in helping individuals with little theoretical understanding of the interpersonal process in clients with a Borderline Personality Disorder (BPD). The first model incorporates the more traditional concepts of transference, counter transference and projective identification. The second is emotionally focused therapy (EFT) which uses concepts of the abandoned and annihilated clients, which will be put forward as a simpler and more utilisable alternative in understanding the interpersonal process involved for those individuals with a more limited theoretical background. As an experienced clinician with a strong background in different theoretical models I personally find the transference concept very useful, however there are of course many other interpersonal theories, which may better suit other clinicians. This article is aimed more at new or inexperienced counsellors or other professionals who may have regular contact with these individuals, and who may find the application of the theoretical concepts of transference, counter transference and projective identification harder to grasp, (and more importantly to utilise in their response to, or interaction with individuals with BPD).

I was recently teaching a course on helping individuals to recognise and manage the behaviour of individuals with a borderline personality when one of the course participants Wendy described an incident at work. Wendy was a middle-aged lady who was employed to help patients discharged from hospital to manage their finances or budget. She talked about visiting a client recently discharged whom the hospital staff had labeled as difficult and ‘borderline’, but she had little idea of what this meant. When Wendy arrived the flat was untidy and there was almost no food in the cupboards (although the client had money and shops were nearby) She found the client very tearful, helpless and depressed. Being helpful, she went and did some shopping for this client (not something that she would normally have done) who couldn’t praise her highly enough, pointing out how little anyone wanted to help her.

On Wendy’s next visit the client seemed to be coping better, but still complained of not coping at all. Wendy began to feel frustrated when the client demanded that she should use her car to take them shopping. Wendy tried to explain that wasn’t appropriate and glanced at her watch aware that she was already running late for her next appointment. The client then flew into a rage, accusing her of not caring and just wanting to leave as quickly as possible, shouting “it’s alright for you to have someone to go home to, this is just another fucken job for you, you’re just like all the rest, you pretend to care but you don’t give a shit, I am going to report you to the hospital and if anything happens to me tonight it will be your fault!” This unexpected attack left Wendy with strong feelings of anger at feeling bullied, as well as guilt, helplessness and anxiety, and she found herself unsure how to respond to this venomous tirade.

I started to explain to Wendy what had occurred in terms of counter-transference and projective identification, as I find these concepts useful in understanding the process she had just described. I had hoped to help her grasp something of the process that transpired between them, so that she would be more aware of the
courses of action open to her. However in the short time available to me this proved to be a difficult task, more so because of Wendy’s lack of a strong theoretical background. I later reflected that perhaps it might have been more helpful for Wendy if I had used Emotionally Focused Therapy (EFT) terms of abandoned and annihilated clients as a less cumbersome way of explaining what had happened, and what she could have done in response, that may have helped in the situation with the client.

Before we look at the theoretical concepts it may be useful to clarify what a borderline personality disorder is. According to DSM-4 (2000: 685) the general definition of a personality disorder is “an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture. It is pervasive and inflexible and has its onset in adolescence or early childhood. It is stable over time and leads to distress or impairment”. The term Borderline is attributed to Adolph Stern (1938) who described ten characteristics of office patients that were associated with patients becoming worse, or their resistance to or lack of co-operation with psychoanalytic treatment, coining the term “as if” personality. This highlights one of the main clinical features of borderline individuals, that they have poor self-cohesion or boundaries and can quickly regress, or enter into short-term psychotic episodes. Another early description in 1942 is by Helene Deutsch (a private psychoanalyst), who described a group of individuals who had a tendency to depersonalisation, who were passive, empty and capable only of superficial relationships and often took on the characteristics of those others they associated with. Today the most salient clinical features which relate to individuals with BPD are intense, unstable interpersonal relationships, repetitive self destructive behaviors, chronic abandonment fears, chronic dysphoric affect, impulsivity, poor social adaptation, emotional dysregulation and, as mentioned previously, poor self boundaries. Of course they may have some features more markedly than others, and to various levels of intensity and dysfunction.

Let us now look at the terms transference, counter-transference and projective identification and their relevance to our story, and then compare this with the concepts of the abandoned and annihilated client to see if they may be more user-friendly for Wendy.

