Adaptive institutional transference in the treatment of individuals with borderline personality disorder

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The author introduces “adaptive institutional transference” (AIT) and describes how it develops in some patients in response to psychotherapist transfer in psychology training clinics. Individuals with borderline personality disorder are especially likely to develop AIT because of difficulties related to abandonment depression. Directors, supervisors, and student psychotherapists in a variety of training settings should be aware of these dynamics because of their important treatment implications, which are described. Limitations and ideas for future exploratory and qualitative research are also discussed. (Bulletin of the Menninger Clinic, 76[4], 297–313)

Individuals who need low-cost mental health treatment can receive services in a training clinic (Todd, Kurcias, & Gloster, 1994). In this setting, student psychotherapists (e.g., psychology intern, psychiatry resident, social work intern) benefit from gaining experience with close supervision from licensed professionals in their field, and patients benefit from low-cost quality services. Clients, however, often have to cope with their psychotherapist leaving the training clinic, which can be disruptive to their treatment. Depending on patient needs and the length of time each psychotherapist works in the clinic, a patient might be transferred to multiple students throughout long-term treatment. These dynamics can lead to the development of institutional transference (Goldsmith, 1970).
Transference exists when a patient ascribes the qualities of a person from his or her past to the psychotherapist (Gabbard, 2004). Reider (1953) coined the term institutional transference, which refers to the patient’s transference to a clinic rather than to a psychotherapist. He and Safirstein (1973) posited that patients who demonstrate institutional transference lack the qualities needed to develop transference with a psychotherapist and develop transference to an institution instead. The most recent theoretical paper on institutional transference (i.e., Martin, 1989), however, proposed that this understanding of institutional transference was unnecessarily pathologizing. Martin (1989) purported that many patients demonstrate transference to both an institution and a psychotherapist, signifying that the presence of institutional transference does not inherently reflect an inability to develop transference in a relationship. Although no theoretical articles have been published on this topic in more than two decades, institutional transference undoubtedly continues to exist, and it is important for directors, supervisors, and student psychotherapists to understand how it operates in a training clinic.

Various types of patients who might exhibit institutional transference have been described in the literature. Theorists such as Reider (1953), Safirstein (1973), and Byrne and Valdiserri (1982) consistently noted that individuals who tend to use the defense of idealization and who deeply fear feeling abandoned are likely to have transference to an institution. Individuals with borderline personality disorder tend to have these experiences and are potentially more likely than other populations to exhibit institutional transference. The current paper will focus on illuminating not only how institutional transference might operate in a contemporary training clinic, but will also consider how this is relevant to the treatment of individuals with borderline personality disorder through the use of a case illustration. Furthermore, the term adaptive institutional transference (AIT) will be introduced to describe a form of institutional transference that can facilitate the treatment of individuals with borderline personality disorder. Finally, implications of AIT for training clinic directors, supervisors, and student psychotherapists will be discussed.
In 1953, Reider described his observation of a set of patients who tended to accept resident psychotherapist transfers without any reported feeling of loss. He noticed that these patients had transference to the clinic rather than to the psychotherapists with whom they worked. He described this as institutional transference. Throughout the literature, there are various descriptions of the characteristics of individuals who demonstrate institutional transference. This type of patient tends to have an “impersonal attitude toward their therapists” (Reider, 1953, p. 58). The patient has difficulty describing individual psychotherapists and is more apt to talk about the staff as a whole or about the institution. The patient might also talk about getting needs met by the clinic, rather than by the psychotherapist. This impersonal aspect of institutional transference allows the patient to adequately tolerate the transfer to a new psychotherapist (Safirstein, 1973).

The literature also describes the ritualistic nature of the patient’s relationship to the clinic. Reider (1953) wrote about patients who kept their appointments at the clinic even though their psychotherapist was on vacation. Gendel and Reiser (1981) described a case in which the patient went to a certain business, such as a bank, before each appointment. The patient might also arrive well ahead of scheduled sessions and sit in the waiting room until the session starts (Safirstein, 1973). Idealization of the institution is another characteristic of institutional transference. A patient with an early developmental arrest might attribute the idealized image of a parental figure to the institution rather than to the psychotherapist (Reider, 1953). Idealization aids the transition between psychotherapists because the patient accepts the new psychotherapist based on the belief that she or he must be good because she or he works at the institution, regardless of other seemingly more important factors such as level of experience.

