REMEDIATION FOR TREATMENT-RESISTANT BORDERLINE PERSONALITY DISORDER:
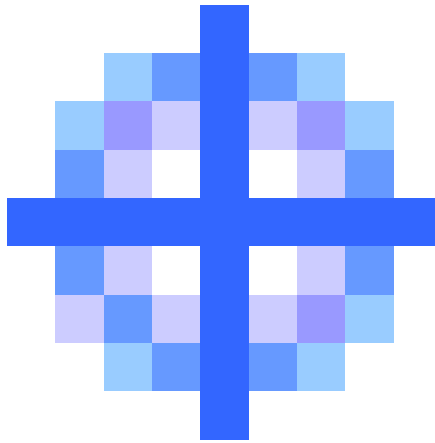
Manual of Dynamic Deconstructive Psychotherapy

Robert J. Gregory, M.D.

DDP

Clinical, Training, and Research Manual
of
Dynamic Deconstructive Psychotherapy ©

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TABLE OF CONTENTS

PREFACE

I have written this manual in order to present a training tool for treatment of borderline personality disorder (BPD), especially for those patients who are most challenging to engage in a therapeutic relationship, such as those having substance use disorders. The purpose is to delineate an approach that is evidence-based, reliable, time-limited, and relatively easy to learn. On the other hand, I am well aware of the dangers of oversimplifying human pathos and imposing a reductionistic and rigid treatment model that disregards individual differences. I have therefore attempted to maintain a balance between clarity and complexity and a broad enough framework to accommodate different patient needs and individual therapist styles of interaction.

In this manual I introduce a treatment paradigm, labeled dynamic deconstructive psychotherapy (DDP). The theoretical basis for DDP integrates translational neuroscience with object relations theory and Jacques Derrida's deconstruction philosophy. These three frameworks are surprisingly compatible with one another, and each contributes a useful perspective on borderline pathology and treatment. Case vignettes are utilized throughout the manual to illustrate key points. Each patient provided consent for use of video recorded material in scientific publications. Nevertheless, each vignette has undergone careful editing to disguise any identifying information and maintain confidentiality.

The manual incorporates both theory and technique to take the reader step by step through key concepts and treatment interventions. The first two chapters summarize the treatment model. The next two chapters, *Establishing the Frame* and *Stages of Therapy*, provide a chronological sequence of treatment, focusing on the major tasks, themes, and interventions that characterize each stage. The following three chapters, *The Therapeutic Stance, States of Being,* and *The Deconstructive Experience,* focus more in depth on the patient-therapist relationship, including how to promote a therapeutic alliance, reflective functioning, and individuated relatedness, and how to recognize and disrupt emerging enactments. The next two chapters, *Specific Techniques* and *Psychotropic Medications*, delineate core DDP interventions, as well as provide a brief summary of principles of medication management. The DDP interventions are organized by the specific neuroaffective deficit that is being targeted for remediation. Each section also contains a list of proscribed interventions. These chapters are followed by a discussion of circumstances that sometimes require modification of technique, summarized in three chapters entitled, *Psychiatric Comorbidity, Special Situations,* and *Medical Care.* The final chapter, *Developing a DDP Program*, contains guidelines for readers to develop their own training and/or clinical program in DDP and the requirements for achieving certification of competency.

There is no theoretical explication in the manual of relative contributions of the genetic and developmental factors that lead to this pathology. This is because the etiology is still under investigation and speculation regarding origin risks creating a false sense of surety about the disorder that could unfairly label or stigmatize patients and/or family members. There is evidence supporting both developmental determinants (Battle et al., 2004; Johnson et al., 2006), intergenerational transmission (Weiss et al., 1996), as well as genetic factors (Kendler et al., 2008; Distel et al., 2008; Silverman et al., 1991; Torgersen et al., 2000). But their relative contribution likely varies among different individuals with the disorder.

The term *deconstructive* in labeling the treatment method is not meant to indicate a radical departure from accepted practices or to indicate a destructive process, but rather to describe a confluence between deconstruction theory and a specific subset of psychoanalytic theory and technique. To give a few examples, the psychoanalytic emphasis on neutrality that maintains a non-judgmental and non-directive stance, is consistent with the deconstructive emphasis on openness to the *other*. The concept of splitting can be usefully compared to the deconstructive concept of binary oppositions within a text and intolerance of ambiguity. Psychoanalytic concepts of observing ego, empathy, and mentalization can be seen as elements of *alterity* and the movement from subjectivity to objectivity.

Throughout the book, I have endeavored to maintain a multidisciplinary and pantheoretical orientation. It is likely to be as relevant to psychiatrists as it is to psychologists, clinical social workers, and other mental health practitioners. In explaining concepts and methods, I have intentionally attempted

to maintain language that is shared across most mental health disciplines. Nevertheless, I employ some terms and concepts from the psychoanalytic, philosophical, and neuroscience literatures that I realize many readers will find challenging to grasp. I did not want to gloss over difficult but relevant concepts for the sake of simplicity. I have a deep respect for the complexity, individuality, and endless enigma of the human experience. My experience with trainees who have employed the manual is that it can be read on many levels.

Some therapists will have more difficulty than others in learning and applying the techniques outlined in the manual. The reliance on moment-by-moment inter-subjective experience in DDP presumes some degree of self-awareness and self-acceptance, toleration of uncertainty and ambiguity, humility, and openness to change on the part of the therapist (Fishman, 1999). However, after many years of training therapists in these techniques, the most common reason I have observed for therapists' failure to reliably implement the treatment is reluctance to give up sources of gratification inherent in idealized, authoritative therapist roles.   It can be very difficult for many therapists to be truly non-judgmental and to withhold a profound pronouncement, validation, interpretation, or sage advice.

Empirical research on DDP is substantial and ongoing, and includes theoretical papers, two randomized controlled trials with follow-up, two naturalistic cohort studies, a brief training paper, and a study of mechanisms. This research is summarized on the DDP website: www.upstate.edu/ddp. Approximately 90% of patients who stay in DDP for a full year of treatment will achieve substantial improvement in symptoms and functioning (Gregory et al., 2008; Gregory, Delucia-Deranja, & Mogle, 2010; Gregory & Sachdeva, 2016). Because of strong evidence for effectiveness, the federal agency SAMHSA classified DDP as a program "with evidence of effectiveness" on its Suicide Prevention Resource Center website: https://www.sprc.org/resources-programs/dynamic-deconstructive-psychotherapy-ddp

Independent ratings of video recorded DDP sessions indicate that adherence to DDP techniques is strongly correlated with treatment outcome (Goldman & Gregory, 2009; 2010). This finding suggests that the treatment works in a specific way to effect change, rather than relying primarily on factors common to all therapies. Because of the importance of treatment adherence in optimizing outcomes in this challenging patient population, I have included the DDP Adherence Scale, along with instructions for rating, in an appendix to this manual. I recommend employing the scale for monitoring adherence to DDP in clinical, teaching, and/or research programs that wish to incorporate this promising treatment approach.

Chapter 1. CONCEPTUALIZATION OF BORDERLINE PERSONALITY DISORDER

Between the too warm flesh of the literal event and the cold skin of the concept runs meaning **(Derrida, 1978, p. 75)**

The term, borderline personality disorder (BPD), derives from an older psychoanalytic term of "borderline personality organization". A borderline level of personality organization was originally meant to describe patients who are neither psychotic nor neurotic, but intermediate or on the "borderline" between these two levels of organization (Stern, 1938). Kernberg (1967) elaborated this concept in a seminal paper and defined borderline as having a characteristic triad of identity diffusion, generally intact reality testing, and the use of maladaptive defense mechanisms, especially splitting. Borrowing from psychoanalytic perspectives of borderline personality organization, Gunderson (1984) helped to establish borderline personality disorder in formal psychiatric nomenclature as a disorder of identity and self. According to the DSM-5 (American Psychiatric Association, 2013), "the essential feature of borderline personality disorder is a pervasive pattern of instability of interpersonal relationships, self-image, and affects" (p. 663). To meet diagnostic criteria for BPD, persons must have at least 5 of the 9 symptoms outlined in Figure 1-1. These symptoms are highly correlated with one another, supporting the validity of the construct of BPD (Clifton, 2007; Johansen, Karterud, Pedersen, Gude, & Falkum, 2004).

Although the diagnosis of BPD has been shown to be valid and reliable, the mechanisms and etiology of the disorder are still very controversial. The present chapter lays out a theory postulating that the phenomenology of the disorder is accounted for by a combination of an imbedded sense of badness and specific neuroaffective deficits in processing of emotional experiences.

Figure 1-1: DSM-5 diagnostic criteria of borderline personality disorder

1. Frantic efforts to avoid real or imagined abandonment.
2. Unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance misuse, reckless driving, binge eating).
5. Recurrent suicidal behavior or threats, or self-mutilating behavior.
6. Instability of mood and marked reactivity of mood.
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger.
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

EMBEDDED BADNESS

Clinical experience, as well as research findings, suggest that a core difficulty of BPD is a deeply embedded and often unconscious self-perception of inherent badness, i.e. evil, defective, worthless, lazy, or ugly (Gregory, 2004; Gunderson, 1984; Rüsch et al., 2007). This sense of badness is often not immediately apparent and difficult to measure in research studies since it can be repressed and denied, even to the point that patients can appear grandiose with an inflated self-appraisal for much of the time, or denigrate others as a way to protect against feelings of shame. The badness can also be projected onto others, such that BPD patients can become mistrustful, avoidant, or rejection sensitive (Berenson et al.,

2018). The projected badness can appear in creative activities or in dreams, often as dangerous shadowy figures chasing the patient.

Causes for embedded badness may be manifold. In his work with traumatized and delinquent children, Fairbairn (1943, 1944) noted that they were prone to sacrifice their self-esteem and develop an inner sense of badness in an attempt to maintain an idealized image of an abusive parent. Fairbairn hypothesized that the child splits the image of the abusive parent into both good and bad objects and internalizes the *bad object* so as to maintain the fantasy of the parent as the idealized *good object*. Thus the child is sacrificing his/her own self-esteem and developing a sense of embedded badness by taking on all the responsibility for the abuse in order to maintain the fantasy of an idealized, safe caregiver.

Both trauma and neglect have been associated with the development of BPD in longitudinal studies (Johnson, Cohen, Chen, Kasen, & Brook, 2006). However, many patients with BPD have no history of trauma or neglect, and an embedded sense of inner badness might result from teasing or bullying at school, problematic early mother-infant attachment (Green & Goldwyn, 2002), or inherited tendencies towards social inhibition, impulsive aggression, or negative affectivity (Conway, Hammen, & Brennan, 2015; Kendler et al., 2008).

Regardless of cause, embedded badness can account for much of BPD pathology, such as chronic dysphoria and low self-esteem, mistrust and bouts of hostility when the badness is projected onto others, episodes of severe depression and suicide ideation when the badness is put on oneself, and tendencies towards self-damaging behaviors, such as cutting or purging. From a social perspective, it may lead to feelings of embarrassment and anxiety around others assuming others are judging them or laughing at them, a continuous need for reassurance, and trying to put up a false and compliant front. Imbedded badness also leads to self-doubt and poor assertiveness in relationships, partly accounting for the tendency of individuals with BPD to get into abusive or maladaptive relationships. They develop a core conflict around issues of justification in relationships, asking themselves: "Do I have a right to be angry?" or "Are my needs legitimate?" (see Chapter 4: *Stages of Therapy*).

Interventions that attempt to persuade and reassure BPD patients out of their sense of badness are generally ineffective, especially in the early stages of treatment. Such efforts often come across as unempathic, as though the listener does not understand how very bad the patient really is. Instead, it is first necessary to remediate the neuroaffective deficits that interfere with a person's ability to identify, acknowledge, and accept painful emotions and attributes that have been avoided or split off. When negative emotions and painful conflicts can be more fully verbalized and symbolized, it becomes possible to gradually work towards acceptance of limitations of oneself and others, self-compassion, realistic self-esteem, and more authentic and fulfilling relationships. The capacity for acknowledging and tolerating strong emotions, as well as the capacity for authentic relationships, have been shown to be key capacities needed to develop long-term, secure intimate relationships (Waldinger & Schulz, 2016).

NEUROAFFECTIVE DEFICITS IN SELF-STRUCTURE

The neuroaffective deficits of BPD do not involve problems with intelligence, but rather involve problems with the emotion processing system. In order to have a coherent, stable, and differentiated self, it is necessary to have three essential neuroaffective capacities. These include the ability to verbally represent experiences, to develop complex and integrated attributions of these experiences, and to be able to assess the accuracy of attributions and motivations. Thematically, these could be expressed as: "What do I experience?" "What do I believe and want?" "Are my beliefs and wants realistic?" Gregory and Remen (2008) have labeled the corresponding three neuroaffective functions as *association, attribution*, and *alterity*.

1. Association – *What do I experience?*
Figure 1-2 is a simplified diagrammatic display of adaptive processing of emotional experiences. The first step needed for adaptive processing is to encode our experiences into language, metaphor, and other symbols, so that they can be acknowledged, understood and communicated (Bucci, 2002). A

provocative interpersonal encounter creates an affective response, which is experienced in the body. Depending on the functioning of the emotional processing system, the individual will then either automatically react in a fight or flight response, or try to make sense of this experience by creating a verbal symbolic description. The ability to put the experience into words, label emotional reactions, and link them to the initial provoking event, dampens arousal and enables rational decision-making for next steps (Lieberman et al., 2007). As individuals repeatedly make these links between interpersonal encounters and emotional responses, they encode these links into their implicit memories, and they develop a complex set of expectations and attributions regarding themselves and others, which has been called a schema or representational system. For example, when someone makes a demeaning comment, most people will respond by creating an internal dialogue, acknowledging to themselves how that person is making them feel. They may then ask themselves whether the demeaning comment is accurate or whether the person was making an unjustified attack and respond accordingly.

Figure 1-2: Adaptive emotion processing of experience
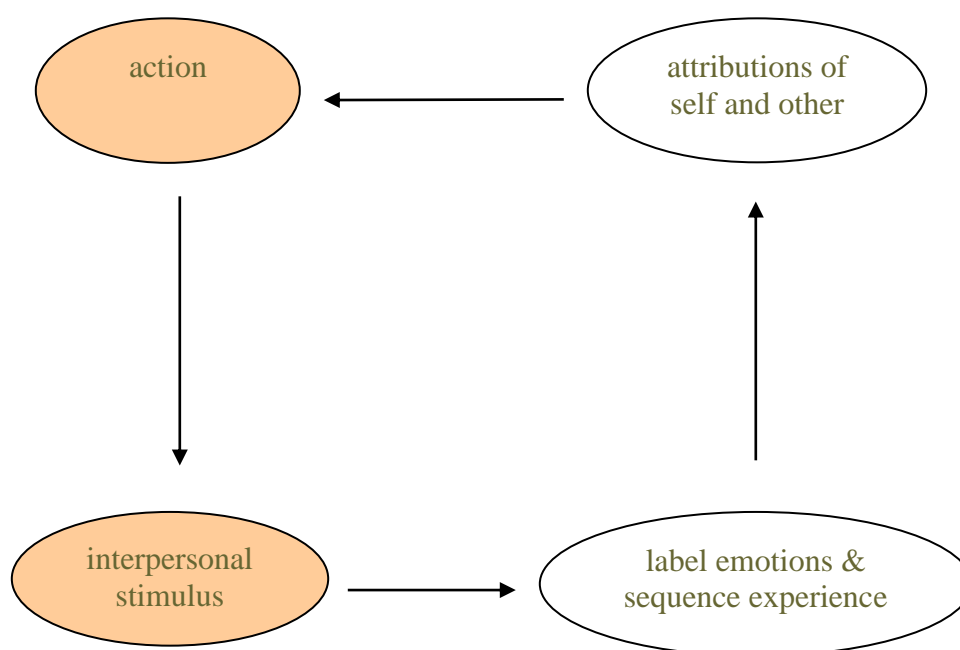
The labeling and sequencing of one's emotional experiences I am calling *association* functions. This capacity helps connect us to our experiences and verbally represent them, so that they do not overwhelm us. This function also begins to create a reflective space between the experiencing and observing parts of the self so that we are able to comment on our experiences in an internal dialogue and communicate them with others. The ability to observe, label, and comment on one's experiences provides self-soothing functions and is an essential component of consciousness and a subjective sense of self.

As Figure 1-3 schematically displays, a key hypothesized functional deficit of BPD is the ability to verbally represent emotional experiences. Persons with BPD often have a rich ability to employ abstract metaphors and visual symbols through poetry and art, but have much difficulty consciously linking their verbal symbolic capacity to their experiences. They often have difficulty interpreting their poetry or art, labeling a particular emotion, or even acknowledging words that they just employed (Ebner-Priemer et al., 2007; Levine, Marziali, & Hood, 1997; Zlotnick, Mattia, & Zimmerman, 2001).

Figure 1-3: Emotion processing in borderline personality disorder
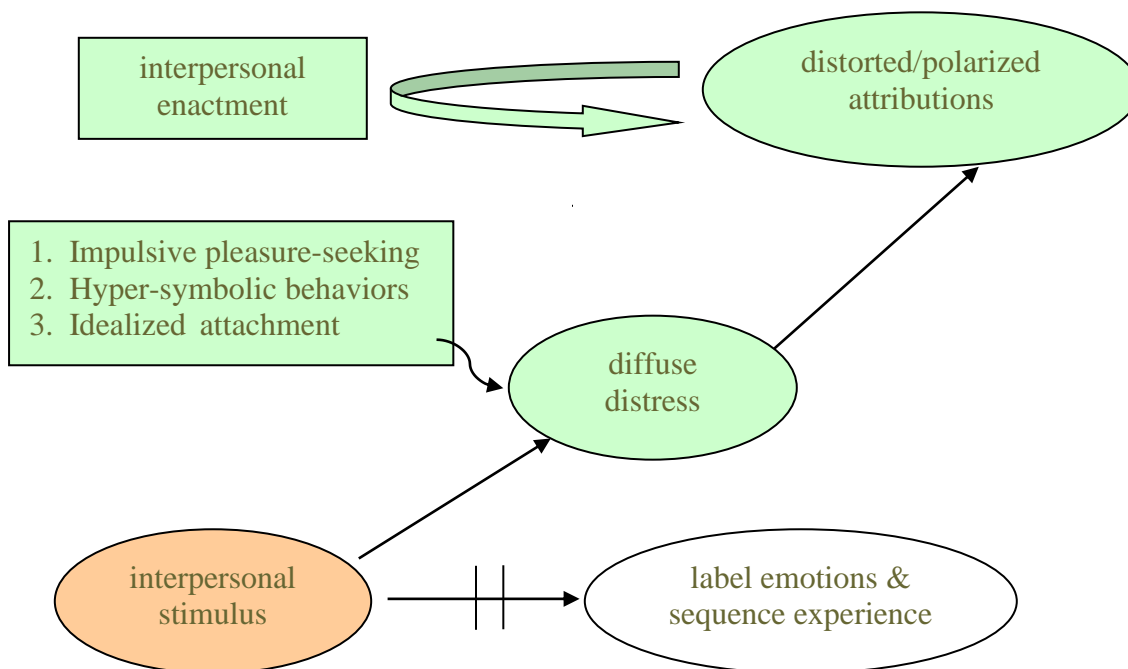
This deficit in verbal symbolic capacity contributes to difficulty in the ability to consciously link affective responses to precipitating events. More specifically, individuals with BPD often have a limited ability to coherently narrate specific emotionally-charged interpersonal encounters and put events, emotions, and actions into a clear sequence, a capacity that has been called episodic or autobiographical memory (Beran, Richman, & Unoka, 2019). For example, they may complain of depression or anxiety that comes "out of the blue" and not be able to identify the specific event that triggered their change in mood. Alternatively, some individuals may produce over-general memories and describe general patterns of interaction instead of specific incidents. For example, they may glibly verbalize a litany of complaints about how a given person has mistreated them, but may stutter and stammer when asked to provide a specific example. A deficit in episodic memory and tendency to produce over-general memories has been linked to depression, dissociation, post-traumatic stress disorder, eating disorders, and suicide attempts (Arntz, Meeren, & Wessel, 2002; Heard, Startup, Swales, Williams, & Jones, 1999; Williams et al., 2007).

Episodic memory deficits are most often seen when BPD is accompanied by dissociative symptoms (Fonagy et al., 1996) or by an *incoherent/disorganized* attachment style on the adult attachment interview (Levy et al., 2006; Westen, Nakash, Cannon, & Bradley, 2006). Individuals with severe association deficits may have disorganization, confusion, memory lapses, and incoherence of narratives when describing emotionally evocative events. Narrative accounts of social interactions may suddenly and repeatedly switch contexts to different persons, places, or times. The listener ends up feeling very confused, as well as often bored and detached. Clinical experience suggests that the disorganized subgroup of patients need considerable work early in the treatment on helping them to make basic narrative connections.

The inability to identify, acknowledge, and sequence emotional experiences contributes to a poor ability to self-sooth, distress intolerance, and the use of maladaptive coping (Bornovalova et al., 2008). It also leads to feelings of emptiness and lack of a subjective sense of self (Johansen et al., 2016).

2. **Attribution** – *What do I believe and want?*

In addition to association functions, a second neuroaffective component of our emotion processing involves attributing meaning to those experiences. We learn what responses and behaviors to expect from ourselves in diverse situations, and what kind of responses to expect from others. We make attributions regarding responsibility, praise, and blame, portioning out agency to self or others according to the situation.

This capacity to form complex and coherent attributions of oneself and others is deficient in persons with BPD. Instead, they tend to form simplistic and polarized attributions of their experiences (Coifman, Berenson, Rafaeli, & Downey, 2012). Representations of self and others are distorted and poorly integrated (Berenson et al., 2018; Semerari et al., 2005). Thus the person with BPD lives in a black and white fantasy world, full of cardboard cut-out villains and heroes. Polarization of self and other attributions into all-good and all-bad when combined with the polarized responses this induces in caregivers, has been labeled *splitting* in the psychoanalytic literature (Kernberg, 1975).

 Polarized attributions may serve to help limit the pain and dysfunction of embedded badness. One strategy for coping with embedded badness is to split off negative self-attributions from consciousness and project those onto others. Employing this strategy, self-image is transformed into an all-good idealized self-image, innocent of any wrong-doing, whereas others are perceived as trouble-makers. However, this coping strategy is unstable, and persons with BPD often alternate between a self-image that is either all-good or all-bad. The oscillation in self-image contributes to an identity disturbance, to an unstable relatedness pattern of idealization and devaluation, and to symptoms of mood lability (Koenigsberg et al., 2001). When the self is perceived as all-bad, then mood becomes depressed, but relatedness is maintained with an all-good other. When the badness is projected onto others, then mood becomes angry or elated, but relatedness is compromised (see chapter on *States of Being*).

Another function of a polarized attribution system is to maintain a sense of certainty. Research in experimental psychology suggests that uncertainty drives our tendencies to make attributions of causality (Burger & Hemans, 1988; Pittman & Pittman, 1980; Weiner, 1985). Because of their inability to verbally represent their emotional experiences, persons with BPD are essentially emotionally "blind" and live in an uncertain world. The absence of an emotion anchor when combined with over-general memories may lead individuals to make black and white, polarized attributions and thereby eliminate ambiguity and create an artificial sense of certainty (Viamontes & Beitman, 2006).

A common manifestation of the need for certainty is a need for complete understanding from others (Bateman, 1996; Shapiro, 1992). Individual may employ a binary system of logic and attribution that excludes alternative perspectives that may create ambiguity. For example, they may tell their therapists, "If you really cared about me, then you would let me call more often. All you care about is your money!" On the surface, the proposition appears logical and irrefutable. However, there is an underlying assumption that the therapist's primary mission should be to care and nurture their patients like a mother. There is also an implied dichotomy or split in the perspective of the therapist as either totally caring and accommodative, or totally cold and callous. There is no room in such a polarized attribution system for a more ambiguous and realistic perspective of the therapist as having complex motivations, including some genuine caring for the patient, but within certain limits.

3. **Alterity** – *Are my beliefs and wants realistic?*

Although an ability to verbally represent experiences and attribute complex and coherent meanings to them is necessary for a subjective sense of self, an additional neuroaffective capacity is needed in order to develop a differentiated self that is capable of self-soothing and individuated relatedness. *Alterity* is a word meaning *otherness,* borrowed from the philosophical literature. Alterity refers to a capacity to have a reference point outside the subjectivity of the self, what Derrida described as *an absolute outside* (Derrida, 1978, p. 106). This is analogous to a ship's need for an outside reference point, such as a lighthouse, star system, or satellite, in order to know its position.

An outside reference point enables us to have a dual consciousness of simultaneous subjectivity and objectivity. One aspect of alterity is therefore the capacity to reflect on our attributions and motivations from an outside or "objective" perspective, i.e. "How realistic are my attributions and motivations?" When the capacity for alterity is diminished, individuals live in a magical world, where subjectivity is ungrounded in reality. In this magical world, behaviors such as cutting, purging, restricting, and substance use can take on special significance and be used for coping (Gregory & Mustata, 2012). For example, a person with an alterity deficit can cut his/her arm and believe that the blood pouring out of the body is "the badness flowing out of me." In this instance, the blood symbolizes the self's inner badness that is released from the body. Likewise alcohol and other drugs can magically substitute for interpersonal relationships ("my best friend is the bottle") and thus help meet attachment needs (see chapter on *Psychiatric Comorbidity* for further discussion).

Alterity also enables us to realistically appraise the attributions and motivations of others; a capacity that has been termed *mentalization* (Fonagy & Target, 1996), derived from *theory of mind* (Premack & Woodruff, 1978). Individuals with BPD may scan others for social cues and then make very distorted and polarized attributions of them in the face of contradictory evidence, which has been called *hypermentalization* (Sharp & Vanwoerden, 2015). For example, persons with BPD have been shown to misread others' intentions in an economic game of trust, thus leading to poor overall performance (King-Casas et al., 2008).

Similarly, alterity includes the capacity to be authentic and differentiated in relationships, holding onto one's own attributions and motivations, while having a realistic appreciation of those of the person with whom one is in relationship. This capacity for an authentic duality in relationships can be called *individuated relatedness*. A deficit in *alterity* is characterized by lack of clear boundaries between self and other, including an inability to differentiate one's own emotions, attributions and motivations, from those of other people. Individuals with BPD adopt the values and opinions of the other person in order to maintain relatedness, much like a chameleon. Alternatively, in order to maintain a stable sense of self, they may distance themselves from others in a paranoid or narcissistic manner. For example, persons with BPD may assume that others are looking at them in a derogatory way, when in fact it is they themselves who are feeling ashamed.

In philosophical terms, the person with BPD can be viewed as having unchallenged and unlimited subjectivity and an inability to incorporate recollections of interpersonal experiences that are inconsistent with their expectations. Patients with BPD seem to be unable to learn from experience and repeat maladaptive interactions over and over again. They hold on tightly to their attributions and patterns of behaviors despite negative consequences.

What makes working with this population so difficult is the patient's ability to provoke others into responding in a way that is consistent with the patient's attributions and expectations. In other words, the patient expects others (including the therapist) to behave in a certain way and the therapist may feel compelled to behave in a way that is consistent with the patient's expectations, an interpersonal process that has been called *enactment*. The confluence between the patient's expectations of others and the actual behavior of the therapist results in reinforcing the patient's expectations and the distorted attributions of self and other upon which those expectations are based (see Figure 1-3). Therapists may have a difficult time discerning whether negative encounters with a patient resulted from the patient's attributions and responses or from the therapist's (Racker, 1957).

Healing comes, in part, from the patient's discovery of the person of the therapist as *not me* (i.e. contrary to stereotyped projected expectations). This discovery provides an essential outside reference point for defining the boundaries of the self. In order for patients to develop objectivity and differentiate self from other, the therapist must disrupt patient-therapist enactments by interacting in ways that challenge expectations and create opportunities for relating as two separate individuals. Derrida (1997a) addressed this issue as follows, "Separation is the condition of my relation to the other. I can address the other only to extent that there is a separation…so that I cannot replace the other and vice versa" (p. 14). The experience of achieving a relationship that is both close and separate is a novel experience for the BPD patient and is one of the goals of treatment.

NEUROBIOLOGY OF BPD

Neural networks for association, attribution, and alterity functions

In this section, I put forward the *Emotion Processing Hypothesis*. Instead of BPD being a disorder of emotion dysregulation, i.e. a problem with how patients regulate and cope with emotions, I am positing that BPD is a disorder of emotion processing. There is evidence to suggest that in normal and adaptive processing of emotional experience there is a lateral to medial movement of information through the prefrontal cortex and integration of cortical and subcortical neuronal networks. However, in response to interpersonal stress, persons with BPD appear to exhibit relatively less activation of the prefrontal cortices, greater activation of subcortical limbic structures, such as the ventral striatum and amygdala, and less integration of cortical and subcortical networks. These differences in processing of emotion processing through the central nervous system may account for the *association*, *attribution*, and *alterity* deficits mentioned in the previous section.

Association capacity, i.e. the encoding of emotional experience into language, may be mediated through the temporal lobes and prefrontal cortex. Within the medial temporal lobe, the posterior hippocampus may be responsible for integrating episodic memories with spatial-temporal contextual input from the parahippocampal cortex and the perirhinal cortex may place events into a temporal sequence (Eichenbaum, 2010; Naya & Suzuki, 2011; Smith, Henson, Dolan, & Rugg, 2004). Other cortical regions, including the insula, medial prefrontal and ventrolateral cortices may be responsible for encoding episodic memories and affect into language (Buccino, Binkofski, & Riggio, 2004; Nelissen, Luppino, Vanduffel, Rizzolatti, & Orban, 2005; Ochsner et al., 2004). There is also evidence that labeling of emotions requires coupling of prefrontal activity to the subcortical limbic system, perhaps mediated through the anterior cingulate gyrus (Lane et al., 1998; Lieberman et al., 2007; Wager, Davidson, Hughes, Lindquist, & Ochsner, 2007).

Self-referential capacity, including attribution and alterity, may be mediated by the default mode network. This network includes the medial posterior parietal regions, the inferior parietal lobules and the medial prefrontal cortex. These brain regions appear to be able to integrate information gleaned from association capacities into attributions of self and other. Attribution capacity may be mediated through medial posterior parietal regions, especially the precuneus and posterior cingulate cortex. These regions are highly active in the resting state and interconnected with other brain regions, including the thalamus, posterior hippocampus, and medial prefrontal cortex. Based on functional imaging and lesion studies, the precuneus and posterior cingulate cortex have been implicated in mediating awareness and ownership of one's body (Ruby & Decety, 2001; Vogt & Laureys, 2005), reflecting on one's personal characteristics (Delahoy et al., 2022; Kjaer, Nowak, & Lou, 2002; Lou, Nowak, & Kjaer, 2005) and those of others (Modinos, Ormel, & Aleman, 2009). Attributing agency to self versus others may be mediated via the cingulate cortex and mapped along anterior to posterior regions (Tomlin et al., 2006). Together, the studies suggest that these regions are responsible for maintaining attributions of self and others, states of being, embodiment, consciousness, and a subjective sense of self.

Whereas the medial parietal regions appear central to the capacity for attributions of self and other, the inferior parietal lobules and medial prefrontal cortex, including the anterior cingulate gyrus and Brodman areas 9, 10, and 11 appear to be responsible for the capacity of alterity. The inferior parietal lobules and medial prefrontal cortex are able to mediate the integration of new information from episodic memory and emotional cues, change attributions based on new information by inhibiting posterior medial parietal activity, and while accommodating a reflective and objective perspective on oneself (Delahoy et al., 2022; Koenigs & Tranel, 2007; Noël, Van Der Linden, & Bechara, 2006, Tse et al., 2011). The capacity to integrate new information and change attributions suggests that these regions mediate alterity functions. This hypothesis is supported by studies locating reflective functions, such as mentalization (Gallagher et al., 2000), empathy (Shamay-Tsoory, Tomer, Berger, Goldsher, & Aharon-Peretz-Tsoory, 2005), moral judgment (Greene & Haidt, 2002), toleration of uncertainty (Krain et al., 2006), and self-awareness (Gusnard, Akbudak, Shulman, & Raichle, 2001) to the medial prefrontal cortex. Furthermore,

imaging studies suggest that idealized love can deactivate the medial prefrontal cortex, i.e. "love is blind" (Bartels & Zeki, 2004).

This region also appears to be responsible for self-other differentiation, an important aspect of alterity (Mitchell, Banaji, & Macrae, 2005). Mentalizing about others deemed similar to oneself activates the ventral region of the medial prefrontal cortex (BA 9), whereas mentalizing about others deemed different from oneself activates the dorsal region (BA 10, 11).

Aberrant networks of borderline personality disorder

Instead of verbal/symbolic linking and reflective modulation in a lateral to medial processing through the temporal lobe and prefrontal cortex, emotional experiences in persons with BPD appear to be processed through pathways in the subcortical limbic system. Structural and functional deficits have been identified in regions responsible for emotion processing, including the amygdala, hippocampus, anterior cingulate gyrus, and medial prefrontal cortex (Aguilar-Ortiz et al., 2018; Bohus, Schmahl, & Lieb, 2004; Nunes et al., 2009; Schmahl & Bremner, 2006).

Patients with BPD respond to emotional stimuli, such as facial expressions, trauma scripts, aversive pictures, or negative word cues, through greater activation of subcortical limbic structures, including the amygdala, anterior hippocampus, and anterior and ventral striatum than healthy controls (Donegan et al., 2003; Herpetz et al., 2001). Memory processes through the hippocampus change from nuanced and contextual memory consolidation of the posterior hippocampus and posterior association areas, to more rapid and automatic memory through the anterior hippocampus, dorsal striatum, and amygdala, leading to simplistic schema and impulsive reactions (Conny & Schwabe, 2018; Sekeres, Winocur, & Moscovitch, 2018).

On the other hand, there is relative deactivation of the subgenual cingulate gyrus and medial prefrontal cortex under conditions of strong emotional stimulation (Donegan et al., 2003; Schmahl, Vermetten, Elzinga, & Bremner, 2004; Silbersweig et al., 2007), as well as decoupling of limbic and cortical networks (New et al., 2007). One consequence of deactivating these regions is an *association* deficit characterized by difficulty encoding experience into language, including difficulty identifying, labeling, and acknowledging emotions (Ebner-Premier et al., 2007; Levine, Marziali, & Hood, 1997; Zlotnick, Mattia, & Zimmerman, 2001). Failure to identify and label emotions among individuals with BPD and other populations has been associated with hyperarousal, autonomic activation, and amygdala activity (Ebner-Premier et al., 2008; Gur et al., 2007; Lieberman et al., 2007). Thus, instead of being able to experience and describe discrete emotions in response to interpersonal encounters, individuals with BPD are likely to experience diffuse distress and/or sense of impending doom.

Amygdala activation triggers a primitive neural pathway labeled the PANIC system, which is associated with separation distress in laboratory animals and is mediated through glutamate transmission (Zellner, Watt, Solms, & Panksepp, 2011). Amygdala activation creates diffuse distress and hyperarousal, with symptoms of anxiety, restlessness, insomnia, and irritability (Ebner-Priemer et al., 2008; Fitzgerald, Angstadt, Jelsone, Nathan, & Phan, 2006; Stein, Simmons, Feinstein, & Paulus, 2007; Stiglmayr et al., 2005).

The PANIC system is down-regulated through kappa-opioid receptors. Individuals with BPD have been reported to have a deficiency in endogenous opioids (Stanley & Siever, 2010). It is possible that they are unable to turn off the PANIC system because of defective transmission to kappa-opioid receptors, contributing to symptoms of mood lability (Silvers et al., 2016). Furthermore, alterity deficits make it more difficult for persons with BPD to deactivate amygdala activity through cognitive strategies of reinterpretation of attributions or self-soothing as an outside observer, and may therefore contribute to distress intolerance (Koenigsberg et al., 2009; Silvers et al., 2016).

Commonly, individuals with BPD attempt to alleviate the distress of the PANIC system by either attempting to discharge unprocessed and overwhelming affect through self-destructive or hostile actions, or by engaging in self-soothing coping mechanisms that activate their ventral striatal region, such as seeking attachment figures for reassurance or impulsive pleasure-seeking. Panksepp has labeled the latter the SEEKING system, which seeks sensory rewards through attachment, substances, and other

pleasurable activities, such as shopping, gambling, or bingeing (Zellner et al., 2011). A hug and a drug can provide identical pleasure sensations and provide the same soothing qualities. The SEEKING system is mediated through mu-opioid receptors, which have been found to be up-regulated in BPD (Prossin, Silk, Love, & Zubieta, 2008). Animal and human studies have indicated that activation of the ventral striatum can modulate the amygdala (Ernst et al, 2005; Koelsch, Fritz, Cramon, Muller, & Friederici, 2006; Louilot, Simon, Taghzouti, & Le Moal, 1985; Yim & Morgenson, 1989). Thus activation of the SEEKING system may be an alternate coping strategy for individuals who are not able to employ to label emotions or to apply cognitive modulation of emotions through prefrontal pathways. In other words, persons with BPD employ limbic solutions to interpersonal problems. The mechanism may well account for impulsive pleasure seeking of persons with BPD, as well as their strong need for attachment.

Dissociation may be a second pathway through which individuals with BPD down-regulate hyperarousal and amygdala activation. Neuroimaging studies of patients with BPD have indicated that during conditions of aversive stimuli, increased dissociation is correlated with decreased activation of the amygdala (Hazlett et al., 2012; Krause-Utz et al., 2012).

It is unclear why persons with BPD have aberrant neural pathways and/or atrophy of the brain structures responsible for adaptive processing of emotional experience. Is it an inherited defect or are the biological deficits a result of adaptation to the early social environment? The best evidence is that both may be true, with the contribution of genes versus environment varying from one individual to another. Twin studies suggest an average heritability of approximately 46%, with the remaining risk accounted for by the childhood environment or by gene-environment interactions (Skoglund et al., 2021). There is evidence that some individuals are born with deficits in the emotion processing system, whereas with others experiences of trauma, neglect, or early attachment can cause atrophy of major brain pathways and structures (Lange et al., 2005; Pryce et al., 2004; Teicher et al., 2004). However, it is also possible that the shutting down of emotion processing serves a defensive function, enabling the person to block awareness of painful emotions and thus cope with severe interpersonal stresses. Defense may turn to defect over time if certain brain regions remain underutilized.

Chapter 2. OVERVIEW OF TREATMENT

The tension between play and presence. Play is the disruption of presence **(Derrida, 1978, p.292)**

Dynamic Deconstructive Psychotherapy (DDP) is a 12-month treatment for borderline personality disorder and other complex syndromes, such as alcohol or drug dependence, self-harm, eating disorders, posttraumatic stress disorder, chronic depression, and suicidality. DDP helps clients connect with their experiences and develop authentic and fulfilling connections with others. During weekly, 1-hour individually adapted sessions, clients discuss recent interpersonal experiences and label their emotions, reflect upon their experiences in increasingly integrative, accepting, and realistic ways, and learn how to develop close relationships with others while maintaining their own sense of self.

Treatment is divided into four stages (see chapter on *Stages of Therapy*). Twelve months is optimal for most patients to work through the stages. Setting the time frame at the beginning of treatment helps to establish the boundaries of the treatment relationship, limits excessive or prolonged dependency, and facilitates more rapid movement through the stages.

The four stages have overlapping tasks (see chapter on *Stages of Therapy*). The first stage involves establishing the treatment framework and the therapeutic alliance (see chapter on *Establishing the Frame*). The specific objectives for this stage include setting very clear roles and expectations for the treatment, encouraging autonomous motivation, and facilitating the kind of treatment relationship that will foster the development of *individuated relatedness*, i.e. the capacity to be authentic and differentiated in relationships, holding onto one's own attributions and motivations, while having a realistic appreciation of those of the person with whom one is in relationship (see previous chapter). Therapist facilitation of individuated relatedness involves avoiding authoritative assertions or giving advice, and being receptive to disagreements or criticisms. This may seem easy in theory but can be extremely difficult in practice and involves a certain amount of faith on the part of the therapist that the patients themselves are ultimately better able to find and decide upon the solutions for their own life problems.

Patients will develop a negative transference at various times, characterized by expectations for the therapist to be abandoning, humiliating, intrusive ineffective, or unreliable. These negative expectations need to be deconstructed in order to establish or restore the therapeutic alliance (see chapters on *States of Being* and *The Deconstructive Experience*).

During the first stage of treatment, therapists also begin to apply *association techniques* whereby patients recount recent interpersonal experiences, including identifying and acknowledging emotional reactions to the encounter, putting interactions into a chronological sequence, and linking emotions and events to maladaptive behaviors (see chapter on *Specific Techniques*). Very often, arousal and anxiety markedly diminish during this stage as patients begin to verbalize their experiences and an alliance is formed.   In a meta-analysis of studies of psychodynamic psychotherapy, a focus of helping patients to identify and verbalize their emotional experiences has been shown to be an important predictor for outcome (Diener, Hilsenroth, & Weinberger, 2007). In DDP research, association techniques have been shown to have a greater overall impact on outcomes than any other set of techniques (Goldman & Gregory, 2010).

During the second stage, patients continue to explore recent interpersonal experiences and become more aware of how they attribute meaning to experiences. The therapist employs more *attribution techniques* to help patients develop a more complex and integrated perspective on their experiences (see chapter on *Specific Techniques*). The therapist tries to stay neutral between two opposing attributions, neither supporting one side nor the other. In this way, polarized attributions turn into conscious conflicts that can be acknowledged and resolved (see chapter on *The Therapeutic Stance*).

The development of a capacity for *alterity* primarily occurs in the last two stages of treatment as patients begin to more realistically appraise their attributions and mourn the loss of idealized fantasies about self and others. The development of alterity entails coming to terms with the realities of past and

present relationships, experiences, and abilities. It includes mourning the loss of idealized fantasies regarding parental figures and of what was missing in childhood. Patients must also mourn the loss of grandiose fantasies and come to terms with the reality of their own limitations. In the final stage, patients must let go of idealizing fantasies they hold regarding the therapist and to understand that the therapist has a limited capacity for love and empathy, and can never complete what has been missing in the patient's life. The process of mourning limitations and the development of objectivity leads to self-acceptance, the capacity for empathy, and the development of more authentic and mutual relatedness.

       The therapist's general stance seeks a balance between satisfaction of the patient's wishes for a soothing, idealized therapy relationship, with the patient's needs for objectivity, individuation, and differentiation. The therapist must have the same qualities as transitional object, i.e. understanding and soothing like mother on the one hand, but separate or *not me* on the other hand (Winnicott, 1953). The therapist serves as an intermediary between self and *other*, where the *other* represents the real or the *not me*, as opposed to the imaginary projections of the self. The gradual introduction of the therapist's role as *Real Other* into the patient-therapist relationship facilitates the patient's capacity for authentic and individuated relatedness (see chapter on *The Deconstructive Experience*). The dual role of the therapist in DDP as intermediary between *Ideal Other* and *Real Other* is outlined in Figure 2-1.

