The Rural Experience of Psychotherapy with Borderline Patients

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Impulsive, acting-out patients present management problems; these problems are greatly intensified when the therapists and the individual in treatment live in the same rural community. Confidentiality and maintenance of professional boundaries are two particularly difficult issues. The authors of this paper each have treated a number of borderline personality disordered individuals successfully while living in rural upstate New Hampshire. The first portion of this paper summarizes their shared observations of the issues which distinguish small town practice from work in an urban setting. This overview then is followed by three case examples illustrating the dynamics described.

The developing of community mental health centers has introduced psychotherapy to rural America during the last decade. Theoretic understanding of the psychodynamics of individuals is useful in whatever setting

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a clinician works, but mental health practitioners working in small towns recognize that psychiatric concepts taught in academic settings have evolved in an urban content. One’s therapeutic stance and techniques must be adapted. Until recently there was a dearth of literature dealing with the aspects of rural psychotherapy. In the article “Transition from Urban to Rural Mental Health Practice” (Riggs & Kugel, 1976), the authors examined the experience of culture shock which most psychotherapists encounter as they move from the megalopolis and their university to small town settings.

The high visibility of individuals living in a small community intrudes upon the psychotherapeutic process. This paper addresses itself to the problems met by the psychotherapist in a small town. These problems exist in all therapy relationships. They are most dramatic when working with a borderline personality disordered person because of the character style of such persons.

The authors live in a rural county in the White Mountains of Northern New Hampshire. It is a federally-designated poverty area whose chief source of income is tourism. One of the writers has been a resident for 35 years. The first 18 years were spent raising a family and as a layperson participating in community affairs. In 1964, when she resumed her professional career, she provided services as a staff member of the state program for alcoholics and other drug abusers. From 1973 to the present she has been in private practice. The other writer has worked for Carroll County Mental Health Service since 1972. She previously had worked in an urban mental health clinic.

Relevant Aspects of the Small Town Experience

Upon moving into a small town from an urban setting one initially is struck by the loss of personal privacy. New arrivals to a small town are the subject of much curiosity and speculation. Information about new people is exchanged within the small town network until each person is categorized and comfortably incorporated. This process helps to maintain the community’s social homeostasis. There is a need to label and to know each person. Once this is completed, the person tends not to be the subject of gossip unless the community notes a change in behavior. If a person deviates from an established pattern, however, the community’s attention again will become focused upon that person.

Small town relationships are composed of interlocking networks. There is social stability in New England towns, as they consist of large, extended families. Although the family may complain about a person’s behavior, there is little recognition that the process of change promoted by therapy may alienate that person from relatives and fellow townsmen. A
person's own resistance to change interacts with that of the community's resistance. Together they retard the progress of the individual's therapy.

A mental health professional is perceived by the community as a resource for the greater human services network. It is common practice for a professional to be asked to serve on volunteer boards of directors for other human service agencies or to serve in an advisory capacity. If the individual chooses to respond to these requests, situations may arise in which the professional is a board member to, and a psychotherapist for, the same person. In urban practice it is feasible to be active in one's community's affairs and to practice clinically in another community. The rural therapist encounters a conflict. As a social worker, one is charged to foster the total social services network. In contrast, as a psychotherapist one ideally would remain anonymous.

The multiple role relationship also enters into situations with other individuals in the community. It is not unusual for a rural therapist to receive some type of service from a person who is also a patient. S(he) may be the gas station attendant, the cocktail waitress, the cashier at the check-out stand at the supermarket, a craftsman, or the lawyer's secretary. S(he) also may be a staff member of another social agency with whom the therapist needs to collaborate. In a small community such experiences are unavoidable.

Another characteristic of small towns which impinges on treatment approaches has to do with limited resources. In our county there are no psychiatric inpatient beds. The nearest private psychiatric hospital is a 2-hour drive through several mountain passes. The only state mental hospital is a 2-hour drive to the south. If a person requires psychiatric hospitalization it severely limits the therapist's ability to continue concurrent treatment sessions. In instances in which the local hospital is an appropriate option, the therapist must maintain an awareness that these hospitals are staffed by members of the community network. The information which is recorded in the medical charts may not be kept confidential. The therapist must work with staff nurses, aides, and doctors, many of whom have had little experience with psychiatric patients and therefore resent their presence in the hospital. Despite these problems, local hospitalization is of great value because it ensures continuity of treatment which may shorten a regressive episode.