**Transference, Counter-Transference and Projective Identification**

Transference as defined in Freudian terms is “displacement onto the analyst of feelings, ideas which derive from the interjected figures or objects acquired in the patients past life” (Appignanesi, 1979: 127). So in the story the client may be seen as transferring feelings from their past (for example perhaps their mother) onto Wendy. However a Jungian perspective takes a broader view of transference than just occurring between individuals. Wilmer (1990: 33) in describing transference in terms of Jungian psychology states, “whenever two people are in close relationship transference is there. It is, first of all personal, a reflection of real people, and then it is non-personal, a representation of inner objects, which are not a part of our subjective life and come from the collective bin of humankind.” An example of the non-personal are the archaic inner forces and images that still live in mythology, fairy tales, legends, heroic fantasies and in the inner world of good and evil.
Counter-transference in the traditional or Freudian sense is the transference from the counsellor’s or helper’s past onto the client, and was perceived as an obstacle in analysis. However counter-transference today it is viewed quite differently, and seen as a rich vein of information of what is happening in the client’s world. So if the therapist is able to maintain an intrapsychic focus as well as an interpersonal focus then affect, which may not be prominent in the client’s awareness, may be experienced by the therapist. This shift started with Winnicott (1949) who suggested that the client was able to evoke feelings like hate in the therapist and in other people consistently, which would be more to do with the client than the therapist’s past. More recently Abend (1989) acknowledged that counter-transference was universally accepted as a potentially crucial source of understanding the client’s inner world. Gabbard and Wilkinson (1994) propose that counter-transference be seen as a joint creation with great responsibility on the therapist to see themselves as both clinicians and as “patients” whose own issues enter into the therapeutic arena. They also state that if one accepts the premise that counter-transference is a joint creation then it follows that the relative contributions of therapist and patient vary according to the severity of the psychopathology, and stress the importance for the therapist of self-analysis.

In the story Wendy experiences a common counter-transference reaction of guilt as she was starting to find the client’s unrelenting demands somewhat trying. This is described well by Gabbard and Wilkinson (1994: 5).

> Borderline patients possess 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 that the therapist is wishing that the patient would disappear, the patient may accuse the therapist of not caring and disliking the patient. Such accusations may create in the therapist the feeling of having been “found out”. Under such conditions the therapist may reproach themselves for lack of professionalism and attempt to made amends to their patients by professing undying devotion.

Finally we come to projective identification, which in the past has been seen as a primitive defense mechanism where unacceptable feelings or parts of the self are projected onto others. However more recently projective identification has been seen as having a number of purposes which are well described by Scharff (1992: 29):

> (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.
Scharff also stressed that the patient and therapist engage in a mutual process and that introjective identification is determined in part by the therapist’s own tendency to respond in an identifying manner with what is projected by the patient. In other words some projections are a ‘good fit’ whereas others may be experienced as foreign and cast aside. This can in non-therapeutic situations be seen when the patient’s projections are ‘stuffed back down the patients throat’, usually leading to an intensification or escalation of the situation.

Lastly control is an important factor in the process of projective identification as Gabbard and Wilkinson (1994: 15) write “most of those that write about projective identification agree that control is a central feature of this process. Patients may experience that the depositing of aspects of themselves in the therapist forges a powerful link between the two members of the dyad, giving them the illusion of influence over the therapist”.

In the story Wendy’s sense of feeling bullied (controlled) and of helplessness and not knowing what to do are most likely projective identifications from the client, although on the surface the client appears angry and vindictive, they are more likely responding to perceived rejection and its associated pain and hurt.

Abandoned and Annihilated Clients

Now let us look at using the Emotionally Focused Therapy constructs of the abandoned and annihilated clients as a way of explaining what happened between Wendy and the client, and possible options in responding. The abandoned and annihilated client concepts arose initially from the article Mirror, Mirror by Dr Michelle Webster (1994). She subsequently refined and utilised them in assisting students at the Institute of Emotionally Focused Therapy in Annandale in organising or understanding information presented to them by the client, and as a guide in assisting them in responding adequately to the client.

In writing about the background of the abandoned and annihilated concepts, Webster (2005: 7) explains:

>All therapies have ways of structuring information, or have ways of thinking about clients and what is presented. In EFT a way of thinking about clients has developed out of beginning to conceptualise about how individuals view themselves. The dimensions of lovability and worthiness are two major dimensions that EFT considers when working with clients. Lovability incorporates acceptability and is about notions of being-ness, whereas worthiness is about approval, competency, and doing. Further in EFT, these two Dimensions have been incorporated into two major themes: abandonment and annihilation. Abandonment and annihilation refer to different forms of rejection. Rejection can occur from specific or ongoing trauma as well as from generalised patterns of relating.