Theorists also hypothesized about why institutional transference occurs with some patients more than others. Reider (1953) purported that a patient with institutional transference appears to struggle with how to meet narcissistic needs while fearing that the person who fulfills those needs (i.e., the psychotherapist) will abandon her or him prematurely if there is any expression of dis-
content about the transferring of psychotherapists. Reider added that this type of patient often tends to pay low fees for services because they are provided by students and thus the patient does not feel entitled to complain about clinic practices. He proposed that transference to the clinic, which is inanimate, but also permanent, can be viewed as a resolution of this conflict. Reider (1953) found that many of these patients had lost a parent early in life and then idealized the surviving parent, while others had traumatic events in their histories that led to isolation. More generally, he postulated that a common component of institutional transference is “regaining a lost omnipotence by participating in a great organization” (Reider, 1953, p. 62).

Reider’s (1953) and Safirstein’s (1973) conceptualization of institutional transference laid the groundwork for future discussions of this topic. Later writings included the observation that some individuals exhibit institutional transference along with transference to their psychotherapists. For example, Gendel and Reiser (1981) presented a case study in which the patient demonstrated both types of transference; the authors stated that a patient such as theirs “will very much mind changing therapists” (p. 510). Similarly, Martin (1989) stated that the early writings on institutional transference offered a narrow and potentially pathologizing view of the subject.

Martin (1989) contributed to the understanding of this phenomenon by identifying and describing four subtypes of patients who develop institutional transference. He described Type 1 patients as those who do not develop transference to their psychotherapists and may or may not develop transference to the institution. Type 2 patients demonstrate transference to both the psychotherapist and the institution. Martin (1989) noted that some patients at the Veterans Administration Medical Center (VAMC), for example, come to the hospital and sit in the waiting areas or cafeteria when they do not have appointments. While this likely reflects institutional transference, it does not indicate that the patient does not also have a transference relationship with the psychotherapist. Type 3 patients develop an institutional transference that they then indiscriminately assign to all who are associated with the given institution. The transference is not
necessarily positive and idealized, as Reider (1953) and Safirstein (1973) described, but it could be related to negative associations to early relationships in life. Type 4 patients exhibit institutional transference that is “a reasonable adaptation to reality” (Martin, 1989, p. 60). The reality Martin described is the training institution dynamic in which student psychotherapists rotate often and the patient’s care is transferred repeatedly. Some patients cope with this by developing transference to the more stable and predictable institution, rather than to the ever-changing psychotherapist. These patients absolutely may also have the capacity to have transference to a psychotherapist, but this is not manifested because of how they adapt to this reality.

The literature on institutional transference, from Reider’s (1953) coining of the term to Martin’s (1989) elaboration on the concept, focused not only on describing the phenomenon, but also on understanding who might exhibit this type of transference. As described here, Reider (1953) wrote about these clients’ fear of losing the relationship with a psychotherapist. Multiple theorists also commented on the idealized nature of the transference. Byrne and Valdiserri (1982) stated that institutional transference is most likely to occur in patients who perceive individual relationships as threatening. Fear of abandonment, idealization, and the perception of others as threatening are all common characteristics of individuals with borderline personality disorder. In order to understand how institutional transference affects the treatment of individuals with borderline personality disorder, it is helpful to first review some of the literature related to this disorder and how the holding environment is a crucial component of treatment.

Borderline personality disorder and the holding environment

Borderline personality disorder can be understood with respect to two different diagnostic systems. The first is rooted in traditional psychoanalytic theory and speaks to a level of personality organization in which the person has better reality testing and less internal chaos than an individual with a psychotic organization, but more instability and less integration than a person with a neurotic
organization (Kernberg & Michels, 2009). The second system, which is that of the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM-IV-TR; American Psychiatric Association, 2000), states that borderline personality disorder is marked by a “pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity” (p. 706). This description is subsumed in the traditional psychoanalytic description (Kernberg & Michels, 2009).