Figure 2-1. Role of therapist as intermediary between self and other.
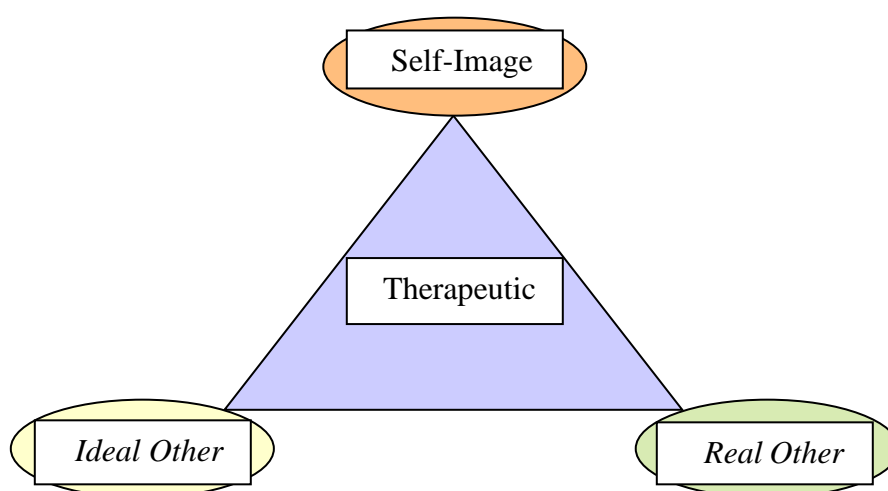
In summary, DDP interventions involve:

- Establishing an initial written treatment agreement, which includes explicit commitments for patient and therapist
- Fostering verbalization of recent affect-laden interpersonal experiences into simple narratives
- Exploring alternative or opposing attributions towards self and other, while remaining generally non-directive and non-judgmental
- Providing novel experiences in the patient-therapist relationship that promote self-other differentiation and deconstruct enactments
- Facilitating mourning regarding the limitations of self and others

Comparison with Other Psychodynamic Approaches

There are similarities and differences between DDP and other psychodynamic approaches to BPD. In fact, a typical session of DDP might look very similar to a typical session of other structured psychodynamic treatments; thus many of the differences are in emphasis, rather than absolutes.

Peter Fonagy (2000) has extended Bowlby's attachment theory to the etiology of borderline personality. He emphasizes a deficit in the capacity for reflection and understanding of self and others' mental states (*mentalization*) as the central problem in borderline pathology. The deficit in mentalization is thought to result from insecure attachment with mother and contributes to an identity disturbance (Fonagy, 1998).

Applying this theoretical model, Bateman and Fonagy (1999) demonstrated the effectiveness of a psychodynamically-oriented partial hospitalization program for patients with BPD. Self-destructive behaviors, inpatient days, depression, and social functioning demonstrated significantly greater improvement with psychodynamic treatment as compared to usual care. They have labeled their approach as *mentalization-based treatment* (MBT--Bateman & Fonagy, 2004). They emphasize exploration and clarification of perceptions and motivations of self and others in the here-and-now of the patient-therapist relationship and in other recent interpersonal interactions.

Like DDP, MBT posits that the development of the capacity for reflecting on experiences is a major goal of treatment. With both treatments, there is considerable time spent identifying and exploring specific emotions and linking them to stressors, wishes, and actions. However, DDP is more explicit in its emphasis on narrative construction and labeling emotions through association techniques and on the development of a differentiated self through transformative experiences within the patient-therapist relationship. MBT involves a more explicitly supportive and directive therapist stance than DDP.

American object relations models have emphasized drive theory, the structural model, and Kleinian theories of splitting. According to this theory, an excess of aggressive drive leads to dissociative splitting of the ego into positive and negative introjects and the use of other primitive defenses (Kernberg 1975). Each introject or ego state is dyadic and contains an "object image, connected with a complementary self-image and a certain affect disposition which was active at the time when that particular internalization took place" (Kernberg 1975, p.34). The clinical application of this theory, labeled *transference-focused psychotherapy* (TFP), involves bringing these conflicting self-other dyads into consciousness by clarifying and interpreting defenses employed in here-and-now interactions between the patient and therapist (Clarkin, Yeomans, & Kernberg, 2006). In a study comparing TFP to dialectical behavior therapy (DBT) and a manual-based supportive psychotherapy, Clarkin and colleagues (2007) demonstrated comparable 12-month efficacy among the three treatments, with TFP improving a wider range of outcomes.

Both DDP and TFP establish a detailed initial frame by defining the parameters of treatment and making treatment expectations clear and explicit. Clarification of role expectations within the patient-therapist relationship serves to contain neediness, anxiety, and aggression so that patients are less anxious regarding boundary violations and destructiveness.

Both DDP and TFP explore polarized attributions and attempt to help patients to work towards integrating them. TFP, however, focuses primarily on clarifying and interpreting the patient-therapist relationship. DDP's primary focus is on recent interpersonal encounters outside of the patient-therapist relationship, but will also address negative transference reactions. DDP is similar to the approach advocated by Buie and Adler (1982) in this respect, tolerating an idealized transference in the initial stages of treatment in order to facilitate soothing aspects of patient-therapist interactions. A positive transference serves to help the patient face difficult emotions and painful realities. However, in the final stage of therapy, the idealization of the therapist must also be deconstructed.

Although both treatments attempt to integrate polarized attributions, DDP more explicitly emphasizes narrative construction and emotion labeling through associative techniques. Moreover, a deconstructive experience between patient and therapist that promotes differentiation is considered an important component of recovery in DDP, but is not emphasized in TFP.

In addition to these differences in process, the treatment structure also differs in MBT and TFP. MBT involves weekly individual and group therapy and TFP involves twice weekly individual sessions with no clear limit on duration. DDP comprises only weekly individual sessions and has a predetermined duration.

In addition to MBT and TFP, unstructured forms of psychodynamic psychotherapy are often employed in the treatment of BPD. DDP is modified from unstructured psychodynamic psychotherapy as it is typically administered in the community in the following ways:

- Treatment includes an explicit written treatment contract and is time-limited
- The therapist does <u>not</u> link patient's current perceptions to experiences in the past or focus on childhood trauma, except sometimes in later stages
- The therapist does <u>not</u> focus on similarities among the patient's relationships repeated over time or setting
- The therapist does <u>not</u> attempt to interpret or make sense of the patient's experiences (except through *framing* interventions in Stage I)

Comparison with Cognitive-Behavioral and Supportive Approaches

A number of supportive and cognitive-behavioral approaches have been developed for treatment of BPD and have been tested in randomized controlled trials (Blum et al., 2002; Giesen-Bloo et al., 2006; Linehan, 1993; Rockland, 1992; Tyrer et al., 2004). Of these, DBT comes closest to DDP and has the most established track record (Linehan et al., 1991). Both DBT and DDP emphasize on-going clinical supervision of therapists and clear patient expectations, limits, and boundaries. Moreover, both attempt to establish links between stressors, emotions, and maladaptive or self-destructive behaviors.

However, there are important differences between DDP and DBT. They differ in their theoretical models of BPD pathology, goals of treatment, mechanisms for change, specific techniques, and therapist stance. Whereas DBT hypothesizes that BPD is a disorder of emotion regulation with inadequate control of negative emotions; DDP hypothesizes that BPD is a disorder of emotion processing and that both negative and positive emotions are healthy and adaptive. Whereas the DBT therapist explores interpersonal issues for the purpose of identifying problem areas and teaching new skills, the DDP therapist explores interpersonal issues for the purpose of remediating specific neuroaffective capacities and healing embedded badness.   Whereas the stance of the DBT therapist is that of an advisor, coach, and cheerleader, the DDP therapist avoids (as much as possible) imposing his/her own values or meanings.

Moreover, DDP is far less directive than DBT. DDP explicitly avoids advice, validation, problem-solving, or suggestions, and attempts to encourage a sense of ownership within patients for their treatment and recovery. A study by Karno and Longabaugh (2005) indicated that the outcome of alcoholic patients with moderate or high reactance is strongly and negatively related to the degree of therapist directiveness. Patients who have a co-occurring substance use disorder or those having narcissistic or antisocial traits may particularly benefit from less directive approaches.

Aspects of DDP that differ from CBT and supportive approaches are summarized below:

- The therapist does <u>not</u> give advice or direct suggestions
- The therapist generally does <u>not</u> initiate topics
- The therapist does <u>not</u> help the patient solve problems
- The therapist does <u>not</u> teach the patient new coping skills
- The therapist does <u>not</u> provide reassurance
- The therapist does <u>not</u> make judgments as to whether the patient's emotions and attributions are valid or invalid

The next chapter, entitled *Establishing the Frame*, summarizes how to get started with DDP. The initial sessions establish the framework and parameters of DDP, and also set the tone of the patient-therapist relationship.

Chapter 3. ESTABLISHING THE FRAME

Before setting up an initial meeting with a prospective patient, I mail to the patient a packet of self-report questionnaires and then score and review them. Questionnaires provide another perspective on a patient's difficulties and a reference point for monitoring progress during the course of treatment. In general, I employ questionnaires that are easy for the patient to understand and take a minimal amount of time to complete. A very useful outcome measure is the well-validated 15-item Borderline Evaluation of Severity over Time (BEST; Blum et al., 2002), which can be administered at intake and then quarterly to assess improvement. It can also be used as a screening measure. When compared to the SCID II interview for diagnosis of borderline personality disorder (BPD), we found that a cut-off raw score of $\geq$ 35 on the BEST is a good estimate for the presence of BPD, with a sensitivity = 91 and specificity = 69 in one outpatient sample (n = 70), and a sensitivity = 87 and a specificity = 61 in another outpatient sample (n = 375; unpublished analysis). Another very useful and quick screening and outcome measure of maladaptive behaviors is the Upstate Behavior Inventory (see Appendix B), which quantifies a wide range of maladaptive and potentially damaging behaviors, but has not yet been validated, I also add measures of anxiety, depression, and functioning for quarterly outcome assessments.

The initial sessions are extremely important for establishing the treatment parameters and the therapeutic alliance. See Figure 3-1 for a summary of the tasks for these sessions.

Figure 3-1. Therapist's tasks in the first 2-3 sessions

Session 1
- Elicit the chief complaint and gather initial history
- Determine eligibility for DDP
- Provide patients with a formulation of their difficulties that links the chief complaint with the need for DDP
- Inquire whether the patient agrees with the formulation and wishes to pursue treatment

Sessions 2 and 3
- Finish gathering the history
- Explain the treatment in more depth, including process, frequency, and duration
- Define roles, boundaries, and expectations
- Discuss supplemental treatment, including medication
- Obtain written consents as applicable, including videotaping, treatment plan, release of information
- Inquire whether the patient still wishes to pursue treatment

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1. ELICIT CHIEF COMPLAINT AND GATHER THE HISTORY

The treatment process begins at the first meeting between patient and therapist when the chief complaint is elicited, i.e. asking what the patient would like from treatment. Having patients come up with a chief complaint gives them a sense of ownership of their disorder and their desire to recover from

it. It is the beginning of facilitating autonomous motivation and individuated relatedness with the therapist. This seemingly simple task can be very difficult for patients with BPD; they may disown a chief complaint and respond, "I'm only here because my parent wants me to." It may be necessary for the therapist to first move to other parts of the history to gather evidence for symptoms and functional impairments that the patient would like improved.

After eliciting the chief complaint, it is helpful to begin with relatively non-threatening questions, including present symptoms, onset, course, medications, and medical issues. Explicitly screen for common comorbid psychiatric conditions, including major depressive disorder, bipolar disorder, obsessive compulsive disorder, eating disorders, and psychosis. Suicide ideation, intent, means, and plan should be elicited, as well as previous attempts. Posttraumatic stress disorder should be screened for later in the interview, as screening for that disorder can sometimes generate considerable anxiety.

Explore major coping and defense mechanisms. What does the patient do when feeling stressed? Does the patient dissociate under stress? Does the patient tend to blame self or others for problems that have come up? Ask specifically about impulsive behaviors, such as risky driving, promiscuity, bingeing, and excessive spending. Self-destructive behaviors should be elicited, including cutting, overdosing, bingeing, purging, and pulling hair. Also ask specific questions about addictive behaviors, including alcohol, gambling, and recreational drug use. Include the CAGE screening items and ask about history of blackouts and DWIs.

Review previous treatments, including details about medications and past therapy relationships. Try to get a sense a typical psychotherapy session and why the therapy ended. Speaking with a previous therapist or a family member (after obtaining consent) can provide useful information. However, there is a risk that the patient will believe that the present therapist is now colluding with them.

Ask about current relationships with family and friends. Is there a sense of emotional closeness? How do they spend time together? How do they resolve conflicts? Have there been any romantic relationships? Have there been significant losses of people to whom the patient felt close? How do these relationships typically end?

Inquire about occupational and legal history. What is the longest period of time the patient has been employed? How did the patient get along with co-workers and supervisors? Has the patient ever been arrested?

Explore childhood relationships, including parental separation, illness, peer relations, family relations, school performance, physical abuse, and sexual molestation. It is helpful to remind the patient before asking questions in this section that some of the material may be painful to think about and if the patient is not ready to talk about it right now, that's okay. Do not suggest or imply that the patient has undergone abuse or trauma unless the patient specifically puts past experience in those terms.

Perform basic cognitive testing to assess attention, concentration, and intelligence. High intelligence is a good prognostic indicator for DDP. However, I have also seen patients with IQ in the 70's achieve significant, albeit more modest, benefits from DDP. I have found the following three tests particularly useful for screening, and look for adequate performance on at least two of the three:

1. Performing serial 7s (5/5 calculations correct).
2. Copying interlocking pentagons (5 corners to each and a diamond shape where intersected).
3. Interpreting a simple proverb abstractly (e.g. "don't cry over spilt milk").

2. DETERMINE ELIGIBILITY

After a detailed evaluation, the therapist is in a better position to determine whether DDP is indicated and to anticipate problems that may arise. Although there are no absolute contraindications for the use of DDP for BPD, some of the factors that worsen prognosis include developmental disability,

older age, and co-occurring schizophrenia. Treatment may still be helpful, but progress is usually slower and treatment retention is more challenging.

Treatment of patients with comorbid antisocial personality disorder can be very challenging, but can still be effective. Many of these patients derive self-esteem from antisocial behaviors and may relish their ability to fool the therapist (see the *Demigod Perpetrator State* in the chapter, *States of Being*).

I generally do not employ DDP for teenage minors unless they are in a stable and supportive family environment. Patients describe DDP as an awakening to the reality around them. If they awaken to a traumatic or unloving environment, and are disempowered to change their environment because of their age, the result can be despair and increased suicide risk. For teens in a chaotic or abusive home environment, I recommend a different treatment approach, such as family therapy and/or a focus on learning coping skills, such as with dialectical behavior therapy.

I have found that the patients with the best prognosis are those who are emotionally engaged with the therapist within the first couple of sessions, and are 25 to 35 years of age. By age 25, most patients have discovered that other solutions don't work very well, e.g. medications, drugs, or non-specific counseling, and they are more willing to commit to DDP. Many older patients have adjusted to being chronically ill, and may be less motivated to do the difficult, frightening, and painful work of recovery.

Consideration must also be made for patient resources of time and money. Does the patient's insurance cover weekly psychotherapy visits for at least a year? If not, does the patient have the financial resources to make up the difference? If the patient has to leave treatment in the early stages because of inability to pay, this can lead the patient to feel re-traumatized, used, betrayed, rejected, and/or abandoned. On the other hand, if the therapist sees the patient for little or no fee, this can paradoxically worsen the treatment alliance through blurring of boundaries and roles.

Finally, in order for treatment to be effective the patient must decide:
1. I have difficulties that I need help with (i.e. takes ownership of having a Chief Complaint).
2. DDP is the best solution to my difficulties (i.e. agrees with the therapist's formulation).
3. My therapist is trustworthy (i.e. believes therapist is caring, respectful, and reliable, with clear expectations, roles, and boundaries).

3. PROVIDE A FORMULATION

It is important for patients to have a basic understanding of their illness that explains the difficulties that they are experiencing and makes sense to them. Simply being provided with a reasonable explanation and diagnosis can instill a sense of legitimacy, hope, and understanding. Once this stage of mutual agreement on the causes of the difficulties is reached, the patient is ready and receptive to hear how treatment that is focused on the underlying causes can be helpful. These two components, i.e. the causal explanation and how treatment can help, constitute the formulation. These two components can be broken down into sequential steps:

1. A recapitulation and summary of pertinent aspects of the patient's history that has led him/her to treatment.
2. A brief formulation of the patient's difficulties employing common language and incorporating the patient's chief complaint. The depth of the formulation will depend on the patient's psychological mindedness and on the material that was presented during the history taking, and can be put into either psychological or neurobiological terms.
3. The goals and the tasks of treatment; for example, activation of the areas of the brain responsible for processing of emotional experiences, which leads to improved symptoms and a capacity for differentiated relatedness.
4. The process of therapy, i.e. creative exploration involving verbalization of recent social encounters, or exploration of dreams, poems, or creative artwork.

An example of a framework for a patient with a history of childhood abuse might be as follows:

> *You seem to be stuck in a rut. You have had a lot of bad things happen to you growing up, and that can sometimes lead to your brain shutting down awareness of emotions and of the experiences around you. Early trauma can also lead to an inner sense of badness and confusion as to whether you are a bad person or a good person. That inner sense of badness may have been confirmed by some of the bad things you have done in your life and by trauma that you suffered as an adult. Part of you may believe that you deserve all the problems in your life because of your bad thoughts and behaviors, but the other part of you may want to blame other people. The goal of therapy is therefore to help you activate the parts of the brain that have been shut down so that you are more aware of yourself and your experiences and can start to figure out who you are. Treatment doesn't necessarily involve digging up and re-hashing old dirt, but instead starting to talk about your recent experiences and find yourself. This may involve telling me about something that happened recently in a relationship. Or you may find it helpful to explore your dreams, poems, or art with me. Through this process of exploration, you may find that a more positive, complete, and secure self begins to emerge. Does this sound like something you would like to try?*

Note that the initial framework should end with a question as to whether the patient agrees with the formulation and wants to undertake this kind of treatment. It is essential that the patient be an active participant and commit himself/herself to treatment for it to be successful. Recent studies suggest that autonomous motivation may be an even more important predictor of outcome than the therapeutic alliance (Zuroff et al., 2007). Statements such as, "You're the doctor, whatever you think is best" need to be challenged so that the patient has a sense of ownership of the treatment. A suitable response to this statement would be, "Although this is what I am recommending, only you can decide if it makes sense to you and if you want to give it a try. Therapy is gratifying, but also very difficult. And moving on with your life can be scary. It's very reasonable to say I'm not ready for this. Are you sure you want to give this treatment a try?" Note that the therapist is assisting the patient in his/her decision by pointing out pros and cons, but is nevertheless respecting the decision-making capacity of the patient to ultimately decide what is in his/her own best interest.

On occasion, patients may become defensive during the initial interviews, particularly if they use projective defenses. Establishing a dialogue early on regarding here-and-now patient-therapist interactions helps to disrupt a negative transference and also sets the stage for later explorations of the transference.

Many patients will not present a history of trauma or neglect. The formulation would then have to be modified from the example above. For example, the formulation might focus instead on the sense of emptiness or disconnectedness with what's going on around them. The rationale for psychotherapy would emphasize the importance of getting to know themselves and their feelings, so that they can experience a sense of wholeness and develop more fulfilling relationships. For example, the therapist could state,

> *You seem to be stuck in a rut. You are experiencing chronic depression and feelings of emptiness inside without knowing where that is coming from. You also mentioned that you feel pulled in different directions and don't have a clear sense of who you are or where you're going. I noticed in the interview that you had difficulty describing some of your experiences and knowing exactly what you are feeling at any given time. When people are out of touch with their experiences, it can lead to feelings of emptiness, confusion, and a lack of a sense of self. The goal of this therapy is therefore to help you become more aware of different parts of yourself, start to figure out who you are, and work towards self-acceptance. Treatment involves exploration of your emotions*

and experiences. Often a useful emphasis is to talk about recent encounters you have had with other people. Or you may find it helpful to explore your dreams, poems, or art with me. Through this process, you may find that a more positive, complete, and secure self begins to emerge. Does this sound like something you would like to try?

Patients with co-occurring substance use disorders can be especially difficult to engage in treatment. They tend to be very medication focused, seeking a magical potion (medication) or substance that will relieve their symptoms without having to engage in a close therapeutic relationship. "You need to give me something to calm my nerves" is a frequent refrain. Patients with BPD frequently meet diagnostic criteria for multiple other major mental disorders, and this serves as a justifiable rationale for this demand (see chapter on *Psychiatric Comorbidity*). Even patients who have failed multiple trials of all the major classes of psychotropic medications may nevertheless demand a primary pharmacological solution to their difficulties. Such patients require a re-framing of their condition from a biological point of reference to a biopsychosocial model. A suitable response to patients who believe that all their problems would be solved by another trial of an antidepressant medication would be to state:

Given that you have been on multiple antidepressant medications and none of them have helped very much, it seems likely to me that you have a type of depression that doesn't adequately respond to medication. I think your depression is related to poorly integrated images you have of yourself and how you have been coping with some of the stressors in your life. Even during our interview I noticed that you can switch between blaming others for your difficulties to total self-blame for every problem that has ever happened in your life. Recovery from depression will involve getting in touch with your feelings and experiences and working towards developing into a whole and integrated person. Medications can take the edge off symptoms, but are not likely to help as much as psychotherapy. Is this treatment something you'd like to try?

Although many patients with BPD have unrealistic expectations about medications, they usually can receive at least a modest benefit from them. The exception may be benzodiazepines and I usually insist that we taper off medications of this class as a precondition of treatment. The rationale for this is that although benzodiazepines can decrease anxiety, they can worsen the course of the disorder and impede recovery through shutting down emotional awareness and decreasing the patient's self control of destructive impulses and mood lability through disinhibition (see chapter on *Psychotropic Medications*). Patients usually understand this rationale and often have had similar concerns, though may be reluctant to admit it.

I try to complete all of the above tasks in the first session. In order to complete all the tasks outlined in the figure, the therapist will need to stop gathering history before the end of the session and leave about 20 minutes for presenting the formulation of the patient's difficulties and the goals and tasks of treatment. Thus history-taking in this first session should focus on determining eligibility and the central relationship issues that are keeping the patient stuck. I find it helpful to schedule 90 minutes for the first session to ensure sufficient time for this very important meeting. At the end of the first session, I will also hand the patient an informational sheet on borderline personality disorder. In the following session(s), questions and concerns can be addressed, a more complete history can be obtained, and explicit treatment commitments reviewed.

3. DEFINE ROLES, BOUNDARIES, AND EXPECTATIONS

During the first 2-3 sessions, it is extremely important to clearly define treatment expectations and parameters. Conveying explicit expectations and parameters meets the BPD patient's need for

certainty and also addresses potential safety concerns regarding abandonment and containment (see next chapter on Stages of Treatment).

Active substance use must be taken into account when setting up the parameters of treatment. Substance misuse is an important coping mechanism used by many individuals with BPD. It is an effective strategy for dampening anxiety and arousal associated with amygdala activation under conditions of emotional stimulation. However, substance use exacerbates disconnection from emotions and experiences, and therefore prolongs recovery, interferes with relationships and functioning, and contributes to a sense of emptiness. Moreover, patients are likely to have exacerbation of underlying shame and guilt through repeated relapses and may be vulnerable to getting traumatized while intoxicated.

However, it is unrealistic to insist that patients maintain abstinence before or during DDP given that substance use disorders are chronic and relapsing conditions. Under these circumstances, patients are likely to simply lie about their substance use and get into external control struggles, viewing their therapist as harsh and judgmental. It is far more helpful to encourage on-going substance-related treatment, either through rehabilitation groups or Alcoholics Anonymous (AA). During treatment with DDP, frequent checking in with the patient regarding substance use is also helpful (see section on *Managing Maladaptive and Self-Destructive Behaviors* in the chapter on *Specific Techniques*).

As treatment with DDP progresses, patients will often enact conflicting wishes for dependency and autonomy in the patient-therapist relationship. Establishing clear roles and parameters at the beginning of treatment helps prevent boundary violations derived from complicit unconscious gratifications, such as physical contact between patient and therapist (Langs, 1975). Minimal treatment parameters should include:

- limiting physical contact to hand-to-hand, e.g. shaking hands
- limiting sessions to weekly with <u>rare</u> exceptions
- limiting contact outside of sessions to occasional brief phone calls
- strictly adhering to the time limits of sessions
- adhering to the established rules and parameters set at the beginning of treatment
- ending regular person-to-person contact after therapy termination
- refusing to divulge personal information when asked, e.g. "Do you have children?"

Requests from patients to go beyond these limits and inner urges by therapists to make exceptions to these rules are common in the treatment of BPD. In part these demands reflect patients' unmet dependency needs. In part they also reflect poor boundaries between self and other, enactment of pathological attributions, unconscious testing of safety concerns, and the unconscious wish for the therapist to set limits and contain their neediness. If the patient appears to need more support than is met with the current treatment plan, it is better to add different types of treatment, such as group therapy or AA, rather than increasing the frequency of individual psychotherapy or telephone contact.

Treatment parameters and boundaries can sometimes seem rejecting, arbitrary or punitive to patients and they often question them. After exploring the patient's feelings about a given boundary, a non-rejecting framing response can be provided if the issue comes up early in treatment (see chapter on *Specific Techniques*). An example would be to state, "I know it's hard that I keep refusing to answer personal questions, but I want this treatment to be about you, rather than about me. I want this to feel like a judgment-free zone, where you don't have to worry about others' needs or how they will react to things you bring up. This is an opportunity for you to creatively explore and find yourself."

In addition to verbal discussion, it is extremely helpful to have a written agreement of treatment commitments to maximize clarity, foster a sense of ownership, and prevent future misunderstandings. A written agreement helps to decrease anxiety by making expectations clear, facilitates containment of hostility by outlining prohibited behaviors, and also provides a forum for exploring future breaches of the treatment parameters (Yeomans, Selzer, & Clarkin 1992).

Major components of a written agreement should include responsibilities of the patient, unacceptable hostile behaviors, and conditions for discharge. The specific content will vary depending on therapist tolerance and the particular needs of a given patient. For example, patients with severe eating disorders should be required to maintain regular visits with a primary care physician, to allow contact between the therapist and the primary care physician, and to maintain a minimum weight of 10-15% below ideal body weight. Patients can be given a copy of the agreement, with a copy kept in the medical chart. I do not recommend having the patient sign the agreement, since this tends to distort the therapy relationship into a legalistic arrangement.

A sample written agreement is outlined in Figure 3-2. Note that the commitments are generally phrased in positive behaviors, rather than prohibited behaviors (the exception is #6). When discussing the rationale for each of these limits, it is important to avoid the appearance of being punitive or rejecting, and to emphasize that these are more commitments to themselves, rather than just to you. A good way, for instance, to phrase the reason for limiting phone calls is to state, "This limitation is essential to prevent me from getting burnt out so I can remain emotionally available to you and effective as a therapist."

Figure 3-2. Example of Written Treatment Commitments

1. Reliably attend sessions. Cancellations should be at least 24 hours in advance. Multiple cancellations or long gaps will hinder progress.
2. Pay insurance co-pays at the beginning of each session. This demonstrates that you are serious about treatment and recovery.
3. Actively participate in treatment. This can include bringing up relational issues or discussing thoughts, feelings, or behaviors. You are also encouraged to share and explore dreams, creative activities, and Daily Connection Sheets. Active participation also includes being free from the influence of drugs or alcohol during sessions for the sessions to be helpful to you. Active participation demonstrates a commitment to recovery and is necessary for treatment to be effective
4. Participate in quality assurance, including completion of questionnaires and video recording of sessions. These allow the quality and consistency of treatment to be evaluated and maintained.
5. Work towards health and recovery between sessions. This includes pursuing a healthy lifestyle, maintaining a healthy weight, staying connected with your experiences, taking medications as prescribed, obtaining appropriate medical care, and keeping yourself safe, e.g. admitting yourself to the hospital when necessary. These steps demonstrate that you are committed to working towards health and recovery. I can only be helpful if you want to be helped.
6. No hostile behaviors during sessions, including profanity, lying, violence, or threats. Such behaviors are destructive to the treatment relationship.
7. Telephone calls should be limited to waking hours and no more than twice a week. They should be brief since psychotherapy over the telephone is ineffective and often counterproductive. Texting should be rare and limited to scheduling issues.

5. SUPPLEMENTAL TREATMENT AND ACTIVITIES

Other Counseling:
One of the preconditions of DDP is that the patient is not engaged in any other form of individual psychotherapy. Because of their polarized attributions, patients with BPD have a tendency to idealize one therapy and devalue the other. Nevertheless, individual counseling at rehabilitation centers can sometimes by a useful supplemental treatment if the focus there stays on substance-related issues. However, if the alcohol/drug counselor maintains a broader interpersonal focus, this can be counterproductive due to potential for incompatible formulations of difficulties and treatment goals, as well as patient tendencies towards idealization and devaluation. Thus it is important for the DDP therapist to call the counselor to ensure agreement on respective roles.

Medications:
Medications can be either prescribed by the therapist (if he/she has prescribing privileges) or by another provider (see Chapter 9). If the latter scenario pertains, however, the therapist must already have established a good working relationship with the prescriber and maintain frequent direct contact. Ideally, the prescriber should understand the goals and structure of treatment and agree with the major treatment principles. If these contingencies are not met, the outside prescriber can often undermine the therapeutic alliance by suggesting alternative formulations or solutions to the patient's difficulties, i.e. "You simply have a chemical imbalance."

Group Therapy:
Concurrent group therapy can sometimes be very helpful for successful use of DDP. Group therapy provides another avenue for support and opportunities to develop more authentic relatedness. Multi-modal treatment also helps to "spread the transference" so that individual therapy is less likely to become overwhelmed by transference distortions (Alexander, 1950). Groups often help patients to realize that they are not just a weird crazy person, but that other persons have similar struggles. Concurrent treatments that I have seen successfully employed for this purpose include art therapy, psychodrama, psychodynamic or interpersonal groups (such as Systems Centered Therapy), DBT skills group, and self-help groups, including AA, Al-Anon, and Adult Children of Alcoholics (ACOA). On the other hand, certain types of support groups defined by a particular diagnosis may be counterproductive and serve to either reify biologically based explanations of impairment or to encourage pursuit of more aggressive pharmacological modalities of treatment. Likewise, some trauma groups may be contraindicated if the focus is sharing explicit traumatic memories within the group.
Many patients need to be in DDP for awhile before they are willing to join a group or use it productively. For example, many patients are in denial regarding their substance misuse and the negative consequences that arise from it. Non-judgmental exploration of the antecedents and of the positive and negative consequences of the patient's substance use gradually leads to increased motivation for achieving abstinence.

Family Involvement:
Often family members will want to be involved in the patient's care, especially seeking input as to how to manage the patient's outbursts and impulsive behaviors. However, in order to maintain a focus on the patient's goals, instead of the family's, and to establish trust in the patient-therapist relationship, the DDP therapist attempts to limit contact with family members after the initial sessions, except in emergencies. For teens or young adults who are still living with their parents, a 20-minute educational meeting with family members during the third or fourth session can help provide them with information about the disorder, treatment, and prognosis, and also establish the importance of boundaries between therapist and family members. Input from family members may also provide important information that

was not gleaned from the patient interview. However, if the patient and family want further sessions together, they should be referred to a family therapist.

School or Job:

Patients will also often ask whether they should return to school or work full-time while in treatment. Often underlying this question is the central thematic question of 'Are my needs legitimate?' i.e. 'Do I have a legitimate disorder or do I just need to pull up my bootstraps and get to work?' In general, having some structure to the day and opportunities to interact meaningfully with other people is helpful to the recovery process. However, patients should be informed that research indicates that BPD is a very disabling illness, more so than major depressive disorder and many chronic medical illnesses (Skodol et al., 2005). This information serves to reduce pressure from unreasonable expectations, and paradoxically increases the chances for improved functioning. Very few BPD patients early in recovery are able to go to school full-time or maintain full-time employment. It's generally more helpful to maintain part-time school or work activities, or to start volunteer work if these are not feasible.

Workbooks:

The most important supplemental treatment or activity is the use of Daily Connection Sheets (see Appendix D). These sheets involve a very brief daily record of interpersonal encounters and the emotions that were elicited in the patient during these encounters. They provide a way to extend the process of connecting to emotional experiences beyond the weekly 45-50 minute sessions. They also serve to encourage active participation in treatment and recovery, enabling the patient to gain a sense of ownership of it, and can be used to identify and discuss ambivalence towards treatment when (as is often the case) the sheets are not completed. Almost every patient who completes Daily Connection Sheets finds them to be helpful, but every patient finds them extraordinarily difficult to complete since they are trying to change neuropathways and change lifelong patterns of avoiding awareness of emotions.

The next chapter summarizes the sequential stages of recovery in the treatment of borderline personality disorder. Each of the four stages has a central thematic question that must be resolved before the patient progresses to the next stage (Gregory 2004).

*Chapter 4. STAGES OF THERAPY**

STAGE I. "CAN I BE SAFE HERE?" ESTABLISHING THE TREATMENT ALLIANCE

…the negation of alterity first necessary in order to become 'self-consciousness' 'certain of itself' **(Derrida, 1978, p. 92)**

The first 2-3 sessions are necessarily fairly directive and structured in order to accomplish the many tasks necessary during the evaluation process. The therapist must switch to a non-directive and exploratory stance after these initial sessions so that the patient can become a more active participant. This sudden switch in therapist stance is helped by some brief re-framing, e.g. "I know the last couple of sessions I have been asking a lot of questions. For this next session, I'm going to stop talking so much so that you have a chance to bring up what you think you would like to explore. There are no right or wrong issues to bring up here."

The first stage of DDP can sometimes be stormy and tumultuous, or disconnected. The patient-therapist relationship during Stage I is analogous to Searles' (1961) first two phases in the treatment of schizophrenia. Searles described patients moving from "out of contact" characterized by disengagement to an "ambivalent symbiosis" characterized by testing of the therapist. Unconsciously, patients are testing whether their therapists are going to respond to them in the ways they hope, fear, and expect. Will the behavior of my therapist match my hopes for an all-loving, all-knowing, all-good, and all-powerful Ideal Other, or will the therapist match my fears of a devaluing, controlling, intrusive, and persecutory other? These questions underlie poorly integrated competing motivations within the patient of *autonomy vs. dependency*. Thus the borderline patient begins a relationship with the therapist with the primary thematic question of "can I be safe here?" The development of attachment to the figure of the therapist is contingent on establishing a sense of safety (Ainsworth, 1989).

The three basic components to these concerns are outlined in Figure 4-1. These concerns could be summed up as caring, respect, and containment.

Figure 4-1. The Three Basic Safety Concerns of Stage I

1. **Caring.** Will my therapist provide the kind of nurturance and support that I so desperately want and need, or will he/she be cold, humiliating, or abandoning?

2. **Respect.** Will my therapist support my independent decision-making and differentiation, or will he/she take away my autonomy and sense of self through infantilizing, intrusiveness, control, and smothering?

3. **Containment.** Will my therapist be able to contain my neediness, grandiosity, and rage, or will I end up destroying the relationship?

Each component question regarding safety is usually unconscious, but is tested in the patient-therapist relationship. The therapist who fails to address these concerns runs the risk of a shaky therapeutic alliance, clinical deterioration, and poor retention.

One could ask why these particular concerns are so important to this patient population? One possibility is that the safety concerns relate to patients' poorly integrated and opposing motivations for *dependency vs. autonomy* and the associated fears of separation and merger. An additional possibility is that the patient is seeking in the therapist the very qualities that he/she is lacking, i.e. acceptance, respect, and impulse control. This latter hypothesis is consistent with the idea of poor self-differentiation and blurring of the boundaries between self and other. The Ideal Other fulfills what is lacking in the patient's self and (if tested to be durable and real) presents the possibility for these qualities to be owned by the self.

Stage I is characterized by testing and double binds. There are trade-offs to each of the safety concerns. In order to successfully help the patient to negotiate this stage of treatment, the therapist must exhibit qualities of warmth, acceptance, and empathy, while supporting autonomous decision-making. To ensure containment, the therapist also must be very clear regarding respective roles, boundaries, expectations, and parameters of treatment (see chapters on *Establishing the Frame* and *The Therapeutic Stance*).

Some of the sessions will be spent on exploring why patients are having difficulty meeting treatment commitments. These discussions typically follow a pattern of the patient breaking a commitment, e.g. not showing up to a session without prior notification; the therapist pointing it out and asking about it; the patient providing a rationale, e.g. "I had a dentist appointment;" and the therapist then trying to explore possible other reasons, e.g. fears of closeness/merger with the therapist, anger over perceived rejection, hopelessness. This kind of discussion continues to some extent throughout the course of treatment, but is most prevalent while the treatment alliance is being established. A combination of direct questioning of parameter violations, non-defensive receptivity to implied criticisms, and maintenance of strict boundaries are most likely to be helpful in re-establishing a fractured alliance.

The limit of the therapist's caring (safety concern #1) is often tested through pushing the agreed parameters and boundaries of the patient-therapist relationship. Prolonged engagement with a nurturing therapist can intensify dependency wishes and lead to desperate attempts to engage the therapist (i.e. safety concern #3 regarding containment of uncontrolled neediness is triggered). The empathic therapist will detect the patient's desperation and child-like qualities, and naturally respond with rescue fantasies of his/her own. If treatment parameters are not maintained, a vicious cycle may ensue entailing progressive regression to a helpless, infantile, and dependent state, alternating with rage and/or self-destructive behaviors. The therapist has the feeling that he/she is in the midst of a feeding frenzy.

Likewise, therapists should avoid infantilizing or smothering the patient through providing suggestion, advice, and reassurance. These interventions threaten safety concern #2 that the therapist is going to take away the patient's autonomy. Patients will often strongly seek such responses, e.g. "I get so anxious sometimes that I can't think and can't function at all. What should I do when that happens?" A good rule of thumb is that the more strongly a therapist feels compelled to offer suggestions or reassurance, the less beneficial these interventions are likely to be. It is more helpful instead for therapists to ask themselves whether they are participating in an enactment. In the above example, a suitable response would be to make an empathic comment, a framing comment, and then to explore the feelings in more depth. For example, "So the anxiety becomes really overwhelming for you? That's very common when people have a lot of unprocessed emotion. Let's see if we can find out where the anxiety is coming from. Can you tell me about the last instance when this happened?"

For patients who remain mostly in the autonomous states, i.e. *angry victim* or *demigod perpetrator*, a fear of merger (safety concern #2) supercedes their wish for closeness. They fear losing their nascent autonomous functioning and slipping into a dissociative or regressed infantile state when they detect a therapist's nurturing attitude. Kohut (1971) has referred to this fear of losing a fragile self as annihilation anxiety. This fear is mostly unconscious, but is tested in numerous ways throughout Stage I.

A common way in Stage I that patients test safety concern #2 is by expressing difficulty bringing in material for exploration. They may state, "I can't think of anything to bring up today. Ask me some questions." It is usually helpful at this point to reiterate that the patient may bring up for discussion anything that is on his/her mind that he/she would like to explore. If this intervention fails, it may be helpful to remind the therapist is unable to help unless the patient actively participates and that if the therapist is the one setting the agenda, then the treatment is about the therapist, not the patient. A common mistake is for the therapist to respond to the passive patient by becoming more directive and authoritative and asking a multitude of specific questions. Such interventions represent an enactment of an intrusive interrogation of a helpless child and take away the patient's sense of autonomy.

Another common way that safety concern #2 is tested in Stage I is through contact with family members. Some version of the following scenario often plays out early in treatment. In this example, an (adult) patient calls the therapist and hands the phone to his mother:

Patient:	Doctor? My mother wants to talk to you. Here she is.
Therapist:	Wait!
Mother:	Doctor, I'm really worried about my son. He just cut his wrists. What should I do?
Therapist:	How serious are the wounds?
Mother:	Well they're dripping blood. What do you expect?
Therapist:	Sounds like he may need to go to the emergency room to get checked out. Let me speak with him.
Mother:	Doctor, when is all this going to end? Things can't keep going on like this. I need to know what's happening with my son so that I can be more helpful. I don't know what to do.
Therapist:	I understand how difficult it must be to see your son suffering and not knowing what to do. However, as I mentioned before it's very important that he have a treatment that is just his and doesn't involve the family. I'd be very happy to refer you to an individual or family therapist who may be able to help you deal with your very legitimate concerns. You also always have the option of calling the police if you feel your son is in imminent danger and is refusing help.
Mother:	Can you at least give me some inkling as to what he's been discussing in his treatment with you? We need some help here!
Therapist:	I understand your frustration and I'm glad that you told me of your concerns. If you give me a call tomorrow, I can discuss some referral options for you. But right now, I'm worried about your son's injuries. May I please speak to him?

It is difficult for such conversations not to end on an angry note if the therapist maintains strict boundaries. However, it is imperative in this form of therapy that contact between the patient's therapist and family members be limited to a single meeting early in treatment to provide information about the disorder and the treatment frame. Further contact should be restricted to emergency situations, even though family concerns may be legitimate and even though the patient has given the therapist permission to communicate with family members. Patients with BPD struggle with individuation and self/other differentiation. So maintaining the boundaries of the therapist-patient relationship distinct from the patient-family relationship and supporting patient autonomy despite outside pressures provide a novel and deconstructive experience for many patients. Patients need a place that they feel is just for them, free of judgment, where they can feel free to bring up any topic within the parameters of the treatment frame without fear of retribution.

Safety concern #3 may be also be tested in Stage I. Common ways include verbal hostility (including lying, profanity, or demeaning comments), threats or innuendos, frequent telephone calls, and non-compliance with medication recommendations. Winnicott (1969) stressed that the use of an object is dependent on its ability to survive the patient's neediness and rage without collusion, retaliation or abandonment Safety concern #3 can be adequately addressed only if therapists first acknowledge,

identify, and accept negative countertransference reactions within themselves when they occur (Winnicott, 1949). Therapists are then in a position to evaluate the patient's *state of being* and provide an appropriate response to deconstruct that state (see chapter on *States of Being*). Depending on the particular *state of being*, appropriate responses may include receptivity and acceptance of implied criticism or, on the other hand, experiential challenge and limit setting.