In discussing further the context of rejection to abandonment Webster (2005: 12) in ‘Mirror Mirror’ states “Abandonment is more than rejection. It is rejection in the sense that a person is not accepted, is refused recognition and is cast off. Abandonment is also about being left, forsaken and given up without concern. Abandonment is about not having a mirror”.
The concept of Mirroring is important in understanding the resultant adult characteristics of the abandoned client. What is a mirror? I tend to think of a mirror in object relations terms, with a responsive selfobject as a mirror. That is as a child we gain a sense of ourselves through acceptance, validation and nurturing by the main caregiver. If this is adequate then the child is able to learn to soothe itself (regulate emotions) and starts to develop confidence (mastery of environment), as well as a sense of self worth and self-identity. Imagine a child with no adequate mirror to inform and validate its existence, (in the annihilated client the mirror is present but grossly distorted). What would be the resultant characteristics in an adult of poor or inadequate mirroring? Firstly they would have a poor sense of self and very diffuse or permeable inner and outer boundaries, which can collapse easily, with the result that the client can quickly regress or experience depersonalisation, derealisation or dissociation.

Another effect of these loose boundaries is that the client shows a poor ability to contain their feelings, and also to soothe or calm themselves. They therefore can very quickly become overwhelmed with their feelings, which they find difficult to regulate. I agree with Webster (2004: 180) when she states that, “an example of an extreme abandoned experience is the borderline person who is not able to hold their outer boundary in a functional way”. However although the client with a BPD would be primarily at the high end of the abandonment spectrum, they will also have some experience of annihilation, perhaps through physical or sexual abuse. In annihilation the mirror is distorted with the reflection being critical of the child. The annihilated child is put down, told that nothing they do is good enough, unfairly punished and told that they are bad or unlovable. The result of these attacks is a child who in an effort to maintain a sense of self becomes compliant and doesn’t voice its needs or wants. A child who becomes silent and learns to think ahead anticipating possible consequences, a child who learns to control themselves, not to have needs and are able to stop feeling. As an adult they can present as cool or emotionally distant, suspicious, defensive and blaming of others. Their views or often ridged and inflexible, whilst inside they can feel hurt, misunderstood and helpless. However as the borderline client is mainly about abandonment, that is what we will now focus on.

Webster (2005: 10) describes the characteristics of the abandoned client under the following headings (she also mentions boundaries, which have already been discussed above):

*Patterns of relating:* Abandoned adult clients in relating to others are generally compliant and keen to please and mollify others, they prefer to follow rather than lead, are submissive rather than assertive, and they worry if what they do is good enough.

*Emotional experience:* Abandoned clients often present as anxious or confused. In EFT theory this is called their secondary experience, which is what we have when we can’t have our primary experience. This is due to inadequate mirroring and means that the abandoned client is not aware of their true emotional experience or feelings, but instead they get flooded with their secondary feelings which cause them great distress and fear.
**Self experience:** Abandoned clients usually have a perception of themselves as worthless or no good and tend to see any obstacles in their life as their own fault, and easily blame themselves believing that they are unlovable.

**Inner child:** In considering the abandoned client’s inner child again we consider the lack of mirroring. The child wants to be seen and this may have to be accomplished by putting aside their true feelings and being non-complaining, complaint and good, or by acting as an adult and taking a parental or nurturing role (commonly seen in the children of adults with schizophrenia). This is the responding child, aspects of which can be seen in the adult abandoned client. However the true self or free child gets hidden away and can only be accessed when the client is able to gain a strong enough adult aspect to be able to hold themselves and their feelings, whilst also being able to continue to evaluate what is transpiring and their options without regressing. It is only then that the true or authentic self can emerge.

But what does this all mean to Wendy? As you can see, the abandoned client with their loose boundaries, self-hatred and poor sense of self, poor emotional modulation and a lack of who they are, fit nicely into the abandoned client framework. More importantly this framework can provide Wendy some ideas or options in dealing with her client who has a BPD as the theory points the way to the intervention.

So when the client angrily starts to attack her for perceived rejection Wendy (if she can hold herself, and remain focused that this is not about her personally) will need to provide a mirror for the client by acknowledging and validating their experience (this doesn’t mean that she has to agree with it). This will help the client to regulate their emotions and de-escalate the situation; Wendy taking umbrage and retaliating with a few home truths will only increase the client’s emotional arousal as they experience being ignored, or their experience being invalidated again. Wendy by acknowledging and validating the client’s experience is providing containment and helping to strengthen their adult aspect; however she also needs to be clear and firm on boundaries and what is and isn’t her role in this situation. The client may not like this but Wendy is modeling consistency and this will help the client maintain their boundaries.

**Conclusion**
I believe that the abandoned client concept in EFT can be of more benefit than traditional theories in helping counsellors, particularly those who are inexperienced or have little clinical background, in understanding and intervening in encounters with clients with a BPD. I feel that both the abandoned and annihilated client concepts are also useful in explaining the emotional development of individuals with BPD, their poor sense of self and especially the difficulties they experience with emotional regulation. The abandoned and annihilated concepts are I feel more accessible in both the context of their language, and more relevant from a humanistic perspective. Most importantly it supplies the individual worker with practical strategies when engaging with, and managing a very difficult and demanding client group.
References