When being treated in a training clinic, an individual with borderline personality disorder will likely work through concerns related to abandonment with each psychotherapist transfer. Masterson’s (1988) description of the development and treatment of this population provides a useful framework when trying to understand how institutional transference can impact treatment of this population in this setting. He wrote that for individuals with borderline personality disorder, each person, the world, and even the individuals themselves appear hostile and have the potential to leave them feeling abandoned. These patients are consumed with trying to arrange their life so that they can ward off the painful feelings associated with this abandonment depression.

Masterson (1988) identified that the primary goal of the treatment with this population is to create a genuine therapeutic alliance. This requires that the patient be in touch with his or her real self, rather than the false self that tries to ward off abandonment depression. She or he must also have an accurate (i.e., not idealized or devalued) perception of the psychotherapist. Similarly, Clarkin, Yeomans, and Kernberg (2006) described the working alliance as one in which there is collaboration between the psychotherapist and the healthy aspects of the client. Building a genuine alliance is relevant to institutional transference, in which the idealized transference of the clinic is displaced onto the psychotherapist. According to Masterson (1988), working through abandonment depression is a main component of overcoming idealization and creating a true alliance. This involves empathically pointing out the patient’s use of the false self to ward off abandonment depression, while accepting the patient’s display of the real self.
The acquisition of a genuine therapeutic alliance is facilitated by the presence of a holding environment (Chessick, 1979). Winnicott (1965) coined the term holding environment and used it to liken aspects of the therapeutic relationship to the mother–child relationship. Chessick (1979) wrote about how to achieve a “good enough holding” (p. 536), which he identified as the key to attaining a working alliance with the client. This type of holding environment allows the patient to feel safe enough to regress. In this regressed state, the patient can work through early experiences by being in touch with genuine affects. This allows the patient to identify with the real self and work through transference to the therapist, which is based on these early experiences. The holding environment helps contain the patient through this difficult process and creates a reliable and consistent therapeutic environment (Rucker & Slater, 1983), which the patient will eventually be able to create independently (Gunderson, 2001). Modell (1976) proposed that the existence of a holding environment allows a patient to move through the stages of psychoanalysis. Giovacchini (1993) similarly identified that the “principle analytic task is to create a setting in which the patient can comfortably regress” (p. 231). Thus, the literature clearly supports the notion that developing a therapeutic alliance with a patient with borderline personality disorder is not possible without the presence of a holding environment.

Adaptive institutional transference

The nature of the contemporary training clinic setting creates a barrier to the preservation of the holding environment. This barrier exists because student psychotherapists only work in the clinic for a few years as they progress through graduate school. If a patient requires treatment that lasts longer than this time frame, she or he will inevitably have to be transferred to another psychotherapist. Each termination will involve the ending of the particular holding environment created in that unique patient–therapist relationship. Transfers can particularly affect individuals with borderline personality disorder because long-term psychodynamic treatment is indicated for this population (Gunderson &
Gabbard, 1999). With each transfer, the new psychotherapist will begin the process of creating a holding environment for the patient again and working toward a therapeutic alliance. Thus, the long-term treatment of individuals with borderline personality disorder can be greatly disrupted due to the parameters of receiving care in a training clinic. AIT, however, appears to ameliorate this problem.

AIT has characteristics similar to those of traditional institutional transference (e.g., impersonal and ritualistic) and some properties of Martin’s (1989) types, but it is distinct in an important way. In AIT, the patient adapts to the reality of psychotherapist transfers by developing institutional transference. This is similar to Martin’s (1989) Type 4, but the development of AIT does not preclude the patient from also developing transference to each psychotherapist with whom she or he works. Rather, the transference to the clinic is what allows the patient to develop transference to the psychotherapist. The Type 2 patient identified by Martin (1989) also develops transference to both the institution and the psychotherapist, but as he described it, this is not in the context of psychotherapist transfer. Thus, AIT is proposed as a type of institutional transference that serves a different function than those identified by Martin (1989). In AIT, the patient adaptively develops institutional transference to cope with the reality of transfers, which allows for the development of transference relationships with each psychotherapist through the existence of an external, sustainable holding environment.