Patients may sometimes test safety concerns by making devaluing comments to the therapist, e.g. ridiculing their level of training, interventions, or expertise, or through intrusive or controlling actions, e.g. insisting that the therapist read a certain book or interact in a certain way. Such comments or actions occurring early in the therapy are testing whether the therapist is going to accept or reject such a "nasty" patient (safety concern #1), whether the therapist will be humiliating or controlling in return (safety concern #2), and whether the therapist is going to find a way to limit the patient's hostility (safety concern #3). The therapist feels trapped into making a comment that is going to jeopardize the therapeutic alliance, regardless of how he/she responds. In general, when a therapist feels trapped by competing safety concerns in Stage I, it is often best just to state that and to use the opportunity to acquaint patients with their competing safety concerns or opposing attributions. For example, a therapist can state:

> *Your request that I give you a hug at the end of this session puts me in a dilemma. On the one hand, if I refuse to hug you, it's going to come across as uncaring. On the other hand, if I go along with it, we will be crossing usual patient-therapist boundaries and I'll come across as unreliable. Either way I come out the bad guy. Your request reflects different and poorly integrated safety needs that you have in relationships, including the patient-therapist relationship. You need a relationship that is caring, but also respectful and reliable. So the question is, can you see me as caring, even if I don't cross boundaries and give you a hug?*

In addition to framing the safety concerns and core conflicts, the therapist must set limits on certain behaviors. If the patient's behavior is frankly hostile, intrusive or controlling and the behaviors are based on grandiosity rather than paranoia, then the patient is likely in the *demigod perpetrator state* and these behaviors should be met with experiential challenge (see chapters on *States of Being* and *Specific Techniques*). Defining and maintaining the parameters of treatment, including setting limits on certain types of behaviors, serves several functions:

- Avoids excessive gratification of dependency wishes and unrealistic expectations of the therapist-patient relationship
- Restraining merger wishes and fears by clearly defining the type and frequency of patient-therapist contact.
- Diminishing fears of rejection and abandonment by explaining the rationale for limiting patient-therapist contact and by clearly defining the conditions for termination of the relationship.
- Containing patient aggression by forbidding explicit hostile behaviors within the session.
- Creating a basis for future exploration and discussion of deviations from the agreed parameters.

Sensitive limit-setting becomes a deconstructive experience by preventing enactment of uncontained aggression. The therapist's ability to set limits deconstructs the patient's attribution of the other as being without agency and the expectation that aggression or neediness will not be able to be contained. The patient usually greets limit setting with a sigh of relief if it is done early in the course of treatment and with empathy.

In addition to testing safety concerns, much of the first stage of treatment is spent developing a rhythm to the pattern of interactions between patient and therapist that prepares them to go beyond safety concerns into reflective exploration. If the treatment is going well, patients will begin to bring up recent relational episodes during sessions. The therapist should look for these opportunities and apply

associative techniques to develop narratives. For example, when a patient states, "My husband was hassling me yesterday", the therapist can ask questions to develop the narrative, such as "What did he say?" "How did you respond?" "How did that make you feel?" See chapter on *Specific Techniques – Associations* for a more complete summary of interventions at this level of discourse.

The patient can also be encouraged to share dreams or creative endeavors such as poetry, creative writing, or artwork. Some patients find it helpful to keep a journal, but this is generally not encouraged since journals can sometimes serve to reinforce negative expectations of self and others within the patient's distorted attribution system. Creative endeavors allow feelings to be symbolically processed into images or words, therefore providing space for acknowledgement and reflection of experiences. Moreover, allowing the patient to choose the topics for exploration facilitates an active and responsible role for the patient in the treatment, creates a sense of ownership for the treatment, and helps prevent regression to a passive and dependent stance.

The therapist's stance during the patient's active exploration of experiences should be that of a mirror. This includes repeating back narrative connections in order to reify them and convey empathic understanding, repeating back positive self-attributions in grandiose patients in order to support self-esteem, empathically attending to affect in the here-and-now, and providing a framework to help patients understand their safety concerns, core conflicts, and central thematic questions (see chapter on *Specific Techniques – Ideal Other*).

During the process of exploring interpersonal experiences, there are three patient constructions that should never be challenged during Stage 1. These include:

1. Bad things that happened to me in the past are best forgotten.
2. I am not an angry person.
3. Deep down my caregivers really loved me.

These constructions are so central to the borderline's *state of being* that challenging them provokes high anxiety and defensive reactions that threaten the patient-therapist alliance, increase dysfunction, and undermine the establishment of safety. Therefore the areas of exploration that should generally be avoided during Stage 1include details of early trauma, feelings of anger, and ambivalence towards parental figures. At later stages in the treatment, all these issues can be explored and worked through as they relate to attributions of self and others. It is also helpful to provide an educative frame regarding the difference between the feeling of anger, the destructive actions of hostility, and identity as a bad person (see chapter on *Specific Techniques*).

The development of a fairly stable idealizing transference (therapist as soothing and safe presence) marks the end of Stage I. In Searles' (1961) terminology, the patient-therapist relationship has moved to "full symbiosis" and the therapist has the feeling of a "Good Mother". The patient is engaged in the treatment process and is experiencing moderately decreased symptoms in all domains as a result of a positive therapeutic alliance and verbalization of emotional experiences. The patient spends more time exploring interpersonal interactions and less time testing the three safety concerns. There is an increased awareness of emotions, and some ability to connect feelings with actions. The duration of Stage I is generally a few months, but in more detached or disorganized patients may last much longer, even with optimal treatment.

STAGE II.   "DO I HAVE A RIGHT TO BE ANGRY?"

***Meaning must await being said or written in order to inhabit itself, and in order to become, by differing from itself* (Derrida, 1978, p. 11).**

The question of justification underlies one of the core unconscious conflicts of BPD. Ways to phrase the question include, "Do I have a right to be angry?" "Have my relationships been so awful because people have treated me unfairly, or am I the cause of my awful relationships because I am so ugly, defective, and evil as to be unlovable?" "Am I to blame, or are they?" The primary attribution underlying these questions is that of agency and the accompanying split into opposing self-images of either victim or perpetrator. This opposition can be a response to severe trauma or traumatic loss, but is also evident in persons with BPD who deny a history of trauma. In the victim role the patient can appear helpless, passive and dependent, or enraged and self-righteous. In the perpetrator role, the patient is depressed, guilt-ridden, suicidal, and/or self-destructive.

Helping the patient to integrate these opposing attributions into some sort of reflective ambivalence is a long-term process and typically proceeds throughout all 4 stages. For the patient, it often involves repeated testing and engagement in maladaptive relationships. For example, a woman with BPD involved in a physically abusive marriage had experienced feelings of self-righteous anger towards her husband with wishes to separate, alternating with feelings of self-condemnation. This latter frame of mind would become stronger during periods of abuse, and suicide attempts would regularly follow traumatic incidents.

Polarized and poorly integrated attributions of motivation also enter into the second stage. Patients are struggling with finding a comfortable interpersonal space where they can maintain their individuality and yet feel close. The central conflict is one of *autonomy vs. dependency* and is another aspect of the question of justification. Ways that patients may phrase this dilemma include, "Do I need to put my own needs and desires aside and create a false compliant persona in order to maintain a close relationship?" "Are my wants, needs and opinions legitimate, or am I just a crazy person?"

The predominant transference during Stage II is idealized and maternal. The patient views the therapist as caring, warm, and protective, but unconsciously still worries about being smothered, controlled, intruded upon, or abandoned. These worries are related to the central thematic question of Stage II and get played out in the transference, especially around vacations. I.e. "Do I have a right to be angry that my therapist abandoned me at a critical time in my treatment, or should I be understanding that he/she needs a break and just keep my stupid mouth shut?" "If I protest too loudly, will my therapist get rid of me?" Non-judgmental exploration of feelings both preceding and following the vacation with appropriate framing of these thematic questions is most likely to be helpful.

A common trap that therapists fall into during Stage II is to become overprotective or intrusive regarding maladaptive relationships that the patient is engaged in. This includes deviating from a non-judgmental position of neutrality and telling the patient that he/she <u>should</u> get out of the relationship. This "good advice" becomes an enactment of a controlling and devaluing maternal transference and undermines the patient's strength and autonomy. Moreover, when the therapist strongly sides with one side of a polarized attribution, it allows encourages the patient to take the opposing side, i.e. "But I don't want to leave him. I love him" and thereby enables the patient to avoid struggling with the central thematic question. What should have been an internal conflict ("Do I have a right to be angry at my abusive husband?" "Should I leave him?) has now become an external opposition between the patient and therapist ("I really love my husband and we would be fine together if this therapist did not keep interfering").

It is far more helpful in this situation to be direct about the devastating effects of abusive relationships, but balance that with an exploration and affirmation of positive aspects of the relationship. The general rule is to keep the conflict within the patient. A sign that the therapy is heading in the wrong direction is if therapists find themselves getting into arguments or control struggles with their patients. Thus the conflict should be defined and explored, but the patient resolves it for himself/herself. For example, it is helpful to make framing statements or exploratory questions that help the patient see the harmful aspects of the relationship. Some examples include:

- "It's difficult to move on in recovery if there is on-going abuse because it reinforces your self-image as bad and makes it difficult to integrate opposing parts of yourself."

- "All your suicide attempts have been preceded by violence from your husband. Do you think there's a connection?"
- "Abuse creates an internal sense of badness and a tendency to blame oneself."

On the other hand, it is important to explore and discuss the other side of the ambivalence in a non-judgmental manner. For example, it is helpful to state,

- "So you are saying you are very attached to your husband, rely on him greatly, and worry if you would be able to find anyone else if you separated."
- "Although you're angry at your parents for how they're acting, are you also wondering whether you provoked them into responding to you like that?"

Note that in each of these examples, the therapist is helping patients to see both sides of their polarized attributions, thereby creating a conscious conflict. The therapist provides information about the detrimental effects of abuse, but this is balanced by a discussion of positive aspects of the relationship. The therapist avoids suggesting that the patient either leave or stay, or that the patient's anger is either justified or unjustified. The conflict therefore remains in the patient. By becoming conflicted about maladaptive relationships or behaviors, the patient is in a position to begin to change them. Prior to this kind of intervention, the patient may have never been in conflict because one part of the opposition had always been excluded from consciousness and/or projected onto another person. For example, when patients become overly dependent in relationships, they often blame themselves for any difficulties that arise. However, by doing so, they are excluding from consciousness the part of them that resents the dependency, smothering, and control.

During Stage II, as patients learn to verbalize their experiences and become more aware of their conflicts in relation to the central thematic question, they will feel less anxious and more willing to acknowledge feelings of anger and dissatisfaction about current and past relationships. However, open acknowledgement of anger and resentment increases separation anxiety. As separation anxiety increases, the patient may enter the *Guilty Perpetrator State* periodically (see chapter on *States of Being*) and have bouts of increased depression and suicide ideation.

Patients usually continue to engage in maladaptive or abusive interactions in Stage II as they attempt to answer the question of justification. Although patients tend to be the most engaged in treatment during Stage II, they are still ambivalent about the recovery process. Ambivalence during this stage is often related to becoming more aware of their anger and of alternating self attributions of *victim vs. perpetrator*. Ambivalence may also simply reflect an attitude of not prioritizing themselves or their recovery over other concerns. This relates to the central thematic question of whether they are justified to receive treatment, e.g. "Are my needs legitimate?"

If the patient appears ambivalent, the therapist should also consider whether the patient has unspoken anger towards the therapist and is trying to settle the question of "right to be angry" in the transference. Non-judgmental exploration of these possibilities usually reveals whether this is the case and helps gives the patient the message that he/she is free to bring up any concerns or disagreements in the therapy relationship. Non-judgmental acceptance by the therapist of the patient's anger or dissatisfaction represents a deconstructive experience of supporting differentiation and opens up new interpersonal potential.

If the patient shows evidence of clinical deterioration during this stage it could be due to a number of factors. Often clinical deterioration will follow a traumatic incident, which the patient may or may not volunteer. It may also follow increased assertiveness in relationships followed by increased separation fears or depression. When the therapist observes clinical deterioration, he/she should also consider whether the patient is re-engaging in traumatic relationships or impulsive behaviors that the patient is not sharing during sessions. Excessive drinking or drug use can lead to increased mood lability and increased dysphoria.

As patients continue to work through the central thematic question in different relationships and contexts, the therapist can provide a variety of useful interventions. These include empathic and reflective listening, facilitating the development of affect-laden narratives, framing regarding the central thematic question and the core conflicts, exploring the patient's poorly integrated and conflicted feelings and attributions towards friends or relatives, and supporting autonomous motivation by emphasizing that the patient can choose not to engage in such relationships, not to be self-destructive, to stay in treatment, and to move on with his/her life. The idea of choice challenges opposing self-attributions as either helpless victim or guilty perpetrator and suggests a third alternative as a strong, assertive, and autonomous individual.

The split between competing self-attributions of *victim vs. perpetrator* influences the patient's understanding and handling of even minor stresses. For example, a patient whose cell phone was stolen came to a session complaining of feeling traumatized and violated. However, she also felt more depressed and had urges to cut herself and commit suicide. As we explored the incident further, the patient realized that she felt totally responsible for the incident, i.e. "bad things happen to me because I'm evil."

In some individuals, the dissociative split in polarized attributions is so severe that the patient may form separate competing identities, i.e. dissociative identity disorder. This is best handled by framing the different identities as conflicting aspects of the same person, rather than separate individuals. I strongly discourage the therapist from calling each of the identities by name or attempting to speak with just one of them at a time since this is likely to strengthen the dissociation (see chapter *on Special Situations*).

Through repeated exploration and processing of interpersonal interactions and maladaptive behaviors, and bringing conflicts into consciousness, patients gradually improve. The first aspects of BPD to improve are self-destructive behaviors, dissociation, and inpatient utilization as patients feel soothed by the Ideal Other of the therapist. Progress in these areas, however, will vary from day to day and week to week. Occupational and social functioning is likely to remain marginal during this period. Mood lability and impulsive behaviors, including substance use, usually continue, but to a lesser extent. Also during this period, the patient notices that a new, more cohesive and more positive sense of self is starting to emerge and the patient starts to feel like he/she "has a voice." This new emerging self, however, tends to be transient during this stage and easily overpowered by negative self-images and negative self-talk.

STAGE III. "AM I WORTHWHILE?" GRIEVING THE LOSS OF AN IDEAL AND WORRIES ABOUT SELF-WORTH

***Why would one mourn for the center? Is not the center, the absence of play and difference, another name for death?* (Derrida, 1978, p. 297)**

New themes begin to emerge in Stage III that reflect patients' growing awareness of their experiences and increasingly realistic appraisals of self and others. Sustaining idealizations of self and/or others begin to be challenged and worries about competency emerge as patients try to find their place in the world and become more aware of their imbedded sense of badness. Stage III is characterized by mourning for what is being lost, even as the patient moves forward towards independent functioning, more authentic relationships, and realistic self-esteem. In philosophical terms, there is a movement away from pure subjectivity and towards the development of alterity.

Patients with BPD carry with them sustaining idealizations that help them to survive a life of continued disappointments in themselves and in others. Sustaining idealizations of self take the form of grandiose fantasies. This is most evident in patients with prominent narcissistic traits, but, paradoxically, may also be found in patients with low self-esteem and frequent bouts of depression. For example, "If I

ever really tried, I could breeze through college with straight A's." In Stage III such grandiose fantasies begin to be challenged as patients relinquish the sick role and face adult responsibilities and realities.

Those patients with a history of abusive caregivers or partners rely heavily on idealizing fantasies of the all-loving other in order to sustain them. Thus, answering the question of "whether I have a right to be angry" poses a major problem. For if the abuse from caregivers was not entirely my fault, it means that those persons may not have been as loving and perfect as I had presumed. The fantasy is that "my family, spouse, etc. deep down really loved me. They just didn't get a chance to show how much they loved me because I was so bad." There is considerable anxiety associated with challenging this fantasy of idealized others who never had a chance to show how much they really cared. When the patient is ready to relinquish this fantasy of secret love, it feels like a loss and there is a grieving process involved (Searles, 1985). At the same time, fears of separation and individuation are still present. So the patient is in the process of separating both literally and intrapsychically on the one hand, and worrying about competency and ability to form relationships on the other hand.

As patients begin to realize their loss of sustaining idealizations and face the challenges of independent living, doubt and misgivings about the recovery process begins to grow. Patients can develop periods of deep depression and hopelessness early in this stage as they grieve losses or become overwhelmed by new responsibilities. Patients should not be pushed towards separation or towards treatment, but instead issues of loss and ambivalence should be brought to consciousness and discussed.

Regression to earlier modes of coping and relatedness is common in Stage III, accompanied by symptomatic worsening. Because of imbedded badness, sometimes previous modes of interaction seem more real and alive, than healthier modes. There may be reengagement in maladaptive or abusive relationships. Suicidal and self-destructive behaviors become more prevalent and the patient is likely to relapse into maladaptive coping, such as drinking behaviors.

Regression to earlier modes of maladaptive coping is a manifestation of ambivalence about the recovery process. One common cause for misgivings about treatment and recovery during this stage is an increasing sense of uncertainty as patients begin to integrate their opposing attributions. When I asked a patient what she found most difficult about treatment, she stated: "There is no longer any certainty…and I don't know what to do and I don't know what I want. I get so many ideas that are so opposite and I don't know how to weigh one out more than the other." The patient is describing the development of an integrated self that no longer has split-off polarized attributions, but is instead capable of conscious conflict. Attributions of self and others are no longer black and white, but become gray and ambiguous. However, the price of integration is uncertainty and the responsibility of having to make decisions for oneself.

Other patients will speak of recovery as feeling like losing a part of themselves. Their previous identity may have been formed around the sick role, e.g. as being "bipolar" or "a cutter". One aspect of the sick role is not having to take responsibility for success or failure and to rely on others for support or care-giving. Sometimes patients describe feeling most loved by caregivers when the patients are sick. As they become more autonomous and healthy, patients with BPD must relinquish the sick role and undertake the overwhelming task of finding a place in the adult world with adult responsibilities.

Other patterns of relatedness are also changing. In the past, patients may have felt most alive when engaged in the drama of sadomasochistic relationships. Patients with antisocial traits may have derived self-esteem from their sense of powerful badness and their ability to manipulate others. As these are relinquished, patients often complain that "all the passion has gone out of my life." Now the patient is faced with fears of having to develop closer relationships characterized by increased honesty and vulnerability. A major task for the therapist during Stage III is to bring the patient's ambivalence about recovery into consciousness where it can be worked through and to help the patient to mourn his/her very real losses.

As patients develop increased strength and autonomy, the families of some patients can be very supportive, and new and healthier ties between the patient and family members can develop. Other families, however, are very pathological and may have scapegoated the patient and used his/or sickness as an excuse for all the problems within the family. For such families, recovery poses a major threat to the

integrity of the family unit and members may try to undermine patient success, either directly or indirectly. For instance, they may cut off financial support or give the patient negative messages e.g. "you think you can make it on your own? That's a laugh." It is helpful for the therapist to explore the patient's ambivalent feelings regarding such encounters. It is equally important for the therapist to avoid advising the patient how to respond to such an encounter. Otherwise, the therapist will be taking one side of the patient's ambivalence and not allow him/her to resolve it.

Frequent fears of patients during this stage include fears of eternal aloneness and incompetency, and feeling pressured by new responsibilities, i.e. "I'm never going to find someone" and "I just can't do this." Paradoxically, a great deal of this stress emanates from increased hope they have for themselves. In a life without hope, there is no pressure or expectation to succeed. The presence of hope leads to self-expectations of competency, responsible behavior, and reliability. Living up to these new expectations can feel overwhelming, and there is often a longing for the simpler times of the sick role and freedom from responsibility. The pressures of recovery contribute to patients' tendency to regress during this stage. Old behaviors, such as substance use, may crop up and should be monitored. Patients will often not want to admit to themselves or their therapist that they are doing worse again. During those times when patients are regressed and depressed in Stage III, they need to be directly challenged about the pros and cons of either remaining the sick child or moving on in the hard work of therapy.

Fortunately, during this stage patients often begin to develop closer, healthier, and more authentic relationships outside of therapy. Such relationships are critical for letting go of the sense of imbedded badness, realizing that they can be loved and accepted by others for who they really are. This experience, in turn, leads to increased self-acceptance and acceptance of others' limitations. Patients will also often improve their capacity for employment during this stage, but need to let go and grieve grandiose hopes and ambitions that had sustained them previously and set more realistic occupational goals.

A regressive wish and emerging fear of abandonment can play out in the therapy relationship with increased demands for therapist time. The therapist going on vacation or sick leave may create large anxieties that were not present in Stage II. The therapist may react with countertransference feelings of guilt and excessively reassure the patient, instead of exploring and allowing the patient's fears to be brought to consciousness. The patient may misinterpret therapist words or actions as wishes to terminate the therapy.

Commonly the transference shifts from a warm and nurturing maternal figure to a strong, moral, idealized paternal figure during this stage, sometimes with an erotic component. In part, this shift can be seen as a way to overcome fears of incompetence or unattractiveness by merger and identification with an idealized image of the therapist. In part, it can also be seen as a way of postponing the necessary work of mourning and individuation, and instead merging with an idealized all good, caring, and powerful person, the so-called "golden fantasy" (Smith, 1977).

Frequent countertransference reactions of therapists to this shift in transference include feeling frightened, embarrassed, grandiose, attracted, or repulsed. It is important for the therapist neither to condemn patient feelings as "inappropriate" nor to defensively interpret the transference as a way of keeping it at a safe intellectualized distance, e.g. "Those are the same feelings you had about your father and they're being played out in the transference with me." Instead, it is more helpful to explore, acknowledge, tolerate, and accept the patient's idealizing and/or erotic feelings and fantasies. The identification and idealization process can be an important step in recovery. Of course, boundaries should be maintained, but care should be made to not reject the patient by continually reiterating boundaries as a defensive response to countertransference feelings.

As patients start to discover their unique attributes and gain realistic self-esteem, the nascent self becomes stronger and more integrated, with a sense of continuity and identity. A true sense of morality and empathy also begins to form as patients develop richer, more realistic and comprehensive understanding of the perspectives and motives of other persons and become conflicted about some of their impulsive or antisocial behaviors.

STAGE IV. "AM I READY TO LEAVE?" OVERCOMING BARRIERS TOWARDS SELF-ACCEPTANCE AND LONG-TERM RELATIONSHIPS

The disciple must break the glass, or better the mirror, the reflection, his infinite speculation on the master. And start to speak. **(Derrida, 1978, p. 32)**

Successful negotiation of Stage IV is marked by further movement towards a realistic perspective of self and others, as well as gaining a capacity to bear sadness and loss. As difficult and painful as termination is, learning to leave relationships without feeling rejected or abandoned is a new experience for patients with BPD that helps them to develop a more integrated self and diminished fears of abandonment. The desired end point is characterized by increasingly realistic, integrated, and complex perspectives on oneself and others, and a capacity for more fulfilling and authentic relationships.

As in Stage III, there is continued work on developing more realistic appraisals of themselves and others. Patients must still work through their deep-seated sense of badness as they try to find their place in the world and where they fit in. There may be frantic efforts to improve self-esteem. These may include buying expensive clothes or equipment to feel "normal" or becoming a workaholic to generate more money.   There may be feelings of alienation commingled with resentment, as patients perceive themselves as being different from all the "perfect" people around them, along with increased sensitivity to criticism, real or imagined. At some level, this striving for perfection can be seen as a form of avoidance. It indicates a desire to be free from blemishes so that they can never be criticized, as well as detached from emotions and in control of others so that they can never be hurt. A useful metaphor to bring up with patients is the ideal of the "ice queen" or "ice king", cold, cool, and collected. The therapist can question them, "Are you sure this is what you want? Or do you want loving and fulfilling relationships? If you want the latter, then you need to take some risks and be willing to feel both pain and loss, as well as great joy."

It's incredibly anxiety-provoking for patients to think of removing the camouflage and armor that they have encased themselves with, and to gradually self-disclose and becoming more authentic in their relationships. As patients find that others accept and appreciate them for who they are, despite all their faults, they begin to become more confident in relationships. Group therapy is often a relatively safe place to practice limited self-disclosure and gauge reactions from others.

Until patients move toward acceptance of limitations of self and others, healthy long-term relationships are impossible. In addition, re-engaging in romantic relationships may symbolize total submission and loss of the fledgling self. There are also fears of becoming re-traumatized. One role of the therapist is to bring these fears and concerns into consciousness. Developing close, fulfilling, and non-traumatic romantic relationships is one of the most difficult tasks in recovery from BPD (Stone, 1990; Paris, 2003).

Acceptance by others also facilitates becoming more accepting of self, no longer as afraid of the "monster" inside. A central goal of therapy during this stage is to help the patient continue to mourn the limitations of self and others so that he/she can move towards realistic self-esteem and balanced relationships, acknowledging and accepting both strengths and limitations.

One important limitation that the patient needs to come to terms with is the limitation of the therapist and the patient-therapist relationship. Because of pending termination, it becomes increasingly clear to the patient that the therapist is not a parent-substitute who will be there forever. The nature of the therapist-patient relationship shifts to what Searles (1961) termed "resolution of symbiosis". A major task for the patient is to develop a capacity to perceive the therapist more realistically, reviewing the course of treatment while integrating both positive and negative aspects, and seeing the therapist as a separate person with his/her own needs, limitations, and points of view. Realistic and differentiated attributions of the therapist help promote realistic and differentiated self-attributions (Harpaz-Rotem & Blatt, 2009). Fairbairn (1941) described the transition from identification with the object to differentiation from the object as a necessary stage of maturation.

The therapist will know that patients are in Stage IV because of the increasing emergence of themes of loss, rejection, and abandonment; usually these will appear to be totally unrelated to therapy ending. If patients do not bring up termination within 4 months of their scheduled end date, the therapist should find an opportune time to do so that coincides with discussion of related themes. For example, the therapist can state, "you mention feeling very disappointed and abandoned by your mother during times that she ignored your distress. I wonder if you are also feeling that way about me as we near termination?" Although this may sound relatively simple to do, most therapists find it extremely difficult because of their own feelings of concern, worry, sadness, and guilt regarding terminating the therapy relationship. To some degree, there is commonly a shared avoidance of the topic.

The anxiety experienced by patients regarding termination cannot be overstated and can present as panic attacks. Increased anxiety is not only related to separation fears, but is usually a manifestation of unacknowledged emotions of anger and shame. Patients will attempt to cope with the anxiety and underlying emotions in different ways. Some patients will attempt to avoid their emotions by turning again to substance use. Others may start to miss appointments. Still other patients will attempt to diminish the importance of the therapy relationship and be very devaluing of it or the therapist, thereby avoiding the pain of separation. For example, the patient may state, "The therapy hasn't helped me at all. You have never cared about me and now just want to get rid of me!" Therapist comments that were seen as amazingly insightful just a few months ago may now be ridiculed as way off the mark. The therapist's non-defensive receptivity to devaluing attacks, even if they are very unjust, will help move the patient into a more reflective state and restore the alliance. Once the alliance is restored, it is helpful for the therapist to point out that the devaluation may be an attempt to create distance in the relationship so as to avoid feelings of sadness and loss. For example, the therapist can state, "The challenge for you as we terminate will be to not put me in the box of being like every other person in your life who has failed you. Something different has happened here and it's going to be a challenge for you to hang on to that good, despite the sadness and despite the realization of my many limitations."

Alternatively, patients may deal with unconscious anger be displacing it onto themselves. Instead of being devaluing towards the therapist and feeling abandoned and betrayed, the patient may instead turn the rage on themselves and become depressed and suicidal, or engage in self-harm. The fantasy here, which is often unconscious, is that the therapist is terminating the relationship because the patient is fundamentally bad and unlovable, not worthy of attention. Patients usually experience the depression as coming out of the blue, or due to some external factor, and the first step for the therapist is to ask whether it is connected to the pending termination and feelings of rejection? If the patient can acknowledge perceived rejection, then the therapist can move onto other interventions. Reassurance of the worthiness of the patient at this stage is unlikely to be helpful. Instead, the therapist needs to try to integrate the split of bad patient versus bad therapist, and then to try to help the patient move beyond the split to a place of sadness and loss, where no one is bad and no one is to blame.

An *Attribution* technique to work towards integration would be to proceed through a series of questions and explorations: "Even though part of you sees yourself as the bad one, unworthy of attention, and thus to blame for the upcoming termination, I wonder if another part of you sees me as the bad one? After all, I'm the one terminating treatment." Regardless of the patient's response to this question, it is helpful to follow it with the following interpretation that sets the stage for the remainder of the treatment: "The major task for you in the remainder of our time together is to get out of the blame game and to allow yourself to be sad about ending our relationship. We are not ending because you are bad and we are not ending because I am bad. No one is to blame. We have had a close relationship with a lot of good in it. So it's a loss for both of us, and it's going to be sad. The challenge for you will be to feel the loss, grieve it, and feel sad, rather than feeling rejected or abandoned like all your prior endings. To end a relationship in a good way is new for you, and it's going to be painful and difficult." Sadness implies loss and is an integrative emotion. To end treatment with sadness will enable patients to tolerate and move on from other losses in their lives and will diminish their fears of abandonment.

During Stage IV, there is sometimes an unspoken or spoken wish by the patient for the relationship with the therapist to continue in a different form after termination, i.e. a friendship or

romance (Freud, 1914; Smith, 1977). The patient's wish may be mirrored by a similar wish within the therapist and represents the final form of avoidance of the pain of termination and a trap that the therapist must avoid in order to prevent disastrous consequences. The therapist-patient relationship is fundamentally different from other relationships and cannot be converted to a friendship or romance following termination without ultimately harming the patient or impeding his/her recovery. Frequently the therapist experiences feelings of pride and satisfaction co-mingled with feelings of sadness and loss; loss of both the close relationship with the patient and loss of the pleasure in the patient's idealization. After termination of therapy, the relationship should be limited to <u>infrequent</u> and brief written correspondence to "let me know how you're doing".

During the last few months of treatment, the patient will need to make a decision whether to pursue psychotherapy after termination of weekly DDP. Patients should be reminded that recovery is a lifelong process and that they will not be completely better by the end of treatment. Most patients are taking stable dosages of psychotropic medications at the time of termination and can usually find primary care physicians willing to take on a prescribing role. Patients who were involved in group psychotherapy during DDP may elect to give up weekly individual therapy but to continue the group.

For those patients who have had a good or partial response to the initial 12-month trial of DDP, the therapist can ask the patient's preference to either take a break from all psychotherapy or to continue to meet on a monthly basis for maintenance therapy. An offer of continued low intensity treatment helps ease patient anxiety about termination. Maintenance therapy includes a combination of supportive and DDP techniques. A common focus is to help patients identify ways that they are returning to earlier avoidant coping mechanisms, so that they can get back on track with recovery.

Although most patients do well after termination of weekly visits, some need another round of intensive DDP. If patients start to decompensate during the maintenance phase, they can be offered a 6-month course of weekly intensive DDP *booster* sessions. In my experience, patients usually make far more gains during those 6 months than if they had continued for an additional 6 months of treatment without attempting termination.

If there is no substantial evidence of improvement after the initial 12 month trial of DDP or after the 6 month booster, patients should be referred to a different evidence-based treatment modality, such as dialectical behavior therapy, mentalization based treatment, or transference focused psychotherapy. If these are not feasible or do not work out, it is sometimes helpful for the patient to restart DDP with a different therapist.

Chapter 5. THE THERAPEUTIC STANCE – FINDING BALANCE

This chapter describes the optimal stance for therapists employing DDP. A proper stance is essential for facilitating exploration, the therapeutic alliance, and self-other differentiation. It involves a balance along four different dimensions, as outlined below. However, it is also important to note that a perfectly optimal stance is impossible to achieve.

1. Balancing Attention

The schema of the double register: narration and look at the narration. **(Derrida, 1978, p. 21)**

The therapist must simultaneously attend to patients' narrations of their experiences, as well as to the process of how the narrations are being conveyed and listened to. The term, *process*, refers to the interaction between patient and therapist in the present moment. The process of the interaction is different from the content of what the patient is saying. For example, a patient may be describing a recent interaction with his mother (the content), but the patient may be presenting the narrative in a whiny manner that induces feelings of irritation in the therapist (the process). The therapist must try to fully listen and empathize with the content of the patient's narratives and attributions as a participant in the inter-subjective moment. Paradoxically, the therapist must also serve the role of an outside observer who is attending to and reflecting on the process. In this way, the therapist serves as intermediary between self and *other*, developing both the subjective and objective aspects of the patient's self structure.

$$PROCESS \quad \leftrightarrow \quad CONTENT$$

Therapists' reflection on their own countertransference responses is the single most important guide to the process and is a compass for the direction the treatment needs to take. For example, a patient was complaining bitterly about the actions that Child Protective Services was taking to keep her from seeing her children, and yet she had a sad look on her face and the therapist felt sad with the patient's sadness. Instead of focusing what actions the agency was taking, the therapist responded, "are you thinking about missing your children right now?" This helped the patient realize the depth of her sadness and longing, as well as to feel understood by the therapist.

Therapists' lack of awareness of their own countertransference responses and sources of gratification almost inevitably leads to enactment of the patients' projected expectations (see chapter on *States of Being).* Therapist enactments can include subtle forms of rejection, devaluation, control, intimidation, or rescue. It is important for the therapist to be aware of negative emotions (such as anger, despair, helplessness, boredom, intimidation, or devaluation), positive emotions (pride, sympathy, attraction), and the subsequent urges to either seek relief from negative emotions or to enhance positive emotions through interventions such as advising, educating, reassuring, interpreting, or limit-setting. A good general rule is that the stronger the urge to make an intervention with a patient, the more likely it is going to be an enactment that only serves to reinforce the patient's pathology.

2. Balancing Between the Oppositions

To risk meaning nothing is to start to play **(Derrida, 1981, p. 14)**

Neutrality has been defined and applied in different ways, including therapist withholding emotional responsiveness in an attempt to maintain "the same measure of calm, quiet attentiveness – of evenly-hovering attention" (Freud, 1912, p.324). The rational for 'evenly-hovering attention' is to

facilitate the patient's free association. If the therapist shows more interest in one topic versus another, it has the potential to disrupt associations and encourage patients to select topics that they believe might most please the therapist.

However, patients having borderline personality disorder generally cannot tolerate evenly hovering attention. Many patients will interpret even attention as indicating that the therapist is callous, cold, and uncaring. Thus Safety Concern #1 (i.e. dependency needs) is not met and there is difficulty establishing a therapeutic alliance. 'Evenly-hovering attention' also makes the therapist an easier target for the patient's projections and can lead to unmanageably strong negative distortions of the therapist's intentions.

Although "evenly-hovering attention" is not useful for treatment of BPD, "balance" is critically important. I am using the term "balance" to refer to a different aspect of neutrality, i.e. remaining "equidistant" between competing aspects of the self (Freud, 1936). Although Anna Freud was referring to being equidistant among ego, id, and superego, I am referring to remaining equidistant between polarized attributions. This stance helps patients to feel free to explore different or opposing parts of themselves without worrying excessively about the therapist's approval. Neutrality also implies a warm and supportive, but non-directive stance (maintaining balance between dependency and autonomy). A non-directive and non-judgmental stance helps to keep the patient's poorly integrated polarized attributions from being externalized into a conflict between therapist and patient, and instead keeps the attributions internal, where they can be acknowledged, reflected upon and integrated into a conscious conflict. In order to resolve a conflict, it must first be acknowledged.

The idea of neutrality as balance between opposing attributions is consistent with other definitions of neutrality. Moore and Fine (1990) in their compendium of psychoanalytic terms define neutrality as "avoiding the imposition of one's own values on the patient…to minimize distortions that might be introduced if he or she attempts to educate, advise or impose values on the patient based on the analyst's countertransference" (p.127). Similarly, in *The Psychoanalytic Attitude,* Roy Schafer (1983) describes the neutral analyst as "attempting to avoid both the imposition of his or her personal values on the analysand and the unquestioning acceptance of the analysand's initial value-judgments" (p.6). Neutality has been found to be a strong predictor of positive outcomes with psychodynamic or eclectic psychotherapy (Sandell et al., 2006). In that study, neutrality included the therapist not answering personal questions or sharing feelings, keeping verbal interventions brief, avoiding physical contact or extended communication with family members, maintaining the therapeutic frame, encouraging expression of emotions, and utilizing countertransference reactions to inform therapeutic interventions. Each of these aspects of neutrality is consistent with DDP.

For the opposing attributions of *dependency vs. autonomy*, neutrality entails simultaneously attending to the part of the patient's self that wishes for closeness or dependency, and attending to the part of the self that wishes for separateness or autonomy. Neither side should be excessively gratified at the expense of the other. For example, advising patients on their finances gratifies dependency at the expense of autonomy (see discussion below on "Balancing Between the Safety Concerns").

For the opposing attributions of *victim vs. perpetrator*, neutrality entails the therapist neither siding with the part of the self that puts blame on others, nor with the side that takes on total responsibility. In other words, the therapist must neither imply that the patient is an innocent victim of others' transgressions, nor that the patient is either bad or ungrateful. For example, if the patient seems to be misunderstanding the intentions or actions of a parent, it is very difficult for the therapist not to point that out (thereby siding with the part of the patient that blames himself/herself). On the other hand, if a patient is making excuses for a parent's derogatory or manipulative comments, it is difficult to not point out that the comments were unjustified and inappropriate (thereby siding with the part of the patient that feels victimized). Although these interventions seem reasonable, taking one side of the polarity allows the patient to take the other side and thus avoid acknowledging the conflict and taking steps to resolve it.

Balance tends to be the most difficult aspect of the therapeutic stance. As therapists we have a need to feel we are competent and effective. In order to meet that need, our tendency is to rescue through taking charge, giving advice, becoming a legal advocate, and trying to "fix" maladaptive behaviors, such

as drinking, cutting, violence, etc. Therapists have to sometimes remind themselves that the primary aim of DDP is <u>not</u> for patients to work through early trauma, leave or repair current abusive relationships, gain self-esteem, decrease maladaptive behaviors, or improve occupational functioning. The paradox is that although each of these aspects often improves during DDP, if the therapist directly intervenes towards these aims, positive change is unlikely to happen. Instead, the therapist must keep the focus on remediating patients' ability to process emotional experiences so that they can develop a coherent and differentiated self.

Maintaining a balanced stance is also very difficult when it comes to patient attributions regarding maladaptive behaviors, especially drinking (see section on *Managing Self-Destructive and Maladaptive Behaviors* in Chapter 8, *Specific Techniques*). A common polarity regarding drinking behavior is that alcohol is fun and helpful versus alcohol is bad and shameful. For example, a patient in Stage I was describing how she had recently had a bout of heavy drinking with a male "friend" and then was subsequently beaten and raped by him. The therapist remembered that the patient had experienced similar incidents in the past. The therapist then acted upon an overwhelming urge to suggest that the patient should stop drinking. By doing so, however, the therapist was enacting the patient's attribution of the other as shaming and controlling. The patient became defensive and a control struggle developed regarding the patient's drinking. A better response for the therapist in this situation would have been to empathically explore the patient's reactions to the incident and then to non-judgmentally point out the pattern of the patient's drinking behavior and subsequent trauma. This would include mentioning that the drinking must somehow be very helpful in some way; otherwise she would not continue doing so despite such negative consequences.

3. Balancing Between Competing Needs in the Role of Ideal Other

By virtue of hearing oneself speak…the subject affects itself and is related to itself in the element of ideality (Derrida, 1997b, p. 11)

One challenge for the therapist in the first stage of treatment and recovery is to satisfy the patient's needs for an *Ideal Other* (also see chapter on *Stages of Therapy – Stage I*). These needs could be summarized as dependency, autonomy, and containment, i.e. Does the therapist care? Will the therapist respect my wishes and decisions? And will the therapist contain my neediness and rage? It is partially the satisfaction of such needs that helps the patient to look forward to visits and keep appointments. The Ideal Other serves to facilitate soothing, which promotes reflective functioning and reduces distress and maladaptive behaviors.

The therapist can convey caring by expressing warmth and sympathy regarding difficult situations and concern regarding dangerous situations. Caring is also conveyed by availability (within limits) and by the simple act of listening to what the patient has to say.

Caring involves more than expressing concern. It involves expressing active interest and non-judgmental acceptance for any topic that the patient brings to session (within the limits set at the beginning), tolerating the patient's dependency needs, and not challenging the patient's expectation for perfect empathic understanding between the self and the Ideal Other. Many patients also seek advice, direction, and reassurance from their therapists in order to meet their dependency needs. However, therapists must avoid gratifying their patients (and themselves) in this way since it undermines their patients' need for autonomy and their progress towards individuation.

The therapist can convey respect and support autonomy in several ways. By putting the patient in charge of the agenda for sessions, by seeking agreement on goals and objectives, by allowing the patient to disagree or criticize the therapist, by remaining neutral between the oppositions, and by supporting independent decision-making, especially regarding decisions that the therapist may disagree with, such as drinking. In order to make these interventions, the therapist must adopt an essential optimism regarding

the capacity of intelligent individuals to find their own solutions to life's difficulties, even if those solutions differ from what the therapist thinks is best. The job of the therapist is not to provide solutions or to disagree with bad decisions, but instead to help the patient to become aware of conflicting aspects, desires, and fears, so that he/she can get unstuck and decide what to do.

Figure 5-1

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                    Dependency

                    Ideal Other

      Autonomy                    Containment
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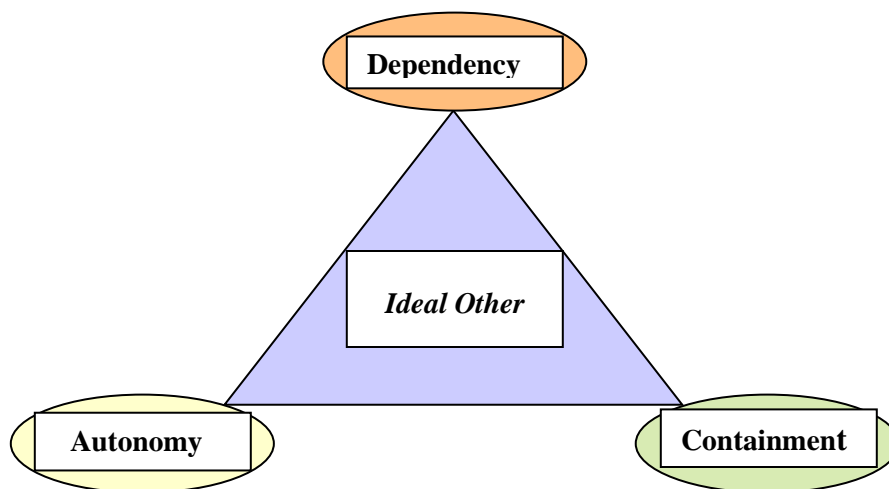
Therapists' support of autonomy includes never putting themselves on the judgment seat by saying, "should". Therapists can also convey respect by not making a priori assumptions about what the patient is experiencing or why. Therapists continually generate hypotheses about patient perceptions and motivations during sessions based on their prior experiences with other patients and based on dearly held theories. To maximize therapeutic effectiveness, however, therapists must adopt a receptive attitude, keep their assumptions, theories, and hypotheses on a back burner, and look at each patient as a unique individual with a unique background, struggles, desires, and needs, and who is involved in a creative process of exploration.