There are a number of other advantages inherent in working with rural community resources. The therapist becomes familiar with those persons working in the human services network. This facilitates the developing and maintaining of a consistent treatment plan. It offers many informal opportunities to educate community caregivers about psychological concepts. Also, the therapist often knows many of the people mentioned by the patient, which provides a broader base of knowledge from which to work.
The Issue of Confidentiality

Maintaining confidentiality in a therapy relationship is understood to be central to the development of trust. In a rural setting the fact of being in therapy generally is known by the community. Concerned residents feel entitled to receive reports about the progress of their neighbor who is coming for treatment. When told that this would be a breach of professional ethics, frequently the enquirer responds with anger, stating that s/he is a person who can be trusted and needs help in understanding her or his neighbor. In time, a therapist learns a style of responding to requests for information that does not alienate the questioner and, at the same time, preserves the patient’s privacy.

Extended families make it difficult for the therapist to maintain confidentiality. One of the author’s first cases at the mental health clinic was a young borderline man who recently had taken an overdose of amphetamines. The receptionist working at the clinic was distantly related to him. One of the patient’s parents was then serving on the clinic’s board of directors. Understandably, this made the initial establishment of trust in the therapy relationship more difficult. The therapist experienced more pressure to help the patient improve; the patient had difficulty trusting that his feelings and problems would be held confidential.

Another problem area affecting confidentiality in the rural clinic is the fact that community mental health centers are funded through multiple sources. Carroll County Mental Health Service receives monies voted on at town meetings in each of the towns of the county, as well as from the county appropriations. This makes stringent demands on the clinic, as the funding sources expect direct accounting of how funds are spent. Town selectmen and members of the county delegation want information about the treatment we are providing. When working with an acting-out borderline personality, it is difficult to maintain confidentiality without the possibility of jeopardizing one or several of the funding sources.

Borderline Personality Organization

The behavior patterns of the borderline personality disorder are characterized by acting-out. This makes the development of the therapeutic alliance difficult. In the context of small town work described above, the difficulties become even more dramatic.

The diagnostic category of the borderline personality disorder has been described clearly in the literature in the past 10 years. Individuals presenting with this personality disorder initially are difficult to diagnose. They are characterized by areas of healthy psychosocial functioning existing with relatively severe psychopathology. As infants, they received adequate nur-
turing to which the coping part of themselves gives testimony. It is believed etiologically that these persons experienced a significant emotional loss some time between 18 and 36 months of age. Typically, their parenting was characterized by double binds; they received the message that they should not leave their mother’s presence, but simultaneously were pushed away harshly.

Borderline persons experience a desire to fuse with the person whom they trust. At the same time, they experience terror when they begin to develop a sense of closeness. They tend to act out, with drug abuse, sexual promiscuity, and suicidal gesturing common. Some borderline personalities are subject to fleeting psychotic episodes which can present difficult management issues.

Otto Kernberg’s paper “Borderline Personality Organization (Kernberg, 1967) identifies specific defensive operations which typify borderline persons. Included among these are the mechanism of splitting, a tendency toward primitive idealization, a use of early forms of projection, especially projective identification, and heavy usage of denial. These defensive maneuvers combine to produce an intense volatile transference which often involves continuous testing of the therapist.

The Therapist

The community’s perception of the borderline individual is a contradictory picture. Sometimes the image is one of a productive, competent person; on other occasions, it is of a highly disturbed person. To deal with being a psychotherapist in a small town requires a high degree of comfort with one’s professionalism. The community expects the therapist to make patients behave properly. A therapist rejects the role of agent of social control. Dealing with these conflicting demands challenges a therapist to grow. To be so closely scrutinized requires mature ego strengths and comfort with one’s own humanness.

The social life of a small town psychotherapist can overlap with her professional practice. Accepting a social invitation can result in an embarrassing situation. After living in Conway for a year, one of the authors was invited to a neighbor’s party. One of her patients, a young man, diagnosed as borderline, arrived. He shrieked her name and left abruptly. Understandably, this created an uncomfortable situation for everyone. Equally, it created additional barriers to forming a therapeutic alliance with this patient.