The nature of AIT is such that the institution is experienced as a holding environment, which allows the patient to feel protected and safe with respect to the institution. Thus, when the inevitable psychotherapist transfer occurs, the patient can maintain a level of safety and stability that would not be present if the patient did not develop AIT. Various theorists have commented on how an institution (i.e., not only a therapeutic relationship) can exhibit the properties of a holding environment. For example, Twemlow, Fonagy, and Sacco (2002) compared the school setting to a holding environment, highlighting the fact that the broader environment within an institution can serve the functions of a holding environment. Importantly, de Bosset (1984) compared the clini-
cal setting to a holding environment because it can provide the structure necessary for the patient to be able to develop a therapeutic alliance.

As noted above, AIT may be especially relevant to individuals with borderline personality disorder because of the long-term nature of their treatment needs. In the context of a training clinic, these patients are potentially faced with the prospect of feeling abandoned by their psychotherapist multiple times. Masterson (1988) described the significant impact that the fear of abandonment can have on a patient as she or he utilizes defenses to ward off the associated depressive feelings. The attachment to the clinic in AIT makes it less likely that the patient will feel such intense fear of abandonment depression because of the comfort provided by the holding environment. The most significant consequence of this aspect of AIT is that the patient feels safe and secure enough to develop transference to each psychotherapist, with full awareness of the time-limited nature of the relationship, and without having to completely recreate the holding environment in order to work toward a genuine therapeutic alliance.

Case illustration

In the third year of this author’s doctoral training in clinical psychology, a transfer patient was referred to this author from another student psychotherapist who was terminating treatment with her patient because she was departing for an internship. The description of this clinical case illustrates and provides evidence of how AIT can operate in the treatment of an individual with borderline personality disorder. The patient’s name and all potentially identifying information about her have been changed to protect confidentiality.

When this author started working with her, Sara was a 56-year-old single male-to-female transgender lesbian woman. At the time she started seeing me, she had been treated in the psychology training clinic for 6 years, and this author was her fifth psychotherapist. Sara initially presented to treatment to gain support around her decision to transition from male to female. Throughout treatment, her psychotherapists gained a better diagnostic un-
derstanding of her clinical presentation, which reflected borderline personality disorder. Sara described her childhood as lonely and recalled many incidents of being verbally and occasionally physically abused by her family and peers because of her gender expression. Sara was strongly rejected for who she was. This author worked with Sara in psychotherapy for 2 years before she was transferred to her sixth psychotherapist because of this author's departure for internship. Evidence of Sara’s transference to both the clinic and to her psychotherapists was apparent in my experience with her, reviewing her chart, and consulting with my supervisor, who had also supervised Sara’s third psychotherapist.

A crucial component of Sara’s AIT was that she perceived the atmosphere of the training clinic to be a holding environment. This was evident in her first year at the training clinic. For example, it was at the training clinic that Sara began to experiment with dressing as a woman. She arrived even earlier than usual to her appointments to change into women’s clothing and to apply makeup in the clinic restroom. She then sat in the waiting room dressed as a woman while she waited for her appointment. In order for Sara to do this, she had to feel safe and confident enough that she would not be rejected for expressing who she really was. Importantly, this feeling of safety was present in the clinic itself, not only in the therapeutic relationship.

Sara also expressed qualities that are consistent with those described in the traditional understanding of institutional transference. When describing the impersonal nature of the relationship to the psychotherapist, Reider (1953) provided the example of the patient going to the clinic to get her needs met, rather than to her psychotherapist. Similarly, Sara spoke about her psychotherapists meeting her needs, but she also used the clinic itself to meet her needs when her psychotherapist could not. For example, her third psychotherapist went out of town one week, and this left Sara feeling deep emotions associated with abandonment depression. In response to these emotions, she showed up at the clinic because she “needed care,” even though her psychotherapist was not there. Sara had developed a positive-enough transference relationship to the clinic that she believed the clinic could meet her needs, which, importantly, it did. When Sara was distressed, she
knew that coming to the clinic would soothe her. She ended up speaking with various staff members at the clinic and the psychotherapist’s supervisor. Staff worked with her to cope with issues related to suicidal ideation and housing stress. Simply sitting alone in one of the clinic therapy rooms also effectively soothed Sara.