The therapist attempts to walk a fine line between conveying caring on the one hand, while avoiding smothering, control, and intrusion on the other. For example, a patient may ask for advice on how to go about getting a job. This puts the therapist in a dilemma. On the one hand, by giving advice the therapist is demonstrating concern, understanding, and knowledge, and is therefore meeting the patient's need for dependency. Refusing to give advice under these circumstances comes across as withholding, rejecting, and uncaring. However, giving advice jeopardizes the patient's opposing need for autonomy. It involves a paternalistic and self-gratifying attitude of therapist as expert job seeker that says, "I know better than you how you should live your life and resolve your conflicts. You are just an incompetent and helpless child." The role of authoritative expert represents an enactment that invites control struggles and can undermine the establishment of a therapeutic alliance, especially for patients who remain mostly in the autonomous *states of being*.

Strength, certainty, and reliability are also important idealized qualities and relate to need #3, i.e. containment. Strength does not refer to dominating or controlling the patient. Nor does it mean that therapists can never change their minds, apologize, or give in to patient demands. Strength here refers to drawing a line in the sand that cannot be breached in order to keep the therapeutic relationship from being destroyed through transgressions. Although it is helpful for therapists to demonstrate flexibility, there are two boundaries that require consistency despite both internal and external pressures. These include refusing to be threatened or intimidated, and avoiding physical contact. Unconscious fear and desire can pressure the therapist to breach these boundaries, but both represent enactments having high potential for

harm. Therapist reliability is closely related and provides the patient the message that this person can be trusted and counted on with a high degree of certainty. Therapists convey reliability through actions, such as starting appointments on time, returning telephone calls promptly, and refusing to make promises that may not be possible to keep, e.g. "I'll never abandon you."

Limit-setting is important but should be couched in language that supports dependency and autonomy, instead of threatening the patient with abandonment. For example, the rationale for each of the written patient commitments should be carefully explained as the minimum necessary for the treatment to be effective in helping the patient attain his/her own treatment goals, rather than rules intended to find ways to kick the patient out of treatment, but (see chapter on *Establishing the Frame*).

Patients having schizoid or schizotypal traits may be especially difficult to engage and may require a more active stance than with other patients. With this subgroup, therapists often feel emotionally cut-off, anxious, scattered, or bored, and have difficulty making an empathic connection. Patients may become fixated on topics or talk about superficial everyday events, such as what they purchased at the store. They may describe themselves as feeling dead, or like a zombie. If the therapist becomes more directive and tries to structure the session, assign tasks, and ask more questions, the process becomes an interrogation and patients may subsequently become more paranoid or detached. Often a playful attitude is most successful with this subgroup to engage and enliven them, e.g. asking absurd questions or playing with a metaphor in a different context. For example, "So you're feeling like a zombie. What do zombies eat? Aren't zombies a little dangerous?"

4. Maintaining Balance Between the *Ideal Other* and *Real Other*

Affecting oneself by another presence, one corrupts oneself, makes oneself other (Derrida, 1997b, p. 153)

As mentioned above, in order to establish and maintain a therapeutic alliance, it is necessary for the therapist to become the patient's Ideal Other. However, this stance is insufficient to facilitate the patient's movement through treatment and recovery.

The problem with therapists attempting to maintain an extended role as the Ideal Other is that this stance does not allow patients to integrate devalued and idealized aspects of the self and to differentiate self from other. Sigmund Freud's wrote, "We rejected most emphatically the view that we should convert into our own property the patient who puts himself into our hands in seek of help, should carve his destiny for him, force our own ideals upon him, and with the arrogance of a Creator form him in our own image and see that it was good" (Freud, 1919, p.398). The challenge in following Freud's advice is that it can be extremely difficult for therapists to give up the immense gratification inherent in becoming an omniscient parental figure whom patients increasingly depend upon for guidance and support.

Although symptomatic improvement can occur if the idealized therapeutic relationship is maintained (through soothing attachment functions of the Ideal Other), treatment can become prolonged and characterized by excessive dependency or regression. In order for the patient to progress to independent role functioning, the therapist must be willing to relinquish the role of the Ideal Other and begin to introduce the *Real*, i.e. the *not me*, into the treatment. The therapist therefore tries to find a balance between experientially signifying the Ideal Other who satisfies the patient's *logocentric* needs for certainty, understanding, and idealization; and the Real Other or *not me* object (Winnicott, 1953).

The Real is introduced by all the ways the therapist disappoints the patient, i.e. ending sessions on time, limiting the number of phone calls, making unempathic comments, refusing to give advice or reassurance, going on vacation, and, especially, ending treatment at 12 months. The inevitable introduction of the Real Other can jeopardize the treatment and the therapeutic alliance. But it also creates opportunities for strengthening the patient and fostering an adult role. The patient's realization of a *not me* other in the person of the therapist facilitates differentiation of self from other, and the

opportunity to reflect upon and define the self from a position exterior to the self (See *Stages of Therapy – Stage IV*).

Chapter 6. STATES OF BEING[*]

Being must hide itself if the other is to appear (Derrida, 1978, p. 29)

A diagnostic symptom of BPD is "identity disturbance: markedly and persistently unstable self-image or sense of self" (American Psychiatric Association, 2013, p. 663). Persons with BPD will often display a different interactional pattern, self-image, and mood in different situations, consistent with the concept of shifting and poorly defined self-states. Kernberg (1975) has explained this identity disturbance on the basis of poorly integrated (split) object relations. Other investigators have employed attachment theory to explain the identity disturbance of BPD. Ainsworth (1993) reported that internal working models of infant attachment could be classified into secure or anxious categories. Main, Kaplan, and Cassidy (1985) extended the concept of internal working models to involve mental representations of "others, self, and the relationship to others that is of special significance to the individual" (p.68). Instability of internal working models of attachment, including conflicting representations of self and others (Liotti, 2004), provides an alternative explanatory model for the identity disturbance noted by Kernberg of borderline personality organization.

Common to each of these models (i.e. phenomenological, object relations, and attachment) is that an essential feature of BPD is a poorly integrated identity or sense of self, characterized by instability of relationships, self-image, and emotions. DDP hypothesizes that an important cause of this identity disturbance is a deficit in the ability to integrate polarized attributions or beliefs. Persons with BPD assign polarized, binary attributions to their experiences for the purposes of generating meaning, eliminating ambiguity, and maintaining idealizations. In this chapter I will delineate two types of binary attributions of self and other, i.e. value and agency, and discuss how these attributions interact to form discrete states of being.

Binary Attributions of Value

The observation that patients with BPD exhibit opposing, binary attributions has been incorporated into psychiatry's modern diagnostic classification system. Perceptions of self and others are noted to be either all-good or all-bad, i.e. "characterized by alternating between extremes of idealization and devaluation" (American Psychiatric Association, 2013, p. 663). The phenomenon of perceiving others as all good or all bad has been labeled as "splitting". Splitting serves to maintain an artificial sense of certainty, as well as to split off the embedded sense of badness and maintain idealized attributions of self and others.

Binary Attributions of Agency

Another type of attribution that becomes polarized in persons with BPD is that of agency, i.e. the agent of change is attributed to either self or others. If self or others are assigned agency, they are perceived as powerful, responsible, effective, or guilty. If self or others are lacking agency, they are perceived as helpless, blameless, ineffective, or innocent. As agency shifts from self to other, the locus of control shifts from internal to external. In persons with BPD, agency can rapidly shift from self to other and back again. The following case illustrates this point.

Mr. R was a man in his early twenties seen in the emergency department (ED) following lacerations to his wrist. The incident began when he was out with a group of friends, including his girlfriend. During the outing, his girlfriend was paying him little attention except to jokingly belittle him in front of his friends. He took great offense to this and loudly berated her, feeling totally justified in so doing. When he returned to his apartment, however, he began to feel ashamed and remorseful and also feared that she would end their relationship. He then grabbed a knife and deeply slashed his wrists

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hoping to die. When Mr. R saw the blood pouring out, he experienced some relief from his dysphoria and decided to get help. So he called for an ambulance and was rushed to the emergency department (ED). As soon as he arrived there he telephoned his girlfriend and told her what had happened to him.

This case illustrates how binary attributions of value and agency can be clinically manifested. Initially, attributions of agency were entirely in the other and not in the self, i.e. locus of control was initially external. Mr. R's self-perception was as an innocent victim with total justification for his anger towards his bad girlfriend. Self-perception then dramatically shifted into a guilty perpetrator assuming total responsibility for the incident. In other words, the agency or locus of control shifted from other to self. Cutting then served as a form of atonement for his actions through discharging aggression towards the self, getting the badness out of his body symbolically through release of blood (Gregory & Mustata, 2012), and indirectly back again at the girlfriend via the telephone call from the ED.

Karpman (1968) has noted a "drama triangle" of victim, persecutor, and rescuer that constitutes the basic structure of fairy tales and heroic narratives within the classic literature. Liotti (2004) has employed this drama triangle to explain shifts in the internal working models of persons having a disorganized/disoriented attachment style and a history of trauma. "These two opposed representations of the attachment figure (persecutor and rescuer) meeting a vulnerable and helpless (victim) self" (p.479). In the drama triangle, the agency is shared between the evil persecutor and the good rescuer, but the victim has none. Similarly, Blizard (2001) has proposed that borderline personality disorder is a form of dissociation between opposing ego states of victim and perpetrator and alternating attachment styles of either anxious/preoccupied or avoidant/dismissive. Mr. R's perspectives of himself and his girlfriend alternated between victim and perpetrator with the ED as rescuer.

The shift in self attributions from victim to perpetrator described by these investigators corresponds to observations by Kernberg and Meissner. In his later work, Kernberg (2003) has postulated that a dominant object relation of borderline personality organization is victim and victimizer with rage as the underlying affect. Similarly, Meissner (1993) has posited that the central transference configuration within borderline personality is comprised of a dialectic between a victim introject and an aggressor introject. These investigators might explain Mr. R's shift in the attribution of agency as alternating shifts in identification between victim and perpetrator.

Although each of these investigators brings in diverse theoretical perspectives of borderline personality, there are also commonalities. Each of them has described how agency and responsibility is shifted back and forth between self and others. That is, the locus of responsibility is shifted from a position of no responsibility for consequences as victim, to total responsibility for negative consequences as perpetrator.

States of Being

The two different types of binary attributions, i.e. value and agency, interact to form dissociated self-structures or *states of being* within any given person (see Figure 6-1). Each *state of being* is characterized by an attributional system of well-defined (though simple and distorted) perceptions and expectations for self and other. At any given moment there is a level of certainty about the attributions and expectations of self and others and an inability to integrate conflicting perspectives (Akhtar, 1998).

Polarity of the attributions of self and other within each state leads to repetitive stereotyped patterns of interpersonal relatedness. Thus each state is characterized by a *pseudo-personality* or way of being in the world that is complete in itself, but also dependent upon continued inter-subjective enactments with others in order to be maintained. When immersed in a *state of being*, persons with BPD are unable to see other people for who they really are, as separate entities with unique wishes, motivations, and values. Others become distorted through split-off projections of the self.

The term, *state of being*, was chosen to reflect the unchallenged subjectivity of these states with no referent outside the self. This includes the inability to incorporate experiences that contradict the attributions of self and other upon which each state is based, i.e. an inability to develop objectivity. *Being* "is subjectivity itself, the immanence of self in self" (Sartre, 1992,

p.17). The unchallenged subjectivity and the ability to shift *states of being* is a central aspect of borderline personality disorder (Lyons-Ruth, Melnick, Patrick, & Hobson, 2007) and contributes to an identity disturbance characterized by "incompatible personality attributes" (Akhtar, 1984, p.141) or "contradictory character traits" (Kernberg, 1975, p. 165). It is also consistent with the essential feature of instability, as outlined in the DSM-5.

Figure 6-1 illustrates how polarized attributions of value and agency interact to form the four states of borderline personality disorder. Each of these *states of being* is characterized by a predominant motivation to either attach or separate, and assignment of polarized attributions of value and agency to self and others. These states are labeled as *helpless victim, guilty perpetrator, angry victim,* and *demigod perpetrator*, and are reviewed below.

Figure 6-1: Self and other attributions of four states of being

		AGENCY	
		SELF	OTHER
VALUE	SELF	DEMIGOD PERPETRATOR	ANGRY VICTIM
	OTHER	GUILTY PERPETRATOR	HELPLESS VICTIM

The splitting of value and agency leads to stereotypical patterns of social interactions within each state of either dependency or autonomy (Leihener et al., 2003). The corresponding fears are between abandonment, aloneness, and rejection versus smothering, engulfment, and intrusion. There is thus a perceived trade-off between relatedness and aloneness, leading to an inability to feel close and separate at the same time (Fairbairn, 1941; Akhtar, 1994). To be close is to give up one's own values, opinions, and motivations and completely conform to the expectations of the other. To be autonomous is to withdraw from all close relationships and to become isolated, detached, and alone.

Competing wishes for dependency and autonomy are implied within Margaret Mahler's writings. Mahler (1971) situated borderline personality as a developmental fixation at the rapprochement sub-phase of separation-individuation. During this sub-phase, the toddler is torn between a pull towards symbiotic reunification with mother, counterbalanced by fears of loss of autonomy and strivings towards separateness (Mahler & McDevitt, 1989; Pine 2004).

Individuals tend to spend more time in certain states than others. For instance, those having stronger dependency wishes and greater fears of separation and aloneness are more likely to stay in the *helpless victim state* and the *guilty perpetrator state*. Others having stronger autonomy wishes or persecutory fears and are more likely to stay in the other two states. The latter is more characteristic of males than females, consistent with findings that men with BPD are more likely to have co-occurring substance use disorders, as well as meet criteria for co-occurring paranoid, narcissistic, and/or antisocial personality disorders (Johnson et al., 2003). However, it is a defining characteristic of borderline personality disorder to fluctuate among the different pathological states, thereby appearing to have very different personality characteristics from one moment to the next.

I. HELPLESS VICTIM STATE *(other is good, other is bad)*

In the *helpless victim state* of being, both agency and value are assigned to others. Self-image is as an innocent and helpless child, whereas other people are split into either all good and powerful or all bad and powerful images, thereby creating a triadic attribution system analogous to Karpman's (1968) drama triangle of victim, rescuer, and persecutor .

The triad of helpless victim, evil perpetrator, and idealized rescuer is pervasive in popular mythology and epitomized by the legend of Saint George and the dragon (Caxton, 1483). In this myth, a holy knight subdues a dragon that is about to devour a princess. The princess was wearing a wedding dress, thereby symbolizing innocence and purity, and consistent with lack of agency.

The helpless victim state allows patients to maintain self-esteem through shifting the locus of responsibility for negative consequences from self to others. It also satisfies the patient's need for unification with an idealized caregiver, though at the cost of authentic relatedness and at the cost of undercutting the patients' autonomy and individuation.

Countertransference reactions to patients in this state are generally positive, assuming that the therapist is the idealized other, rather than the devalued other, in the triad. Therapists find gratification in their patients' idealization of them and feel effective and omniscient as patients seem to hang on their every word. At the same time, therapists feel warm, sympathetic, and protective towards the patient who so clearly is in need of help and appreciative of their efforts. Therapists often respond to such feelings with an impulse towards directive interventions, including sage advice, suggestions, and insightful interpretations in the role of the wise counselor/rescuer who is going to help steer this unfortunate person/victim in the right direction (Searles, 1961). These interventions satisfy the patient's wish for dependency and provide a feeling of soothing and protection, but there is an unconscious expectation of intrusion and merger.

The *helpless victim state* has advantages from a therapeutic point of view. There is a strong alliance, decreased symptoms, and improved functioning, unless too regressed.   Moreover, the soothing qualities of an Ideal Other combined with externalization of patient's inner sense of badness allows them to start examining and reflecting on distressing experiences and reconnecting with painful affect (Fonagy, 2000).

Although the *helpless victim state* offers therapeutic opportunities, there are also pitfalls. Because this state is mutually gratifying, treatment can proceed for decades with very little progress occurring. It seems like the patient is making use of support, advice, education, and insights, but the treatment never ends. This is because therapist enactment of the role of an idealized parental figure protecting the patient from a persecutory "other" reinforces the patient's self-image as helpless, vulnerable, and dependent.

Alternatively, therapist enactment of the *helpless victim state* can lead to a worsening of the patient's condition. This state can stir up deep felt longings and frustrated rage for an idealized mother-figure and infantile needy behaviors can escalate into a kind of feeding frenzy, especially if the therapist has difficulty setting clear boundaries (Kernberg, 1975). As dependency wishes are activated, separation fears and rejection sensitivity also increase, often triggering a switch into the *guilty perpetrator state* when the therapist inevitably fails to meet the patient's increasingly demanding expectations for the idealized rescuer. For patients' whose childhood experience suggests that relatedness must come at a price of authenticity (Winnicott, 1955), the patient may increasingly fear a loss of autonomy and switch into the *angry victim state*.

In order for the therapist to be of use to a patient in the *helpless victim state*, the therapist must have the same qualities as transitional object, i.e. comforting and soothing like mother on the one hand, but separate or *not me* on the other hand (Winnicott, 1953). The therapist partially gratifies dependency wishes by a warm and soothing manner in the role of the Ideal Other, while also supporting the patient's independent decision-making and creative exploration of his/her unique attributes in the role of the Real *Other*. This experience in the therapy runs contrary to the patient's projected expectations of rejection or intrusion. It is in such *transitional space* between merger and separateness that patients can creatively find and explore their sense of self.

A common challenge early in treatment comes when the patient becomes more infantile, needy, helpless, and confused. The dilemma for the therapist is that the regression may worsen if the therapist crosses the usual therapy parameters and starts to give excessive advice, suggestions, or reassurance. On the other hand, if the therapist withholds advice in the face of patient's needy demands, the therapist is seen as cold and uncaring. The best intervention in this circumstance is often for the therapist to openly state the dilemma. See chapter on *Stages of Therapy – Stage I.*

Other techniques useful in this state are included in the chapter on *Specific Techniques – Associations.* The patient is generally engaged in treatment and the therapist role is mostly to empathically listen and facilitate exploration, while avoiding the gratification inherent in advice, reassurance, problem-solving, and interpretations. Inevitably, in the course of treatment, there will be times when the therapist disappoints the patient in his/her role as Ideal Other. In such situations the patient will struggle with the central thematic question of, "Do I have a right to get angry at this therapist who has been so kind in so many ways?" These disappointments represent therapeutic opportunities. Non-defensive exploration of the patient's hurt and disappointment, and acceptance of the patient's anger runs counter to what the patient expects and can start to deconstruct the patient's binary attributions of value and agency. It also allows the patient to reflect on other disappointing relationships in his/her life and address the core conflicts and central thematic questions in these relationships.

In summary, the *helpless victim state*'s triadic structure provides opportunities for reflection and integration. In early stages of treatment, the therapist does not attempt to deconstruct this state, unless the patient is regressed and dysfunctional. Rather, the therapist allows a soothing, idealizing transference to develop while preventing regression. Regression is abetted by directive interventions and restrained by the therapist's strict maintenance of the parameters established at the beginning of treatment. During the course of treatment, the therapist gradually relinquishes the role of the Ideal Other by fostering patients' independent decision-making, facilitating opportunities for the patient to express non-hostile differences of opinion and criticisms of the therapist, and working through disappointments in the limitations of the treatment and in the patient-therapist relationship (see chapter on *Stages of Treatment*).

II. GUILTY PERPETRATOR STATE *(other is good, self is bad)*

The *guilty perpetrator state* is characterized by depression and hopelessness. Self-image is very negative as the patient assumes total responsibility for every bad thing that ever happened. Individuals in this state perceive themselves as inadequate, defective, evil, and/or a hopeless case, i.e. "I'm just this crazy person who will never get better, so I might as well end things right now." There is a significant risk of suicide.

This depressive state is commonly triggered by separation fears and/or fears of retaliation for attempts to differentiate the self through assertiveness (Rogers, Widiger, & Krupp, 1995). It serves to maintain idealized attachment in a conflicted relationship by owning the blame (i.e. self-agency) for any difficulties. The guilty perpetrator state avoids conflict over agency and the central thematic question of "do I have a right to be angry?" It represents a last ditch effort to hold onto an untarnished image of the Ideal Other in the context of emerging feelings of anger and resentment, but at the price of the patient's self-esteem. For example, this state often follows a therapist's vacation or an incident of physical abuse from a spouse.

Self-destructive behaviors, such as cutting or overdose, are common in this state and serve as a form of atonement for self-perceived badness and thus relieve dysphoria. They also serve to displace aggressive impulses that might otherwise jeopardize a relationship. However, the dependent attachment of the guilty perpetrator state is at the cost of self-esteem, autonomy and genuine relatedness.

The guilty perpetrator state induces anxious and dysphoric countertransference reactions. The therapist is in the awkward position of being stuck in the role of the idealized rescuer, but having no agency and feeling very helpless and/or hopeless. For example, the patient might state, "I know you mean well, but nothing seems to be working. I'm so depressed and need some help!" Therapists are

impelled by an urgency to do something and so regain a sense of their own efficacy.   There may be increasingly heroic attempts at treatment, including escalating dosages of medications, multiple suggestions, and frequent reassurance that things will get better. However, each failed intervention enacts the patient's attributions of the self as being bad beyond redemption and the expectations for the other to be helpless and abandoning.

In addition to feeling desperate and inadequate, therapist may also feel a smoldering resentment towards patients in this state for their lack of response to interventions and their negation of therapist agency. While in the guilty perpetrator state patients may violate agreed parameters of treatment by making increased demands for therapist time (such as multiple telephone calls) even while demonstrating increased passivity and lack of involvement during sessions. The therapist feels victimized by the patient's violations of treatment parameters, passivity, and/or threats of suicide, but also feels trapped by a sense of guilt and worries about tipping the patient into suicide by challenging or setting limits. The therapist is unsure whether he/she has a right to be angry at the patient or whether to take responsibility for the treatment failure. In this way the patient's central thematic question of, "Do I have a right to become angry?" becomes the therapist's and self-doubt becomes a common countertransference reaction.

The guilty perpetrator state can sometimes be mistaken for the *angry victim state* since with both states there can be implicit criticism of the therapist and countertransference reactions can include irritation and inadequancy. However, in the former state the patients engage in explicit self-blame or describe themselves as hopeless cases (having all the agency) and their mood is depressed. Moreover, countertransference reactions to this state include self-doubt, in contrast to the common countertransference reaction of scornful certainty when dealing with the *angry victim state*. Complicating this situation is that patients can sometimes move back and forth rapidly between states in a single session, requiring the therapist to nimbly switch techniques moment by moment.

In order to deconstruct the guilty perpetrator state, it is imperative for the therapist to avoid enacting the role of victimized rescuer, regain agency and restore genuine relatedness so that patients can acknowledge and bear their conflict regarding agency within themselves. One component of treatment is simply to help patients create narrative linkages between their experiences so that they begin to understand the triggers. "When you say depressed, what are you actually experiencing? When did you start to feel this way? What was going on at the time? Did you have a fight with your boyfriend? Did you talk to any of your family members?" However, insight into triggers is unlikely to bring patients out of this state, nor are integrative comments regarding their polarized attributions. Patients in the guilty perpetrator state have a limited ability to reflect on their experiences and therapist interventions to build insight often only serve to deepen this state. Interpretation may represent yet another enactment of the therapist as ineffective rescuer. This state needs to be experientially deconstructed in order for patients to move on in recovery. However, deconstructing the guilty perpetrator state can be challenging.

Deconstructing this state involves the therapist responding in a way that is paradoxically both within the role of rescuer, but contrary to the patient's expectations, i.e. not "all good", not helpless, but confidently challenging patient passivity (see also chapters on *The Deconstructive Experience* and *Specific Techniques – Alterity*). This can be done in a number of ways. A useful rule-of-thumb to keep in mind is that patients with BPD are unable to be depressed and angry at the same time (i.e. depression implies self-agency and no justification, and anger implies other-agency and total justification).

1. The therapist can regain agency by challenging patients on areas where they are not following treatment parameters or participating fully in treatment; for example, by pointing out how the patient may be calling frequently in crisis, but missing sessions or arriving late. These interventions provide an *experiential challenge* to the patient's expectations of the helpless rescuer, and also serve to enable the therapist to feel more empowered and so increase the therapist's empathic capacity.
2. Likewise, the therapist should maintain a non-directive stance in the face of patient demands to do more. This includes letting the patient bring up topics to explore. The message that needs to be conveyed is, "I can't help you unless you decide that you want to move forward in your

recovery by being an active participant." This also conveys hope, because it lets patients know that there are specific actions that they can take to move on in recovery, if they so choose. If patients then switch into the angry victim state and reply with concerns and fears that the therapist is either uncaring or controlling, these should be non-defensively explored through *experiential acceptance.*

3. Since the guilty perpetrator state is often a way of maintaining idealized attachment and diminishing separation fears, this issue should be explored in relation to recent events. This approach is especially relevant in Stage III. With some help, patients are often able to acknowledge how frightening it is to begin to have a voice, a sense of self, to realize self-limitations, and to challenge idealized authority. Many patients will wish to return to the sick role. In Stage III, the guilty perpetrator state can serve the purpose of warding off the patient's anxiety regarding independent adult functioning by becoming depressed, helpless, and hopeless once again, i.e. a depressive regression to the sick role. The conflict of moving on as a recovering adult versus wanting to stay as a sick child can be non-judgmentally brought to consciousness. Patients will begin to talk about how frightening it is to have hope of a future and the pressure of meeting new expectations for themselves. They can be reminded that recovery is a choice and that it is reasonable to elect not to proceed in such a difficult process.

4. Given that the guilty perpetrator state serves a defensive reaction to separation fears and transforming feelings of anger into self-directed aggression, it is helpful to explore patient reactions to recent relational situations and then to bring these into the discussion. For example, "How did you feel when your father refused to help you on the ski slope? Do you sometimes feel the same way here with me? So you sometimes see me as very uncaring and withholding…that sounds important…can you say more about that?" This serves to bring the central thematic question ("do I have right to be angry?") into the transference, where it can be deconstructed through providing the experience of non-judgmental acceptance of negative feelings, disagreement, or criticisms of the therapist within the here-and-now of the patient-therapist relationship. The therapist seeks to convey a message of acceptance (instead of rejection/separation) for the patient's frustration, irritation, or dissatisfaction with the therapist. This approach is especially relevant in Stage IV, where the patient is experiencing separation anxiety, anger, and disillusionment with the therapist and the treatment process. Successful deconstruction of the guilty perpetrator state in Stage IV involves bringing those emotions and perspectives into consciousness and providing empathic and non-defensive acceptance.

5. Other patients benefit from more subtle, indirect or paradoxical approaches. For example, it may be helpful to state, "it will be a great achievement in your recovery when we can have a disagreement or argument that doesn't end in hostility, self-destructive behaviors, or fears that the relationship will end over it." With each of these techniques, the therapist is helping to put the central thematic question and conflict where it can be resolved, i.e. within the patient.

III. ANGRY VICTIM STATE *(self is good, other is bad)*

In this state, agency is assigned to others, who are seen as persecutory. Patients' self-image is idealized as the heroic victim who endures life's trials. Their slogan is "I can't soar like an eagle when I'm surrounded by turkeys."

The *angry victim state* serves to enhance self-esteem and protect against feelings of shame and fears of humiliation through externalization of responsibility/agency for negative consequences and through idealization of the self. They have prominent paranoid and/or narcissistic traits, devaluing, suspicious, entitled, and blaming others for their problems. If their focus is primarily on the persecutory other, i.e. blaming others for negative consequences of their own actions, then the predominant

personality tone will be paranoid. If their focus is primarily on the idealized self, then the predominant tone will be narcissistic, and they will appear grandiose and pompous.

In this state, patients typically complain about other people, including their motivations, interactions, and behaviors. They feel totally justified in those complaints since the locus of responsibility is external to the self. Patients' behavior is frequently demeaning, controlling, and intrusive towards the therapist.

From a relational perspective, this state fulfills wishes for autonomy and mitigates merger fears. "These patients identify themselves with their own self images in order to deny normal dependency on external objects" (Kernberg, 1975, p.231). The cost to the patient, however, is isolation and fearfulness. Unlike the *helpless victim state*, there is not the soothing Ideal Other to allow space to reflect upon the split oppositions and begin to integrate them. Instead, the patient's potential conflict regarding opposing attributions of agency is externalized into control struggles, i.e. the internal conflict becomes an external conflict. Hostility and threatening behavior also can become an issue in this state since the patients feel totally justified in their actions towards a persecutory other. Hostility is as harmful to the perpetrator as the victim; it ultimately reinforces a negative self-image and the embedded sense of badness, and therefore impedes recovery.

Substances are frequently utilized by individuals in this state as a substitute for the soothing functions of the Ideal Other (Johnson, 1993). There is evidence that attachment behavior and the use of addictive substances are mediated through the same neurobiological pathways (Moles, Kieffer, & D'Amato, 2004; King-Casas et al., 2005; Bartels & Zeki, 2004). Substance use facilitates patients' toleration of separation and allows them to stay distant and in control. Patients may describe drinking or drug use as the only way they can be themselves, i.e. authentic, and be relieved of the burden of meeting others' expectations in order to maintain relatedness.

Countertransference reactions to the angry victim state closely parallel those of the patient, making this state the most contagious of the States of Being. Therapists may feel victimized and devalued by the patient's criticisms and whining complaints. Typical countertransference reactions are scorn and/or irritation. There is a strong impulse to retaliate for the patient's unjust attacks by "setting limits" or giving the patient a "reality check". These interventions are often rationalized by the therapist as fully justified in order to contain the patient's grandiosity and sense of entitlement. However, they end up enacting the patient's expectations for humiliation and rejection.

Winnicott (1969) posited that the key to recovery is survival of the patient's destructive attacks without retaliation. Acknowledging (to oneself) hateful feelings towards patients when they occur allows the therapist to reflect, instead of retaliate, and to interact in a way that is contrary to the patient's projective expectations (Winnicott, 1949).

Specific techniques that may be helpful include mirroring of grandiosity, non-defensive process exploration, and internalizing (see chapter on *Specific Techniques*). Mirroring is an intervention that is diametrically opposed to the patient's projective expectations of the other as humiliating and rejecting. It involves going against the complementary tendency to deflate the grandiosity, but instead to express appreciation for the apparently stellar achievements or qualities that the patient is boasting of. Paradoxically, the response to mirroring can be a sudden and dramatic elimination of grandiosity and defensiveness, and the beginning of genuine engagement.

Experiential acceptance is a primary tool for deconstructing the Angry Victim State (see chapter on *Specific Techniques – Alterity*). The countertransference response to demeaning and suspicious comments towards the therapist is commonly a feeling of angry resentment regarding the patient's unjust attacks and an urge to either go into defensive explanations or to "set some limits" and let the patient know he/she is being hostile. For example, the patient may imply that the therapist simply wants a guinea pig for his/her experiments, doesn't have a clue how to be an effective therapist, and lacks genuine concern regarding the patient's welfare. The natural tendency is for the therapist to respond with reassurance regarding a genuine commitment to the patient's recovery and to indicate that the patient is jeopardizing recovery by assuming a suspicious and hostile attitude. However, this intervention usually sounds defensive to the patient's critical ears and results in further testing, i.e. the therapist is an outside

other who cannot be trusted. Alternatively, the patient may take the therapist's words to heart, become extremely remorseful, and switch into the *guilty perpetrator state*. Although this switch helps the therapist feel more relaxed, confident and in control, it does nothing to aid the patient in the task of recovery. A better response would be to empathically bring out the concerns into the open without challenging them, as if talking about a third person. For example:

> It sounds like you're concerned that I just see you as a guinea pig. What is that like for you to have a psychiatrist who you feel sees you as a guinea pig?

In this way the therapist is both an empathic insider, as well as a hostile outsider. The therapist's position as both inside and outside of the patient's self-structure and receptivity to the patient's efforts at self-assertion challenges the patient's sense of certainty regarding the attribution of the other and challenges the expectations for the other to be humiliating and rejecting (see chapter on *The Deconstructive Experience*).

Yet another effective technique for the angry victim state is *internalization* of agency (see chapter on *Specific Techniques – Attributions*). Internalization subtly challenges the patient's externalization of conflict. For example, if the patient is complaining about people treating him like he's crazy, the therapist can gently inquire whether the patient has also had doubts about his sanity. This puts the conflict of responsibility and self-image back into the patient, where it can be processed and worked through. Since this technique involves an indirect challenge to the patient's self-esteem, it should be used sparingly in the first stage of treatment, when the patient is testing safety concerns regarding the therapist.

IV. DEMIGOD PERPETRATOR STATE   *(self is good, self is bad)*

In the *demigod perpetrator state*, attributions of the other are without either agency or value. The attribution of the self is an idealized badness. Self-esteem is derived from the ability to manipulate and use other people and relatedness has a detached quality. Antisocial traits predominate. The mood tends to be either elated or blunted.

Patients are likely to enter this state when fears of intrusion or persecution become very strong. The *demigod perpetrator state* creates distance and a sense of empowerment in relationships. In this state, other persons are non-entities, neither good nor bad, merely helpless pawns on a chessboard to be used, discarded, ignored, or tormented according to the pleasure of the master. There is also gratification from aggressive discharge and sadistic activities. Recent neurobiological research confirms that aggression activates areas of the brain associated with anticipated rewards and pleasures (de Quervain et al., 2004). Patients who stay in this state often engage in thrill-seeking activities and exciting sadomasochistic dramas in order to provide a sense of "realness" or "aliveness" that they are unable to derive from their shallow relationships.

Substances are frequently employed in this state to provide soothing functions, as well as to enhance feelings of elation, detachment, and/or omnipotence. However, the sense of omnipotence combined with frequent substance use and sadomasochistic engagements often lead to repeated re-traumatization through physical altercations. They may also engage in indiscreet, impulsive or hypomanic behaviors, which they later regret. The negative consequences challenge their sense of agency and omnipotence. It is therefore not uncommon to rapidly move back and forth from this state to either the *angry victim state* or the *guilty perpetrator state*.

Whereas relatedness in the *angry victim state* is characterized by devaluation and suspiciousness, relatedness in the *demigod perpetrator state* is characterized by devaluation, detachment, and/or intimidation. Countertransference emotions can vary from shared elation to detachment to fearfulness and reactions tend towards appeasement. Sessions can be jovial and chatty; the therapist may share delight in the patient's exploits and feel relieved that the patient no longer seems whiny, angry, or

depressed. Other feelings can include boredom or detachment as the therapist struggles to elicit any meaningful emotional response from the patient.

Alternatively, the patient's attitude may be controlling, intrusive, and intimidating. In these circumstances, therapists may feel too frightened to set limits on the patient's demands, like a mouse paralyzed by a snake's glare. By letting themselves be intimidated, however, therapists inadvertently reify the patient's empowered self-attribution and negation of the other.

The attributions of self and other in the *demigod perpetrator state* resemble Kernberg's (1989) description of a merged grandiose and sadistic self in antisocial personality. Kernberg differentiates antisocial personality from malignant narcissism on the basis of an inability to idealize others in the former case, including "a dramatic conviction of the impotent weakness of any good object relation" (p. 567).

The following example illustrates interactions within the *demigod perpetrator state* and the potential for enactment. An exotic dancer in her early thirties was generally very chatty during sessions and would dress seductively. She stated that all her former therapists became her "friends". In fact, I found it difficult not to chat and joke, as this was a very enjoyable mode of interaction with the patient. She insisted that all sessions be paid in cash (the currency of her profession), which she would throw on the table in a contemptuous fashion at the end of each session. She was displaying towards me the same contempt that her clients showed her.   It was only through repeated confrontation and clarification of this interpersonal pattern that the patient was able to begin to relate in a genuine and open manner.

To deconstruct this state, the therapist must be able to limit the patient's hostility and so place himself/herself outside of the patient's omnipotent control (Winnicott, 1969). This involves interacting in a way that is different from the patient's expected attributions of the other as without agency or value, and for the therapist to feel empowered in the relationship. That can be difficult in a setting of intimidation, but is necessary if the patient is going to successfully and meaningfully engage in therapy.

Hostility or boundary violations in the therapy can be subtle. For example, the patient might start calling the therapist by his/her first name without being invited to do so. An important clue to the dynamics is the therapist's countertransference reaction. A countertransference reaction of fear, intimidation, or appeasement suggests that the patient's attributions of the other are without value or agency and that the therapist is identifying with these attributions. Under these circumstances, to do nothing represents an enactment of the patient's expectations.

Such boundary infringements are most likely to occur in the initial stage of therapy and represent a testing of safety concern # 3, i.e. "is the therapist able to contain my powerful aggressiveness?" The challenge is how to set limits on patient's hostility, demeaning attitude, or boundary violations and still maintain an empathic attitude. Often an explicit discussion of conflicting safety concerns, i.e. needing a therapist who is both caring and containing, can provide a helpful framework to decrease anxiety, and also helps to define the issue as a conflict that the patient needs to resolve.

Other techniques include pointing out the patient's detachment or chattiness and providing an experiential challenge to the patient's commitment to recovery (see chapter on *Specific Techniques – Alterity*). Such challenges must be introduced slowly and empathically, however, given the sheer terror that these patients have regarding emotionally close relationships. Parameters of treatment need to be maintained, including limiting hostility and insisting on patient ownership of the treatment process. At the same time, the therapist needs to empathically explore and empathize with the patient's fear of closeness and need to be in control. Problematic behaviors, such as drinking, should be explored within this context.

OTHER PERSONALITY TRAITS

The *states of being* do not account for co-occurrence of histrionic obsessive-compulsive, schizoid, or schizotypal traits. These traits can occur within or outside any of the states and thus are not amenable to experiential deconstruction. Patients having schizoid or schizotypal personality traits are especially

challenging since they have more muted and less emotionally engaged transference to the therapist and thus are unable to benefit as much from experiential techniques (See Chapter 5, The Therapeutic Stance). They may therefore require a prolonged period of treatment in Stage I in order to develop a trusting, soothing relationship with an idealized other.

SUMMARY OF TREATMENT IMPLICATIONS FOR THE STATES OF BEING

The term enactment refers to those occasions when there is confluence between the patient's expectations of the other (based upon polarized attributions of self and other in any given state) and the actual behavior of the other. Although some theorists argue that enactment is an inevitable component of countertransference, I am distinguishing between countertransference as a <u>feeling</u> and enactment as an <u>action</u>. Whereas countertransference is a helpful compass to guide the therapist's interventions, enactment reinforces patients' pathological expectations of themselves and others.

The term countertransference is employed in a broad sense in this manual to describe any feelings that the therapist may have towards the patient for whatever reason. These can also be either positive or negative. What is most important is for the therapist to learn to recognize and acknowledge such feelings, particularly when the therapist feels compelled to initiate an intervention. Because of inherent tendencies towards enactments in the treatment of BPD, the therapist's countertransference feelings provide an important clue regarding the moment-by-moment process within the patient-therapist relationship and for patient expectations for others' behavior. Negative feelings towards a patient are not bad in and of themselves. It is only when those feelings turn into an enactment that they become harmful.

If the supposition is correct that persons with BPD have *logocentric* self-structures characterized by a need for certainty and for unified understanding between speaker and listener, then it follows that the therapist should, to some extent, accommodate these needs in order to decrease anxiety and maintain an alliance. For example, the *logocentric* need for a unified understanding with the Ideal Other can be accommodated through reflective listening and empathic statements that convey understanding (see chapter on *Specific Techniques – Ideal Other).* Numerous clinical investigators have highlighted the importance of reflective listening and empathy, and have noted that such interventions serve to decrease anxiety (Rogers, 1992).

In addition, providing explicit treatment expectations and contingencies can accommodate the patient's need for certainty, including what is expected of the patient and what the patient can expect from the therapist. Other investigators have noted that formalized written treatment commitments improve the therapeutic alliance and allay anxiety, and have incorporated this strategy into their treatment methods for borderline personality disorder (Bateman & Fonagy, 2004; Clarkin et al., 2006; Linehan, 1993).

However, as patients progress through treatment, *logocentric* needs, idealizations, and devaluations must begin to be challenged in order to maintain a therapeutic alliance and promote differentiation and individuation (Gregory 2004, 2005). Because each *state of being* is maintained by interpersonal enactments, therapists' responses can either reify the attributions and expectations of a given state, or begin to deconstruct them. By interacting in a manner that contradicts the patient's one-sided attributions and expectations of the other, the therapist is able to challenge the patient's attribution system, and open up new perspectives and possibilities. A change in the patient's expectations of the other necessarily challenges the expectations for the self.

The therapist therefore tries to find a balance between experientially signifying the Ideal Other who satisfies the patient's *logocentric* needs for certainty, understanding, and idealization; and the Real *Other* or *not me* object (Winnicott, 1953) who signifies "a displacement that indicates an irreducible alterity" (Derrida, 1981, p. 81). The patient's realization of a *not me* object in the person of the therapist leads to differentiation of self from other, and the opportunity to reflect upon, self-soothe, and define the self from a position exterior to the self (see chapter on *The Deconstructive Experience*).

In addition to experiential interventions, the therapist can also deconstruct *states of being* through a play with patients' descriptions of their polarized attributions (see chapter on *Specific Techniques – Attributions*). The therapist attempts first to open up new meaning through inquiring about alternative or

opposing attributions, and then to bring together opposite attributions simultaneously. For example, a therapist utilizing this technique might state to Mr. R, "I notice that you either blame others and see yourself as a victim, or blame yourself for all your difficulties and see yourself as the perpetrator. When you are the victim, it is your girlfriend who is the perpetrator and vice versa." Kernberg (1991, p.197) described this type of intervention as an *atemporal transference interpretation*, serving to neutralize splitting and build ego strength.

Such an intervention is also consistent with deconstruction theory. Derrida proposed that a deconstructive reading of a text involves trying to "find out how their thinking works or does not work, to find the tensions, the contradictions, the heterogeneity" (Derrida, 1997a, p. 9). It then involves bringing together the "two poles of an opposition…each challenging, perverting, and exposing the impurities and contradictions in their neighbor; and at some point…give rise to something else" (Derrida, 2004, p. 153). Derrida (1981) employed the term *différance* to describe the potential for new meanings and possibilities to emerge through this process of binary analysis, i.e. *différance* is "that which produces different things, that differentiates" (p. 9).

Chapter 7. THE DECONSTRUCTIVE EXPERIENCE

The organ thus welcomes the difference of the stranger into my body: it is always the organ of my ruin **(Derrida, 1978, p. 186)**

Deconstruction theory was developed by Jacques Derrida as a reaction to classical Western philosophy's assertion of essential meanings or truths and delineation of definite identities. An essential meaning or identity implies a degree of certainty, lack of ambiguity, and exclusion of opposing ideas. Derrida referred to this phenomenon as *logocentrism*, i.e. the "ideal of perfect self-presence, of the immediate possession of meaning" (Derrida, 2004, p. 147).