In “The Bipersonal Field” (Langs, 1976), Langs emphasizes the importance of maintaining the boundaries of the psychotherapeutic relationship. In a small town the psychotherapist has little control over the degree or frequency of out-of-the-office encounters with patients. A brief example
illustrates. After a particularly difficult therapy hour a borderline patient in her mid-40s left angrily, stating that she doubted she would be alive at the time their next appointment was scheduled. By happenstance, both therapist and patient chose that particular afternoon to buy dog food. Since the patient felt conflicted about her large number of household pets, meeting her therapist at the pet aisle inadvertently offered her support. This implied support made her anger less accessible at a time when it was therapeutically useful.

Our examples demonstrate that a therapist living in a small town does not have clear boundaries between professional practice and private life. A therapist must consistently examine the diverse contacts with each patient and openly discuss the feelings which are provoked. Working with borderline patients, a therapist experiences "intensive emotional reactions having more to do with the patient's premature, intense and chaotic transference and with the therapist's capacity to withstand psychological stress and anxiety, than with any specific problem of the therapist's past" (Kernberg, 1975, P. 54). The countertransference provoked by working with borderline patients is intensified in the small town setting. The therapist constantly must be processing the effect of events such as those we have described above to obtain an accurate perspective.

Case Examples

When a therapist is confident, the difficulties we have enumerated may be worked through satisfactorily. We offer three case vignettes as examples. Details have been altered out of respect for confidentiality.

1. Mrs. Wood was a married, middle-aged mother of three children. She was a college graduate who held a professional job. Initially she sought treatment because of fears of going mad. She experienced intrusive thoughts of her husband's infidelity and was having violent, uncontrollable temper tantrums which included head banging. The Woods had been married for 25 years. During the last 5 years, Mr. Wood was spending longer periods away from home working as a traveling salesman. Their marriage was a passionate, violent relationship. Mr. Wood drank heavily. Their frequent arguments often were physical. Mrs. Wood had been to the hospital emergency room for stitches on several occasions, but would not consider legal action as she believed her husband was entitled to beat her.

After several years of treatment she came to the clinic in crisis, stating that her husband finally had proved her suspicions to be correct. She stated that he had been having an affair with a young woman. Mrs. Wood expressed the fixed belief that she was dead. She felt empty. For the first time she also began drinking heavily. Her actions became increasingly im-
pusive. Finally she called the clinic emergency service stating that she had taken an overdose.

She lived 30 miles from the general hospital. It was apparent that she was unable to drive. Mr. Wood was not able to be located. In keeping with the clinic practice, the sheriff’s department was contacted, and they in turn located the two part-time town policemen (one a full-time teacher, the other a store clerk). The situation was described to them. They agreed to transport Mrs. Wood to the hospital. When the officers arrived Mrs. Wood refused to accompany them. She became involved in a physical brawl which resulted in both officers sustaining injuries and their finally making the decision to leave her at home. Later, in response to what he perceived as an assault upon his wife, Mr. Wood made verbal threats to the therapist that he intended to kill the officers.

As a result of this crisis, the Woods reconciled and united against the town’s police force. Mrs. Wood’s suicidal potential diminished significantly and she was able to continue in treatment. The therapist met with the police to warn them of the threat. The opportunity was employed to offer them some information about psychological issues such as suicidal behavior and to explain to them this couple’s pattern of interaction. The officers agreed to maintain a low profile in the Wood’s neighborhood. They experienced relief for the opportunity to ventilate their fears and anxieties about the possibility of violence. Mr. Wood was told that the therapist would need to meet with the officers. It was requested of the officers that the meeting not become community knowledge. The request was honored.

Treatment with Mrs. Wood continued satisfactorily. Although plagued by intrusive, uncontrollable thoughts and frequent arguments with her husband, she was able to teach and maintain her home. Her use of splitting actually allowed her to tolerate the therapist’s intervention by blaming the officers for the episode. She was able to work through her rage toward them and accept their role as helpers.

This case illustrates a situation in which the rural therapist was needed by both the police and the patient.

2. Mrs. Grace was a warm, motherly person, in body form and personality. In her late 30s, she was mother of four, divorced, and on welfare. Her behavior patterns exhibited extremes; at times she hardly met her children’s physical needs, at other times she obsessively baked for them and was a model mother, encouraging her children’s individual interests. She frequently humiliated them with her neighborhood quarrels when she was “hitting the bottle”.

Mrs. Grace took an active and creative part in local politics. The community’s response to her was sympathetic. They saw her as a lonely, single parent with responsibility for four children. This provided an element of
secondary gain. She befriended an older man who provided her with companionship and relief from her demanding role. But her spirit was not satisfied. She obtained employment in a Federal Project Office and did well. However, she clashed with her young, aspiring, male chauvinist boss and missed many days of work. Some days she was only able to tolerate the work situation by having a beer for lunch at the local pub.