Sara’s behaviors outside of the therapeutic hour also provide evidence of the ritualistic nature of institutional transference. Throughout treatment with her five psychotherapists, Sara tended to arrive to sessions at least 1 hour before the scheduled appointment time. During this time, she went to the restroom, purchased a specific drink from the vending machine, and sat in the waiting room. She checked in at the front desk after being at the clinic for at least 20 minutes and signed in the same way each time. Following each session, she expected her psychotherapist to walk her to the front desk and give her a clinic appointment card. From these examples of the impersonal and ritualistic nature of the transference, it is evident that Sara demonstrated institutional transference to the training clinic and that she experienced the atmosphere of the clinic as a holding environment. The development of institutional transference in Sara’s case was adaptive, and thus is an example of AIT.

AIT aided in the transition between psychotherapists and also in building transference relationships with each psychotherapist, while working toward achieving a true therapeutic alliance. Sara showed signs of abandonment depression when her first psychotherapist talked to her about termination. She responded with acting-out behavior and shared her feelings that she was not important and was being left behind while the psychotherapist moved on with her life. The prospect of losing the holding environment and transference relationship with the psychotherapist was initially devastating for Sara. However, she ended up transitioning to her new psychotherapist with relative ease. This process was aided by Sara’s utilization of the holding environment of the clinic, which did not change or “reject” her. Additionally, Sara always had a contact person (e.g., the clinic director) to call if needed during transition periods, which provided her with continuity and security and decreased her feelings of abandonment.
By the time Sara was working with her third psychotherapist, her transference to the training clinic was much more apparent. Concurrently, she was able to develop a much more reality-based transference relationship with her third psychotherapist than the two before. She developed a ritual by which she eased into each successive psychotherapy relationship. This involved showing her new psychotherapist pictures of herself as a young boy and adult male. She also discussed media resources that were important to her. Although somewhat rigid, this ritual allowed her to quickly show aspects of her real self and to have them accepted. This adaptive response to transitions allowed her to build a connection with each successive psychotherapist more easily. Over time, Sara also became more aware of her reactions to terminations and faced some of her genuine emotions related to abandonment depression.

Negative transference with respect to both the clinic and her therapists often emerged when Sara was confronted with abandonment depression. For example, in therapy with this author, Sara stated that she hated all of her therapists and the clinic around the time of year when transfers typically occurred (i.e., August). The intense negative transference Sara felt was displaced onto the clinic because at this point in therapy she did not feel safe enough to tell this author that she deeply feared being “abandoned.” Importantly, Sara was eventually able to discuss these fears, which were related to her true self and helped to work toward a genuine alliance. Toward the end of therapy, when faced with termination, she was able to express her feelings of hate toward this author. Sara and this author were then able to explicitly work through her feelings of abandonment depression and negative transference in the context of the relationship.

Documenting all of the impressive progress that Sara made is unfortunately beyond the scope of this article; these gains were possible because she did not have to completely recreate feelings of security in each relationship because the training clinic “held” her between transfers. Throughout these difficult transitions, Sara’s real self was continually accepted by the clinic and her psychotherapists. It is doubtful that this would have happened in the
same way if she had not developed transference to the training clinic.

Summary and conclusions

Adaptive institutional transference is a phenomenon that is especially common in training clinics and other locations where student psychotherapists complete their practicum or internship work. AIT is not only relevant to the field of psychology, but also may apply to settings such as psychiatric residencies, social work training locations, and any other settings in which patients are commonly transferred. AIT has some of the same characteristics of traditional institutional transference, but it is not viewed as a sign that the patient cannot have transference relationships to other people, including the psychotherapist. Rather, AIT serves an adaptive function in that it can help a patient with borderline personality disorder to feel a sense of safety and stability through difficult transition periods. This enables the patient to start a new psychotherapist relationship feeling more secure than if all aspects of his or her therapeutic environment had changed. Additionally, AIT helps a patient with borderline personality disorder to better manage feelings of abandonment depression.