In his later work, Derrida extended the concept of *logocentrism* to societal values and group identity. For example, Derrida argues that exclusion and devaluation of others is an inherent part of *logocentrism* and creates a sense of unified identification and belonging among the insiders – the valued group. Derrida is referring here to the *other* as representing the devalued and excluded group, the outsiders, the contaminants. For example, the identity and coherence of Nazi Germany as a pure and superior Arian race depended on the devaluation and exclusion of the Jews and other ethnic groups. "The rapport of self-identity is itself always a rapport of violence with the other…dependent on an oppositional relation with otherness" (Derrida, 2004, p. 149).

The following case illustrates how this aspect of *logocentrism* can be relevant to the clinical situation.

Case

Ms. A was a young woman who was seeing me in weekly psychotherapy for treatment of self-injury related to borderline personality disorder. As a teenager, she had left an abusive home situation to enter into a long-term relationship with a boyfriend who was also sometimes physically abusive. The relationship was chaotic and her perception of self and other would radically differ at various times. Often she would describe her boyfriend in idealized terms, as being thoughtful and considerate, and she would imagine the perfect union with her future husband. Other times, she would angrily describe her boyfriend in devaluing terms. On these occasions she perceived herself as the heroic victim putting up with his transgressions. This perception would shift, however, immediately after episodes during which he would become violent towards her. Paradoxically, Ms. A would react to his violence by blaming herself for provoking him or for being insufficient to meet his needs, and would enter into a very depressed state accompanied by self-injury. Each of these three situations was accompanied by a sense of certainty or truth about her perceptions of herself and her boyfriend. There was no recollection that she held very different perceptions of self and other on previous occasions.

This case ties into the concept of *logocentrism* in that idealization of self was dependent upon devaluation of other, and vice versa. Another aspect of *logocentrism* was that in each of the three scenarios, the patient manifested certitude, lack of ambiguity, and inability to self-reflect. There was no integration of previous experiences or perceptions that contradicted her present belief system. This is consistent with the previous discussion on *states of being* . Ms. A was manifesting a different *state of being* in each of these scenarios. Each state has characteristic attributions of self and other guiding patterns of interactions with no integration of alternative self and other attributions.

Case (continued)

Ms. A's perceptions of me and the pattern of our interactions would shift depending on her relationship with her boyfriend. For instance, during times when she would idealize her relationship with

her boyfriend, Ms. A would be more detached from me in our sessions and have difficulty bringing up meaningful material. I would not hear from her between sessions and during sessions she would talk about leaving therapy and not needing it anymore.

However, she would reattach to me after each of her boyfriend's violent episodes. Ms. A would call me between sessions expressing feelings of depression and desperation (even calling more frequently than our treatment contract of up to two telephone contacts per week). During sessions she was emotionally involved but very passive, waiting for me to ask questions and to provide direction. None of my suggestions, however, seemed to help. While in the midst of one of these depressive episodes she stated, " I can't believe I drove him to do that. Now he's going to leave me. I just feel like dying! What should I do?"

Ms. A was unable to integrate conflicting perceptions and experiences with her boyfriend or me and so lacked an empathic and realistic understanding of our motivations. At any given time I was just an idealized or devalued extension of her *logocentric* self-structure. She was unable to see me for who I really was. Thus when she idealized the relationship with her boyfriend as a united and perfect couple, I became devalued and excluded as an interfering interloper. I was an outsider, a contaminant, and the *other*. Paradoxically, I was also an essential extension of the self, albeit an externalized and devalued aspect, that allowed Ms. A to maintain an idealized view of herself and a unified relationship with her boyfriend. I.e. I was still within her hierarchical *logocentric* self-structure of idealized and devalued attributions, even though I was consciously considered an outsider.

When Ms. A became depressed, the s*tate of being* shifted to the g*uilty perpetrator state* but remained *logocentric*. I became idealized in the role of rescuer and the boyfriend became the idealized victim, even though he had been physically violent. Ms. A now devalued herself as an outsider who was going to be excluded, i.e. abandoned by her boyfriend and/or myself. Paradoxically, but consistent with the *guilty perpetrator state* (see chapter on *States of Being*), she retained the agency as being irredeemably bad. I was the helpless rescuer who was unable to make positive suggestions.

What is the most helpful intervention for the therapist to make in this situation, other than ascertaining and assuring safety issues? Ms. A is depressed and asking for help. One option is to advise the patient to leave her boyfriend. Assure Ms. A that no one has the right to be violent, that she is not to blame, and that the stress of trauma is causing her depression. The difficulty with this strategy is that even if the advice succeeds and Ms. A leaves the relationship, her self-structure remains unchanged, and the idealized and devalued attributions of self and other merely exchange places. The therapist becomes the idealized and effective rescuer, the patient is now the innocent victim, and the boyfriend becomes the devalued perpetrator who is now excluded from the relationship between patient and therapist. If the advice fails, then Ms. A reverts to the previous state where the therapist is the excluded interfering interloper. Whether or not Ms. A follows the advice, the self-structure remains the same.

An alternative intervention is for the therapist to interpret or point out Ms. A's pattern of alternating idealizations and devaluations. Kernberg (1975) developed this intervention for the treatment of borderline personality organization. Treatment involves bringing both poles of idealized and devalued attributions into consciousness simultaneously, thereby neutralizing the splitting. For example, the therapist could state, "right now you have a need to see me as all-good and yourself as all-bad. But yesterday the roles were reversed and I was the all-bad, interfering therapist. For you there is no in-between." Such an intervention is consistent with the aims of deconstruction to make explicit both the idealizing and devaluing aspects of a supposition and can be useful for that purpose.

A risk to interpretation of splitting, however, is that interpretation given with assurance can sometimes reinforce *logocentrism* within the patient-therapist relationship. Interpretation is an act of translation that potentially limits ambiguity in order to determine a certain meaning. In striving to achieve a definite meaning, interpretation therefore risks colluding with the patient's exclusion of alternative perspectives and complexities of meaning.

In addition to limiting ambiguity and complexity, assured interpretation also risks reinforcing the perception of the therapist as the all-wise, idealized conveyer of meaning and of the patient as helpless

and child-like, thereby experientially confirming the splitting of the underlying self-structure into idealized and devalued attributions. Risks inherent in authoritative interpretations have been debated extensively and are reviewed elsewhere (Kernberg, 1998; Schafer, 1998). Derrida warned to "avoid both simply neutralizing the binary oppositions of metaphysics and simply residing within the closed field of these oppositions, thereby confirming it….To deconstruct the opposition , first of all, is to overturn the hierarchy at a given moment" (Derrida, 1981, p. 41).

If authoritative assertions run the risk of experientially reinforcing *logocentric* self-structures, what kinds of relational experiences might challenge or disrupt a *logocentric* self-structures, instead of merely switching states? This question is closely related to the concept of the *corrective emotional experience* and to other therapy modalities that rely on experiential aspects of the patient-therapist relationship. The corrective emotional experience is a term employed initially by Franz Alexander (1950) to describe innate healing aspects of the patient-therapist relationship. He posited that healing does not result solely from insight or interpretation, but instead from the way in which the therapist interacts with the patient. The patient-therapist relationship can provide healing insofar as it differs from, corrects or repairs earlier traumatic childhood interactions, instead of reenacting them. Alexander may have answered Ms. A. with suggesting an increase in the frequency of sessions or telephone calls as a way of assuaging her fears of rejection and preventing reenactment of abandonment.

The therapist role as substitute parent is concordant with Ms. A's wish for merger with an idealized all-loving parental figure. Patients can feel enormously soothed and relieved through such an idealized relationship (Kohut, 1971). As with the previous interventions, however, the therapist runs the risk of reinforcing the patient's self-attributions as child-like, helpless, and defective. By staying within the *logocentric* hierarchy the therapist inadvertently fosters dependency, repeating the pattern of idealization and devaluation with different configurations or different players in "an interminable analysis. The hierarchy of dual oppositions always reestablishes itself" (Derrida, 1981, p. 42).

Can deconstruction theory help provide an alternative experiential model to parental substitution? The application of deconstruction theory to treatment would emphasize deconstructing Ms. A's pathological *logocentric* self-structure, rather than adding what is missing. How can the therapist experientially disrupt the patient's self-structure and still retain relatedness?

The challenge is that the therapist often feels compelled to act in a way that is consistent with the patient's polarized attributions of the other. In Ms A's case, I felt compelled to advise her to leave her boyfriend. I enjoyed Ms. A's idealization of me, but felt helpless to offer anything of value, and thus was compelled to do more. However, every directive intervention I made was ineffective and only reinforced the patient's self-attribution of being irredeemably bad and of the patient's attribution of the other as meaning well, but lacking agency to effect change.

Therapists' identification with their patients' polarized attributions provokes counter-therapeutic interventions that are consistent with expectations, and which form the basis for enactment (Racker, 1957). Enactment may or may not be traumatic, but is always stereotypical and reinforces the *state of being* derived from those attributions. When therapist interactions do not conform to expectations, *states of being* can begin to deconstruct into more integrated, complex, and differentiated self-structures. In order to experientially challenge a pathological and polarized self-structure, the therapist attempts therefore to provide a *deconstructive experience*, rather than an emotionally corrective experience.

In philosophical terms, the therapist is attempting to create a *différance* from the duality of signified and signifier (Derrida, 1981). In other words, the therapist must not only be signifier for the patient's idealized and devalued attributions, but must also create a *différance* or space between the patient's attributions and the actual behavior of the therapist. The patient must experience the therapist's position as within the conflict, as well as outside of it (Derrida, 1981). "Deconstruction is not a method or some tool that you apply to something from the outside. Deconstruction is something which happens and which happens inside" (Derrida, 1997a, p. 9). An experience whereby the signifying extension of the self (the therapist) behaves differently from expectations provides an opportunity for the self to "appear to itself as other than itself, so that it can interrogate and reflect upon itself in an original manner" (Derrida, 2004, p.140).

The deconstructive experience is a technique that can be employed to disrupt negative enactments within the patient-therapist relationship or to support patient individuation and differentiation (see chapter on *Specific Techniques – Alterity*). In brief, the deconstructive experience is informed by paying attention to the patient's emotional themes within their narratives and the therapist's own countertransference responses, and assessing the patient's current stage of recovery and *state of being*. This information together can help the therapist understand the underlying dynamics of the process so as to determine the most suitable intervention to disrupt this process.

What would have been a deconstructive experience for Ms. A? Since her attributions included the therapist as idealized but lacking agency, and the patient as irredeemably bad, the experience with the therapist would necessarily challenge those perceptions while retaining relatedness. For example, the therapist might point out how Ms. A has not been actively bringing up material during sessions and yet has been calling more in-between sessions. The therapist may express puzzlement with her about the behavior and inquire whether she has mixed feelings about treatment. The therapist has thus refrained from assuming either an expert or rescuer role, but instead is observing that the patient is choosing to not fully participate in treatment.   The therapist is regaining agency by challenging Ms. A's self-attributions of being irredeemably bad and deconstructing her expectation that the therapist would try to rescue her, but would be ineffective. A deconstructive experience can broaden attributions to include new possibilities for the self and move patients into a more reflective and differentiated state.

Of course, several theorists have already incorporated aspects of the deconstructive experience into their frameworks employing different nomenclature. Of the major theorists, Roger's (1992) has perhaps been most explicit regarding his attempt to overthrow the usual hierarchy of the patient-therapist relationship. His client-centered treatment model emphasizes a therapeutic stance of mutual openness, authenticity, acceptance, and equal authority between therapist and client. A potential risk, however, is for the therapist to be devalued and excluded (since the therapist is refusing to be idealized) thus making it harder for the client to engage in treatment. Alternatively, the therapist who combines mutual openness with directive interventions risks blurring boundaries of self and other, and may be perceived as an idealized extension of the *logocentric* self-structure.

Winnicott's description of the transitional object as the first *not me* possession (Winnicott, 1953, p. 1) is consistent with deconstruction qualities of being both within and outside of the self. I.e. "the transitional object is never under magical control like the internal object, nor is it outside control as the real mother is" (Winnicott, 1953, p. 10). It is a symbolic object that is both united with mother and apart from her, i.e. "its not being the breast (or the mother), although real, is as important as the fact that it stands for the breast (or mother)" (Winnicott, 1953, p. 6). Finally, Winnicott discusses transitional phenomena, such as play, as being "not *inside* by any use of the word…. Nor is it *outside*, that is to say, it is not a part of the repudiated world, the not-me, that which the individual has decided to recognize (with whatever difficulty and even pain) as truly external, which is outside magical control" (Winnicott, 1999, p. 41).

Thus the deconstructive experience involves the use of the therapist as a transitional object who is simultaneously both part of the split-off and projected self, and who is also a separate person standing outside the self. Therapy itself becomes a transitional phenomenon that allows the patient to "weave other-than-me objects into the personal pattern" (Winnicott, 1953 p. 3) and thus develops a capacity to differentiate between self and others and to gain more realistic appraisals. The ability to maintain an outside perspective towards oneself and others I have labeled as *alterity* (see chapter on *Conceptualization of Borderline Personality Disorder*).

Other clinical theorists have also incorporated deconstructionist elements. Buie and Adler (1982) have described disillusionment in the idealized image of the therapist as a necessary stage in the treatment of borderline personality disorder. I.e. it is necessary for the therapist to first be idealized as an extension of the patient's self-structure. However, the therapist must eventually be de-idealized through disappointments in the patient-therapist relationship and be seen as a separate person in order for the patient to develop a sense of self.

Searles (1961) emphasized similar stages in psychotherapy of schizophrenia. Searles describes the patient-therapist relationship evolving from *out of contact* to an idealized *symbiosis* to *resolution of symbiosis*, characterized by relinquishment of symbiotic modes of relatedness and the ability to relate to others as separate persons with their own needs and wishes apart from those of the patient.

In his treatment model for narcissistic personality, Kohut (1971) argued that the therapist must become an idealized or mirroring self-object of the patient in order to maintain a cohesive self-structure. In Kohut's model, however, it was not the creation of an idealized self-object that was transformative. Rather it was graded, non-traumatic disappointments and disillusionment in the self-object that built ego strength, the so-called experiences of "transmuting internalization".

Conclusion

Idealizations and devaluations, a high degree of certainty, simplicity, lack of ambiguity, and an inability to consider alternative perspectives, are indicative of a *logocentric* self-structure and often characterize the narratives of patients with BPD. *Logocentric* self-structures, or *states of being*, consist of poorly integrated, polarized, rigid, and stereotypical attributions of self and other. A consequence of this self-structure is a limited capacity for empathy and an inability to realistically appraise complex attributes of self or others.

Patient-therapist interactions have the potential to either reinforce or to deconstruct *logocentric* self-structures, regardless of the overarching treatment model that is employed. Therapist interventions that rely on advice, suggestion, or assured interpretation run the risk of reinforcing patients' *logocentric* self-structure through limiting ambiguity of choice and meaning. A *deconstructive experience* is a therapeutic intervention that aims to disrupt *logocentric* self-structure through providing experiences within the patient-therapist relationship that challenge stereotyped attributions and expectations, broaden perspectives of self and others, and support the development of a differentiated self.

Chapter 8. SPECIFIC TECHNIQUES

The following chapter summarizes each of the central techniques employed in DDP. The first four sections, i.e. *Association*, *Attribution*, *Ideal Other*, and *Alterity*, organize techniques by the particular neuroaffective function that is being remediated or the type of relationship that the therapist is trying to build. Proscribed techniques are delineated at the end of each of these sections. The chapter wraps up with a fifth section outlining specific management strategies for self-destructive and/or maladaptive behaviors. There are a host of other techniques not included in the manual, which are not central or proscribed, but may sometimes be helpful, e.g. clarifying patient's attributions.

Adherence to appropriate technique can be rated on a standardized scale (see Appendix) by the therapist or outside observer employing video recordings of sessions. This scale includes both the central techniques, as well as proscribed techniques, and is scored as percent adherence.

I. ASSOCIATION METHODS

In emerging from itself, hearing oneself speak constitutes itself…Thus it differs from itself in order to reappropriate itself **(Derrida, 1978, p. 166)**

1. Verbalization and Elaboration of Narrative Sequences

When starting a session, the therapist should allow the patient to pick the focus for discussion. The therapist attitude that "whatever topic is important to you is also important to me" helps patients feel accepted and respected. It also provides the patient with a sense of ownership and responsibility for the treatment, and so discourages regression. The primary role of the therapist is therefore to support the patient's exploration and reflection of narratives and attributions.

As patients become more comfortable with the therapist and more reflective, they will bring up recent interpersonal encounters. This tends to be the most fruitful area of discussion for most patients as it provides opportunities to enhance awareness of feelings, to begin making basic connections in their sequential experiences with others, and to link these experiences to their emotions.

The role of the therapist is simply to help patients to verbalize narratives of recent interpersonal encounters and elaborate their emotional experiences. However, this simple intervention can be very difficult in practice. Patients with BPD have an enormously difficult time getting down to the level of specific experiences. Instead, they are much more comfortable talking about general patterns of interaction, e.g. "He is always criticizing me". Or they will talk at length about the meaning of their experiences or others' intentions and attributions, e.g. "she's just trying to get rid of me". The therapist practicing DDP continually asks, "Can you give me an example of that?"

A complete narrative can be described as having three components: a wish or intention, a response from the other or "RO", and a response from the self or "RS" (Luborsky & Crits-Christoph, 1998). For example, the statement, "I hoped my mother would have baked me an apple pie, but instead she baked me a cherry pie and I was very disappointed," is an example of a complete narrative. The wish is for an apple pie, the RO was baking a cherry pie, and the RS was a feeling of disappointment. In applying DDP, the therapist helps the patient to connect the RS and RO components within narratives and to clarify the associated affects. For example, the therapist might ask, "What did you say to your mother when you found out she had baked you a different pie from what you had hoped for?" "What did she say back to you?" "Were you feeling anything else at that moment, other than disappointment?"

The following vignette is a fairly typical segment of a session transcript of a young man with BPD in Stage II that illustrates these simple but important techniques:

P(atient): *My regional manager called and harassed me three times when I was sick; so, the day after that happened I told my Mom I do not stand for harassment; it's not something I'm willing to take; so I'm*

going to go ahead and quit. And she was telling me not to, which went against what I believe in. If I went back to work for them, it would be saying that harassment is all right, and I don't stand for that.

T(herapist): *Mm…so she said…*

P: *…That I should quit.*

T: *How did you feel about that when she said…*

P: *That I should just confront my manager. I'm like, 'I'm sick in bed and you make me call you three times to get out of bed. That's just rude and it's unhealthy for me.' I get even sicker with the flu than other people and that's why my doctor was very cautious about it. He was going to give me medication, but he decided not to. He said to stick by my ibuprofen.*

T: *So in that last conversation with your regional manager, what happened during that last time, the third time he called?*

P: *He was still going on about the doctor's note. He was like, 'Have you gone to the doctor today yet?' And I was like, 'No! I'm sick in bed with a 104 fever. What do you expect from me?' He was like, 'just give me a doctor's note.' And I was like, 'I'm not going to take this.' So two days after that…*

T: *What did you say when he said, 'Just give me a doctor's note?'*

P: *I said, 'Okay sir, I will do that.' And next morning he called again, which was the fourth time.*

T: *Oh!*

P: *And I just had enough of it and told him not to disturb me again because I was sick and if I really wanted to, I could file harassment charges against him.*

T: *That's what you said, huh?*

P: *Yeah, I told him I'd file harassment charges because I was in no condition to even go out in the weather. I was in really bad shape. I lost 11 ½ pounds.*

T: *My goodness!*

P: *My body just would not eat.*

T: *Well, what was it like to say that to him?*

P: *It felt powerful and I was worried that he might fire me for it.*

T: *So you felt powerful on the one hand, but also worried a bit as well.*

P: *Yeah, and then on Friday I…*

T: *But what did he say after you said that you might file harassment charges?*

P: *He hung up on me.*

T: *And were you more nervous after he hung up?*

P: *I was a little bit. But I thought about it hard and then the next morning I called in to the local manager and said, 'I'm sorry to do this to you, but I quit.'*

T: *What did she say?*

P: *She said, 'That's fine. See you tomorrow.'*

In this vignette the patient offers three discrete interpersonal episodes, the first with his mother, the second with his regional manager, and the third with the local manager. The sequence, "He was like, 'Have you gone to the doctor today yet?' And I was like, 'No! I'm sick in bed with a 104 fever. What do you expect from me?'" is an example of a complete but simple narrative. The statement by the regional manager, "Have you gone to the doctor today yet?" is the RO. This RO is followed by an RS of, "No! I'm sick in bed with a 104 fever. What do you expect of me?"

Throughout the vignette, the therapist attempts to develop the narratives by asking about links between RS and RO and helping the patient to identify and verbalize the associated affects. For example, the therapist helps the patient to narrate the RS that follows the RO of, "Just give me a doctor's note" by asking, "What did you say when he said, 'Just give me a doctor's note?'" On the other hand, the therapist helps the patient to narrate the RO that follows an RS by asking, "But what did he say after you said that you might file harassment charges?" The therapist also attempts to clarify associated affects at various points in the interview. For example, "How did you feel about that when she said…?"

These therapist interventions would not be unusual in other psychodynamic treatment models. The explicit purpose of such interventions might be to develop insight into maladaptive interpersonal patterns (Strupp & Binder, 1984), correct misperceptions of others' intentions (Bateman & Fonagy, 2004), or to identify polarized attributions (Clarkin et al., 2006). In this vignette, however, the primary aim of helping this patient to develop his narratives was not to facilitate insight into maladaptive patterns or to correct misattributions. Rather, verbalization of emotional experience and linking-together sequential responses into a narrative account can be therapeutic in themselves by activating *associative* functions and fostering a subjective sense of self.

Notice in the vignette that the patient repeatedly gets sidetracked away from the interpersonal episode into discussion of other issues. The therapist repeatedly redirects the conversation back to the level of experience to verbalize and elaborate the narratives that the patient started.

Also notice that the patient is preoccupied with issues of justification throughout the vignette, consistent with the Stage II central thematic question of, "Do I have a right to be angry?" For example, he provides several reasons why he was too sick to return to work so as to feel sufficiently justified to finally assert himself with his regional manager. The patient relates feeling powerful about his self-assertiveness, but this is also accompanied by fears of abandonment (i.e. getting fired). Thus the patient feels obligated to either be in total conformity with the wishes of the manager ("okay sir. I will do that), or to totally leave the relationship by quitting his job. The patient is illustrating the difficulty in being close but separate in relationships.

With more disorganized patients, a common error that therapists make in working with patient narratives is to repeatedly try to clarify the context, instead of asking about RS, RO, and associated affects. This is understandable given how confusing these narratives can be. Disorganized patients can suddenly switch pronouns or switch scenes jumping through time so that it becomes impossible for the listener to discern who is speaking to whom at any given moment. The therapist must learn to tolerate a certain degree of confusion and uncertainty rather than continually interrupting the flow of the narrative to clarify context. Otherwise, the therapist runs the risk of cutting off the affective connections to experience and creating a passive and dependent enactment.

Acknowledgement of feelings and verbalization of narratives begins to create a separation between patients' here-and-now consciousness and their emotional experiences, between observing and

experiencing. Thus a space is opened up for reflection on experiences, for ownership of them, and for the beginning of a subjective sense of self. The following statements by a patient with BPD and crack cocaine addiction illustrate how verbalization of emotional experiences in the context of the patient-therapist relationship can foster the development of a subjective sense of self.

> *As I start to develop feelings surrounding certain situations that I share with you…like I think verbalizing some of the things that I have going on in my head sort of acknowledges the feelings exist, as opposed to just something sort of crazy that…maybe like if I don't share them, like no one knows…and I don't know how much they exist. And honestly, I think the less I share with people, the less I feel I exist, and there's many days where I feel sort of invisible.*

Note that this therapist had not tried to validate the patient's emotions, but simply had provided an opportunity for the patient to verbalize them. An essential component of a subjective sense of self is the ability to form a dialogue with an internal or external other. In the above example, the patient is able to discern that her sense of existing as a person derives from her ability to acknowledge to herself feelings about certain situations and to share these feelings with other people.

Although Association techniques appear to be simply and easy, patients find them extraordinarily difficult. They are much more comfortable speaking about general patterns of interaction and will avoid speaking about specific encounters and labeling specific emotions. The therapist must therefore gently redirect the patient back to specific examples, while avoiding the temptation of over-structuring the session and setting the agenda (see Chapter 5, *The Therapeutic Stance*). Between sessions, it is helpful for the patient to continue the work of therapy through application of Daily Connection Sheets (see Chapter 3, *Establishing the Frame*, and Appendix D, *Daily Connection Sheets*).

2. Exploring emotional themes of creative activities

Encouraging creative endeavors and helping patients to link them to emotional experiences is another aspect of DDP that fosters a sense of self. Creative endeavors can include drawing, pottery, sculpting, creative writing, poetry, or exploration of dreams. Even allowing the patient to choose topics for discussion is a form of creative exploration whereby the interpersonal experience between patient and therapist can take on characteristics of play. Creativity provides an avenue for the flow of unconscious wishes, fears, and conflicts into a tangible symbolic expression that allows space for reflection. The patient will most be able to benefit from these techniques after safety concerns are addressed in Stage I and the therapist is in the role of the Ideal Other.

Artistic explorations tend to work best for patients who already have inclinations in that direction. I will encourage patients to draw, write, or paint between sessions, especially during times when they are feeling overwhelmed. Sometimes I will also encourage patient's to draw or paint within a session if they appear to be struggling with some emotion but are having difficulty putting it into words. When drawing, it is helpful to instruct patients to draw whatever comes to mind, instead of simply copying a design. The patient's associations to the drawing can be explored. It is then helpful for the therapist to share his/her associations and feelings about the figures. Pay particular attention to the affect that the various figures or parts of the drawing evoke. Look for polarized attributions of self and other (see chapter on *States of Being*). A similar process can be used to explore poetry and prose.

Much has been written about dreams and their exploration and interpretation. I tell patients that dreams have many possible meanings, rather than just one, and that there are many ways to explore them. In my work, I have found it more helpful to focus on affective themes and associations in the exploration of dreams, rather than on dream symbolism and *double entendres*. For example, the therapist can inquire about the particular emotion that the patient was experiencing at a particularly intense moment in the dream. This question often leads to the patient's free association of a similar affective theme in other relationships. Depending on the particular dream, the therapist may also want to inform the patient that "one way to interpret dreams is that all the characters within the dream are different aspects of yourself."

The following example is regarding exploration of a dream of a patient in Stage IV of treatment. The patient has been discussing how angry she felt at the therapist for not fully informing her about aspects of a group therapy he had referred her to. The therapist feels that the criticism was unjustified, but does not explain away the misunderstanding and therefore invalidate her feelings. Instead he continues listening. The patient then associates to a dream she had the previous night:

> *I was walking through a garden and there are colorful, poisonous snakes intertwined with one another. I was trying to get away from them. Just then my Mom came along and caught one of the snakes by the neck so it couldn't bite me. But the snake was still hissing at me. I was like, 'Thank God! Thank God! She protected me.' And then, [pause] she took the snake and threw it at me. In my dream I was like, 'I knew I couldn't count on you.'*

The therapist then asks the patient to label the emotions she was feeling at the moment her mother threw the snakes. The patient states, "It's a feeling of anger and betrayal. People have betrayed me my whole life." The therapist associates to the earlier discussion they had had regarding the group therapy and attempts to provide experiential acceptance by asking whether she had the same feelings towards the therapist, which the patient affirms. The patient then thanks the therapist for acknowledging how his actions made her feel and goes on to explore some of the profound disappointments she had experienced in her relationship with her parents.

3. Proscribed Techniques

There are certain areas of discussion that will trigger hyperarousal in most patients, particularly in Stages I and II. The level of arousal will be too high for productive exploration and processing, and can lead to increased dissociation, depression, or psychosis. Two problematic content areas include:

1. Details of traumatic experiences
2. Challenges to the sustaining fantasy of the idealized parent.

Exploration of these areas early in treatment is likely to be viewed as intrusive and traumatizing. Although these areas are extremely important and sometimes even the primary cause of their pathology, they cannot be usefully processed until patients have gained a capacity to process, acknowledge, label, and contain emotionally laden experiences. Some patients will even need to be constrained from excessively dwelling on traumatic experiences because they have the idea that if they can somehow get all the traumatic memories out of their system by vomiting them into the lap of the therapist (figuratively speaking) then everything will be better. For the BPD patient, however, such "behavioral desensitization" often leads to clinical deterioration because of an inability to process the experiences, particularly in Stage I. By Stage III, patients will usually have sufficient capacity to verbally represent and contain their affect that they are able to gradually bring forth repressed memories without prompting from the therapist and without dissociating or regressing.

In addition to circumventing highly loaded areas of exploration, the therapist must be alert for patient's defensive avoidance. Many patients will attempt to divert discussions into elaborations of their physical symptoms, financial needs, legal concerns, or medication issues. Diversion into these topics subtly shifts the role of the therapist to a rescuer or authority figure, and also serves to avoid exploration of emotionally laden experiences. For these reasons, such discussions should be deferred to the end of the session.

Assured interpretations are to be avoided, including interpretations linking patient-therapist transactions to earlier child-parent experiences (so-called *genetic* interpretations) or interpreting the patient's defenses. These are especially to be avoided early in treatment. Assured interpretations can feel intrusive and create the perception that the therapist is imposing his/her own "reality" and way of structuring the world onto the patient, and so undermines the patient's need for autonomy. See chapters on *The Therapeutic Stance* and *The Deconstructive Experience* for a more complete discussion. Genetic

interpretations can also create overwhelming anxiety in Stage I or II if they challenge the idealized image of parental figures. However, there is a role for interpretations in Stages III and IV, as both therapist and parental figures are de-idealized and there is defensive avoidance of mourning.

In general, listening techniques do not include advice, suggestion, and reassurance. Their absence is one of the defining characteristics of DDP, as opposed to supportive or CBT treatments. Paradoxically, the patient may strongly press the therapist for these interventions because of strong dependency wishes. However, the patient's sense of autonomy is sacrificed in the process with resultant regression and control struggles (see chapter on *Stages of Therapy – Stage I* for further discussion of this topic).

II. ATTRIBUTION METHODS

1. Asking About Alternative or Opposing Attributions

Its force is a certain pure and infinite equivocality, which gives signified meaning no respite, no rest, but engages it in its own economy so that it always signifies again and differs.
(Derrida, 1978, p. 25)

As outlined in previous chapters, BPD is characterized by poorly integrated polarized attributions of value, agency, and motivation regarding self and others. Thus patients with BPD have difficulty holding in their consciousness two opposing attributes simultaneously. People are seen in black or white, all one way or all another. DDP helps patients consider alternative perspectives to their experiences and to be able to tolerate consideration of conflicting viewpoints. In this way, patients move from a state of *logocentric* certainty to one of reflective ambivalence.

Neuroscience research supports the effectiveness of attribution techniques for adaptive emotion processing. Reappraisal of emotional experiences has been shown in multiple studies to be more effective than distraction or emotion suppression in decreasing distress associated with emotional stimuli and in dampening physiological arousal (Kalisch, 2009). The therapist should suspect poorly integrated polarized attributions when the patient is expressing a viewpoint with vehemence and certainty.

The first step in helping the patient to develop more complex and integrated attributions is simply to ask the patient about alternative or opposing viewpoints. For example, the therapist can ask, "Although you are sad that your girlfriend broke up with you, are you also relieved?" Or, "Despite saying that you hate your ex-boyfriend, I wonder if you also still care for him?" Or, "So you feel you need to go in the hospital? Do you have any reservations about it? Or, "You commented that you enjoy having power over your parents by getting them to behave as you wish, but the fact that you keep bringing up this issue makes me wonder whether you also have some mixed feelings about your actions. Do you think you do?"

A related intervention is to make an *internalizing comment* in response to patient's use of externalization. Externalization is a common defense employed by BPD patients and refers to a shift in agency from self to other. Attribution of self-agency is not only disowned and dissociated from consciousness, it is also projected onto another person. Agency is externalized to the other in the *helpless victim state* and the *angry victim state* (see chapter on States of Being). By shifting responsibility onto others, externalization provides a means of transforming internal conflicts into external conflicts and avoids underlying feelings of shame (Freud, 1965; Novick & Kelly, 1970). Thus, in the case of alcoholics, externalization allows them to avoid feeling conflicted about their drinking and instead maintain the fantasy that "I want to drink and would be fine if I didn't have my wife, children, therapist, etc. hassling me all the time about my drinking. They treat me like an imbecile!" A helpful and internalizing comment that the therapist could make in return is, "Even though you know it's not true, I

wonder if part of you believes that you <u>are</u> an imbecile regarding your drinking? Is this how you feel sometimes?"

Internalization represents one of the most simple and effective techniques that can be applied for patients in the *angry victim state* to open up meaning, bring in opposing attributions, and move patients to a more reflective and integrated mind-set. This technique can be employed when patients excessively complain about how others are mistreating them. Internalization serves to transform a conflict from external and interpersonal to internal and inside the person, where it can be acknowledged and worked through. This technique is most effective in Stages II, III, and IV and should be applied only sparingly in Stage I, i.e. before there is a solid therapeutic alliance.

Below is a transcript where an internalizing comment was made:

P(atient): *The person in the business office required all this I.D. before she would take my request seriously. I needed to prove to her that I was a legitimate person.*

T(herapist): *She didn't believe that you are a legitimate and competent person?*

P: *That's what I felt like. I don't think most people do see me that way. Even my friends sometimes say "God has one hand on (patient) and one hand on the world."*

T: *But you know, of course, your harshest critic?*

P: *Is moi?*

In this example, the internalizing question of, "Are you your harshest critic?" allowed the patient to realize that her primary problem was not others' perceptions of her, but how she perceived herself. When making internalizing comments, great care should be taken to protect the patient's self-esteem and not give the impression that the therapist believes that the patient deserves criticism.

Another type of internalizing comment can be made for patients who are trapped in want/should dilemmas. For example, "I really want to drink, but know I shouldn't." Or, "I don't want to attend my classes, but know I should." In these cases, patients are in a control struggle, but it is with a harsh part of themselves that is not well integrated and feels external to who they really are and to what they really want. There is no way for patients to resolve a want/should dilemma. It feels like endless torment of continuous self-shaming. In this circumstance, the goal for the therapist is to transform the want/should dilemma into a want/want dilemma. Patients must come to acknowledge that the "should" represents a part of them that is concerned about their behavior and wants something better. In this way patients take ownership for having conflicting desires over the behavior and are in a position to resolve the conflict. The conflict becomes, "I know there are pros and cons to the behavior, but what do I really want?"

In later stages of treatment, internalizing comments can also be helpful when patients project shaming and judgmental aspects of themselves onto the person of the therapist. For example, a patient may assert, "You just think I'm crazy and want to get rid of me." A good internalizing response would be to state, "By asking me that I wonder if you are questioning whether you're crazy and whether you deserve to be kicked out of treatment? Do you sometimes ask yourself that?" If this intervention is ineffective and the patient responds with, "No, this is about you not about me," then the therapist can apply *experiential acceptance* and ask, "What is it like to have a therapist who you feel just wants to be rid of you?" See section on Alterity in this chapter for more information on this technique. A response of defensive reassurance, such as "You are certainly not crazy and I'm not going to leave you," would likely be met with disbelief, mistrust, and need for more reassurance.

2. Integrative Comments or Questions

The next step beyond suggesting alternative or opposing attributions is to bring both poles of the oppositions into consciousness simultaneously through integrative comments or questions. So, for

example, when a patient is in the *angry victim state*, his or her spouse may be perceived as horribly abusive (see chapter on *States of Being*). When a patient is in *guilty perpetrator state*, the same spouse may be viewed as kind and loving. An integrating comment would point out these two opposing viewpoints. By becoming aware of one's divergent and conflicting attributions, an integrated self can develop. It is important to keep in mind that the two sides of an opposition can be integrated, but not necessarily resolved. For example, issues of how to balance responsibility between self and other and how to preserve autonomy in close relationships are inherent aspects of the human experience and can never be resolved completely satisfactorily. However, opposing attributions move from being split-off and poorly integrated, to conscious internal conflicts within a whole person.

Integrative comments are very similar to internalizing comments. In both types of intervention, split-off attributions are brought into consciousness. In the following example, a patient is demonstrating poorly integrated attributions towards her mother, her favored sister, and her husband:

Patient: *I don't know why I'm so jealous of my sister and am thinking it's really immature of me. I'm just thinking I need to get over this because we're going to the same church, she's going to be her and I'm going to be me, and I'm going to need to find my place in this world regardless of my sister and all her fan club. It's just that I don't like the fact people don't acknowledge all I've gone through, but give sympathy and assistance to her. It makes me mad. At a party my mother was telling me, 'it's so awful what (my sister) went through with her husband, thank God she's away from him.' And I was like, "and thank God I'm away from my husband!" And then she spoke of how my ex-husband is on the worship team and 'maybe he's changed.' Like my sister's could never change! I just wanted to deck her.*

Therapist: *It's definitely a sensitive spot, because that's exactly what you are struggling with. Is my husband just this nice earnest guy who is trying to reform? Is it just my attitude that's the problem? Do I have any right to be angry and any value in myself? And so, it's a very sore spot.*

Patient: *I think I'm coming to terms with it though.*

In the above example, the patient starts out with attributing all agency or responsibility to herself, i.e. "I'm so jealous…." She quickly moves to the other pole by attributing all agency to others, i.e. "people don't acknowledge all I've gone through…." The therapist attempts to bring both poles of her attributions into consciousness with an integrative comment.

Polarized attributions also often manifested in attitudes and behaviors towards the patient-therapist relationship. Patients may sometimes believe that they are being rejected or victimized by the therapist, and other times believe that the therapist is their savior. Likewise, they may sometimes wish for the therapist to tell them what to do and take care of them. Other times, patients might rebel against therapist recommendations in an effort to assert autonomy.

Among patients with co-occurring alcohol dependence, there are often polarized attributions regarding self-image related to drinking. For example, there may be polarized self-images of an omnipotent he-man who can hold his liquor and of a foolish drunk who can't control his drinking and the raging consequences of the drinking. Pointing out both sides of patients' self-attributions in relation to their drinking allows them to have a more realistic and integrated self-image and to weigh the pros and cons of their behavior.

3. Proscribed Techniques

The challenges to making effective integrative interventions include recognizing polarized attributions when they occur and overcoming countertransference reactions. When these challenges are not met, the therapist often takes one side of the ambivalence thereby allowing the patient to take the other. For example, when the therapist's countertransference reaction is a wish to rescue and comfort the patient, the therapist may make a reassuring and hopeful comment, such as "don't worry…it will all work

out. You just have to be patient." Paradoxically, however, such reassuring and hopeful comments are often perceived by the patient as unempathic. The patient may believe that the therapist does not understand the depths of his/her despair and will remain stuck feeling hopeless and unlovable. The patient may be thinking, "I'm glad you think things are so rosy. I wish I did." Inherent in the successful integrating comment is the recognition that the patient must be the one to resolve his/her ambivalence, not the therapist. In the above example, the patient must resolve that question of whether or not he/she is a hopeless case. Reassuring comments from the therapist will not magically persuade him/her otherwise.

Integrating comments are often less useful for patients in Stage I who have very poor reflective functioning. Such patients may have opposing attributions that are so completely polarized that integrative comments come across as unempathic or critical. The patient then feels misunderstood and the therapeutic alliance is threatened. In the early stages of treatment, such patients are more likely to benefit from listening techniques, such as repeating back what the patient has just said in the therapist's own words, or from experiential techniques (see sections in this chapter on *Ideal Other* and *Alterity*).

A common error in exploring attributions is for the therapist to seek definite meaning, instead of opening up new possibilities and tolerating uncertainty and ambivalence. This is an easy error to slip into since BPD patients have a strong desire for certainty and will push therapists to make black and white categorizations. For example, a patient might rail against a family member and seek justification from the therapist for feelings of anger or hostile reactions. The therapist will be tempted to "validate" and normalize the patient's point of view by stating: "Anyone would feel angry if their family member were to tell them such a thing." It is important for the therapist to stay neutral in exploring attributions to keep open both sides of the oppositions (see chapter on the *Therapeutic Stance*).

Another common error is for therapists to spend an excessive amount of time clarifying attributions or general patterns of interaction, instead of bringing the level of discourse to specific interpersonal experiences. BPD patients can spend a great deal of time trying to make sense of their interactions with other people and come up with simplistic and polarized explanations about others' motivations. Such discussions tend to be non-productive and only serve to reinforce a distorted and stereotyped world-view. Instead of encouraging patients to elaborate their viewpoints and the reasons behind them, therapists applying DDP need to either open up new meaning by asking about alternative explanations, or to redirect the conversation to the detailed sequence and associated emotions of specific interpersonal incidents.

III. FACILITATING THE IDEAL OTHER

For in its representation of itself the subject is shattered and opened **(Derrida, 1978, p. 65).**

A discussion of the importance of the Ideal Other is outlined in the chapter on *The Therapeutic Stance*. This stance includes satisfying *logocentric* needs for certainty and perfect understanding. It also includes finding balance between competing safety concerns. How are these accomplished?

1. Mirroring – Affective Attunement

As mentioned previously, persons with BPD often are unaware of their underlying emotions. There is a disconnection between stressor/event, evoked emotion, and subsequent action taken. Instead, stressful events are likely to create a state of generalized hyperarousal characterized by anxiety, vigilance, confusion, and/or feeling overwhelmed.

One important technique for helping patients to become aware of their emotions and for maintaining the soothing functions of the Ideal Other is mirroring. Mirroring is a term first applied by Lacan (1949) and later modified by Winnicott (1999) to describe the function of the mother in fostering her infant's sense of self. According to Winnicott, "the mother is looking at the baby and what she looks like is related to what she sees there" (p. 112). In other words, the infant finds him/herself by scanning

the mother's face during interactions with her. If the infant is happy, the smile on the mother's face tells the infant that he/she is happy and has been recognized as such.

Thus, an important function for the mother, and ultimately for therapist as idealized mother, is empathic attunement. This involves simply questioning patients about their present emotions when they seem to be displaying some affect, such as tearfulness, that they are unable to verbalize. For example, the therapist can state, "I notice you seem to be struggling with some emotion right now, can you tell me what you are experiencing?"

Note that tearfulness is very common among patients with BPD and therapists commonly assume that tears are an indicator of sadness. However, patients with BPD are often unable to experience genuine sadness until later in treatment, and tears are more often expressions of anxiety, anger, fear, shame, or feeling overwhelmed.