Mrs. Grace responded initially to therapy with intense and vacillating emotions. She felt delight in being accepted and feeling understood. She experienced anger when the therapist was not able to change things for her. This intense transference is typical of borderline personalities.

A crisis occurred after a therapy session in which she was more realistically confronting herself. Agitated, she roamed the town streets that evening. Her high school daughter called the police in response to her own feelings of rejection and abandonment. Although Mrs. Grace’s drinking was known to the police, she was sober that night. The police took her to the hospital emergency room and she was hospitalized by her family physician. This physician originally had referred her for therapy. By the next day, the physician had made arrangements for her commitment to the state hospital without consulting the therapist. He had long dealt with her personal and family needs and was alternately sympathetic, annoyed, and despairing. He was unwilling to reverse his decision. (This, the therapist reflected ironically, was Mrs. Grace’s reward for working hard in therapy.) The therapist visited her several times in the state hospital and was warmly received as “my psychologist”. However, she did not return to therapy when she was discharged. Later, when she did, she gave the therapist a severe dressing down. Her loud voice and its angry tones completely disrupted the therapy sessions going on in adjacent offices. The therapist was, in Mrs. Grace’s belief, responsible for her commitment. She had been rejected and abandoned. The sharp contrast in her behaviors toward the therapist reflects the defensive mechanism of splitting. Therapy continued sporadically but the therapeutic alliance had been damaged.

This is an example of how a borderline woman was seen by different factions of the community. Several years after this episode Mrs. Grace met her therapist by happenstance. She told her in her effusive manner that she had found a job which better fitted her personality needs and enabled her to get off welfare. With an upsurge of self-esteem she had stopped drinking, lost weight, and found an acceptable peace with the world. Here we see another feature of the borderline syndrome. In contrast to Mrs. Grace’s pathological behavior, she also exhibited healthy psychosocial functioning.

3. Miss White was a young woman in her early 20s who had been in continuous treatment for 4 years. While in treatment she made numerous
suicidal gestures such as cutting her wrists, taking overdoses, and drunk driving, which resulted in two destroyed cars. Her sexual functioning was characterized by both homo- and heterosexual relationships. She had had two abortions. While engaged in this acting-out behavior she maintained a sufficiently low profile so that her community reputation continued to be that of a shy young girl.

The operation of splitting was evident in a succession of relationships in which she acted out against the therapist by becoming engaged with other care-givers in the community, from whom she received reports of the therapist’s incompetence. For example, there was a lawyer in the community who had long offered informal counseling. He was instrumental in the opening of the community mental health center, but later felt threatened by the young professionals hired to work there. He expressed hostility by claiming that the staff was unqualified and incompetent. Miss White frequently brought stories of the lawyer’s negative perception of her therapist. Since this lawyer was a major community figure, it placed additional pressure on the therapist’s work with a difficult patient.

Miss White also had considerable skills as a caterer. She successfully worked for several of the therapist’s colleagues in this capacity. This posed a dilemma for the therapist. If the therapist chose not to attend a party, in consideration of the therapeutic alliance, she felt resentment. If she attended the party, it provoked intense fantasies for the patient, which then were addressed in the therapy hour.

Summary

This paper has highlighted some difficulties of practicing psychotherapy in a small town with particular emphasis placed upon persons diagnosed as borderline personality disorder.

We offer the following guidelines as aids to therapists new to a rural practice:

1. Learn both the formal and informal networks of community caregivers.

2. Develop personal relationships with these care-givers to facilitate good communication during times of stress.

3. Be sure to structure time each week for case discussion of both transferential and countertransferential issues. It is imperative that the private practitioner plan to meet these needs (i.e., the authors have met weekly in peer consultation for the past 10 years).
4. Take advantage of emergency episodes and mutual case involvement, for teaching opportunities.

5. Recognize that a rural practice provides you with an opportunity to develop and maintain a realistic perspective on the impact of your work.

6. Develop a comfortable balance between the activities of your professional work and your recreational pursuits.

7. Learn to recognize when you need to “get out of town” for a breath of fresh air or a relaxing vacation.

Our belief, which reflects our experience, is that as professional confidence evolves, the small town experience of being a psychotherapist is particularly humanizing and rewarding.

References