It is important for directors, supervisors, and student psychotherapists in training clinics to fully understand the dynamics of AIT because it has important treatment implications. Todd, Deane, and Bragdon (2003) proposed that environmental factors, such as the therapist’s completion of training, are more likely to influence treatment in long-term therapy than in short-term therapy. Thus, the issue of patient transfer and AIT is particularly relevant in clinics that allow for long-term work to be done. Martin (1989) underscored the fact that making a correct assessment of institutional transference has important impacts on treatment. Such assessment can prevent a psychotherapist from inaccurately assuming that its presence means that the patient cannot connect with his or her psychotherapist. With increased knowledge of how AIT operates in a given patient, the supervisor and the student psychotherapist can develop a more accurate conceptualization and accordingly make more effective treatment decisions.
Additionally, the director of a training clinic may have a unique perspective on a patient’s AIT that possibly the psychotherapist and the supervisor may not have because they are new to the case. This perspective may inform decisions that the director makes regarding case assignment and also the patient’s course of treatment. For example, the clinic director may be in the position to assess whether or not the AIT is continuing to serve the patient, rather than negatively affecting care in some way (e.g., the patient is not working on issues related to abandonment depression in the therapy).

AIT can possibly create difficulties in treatment in addition to the potential benefits. Byrne and Valdiserri (1982) studied institutional transference in a VAMC and identified both positive and negative effects on treatment. They observed that a patient could develop negative transference to an institution, which could impact the patient’s view of the psychotherapist. It is especially important for student psychotherapists to be aware of this so that they can accurately understand the transference and not take it personally, which student psychotherapists might be prone to do. Supervisors can help student psychotherapists become aware of these dynamics. Furthermore, AIT can potentially produce negative iatrogenic effects. For example, over time, the patient may begin to believe that she or he cannot function without the training clinic, which could impede progress. Training clinic directors should be aware of this possibility because they are likely in the best position within the clinic to track the patient’s progress over an extended period of time. AIT might also prevent the patient from truly working through abandonment depression in the way that Masterson (1988) recommends because the patient is somewhat protected from the intense feelings that accompany this depression. Again, supervisors and student psychotherapists should be aware of this possibility, and directors should be aware of their unique role.

Along with being conscious of both the positive and negative consequences of AIT, student psychotherapists should also pay attention to their countertransference reactions to the patient’s transference. Gendel and Reiser (1981) noted that a psychotherapist who receives a transfer case might feel anxious about work-
ing with the patient differently from past psychotherapists. Thus, one recommendation is for psychotherapists who work with a patient with AIT to avoid becoming overwhelmed with concern to be like past psychotherapists or to fit into the patient's transference to the clinic. Additionally, Gunderson (1992) pointed out the importance of realizing that each psychotherapist who works with an individual with borderline personality disorder is likely part of a “bucket brigade” of psychotherapists (p. 297). He noted that the patient likely uses each psychotherapist with whom she or he works in distinct and important ways. Supervisors can help the student psychotherapist gain awareness of these potential countertransference reactions related to AIT.

The current article has various limitations, which lead to suggestions for future research. First, this author's observation of AIT occurred with one patient in one treatment setting. AIT likely exists in other settings (e.g., psychiatry residencies) and with other patients, but generalizations are limited based on only one case illustration. A second limitation is that much of the literature on institutional transference is dated and clinical settings have changed over time. Although the current article addresses this lapse in the literature, studies regarding the presence of institutional transference in general are needed. Future exploratory research could study the prevalence of AIT and explore what populations, other than individuals with borderline personality disorder, tend to exhibit AIT (e.g., veterans at VAMCs). Qualitative research could be conducted to understand what exact properties of institutional transference are similar to those of a holding environment. Additionally, program evaluation research could focus on service utilization and outcomes of individuals who present with AIT. This research could guide clinical decision making and improvement of patient care. Future research in these areas would lead to a better understanding of AIT, which could have important implications for the treatment of individuals who manifest AIT and would also offer more guidance to training clinic directors, supervisors, and student psychotherapists.
References


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