Often the most accurate way of gauging the underlying emotions of the patient is for therapists to monitor their own countertransference responses. Persons with BPD universally evoke strong emotions in their therapists at various points in their treatment. Like their patients, however, therapists are not always aware of what emotion they are experiencing at the moment or why.

As a general rule, the emotional responses of therapists to their BPD patients derive from unconscious identifications. Thus, very often the therapist and patient may be experiencing the same emotion. In subtle ways, the patient's feelings can be transferred onto the person of the therapist. For example, therapists may find themselves becoming angry, but are not sure why. There has been no direct provocation and the patient does not appear to be angry. The therapist can explore whether this feeling is emanating from the patient by stating, for example, "I somehow sense that you might be angry right now. Are you feeling that way?"

2. Mirroring -- Repeating Back Narrative Connections

Attending to affect-laden interpersonal experiences can help the patient to develop a subjective sense of self. "When I look I am seen, so I exist" (Winnicott, 1999, p. 114). Patients with BPD often have difficulty making sequential narrative connections, and when they do, the connection may not be acknowledged to themselves. For example, a patient may state, "When he said that, I got so mad that I just left the room." However, if the therapist then were to ask, "What got you so angry?" it is not uncommon for the patient to deny having experienced any feelings of anger whatsoever and end up feeling misunderstood.

Paradoxically, therapists working with BPD patients cannot assume that the patient's own words are registering with the patient. A simple technique to help reify experience is to simply repeat back the narrative sequence that the patient has just stated. This technique not only helps patients feel understood, but also helps them to acknowledge their experiences. Using the above example, the therapist can state, "So when he said that, you got angry?" The process of patients linking their experiences into narratives and having these narratives heard and restated by the Ideal Other (the therapist), allows patients to extend the range of their subjectivity and to develop a sense of self or *being* in the world.

3. Mirroring -- Repeating Back Assertions of Positive Self-Attributions

Mirroring responses may support not only a sense of self, but also may build self-esteem for patients with prominent narcissistic traits. Kohut (1971) used the term mirroring to describe "the gleam in the mother's eye, which mirrors the child's exhibitionistic display" (p.116). With this technique the therapist acts as a mirror to the patient's grandiosity, i.e. repeating back the patient's positive self-attributions instead of challenging them. Therapists may be reluctant to mirror a grandiose, demeaning, and entitled patient, but paradoxically, this technique allows the patient to give up his/her grandiosity and to meaningfully reflect on experiences and attributions. So, for example, if the patient challenges the therapist's expertise and goes into a discussion of psychoanalytic theory, a suitable response would be to state, "I guess you really know a lot about psychodynamics." This technique is most likely to be helpful

for the *angry victim state* and can often help to experientially deconstruct that state and move the patient into a more reflective and engaged stance.

The intervention of mirroring, as defined by Kohut, is closely related to another intervention in the psychological literature labeled self-affirmation. Self-affirmation seeks to restore self-image after a threatening event by helping patients to remember their personal values and priorities. Self-affirmation has been shown to improve mood and self-esteem (Koole, Smeets, van Knippenberg, & Dijksterhuis, 1999), enhance the mind's ability to suppress unwanted thoughts (Koole & Knippenberg, 2007), and gain more realistic perspectives of visual images and social interactions (Whitson & Galinsky, 2008).

4. Framing – Circumscribed Education

The word, *framing,* in this manual encompasses a need to establish a starting point in therapy, a location of definite meaning. It is an educative intervention that defines the nature of the treatment, acceptable behaviors and the patient-therapist relationship. The nature of the treatment encompasses the goals and tasks of treatment and why it may be helpful for the patient's condition. It also encompasses delineation of the three basic safety concerns, the two core conflicts of *victim vs. perpetrator* and *autonomy vs. dependency*, and the central thematic questions.

Because framing is educative, it involves imposing basic meanings and rules for the patient. Thus it is not a *deconstructive* intervention that opens up meaning to allow full reign to the patient's creative impulses. Instead, framing is a way of setting a boundary for those impulses…a line that cannot be crossed or a steppingstone to build upon. The artist needs a *frame* for the painting as well as materials and a setting in order to begin a creative endeavor. Framing is used primarily in Stage I and feels containing to overwhelmed, fragmented, and frightened patients. Framing is sometimes used in later stages as a containment tool when necessary. However, if framing is being used extensively in later stages, it commonly reflects enactment of therapist urges to rescue in the role of the omniscient parent and patient wishes to regress to earlier stages, and thus can be counterproductive.

Framing does not incorporate psychoanalytic terms of *clarification* or *interpretation*. These terms are usually defined as interventions that clarify unconscious feelings and relationship patterns so as to provide insight. In so doing, they necessarily impose the therapist's construction of meaning onto the patient. In this manual, those terms were avoided both to de-emphasize the role of insight and also to delimit the therapist role as conveyer of meaning. In DDP, the therapist may offer potentially useful metaphors and may ask about alternative or opposing meanings, but care is taken not to impose them on patients or to state them with religious conviction.

Common types of framing can be summarized as follows:

- education about the treatment process, including goals, structure and expectations
- education about the respective roles of patient and therapist and why these boundaries are important
- description of the core conflicts, stages of recovery, *states of being*, and the central thematic questions
- education about the connection and differences between feeling and action, e.g. the role of emotions and how unprocessed feelings of anger can turn into either self-harm or hostility

In the patient's mind, the emotion of anger is often confused with hostility, especially if they grew up in a household where expression of anger was always accompanied by hostility and they were never able to witness appropriate assertiveness. Patients therefore often deny when they feel angry, try to suppress that emotion, and feel shame when they acknowledge it. When the therapist observes patients struggling with acknowledging anger, patients benefit greatly from the following framing intervention: *Emotions are like our sixth sense; they inform us of what is going on in our relationships. We can't stop ourselves from feeling, anymore than we can stop ourselves from seeing what's in front of us. If we block out our emotions, it's like shutting our eyes while we are trying to find our way out of a forest. We wont know where we are and will bump into trees. Anger is neither good nor bad, but is just an emotion signaling a problem in a relationship. If we try to block out awareness of anger, it turns into anxiety, depression and*

physical symptoms, or can suddenly burst forth in a fit of rage. Once you acknowledge anger, you are in control what to do with it. You can decide to not express it, or you can decide to assert yourself. Assertiveness is disagreement or criticism of the other's <u>action</u> for the purposes of repairing the relationship. Verbal hostility is criticism of the other's <u>motivation or character</u>, i.e. a personal attack, and always has the consequence of damaging the relationship and the persons involved. In fact, it's just as damaging to you when you are hostile as it is to the person who is the target of the hostility, since it reinforces the idea that you really are a bad person underneath it all, and therefore makes it more difficult to work towards self-acceptance. The first part of the preceding framing intervention is particularly helpful in Stages 1 and 2, when patients are struggling with acknowledging anger. The second part of the framing is particularly helpful in Stage 3 when patients are testing the realistic limits of their relationships through self-assertiveness.

Another emotion that is helpful to frame is sadness, particularly at the beginning of Stage 3 when patients first begin to experience as sense of loss. Prior to Stage 3, patients often confuse sadness with depression. In DDP theory, depression is an attack against the self and is accompanied by thoughts of worthlessness and hopelessness in the patient, and countertransference of helplessness in the therapist. On the other hand, sadness is a healing and integrative emotion, even though it is very painful. The countertransference of the therapist is warm and connected, and the therapist's eyes might fill with tears. Sadness is a necessary accompaniment of grieving, which enables patients to come to terms with painful realities in Stages 3 and 4, and finally to move on with their lives. Framing the difference between sadness and depression is helpful, as is laying out the work of Stage 3 when the patient starts to grieve painful realities and limitations regarding themselves and their relationships.

Framing the core conflicts and central thematic questions of each stage can also be very helpful. Framing creates a language and offers a set of metaphors for the patient's experience. In the following example, the patient had difficulty responding to an innuendo made by her ex-husband.

P(atient): *My ex saw somebody in church with me and he was like, 'Who was that, your boyfriend?' I am like, 'No'. And I had wanted to say something to him and I wondered why does it take me so long to register when it comes to communication?*

T(herapist): *It was hard to stick up for yourself?*

P: *It always has to do with sticking up for myself. Always. That's where the hole is. That's where the missing link is and I get so angry with myself because it comes later. It does eventually come together. I get it eventually. You know what I mean.*

T: *Mm hm. It's a fundamental question for you, "do I have rights?" Do I have a right to exist? Do I have a right to have my own opinion? Do I have a right not to be abused? Is that something I deserve?*

P: *Yeah. Then I thought about my court battle with my ex and my mom. This voice just said, 'what is the point in calling her since she's not going to stick up for you?' And it just added to my anger because I was thinking of all the times she hasn't stuck up for me. I was just so angry. I wanted to leave or kill myself.*

T: *The question you're struggling with is 'Do I have a right to be angry?'*

P: *Do I have a right to be angry? I know the answer…on some level.*

In the above example, the thematic question of "do I have a right to be angry?" dominated the discourse. Underlying this question is a polarized self-image of *victim vs. perpetrator* and polarized wishes for *dependency vs. autonomy*. Bringing the question into consciousness allowed the patient to have a framework and to develop a set of metaphors for further exploration.

The most common countertransference feeling driving a framing response is a feeling of helplessness and the need to rescue or "do something for the patient." The challenge for the therapist is to not immediately jump into rescue action in order to relieve his/her own feelings of helplessness. When a therapist is using multiple framing responses within a session, especially after Stage 1, it usually indicates that the therapist is enacting the role of rescuer. Other such actions within that role can include changing medications, hospitalization, increasing the frequency of sessions or phone calls, or giving advice or false reassurance. Many of these interventions may be indicated in a crisis, but the therapist must think through whether he/she is simply reacting to an uncomfortable feeling or is doing what's best for the patient. Raising this question in supervision can be essential to answering this question and deciding upon an appropriate intervention.

Another situation that frequently provokes inappropriate framing is when the patient shares idealized or eroticized transference feelings, wishes, or fantasies. The countertransference impulse in this situation is usually to create distance, sometimes through intellectualization. In this way, the patient is consciously taking one side of the *dependency vs. autonomy* opposition, i.e. wish for idealized merger with the therapist, and the therapist is taking the other side, i.e. wish for distance and autonomy. Maladaptive but common reactions are for therapists to relieve their own discomfort by either clarifying boundaries or by defensively explaining them away as part of the transference, i.e. "you don't really wish I would move in with you, but instead you actually wish you had a more loving mother." A better approach is to empathically explore, accept, tolerate, and contain positive transference feelings. Boundary clarification should be reserved for situations where positive feelings, wishes, and fantasies towards the therapist become replaced by actions.

Note that framing does not include supportive psychotherapy interventions of advice, suggestion, skills training, reassurance, or problem solving. The therapist needs to empathically understand, tolerate, and accept patient feelings, fantasies, and motivations, without telling them how they should think or act. Similarly, therapists walk a fine line in exploring and framing patient conflicts and dilemmas, without suggesting how to resolve them.

5. Proscribed techniques

A danger in adopting the role of the Ideal Other is the difficulty in giving it up. It feels wonderful to be idealized and to be seen as all-caring, all-knowing, or all-loving and it can be very difficult to maintain a neutral position between polarized attributions and watch your patient struggle. Therapists as Ideal Other cross the line when they begin to assertively attribute a certain motivation, value or emotion to the patient or others, e.g. "That must have made you angry." Paradoxically, such comments can come across as intrusive and unempathic. A danger signal is when therapists find themselves starting sentences with, "It sounds like…" or "You must have…."

Another proscribed technique is to persuade, encourage, reassure, or advise in response to the patient's passivity or hopelessness. These responses cause the therapist to assume a parental role. Patients have often told me that when their therapist would reassure them, e.g. "Don't worry, you'll get through it," they end up feeling like their therapist just doesn't understand them.

IV. ALTERITY – Introducing the Real *Other*

Only pure absence—not the absence of this or that, but the absence of everything in which all presence is announced—can inspire (Derrida, 1978, p. 8)

Like many terms, enactment is employed in different ways in the psychoanalytic literature. For the purposes of this manual, I am defining enactment as patient-therapist interactions that reinforce the patient's polarized attributions of self and others. I do not necessarily mean that patient and therapist are reenacting a traumatic relationship from the past, though this is sometimes the case. Instead, I am suggesting that enactment reinforces character pathology and the patient's polarized attribution system.

The opposite of enactment would be a *deconstructive experience*, i.e. the therapist in the role of the Real O*ther* interacts with the patient in a way that is inconsistent with the patient's polarized attributions. The Real *Other* represents the other that is *not me* or not within the subjectivity of the self. The Ideal Other represents a projection of positive self attributes and the Devalued Other represents a projection of negative self attributes, but the Real *Other* is an unreachable reference point beyond the projections of the self, the absolute outside. It moves the perspective on the self from subjective to objective and introduces a new relational element, the differentiation of self from other.

In order to prevent enactments and maximize differentiation, it is necessary for the therapist to pay attention to the process of patient-therapist interactions and to attempt to understand at any given moment the patient's expectations for self and other (See chapter on *States of Being*). It is also necessary to pay attention to how the patient is defining himself/herself within a given state and what is possibly being split off from consciousness in order to maintain the self-attributions of that state, e.g. recognition of maladaptive behaviors. Thus simply checking in about maladaptive behaviors can represent an intrusion of the *Real* into the patient's subjectivity.

Persons with BPD often provoke intensely negative feelings in people with whom they interact. Others then react to those feelings in ways that end up reifying the patient's negative expectations. This kind of negative enactment is a key mechanism for the stereotypical patterns of maladaptive relationships seen in this population. For example, a patient of mine with strong dependency needs expected others to be rejecting and abandoning of her, and this was the story of her life. Her typical pattern in a telephone conversation with a friend or relative was to keep that person on the telephone as long as possible. If the other person were to delicately hint that it was time to go, the patient would ignore the hint and begin a new and urgent topic of conversation. Eventually the person on the other line would be forced to be rude and hang up the telephone, leaving the patient feeling rejected and abandoned yet again. Unconsciously, the patient had created an enactment, which reinforced her expectations for rejection and the polarized attributions of self and other that formed the basis for those expectations.

A way to begin to disrupt this relational pattern is to learn to recognize unfolding enactments and to introduce new, unexpected elements into the relationship. Unfolding enactments may be signaled by patterns of interaction (such as passivity), relational themes in the patient's narratives (such as being misunderstood by others), patient actions (such as missed sessions), or by strongly positive or negative countertransference reactions accompanied by a compelling urge to intervene in some manner. Thus, a therapeutic intrusion of the *Real* that disrupts unfolding enactments requires moment-by-moment empathic attunement to the patient, as well as self-awareness and acceptance of the therapist's own emotional reactions (Winnicott, 1949). Ultimately, a task of treatment is for patients to be able to experience a new way of relating, one that is close, but is also respectful, non-destructive, and non-traumatic. Specific interventions that introduce *alterity* and support patient individuation and differentiation are outlined below:

1. Questioning possible negative or mixed feelings towards the therapist, the treatment, or recovery in response to indicative behaviors or comments

An important intervention to disrupting a negative transference is to check in and openly explore with the patient what is transpiring here-and-now in the patient-therapist relationship. Exploration of the transference relationship can sometimes serve to clarify the reasons for deterioration in the relationship. But, more importantly, it gives an experiential message to the patient that it is okay to bring up disagreements or criticisms, i.e. the patient does not have to give up his/her own values and opinions in order to have a relationship with the therapist and is allowed to differentiate from the therapist as a unique individual.

In Stage I, the patient is primarily concerned with safety within the therapeutic relationship. During this stage patients are very sensitive to perceived rejection (safety concern #1) and can react with rage over a seemingly minor off-hand comment made by a therapist. Patients with BPD are unable to assert themselves in a healthy way, e.g. they are unable to state, "It really hurt and angered me when you made light of my recent overdose." Patients are usually very reluctant to acknowledge either to

themselves or to their therapist that they are angry. Instead, they are likely to express outrage indirectly through actions, i.e. a missed session, tardiness, increased use of profanity, increased cutting, etc., or alternatively through turning their rage into depression. It is always helpful to ask in these circumstances, "Was there something I said last session that upset you?"

Missed sessions or tardiness can also be an indicator of ambivalence about the treatment process, rather than anger or dissatisfaction with the therapist. For example, it may be difficult for patients to acknowledge certain feelings or conflicting attributions and the patient may wish for simpler solutions, such as finding the right pill or magic potion that will make everything better. Greater emotional distance often follows an intense session, particularly if the patient brought up feelings of anger, traumatic experiences, or denigration of parental figures. This possibility needs to be gently but directly probed. It is important to keep in mind that in Stage I, patients with BPD are unable to assert themselves in verbally appropriate ways with the therapist, i.e. they are unable to be close and separate at the same time. So ambivalence is almost always manifested by actions rather than words. The following intervention suggests how the therapist can probe the patient's ambivalence without forcing the patient to directly express dissatisfaction or criticism:

> *I've noticed you have had difficulty getting to sessions lately. You mentioned it's been hard to find rides and sometimes you've forgotten. You also mentioned that you have found our sessions helpful and that you want to come. But sometimes things that we know are good for us can be difficult or unpleasant. For example, I find myself sometimes forgetting appointments to the dentist or find that things come up that prevent me from getting there. On the other hand, I always remember to go the candy store and am always able to get there. And I'm wondering whether coming here feels more like coming to a dentist's office or a candy store?*

This intervention stays in the middle of the patient's ambivalence about treatment and allows the patient to regain a sense of ownership for the treatment. It also disrupts the emerging enactment of the helpless patient being interrogated by the intrusive therapist.

In Stage II, patients are more directly involved in the process of self-other differentiation, including challenging the authority of others and questioning their own legitimacy. Are my needs, values, and opinions legitimate, or must I subjugate myself to conform to the needs, values, and opinions of the other person in order to maintain a relationship? Characteristically, BPD patients assume that any efforts towards self-assertiveness will be met with rejection and/or abandonment.

Of course, this also pertains to the patient-therapist relationship. The therapist as Real *Other* can deconstruct those expectations and promote self-other differentiation by being very receptive or even encouraging to efforts by the patient to disagree with or criticize the therapist. For example, if patients are discussing how someone is controlling or mistreating them, the therapist can ask, "Do you sometimes feel that way here?" Sometimes encouraging patient self-assertiveness or differentiation can take a playful tone, as in the following example, "I'm a bit disappointed that you are saying you are not angry with me. It will be a sign of progress when the two of us can have an argument and you can leave the office at the end of the session without worrying about being kicked out of my practice, or without having to go into depression or punish yourself in some way."

In Stages III and IV, patients tend to be very ambivalent about the whole recovery process as they face the realities of moving into an adult role and feel overwhelmed by responsibilities. Mild ambivalence usually takes the form of the patient stating that he or she doesn't know what to bring up for discussion or missing sessions. Stronger ambivalence may be expressed through regression to earlier modes of functional relatedness and maladaptive coping.

Ambivalence can be addressed in a number of ways. If it seems likely that the ambivalence is a temporary reaction to a previous discussion of an intense and overwhelming topic, it may be best just to allow the patient to keep things light, thereby respecting the patient's need for some space. If the ambivalence persists, a gentle inquiry about the process is indicated. For example, "You seem to be having a difficult time engaging in therapy since our session a couple weeks ago. Was there something we

discussed at that session that was upsetting to you?" Or, "You seem reluctant to explore topics in depth today. Why do you think that is?" If repeated attempts to help the patient verbalize ambivalence are failing to engage the patient and the patient is frequently missing sessions, more direct confrontation and containment efforts are needed. The following example indicates how a therapist might address frequent missed sessions in a later stage of recovery:

> *I realize that it's hard to get to sessions with so much going on. On the other hand, with many of my patients, missing sessions or coming late is often due to mixed feelings towards treatment and the recovery process. Change is always hard. Becoming more aware of experiences and moving into an adult role can be difficult and scary. When you first came to me, you were looking for help with low self-esteem and wanting better relationships. The question is whether you feel you have achieved those goals sufficiently or whether you would like to continue moving forward. It's a matter of weighing pros and cons and only you can make that choice. But being half in and half out of treatment is the worst of both worlds. It means you still have to endure these difficult psychotherapy sessions, but aren't able to get much benefit from them since you don't come often enough. Maybe it's just a bad time in your life to make such a commitment toward recovery. I can respect that. But if you are unable to make every session on time, then it's like making a decision not to be in treatment at all, because I'm not going to be of use to you in meeting your treatment goals unless we meet for the full time every week. So it's really up to you and what makes sense for you at this time in your life. I would like to continue working with you towards recovery, but I can also respect your choice of holding off treatment at this time.*

The therapist as Real *Other* does not try to reassure or persuade the patient to persevere, instead the therapist should ask about ambivalence towards recovery, allow the patient to reminisce about simpler times of being the sick child, be receptive to anger towards the therapist for not doing more to rescue, and help the patient weigh risks and benefits of moving forward.

Does the therapist ever intentionally terminate the treatment early?

Early termination is a last resort, but on some occasions is the most therapeutic option. The treatment commitments are not a random list of rules; instead, they are the minimum that the therapist needs from the patient in order to be helpful to him/her. If patients not meeting their commitments, e.g. by frequently missing sessions, it is usually most helpful to keep engaging them, helping them to identify and verbalize their ambivalence, and to repeatedly let them know that they are not meeting the minimum degree of commitment needed for the therapist to be helpful to them in meeting their treatment goals.

There are rare occasions, however, when continuing treatment is enabling the patient's fantasy that "I am doing the treatment but it's not helping." That's a dangerous fantasy because it leads to hopelessness and increased risk. Under these circumstances, it is sometimes more therapeutic to discharge the patient, particularly if the therapist has a good handle on the source of the ambivalence, has repeatedly tried to help the patient to verbalize the ambivalence, and has repeatedly given the patient the message that he/she is not meeting the minimum commitments for the therapist to be helpful. The move to discharge can be somewhat faster if the patient has continuing or escalating hostility.

2. Experiential acceptance

Experiential acceptance is a key therapeutic technique, especially during Stage I and II of treatment. If patients are in a very non-reflective state, they may be unable to make use of any other kind of therapeutic intervention because their level of reflective functioning is so low. Experiential acceptance serves to deconstruct the *angry victim state* through paradoxical non-defensiveness in response to patient accusations. It can also sometimes help to deconstruct the *guilty perpetrator state* by promoting self-other differentiation (see Chapter on *States of Being*).

In the *angry victim state*, the patient's self-attribution is the idealized victim and the patient expects to be humiliated or persecuted by the therapist. This expectation puts the therapist in a precarious

situation. For example, the patient may accuse the therapist of being uncaring and simply wanting to get rich at the expense of patients who desperately need help. If the therapist denies the accusation in as nice and caring a voice as he/she can muster, the patient's doubt, contempt, and suspicion merely increase. On the other hand, should the therapist try to attack back by making the patient submit to an interpretation, e.g. "You are projecting your bad object into me so that you can feel all-good and all-powerful," this will also often make the situation worse. In response to this interpretation, patients in *angry victim state* tend to either become more contemptuous and suspicious, or (if the interpretation is subtle and well-timed) will "get" the interpretation and go into a state of marked self-condemnation, i.e. the *guilty perpetrator state*. Therapists generally feel very good about themselves for moving patients from angry victim to guilty perpetrator. There is a feeling of omnipotence and elation at their cleverness for having transformed the patient through interpretation, i.e. the therapist identifies with the patient's idealized attribution of the other, but the patient remains just as fragmented.

A better way for the therapist to respond to the patient in the above example is to not challenge the patient's attributions directly, either through disavowal or interpretation, but instead to non-defensively explore them through an experiential acceptance. For example, the therapist can ask, "What is it like for you to have a therapist who you think just wants your money, and doesn't give a hoot about you?" If the patient responds by making another accusation, the therapist should respond with another experiential acceptance. This response undermines and deconstructs the attributions of the *angry victim state* far more effectively than disavowal or interpretation and rapidly moves the patient to a state of greater reflection and relatedness.

Often patients will not directly criticize the therapist, but instead may be complaining about other people. The therapist can provide a *deconstructive experience* by bringing the victimization into the transference and asking, "Do you sometimes feel that way here?" Even if the response is denied, i.e. "No, I don't feel that way about you," at least the therapist has implicitly given the patient the message that it's okay to criticize or disagree and we can still maintain a relationship. Thus regardless of whether the patient responds in the affirmative, self-other differentiation is supported.

In Stage II patients are trying to answer the central thematic question, "Do I have a right to be angry?" Although patients will try to sort this out mainly through explorations of current relationships outside the therapy, at some point patients will try to resolve this question within the therapy relationship. Commonly, the patient may express dissatisfaction or anger over something the therapist said or did in a previous session. If the therapist is able to react non-defensively to such a comment and frame it as an attempt to answer the central thematic Stage II question, the patient receives a *deconstructive experience* and gains new perspective and an improved ability to tolerate self-other differentiation.

On the other hand, if the therapist reacts defensively, including denying the validity of the accusation by providing a reasonable and rational explanation, the patient experiences an enactment of expectations to be humiliated and invalidated, as if their own perspective cannot be trusted. Patients in Stage II are likely to suppress feelings of anger or rage at the therapist or direct it onto themselves as the *guilty perpetrator* until they suddenly explode over some seemingly trivial matter. This explosion may be followed by more self-remorse, urges to punish themselves via self-destructive behaviors, and finally attempts at humble and apologetic reconciliation with the therapist. At this point the therapist can still salvage the treatment by reviewing the previous events (this time non-defensively with an experiential acceptance) and framing them as related to the central thematic question, "Do I have a right to be angry?"

The following is an example of experiential acceptance of a patient expressing hopelessness in the *guilty perpetrator state*, Stage II. In this state, patients become depressed, hopeless, and/or self-destructive as a way of avoiding acknowledging anger towards the therapist. Thus they are able to maintain attachment to the therapist as Ideal Other, but at the expense of their own self-esteem. The intention of the therapist's interventions in the following example was to use humor and acceptance of the patient's anger to support self-other differentiation. In this way, the patient no longer would feel that she had to take total responsibility for problems in the therapy relationship in order to maintain attachment.

P(atient): *I feel frustrated with myself. I cut myself again right after we spoke on the telephone.*

T(herapist): *What frustrated you about that whole situation?*

P: *About cutting again and what I did to you.*

T: *You feel you've done something to me? What did you do to me?*

P: *I just feel bad when I inconvenience you by calling.*

T: *Are you telling me that you felt so frustrated for inconveniencing me that you had to cut yourself for it? Is that the main thing you've done to me is inconvenience me? What else?*

P: *I guess I just didn't keep my promise fully not to cut. I feel bad about that.*

T: *Well I kind of like bad people. You know, I think you really haven't been bad enough, to be frank. I think you need to be a little more bad. If anything, you should be angry or frustrated with yourself for not being bad enough. So you need to think of some other ways you could be bad.*

P: *I could cut again [laughs].*

T: *Well that's just bad to yourself. What bad thing can you do to other people? What can you do to me?*

P: *I wouldn't want to do anything bad to you.*

T: *And I really wouldn't want you to. But you can fantasize about bad things you could do to me without actually doing them, like hanging me up by my thumbnails. What else? You need to stretch your imagination a bit here.*

P: *I can't [laughs].*

T: *Well, that will be your homework assignment then to come up with different bad things you could do to me. That way you won't need to feel frustrated with yourself for just making things inconvenient for me. Inconvenience won't seem as big after all the other things you've done to me in your imagination.*

P: *But I don't feel angry with you, I feel frustrated at myself.*

T: *I think that's the problem. This discussion really touches on that central question for you. You know, do you have a right to be angry with me? Are you always to blame? Here I am trying to help you, how dare you be angry with me? So when things go wrong in our relationship, it creates a big dilemma for you. Are you to blame or am I?*

This session marked a turning point in the patient's treatment. She became more engaged in therapy and seemed less stuck in guilt and hopelessness.

3. Experiential challenge in response to passivity or hopelessness

There are times when it is necessary for the therapist to point out recent patient-therapist interactions in a more confrontational or challenging manner. Like experiential acceptance, the purpose of an experiential challenge is to move the patient to a more reflective state. It is a higher risk maneuver that potentially may lead to enactment, so it should be employed sparingly. A good rule of thumb is never to use experiential challenge when the therapist is feeling irritated or frustrated with a patient. Ironically, these are the very times when therapists will be most tempted to use it. For example, when a

patient is constantly complaining about being mistreated by others, it is very tempting for the frustrated therapist to state, "I've noticed that you seem to be able to talk a great deal about others and what they have been doing to you, but never about what you are trying to do to change yourself. What do you make of that?" A countertransference feeling of irritation or frustration indicates that the therapist is likely identifying with attributions of other as perpetrator (see chapter on *States of Being*). In this context, "setting limits" or "giving the patient a reality check" enacts patients' negative expectations and polarized attributions.

Experiential challenge is most likely to be helpful in situations where the patient is in a non-reflective state and self-attributions have all the agency. This situation is most common when the patient is in the *demigod perpetrator state* or the *guilty perpetrator state*. When patients are in the *guilty perpetrator state*, they present with passivity, depression, and hopelessness. The therapist's worry is often about tipping the patient into suicide. The therapist is in the role of ineffective rescuer and feels trapped by a sense of concern for the patient's well-being while also frustrated by the patient's passivity and lack of involvement in recovery. By remaining stuck and helpless, the therapist is enacting the patient's attribution of other as being without agency, attributions of self as being irredeemably bad, and expectations that the patient will overwhelm the rescuing capacities of the therapist. By challenging the patient's passivity and by pointing out concrete steps that the patient can undertake for recovery, the therapist deconstructs the paradigm of victimized rescuer/hopeless case and helps move the patient to a more reflective stance (see chapter on *States of Being – Guilty Perpetrator State* for a summary of helpful interventions). The following is a transcript of a therapist employing experiential challenge for a suicidal patient in the *guilty perpetrator state*.

T(herapist): *How close have you come to doing something?*

P(atient): *Not very close, but I think if I had a gun I would do it. It's not that I could get one, but…*

T: *You would do it?*

P: *I think so.*

T: *Well, then you shouldn't be in treatment here with me. Our work together is about becoming integrated and differentiated as a person. Depression is an important part of the work and if you are not committed to the treatment then you shouldn't be here.*

P: *Well, I don't have a gun.*

T: *But that's not making a commitment to keeping yourself safe and I said at the beginning of our treatment that one of the commitments of therapy is that you keep yourself safe. That means if you have a gun and feel like shooting yourself, you get yourself to the hospital and get admitted.*

P: *What are they going to do?*

T: *They'll keep you safe.*

P: *Would you want to live like this?*

T: *You have to decide that for yourself. I'm not here to see you into a completed suicide. I'm here if you're serious about recovery. In the last few weeks I've seen you not working towards recovery, I've seen you much more constricted. And I know you come up with all sorts of reasons as to why you can't do it… 'I'm afraid, I'm this, I'm that.' You have been going to your group therapy, which is wonderful, but then you didn't show up last Friday and are stating you want to attend less frequently. And you know,*

you can do that or you can work towards recovery. It's that simple. You could be bringing in your dreams; you could be exploring your drinking. There are all sorts of things you could be bringing up. You are making a decision not to make use of…[interrupted].

P: *I'm coming here asking you for help.*

T: *That's not the therapy. Remember one thing we talked about was that you have to be an active participant. The one thing that doesn't work is for you to sit back and say, "Cure me".*

Experiential challenge may appear to be a strange intervention for someone on the edge of death and already obsessed with self-loathing. Paradoxically, however, this technique can be lifesaving. By disrupting the enactment of therapist as ineffective rescuer and pointing out ways that the patient has not been fully engaged in treatment, experiential challenge instills hope into the recovery process. This particular patient had a history of severely refractory depression prior to treatment and multiple serious suicide attempts, including one requiring ICU care. She required many experiential challenges during the course of treatment, but made no further suicide attempts during this time and did not require hospitalization. About halfway through treatment, she described feeling relieved from depression and hopeful about her future for the first time in her life.

Experiential challenge is also useful for patients in the demigod perpetrator state. It can be employed when patients are hostile, intrusive, or detached in sessions. See section below on *Alterity – Real Other Techniques*, *Managing Self-Destructive and Maladaptive Behaviors*.

4. Proscribed techniques

The difficulty implementing experiential methods is in the timing. Our own unprocessed countertransference feelings drive us to intervene at the worst possible moments. We are urged to rescue or reassure at the very time that the patient needs to be challenged and we are urged to challenge or confront at the very moment when we should be receptive, mirroring, or accepting. Therapists should therefore attempt to identify and process any feelings they have towards the patient that arise in the course of therapy to help identify the particular enactment that is developing and the *state of being* that the patient is entering. This is most easily accomplished by sharing those feelings with a psychotherapy supervisor or in a consultation group.

As a general rule, it is <u>not</u> recommended that therapists share their countertransference feelings or details of their private lives with their patients. These interventions almost always represent an unconscious enactment whereby therapists unburden themselves of feelings that are too difficult to contain or accommodate an intrusive patient. In response, patients may feel burdened to take care of the therapist, feel guilty that they provoked anger, or believe that the therapist is unable to contain their intrusiveness. In any of these scenarios, the net result is inhibition of creative exploration and the individuation process (Gill, 1983).

V. MANAGING SELF-DESTRUCTIVE AND MALADAPTIVE BEHAVIORS

***The supplement occupies the middle point between total absence and total presence. The play of substitution fills and marks a determined lack* (Derrida, 1997b, p. 157)**

Therapeutic Stance for Behaviors

The most important principle of treatment is to maintain a therapeutic stance that keeps the conflict within the patient (see chapter on *The Therapeutic Stance*). Self-destructive or maladaptive behaviors generate conflict because they are so helpful on the one hand, and yet so shameful on the other hand. They can elevate mood, reduce distress, and satisfy attachment needs (see Chapter 10). On the

other hand, maladaptive behaviors eventually undermine self-esteem through an inability to control the behaviors and through negative consequences and personal failures stemming from the continued use of the behaviors. In order to avoid this conflict, patients will attempt to provoke therapists into taking on one side or the other.

The most common enactment is a mutual fantasy that the therapist can control the drinking, cutting, etc. with some sage advice, keen insight, or magic potion. What should be an internal conflict regarding the behavior, i.e. "Should I drink or shouldn't I drink?" becomes an external conflict with the therapist. This conflict can take two forms depending on the patient's *state of being*. In an autonomous state, such as *the angry victim state* or the *demigod perpetrator state*, the external conflict becomes, "I want to drink and would be fine if I didn't have the therapist on my back all the time about it." Less commonly, in a dependent state, such as the *helpless victim state* or *guilty perpetrator state*, the external conflict becomes, "I don't want to drink anymore, so why doesn't my therapist do more to help me?" In both situations, instead of giving advice to cut down the behavior, the therapist should help patients explore their positive and negative attributions about their behavior so they can develop an internal conflict about whether to continue it.

Addicts are especially likely to externalize conflict due to enormous shame regarding their behaviors. This shame is often covered over by a grandiose or entitled manner, but is nevertheless still present. It is particularly important therefore for the therapist to support self-esteem when addressing substance misuse. The stance should be completely non-judgmental, neither explicitly approving nor disapproving of maladaptive behaviors, not encouraging or congratulating patients when they abstain. Instead, the therapist can empathize with the many negative consequences and suffering that patients are going through because of them. A non-judgmental stance also helps move the behavior out of the moral realm and into the medical realm and serves to keep the conflict within the patient.

Association Techniques for Behaviors

Therapeutic interventions for maladaptive and self-destructive behaviors are essentially the same as for other types of experiences. The therapist attempts to help patients fit their behaviors into narrative sequences and also helps them to identify their polarized attributions regarding the behaviors. The only exceptions to this overall treatment strategy are that the therapist must periodically check-in regarding relapse of the behaviors due to avoidance (see section below) and the therapist must check for whether the patients are able to keep themselves safe and assess need for hospitalization (see chapter on *Special Situations*).

Behaviors can substitute for the "response of other" when helping patients to fit together an RS-RO narrative sequence (see section on *Association* in this chapter). The therapist can help the patient to identify an interpersonal event preceding a maladaptive behavior, as well as help the patients to identify their emotions before, during, and after the behavior. For example, patients may describe a release of tension, along with feelings of shame and a fear of loss of control after a drinking binge.

Helping patients to fit their maladaptive and self-destructive behaviors into narrative sequences can be challenging since patients will often experience their relapses as coming "out of the blue". Because of aberrant processing of emotional experiences, patients are often unable to recall recent interpersonal encounters and identify associated feelings. Thus a major task for a therapist is to help patients to connect specific encounters, events, and emotions with their behavioral relapse. Common triggers include recent traumatic events, a rejecting response from another person, anticipated rejection, and transference feelings that emerged in response to a recent session. There may be a strong concomitant fear of separation or abandonment. The therapist should explore with the patient links between stressors, feelings, and behaviors.

Usually patients will attempt to construct simple explanations for their relapses, and these should not be taken for face value without further exploration. The most common explanation that patients will provide is that their sudden impulse "came out of the blue." Other common explanations include, "My medications aren't working any more" and "It's just been a hectic week." For example, I had a patient who would repeatedly become suicidal and engage in self-harm when her husband would hit her, but was

consistently unable to connect the two events on her own. She would even neglect to mention the abuse and didn't realize the impact it was having. I had to explicitly ask whether her husband had recently hit her since the patient would not volunteer that information. Helping this patient establish conscious links between her episodes of suicide ideation and traumatic events eventually motivated the patient to take the necessary steps to protect herself.

Aspects of maladaptive or self-destructive behaviors that need to be explored include:

1. Context of the behavior/traumatic event. "When exactly did you first notice wanting to self-harm this week?" "When did it start getting worse again?" "What else was going on?" "Were you drinking at the time?" "Where were you when it happened?"
2. Antecedents. "What was going on right before you cut?" "What were you feeling at the time?" "Had anything stressful happened to you that day?"
3. Consequences. "What were you experiencing while you were cutting into your arm?" "What did you feel afterwards?" "What was the feeling of drinking like for you?" Did something bad happen to you while you were intoxicated?" "Did you go to the emergency room?"
4. Connections. "Have you had any upsetting experiences this week?" "I notice your mood swings have been getting worse since the time you say you started drinking again. Is that something you noticed too?" "Do you think the suicidal thinking that you've been experiencing lately is connected with getting beat up by your boyfriend?" "What was the last session like for you?"
5. Metaphors. Very often self-destructive and maladaptive behaviors can serve as symbolic substitutes for what is missing in relationships or self-structure, and it is sometimes helpful for patients to become more aware of this. Some behaviors can promote a sense of autonomy and control, e.g. food restriction. Others can provide a substitute for the soothing functions of attachment, e.g. addictions. Still others can sometimes allow the patient to displace feelings of anger in order to maintain attachment, e.g. cutting and purging. See Chapter 10 on *Psychiatric Comorbidity* for a fuller discussion.

Attribution Techniques for Behaviors

The process of exploring a behavior helps patients to fashion words for it and so creates a space for reflection between the subject and the behavior. The patient is then in a position to reflect on the meaning of the behavior and to integrate polarized attributions they may have regarding the behavior.

Denial is often integral to self-destructive and maladaptive behaviors. An essential aspect of denial is a splitting of consciousness. That is, persons who use denial are able to discuss either the positive aspects or the negative aspects of their behavior, but not both simultaneously. They have polarized attributions of value towards their behaviors, seeing the behaviors in either idealized or devalued terms. Thus they are unable to weigh the pros and cons of a behavior in order to make an informed choice as to whether or not to continue it. A role of the therapist therefore is to help bring both sides of their polarized attributions of towards the behavior into consciousness. For example, patients may talk about their drinking as a nasty habit that doesn't do anything for them, but they just can't stop. In this case, the therapist could state, "for you to continue drinking despite all the problems it is causing you indicates that drinking must do something really terrific for you. Let's explore the drinking and find out what it does for you."

Alternatively, patients may take the other pole of their attributions and only be able to discuss positive aspects of the behavior, while blaming the negative consequences on other things. For example, "Pot is the only thing that calms me down when I feel really stressed. It works better than any of the medications. The only reason I'm thinking of quitting is that my girlfriend gets on my case about it, but I don't want to give it up." In this situation it is necessary for therapists to bring to consciousness the negative consequences while trying to maintain balance between the opposing attributions, i.e. to neither encourage nor discourage the behavior. For example, the therapist can state, "

It sounds as if pot is incredibly helpful for you and you really rely on it to calm things down. On the other hand, there is research evidence that pot causes memory problems and worsens disorganized thinking. I notice that every time that you start using it heavily again, your thinking becomes more disorganized and you forget what we talked about in sessions. So you need to decide whether continuing to use pot is worth the negative consequences of interfering with treatment and your relationship with your girlfriend and possibly delaying your recovery. It very well may be worth it, and if so, you should definitely continue using it. On the other hand, if you're sick of the negative consequences and want to move forward in recovery, then we'll need to figure out how else you are going to feel soothed when you feel really stressed.

In addition to polarized attributions of value, very often patients will have polarized agency regarding their behaviors. In other words, they may get very down on themselves for the behavior, e.g. "I should be able to control this. I'm just a weak person". Alternatively, they may externalize agency and blame their behaviors on others, e.g. "I only cut because there's no one there to support me." Motivation for change is also often externalized, e.g. "I'm only going to rehab because my wife wants me to." Therapists can help explore and integrate both poles of the patient's attributions of agency. For example, "I notice you alternately either blame yourself as having a weakness for drinking or blame it on your husband." Another example, "Does it sometimes get confusing as to what you want for yourself and what others want for you?"

It is most helpful for the therapist to avoid control struggles over maladaptive behaviors by employing a more non-directive approach, helping the patient weigh risks and benefits. A striking example of this principle was with a patient who was developing increasing cutting behaviors. She would often call me prior to cutting, but my exhortations and listing of alternative coping strategies would never decrease her urge to cut. Finally, I recognized that I might be engaged in an enactment of a mutual fantasy that I could control her cutting. From another perspective, the patient was avoiding an internal conflict regarding her cutting by getting into a control struggle with me. The next time she called complaining of an urge to cut, I stated,

I hear you saying that you don't want to cut anymore because of the disfigurement and because it makes you feel like you are crazy. On the other hand, I understand that cutting does great things for you. It's able to take away the feeling of guilt through self-punishment like nothing else can. And I'm beginning to realize that I haven't been as respectful as I could have been regarding how important cutting has been to you. In fact, you may decide that cutting is the best solution for how you're feeling at this stage of your treatment, and I have to respect that.

This was the gist of a more extended conversation. For once, the patient did not cut immediately after our conversation. Remarkably, the patient never cut again over the course of our treatment together.

Ideal Other Techniques for Behaviors

The primary component of this set of techniques for managing behaviors is the treatment frame itself. A clear treatment frame serves to contain problematic behaviors and helps keep them from disrupting the treatment or from leading to serious harm. It is imperative that at the beginning of treatment, the therapist makes clear to the patient those behaviors that are acceptable and those that are not. Behaviors are frequently used to test the limits of the patient-therapist relationship by expressing in action what cannot be put into words. For example, a patient may test the limits of the therapist's caring by losing more and more weight. A test of the therapist's respect for autonomy may be to tell the therapist about a recent drinking binge. Patients may test the ability of the therapist to contain their neediness by calling more and more frequently. However, if the expectations are clear from the beginning, patients have less of a need to test the boundaries (see chapter on *Establishing the Frame* for instructions on how to set up a clear treatment frame).

The therapist can tailor treatment commitments to the needs of a given patient. For example, patient with eating disorders should be told at the beginning of treatment to keep their weight above a certain minimum, to get regular follow-up with a primary care physician, and to allow open communication between the therapist and physician. Patients who are very needy should be carefully informed about duration of sessions and limitations on telephone calls. Patients with drinking problems should be told that they cannot come to sessions intoxicated. Patients with frequent cutting should be told that they need to agree to go to the emergency room to evaluate their cuts when their therapist recommends it. Patients with frequent aggression should be told very explicitly about unacceptable hostile behaviors during sessions. And all patients should be told to work towards health and recovery, including keeping themselves safe. This includes patients taking responsibility for getting to an emergency room when they feel they are no longer in control of their suicidal impulses.

Another important Ideal Other technique for managing behaviors is framing. For managing behaviors, framing involves providing education about the behaviors based on research evidence or clinical experience. An example of a framing response regarding benzodiazepines is to state:

> *Although patients often find benzodiazepines enormously helpful for decreasing anxiety, there is research evidence that they actually worsen the course of borderline personality disorder and can prolong recovery. In particular, they can worsen mood swings and increase self-destructive behaviors. So even though they are incredibly helpful to you, I am not able to prescribe them because of their harmful effects. I'm kind of stuck with the ethic, 'First do no harm.'*

A similar kind of framing response can be made with heavy drinking. For example, the therapist can state:

> T. *From what you are saying, it seems that the drinking helps you feel relaxed when you're under a lot of stress. However, I want you to make an informed choice as to whether to continue it. Because one of the negative aspects of drinking that it has a prolonged withdrawal syndrome that often worsens symptoms of borderline personality disorder for 1 to 2 days after drinking even relatively modest amounts. And I've noticed that pattern with you as well. You seem to get more depressed and moody for 1 to 2 days almost every time you drink.*
> P. *But drinking is the only thing that helps me to relax.*
> T. *Yes. It sounds very helpful to you. I just want to let you know that there are negative consequences in terms of your recovery. It's up to you to decide whether the positive aspects outweigh the negative consequences.*

Although management of behaviors is a primary concern, management is going to be ineffective without an adequate therapeutic alliance. Patients with addictive tendencies are especially challenging to form an alliance with. In addition to the control struggles referred to earlier, a related challenge is that patients with addictions are often in one of the autonomous states of being, such as the Angry Victim State or Demigod Perpetrator State, instead of the dependent states (see Chapter 6, States of Being). In the autonomous states, patients have negative attributions of others and a desire for autonomy. They avoid getting close to their therapists because of fears of intrusion, control, or humiliation. Moreover, their substance use serves as both a chemical and symbolic substitute for attachment, so they often are less driven to bond with their therapists than patients without addictions. Authoritative assertions, judgments, or directions may be extremely well received by patients in dependent states and even serve to strengthen the alliance. However, for patients in autonomous states, these interventions cause increased anxiety or resentment. Even an overly warm and empathic manner can be perceived by some patients as cloying and intrusive. It is thus particularly important when engaging with this subgroup of patients for the therapist to intervene in a non-directive and non-judgmental manner, maintain a highly respectful

stance of patient autonomy, and support self-esteem through mirroring and framing addictions as an illness.

Alterity – Real Other Techniques for Behaviors

  1. Checking. A very important aspect of managing behaviors is to periodically check in with the patient about these behaviors. There are many times during the course of treatment when patients will not admit maladaptive behaviors because of underlying shame about them. Typical topics that are avoided include substance use, traumatic incidents, treatment non-compliance, and self-injurious behaviors. If these are not directly addressed, they tend to slow down the course of recovery. For instance, a patient may deal with conflicted feelings towards a friend, relative or therapist by going home and cutting every night. The self-destructive behavior is never brought up for exploration and the conflicted feelings are never addressed.

  When checking in, the therapist must bear in mind that patients have underlying shame about each of these topics and so they must be approached in a gentle manner. Because of the shame, patients may not fully acknowledge the extent of their behavior or the consequences. They also may not mention the behaviors to the therapist because of expectations of a condemning response from him/her. The expectation of a condemning response is present because at some level patients have already strongly condemned themselves for their behaviors.

  Any unexpected deterioration in clinical condition should raise cautionary flags about one of these hidden behaviors. Simply asking the patient about each of these is usually sufficient to bring them into discussion. For example, the therapist can ask, "Have you been drinking lately?" "When was your last drink?" For patients with a history of cutting behaviors, the therapist could state, "You seem to have had a stressful week. Did you end up cutting yourself? Did you want to end your life at the time?" Because avoidance and denial can be so powerful, therapists should ask about self-destructive and maladaptive behaviors on a periodic basis and anytime there is deterioration in clinical condition. Once the behavior is identified, it can then be explored further in a non-judgmental manner.

  2. Experiential Acceptance. Experiential acceptance has a circumscribed but important role in managing maladaptive behaviors and is used for those occasions when the discussion about behaviors begins to take on a moralistic tone. This is particularly the case with addictions, but can also occur with cutting and other self-destructive behaviors. Patients have a great deal of shame about their behaviors and tend to see themselves as morally weak. In their minds, they would be able to quit if they were a strong and good person. The addicts' notion of being morally corrupt is reinforced by recollecting all the times in their life that they lied about their behavior and even stole money to continue it. Even some of the language used in addictions, e.g. "I've been <u>clean</u> 5 months" or "you have a substance <u>abuse</u> problem", lends credibility to the moral argument. Someone who <u>abuses</u> drugs is an <u>abuser</u> and, by implication, <u>abusive</u>.

  Therapists and other providers often find themselves adopting a moral tone when talking with patients about their behaviors. A danger signal is when therapists find themselves using the word "should", e.g. "You should really stop drinking." Such a statement reinforces the patient's attribution of self as a naughty child who should be able to control his/her behavior. The statement also reinforces the patient's attribution of the other as moralistic and judgmental, and reinforces an expectation of humiliation.

  In general, the more strongly a therapist feels compelled to make a judgmental statement about a patient's behavior, the more therapeutic it is to remain neutral, emphasizing both positive and negative aspects of the behavior. Experiential acceptance deconstructs patients' pathological attributions and expectations of humiliation, thereby helping patients to move to a more reflective state where they are able to be conflicted about their behavior and to engage in treatment.

3. Experiential Challenge. When problematic behaviors are treatment-related, i.e. either directed towards the therapist or occur during a psychotherapy session, they need to be dealt with through experiential challenge. Treatment-related behaviors can be directed either towards self or other and should be addressed directly and clearly through verbal exploration and/or limit-setting.

a. Challenging self-directed behaviors

Self-directed behaviors during sessions usually involves some kind of cutting or scratching, though head-banging and other types of behaviors can also occur. Patients are typically in the Guilty Perpetrator State or Helpless Victim State during these episodes, but occasionally patients in the Demigod Perpetrator State will test the therapist's containment abilities in this way (see Chapter 6 on *States of Being*).

As a general rule, any self-destructive behaviors occurring during sessions should be strictly forbidden. They should be framed as hostility directed towards the self and thus a violation of one of the written treatment commitments, i.e. "no hostile behaviors". If self-destructive behaviors during sessions are allowed to continue, they tend to escalate over time as the patient seeks to test how much the therapist cares and is able to contain. Instead, the therapist should address behaviors promptly as they come up, e.g. "You can't do that. Cutting during sessions is not allowed. It's a form of self-directed hostility and, as we discussed at the beginning, hostile behaviors during sessions will limit my ability to be helpful to you." Patients generally respond very well to this intervention and feel less need for further testing. Should the behavior continue, however, the therapist should end the session early after assuring that the patient is not an immediate danger to himself or herself.

After the behavior is contained, the therapist can then explore the behavior in the same way as he/she would explore behaviors outside of session. The therapist can ask about the emotion associated with the behavior and attempt to link it to the topic of discussion or thoughts that the patient had had prior to the incident.

b. Challenging therapist-directed behaviors

Maladaptive behaviors directed towards the therapist can be intrusive, detached, controlling, or intimidating. Many persons with BPD have difficulty acknowledging feelings of anger, but persons in the *angry victim state* or *demigod perpetrator state* are more likely to express anger or hostility since they feel totally justified. It is important to distinguish between the two states since the optimal therapist intervention is going to be very different. Experiential challenge should never be used for patients in the *angry victim state* since it will reinforce negative attributions of the other as bad and powerful and an expectation to be humiliated. The countertransference response to patients in the *angry victim state* tends to be irritation or devaluation.

On the other hand, patients in the *demigod perpetrator state* can be frightening. The patient's attribution of others is that they are without agency. Often patients will make subtle twists in the conversation to reveal what has happened to other people who have crossed their paths. There may also be a subtly threatening tone of voice or body language, such as where patients position themselves in the room, intruding into therapist's personal space or blocking the exit. There may be vague and veiled threats. The therapist has an overall sense of foreboding and worries of tipping the patient "over the edge".

This situation needs to be quickly and directly addressed by the therapist. A fearful or hesitant response enacts the patient's attribution of the other as being without agency and will result in escalating more overt transgressions. Experiential challenge is essential to both maintain safety and to provide a *deconstructive experience*. For example, the therapist can state, "When you talk about how you have harmed other people who have given you a hard time, it kind of implies that if I say the wrong thing you might become violent. Is that what you're saying?" If the patient gives any response to that question with anything but a resounding no, the therapist can follow up with, "I want to be very clear on this

point…violence or threats of violence are totally unacceptable here. Even an <u>indirect</u> threat of violence is a form of hostility and will destroy any potential I might have to be of help to you."

Hostility invariably harms the therapy relationship and the patient's recovery, and so must be contained (Bion 1967).   Hostility can take many forms, both direct and indirect. Some of these include use of profanity in session, missed sessions, indirect threats of malpractice lawsuit, multiple telephone calls at inconvenient times, telling stories of violence towards persons who disappointed them, not paying bills on time, etc. Of course, there are other reasons for some of these behaviors and these must be explored before labeling the actions as hostile.

As a prophylactic step towards containment of hostility, it is helpful to set the parameters and the contingencies of treatment at the beginning. This was more fully discussed in the chapter, *Establishing the Frame*. Patients feel less anxious when they know what to expect and what is expected of them. Likewise, they are less likely to test limits through hostile behavior if they know in advance what the limits are.

When clear hostility is demonstrated in sessions, the first step is to label it as such. For example, at the end of a session a patient refused to leave my office until I agreed to have a physical relationship with her. She also stated that unless I agreed to her demands, she would stay put until security dragged her out of my office. However, when I labeled her behavior as hostility directed towards me, she immediately got up from her chair, apologized, and left. The patient later telephoned me concerned that I would terminate because of her hostility. In the subsequent session we explored the sequence of events and reactions leading up to the crisis.

It is also helpful for the therapist to provide a framing response clarifying the difference between anger and hostility. Anger is a <u>feeling</u> and hostility is here defined as a threatening or aggressive <u>action</u>. The therapist can emphasize that anger is a useful feeling and that it signals something wrong in a relationship. However, the patient should be told that when anger spills over into hostile action, it is then universally destructive to the relationship. The patient at that point may need to be reminded of the written treatment commitments and why those are necessary.

After the hostility has been contained, the therapist should explore the sequence of events leading up to the hostility. Reasons for hostility vary and depend in large part on the particular stage of treatment and state of being. Stage-related causes for hostility can include testing of safety concerns in Stage I, perceived negative responses from the therapist to the thematic questions in Stages II, distancing from treatment and recovery in Stage III, and fuller realization of the limits of the patient-therapist relationship in Stage IV.

Beginning therapists are often afraid to directly confront the patient or label hostility, having the mistaken impression that they are always supposed to be gentle, nice, and "supportive" to patients. Firm but empathic limit-setting for patients in the *demigod perpetrator state* can provide a *deconstructive experience* by the therapist acting in a way that is inconsistent with the patient's attribution of the other as lacking agency, and by promoting the idea within the patient that his/her aggression can be contained. In one case, after I had provided written treatment commitments and maintained careful boundaries over several sessions, a patient told me, "You have it too easy here." She then proceeded to make it really difficult for me over the next couple months by misusing my prescriptions. When I finally set limits on the behavior she appeared relieved and increased her engagement in the therapy process. Sometimes persistent hostility and subsequent limit-setting will necessitate ending the therapy relationship, especially in Stage I. But this is rare if the limits and expectations for patient behavior are clear from the beginning and adequate framing and explanation is provided.

Chapter 9. PSYCHOTROPIC MEDICATIONS

Every major class of psychotropic medication (i.e. antidepressants, mood stabilizers, antipsychotics, and anxiolytics) has been tried in the treatment of borderline personality disorder and its varied manifestations. Each class appears to be partially beneficial for some patients, but almost never is there a strong and sustained response and it is impossible to predict which patient is going to respond to which treatment.

A common strategy is to treat the comorbid disorders and symptoms with the corresponding class of medication (Soloff, 2000). For example, symptoms of depression would be treated with an antidepressant, paranoia with an antipsychotic, mood lability with a mood stabilizer, etc. However, there is little evidence to support this strategy (see chapter on *Psychiatric Comorbidity*). Different classes of medication appear to have broad and overlapping, albeit modest, benefits. Patients often end up on multiple psychotropic medications since there is usually co-occurrence of multiple mental disorders and patients tend to be very reluctant to remove a medication. At best, many patients will describe having some of the edge taken off of their distress and symptoms, so that they feel less overwhelmed.

More meta-analyses have supported modest efficacy of anticonvulsant medications and antipsychotic medications for treatment of mood symptoms (anxiety, depression, irritability, and mood reactivity), but have generally found little support for the use of antidepressant medications (Lieb, Vollm, Rucker, Timmer, & Stoffers, 2010). Anticonvulsant medications demonstrated an additional benefit of reducing self-harm behavior, that was not demonstrated for antipsychotic medications. There is some evidence that omega-3 fatty acids, including eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA) may also provide modest benefit in dosages of approximately 1000 mg per day, especially for mood instability (Karaszewska, Ingenhoven, & Mocking, 2021). However, no class of medications has been shown to improve symptoms of abandonment, emptiness, identity, or dissociation. Moreover, the quality of medication studies is often marginal, with low sample sizes, short-term follow-up, small treatment effects, and selective reporting of methods and results. So psychotherapy is still by far the most effective treatment modality for this disorder.

Many patients prefer benzodiazepines to any other class of medications, stating that it is the only medication that reduces their anxiety. Even though they may help with anxiety, benzodiazepines will worsen behaviors, such as outbursts, assaults, self-harm, and/or suicide attempts, in most patients with BPD (Cowdry and Gardner, 1988) and may increase the risk of suicide attempts and self-harm in depressed adolescents (Brent et al., 2009). The mechanism is likely through dampening of cortical inhibition, thereby deregulating mood and releasing impulsive, self-destructive urges (Deakin, Aitken, Dowson, Robbins, & Sahakian, 2004). In an effort to *first do no harm*, benzodiazepines are contraindicated for patients with BPD. However, often a substantial effort at psychoeducation is required for patients to understand and agree with this rationale.

Although anticonvulsants, such as lamotrigine, topirimate, and valproate, have modest efficacy for some of the symptoms of BPD, there are a number of factors that militate against their use for BPD. Individuals with BPD can be highly impulsive, which impedes their ability to maintain steady blood levels, increases risk of overdose, and increases risk for unprotected sex. Only lamotrigine and oxcarbazepine are Category C for risk of fetal abnormalities; topirimate, valproate, and carbamazepine are Category D. Moreover, carbamazepine, oxcarbazepine, and topiramate can lower levels of birth control pills, thereby increasing the risk of pregnancy. Furthermore, anticonvulsants may increase suicide risk, according to FDA analysis, though the evidence for this is not strong. For all these reasons, anticonvulsants should not be the drugs of first choice for most patients with BPD. If one is going to be used, the risk/benefit profile of lamotrigine is probably the most favorable.

Suggested Guidelines

- Provide psychoeducation about the limited efficacy of medications, even if co-occurring major mental disorders are present; keep expectations low and emphasize the importance of involvement in DDP, or other evidence-based therapies, as the best hope for recovery.
- Start with a low-dose antipsychotic medication, e.g. 2-10 mg aripiprazole, 25-100 mg of quetiapine, or 0.5-2 mg of risperidone per day. The dose can be increased if psychotic symptoms, such as auditory hallucinations or ideas of reference, are present.
- Use an anticonvulsant medication if intensive self-injury or bipolar I or II disorder is present. Lamotrigine has the most favorable risk/benefit profile for most patients.
- Consider use of EPA or DHA for mood instability
- Try an SNRI or SSRI if a severe major depressive disorder is present, or if there is marked difficulty with impulsive aggression. Impulsive aggression is a potentially inheritable trait that has been linked to low serotonin levels in the central nervous system (Kendler et al., 2008).
- Consider naltrexone if there are marked difficulties with impulsive pleasure seeking. Although there are no trials of naltrexone in BPD populations, this class of medications has been shown to be helpful for a range of impulsive activities including pathological gambling, binge eating, kleptomania, and alcohol misuse. Studies using it for self-harming behavior have been mixed.
- Avoid PRN medications since they give patients an implicit message that anytime they are distressed, they should take a pill or a substance.
- Prescribe no more than three psychotropic medications at any one time to minimize potential for harmful interactions. For patients who are more impulsive or at higher risk for suicide, medications should be dispensed in relatively small quantities and medications with greater potential for lethality should generally be avoided.

Psychological Factors

Medications can have important psychological significance. Many patients hope for a "magic bullet" that will relieve their distress and explain their suffering. A "chemical imbalance" and medication cure provide a much easier explanation and solution to their difficulties than going through the anguish of self-awareness, conflict resolution, and exploration of relationships. Excessive time and effort spent in sessions finding the best medication shifts the focus from where it needs to be for recovery to progress.

If the therapist has prescribing privileges, medication can also serve the function of a transitional object. Medication can represent a tangible gift from the therapist and token of caring. Non-compliance with medication can reflect ambivalence towards the therapist. Often it is the medication prescribed by the therapist with which the patient chooses to overdose in an unconscious angry and defiant gesture.

As a general rule, if medication management is being discussed every session, regardless of comorbidity, then there is likely an enactment in the patient-therapist relationship that needs to be deconstructed. Most often this sort of enactment occurs early in treatment and involves a patient who is in an extreme state of arousal or dysphoria and there is a shared fantasy that the therapist should be able to make everything better with a magic potion. In this circumstance, when the patient asks, "Doc, you got to give me something to help with this anxiety!" the therapist can provide a reframing response, such as:

> *You are clearly extremely anxious and I can understand you wanting some relief. As we discussed earlier, however, we know that medications have very limited benefits for persons with your condition, so the best we are going to achieve is to take the edge off. What can help more substantially, however, is for you to continue to explore your recent interpersonal experiences, particularly how you respond to them emotionally. As you start to be able to identify and acknowledge your emotional responses, you will find your level of anxiety will decrease substantially. However, it's a difficult and long-term process, and in the meantime, you are going to be anxious. The anxiety won't kill you, but it can be extremely uncomfortable."*

Note that this intervention disrupts the typical medication enactment of the sick helpless child waiting passively for the powerful therapist to provide a cure. The interpersonal dynamic is now changed to one of mutual responsibility shared between two adults.

Chapter 10. PSYCHIATRIC COMORBIDITY

General Management Considerations

Co-occurrence of other mental disorders is the rule, rather than the exception, for persons with BPD and sometimes requires minor modifications of the usual treatment frame, depending on the particular symptom or syndrome (see below). Patients with BPD can often meet the diagnostic criteria for several other mental disorders and these disorders appear to be interrelated with BPD. The DSM system from the third edition onwards has emphasized phenomenology of diagnoses over etiology.   This system has served to enhance diagnostic reliability, sometimes at the expense of validity. Evidence suggests that the pathophysiology, course, family history, and treatment outcomes of major mental disorders may be different for persons with co-occurring BPD. In the co-occurring population, remission of major mental disorders is dependent on remission of BPD and not vice versa (Webber et al., 2015, Zanarini et al., 2004). Moreover, when other mental disorders co-occur with BPD, they tend not to respond to standard treatments (Feske et al., 2004). These studies provide strong support for the hypothesis that other mental disorders in the presence of BPD, with the possible exceptions of bipolar disorder and schizophrenia, should be considered as complications of the underlying personality disturbance and that diagnosis and treatment efforts should primarily be directed towards the BPD instead of co-occurring other mental disorders.

Figure 10-1 illustrates common co-occurring symptoms and syndromes. These symptoms and syndromes often have defensive functions and/or symbolic significance when they occur in persons with BPD. Many of them are also more likely to occur in a particular *state of being* and result from deficits in processing of emotional experience, including intolerance of internal conflict and a need to dissipate dysphoric affects.

The principal role of the therapist is to help the patient explore the linkages between various behaviors, triggering emotions, interpersonal experiences, and symbolic meanings. The therapist generally tries to avoid suggesting a meaning, unless the patient is hyperaroused and fragmented and thus could benefit from such framing as a containment technique. It is better for the therapist to point out and raise questions about possible meanings while suspending presuppositions. This facilitates creative discovery of the self and avoids the intrusive and *logocentric* role of the therapist as the all-wise conveyer of meaning.

Figure 10-1. Common associated symptoms and syndromes

- Depression, suicide attempts, self-mutilation

- Bingeing, purging, dietary restriction

- Compulsive cleaning or checking

- Hypochondriasis, phobias, panic attacks, flashbacks

- Pleasure or thrill-seeking impulsive activity or hostility

- Substance misuse

Depression

Consistent with DDP theory, research findings support the conceptualization of depression in persons with BPD as a reflexive reaction to separation anxiety (see chapter on *States of Being*). Three studies have compared the quality and phenomenology of depression with or without co-occurring BPD (Rogers et al., 1995; Westen et al., 1992; Wixom, Ludolph, & Westen, 1993). These studies indicated that when BPD is present, major depressive disorder is accompanied by feelings of emptiness, loneliness, and longing for attachment figures. These characteristics have a negative correlation to depression severity in patients without BPD (Westen et al., 1992).

Research suggests that the pathophysiology of major depressive disorder (MDD) may also differ when it co-occurs with BPD. For example, the sleep EEG of patients with co-occurring BPD and mood disorders is not usually accompanied by shortened rapid eye movement sleep latency that typically is a biomarker for mood disorders (Benson, King, Gordon, Silva, & Zarcone, 1990). Likewise, in a study of 50 patients with co-occurring BPD and MDD, only 26% had non-suppression on the dexamethasone suppression test (Korzekwa, Steiner, Links, & Eppel, 1991).

In addition, treatment studies suggest some differences in MDD when it co-occurs with BPD. A meta-analysis by Newton-Howes, Tyrer, and Johnson -Howes (2006) indicated that depression was half as likely to respond to treatment with medications and/or psychotherapy when co-occurring personality disorders were present. Joyce et al. (2003) reported a poor response to nortriptyline for patients with MDD and co-occurring BPD. Another study indicated that MDD does not respond to electroconvulsive therapy when there is co-occurring BPD (Feske et al., 2004). A two-year prospective naturalistic study reported that MDD accompanied by BPD takes a significantly longer time to achieve remission than MDD without co-occurring BPD (Grilo et al., 2005). In a large epidemiological survey, BPD was a strong independent predictor of persistence of MDD over 3 years (Skodol et al., 2011). In a 3-year longitudinal study of 161 persons with BPD, Gunderson and colleagues (2004) reported that improvement in BPD preceded improvement in MDD, but improvement in MDD did not precede improvement in BPD. Remission rate from BPD was not affected by presence of co-occurring MDD. The results of longer term treatment studies suggest that depression gradually improves over a period of years, rather than weeks in the co-occurring subgroup (Bateman & Fonagy, 1999; Korner, Gerull, Meares, & Stevenson, 2006).

Nevertheless, short-term treatment studies indicate good responsiveness of co-occurring depression. Hilsenroth and colleagues (2007) reported that a short-term psychodynamic approach with a focus on emotion and affect-laden interpersonal experiences was highly effective in reducing depression severity for patients with co-occurring major depressive disorder and BPD, but the time to response was longer than for patients without co-occurring BPD. Some short-term studies of antidepressant medications with weekly medication management visits indicate no effect of BPD on treatment response for patients with major depressive disorder (Mulder, **Joyce**, Frampton, Luty, & Sullivan, 2006). Alliance and allegiance effects in the first few months of treatment may account for the discrepant findings.

According to DDP theory, most BPD patients with severe depression are in the *guilty perpetrator state* and respond to therapeutic strategies appropriate to that state (see chapter on *States of Being*). Antidepressant medication trials should also be pursued, but are unlikely to lead to sustained remission. Excessive time and effort spent on pharmacological solutions is an error that can often impede recovery by encouraging a passive patient attitude that waits upon rescue from the therapist.

Self-destructive behaviors, including suicide attempts and self-mutilation, commonly accompany depression in persons with BPD. They can serve multiple purposes, including a redirection or displacement of aggression from the other towards the self in order to maintain connectedness in a conflicted relationship and so avoid separation anxiety. They also serve to mitigate the dysphoria associated an internal sense of badness through decreasing dissociation and through symbolic atonement or discharge. In general, the therapist can manage such behaviors through non-judgmental exploration of

associations and *attributions* (see chapter on *Specific Techniques*). However, dangerousness must also be assessed and appropriate actions taken to ensure safety.

Eating Disorders

Eating disorders often co-occur with BPD and are found in approximately 50% of BPD patients admitted to psychiatric wards, with binge eating disorder being the most prevalent of these (Zanarini, Reichman, Frankenburg, Reich, & Fitzmaurice, 2010). Among patients with bulimia or anorexia nervosa, the rate of BPD is approximately 26% (Sansone, Levitt, & Sansone, 2005). Co-occurrence of BPD is an important consideration in treatment of eating disorders since BPD has been shown to negatively correlate with treatment outcome of bulimia (Steiger & Stotland, 1996).

The various symptoms of eating disorders can have magical symbolic significance. For example, bingeing can serve as a self-soothing activity like substance use (see below). Patients also sometimes describe it as symbolically representing filling up their emptiness. Purging, by contrast, can sometimes magically represent a removal of an embedded sense of badness and thus is most often employed when patients are in the *guilty perpetrator state*, whereas dietary restriction can serve to maintain a sense of autonomy and control.

In general, eating disorders can be managed in a similar manner to other self-destructive and maladaptive behaviors. However, some special modifications apply for anorexia and/or bulimia (also see chapter on *Establishing the Frame*). Foremost among these is a close collaborative relationship with a primary care physician who is familiar with some of the medical complications of this group of disorders. The patient's weight, hemoglobin, and electrolytes should be regularly monitored. An electrocardiogram should be obtained to screen for QT prolongation and arrhythmias. In addition, modifications to the written treatment commitments may be made to include regular primary care visits and weight or behavioral parameters that would trigger referral to an inpatient unit or partial hospital. I recommend relatively short stays at eating disorder units since, in my experience, many facilities have difficulty recognizing and appropriately managing patients with BPD. Nevertheless, when a patient's weight falls below 15% of ideal, not only is there an increased risk of dangerous arrhythmias, but patients can become more confused, detached, and less able to identify and label emotions in themselves and others, thereby slowing the recovery process (Oldershaw, Hambrook, Tchanturia, Treasure & Schmidt, 2010).

Anxiety disorders

Anxiety is a nearly universal phenomenon in persons with BPD and is a manifestation of hyperarousal stemming from aberrant processing of emotional experience through the amygdala. Patients will usually meet criteria for discrete disorders, most commonly generalized anxiety disorder and posttraumatic stress disorder, but panic disorder, obsessive compulsive disorder, and phobias also frequently co-occur. Posttraumatic stress disorder (PTSD) occurs in 60% of inpatients with borderline personality disorder and in 30% of individuals with BPD in the general population (Pagura et al., 2010; Zanarini et al., 2004). Obsessive compulsive disorder occurs in about 25% of inpatients with BPD and co-occurrence is associated with a worse response of OCD to usual treatments (Baer et al., 1992; Hansen, Vogel, Stiles, & Gotestam, 2007).

In general, anxiety disorders tend to markedly improve using standard DDP interventions without the therapist having to focus specifically on the anxiety disorders or to add medications. As patients are increasingly able to process their emotional experiences, levels of arousal come down, usually within 2-3 months of beginning therapy. However, if anxiety is severe and distressing, it is useful to add a one-time brief modification early in therapy, including teaching relaxation techniques and/or behavioral desensitization. Because these are more directive interventions, they have the potential to disrupt the nature of the patient-therapist relationship and must therefore be used sparingly. For example, I save relaxation training for the last 10 or 15 minutes of a session as I do for medication management, and introduce it with a caveat that it will only take the edge off the anxiety and that further involvement with DDP is needed for more definitive symptom control.

Posttraumatic Stress Disorder

In PTSD, persons struggle unsuccessfully to keep traumatic recollections or flashbacks out of consciousness. There is a battle between one part of the mind or brain connected with the memory system that is continually pushing the past into the present, and the conscious self that is trying to suppress it. PTSD in patients with BPD can often exacerbate polarized, split-off attributions of agency into *victim vs. perpetrator*. Recollections may be accompanied by a theme of victimization that, paradoxically, can provide a sense of meaning and support identity, i.e. "I was victimized, I am a victim." Alternatively, recollections may be accompanied by a theme of shame and guilt, i.e. "I got what was coming to me." Similarly, PTSD touches on the central thematic question of "do I have a right to be angry?" and "are my needs legitimate?" Very often the fear of acknowledging their own feelings of anger and hatred can be transformed by patients into a severe and refractory fear of their perpetrator through projective mechanisms. In other words, patients state to themselves: "I am not bad; it's the other person who is bad and I fear him/her." In summary, PTSD can serve to connect people with their past, as well as to reinforce polarized attributions, resolve the central thematic questions, and to solidify a passive and child-like self-image as innocent victim or guilty perpetrator.

For patients in Stages I and II, simply facilitating the process of integrating opposing self-attributions of *victim vs. perpetrator* through DDP is usually sufficient to manage PTSD symptoms. Often a framing comment that the patient's fear of the perpetrator also represents fear of the patient's own feelings of anger and hatred is very helpful and makes intuitive sense to most patients with BPD. For patients with marked social withdrawal, I will also spend a few minutes at the end of a session providing a framework for their avoidance and suggesting that they desensitize themselves to feared situations by getting out more in public.

PTSD symptoms can sometimes emerge later in treatment, in Stages III and IV. In these instances, PTSD often signifies ambivalence towards moving forward into an adult role and an unconscious wish to regress back to simpler times when self-attributions were clearer and free of responsibility in the sick role. Sometimes letting go of the recollections of PTSD can feel like letting go of an essential part of the self and the connectedness with important past relationships (Nadelson, 2005). Resolving PTSD through DDP in later stages of recovery involves the therapist attempting to bring into consciousness the patient's ambivalence about recovery and about moving into often overwhelming adult roles and responsibilities.

Bipolar Disorder

Manic-like mood and activity can sometimes appear when patients are in the *demigod perpetrator state* and needs to be differentiated from bipolar disorder. In the *demigod perpetrator state,* there is a sense of euphoria accompanied by idealization of the self. There is a high likelihood of impulsive activities having a high likelihood for negative consequences, including spending sprees, promiscuity, or intoxication. During manic-like activity, patients can appear, domineering, threatening or arrogant. Threatening or hostile behavior can also occur in the *angry victim state* as patients feel justified in retaliating for perceived persecution.

Patients with BPD who display manic-like symptoms and activities may meet diagnostic criteria for bipolar disorder if the period of activity is of sufficient duration. However, diagnosing bipolar disorder is extremely challenging in borderline patients due to overlap in symptoms. It is quite common for patients with BPD to be misdiagnosed as having bipolar illness, particularly bipolar II (Zimmerman, Ruggero, Chelminski, & Young, 2010). Borderline patients have greater mood reactivity than bipolar patients and tend to describe low moods following negative events and high moods following positive events. But because of the borderline's limited range of subjective awareness, they often describe their mood shifts as coming "out of the blue". There is also a danger of under-diagnosing bipolar disorder. In bipolar disorder, the duration of mood shifts lasts longer, mood shifts are more autonomous, impulsivity is restricted to high mood states, and there is usually a family history of severe mental illness. Impulsive behaviors of BPD are present in periods of both low mood, as well as high mood states.

A good general treatment guideline is to treat bipolar disorder and borderline personality disorder fairly independently of one another. Co-occurring bipolar disorder does not appear to affect the course or prognosis of BPD (Gunderson, 2006) and may benefit from adjunctive treatment with a mood stabilizer. On the other hand, there is evidence that bipolar disorder may have a different pathophysiology and treatment course when it co-occurs with BPD. For example, bipolar disorder co-occurring with BPD responds relatively poorly to mood stabilizers in comparison to bipolar disorder without BPD (Swartz, Pilkonis, Frank, Proietti, & Scott, 2005). Furthermore, I have had cases where psychotherapy for BPD led to resolution of bipolar disorder. For example, I previously described a patient with a history of postpartum depression and two very clear manic episodes with psychotic features that required hospitalization (Gregory, 2004). She began a course of DDP and was able eventually to come off all her psychotropic medications. Seven-year follow-up after discontinuing her medications demonstrated no recurrence of major depression, psychosis or mania. In summary, the model of independent disorders for co-occurring BPD and bipolar disorder is a reasonable model for management, but is also insufficient to explain clinical observations and deserves further research.

Substance Use Disorders

Approximately 50-70% of psychiatric inpatients with BPD also meet diagnostic criteria for substance use disorders (Dulit, Fyer, Haas, Sullivan, & Frances, 1990; Zanarini et al., 2004; Zanarini et al., 2011). The prevalence of BPD among patients being treated for drug dependence is variable depending on the sample. In studies employing structured diagnostic interviews, the prevalence of BPD has varied from 18-34% in patients receiving treatment for cocaine dependence (Kleinman et al., 1990; Kranzler, Satel, & Apter, 1994; Marlowe, Kirby, Festinger, Husband, & Platt, 1997) and 5-45% in patients treated for opiate dependence (Brooner, King, Kidorf, Schmidt, & Bigelow, 1997; Cacciola, Alterman, Rutherford, McKay, & Mulvaney, 2001; Cacciola, Rutherford, Alterman, McKay, & Snider, 1996; Darke, Ross, Williamson, & Teesson, 2005). The prevalence of BPD among persons in treatment for alcohol use disorders appears similar to those in treatment for drug dependence, ranging from 16-22% in samples of patients undergoing detoxification, inpatient or outpatient rehabilitation (Martinez-Raga, Marshall, Keaney, Ball, & Strang, 2002; Morgenstern, Langenbucher, Labouvie, & Miller, 1997; Nurnberg, Rifkin, & Doddi, 1993).

There is evidence that co-occuring BPD worsens the outcome of alcohol and drug rehabilitation. In the study by Marlowe et al. (1997) of cocaine-dependent persons, BPD was the only personality disorder that was consistently associated with a negative outcome, including measures of both treatment compliance and drug abstinence, and this relationship was independent of measures of anxiety, depression, or initial severity of drug dependence. Cacciola et al. (1996) examined 7-month outcomes of 197 men admitted to a methadone clinic. In that study, BPD had no significant effect on drug use, but was associated with negative outcomes on other measures, including alcohol use, medical and psychiatric symptoms, and relationships. Darke et al. (2005) examined the impact of BPD on 12-month outcomes of 495 heroin users treated in a variety of settings. They reported that BPD did not affect remission from heroin or other drugs, but it was associated with higher levels of needle sharing, worse global psychological health, and almost four times the rate of attempted suicide.

Two studies have looked specifically at the impact of BPD on the severity or course of alcohol use disorders. In the retrospective study cited above by Martinez-Raga et al. (2002) patients at a detoxification program who had BPD or antisocial personality disorder were significantly more likely to have an unplanned discharge from the facility than those who did not have those personality disorder diagnoses. In the study by Morgenstern et al. (1997), BPD uniquely predicted multiple measures of problem drinking, even after controlling for the effects of gender and other mental disorders. The measures included: lifetime severity of alcohol dependence, psychological problems related to drinking, earlier age of onset of drinking, worse adaptive coping, and suicide ideation. BPD symptoms were sustained during times of abstinence and were predicted by measures of maladjustment in childhood and adolescence. These results suggest that persons with BPD represent a distinct subgroup among patients receiving treatment for alcohol dependence, with unique clinical variables, etiology, and treatment course.

Likewise, studies examining persons treated for BPD have demonstrated that co-occurring substance use disorders adversely affect outcome on measures of psychopathology. Ryle and Golynkina (2000) reported that cognitive analytic therapy for BPD was less effective for those patients with co-occurring alcohol abuse. According to a study by Miller, Abrams, Dulit, and Fyer (1993), BPD complicated by an alcohol use disorder is associated with unemployment, poor school performance, and promiscuity, as compared to BPD without a co-occurring alcohol use disorder. A study by van den Bosch, Verheul, and van den Brink (2001) compared 29 subjects with BPD to 35 subjects who had co-occurring BPD and substance use disorders. The latter group was found to have greater levels of anxiety, antisocial behavior, and suicide attempts. In a large psychological autopsy study of substance-related suicides, female victims were noted to have high rates of borderline personality disorder (Pirkola et al., 1999). In a large longitudinal cohort study of 193 borderline patients interviewed 15 years after residential treatment, co-occurring substance misuse was the single largest predictor of completed suicide (Stone, 1990). In a prospective study of 290 subjects diagnosed with BPD who had been hospitalized at McLean, Zanarini et al. (2004) reported that co-occurring substance use disorders strongly and negatively correlated with remission from BPD at 6-year follow-up. The presence of a substance use disorder had a greater effect on outcome than the presence of any other co-occurring mental disorder, including posttraumatic stress disorder, bipolar disorder, eating disorders, or major depressive disorder. Similarly, a 7-year prospective study of 88 psychiatric inpatients diagnosed with BPD indicated co-occurrence of substance use disorders was associated with increased suicide thoughts and behaviors and persistence of BPD diagnosis at follow-up (Links, Heslegrave, Mitton, Van Reekum, & Patrick, 1995).

DDP posits that persons with co-occurring BPD and substance dependence have strong feelings of vulnerability in relationships and so tend to remain in the autonomous *states of being*. In these states there is a splitting off and denial of the wish for closeness in relationships. Substances serve as a magical substitute for interpersonal attachment and so help to maintain distance.

This model is supported by animal and human studies indicating that the neural network underlying the drug reward system of the brain is the same neural network that maintains attachment. In several animal studies, administration of opioids has been shown to attenuate separation anxiety and this phenomenon has been linked to the μ-opioid receptor (Nelson & Panksepp, 1998). Moles et al. (2004) reported that mice who were lacking the μ-opioid receptor gene displayed both reduced reward dependence to nonopioid drugs of abuse, as well as reduced attachment behaviors towards their mothers. Studies have also linked benzodiazepines and the benzodiazepines receptor complex to separation anxiety (Nelson & Panksepp, 1998). Likewise, Macaques monkeys raised apart from their mothers develop higher levels of ethanol preference (Barr et al., 2004).

Human studies support a common link between the drug reward system and attachment. In large, prospective studies in Denmark, early weaning from breast-feeding has been associated with the development of alcoholism in adulthood (Goodwin et al., 1999; Sørensen, Mortensen, Reinisch, & Mednick, 2006). King-Casas and colleagues (2005) measured neural correlates of trust using functional magnetic resonance imaging of events in a single-exchange trust game. The authors reported that *intention of trust* was mediated through dopaminergic activity within the head of the caudate nucleus, the same neural region implicated in the drug reward system.

For the most part, co-occurring substance use disorders can be managed with standard DDP techniques. See chapter on *Specific Techniques—Managing Self-Destructive and Maladaptive Behaviors* for a summary of these. Because of the strong autonomy needs of this co-occurring subgroup, it is particularly important to maintain a non-directive stance and avoid control struggles. For severe addicts, however, I strongly recommend to them that they be involved in concurrent rehabilitation programs or 12-step groups.

Chapter 11. SPECIAL SITUATIONS

1. Psychiatric Hospitalization

Deciding when to admit a patient to a psychiatric ward is probably the single most vexing dilemma with which therapists are faced when treating patients with BPD. It is challenging to accurately assess potential lethality in this population and difficult to determine the best disposition.

Although patients having BPD are at significant risk for completed suicide, the degree of lethality can be difficult to assess at any point in time. Many patients have chronic suicide ideation (Sansone, 2004). Others have markedly fluctuating mood, and ideation about suicide can vary moment by moment. Borderline patients with antisocial traits and/or substance use disorders may be at higher risk (Runeson & Beskow, 1991). For those patients who have substantial dissociative symptoms, there may be split off aspects of the self that want to die and other parts that want to live. Different parts of the self may come to the forefront at different times. Self-destructive behaviors can similarly run the gamut from cuts that are barely visible, to overdoses of a few pills, to behaviors that necessitate care in the ICU or result in death. Which mood, aspect of the self, or behavior should the therapist pay attention to when determining need for hospitalization?

It is also challenging to determine the benefits versus risks of hospitalization in any given patient. BPD is one of the few conditions that can often be made worse by hospitalization (Paris, 2004; Stone, 1993). The hospital is a very regressive environment. All basic necessities are provided and there is little need for patients to make independent decisions. Staff are always available and potentially can provide continual warmth and support. In these conditions, patients' merger and dependency wishes become strongly activated (Bornstein, Becker-Matero, Winarick, & Reichman, 2010). Similarly, patient fears of loss of autonomy and rejection/abandonment are heightened. The interactions with staff become more intense as these wishes and fears translate into attention seeking, control struggles, and efforts to prolong discharge. Some staff will react with rescue fantasies and will change medications, add diagnoses, or cross usual patient-staff boundaries. Other staff will react negatively to the patient's help-seeking behaviors and patients may make suicide gestures or threats on the unit to demonstrate the legitimacy of their needs (Main, 1957). When discharge or transfer inevitably ensues, patients can feel rejected, depressed, confused, and abandoned, and are often at greater risk of completed suicide after hospitalization than before it.

The other risk of hospitalization is that hospital providers will sometimes recommend a radically altered formulation and treatment plan to the patient. Often co-occurring mental disorders become the focus of inpatient treatment with the implied message, "If only we can find you the right combination of medication, all your problems will be resolved." This message can undermine the therapeutic alliance with the outpatient therapist and discourage patients from facing the arduous task of recovery.

Because of both the difficulty in assessing lethality and the relatively low benefit to risk ratio of hospitalization, the threshold for hospitalization should be higher for patients with BPD than for those with other disorders. On the other hand, some patients can benefit from brief stabilization in a hospital environment. The entire clinical condition needs to be considered when making a decision whether to hospitalize, including:

- Whether the patient's overall condition is stable or deteriorating
- Whether there has been a change in the patient's support system
- Whether there have been unusual or extreme recent stressors
- Whether the therapist has a good working relationship with the inpatient providers
- Whether prior attempts at hospitalization have been generally helpful or harmful

Therapists need to ask themselves whether it is truly in the best interest of a given patient to hospitalize him/her, even if the patient is expressing strong suicide ideation. Often it is more helpful to

explore with patients the antecedents of the suicide wishes so that they can process their emotional experiences instead of seeking immediate discharge of their aroused state through destructive action. If the patient is in the *guilty perpetrator state*, an experiential deconstruction may also be indicated (see chapters on *States of Being – Guilty Perpetrator State* and *Specific Techniques – Alterity*).

Early in treatment, complaints about suicide may represent a test of safety concerns for the patient-therapist relationship. This is particularly true when the patient is refusing hospitalization. So if the therapist doesn't involuntarily hospitalize the patient, the patient believes that the therapist doesn't really care what happens and feels rejected and abandoned. If the therapist does hospitalize the patient, the patient feels controlled and manipulated by the therapist. In this situation, the therapist can point out the conflicting safety concerns and also remind patients of their commitment to keep themselves safe.

When psychiatric hospitalization is employed, it is generally better for it to be of brief duration, usually less than a week to minimize regression. In my experience, one week is a useful rule of thumb for when regression is likely to get out of control. It is very important to coordinate care with the inpatient treatment team, but not for the outpatient therapist to go into the hospital daily to see the patient. This leads to conflicts and boundary issues between the therapist and staff. If the therapist goes in to visit the patient, it should be with permission of hospital staff and a one-time brief encounter.

Useful strategies for the inpatient team include minimizing medication interventions, setting the discharge date at the beginning of the hospitalization, and reversing the usual incentives for discharge. For most other psychiatric patients with behavioral problems, it is helpful to tell them that they can be discharged when they are able to demonstrate reasonable judgment and control over their behaviors. For patients with BPD, however, this strategy gives them the message that they will no longer be cared for once their behaviors or thoughts of suicide improve. It is generally more helpful to warn borderline patients about the regressive danger of prolonged hospitalization and potential worsening of symptoms. Inform them that deteriorating behavior or suicide ideation will be an indication that hospitalization is starting to have a detrimental effect and that earlier discharge is warranted when these signs appear.

All too often the focus of inpatient care becomes the search for a quick and definitive cure and an exclusive focus on their comorbid conditions. This frequently involves starting new medications or radically changing the outpatient treatment plan before consulting with the outpatient therapist. Staff members sometimes make denigrating comments regarding the outpatient therapist, other staff members, or the treatment plan. A more helpful focus of inpatient treatment is collaborative consultation with the patient and outpatient therapist. It is important for the inpatient team to carefully evaluate recent stressors, maladaptive behaviors, and especially how the patient perceives the outpatient therapist. An unfolding negative enactment or feelings of rejection and abandonment are common triggers for hospitalization. There may also be stressors or behaviors that the patient did not share with the therapist. The inpatient team should also meet with the outpatient therapist, paying careful attention to the therapist's countertransference reactions to the patient and to what actually goes on during sessions. Has the therapist been able to maintain appropriate roles, boundaries, and parameters of treatment? Is there an enactment within the therapy? Where is the treatment getting stuck? Gentle but direct feedback to the outpatient therapist regarding these issues can sometimes be critical to overcoming a therapeutic impasse and facilitating continued recovery after discharge.

2. Severe Dissociation

Most patients with BPD have significant dissociative symptoms and some meet criteria for dissociative identity disorder. There are times when patients will dissociate within a session. This may be manifested by episodes of spacing out or blank stares. Alternatively, the patient's thoughts and associations may become more disorganized than usual or cut off from affect.

Dissociation is a complex phenomenon with multiple determinants. For example, although dissociation is most often associated with early childhood abuse, recent drug or alcohol use may increase tendencies towards dissociation. The same may be true of certain diseases of the central nervous. Once a person has a tendency to dissociate, it may be precipitated by anxiety or severe stress, and so may be seen as a primitive and maladaptive defense against anxiety. Part of the management strategy therefore is to

monitor patients' level of anxiety and attempt to keep it within a manageable limit so that they can continue to be reflective and make use of the treatment. This includes avoiding topics early in treatment that can often trigger overwhelming anxiety, such as childhood trauma, acknowledgment of anger, and devaluation of parental figures.

There are also interpersonal aspects of dissociation. An anxious and dissociating patient tends to create a large countertransference response within the therapist of anxiety, helplessness, and a desire to rescue. Therapists may be tempted to go outside of a therapeutic stance during these times and attempt to direct, re-focus, or reassure the patient. As the therapist steps out of neutrality in these ways, the conflict of *autonomy vs. dependency* is often intensified. The patient feels gratified that the therapist is finally showing that he/she is genuinely concerned in taking definitive actions to soothe and rescue. At the same time that dependency wishes are being activated, the patient may be resentful at the loss of control and vulnerability entailed in dissociation and the therapist taking advantage of that by becoming more directive. The net result can be increased dissociation and regression to a helpless, confused, child-like state.

Bearing these factors in mind, it is most important for therapists with dissociating patients to support the patient's role as an autonomous decision-making adult, rather than a dissociating and dependent child. Therapists should control their urges to rescue and reassure, but should instead encourage exploration of the dissociative phenomena. When did it first start? What were the patient and therapist talking about at the time it developed? Had the patient taken alcohol or drugs (including benzodiazepines) the day of the appointment? Framing to provide an explanation for the experience and to decrease anxiety can also be helpful. As anxiety decreases, dissociation will also decrease. If there is a repetitive pattern of dissociation within sessions, the therapist should consider an unfolding enactment and can ask, "What is it like when you dissociate in sessions? Do you feel more vulnerable with me when that happens? Does it feel like I'm taking your concerns seriously?"

For patients who come to treatment with a pre-established diagnosis of dissociative identity disorder, the disorder should be framed as a manifestation of a poorly integrated self-structure. Very often patients with this disorder refer to themselves by the names of their various alters and speak of the alters as if they are separate persons, e.g. "Sam is angry right now." Therapists applying DDP should discourage this behavior, viewing it as regressive, and address patients by their proper name, regardless of how bizarrely they are behaving. When patients begin to speak about characteristics of their alters as separate people, as in the above example, the therapist can attempt to reframe the problem and define the internal lack of integration, e.g. "But, of course, Sam is simply a part of you."

3. Deterioration in Clinical Condition

Deterioration in clinical condition is often manifested by increased self-destructive behaviors or maladaptive interactions. As with ambivalence about treatment, it can sometimes follow a difficult session. Self-destructive behaviors can provide a primitive and maladaptive way to deal with overwhelming feelings. For example, when a patient acknowledges feeling angry with a parent or a therapist, he/she may become flooded with shame about having such feelings and worry about rejection from the therapist. Cutting becomes a means to relieve tension associated with unprocessed emotions, to atone for the "sin" of anger, thereby alleviating the sense of shame, as well as to maintain the relationship by re-directing aggression towards the self. A gentle exploration regarding the previous session and underlying feelings can be extremely helpful. Using the above example one could ask, "What was the previous session like for you? You had touched upon some difficult topics."

On the other hand, clinical deterioration may have nothing to do with what was discussed in the therapy. Often it will follow a traumatic event or perceived rejection by family members. The patient may be reluctant to share these factors because of shame or anxiety, so the therapist has to be alert to them and ask screening questions, e.g. "Was your boyfriend or anyone else violent towards you this past week?"

Alternatively, even small quantities of alcohol can sometimes trigger worsening depression and irritability and therapists should routinely ask the patient about recent drinking behavior or drug use when

there is other evidence of fluctuating mood. See chapter on *Specific Techniques—Managing Self-Destructive and Maladaptive Behaviors* for a complete discussion of intervention strategies once this problem is identified.

In later stages of therapy, clinical deterioration most commonly represents regression and an unconscious wish to return to the sick role. The therapist needs to gently probe this area since patients are often reluctant to acknowledge to themselves ambivalence towards recovery. Helpful screening questions include, "What has the treatment been like for you?" "What's been the hardest aspect of treatment and recovery?" "Do you sometimes wish that things were back the way they were before you started this process?" See chapter on *Stages of Therapy—Stage III* for a more complete discussion of this area and recommended interventions. In summary, there are many possible causes for clinical deterioration and the therapist must specifically screen for each of these causes to gain a full understanding and apply the appropriate treatment interventions.

4. Boundary Intrusions

Boundary intrusions can take many forms, from difficulty leaving the office at the end of the session, to frequent telephone calls, to seductive or flirtatious behavior, to requests for therapist disclosure. These behaviors are most common in Stage I and open exploration can strengthen the treatment alliance. For example, "I notice that it takes us a long time to finish discussions when the sessions are ending. Do you find it hard to leave here when the time is up?" This inquiry is likely to lead into discussions regarding unmet dependency needs and the conflict between divergent wishes for dependency and autonomy.

Frequent telephone calls, letters, e-mails or other indirect efforts to increase time with the therapist may be dealt with in a similar manner. Exploration of the behavior, however, should be accompanied by a reminder of the agreed parameters of therapy and why they are essential. For example, after exploring a patient's need for more frequent telephone calls, the following framing is helpful:

> *I understand and agree with you that one hour per week and a couple phone calls doesn't cut it. Unfortunately though I have certain limitations in what I'm able to provide without getting burnout. If I go beyond those limits, I'm not going to be able to be of much help to you as a therapist. If you are feeling you need more, we should consider adding some other kind of treatment, such as group therapy.*

Flirtatious behavior, chattiness, seduction, or other attempts to engage the therapist in a type of relationship other than the patient-therapist relationship is one of the more insidious forms of boundary intrusions. This is most likely to occur when patients are in the *helpless victim state* or *demigod perpetrator state.* Therapists often enjoy the interactions and patients usually deny the behavior when directly confronted. A gentle exploration of the process is helpful in most situations. For example, "I notice that the past few sessions you've been bringing up a lot of material for discussion, but you also seem to be having difficulty bringing up more sensitive topics or feelings. Would you agree with that?"

Another difficult area is that of disclosure. Patients often question their therapists' habits, interests, and family life. In part, this reflects natural curiosity and a desire for a closer connection. However, repeated personal questions also are intrusive and threaten patient-therapist boundaries. They force the therapist into enactments of either rejecting the patient by refusing to disclose or by crossing boundaries by full disclosure. It is helpful therefore to gently refuse disclosure, reinforce the importance of boundaries, and explore patients' feelings and fantasies underlying the questions, as well as their reaction to the therapist's refusal to disclose.

5. Vacations or Absences

Therapist vacations and other absences have a large symbolic significance in the treatment of BPD. If the treatment is going well, the patient has formed a strong idealizing transference. The

fantasized wish is that the therapist is an all-loving, all-caring, and all-giving parent. Vacations directly challenge this fantasy. The patient's unconscious reasoning is, "If the therapist truly cared about me, the therapist would never leave me knowing how much I need him/her." Feelings of anger, rejection, betrayal, deprivation, and even shame may follow. The patient may even make a suicide gesture prior to departure to show the therapist how much he/she is needed. Other times, the patient may show little emotion, but develop increased suicide ideation as anger regarding the therapist's actions is redirected towards the self. Hospitalization is sometimes indicated during these times.

Process explorations are always indicated before and after vacations, i.e. "what are your thoughts on the news that I'll be gone for those two weeks?" "What was it like for you while I was gone?" The goal is for patients to become more aware of their feelings about the absence, so they can process them instead of entering into a state of arousal, regression and fragmentation.

For patients who are unable to describe any feelings associated with my pending vacation, but who have strong dependency needs and self-destructive tendencies, it is helpful for the therapist to make a negative prediction. Therapists can state, "Even though you are not aware of any feelings about my going on vacation, I'm going to make a prediction. I think that at some level you have anger about my going away and that you will turn that anger on yourself rather than acknowledge it to me." Paradoxically, this intervention often prevents clinical deterioration for a number of reasons. It offers experiential acceptance of the patient's anger. It conveys the message that the therapist understands how difficult the absence will be. And it gives the patient an incentive to prove the therapist wrong and stay safe.

It is natural also for therapists to have strong feelings about their departing on vacation. There is usually a mixture of relief, excitement, and guilt. Therapist guilt about vacations or other absences can sometimes present a major obstacle to useful process exploration. Therapists want to be able to enjoy vacations without worrying about their patients. They may provide their patients with false reassurances or try to find someone else willing to see them in their absence (as if someone else could be an equal substitute). The last thing they want is to encourage their patients to tell them how difficult it is going to be for them. And yet, paradoxically, this is the key to their patients' safety and toleration of therapist absence. If patients can be helped to be made aware of their feelings and also believe that their therapist understands how difficult it is going to be for them, patients will be much less likely to search for ways to discharge those feelings. Therapist vacations are often actually helpful and strengthening for patients. Patients become stronger when they discover that they are able to survive the therapist's absence, that the therapist does eventually return, and that the therapist still cares about them.

A similar type of exploration and discussion needs to take place if there is a premature termination due to the therapist moving to a different region or finding another job. The key again is for the therapist to be able to tolerate his/her feelings of guilt, empathically listen to the patient's feelings and fears about termination, and refrain from giving false assurances.

Chapter 12. MEDICAL CARE

1. Somatization

Borderline personality traits are common in patients with somatization disorder, factitious disorder, or high utilizers of health care. It is easy for enactments of the core conflicts of BPD to get played out in medical settings. The covert message of the medical setting is, "we only care for you when you are sick." Borderline patients may unconsciously or consciously create symptoms of illness in order to convince health care providers that they are sick enough (i.e. worthwhile enough) to be cared for. The central question regarding justification, "Are my leads legitimate?" gets played out here. Likewise, safety concerns are also being tested. In medical settings, BPD patients can present with multiple physical complaints and excessive demands of physician and nursing time and attention. This neediness can create numerous altercations with overworked office staff.

Typically, an initial encounter with a primary care physician may be characterized by the patient's describing unusual but distressing symptoms. The patient complains that previous physicians did not adequately evaluate the symptoms. The physician empathically senses the very genuine distress of the patient and is moved by his/her child-like attributes. Atypical presentations of various syndromes (e.g. lupus or multiple sclerosis) come to the physician's mind and a comprehensive work-up is initiated. The patient senses the empathic response of the physician and idolizes him or her, while denigrating previous health care providers, consistent with the patient's polarized attribution system. A typical comment made to the physician is, "you're the first doctor who has actually listened to me and taken my problems seriously." The physician feels good about the encounter as he or she identifies with the projected idealization and begins to have fantasies of a heroic rescue via a savvy diagnosis and rapid cure. The physician notes that visits with this particular patient take an inordinately long time, but feels okay about this sacrifice since he/she is going to be the doctor that finally finds out what's wrong with the patient and institutes a cure.

This honeymoon period between the patient and physician inevitably starts to unravel. As laboratory tests come back negative, physician hopes for a heroic cure become dimmed and interventions become more cautious. The patient senses the physician's withdrawal and begins to exaggerate current symptoms or come up with new ones in order to regain the nurturing concern of the physician and reestablish legitimacy. However, the new complaints seem less credible to the physician and he/she begins to feel duped and made a fool of. The physician starts to resent the length of the visits and his/her tone of voice is now somewhat abrupt. The patient senses the physician's withdrawal of concern, feels rejected, and makes more frantic maladaptive efforts to regain the relationship and demonstrate that his/her needs are legitimate. This often includes frequent telephone calls, numerous questions, new distressing symptoms, and even sometimes threats of suicide if nothing more is done to alleviate symptoms. Soon after this, an angry confrontation between patient and physician ensues and/or a referral is made for psychiatric treatment. The patient ends up feeling profoundly rejected, abandoned, depressed, and hopeless, thereby repeating a recurrent pattern of traumatic abandonment. If the patient is in the *angry victim state*, he/she can also become hostile. The cycle begins again as the patient seeks a "more caring and competent" physician.

If the outpatient therapist is not cognizant of these issues, he/she may inadvertently foster the enactment by sympathizing with the patient over the poor quality of medical treatment received. Often the therapist steps out of role to try to become an advocate for better care and encourages patient assertiveness.   However, it is generally more helpful for the therapist to try to establish a close and collaborative relationship with the primary care physician and receive written consent from the patient for frequent and free communication of concerns. Assisting the primary care physician to understand the patient's behaviors can greatly increase empathic bonds between them.

In longitudinal studies, the primary care intervention that has been shown to be most helpful for somatizing patients is for physicians to subtly shift their behaviors. This includes shifting the focus from curing symptoms to coping with illness (to allow discussion of psychosocial determinants), withholding

tests and procedures unless there is objective evidence of illness (thereby avoiding iatrogenic harm), keep visits and phone calls brief (to minimize burn-out), and to make visits frequent and regular, rather than contingent on patient symptoms or distress. Decoupling the amount of attention from the amount of complaints gives patients the message that they do not have to be sick to be cared about.

2. Medical hospitalization

Many of the same concerns and management principles apply when a patient is hospitalized for medical reasons as for management of somatization. Patients with BPD can feel frightened, alone, and confused on a medical ward. On the other hand, nursing care and medical attention can increase the pull towards regression to a child-like state with attention-seeking or demanding and entitled behavior. The covert message of the medical setting remains the same, i.e. "we only care for you when you are sick." Patients with BPD get the message that they must remain sick to stay in the hospital and that greater symptomatic distress leads to greater engagement with nurses and physicians.

Many of the patient's regressed behaviors can be irritating to staff. For instance, patients may misread intentions and become unduly suspicious. On the other hand, because of their high anxiety levels and regressed dependency wishes, they may frequently call on staff and need continual reassurance. As staff members begin to respond with irritation, the patient feels rejected or abandoned and then may regress further. Some patients will start to escalate complaints or behaviors in order to prove to staff the legitimacy of their concerns.

Hospitalization also plays on patient fears regarding loss of autonomy. There is little sense of control when staff comes to take blood samples, activity is restricted to bed, and various procedures are endured, including intrusive interviews and physical examinations. Regressed, hospitalized patients with BPD sometimes try to regain a sense of control by refusing procedures and demanding changes in medical regimens.

There are some helpful strategies to prevent escalation of tensions. These include keeping the hospitalization as brief as possible and providing frequent but regularly scheduled nursing attention, regardless of how many or few complaints the patient has. Decoupling the amount of empathic attention from the amount of complaints undermines medical settings' covert encouragement of the sick role. Physicians and nurses should explain as clearly as possible the goals of hospitalization and expectations for patient and staff behavior. Staff should maintain adequate boundaries and interact in a manner that is neither excessively warm, nor cold and rejecting. Likewise, visits to the patient by the outpatient therapist should be infrequent and brief while the patient is in the hospital. As much as possible, the patient should be involved in treatment decisions to foster a sense of autonomy. Collaboration between the outpatient therapist and the medical team to institute a plan of care can sometimes make all the difference between a regressive or progressive hospitalization.

3. Medical complications

Patients with BPD usually require more medical care than other persons the same age. Some common comorbidities include chronic fatigue syndrome, fibromyalgia, temporo-mandibular joint syndrome, and obesity or obesity-related conditions, i.e. back pain, diabetes, hypertension, osteoarthritis, or urinary incontinence (Frankenburg & Zanarini, 2004). The co-occurrence of obesity, especially increasing weight over time, has been found to be an especially poor prognostic factor for BPD, including symptoms, social and occupational functioning, and healthcare utilization (Frankenburg & Zanarini, 2011).

Those patients having eating disorders, such as bingeing, purging, and/or restricting, have a special set of medical problems. The electrolyte disturbances, nutritional deficiencies, and hormonal changes associated with eating disorders can lead to numerous physical problems, which require careful monitoring. This is best done through close coordination with a primary care physician, even if the therapist is also a physician (see chapter on *Psychiatric Comorbidity*). The therapist should not perform

physical examinations, except to assess vital signs. Any form of physical contact between therapists and patients with BPD in general should be avoided.

Self-destructive behaviors, such as overdosing and cutting, may also require urgent medical attention. Any reported overdose is an indication for emergency medical evaluation since patients sometimes minimize the seriousness of the overdose or underestimate the quantities of pills taken. Deeper cuts also require emergency medical evaluation for cleansing and suturing in order to prevent infection and permanent disfigurement or disability. This can sometimes create a control struggle as patients are frequently reluctant to go to the emergency room to get sutured because they fear getting committed to inpatient care. Even superficial cuts can sometimes become infected and require medical attention if they don't readily heal.

Impulsive behaviors, such as drinking, drug use, or sexual promiscuity, also entail medical risks. Sexually active patients should be asked about contraception (including barrier protection). Periodic screening for sexually transmitted diseases may be necessary.

All of these potential problems point to the need for regular follow-up with a primary care physician. Preferably, this should be someone who is sensitive to psychosocial issues and willing to take on challenging patients. Coordination of care between primary care physician and therapist is essential and written consent should be obtained for free communication. It is also helpful to have "obtaining appropriate medical care" as a component of written treatment commitments (see chapter on *Establishing the Frame*).

Chapter 13. DEVELOPING A DDP PROGRAM

1. Training Considerations

As alluded to briefly in the preface, DDP can be readily integrated into clinical, training, and research programs. The techniques are fairly simple and easy to learn for therapists at all levels of experience. However, it can be difficult for therapists to stay within the treatment frame due to strong countertransference pulls towards enactments.

There are two levels of proficiency that can be achieved: basic and advanced. In order to achieve basic competency, the therapist must demonstrate an ability to move a patient from Stage I to Stage II and successfully apply all the major DDP techniques. Achievement of basic competency suggests that the therapist is able to apply effective DDP treatment provided the therapist receives on-going weekly case supervision. This basic level can be attained within 6 months of initiating training for most therapists. A few therapists will achieve proficiency in a much shorter period of time and a few will never achieve proficiency for a variety of reasons. These include a strong allegiance to other treatment paradigms, an inability to tolerate ambiguity or self-awareness, and/or a reluctance to give up gratifications inherent in idealized therapist roles of sage, prophet, or teacher.

In order to achieve an advanced level of competency, the therapist must demonstrate an ability to move at least two patients through all four stages of recovery while receiving case consultation/supervision from an advanced DDP therapist, staying adherent to the treatment model, and demonstrating a wide range of DDP techniques. Achievement of advanced competency indicates that the therapist is able to independently provide effective DDP, to train other therapists in this modality, and to certify other therapists in either basic or advanced competency. The time commitment for training to this level involves seeing 3-4 patients on a weekly basis over 12-18 months (since 1 or 2 may drop out), along with weekly case supervision. Thus this level can be achieved as part of a two-year psychotherapy training program in graduate school or residency, or as a part-time postgraduate fellowship.

In addition to reading the manual and/or working through the web-based module, training in DDP involves on-going weekly individual and/or group case supervision/consultation with an advanced level therapist. Therapists should bring audio or video recordings of sessions to the supervisor to ensure continued adherence with the treatment approach and to manage countertransference. I recommend that audio or video recording be a precondition for treatment with this patient population, particularly during therapist training so as to optimize patient outcomes. At SUNY Upstate's residency training program, a webcam video recording system feeds directly onto a dedicated shared drive in a PC. This is an inexpensive system that provides relatively high quality video and audio and does not require excessive time or technical expertise for supervisors and trainees.

During clinical supervision sessions, therapists in training take the lead in selecting a particular case or issue to discuss. Generally these involve situations within sessions that provoke strong countertransference reactions, such as frustration, helplessness, or fear. The therapist and supervisor then examine together a segment of video to delineate the dynamics of the interaction and determine whether there is an unfolding enactment that needs to be deconstructed. The supervisor will suggest whether the predominant level of intervention for a particular clinical situation should be on *associations, attributions*, or *alterity* and make specific recommendations for technique.

Once therapists begin to develop familiarity and proficiency with techniques, they often benefit from periodically reviewing the video of a complete session they had with a given patient and independently rate their own treatment adherence. The DDP Adherence Scale can be used for this purpose (see *Appendix*). The supervisor may then independently rate the same session on the scale and compare results with the trainee. This exercise, albeit time-consuming, greatly helps improve therapist awareness of patient-therapist process and deepens proficiency with the treatment model.

Even advanced level therapists benefit from periodic consultation with colleagues in order to maintain an outside perspective and a therapeutic stance. Weekly meetings of group consultation with

other experienced therapists provide a very helpful, enjoyable, and functional model. Although the treatment techniques are fairly simple and straightforward, maintaining adherence in the face of strong countertransference reactions can be a major challenge.

2. Clinical Considerations

In addition to establishing a training structure for DDP, treatment effectiveness can be optimized through developing a system of care that includes an intake protocol, a referral network, and outcome measures. The clinical program at Upstate Medical University sends out an intake packet to prospective patients that includes standardized self-rated screening and outcome measures. After an initial intake session, the prospective patient then meets with a clinical coordinator (not the therapist) to receive structured diagnostic interviews, IQ testing, and other measures. All testing is then incorporated into a summary sheet and given to therapist to review with the patient. Self-rated outcome scales are re-administered every 3 months and the results entered into a clinical spreadsheet.

The use of standardized self-rated outcome measures entails minimal time and effort and serves a number of purposes. Firstly, it provides accountability for the treatment program and for the clinicians providing care. Standardized outcomes allow meaningful quality assurance and monitoring of effectiveness. This information can also be used to negotiate with insurance companies and government bodies for appropriate coverage or to meet regulatory requirements. At an individual level, the use of standardized outcomes can provide useful feedback to clinicians and patients regarding progress towards treatment goals. A self-report measure is the Borderline Evaluation of Severity over Time (BEST; Blum et al. 2002). For screening purposes, we use a cut-off score of ≥ 35 (see Establishing the Frame). Scores in the 30s represent mild to moderate pathology and scores in the 40s represent more severe pathology.

Although employment of self-rated measures and a clinical database are useful for clinical and training purposes and assessing quality assurance, they are inadequate for developing a research program. It is beyond the scope of this manual to describe all the components of a research program in DDP. But, in brief, it would require institutional approval, written informed consent, a thoughtful research design, and a far more comprehensive battery of measures, including a combination of both self-rated and observer-rated intake, outcome, and process measures. Because of the time-intensive and meticulous nature of outcome research, it generally requires external funding.

A final consideration in establishing a clinical program in DDP is a referral network. Patients with BPD generally require multimodal care, often including general medical care, group therapy, medication management, case management, drug and alcohol rehabilitation, and/or inpatient psychiatric care. Types of useful adjunctive treatment are discussed in the chapter on *Establishing the Frame*. The most important guideline is to keep open lines of communication and to have a close, collaborative relationship with other clinicians. This includes providing brief education to other providers about the nature of the patient's condition and treatment structure and goals. It also necessitates patient release of information to facilitate free flow of information between providers.

As discussed above there are many essential ingredients to an effective training and/or clinical program in DDP and developing a program entails considerable effort. However, for those therapists committed to this population, there are few things in life as gratifying as helping patients on the brink of despair to discover themselves and transform their lives, and having the opportunity to witness the personal and professional growth of those training in this treatment model.

APPENDIX A -- DDP Adherence Scale

Therapist:_____   Date: _____

Rater: _____   Patient: _____

Instructions to rater: Count the number of times that the therapist performs each of these interventions in a 30-minute interval. Intervals begin from 10 minutes into the session to 40 minutes into the session.

Rating

Associations

1. Asks about the <u>wish/RS</u> that precedes or follows an RO _____

2. Asks about the <u>RO</u> that precedes or follows an RS _____

3. Asks about the RS or RO that precedes or follows maladaptive behaviors _____

4. Clarifies the affect underlying an RS in a narrative _____

5. Clarifies the affects in the patient's art, poetry, or dreams _____

Subscale Score: _____

Attributions

6. Asks about alternative or opposing attributions of emotion, value, agency, or motivation _____

7. Makes integrative comments or questions regarding patient attributions _____

Subscale Score: _____

Alterity: Ideal Other

8. Repeats back the patient's affective RS-RO narrative connections _____

9. Repeats back the patient's assertions of positive self-attributions _____

10. Recognizes and kindly questions the patient's emotions in the moment _____

11. Points out the treatment tasks, central thematic questions, core conflicts, or safety concerns _____

Subscale Score: _____

*Alterity***:** *Real Other*

12. Inquires whether patient participated in recent self-harming behaviors or substance use   _____

13. Questions possible negative or mixed feelings towards the therapist, the treatment,
     or recovery in response to indicative behaviors or comments   _____

14. Receptive comments or questions in response to criticism, disagreement, praise, or desire   _____

15. In response to patient's passivity or hopelessness, therapist points out ways that patient
     could decide to be more fully participating in treatment or recovery   _____

16. Points out intrusive, controlling, or intimidating behavior/comments towards therapist   _____

Subscale Score: _____

Negative Enactment

17. Directs discussion towards experiences in childhood   _____

18. Directs discussion towards physical symptoms or medications   _____

19. Confidently completes patient narratives for them   _____

20. Asserts that a given feeling or action (by self or others) is justified/unjustified   _____

21. Assertively attributes a certain motivation, value or emotion to the patient or others   _____

22. Persuades, encourages, reassures, or advises in response to passivity or hopelessness   _____

23. Provides rationale, denial, apology, or interpretation in response to criticism or disagreement   _____

24. Answers patient's questions about therapist lifestyle or feelings   _____

25. Acquiesces to patient's requests for changing the usual treatment parameters   _____

Subscale Score: _____

Adherent: (A+A+IO+AR)   _____

Total: (A+A+IO+AR+E)   _____

% ADHERENCE: (Adherent/Total X 100)   _____ %

Instructions for Scoring the DDP Adherence Scale

Sessions are scored from minute 10 to minute 40 of the therapy session for a total of 30 minutes. To score each item, the rater simply places a mark next to an item every time a given intervention represented by that item occurs within those 30 minutes. The beginning and end of sessions are not scored since these times may be appropriately used for supportive interventions, such as reviewing symptoms and medications, assisting with disability forms, or rescheduling appointments.

Sessions may be scored from session transcripts, audiotapes, or videotapes. However, the latter is preferred so that the rater can determine whether the therapist is attending to signs of emotions, such as tears or agitation.

Raters should be somewhat familiar with treatment principles and have read the section on "Specific Techniques" in this book. They should have had some clinical experience in psychotherapy, but do not have to been supervised in DDP. Training of novice raters should involve repeated attempts to rate practice videos until a consistently high inter-rater reliability is achieved with an expert rater for at least 5 different patients.

Therapist interventions fall into one of three categories, i.e. adherent, non-adherent (enactments that have the potential to worsen pathology), and neither adherent nor non-adherent. The latter category most commonly includes empathic comments and efforts to clarify patients' meaning or attributions. Such interventions are often useful and necessary, but are not one of the core techniques of DDP and are not rated on the scale.

The first category of adherent interventions is *Associations*. This category includes interventions by the therapist that attempt to develop a narrative sequence of a specific interpersonal interaction and related affects (items 1-3), e.g. "how did you respond after she said that?" or to get patients in touch with their affective experiences (items 4), e.g. "how did that make you feel?" This category can include narratives within dreams, e.g. "what were you feeling when the stranger walked closer"(item 5)? It also includes narrative sequences involving maladaptive or self-destructive behaviors, e.g. "what was going through your mind just before you cut?" "How did that first drink make you feel" (item 3)?

This category does not include attempts by the therapist to clarify how the patient makes sense of an interaction, including possible motivations. For example, the questions "why do you think he said that?" or "why did you do that?" would not be DDP interventions. For the most part, therapist questions beginning with the word, "why", are not consistent with DDP principles. In addition, this category does not include either hypothetical narratives, e.g. "What would you have done if she had hit you?" or narratives regarding patient-therapist interactions, e.g. "How did you feel when I said that?" This category also does not include therapist clarification of feelings regarding general patterns of behavior. For example, the question, "How does it make you feel when he does that?" would not be scored.

The second category of adherent interventions is *Attributions*. This includes efforts by the therapist to open up new meaning by asking about alternative or opposing attributions or affects (item 6), e.g. "Is there a sense of relief in your loss in addition to your sadness?" or "I wonder if you're actually more angry at yourself than the other person?" If the therapist is assertively suggesting a new meaning, e.g. "although you're blaming the other person, you're actually more angry at yourself," it would be rated as an enactment (item 21).

The *Attributions* category also includes interventions to integrate opposing attributions (item 7), e.g. "I notice just now that you went from totally blaming yourself for the accident to totally blaming the other driver." Assertive integrative comments are not marked as enactments.

The third category of adherent interventions is fostering the *Ideal Other*. These interventions help to decrease anxiety and increase reflective functioning by facilitating an idealized, soothing transference with the therapist. These include reifying narrative connections (item 8), mirroring grandiosity (item 9), empathic attunement to patient affect in the here and now (item 9), and educative comments called *framing* responses (item 10). Note that framing is limited to the listed types to be

marked as adherent. These include pointing out the goals and tasks of DDP; the central thematic questions, e.g. "do I have a right to be angry?"; the core conflicts of *victim vs. perpetrator* or *dependency vs. autonomy*; or pointing out the three safety concerns of the patient-therapist relationship.

The final category of adherent interventions brings in elements of the *Real*. Most of these categories involve bringing the discussion to the patient-therapist relationship, but may also involve checking avoidance about behaviors. For example, checking in with the patient about recent maladaptive or self-destructive behaviors (item 12), asking whether the patient has mixed feelings about the therapist or the treatment (item 13), or providing experiential acceptance or challenge when appropriate (items 14-16).

The *Negative Enactment* items are clearly non-adherent and count against the overall adherence score. If the therapist initiates a discussion about childhood experiences (item 17), physical symptoms or medications (item 18), then these are marked as enactments. However, if the patient initiates these topics and the therapist continues the discussion by asking further questions, then these items should not be marked.

For item 19, the therapist completes the narrative sequence or states how the patient presumably was feeling in response to others' actions, e.g. "That must have made you feel angry." This example could alternatively be marked on item 21.

For item 20, the therapist makes a judgment regarding blame, responsibility, or agency for an interpersonal episode or a maladaptive behavior, e.g. "He had no right to say that to you" or "Your parents were just trying to help" or "You should have found a different way to cope with that situation."

Item 21 represents the largest category of enactment for most therapists we have rated. It involves taking an extra step beyond clarifying or rewording what the patient has said to the making of new meaning, i.e. putting words in the patient's mouth, making authoritative interpretations, or assertively assigning a meaning or experience. For example, after a patient describes yelling at somebody, the therapist may be tempted to state, "Sounds like you were feeling angry." This kind of enactment can also include asserting a given motivation, e.g. "You wish your mother loved you more", or of value, e.g. "Seems like you don't think much of him." If the therapist had posed these examples as questions, they would not be marked as enactments. In general, interventions that begin with the words, "sounds like", "you must have", or "seems like" are likely to be enactments. Exceptions to this general rule are if the therapist is essentially restating what the patient just said, is making an integrative comment, is providing a framing intervention, or is attempting to be receptive to criticism, e.g. "You must feel disappointed in having a therapist who doesn't fully understand you." The latter comment would best fit under item 14.

Directive or supportive interventions can be enactments of a parental therapist with a childlike and helpless patient, and certain types of these interventions are prohibited in DDP (item 22). Examples include, "Perhaps it would be better for you to cool down before confronting your wife." Or, "Don't worry, things will get better if you just hang in there."

Item 23 is marked when therapists make defensive comments that absolve them of responsibility in response to patient criticism or disagreement. This can include a rational explanation in response to seemingly unjust attacks by the patient. For example, if the patient states, "You never listen to me," item 23 is marked if the therapist responds; "I can understand how it seems that way when you're upset."

Items 24 and 25 represent difficulties with patient-therapist boundaries. For both items, the therapist displays an inability to set limits on the patient's controlling or intrusive behavior.

In order to calculate overall therapist adherence, each of the marked responses on items 1-16 are summed and the total is put in the space labeled *Adherent*. Then this number is added to the sum of the marks on items 17-25 and put in the space labeled *Total*. To be valid for scoring, the interview should have at least 10 interventions in *Total*. To obtain the percentage of adherent interventions, the number of *Adherent* interventions is divided by the *Total* number of interventions and multiplied by 100. This number is placed in the space labeled % ADHERENCE, and is used in estimating therapist adherence to DDP methods and technique.

APPENDIX B – Upstate Behavior Inventory-9   v. 3.4.20 © *Robert Gregory*

In the **PAST 30 DAYS**: *(for each item, please **fill in the number of days**)*

How many days did you spend in the emergency room or CPEP?   ____

How many days did you spend on a psychiatric hospital ward?   ____

How many days were you paid for working (employment) or were attending school?   ____

How many days did you go on eating binges during which
you ate so much that you felt uncomfortably full?   ____

How many days did you force yourself to vomit, exercise excessively,
use laxatives, or go on strict diets?   ____

How many days did you try to harm yourself by cutting, puncturing,
burning, overdose, or smothering?   ____

How many days did you physically harm or threaten to harm another person?   ____

How many days did you have 5 or more drinks containing alcohol (wine, beer, liquor, etc.)?   ____
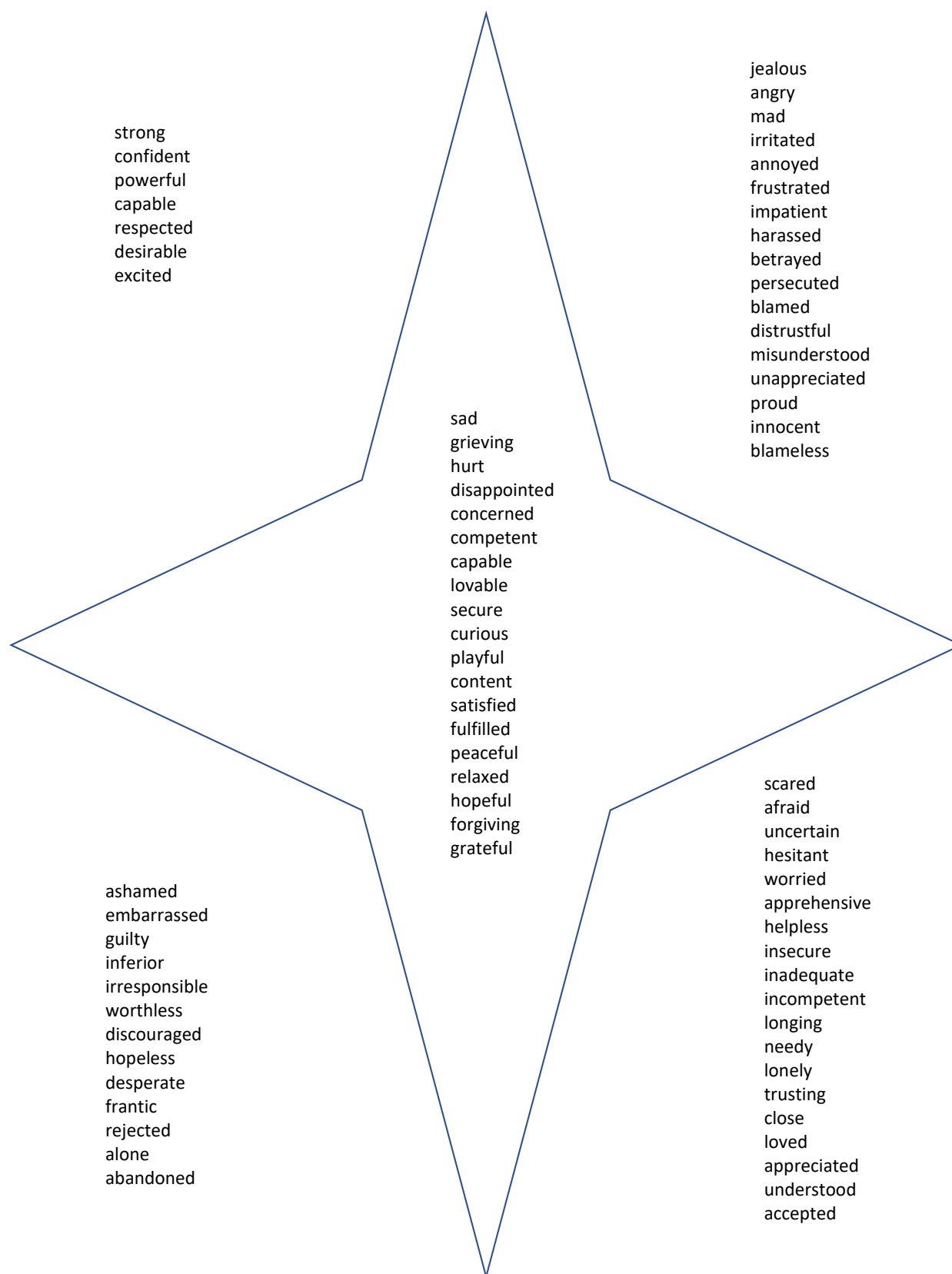
How many days did you use an illegal drug or use a prescription medication for
nonmedical reasons? (Please include marijuana and prescribed THC)   ____

APPENDIX C – Daily Connection Sheet   v. 3.1.14 © *Robert Gregory*

Interaction: For each day of the week, briefly describe a <u>specific interaction</u> you had with another person that day. Choose the single interaction that caused you to have the strongest reaction, either positive or negative, regardless of the time of day. As time permits, elaborate on this interaction in a journal.

Specific emotions: Rate each of the emotions that you had <u>during that interaction</u> from 0 (emotion did not occur) to 4 (very strong emotional reaction). Also, list any other emotions (see back of sheet).

Day	Interaction	Specific emotions				
		Shame 0-4	Relief 0-4	Fear 0-4	Anger 0-4	Other (list)
Mon						
Tue						
Wed						
Thu						
Fri						
Sat						
Sun						

strong
confident
powerful
capable
respected
desirable
excited

jealous
angry
mad
irritated
annoyed
frustrated
impatient
harassed
betrayed
persecuted
blamed
distrustful
misunderstood
unappreciated
proud
innocent
blameless

sad
grieving
hurt
disappointed
concerned
competent
capable
lovable
secure
curious
playful
content
satisfied
fulfilled
peaceful
relaxed
hopeful
forgiving
grateful

ashamed
embarrassed
guilty
inferior
irresponsible
worthless
discouraged
hopeless
desperate
frantic
rejected
alone
abandoned

scared
afraid
uncertain
hesitant
worried
apprehensive
helpless
insecure
inadequate
incompetent
longing
needy
lonely
trusting
close
loved
appreciated
understood
accepted

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